

# **Nurse Role Exploration Project: *The Affordable Care Act and New Nursing Roles***

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*There are over 400,000 Registered Nurses in California. As the largest health care provider group in the state, they represent the greatest opportunity to meet evolving health care needs.*

### **Executive Summary**

In January 2014, more than 5.5 million additional Californians will become eligible for health insurance coverage through the Patient Protection and Affordable Care Act (ACA), but too few primary care partners currently exist to deliver services for them. In addition, California's healthcare system is challenged with a population that is extremely diverse, aging, and mobile. As the largest provider group in California, nurses represent one of the greatest opportunities to rapidly expand capacity within the healthcare delivery system. However, to be fully effective in this context, nurses will need to assume new roles.

The objective of the Nurse Role Exploration Project was to address gaps in care delivery by identifying corresponding new roles for Registered Nurses (RNs) in California's health care system.

In the first half of 2013, a series of facilitated meetings throughout California involved more than 300 people representing academia, practice, government, payers and consumers. After an initial meeting, six consecutive meetings built cumulatively on previous discussions, resulting in an initial consensus regarding top roles for California RNs. Following the series of meetings, an online survey with participants verified outcomes of the consensus process and gathered input on critical next steps to actualize the new roles.

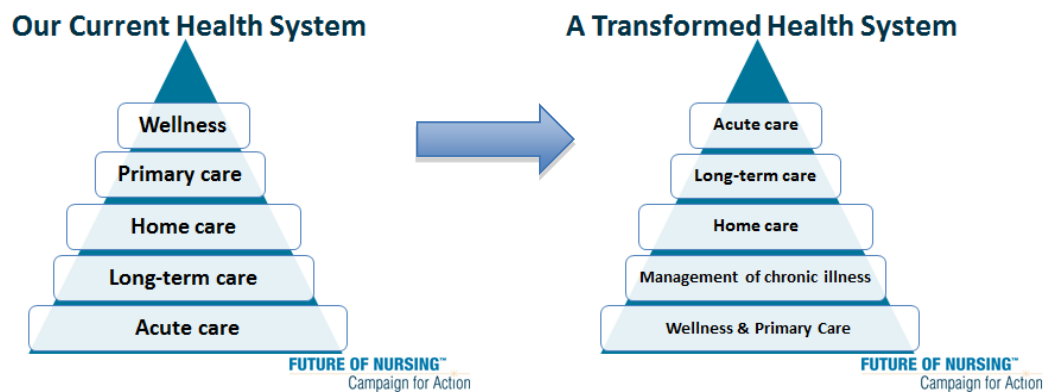
Five new roles were identified as most important for RNs to take on to meet the rapidly expanding demand for health care services in California:

- Care coordinator
- Faculty team leader
- Informatics specialist
- Nurse/family cooperative facilitator
- Primary care partner

This document explores these roles in more depth and offers a call to action to move them toward implementation.

## Background

Beginning in January 2014, 5.5 million more Californians will become eligible for health care insurance, and the state's health care system will need to undergo massive change to meet the extensive demand they represent. In addition, due to the growing diversity among Californians of all ages and the rapidly expanding population of older adults, demand has already substantially increased for both health care and its improved delivery. To date, much of the discussion related to the Affordable Care Act (ACA) has centered on financing and how reimbursement mechanisms will operate going forward. However, reimbursement for services is only one change of many the ACA is intended to create that span the entire culture of health care, as illustrated below:



As the illustration depicts, the current health care system depends heavily on hospitals and other costly settings to provide care. In the transformed health care system envisioned under the ACA, building a more robust primary care model will minimize the need for expensive tertiary care.

The emphasis on wellness and primary care in the transformed system under the ACA implies a definition of health that transcends the absence of disease to embrace social determinants of health, including physical environment, social and economic factors, clinical care, and health behaviors, and considers individuals within the context of family and community. Nursing has a long history

of attending to social determinants of health and wellness in individuals and populations, in addition to providing illness care (Nightingale, 1859; Rogers, 1964).

The Nurse Role Exploration Project (Project) described here followed the release of the Institute of Medicine (IOM, 2011) landmark report, *The Future of Nursing: Leading Change, Advancing Health*. Developed shortly after the passage of the ACA, the IOM report includes specific recommendations “for transforming the nursing profession to improve the quality of health care and the way it is delivered.” These pertain to all facets of nursing education and practice, but a key area of focus is reconceptualized roles for RNs. Thus, the Project occurred at a critical juncture in the profession of nursing. It is aligned with the need to identify new roles for RNs to meet changing health care needs in California—and with a broader movement throughout the U.S. health care delivery system to reconsider the roles of RNs in successfully transforming health care delivery and meeting the growing need for services.

There are more than 400,000 RNs in California, constituting the largest health care provider group. RNs are critical to effective care delivery and represent one of the greatest resources for meeting expanded demands and filling new roles in health care. Despite general agreement that RNs can and will need to play critical new roles in providing care, there is a lack of clarity around precisely what these roles are, how they will be developed, and how they will be implemented. As 2014 nears, it is increasingly important to rapidly identify new nursing roles to allow adequate time to prepare nurses to carry them out effectively. Thoughtful design is equally pivotal.

The Project goals were to: 1) articulate a concise set of new roles for RNs to contribute to the success of expanding care delivery models at meeting demand for services associated with the ACA; and 2) build consensus around the resulting roles.

## **Exploring Nursing Roles**

Project goals were accomplished through a series of regional meetings held throughout California over a three-month period, involving representatives from academia, practice, government, payors and consumers. The consensus achieved during the meetings was verified using an online survey of participants.

The discussion/consensus-building process began in March 2013. The California Institute for Nursing & Health Care (CINHC) extended invitations to an initial focus group meeting to thought leaders from across California. Participants included representatives from government, hospitals, health systems, community clinics, educational institutions, nursing constituent groups, health care associations, and other statewide stakeholder organizations. Participants received background documents related to the ACA, (listed in the Appendix), which they were asked to review in advance of the meeting. At the meeting, a facilitated discussion included the consideration of background documents, exploration of participant assumptions related to the ACA, and consensus-building around key roles that RNs could assume to fill gaps in care delivery. Five roles were identified, which served as the basis for discussion during additional regional meetings.

More than 300 individuals from 27 California counties participated in six regional meetings. They included nurse leaders (from academia, service, and public/community health settings), other health professionals, and representatives of hospitals, government, insurers, as well as consumers, and students. Similar to the initial focus group, each meeting included facilitated discussions with participants who had received the same background information as the initial group, and who engaged in discussions about the most important roles for RNs in relationship to the ACA. The series of meetings resulted in an organic process through which the discussions during each meeting built upon those of the previous ones. Participants were given the opportunity to debate the

recommendations from the previous groups' discussions. They were asked to consider which roles to keep, what they might add, and what should be removed. Participants were divided into breakout groups to process their decisions around the roles and then report out to the entire group. During final discussion among the entire group at the end of each regional meeting, a consensus was reached on the top roles, and the input from that group was captured to bring to the next discussion. Consequently, the draft RN roles evolved from one regional meeting to the next.

### Participants' assumptions about ACA-related changes

Each meeting began with participants identifying assumptions about the ACA and likely associated changes in health care and delivery. Their assumptions centered on factors related to both providers and recipients of care, and, with the ACA as yet largely unimplemented, it is unknown to what extent their assumptions reflect the reality of transformed care. The number of differing assumptions increased with each of the regional meetings as more participant perspectives were incorporated.

The predominant assumptions of participants underlying the discussions around new roles for RNs with the advent of the ACA were the following:

- Changes in regulation and law: There may need to be changes in regulations and laws associated with care delivery.
- Continuum of care: Health care systems representing the continuum of care will become more prevalent versus stand-alone providers.
- Cultural implications: Culture, world view, and multiple other factors impact how health/healthcare is perceived, received, and delivered.
- Episodic to system: Expertise/perspective must move from episodic to system-oriented care that reflects the entire continuum.
- Incentivized changes: Health care reform will force/incentivize changes in care delivery and payment for care.
- Increase in demand: Chronic disease, aging, and the ACA will increase demand for healthcare services



- Interprofessional: Care will be interprofessional and team-based, requiring the resolution of professional boundary issues.
- Decreased use of inpatient care: There will be growing pressure to keep people out of hospitals in order to decrease use of high cost care.
- Metrics: Metrics to measure care under the new models of delivery need to be identified, agreed upon and implemented.
- Patients, families, and communities: Patients, families, and communities will be active partners in care.

These assumptions guided the discussions about new roles for RNs through the course of the Project and were refined during each consecutive regional meeting.

### **Consensus about Roles**

At the conclusion of the regional meetings, five key roles emerged that participants agreed were both relevant and necessary as the ACA is implemented in California. These new roles for RNs are:

- Care coordinator – including population health management and tiered coordination
- Faculty team leader – moving interprofessional nursing education to community settings
- Informatics specialist – roles in design, data interpretation, and tele-health applications
- Nurse/family cooperative facilitator – bringing virtual and in-person health care to people where they live and work
- Primary care partners – providers in community health settings

#### *Care Coordinator*

In every health care environment, there is a growing need for care coordination. The role of care coordinator may take many forms. It may involve providing coordination directly in complex or rapidly changing situations, supervising other team members when care is relatively predictable (tiered coordination), or

advising entire communities (populations) on the best choices for the highest levels of wellness. In the latter, RNs will be involved in population health management, using population-based data and evidence-based practices to bring about large scale improvements in health.

RNs are educated in working across the continuum of care, regardless of setting. They generally have experience working in teams and have learned how to build trust with team colleagues and with people receiving care to provide them with the best outcome. Regardless of whether care coordination is applied to an individual, family, or community, the RN's ability to create a relationship in which people are enabled to hear and respond to the care advice being offered is key to the success of this role. Along with evidence-based interventions, trust is fundamental to care coordination. The role of care coordinator is one that holds enormous potential for improving levels of health and wellness and ultimately reducing the cost of care. It is anticipated there will be exponential growth in this nursing role in settings across the healthcare continuum.

#### *Faculty Team Leader*

Changing how RNs are educated is a daunting task. In *Educating Nurses: A Call for Radical Transformation*, Benner et al. (2009) addressed the need for synergy between classroom content and clinical practice, as well as the importance of interdisciplinary education. This is a natural lead role for nursing faculty; in practice, nurses often assume responsibility for coordinating multidisciplinary care, so it would follow that nursing faculty would take the lead in creating interdisciplinary teaching teams. The teams would role model both interdisciplinary approaches to care and the same collaborative behaviors that would ultimately improve care outcomes.

Faculty team leaders must also address preparing RNs for roles that are increasingly community-based. This will be challenging, given the current learning focus on acute care and licensure exam leanings towards practice in

hospital settings. However, many of the new roles for RNs will be community-based; therefore, so must clinical practice/experiences be. New learning experiences will provide a rich background from which RNs can step into new roles with confidence and with the ability to partner successfully with their colleagues and constituents in community settings. Health care reform is changing not only nursing practice, but also creating a ripple effect for academia that includes the challenge of finding innovative ways of preparing RNs for the new roles.

### *Informatics Specialist*

Informatics is an exponentially expanding field in health care. All too often, RNs adapt practice to accommodate technology, rather than the reverse. There is a need for a shift toward RNs playing critical roles in the development of software and its application. The roles envisioned included informatics design, application, and interpretation across settings. Many opportunities will be in community settings, as RNs use technology to provide one of the most critical components of care – touch. Although it would be a “virtual touch,” when combined with an occasional physical presence, it could be very powerful in supporting successful independent living. In addition, roles for RNs in design and data interpretation are limitless. The ability of RNs to embrace an understanding of the human condition within the framework of the social determinants of health is unique and affords them the ability to understand the context in which health exists for individuals, families and communities. This understanding needs to be captured in electronic form to best support optimal wellness at all three levels.

### *Nurse/Family Cooperative Facilitator*

Participants recognized this role as historically identified as the “district nurse” or “visiting nurse” model. The core of this role is RNs connecting with people where they live and work to understand and adjust elements that will result in healthier, more successful outcomes. Rather than a new role, this is the re-emergence of a role that has origins in the work of Lillian Wald at the turn of the twentieth century

(Buhler-Wilkerson, 1993). Wald understood the social contract of RNs with the communities they serve and worked to improve the living and working conditions of the people she served. She clearly understood the relationship between the environment in which people lived and worked and the ability to be “healthy.” As social determinants of health are studied in more detail, it is clear RNs could be positioned for early intervention and, in many instances, prevent the development of more serious problems. In this role, RNs address both health issues and broader issues that become determinants of health, such as poverty, violence, and substance abuse. This expanding role holds the potential to improve health and positively impact communities.

#### *Primary Care Partner*

Advanced practice nurses have been instrumental in providing care in community settings for many years; the new role identified in this Project is for RNs without advanced certification. Throughout the course of the meetings, participants expressed a strong belief that RNs could add significant value in community settings both qualitatively and by supporting increased capacity in the clinic itself. Participants described added value as ranging from intake screening to providing education, coaching, and support for people with complex illnesses. Participants described a principal value of RNs in primary care as the ability to provide individuals, families, and communities with preventative information and support to help them move to or maintain greater wellness. They also identified supporting individuals in taking charge of their own health as a powerful aspect of a primary care role. In addition, they perceived RNs as well positioned to monitor and manage stable chronic conditions (via protocols) with resulting benefits to both the individual and the clinic provider. A significant focus of the discussion regarding roles for RNs as primary care partner centered on the concept of school-based community clinics. This model would take advantage of the existing synergy between schools and the neighborhoods surrounding them and existing relationships between school nurses and primary care partners in the clinics. School-based clinics would care for children enrolled in the school and family

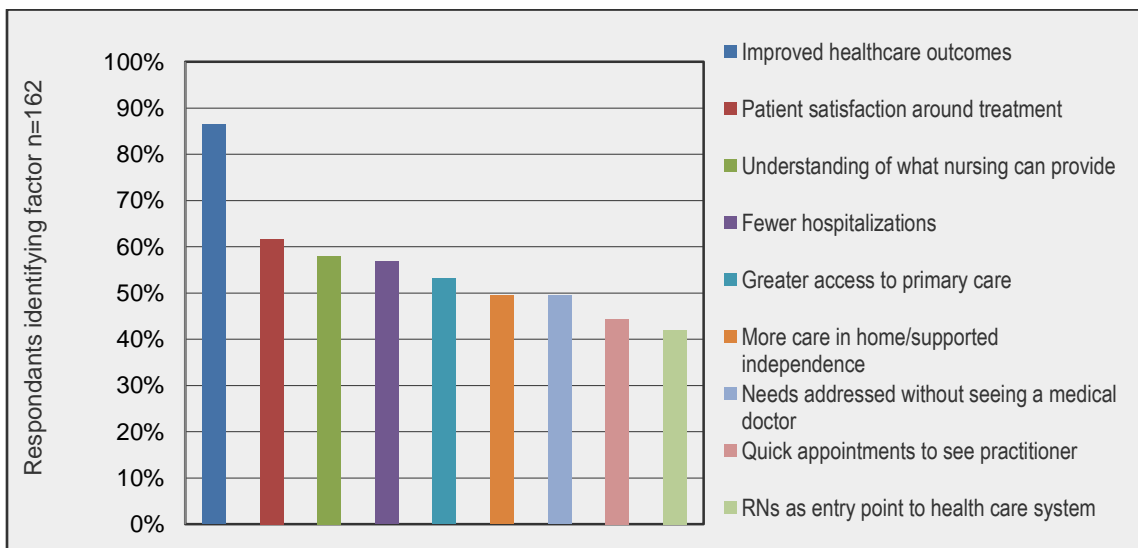
members living in the surrounding community. Participants also suggested the potential for outreach from the clinic into the community using nurse/family cooperative facilitation discussed earlier.

Participants at each regional meeting viewed these roles as critical to meeting the needs of the population due to changes that will be a part of the ACA. Participants also indicated that RNs are uniquely qualified to assume these roles in the changing health care landscape in California.

### Online Survey

Participant perceptions were validated by responses to an online survey that identified perceived consumer expectations of nurses and areas nurses influence relative to providing care and improving health. (see Figure 1, below) 162 individuals responded to the survey. Respondents indicated an understanding as to where and how RNs can lead the initiative to meet the health needs of California's population.

**Figure 1.** Perceived Consumer Expectations of RNs



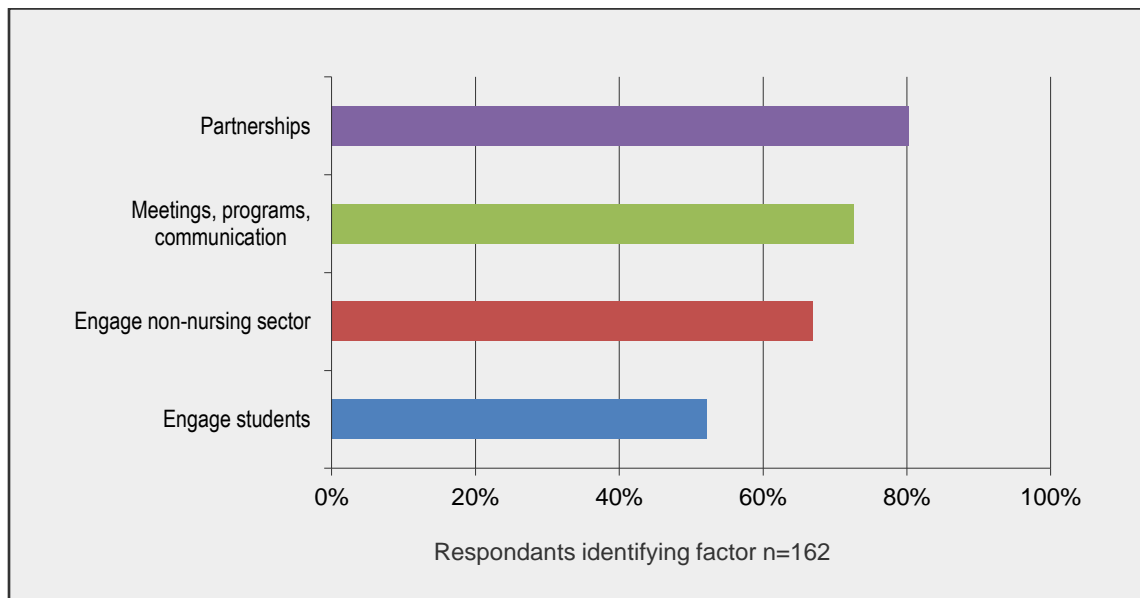
## Recommendations

As group participants explored nursing roles and opportunities for RNs to contribute to improved health of communities, they also discussed the rationale for their decisions and the improved ways that underserved individuals and communities can be supported. They identified the gaps in care delivery that could be eliminated through non-traditional and expanded roles for RNs.

Participants also agreed that nurses would need to take the lead to further describe, define, and evaluate these roles, indicating key next steps, including:

- Execution of an extensive literature review to gather supporting information surrounding these new roles
- Engagement of key stakeholders, in specific ways, to move implementation efforts forward (see Figure 2, below)

**Figure 2.** Stakeholder Engagement



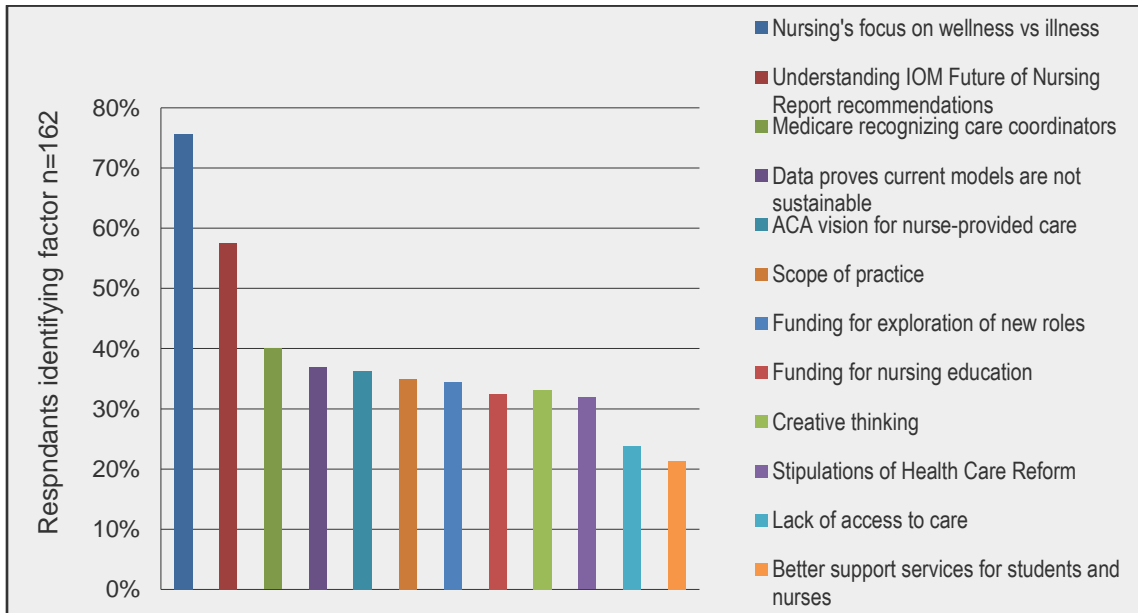
- Convene advisory groups to guide next steps
- Seek funding for pilot projects to implement new roles and measure impact

With over 400,000 RNs in California, there is a decisive opportunity for nurses to step up and lead efforts necessary to improve the health of all Californians. Participants across the state identified the need to speak with a unified strong voice to promote roles for RNs that focus on health and wellness. Participants indicated that motivating the profession to move outside the parameters of traditional nursing will be a challenge, but that there is currently immense opportunity to do so. The ACA, the *IOM Future of Nursing Report*, and the growing need for health care services in California have provided a sense of urgency that participants indicated nursing has never seen. Achieving success will require a collaborative and cooperative approach among providers and broad communication beyond nursing regarding new roles. This will include engaging partners outside the community of health care providers, as well. Participants highlighted the need to approach the development of new nursing roles from an interdisciplinary perspective and involve other stakeholders, such as local Chambers of Commerce, businesses, consumer groups, insurers, policy makers, and professional associations to solidify the roles RNs can play to improve the health of communities across the state.

### **Opportunities and Challenges**

Opportunities and challenges associated with new or expanded RN roles and the implementation of the ACA in California were identified. In addition to reaching agreement on the new roles, regional meeting participants also agreed on a number of opportunities to work more efficiently and collaboratively to ensure better access to care for all Californians. Participants also unanimously agreed that RNs' influence and participation would produce better health outcomes and provide increased coordination across the continuum of care. At each regional meeting, participants were asked to identify major factors that indicate opportunities and provide evidence supporting the need for development and implementation of new roles. A summary of these opportunities, based on discussions and survey data, are listed below (see Figure 3, below).

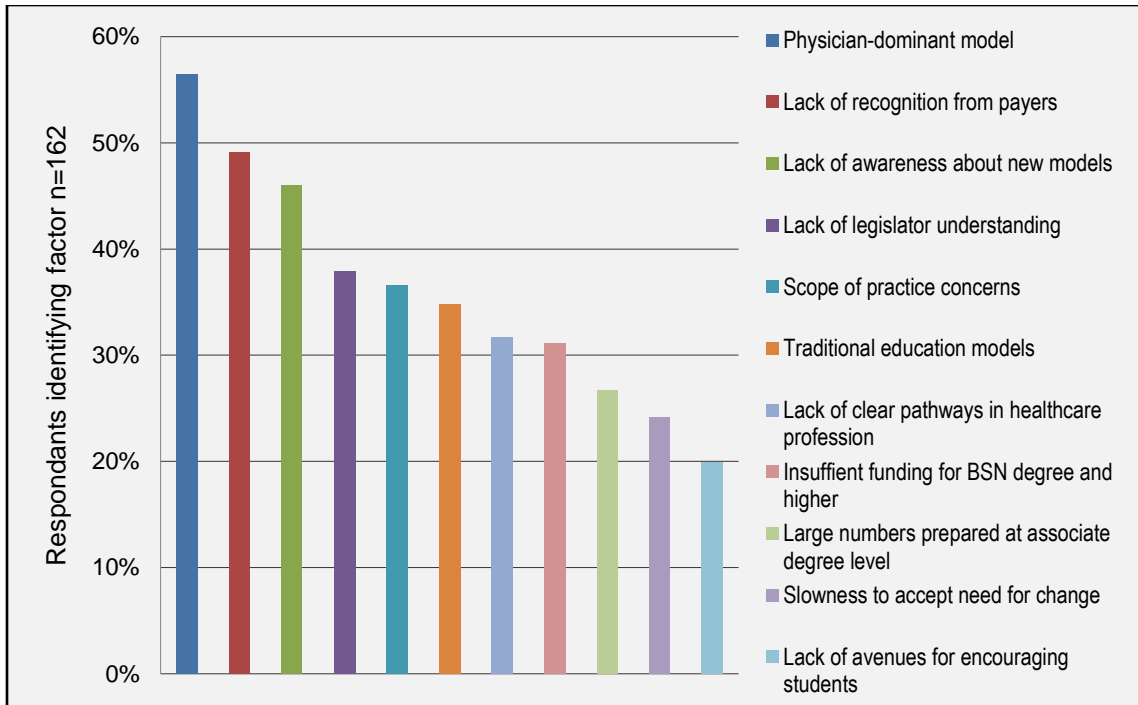
**Figure 3. Factors Supporting the New Roles**



Regional group participants also identified a number of barriers and challenges to creating the new roles and preparing RNs to take them on. The results (see Figure 4, below) were substantiated by the meeting discussions and the survey data.

**Figure 4. Challenges to Implementing New Roles**





Participants agreed that key challenges might also contain opportunities. For example, modifications to nursing school curricula came up repeatedly as a challenge to implementing new roles. Alterations in nursing education are critical to realizing the new roles and developing RNs that are prepared to deliver care outside the acute care setting. Related discussions focused on looking for opportunities, given this challenge. In particular, participants discussed the models of transition-to-practice programs, residency programs, or transition-in-practice placements to give new graduates or practicing RNs the ability to take on one or more new roles. Transition programs in community-based settings could provide the necessary experiences for new graduates and practicing RNs to acquire skills needed for new roles and ultimately improve the health of communities.

### Call to Action

Group discussions indicated a great deal of agreement on many of the opportunities and challenges associated with each role and the need for key

stakeholders to provide leadership to overcome barriers. For example, nursing education will be challenged to consider innovative ways to address curriculum changes and identify alternative sites for clinical rotations to meet evolving workforce needs. In addition, practice sites will need to respond to the changing needs of both nursing students and practicing nurses as they prepare to deploy RNs with new skills to meet the needs of individuals, families, and communities under new incentives and help shape the future of health care delivery in California.

Full implementation of the five roles identified in this project will require additional funding and support; however, evidence suggests that these roles are worthy of exploration and development, and that they represent potential solutions to the growing need for increased capacity, high quality, and cost-effective health care. Convening advisory groups and developing action plans and strategies for each of the five roles will be critical for success and implementation. Some initial considerations follow:

- Care coordinator – An earlier pilot study at CINHC of a transition-in-practice program to prepare practicing RNs to serve as Care Coordinators proved highly successful and will serve as a model. This program conducted with an academic partner in Southern California provided RNs with the skill sets necessary to coordinate care for individuals, families and entire communities. Future sites and funding will be identified for replication.
- Faculty team leader – The concept of transitioning student nurse clinical hours from acute care settings to community settings requires further exploration. A gap analysis will help define existing Registered Nurse Practice Act requirements for nursing education programs, opportunities and barriers for innovation, existing models, such as those in the United Kingdom that emphasize community based practice, and willingness of faculty and academic health care programs to undertake this work.

- Informatics specialist – There is potential for identification of key partners where nurses are already working in cutting edge informatics positions, toward identification of best practices related to role preparation, development and implementation. There is also potential for the engagement of nursing informatics associations as partners in this work.
- Nurse/family cooperative facilitator – It is imperative that assessments of social determinants of health be a part of the overall health plan, as well as the development of strategies to attain higher levels of wellness. RNs able to establish high levels of trust are perfectly positioned for this work at individual, family, and community levels. Advisory groups need to develop structures and identify opportunities for implementation of this role.
- Primary care partner – Since so few RNs currently work in community health clinics due to existing reimbursement models, it will be necessary to design an innovative preceptor model that can support RNs moving into this new practice environment. Academic, service, and funding partners will be key to moving this work forward, as will using an interdisciplinary practice model.

Further discussion is warranted regarding all dimensions of the identified roles, and their development and implementation. It will be essential to identify strategic partners and funding sources to develop and test the roles and identify strategies to bring them to scale as evidence warrants. Next steps include gathering available evidence around existing success related to the five roles discussed here and convening one or more advisory groups to create models and implementation strategies. There is a tremendous opportunity for nursing to lead important changes that are necessary to improved health for all Californians.

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## Appendix

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