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Improving Access to High-Quality Care

Medicare's Program for Graduate Nurse Education

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This *Insight on the Issues* describes how Medicare's new Graduate Nursing Education (GNE) Demonstration and new models of nursing-led care will improve access to high-quality care. The publication also considers how to evaluate the effectiveness of the GNE program.

Health care consumers may soon have a better chance of finding highly qualified clinicians because of a little-known provision of the Patient Protection and Affordable Care Act (ACA). That provision, passed with strong support from AARP and 13 leading national nursing organizations,[1] authorizes Medicare—for the first time—to pay for graduate-level nursing education.

The ACA authorized $200 million for a Graduate Nursing Education (GNE) Demonstration designed to increase the supply of clinicians who provide health care services to the growing number of Medicare beneficiaries. That funding is directed at hospitals[2] in partnership with schools of nursing and with nonhospital, community-based training sites.

The GNE Demonstration requires the Centers for Medicare & Medicaid Services to reimburse hospitals for the costs of clinical training for advanced practice registered nurses (APRNs). Those hospitals work with associated nursing schools to distribute the funds according to the new law's requirements.

Medicare's Demonstration for Graduate Nursing Education

In August 2012, the Centers for Medicare & Medicaid Innovation Center announced that the GNE Demonstration would fund five medical centers: the Hospital of the University of Pennsylvania, Duke University Hospital, Scottsdale Healthcare Medical Center, Rush University Medical Center, and Memorial Hermann–Texas Medical Center Hospital (table 1).

Those medical centers and their partners must spend at least 50 percent of their funding at nonhospital clinical training sites, such as doctors' offices, retail clinics, and federally qualified health centers (FQHCs).

Increasing Funding for Better Care

Traditionally, government funding for graduate-level nursing education has been relatively anemic

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Table 1
Hospitals and Associated Schools of Nursing Funded by the GNE Demonstration

Hospital Demonstration Site	Schools of Nursing
Hospital of the University of Pennsylvania (Philadelphia, PA)	Drexel University Gwynedd Mercy University La Salle University Neumann University Temple University Thomas Jefferson University University of Pennsylvania Villanova University Widener University
Duke University Hospital (Durham, NC)	Duke University
Scottsdale Healthcare Medical Center (Scottsdale, AZ)	Arizona State University Grand Canyon University Northern Arizona University University of Arizona
Rush University Medical Center (Chicago, IL)	Rush University
Memorial Hermann–Texas Medical Center Hospital (Houston, TX)	Prairie View A&M University Texas Woman's University University of Texas Health Science Center at Houston University of Texas Medical Branch

compared to support for medical education. Although Medicare has supported graduate medical education with an average annual expenditure of $9.5 billion, Medicare has contributed little to graduate nursing education.[3] Complementing Medicare's modest support, the federal government funds nursing education primarily through the Public Health Service Act, directing about $225 million to the nation's nursing education programs; most of these funds are dedicated to undergraduate nursing education.[4]

With the GNE Demonstration, Congress recognized a national need to have more nurses with advanced education, specifically to address the changing needs of the growing Medicare population. The Institute of Medicine recommended this type of federal support in 2010 in its landmark report, *The Future of Nursing: Leading Change, Advancing Health.*[5] Both Congress and the Institute of Medicine underscored that an evolving health care system needs clinicians who are better prepared to help the nation improve health outcomes and contain health care costs.

The GNE Demonstration makes possible extensive training for APRNs outside the hospital, which should help nurses meet consumers' health needs in homes and communities. The project will improve care coordination and strengthen links between nursing education and practice by requiring partnerships between hospitals, schools of nursing, and community-based settings. It will provide training for all four types of APRNs—nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse-midwives. During the development of the legislation that initiated the design of the GNE Demonstration, AARP was especially pleased to find that the program would significantly support the preparation of nurses to provide community-based care. AARP members, their families, and most adults would prefer to have coordinated care in their community—to prevent them from being hospitalized or institutionalized.

The program was designed to increase the number of practicing APRNs, which would provide more resources for managing chronic conditions in the home and community, where nurses emphasize patient education, disease prevention, and wellness. Such nurse-led care increases the quality of life of

consumers and their families and reduces costs by keeping individuals out of hospitals and nursing homes.[6] Furthermore, the GNE Demonstration would increase the number of clinicians available to provide and improve care in hospitals. Having more clinical nurse specialists would help hospitals assess and improve processes to decrease hospital-based infections and to reduce unnecessary hospitalizations. Additional certified nurse anesthetists would provide anesthesia services during surgery, and nurse practitioners would provide geriatric, pediatric, and other specialized hospital-based care. Certified nurse-midwives would deliver babies and provide other related women's health care. See table 2.

How Medicare's GNE Demonstration Is Expected to Improve Care for Consumers

A major goal for the GNE Demonstration is for APRNs to provide patient- and family-centered clinical services to the growing number of Medicare beneficiaries. The nurses will lead clinical teams that provide comprehensive care to adults older than age 65. APRNs will also help meet the growing demand for primary care providers for consumers of all ages as more people become insured under the ACA.

In addition, APRNs can help family caregivers provide better care for their loved ones. Recent research shows that the role of family caregivers has dramatically expanded in recent years to include performing

Table 2

Advanced Practice Registered Nurses: What They Do

Who are they?	How many?	What Do they Do?
Nurse practitioners (NPs)	192,000	Nurse practitioners provide primary care, take health histories, and provide complete physical exams; diagnose and treat acute and chronic illnesses; provide immunizations; prescribe and manage medications and other therapies; order and interpret lab tests and x-rays; provide health instruction and supportive counseling; and refer patients to specialists. Practice settings of NPs vary widely and include medical offices, community health clinics, minute clinics, ambulatory and long-term care facilities, and hospitals.
Clinical nurse specialists (CNSs)	70,000	Clinical nurse specialists provide advanced nursing care in hospitals and other clinical sites; provide acute and chronic care management; develop quality improvement programs; and serve as mentors, educators, researchers, and consultants. The most common practice setting for CNSs is an inpatient hospital, but other settings can include medical offices, educational institutions, long-term care facilities, public health settings, and occupational health facilities, depending on the CNS's specialty.
Certified registered nurse anesthetists (CRNAs)	47,000	Certified registered nurse anesthetists administer anesthesia and related care before and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as provide pain management services. Their clinical settings include operating rooms, outpatient surgical centers, and community-based health care facilities. CRNAs deliver more than 65 percent of all anesthetics to patients in the United States.
Certified nurse-midwives (CNMs)	13,041	Certified nurse-midwives provide primary care for women, including gynecological exams, family planning advice, prenatal care, management of low-risk labor and delivery, and neonatal care. Clinical settings of CNMs include hospitals, birthing centers, community clinics, and patient homes.

Source: American Association of Colleges of Nursing, "American Nursing Education at a Glance," 2014, http://www.aacn.nche.edu/government-affairs/Capacity-Barriers-FS.pdf.

medical and nursing tasks of the kind and complexity once only provided in hospitals.[7]

With the GNE Demonstration, Congress recognizes that primary care is often best delivered in the settings where most people prefer to receive care, such as their own homes, medical offices, community health centers, outpatient clinics, and retail clinics.

APRNs Are Key to the Success of Innovative Health Care Delivery Models

Many promising new models of care—designed to increase consumer access, improve health outcomes, and contain costs—depend on high-quality coordinated care regularly provided by APRNs. Growth of these new models, along with the increasing numbers of APRNs, has increased the number of Medicare beneficiaries receiving care from APRNs. As the American Nurses Association explains in an analysis of Medicare reimbursements, APRNs provided 26 percent of Medicare-supported care in 2009, 28 percent in 2010, and 30 percent in 2011.[8]

New models of care often involve APRNs in efforts to help reduce unnecessary hospital admissions, increase quality of life, and improve the way that patients move from one health care setting to another.[9] One example of an innovative model is the Independence at Home Demonstration. Overseen by the Centers for Medicare & Medicaid Innovation Center, the demonstration consists of clinical practices that test the effectiveness of delivering comprehensive primary care services at home—with a particular focus on people with several chronic conditions. The project organizes teams of physicians and nurse practitioners to provide primary care and rewards them for providing high-quality care while reducing costs.

An innovative model that involves nurses is the Transitional Care Model, which has proven to reduce hospital readmissions for very ill adults. Several health care researchers, including nurse-innovator Dr. Mary Naylor, developed the model. For chronically ill older adults, the Transitional Care Model tested creative ways to leverage the skills of nurses, nurse practitioners, social workers, and others during predischarge planning in the hospital, as well as during follow-up care in the home. Those innovations reduced overall costs, improved treatment outcomes, and boosted the ability of consumers to function in their daily lives.[10] The Centers for Medicare & Medicaid Innovation Center is further testing the model through its Community-Based Care Transitions Program.[11]

Another model for health care delivery that is being tested in many states is known as the *medical home*.[12] This team-based approach, frequently led by APRNs, is designed to provide comprehensive, high-quality, accessible care.[13] Medicaid programs in 10 states have established "health homes" to care for beneficiaries with two or more chronic conditions. The homes offer care coordination, health promotion, and transitional care. Many accountable

Quick Facts: The GNE Demonstration

The GNE Demonstration seeks to increase the supply of advanced practice registered nurses who can provide health care services to an increasing number of Medicare beneficiaries.

- Funds support five hospitals with formal partnerships between at least one school of nursing and two or more nonhospital, community-based care entities for four years.
- At least 50 percent of the clinical training funds must be directed toward community-based care settings.
- All four categories of APRN education programs—nurse practitioner, certified registered nurse anesthetist, certified nurse-midwife, and clinical nurse specialist—are eligible for funding.
- The Centers for Medicare & Medicaid Services is authorized to spend up to $200 million—$50 million per fiscal year—from 2012 through 2016.

care organizations (ACOs) and FQHCs serve as medical homes to better coordinate consumers' care.[14] Nurses are usually the leaders or clinicians in health homes, ACOs, and FQHCs.

Convenient care clinics, or retail clinics, have grown in recent years and are expanding their services into chronic disease management.[15] These clinics provide consumers with easier access to primary care services in their communities. Often found in pharmacies, retail centers, and grocery stores, they are frequently staffed by APRNs and physician assistants.[16]

Nurse-managed health clinics provide access to primary care services in communities.[17] A 2011 study found that nurse-managed health clinics deliver high-quality care, particularly in managing chronic diseases.[18] An increasing number of these clinics have been designated as FQHCs.

Policy Considerations

The Centers for Medicare & Medicaid Services is creating an evaluation design for the GNE Demonstration. If the demonstration performs as Congress intended, then Medicare will increase the number of highly skilled APRNs who

- Experience clinical training across a range of care locations, particularly in community-based settings.
- Provide high-quality care to Medicare beneficiaries.
- Provide high-quality primary care to the general public.

The GNE Demonstration will also be effective if it creates or strengthens networks of hospitals, community-based training sites, and schools of nursing. By working together, the networks will host more clinical training of APRNs and will increase the number of clinicians available for Medicare beneficiaries. Those benefits would significantly increase if Medicare permanently supports GNE.

Should GNE become permanent, then the Centers for Medicare & Medicaid Services could develop a more efficient and effective mechanism for Medicare reimbursement of APRN clinical training costs. The current (and outdated) pass-through system of using hospitals as the initial holder of nursing education funds for universities and external clinical sites may prove to be an inefficient use of taxpayer dollars.

1 The 13 are the American Academy of Nurse Practitioners, American Association of Colleges of Nursing, American Association of Nurse Anesthetists, American College of Nurse-Midwives, American College of Nurse Practitioners, American Nurses Association, American Organization of Nurse Executives, Gerontological Advanced Practice Nurses Association, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, National Association of Pediatric Nurse Practitioners, National League for Nursing, and National Organization of Nurse Practitioner Faculties.

In 2013, the American Academy of Nurse Practitioners and the American College of Nurse Practitioners merged to form the American Association of Nurse Practitioners.

2 Centers for Medicare & Medicaid Services, "Graduate Nurse Education Demonstration," http://innovations.cms.gov/initiatives/gne/.

3 See Diana J. Mason, Judith K. Leavitt, and Mary W. Chafee, eds., *Policy and Politics in Nursing and Health Care* (St. Louis, MO: Saunders Elsevier, 2007). See also Linda H. Aiken, Robyn B. Cheung, and Danielle M. Olds, "Education Policy Initiatives to Address the Nursing Shortage in the United States," *Health Affairs* 28, no. 4 (2009): 646–56.

Until the ACA, Medicare funded nursing education solely through registered nursing diploma programs. Those diploma programs were the most common type of nursing education when Medicare was enacted in 1965, but most registered nurses now graduate from college and university programs with an associate or baccalaureate degree or both. See Linda Cronenwett, "Nursing Education Priorities for Improving Health and Health Care," in *The Future of Nursing: Leading Change, Advancing Health*, edited by the Institute of Medicine (Washington, DC: National Academies Press, 2011), 477–564.

4 Public Health Service Act of 1944, 42 U.S.C. § 296 et seq. (1944); Cronenwett, "Nursing Education Priorities for Improving Health and Health Care."

5 Institute of Medicine, ed., *The Future of Nursing: Leading Change, Advancing Health* (Washington, DC: National Academies Press, 2011).

6 Centers for Medicare & Medicaid Services, *Chronic Conditions among Medicare Beneficiaries: Chartbook: 2012 Edition* (Baltimore, MD: Center for Medicare & Medicaid Services, 2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.

7 Susan C. Reinhard, Carole Levine, and Sarah Samis. "Home Alone: Family Caregivers Providing Complex Chronic Care," AARP Public Policy Institute, Washington, DC, October 2012, http://www.aarp.org/home-family/caregiving/info-10-2012/home-alone-family-caregivers-providingcomplex-chronic-care.html.

8 Peter McMenamin, "APRNs Serve 30% of Medicare Fee-for-Service Beneficiaries," ANA Nursespace, January 2, 2013, http://www.ananursespace.org/ananursespace/blogsmain/blogviewer?BlogKey=9632c2fa-6fc3-4a1b-93ad-343cd90058f1.

9 Some of those efforts are included in the ACA. See Public Law 111-148, § 3025, enacted March 23, 2010. The Visiting Nurse Associations of America is also an innovator in this area. See the organization's website

at http://vnaa.org/about-vnaa. See also Jennifer Joynt and Bobbi Kimball, "Innovative Care Delivery Models: Identifying New Models That Effectively Leverage Nurses," Health Workforce Solutions, San Francisco, January 2008, http://www.scribd.com/doc/219494722/Hws-Rwjf-Cdm-White-Paper.

10 For more information about the Transitional Care Model, see the model's website at http://www.transitionalcare.info/.

11 Centers for Medicare & Medicaid Services, "Community-Based Care Transitions Program," http://innovation.cms.gov/initiatives/CCTP/.

12 For more information about the medical home concept, see Leigh Ann Backer, "The Medical Home: An Idea Whose Time Has Come … Again," *Family Practice Management* 14, no. 8 (September 2007): 38–41, http://www.aafp.org/fpm/2007/0900/p38.html. For an interactive map showing state efforts in this area, see National Academy for State Health Policy, "Medical Home and Patient-Centered Care Map," http://www.nashp.org/med-home-map#sthash.a6Wn2gdG.dpbs.

13 Agency for Healthcare Research and Quality, "Patient Centered Medical Home Resource Center," http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Defining%20the%20PCMH_v2.

14 For more about ACOs, see Centers for Medicare & Medicaid Services, "Accountable Care Organizations," http://innovation.cms.gov/initiatives/aco/. For more about FQHCs, see Centers for Medicare & Medicaid Services, "FQHC Advanced Primary Care Practice Demonstration," http://innovation.cms.gov/initiatives/FQHCs/.

15 Ateev Mehrotra and Judith R. Lave, "Visits to Retail Clinics Grew Fourfold from 2007 to 2009, Although Their Share of Overall Outpatient Visits Remains Low," *Health Affairs* 31, no. 9 (2012): 2123–29.

16 National Conference of State Legislatures, "Retail Health Clinics: State Legislation and Laws," http://www.ncsl.org/issues-research/health/retail-health-clinics-state-legislation-and-laws.aspx.

17 Tine Hansen-Turton, "Nurse Practitioners as Leaders in Primary Care: Current Challenges and Future Opportunities," presentation at the National Conference of State Legislatures 2010 Legislative Summit, Louisville, KY, July 27, 2010, http://www.ncsl.org/documents/health/hansenturtonpp.pdf.

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