



**Preparing the Nursing Workforce for a Changing
Health System: The Role of Graduate Nursing
Education
AARP
The Robert Wood Johnson Foundation
Alliance for Health Reform
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ED HOWARD: My name is Ed Howard. Welcome on behalf of Senator Blunt, Senator Cardin and our Board of Directors at the Alliance to this program on the role of graduate nursing education in meeting the healthcare workforce needs in the United States, particularly in the area of primary care. It's hard to avoid a policy discussion around here about graduate medical education, which is mostly funded by federal dollars and mostly from Medicare. But how we educate those seeking to become nurses, especially advanced practice nurses, has received a whole lot less attention and our purpose today is to remedy that. We are going to share some facts about today's arrangements for financing nursing education, look ahead at what is likely to be needed in this area in the near future and we also are going to take a fairly close look at a current four year demonstration program offering Medicare funding for advanced practice nurses.

We are pleased to have as a partner in today's program, AARP and its Public Policy Institute, which carries out and commissions research and analysis on issues affecting older people at all levels from communities to countries, all around the world. We are also grateful for the participation and support of the Robert Wood Johnson Foundation, which has supported many initiatives over the years, promoting the best use of our nursing resources. Take a couple of minutes to do a little logistical orientation. You can see on the title slide that the Twitter #futureofnursing is available for your use. In your packets, you are going to find important information including speaker bios that are more extensive than the introductions that our speakers will get from us today, orally. There is a materials list and copies of the Power Point presentations we received in advance and a lot of background information and I want to say also, there is one particular piece in your packets which is a toolkit on the topic at hand, that is being released today. It collects a lot of background information in one place and I want to thank Beeta Rasouli and Sarah Dash and Zsofia Parragh for their good work on that toolkit.

There is going to be a video recording of this briefing available in a couple days, followed by a transcript a few days after that. Both on our website, allhealth.org. You can also find all the material that is in your packets online, in case you want to share them with folks outside of your office.

At the appropriate time, you can ask our panelists a question, either by filling out the green card that you find in your kits, or by coming to one of the microphones that you will find in the audience. At the end of the briefing, there is a blue evaluation form that we would very much appreciate your filling out so that we can improve these briefings and respond to the needs that you have for better information.

One last point I want to emphasize and I don't do it all the time, but I lose sight of the fact that not everybody knows this. The Alliance is as aggressively non-partisan as we can make ourselves. We don't support or lobby for any bill anywhere and there is no place for advocacy of or lobbying for legislation in the program that we have put together with our co-sponsors.

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Now, let's get to the program. We have some terrific panelists today and we are going to start with my co-moderator, Susan Reinhard, who is Senior Vice President at AARP and Director of its Public Policy Institute. Susan, welcome back to the moderator's chair.

SUSAN REINHARD: Thanks Ed! We have done this before. It's nice to be back and I'm really happy, you have no idea how happy I am to have this panel.

This is an issue that has been very, very, very important to AARP since -- certainly since I got there, which was about seven and a half years ago. When we started at the Center to champion nursing in America, that was in 2007 and it was created with funding from the Robert Wood Johnson Foundation, with the purpose of making sure that all Americans had a highly skilled nurse when and where we need one. And one of the very first issues that we tackled was education. We have these continuing shortages, we have nurses not getting the education they need to advance to advanced practice nurse level, faculty nurse levels, and so that became a big, big part of what we did. I need to acknowledge my team sitting here in the front. Winifred Quinn in particular was instrumental in really organizing this whole event and Peter [Reinachy] and we also have Julie [Scholchowski], who we invited to come, she had been a fellow with us, she is from the University of Pennsylvania, but at the time we were really thinking about these issues, she spent a lot of time with us, thinking about this. Since 2010 we have also been involved with the Robert Wood Johnson Foundation on a campaign for action. The future for healthcare. It has to do with working with states across the country. We have 51 action coalitions really working on implementing recommendations from a historic study, the Institute of Medicine's study that was released almost five years ago. That also had been focused on, what do we do to strengthen the capacity of the largest portion of the healthcare workforce, to be able to deliver the kind of care that all Americans need? This graduate nurse education component was one of the ideas that we put forth and worked with the nursing community, with many different organizations, to really explore what could we do? How do we speed up and make more efficient and effective the production of advanced practice nurses? For those who aren't initiated, those are nurse practitioners, clinical nurse specialists, nurse midwives, CRNAs, the nurse anesthetists -- all of which are needed to be able to deliver chronic care, preventive care, care coordination, the kind of care that frankly people on Medicare need. You can imagine that AARP, being the largest organization in the world of people 50 plus, who care about certainly people 50 plus and their family members, really cares a lot about healthcare and healthcare delivery.

So we did view this demonstration, which we very much supported and helped to create, frankly, the components of this -- and you will hear more about it, but the fact that much of the clinical training is done in the community because we believe people do not live in hospitals, they live in the community. All of those principles, I will say, were very, very important to AARP and its members. So we do this as a historic demonstration. We are very supportive of it. We are not the ones running it by any means, you will hear from those in the field that are doing this work, but we think what they are doing is so important. It's the first time that Medicare has recognized the need to invest in nursing and that's really important. So I just want to turn it back to Ed, but I welcome all of you

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to participate in this, to learn as much as you can. This is an educational session as Ed reminded us, and we want to make sure that you really know about graduate nursing education. It is really new. It is developing and so we invite you to be a part of this pioneering effort. Thank you.

ED HOWARD: Great, thank you, Susan. Let's not delay access to the experts any longer. We are going to start with Ed Salsberg, he is the Director of Health Workforce Studies at George Washington School of Nursing. He was also the founding director of the National Center for Workforce Analysis at the Health Resources and Services Administration. He's been working on nurse workforce issues for decades and he spent a number of years looking at physician workforce needs as well, when he directed the Center for Workforce Studies at the Association of American Medical Colleges. So we have asked Ed to give us a primer on healthcare workforce needs now and in the future with an emphasis on primary care. Ed, thanks for being back with us.

ED SALSBERG: Thank you, it's a pleasure to be here. My goal today is to provide you with some factual background and some framing the issue in terms of the workforce and why really nurse practitioners and other advanced practiced nurses are so important to the health workforce and the delivery system.

First of all, we know that demand as a nation, we are very concerned with the rising demand for healthcare services. The demand for healthcare services is really being driven by three major factors. It's the growth of the population. People don't appreciate how rapidly the nation's population is growing between 2010 and 2025 we will have added about 38 million Americans. The aging of the population, we hear a lot about it, that is clearly one of the main drivers and one of the reasons we are so concerned about the adequacy of the workforce. The percentage of the number of people over 65 will grow by 44% between 2010 and 2025. And I consider the third major factor driving demand really the medical successes of the nation. We don't always appreciate the progress that has been made, but from 1980 alone, the last 35 years, we have added five years to the life expectancy of Americans. This is mostly older Americans who will need more services. And so we know that we are a growing and aging population that is going to need services. Now, some people think that the ACA is another major driver of demand for services, but the ACA was not really a big driver in terms of the demand for services. We are adding 15 to 20 million new Americans and remember I said, the population alone is growing by 25 million, and the number of Americans over 65 will grow from 2010 to 2025 by more than 25 million. So in terms of the demand, it's relatively limited. It is important, but relatively limited. The key impact for the ACA in terms of the service delivery system, however, is really significant. So the ACA is encouraging primary care, it is encouraging a redesign of the service delivery. There is a focus on care coordination and prevention and really trying to encourage efficiency and value. And I would argue that advance practice nurses and particularly NP's are really well situated, given those changes being driven by the ACA.

I think it's important to point out that the use of services in America is really being driven by a relatively small share of the population, so this is from the Kaiser Family Foundation. What we see is 15% of the nation, 15% is using 75% or leading to the expenditures of 75% of the dollar. I think one of the clear implications is that there are a lot of people with chronic illnesses and a lot of the elderly that are using a lot of services. So if you think about advanced practice nurses and what they can contribute, I think they can contribute an incredible amount to this elderly and chronically ill population. I think two of the very major driving forces that the nation is confronting -- one is that we are going to need more services and the other is that we are going to have less dollars or we are not going to have all of the dollars that we would want. So there is the pressure to constrain costs. I think if you put those two together and say, what are the outcomes? Which force is gonna sort of dominate? Is it the need for more services or the need to constrain costs? I think one of the outcomes of that confrontation is that we are going to be under pressure to make better use of the workers we have and look at how we can use our workers, the workforce, efficiently and effectively, because we can't just keep adding.

Now, I think it's really important to be clear that the number of nurse practitioners in America has been rising rapidly. This is the number of new graduates. This is fortunately some good data we have from AACN, that tells us each year how many new nurse practitioners were completing training. And you see it's up to 16,000, so that is the good news because I think it offers an incredible opportunity to assure access to quality care. The importance is seen in this slide, in terms of primary care. This is some analysis of some data that was published in 2012 *Family Medicine*, where they looked at how many patients could an individual family physician serve if they provided them with all of the services that the patient needed? And if they were practicing alone, they calculated that the physician could serve 983 patients. Then they said, well, how many patients could this physician serve if they were part of a team or how many patients could the team serve? And they found they could serve roughly 1,947 patients. So it's so clear to me that if we use other healthcare providers other than physicians effectively as part of a team, we can do a far, far better job of meeting the nation's needs. And so you can't look at, do we have a shortage of primary care physicians, without looking at, do we have an adequate supply of primary care practitioners, which will include nurse practitioners, PA's and others. So the team is really critical. This slide is data from the National Sample Survey of Nurse Practitioners that HRSA published in 2013. I think it's important because it's a really wonderful survey and I will tell you, I was responsible for designing and managing it. I happen to know it was a well designed, well run survey, a representative sample. What it tells us is that primary care is extremely important and around 48% of the practicing NPs are providing primary care. The others are providing services in other areas. I want to be clear that those other 52% are providing incredibly valuable services too. So I want to emphasize that NPs make a major contribution to primary care. The value to the healthcare system goes beyond primary care. They are providing services throughout the healthcare delivery system and we should not in any way negate the contribution, whether it be primary care or specialty care.

This slide is also from the National Sample Survey of NPs, it's a little hard to read and it's easier to see on the slides in your handout perhaps. I put it in because we asked the NPs what services they were providing. If you look at the left hand column, it lists the types of services that they are providing and the first column is those who said they provide those to most of the patients. And what you see is they are really providing high level services. They are working in teams for the most part with physicians, but I don't want it to be thought that they are not providing very high level care of services that are critical to our population. I think there is some good growing evidence that this transformation is happening. We are seeing the increased use of NPs and PAs and other practitioners. As a person who studies health workforce and labor economics, I will tell you its pretty impressive to see the growth in the number of NPs and the fact that the healthcare system is still using them effectively and still wants more. They system really is taking them in and one of the reasons we have been able to deliver more services and more cost effective services is because we are using teams and we are effectively using advance practice nurses.

Then finally, this was from a study that was published in 2013 by Health Affairs. The question of, will the public accept nurse practitioners. This survey asked about nurse practitioners, NPs and didn't distinguish between the two of them. What we see is that for the most part, the public fully accepts NPs and PAs. This one shows the results when asked, if you had to wait another day to see a practitioner and there are two different scenarios, would you prefer to see the NP and PA sooner or wait to see the physician? And the majority said they would rather see the NP or PA today or tomorrow than wait the extra time to see a physician. I think NPs and PAs are being fully accepted within our healthcare system. So finally, the key points, I think, are that clearly there is a growing need for primary care prevention care coordination, just the types of activities and skill sets that NPs and other advance practice nurses have. I think they can help us meet our needs as a nation and they can do it in a cost effective way. It's clear that we really should be training our NPs, PAs, physicians to work in teams. And inter professional education and practice is really critical to an effective delivery system. I think our education system is responding. We are seeing them produce more NPs and PAs and physicians and I think more of them are training them in an inter-professional manner. Then finally, I think the key the point that given the increasing roles and responsibilities of advanced practice nurses, it's really critical for us to think carefully, are we educating them in the right way? Do we have the right experiences? Do we need to look at how we both organize and finance graduate nursing education for an effective nursing workforce in the future? I will stop there, thank you very much.

ED HOWARD: Thanks very much, Ed. Next up is Deborah Trautman. She is the CEO of the American Association of Colleges of Nursing -- AACN. She formally directed the Center for Health Policy and Healthcare Transformation at Johns Hopkins Hospital and harkening back a couple of years, she was a Robert Wood Johnson Health Policy Fellow here on the Hill. Some of you may have seen here there. Dr. Trautman is going to give us a sense of the current mechanisms for supporting the nursing education, especially at the graduate level. Deborah, it's nice to have you back.

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DEBORAH TRAUTMAN: Thank you, it's a pleasure to be here. I want to thank the Alliance, the AARP as well as the Robert Wood Johnson Foundation for hosting this event. Those of you that are staffers, I had the distinct privilege, as you heard, as a fellow, to live your life for a while and I thank you for what you do. It's critically important, it makes a significant difference in the health of our nation and I'm thrilled to be talking with you today about advance practice nurses and the importance of continuing to build on the good work that you have done in the past. Many of you know, but I will remind you, the American Association of Colleges of Nursing is an association that represents -- our members are those who are back -- were the academic voice for baccalaureate and graduate nursing education. We have 750 members and we are passionate about continuing to increase nursing's contribution to improving health and healthcare. As you know, the AACN serves the public interest by setting standards, providing resources and advancing opportunities for leadership development at our member schools. Our vision for the future is a highly educated nursing workforce that continues to make a contribution, working with other healthcare professionals. We know that despite the great progress we have made over the years, there is still so much more to be done to promote a healthier nation and most certainly to have more efficient healthcare delivery. So key to achieving that mission, I believe, and you have heard from Dr. Salsberg the importance of teams and most certainly the role that an advance practice nurse plays in helping us.

So I would like to remind us that for advance practice nursing, there are four professional opportunities and I will speak to you just briefly about them, as you have heard the importance in the work that nurse practitioners are doing. Advance practice nurses work across the life span. The nurse practitioners are the largest number -- the group with the largest number of advance practice nurses. We currently have 192,000. The next largest group that I would like to speak about is clinical nurse specialist and clinical nurse specialists have population and disease specific expertise. They too work across the life span, many of them working in rural and underserved areas and today there are 70,000 clinical nurse specialists.

The next group that I would like to share and speak about is the certified registered nurse anesthetist and there are 47,000 certified registered nurse anesthetists. Nurse anesthetists, in addition to providing analgesia and anesthesia also have a significant role in pain management. Last but not least and in fact have made quite a difference in healthcare for quite some time are the certified nurse midwives and there are currently today 13,000 certified nurse midwives nationwide. They provide prenatal gynecologic care as well as well health care.

So when we think about advance practice education, most of you know, but advance practice nurses start with -- as all nurses -- have baccalaureate program as their foundation. Then there are two paths for preparation. Either the masters prepared or the doctor of nursing practice. Nurses receive extensive clinical and didactic training. That training will depend and vary based on the programs, but it is extensive and provides for a competent practitioner as they complete their studies.

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I would like to take a moment to just bring some of us back to the historical context and as you are aware, the nation has experienced -- there have been several times when we have had extreme nursing shortage. One of the largest nursing shortages that we faced was in the late 1950s and early 1960s and that is where we saw significant federal support for nursing education. And advance practice nurses can receive federal funding through the Stafford loans or other programs, but most certainly the Department of Education. What we saw with support is -- I will show you in these next slides -- that support made a significant difference and impact on the profession. The shortage was nearly 25% and through efforts that were advanced -- through the support of federal legislation, we were able to address the shortage and assure that we had quality safe nurses to deliver the needed care in this country. As you can see on this slide, in 1963 the Surgeon General's report that was towards quality in nursing needs and goals, examined the nursing shortage and it proposed a goal at that time of 850,000 nurses. We now, as you know, have more than three million. We were able to make successful progress towards that goal with the support of the Nurse Training Act and the Nurse Training Act was passed in 1964. President Johnson said -- and I agree with him, it was one of the most significant pieces of legislation to address the needs of nursing.

So I would like to speak about -- as you know, Title 8 is the largest source of funding for increasing the nursing workforce and the goals of the programs today are to continue to support -- by supporting these programs and the finances -- we support increased access to quality care through improved composition, distribution and the retention of the nursing workforce. It continues to provide and support funds for increased diversity in the workforce, increase cultural competence and with both of those, diversity and cultural competence, as many in this room are aware, our nation continues to become more diverse. In 2013, it was the first time ever we had the majority of minority births in this country. We believe it is essential that the nursing population, like the general public, continues to represent and diversify. It's also important that we continue to improve the quality of education and we have many initiatives that are supported to help us do so.

So Title 8 funding, for those of you who are not familiar, it is one of the major sources of funding for nursing education and there are six components that have had made a major impact. The one most directly related to advance practice nurses is the first one that you can see and what we have learned through advance nursing education grants, is that this support again has made a difference in allowing us to continue to grow, as Dr. Salsberg said, a much need workforce.

The other programs that are supported under Title 8 that you can see -- we continue to support efforts to diversify the nursing workforce as well as continuing efforts on quality and safety projects.

The next slide that I would like to speak to you about -- I don't want to pass by the good news. The good news is there has been significant financial support over the past ten years for nursing education. But that support needs to continue and we can't afford to

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have a step back. We did, as did others when our country faced the challenges and fiscal pressures along with sequestration. We did see a dip in funding and we are starting now to recover, but it is very important that we continue to sustain this funding to assure that we have -- when individuals are sick and entering the healthcare delivery system, they have the kind of care they need from the nurses as well as, we have nurses working not only for when they are sick, but helping promote health and healthcare.

The next slide I have to show you, just shows you that growth and it has been sustained and we have grown, except for with sequestration. We need your continued support and those are the bosses -- those of you who have bosses in Congress in this room, as we were to think about how we continue to advance into professional education and practice, the role of advance practice nurses has made a difference in outcomes for patients. Many times advance practice nurses are serving in rural and underserved areas and when advance practice nurses are in other settings, they have made notable differences in improving care coordination and better outcomes for individuals.

The next slide that I would like to talk to you about is that there are other sources of funding and as you are aware, the National Health Services Corps is one of those major sources. Nurses can receive support through loan repayment programs, as well as scholarship programs.

In summary, my last two slides, I would like to remind us about the graduate nursing education timeline. 1993 sometimes seems so long ago, sometimes not. We have really made some great progress, but again, more to be done. I especially would like to acknowledge Representative Caps and Senator Stabenow for the great work that they did advancing graduate nurse education, the demonstration which you are soon going to be hearing about. In summary, I believe that we are grateful and appreciative of the support that we have had in the nursing profession for nursing education, but I would urge you that our work is not done. And as the nation ages and as we face individuals with more chronic diseases and a much more complex delivery system, it is imperative that we have a number of advance practice nurses that will help us meet this need. As you heard from Dr. Salsberg, the need cannot be met by one profession alone. It's critically important that we continue to provide opportunities for advance practice nurses. By doing so, we will indeed improve the health of the nation. Thank you.

ED HOWARD: Thanks Deb. We are going to turn now to Linda Aiken, who directs the Center for Health Outcomes and Policy Research at the University of Pennsylvania. She is a professor of nursing and of sociology there. Her research on healthcare workforce and on the quality of healthcare, I think is generally known to be widely respected both here and around the world. We have asked her today to tell us about the new graduate nursing education demonstration program that Dr. Trautman mentioned and that is being conducted through the Center for Medicare and Medicaid Innovation. Linda, welcome back, we are happy to have you.

LINDA AIKEN: Thank you so much. [inaudible] Projects in five states and these are Herman Memorial Hospital in Texas, Rush University in Illinois, Penn Medicine in Pennsylvania, Duke Medicine in North Carolina and Scottsdale Healthcare in Arizona. We have representatives from each of those projects here and if my colleagues would just raise their hands so people could find them after the meeting. They are mostly here and one over there. And here next to me.

So this is the first time that we really had the opportunity to talk about our experiences with this exciting program. So I'm going to hit the highlights. We could keep you here for days, because we have had so many interesting experiences, but very briefly, this demonstration is addressing the shortage of primary care and the difficulty in producing providers fast enough to fill the gap in primary care. So the demonstration is largely focused on trying to increase the production of advance practice nurses. Particularly, the problem that this demonstration seeks to solve is the lack of clinical sites, which is the major barrier for schools of nursing, to increase graduates from advance practice nursing programs. We have plenty of student applicants, the universities have already expanded, but the primary barriers to expanding further are the difficulties of finding clinical placement sites. Now, the context that this demonstration takes place in, is that clinicians everywhere in the country are under increased pressures to maintain and increase their productivity. Thus, it is increasingly difficult for them to accept trainees of all kinds and their practices, because of the drag of having student learners on their productivity. So this demonstration is to have some resources to help offset the decline in productivity of clinicians that become involved in the educational advance practice nurses. And the principle on which the demonstration is based is very much the same as the original principle involved in the passage of Medicare 50 years ago, which is that Medicare beneficiaries are benefited by having their care in clinical settings where advanced clinicians are learning. There is a benefit to the Medicare patients themselves. Also, that having learners in clinical settings increases the cost of care to those clinical organizations. This is no different than it was 50 years ago, but it is a more pressing problem because of the productivity targets. So we are in the third year of a four year demonstration. I just want to make a couple of points at the outset. There are RNs already that are in this program, but unlike physicians in graduate medical education, APRNs are in degree granting programs, which means they have didactic preparation at the same time they are in clinical practice.

So this has been a very well thought through demonstration and we thank all of those that made it possible and one of the things that we would like to focus on particularly is that the relative flexibility of the demonstration as designed has promoted a lot of innovation and particularly the innovation -- there are many different types of innovations, but one of the areas I would like to focus on particularly are the two models that have evolved naturally through the flexibility that we had in the demonstration. They are a single model that funds Medicare funding to a hospital with its principle nursing school and multiple clinical partners, particularly community based partners. The second model is the consortium idea where a group of regional nursing schools with a funded hospital come together and the funds from Medicare facilitate the clinical preparation of APRNs

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in the multiple nursing schools at a number of different clinical settings, including hospitals and community based settings. Duke and Rush are examples of the single hospital and primary nursing school model and the regional consortia are the Hospital of the University of Pennsylvania that has nine nursing schools. All the nursing school in the Greater Philadelphia area; they train advance practice nurses, all of the health systems and as many of the clinical providers as we can possibly find. So this is a consortium of nine nursing schools and 600 providers. Memorial Herman, Texas Medical Center is focused on the Texas Gulf Coast region. They have four nursing schools, multiple community partners, and Scottsdale Health is focused on the whole state of Arizona and it's for nursing schools.

Both of these models and the entire demonstration have been very successful. The first thing that we have discovered is that it is feasible for hospitals to receive funding for Medicare and distribute those funds to multiple schools of nursing and multiple settings outside of their own organizational structure. This is the familiar model of Medicare payment for graduate medical education and so one of our very firm findings is that this also works for nursing. Additionally, APRN enrollments and graduations have increased as we expected would be the case in the GNE demonstration and we can say now, across all of the sites, that together we have doubled the graduations of nurses across these five states. Just to give you an example: in Philadelphia alone, we produced 703 APRNs last year and that was a 78% increase over the baseline period since the demonstrations started. So, over 700 APRNs in a community, even a large city like Philadelphia, is a substantial increase in primary care and other APRN capacity.

We have challenges and they are worth mentioning and I'm going to go back to a theme that I mentioned earlier that much of what we have been able to accomplish has had to do with the flexibility of the design of the demonstration. Just for our own learning, since it's common now to have various demonstrations and pilot projects and many of you are involved in the design of them, what we are finding is that we can come up with more innovative approaches if we have had greater flexibility in the design of the program. There have been two issues in the design of this particular demonstration that I will use as an example. They were very well meaning, but have created challenges for us. One is this notion of incremental funding. The principle here is that Medicare was already involved. That community was already involved in training advance practice nurses. Medicare did not want to substitute for that training, so they went to this idea of paying for the incremental students above a baseline. As you can imagine when you implement this in a fairly rigid way, that results in a community clinic. This demonstration can pay for this student, but not this student. Well, that is not practical. So in the future if there was greater flexibility, the principle could be implemented. Also in primary care. A goal of this demonstration is that 50% of the training would be in primary care and we all agree on that and all of the sites have met that outcome. Here again, we think that one size fits all, but sometimes it doesn't and the actual definition of primary care, which is non-hospital sponsored community settings, is problematic because in some markets including the one in Philadelphia, integrated health systems that resulted in the incorporation of most of the primary care capacity and so it's not longer in that official

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designation of community based settings any longer, even though we are obviously meeting the primary care target.

So our interim conclusions, the familiar model of Medicare funding of hospitals for clinical graduate education for health professionals works for the case of nursing. The availability of funds to offset clinician's loss of productivity associated with AP and training has been key to nursing schools being able to double the production of nurse practitioner. The interest is high among the settings that have these trainees and hiring them. We haven't had a long enough period of time to tell you where our graduates are working. Finally and interestingly, we have good cost estimates of what it would take to educate APRNs in the context of this demonstration and they show a favorable return on investment. Thank you.

ED HOWARD: Alright, thanks very much, Linda, excellent interim report. We are now going to turn to the results at the ground level. Our final speaker is Brittnee MacIntyre; she is a clinical nurse at the MD Anderson Cancer Center in Houston. She has 14 years of very diverse healthcare experience. She recently completed her training in a program supported by the CMMI Demo that Linda Aiken has just described for us and we have asked Brittnee to share with us her view of this initiative from the inside. Go right ahead.

BRITTNEE MACINTYRE: Hi everyone, I'm Brittnee MacIntyre and I thank you all for inviting me to be a part of this panel. A special thank you to the Alliance and AARP and the Robert Wood Johnson Foundation.

To tell you a little bit about my background, I have about 14 years of various healthcare and social services experience and my most recent experience has been at MD Anderson Cancer Center in Houston as a clinical charge nurse and I will be going into the nurse practitioner advance practice role as a family nurse practitioner in a retail setting at Walgreen's pretty soon, which the Board gets my paperwork all sorted out. I live in Richmond, Texas, which is a suburb outside of Houston, population of about 12,000, so that is where I will be working. The main reason I decided to become an NP is because I wanted to be able to do more for my patients. I was very, very happy being able to help people in their time of acute illness, but I saw that there were many things that could be done upstream in the prevention realm to help people before they needed the hospital bed. I was interested in getting involved in those efforts such as helping a patient maintain a healthy blood pressure so they don't have a stroke.

Before I talk about what it was like to be a student, I want to underscore the importance of the clinical rotation, which integrates the didactic knowledge into the real life patient care. There is absolutely no substitute for hands on clinical experience; some things must be experienced in real life to be truly appreciated. I will never forget the first time I heard the lung sounds of a person with pneumonia. Or the first time I detected a heart murmur.

Now, to tell you a little bit about the process of finding a clinical site. Students were ultimately responsible for finding our own clinical site. One of the biggest differences in

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nursing education compared to other healthcare provider programs is that we don't have formal placements. We had help if needed, but we were encouraged to attempt finding a site on our own and we had a clinical site coordinator at our school that we could turn to if we were unsuccessful after demonstrating a thorough effort. So I began early, essentially cold calling for clinical sites. Often I was not allowed to speak directly to the practitioner, they are busy, they are in the exam room. The office manager answers the phone and usually just takes a message and they are in a hurry too or it's sent to voice mail. Very few times I would get a call back. So I kept a spreadsheet of places that I called, just to be organized and make sure I didn't call places twice or whatever. It was very difficult finding places and frankly, training a student takes a great deal of time and attention and it adds to the burden of the existing patient care activities that are already rushed. Generally there is no incentive to precept a student other than being granted credit hours that can be used towards recertification. So to track my progress, I kept a spreadsheet of clinics that I had called and the outcome of the conversation and I will share with you some of the common reasons for rejection. The list goes from kind of the more common reasons to the less common. The most common was time constraints. Providers barely have enough time for their own patients and adding a student would simply slow them down too much. It's not that they don't like students or don't want to teach, it's just that they have certain things they have to do by the end of the day and not enough time in the day. The burn out effect -- meaning, we just had a student the last two semesters and we need a break. Competition -- we have had a list of students already filled up for the next two years. People in these programs know that it's stiff competition and some people start calling around to secure a spot before they are even in the program. There was unfamiliarity with the role of nurse practitioners or a negative bias. Some places would say, well, we have never trained an NP before, we don't know, what can you do? Some places would start to sound like they were acceptable and accepting of a student but then they would find out I was an NP student and they would say, oh we are only taking MD and PA students. That was a little discouraging.

I found one nurse practitioner who was very, very kind and explained that she loved teaching students, but she said that she had an unfortunate circumstance that her compensation was tied to her productivity and she just couldn't afford to take me under and risk that loss in compensation. So I was discouraged with my lack of prospects. I turned to our site coordinator, who was able to match me with fantastic Medicare GNE demonstration sites. A family practice clinic serving primarily Medicare patients, about 75% of their patients were Medicare and providers were expected to see many patients in a short amount of time. That was one of the most surprising things that I observed in my rotation, was the speed of the appointments. There was a lot of stress to be efficient and to see as many patients as possible. When patients would call with something that would come up, say an unplanned illness like a sinus infection or any other type of thing that could come up unplanned, it was very difficult to fit them in the schedule on the same day.

So I would like to tell you about one of the most beneficial things that I like to do with patients and that helped me in several of my clinical rotations. Then I would like to call it

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the “brown bag check” and basically it’s one of the most eye-opening things to get a handle on what is really going on. What the patient is really taking and it’s helpful to have the caregiver there, if it’s an older person that needs help getting their medications organized. Basically you ask them to bring in everything that you are taking -- your supplements, your vitamins, your prescriptions, herbs, everything. People have things stashed back in their medicine cabinet and you never know what is actually there. So they bring everything in, you set it out on the counter and you go through it and it takes a long time. That is one of the benefits of being a student is that I had that time. So we would go through and it really helps you to be able to talk about what each medicine is for, answering questions they have, confirm whether the medications are being taken correctly. Look and see how many pills are in the bottle. Well, if they are taking it like they should be, are there less than there should be or more? And to also look at a potential drug interaction. There are a lot of herbal things and supplements that interact with prescriptions and sometimes the healthcare team doesn’t know what all they are taking. You watch Dr. Oz and go pick up a bunch of supplements or something. So one example was one of my patients did the brown bag check, brought everything and set it out and he didn’t realize that he actually had two bottles of the same prescription medication. One had the name of the generic name -- each medication has a generic name and a brand name. So one of them had the brand name and one of them had the generic name. So he thought they were two different medicines and he was taking them every day. And it was a beta blocker, which is a medicine that lowers the heart rate -- it’s a blood pressure medicine -- it lowers the heart rate. So he was taking a double dose of this. And he had reported feeling dizzy and tired. So we attributed those side effects to his beta blocker double dose because those symptoms started around the same time that he started taking those. By doing his brown bag check, we discovered the medication error and prevented a multitude of potential hazards such as a fall, resulting in a broken hip and a lengthy hospital stay.

I feel that the Medicare GNE demo project benefits the community by educating patients and providers about the role of the nurse practitioner and helping to integrate them into the community. Most patients and providers overwhelmingly supported the NP role. Patients appreciated the extra time that I was able to spend with them doing things like the brown bag check or explaining to them -- breaking down in layman terms complicated medical terminology. Providers liked that I was able to spend time with their patients doing the brown bag check and providing education. There is a lot of education that patients and their caregivers need. A lot of these are complicated medications and diagnosis. I think that the GNE placements will help integrate NPs into the community clinics and ultimately help address the shortage of primary care providers. As an example, one of the clinical sites, one of my GNE sites, hired their first nurse practitioner into the practice after she had completed her rotation through that site as a student, as a GNE student. It was a great relationship that they had, the nurse practitioner and the physician and it was a really unique experience for me to be able to see the relationship that they had working together -- NP and physician.

I'm tremendously thankful for the Medicare GNE demonstration project and I honestly don't know how I would have found a clinical site without it. I think you so much for your time and attention.

ED HOWARD: Thank you so much. You now have a chance to ask a question orally, fill out a green card and hold it up and it will be brought forward. Let me just follow up with taking off from Brittnee's experience and maybe Linda's. A place to start with an answer. Linda, talk about the five sites and how the mechanism for finding the clinical sites that you said was so crucial, works from one to the other. Do they all have to exhaust the possibilities and themselves on their own before they get the help from the coordinator?

LINDA AIKEN: Well, Brittnee gave a wonderful description of what is and what the GNE demonstration is changing. What we are changing is we are establishing a portal that more standardizes the process of matching the trainees with the clinical sites. Good clinical sites and clinical sites in the community. So this is what the real focus is, to try to get a process that looks more standardized like the distribution of medical residents in hospitals, there is a whole matching system. So we are in the process now of building the portal and the distribution and then of course we have centrally the resources to encourage new sites to join our portal because we can help offset their productivity losses involved in taking the students.

ED HOWARD: And that is the explanation also for one of the comments that Brittnee got about having a compensation tied to productivity. That is sort of the [unintelligible] position and the demonstration is aimed to changing that.

LINDA AIKEN: Yes.

ED HOWARD: Is there an easy answer to the question of how much money we are talking about here? Either per enrollee or over the course of the year to get to the 700 nurse practitioners that your program produced last year?

LINDA AIKEN: Well, these are all informal numbers and I don't want to speak for the whole demonstration because this is all evolving, but I will say in our own project in Philadelphia, we are spending about \$35,000 on each APN for their clinical education only. Now remember, all of these students were paying tuition, so this is an important factor to realize, that students are already paying a lot of money for their education and there is really no capacity to add on this amount of money to an individual student, right? So this is the sort of issue that we are in. So it's a very good buy from a value point of view and in comparison of course to what -- for example -- a primary care physician costs to educate. Nevertheless, it is an amount of money that if we don't have another source for, it would be hard to figure out how we are going to solve this problem of the shortage of clinical placements.

ED HOWARD: One of the questions that got raised in the context of some of the materials that you have in your packets and in the toolkit that our staff put together with the help of some of our colleagues at the podium here, is that although there is a shortage that one might predict of nurse practitioners and nurses over a period of time, that the extent of the shortage and even the existence of the shortage varies substantially from state to state. I wonder, maybe Ed Salsberg could give us some sense of why that is the case and how disparate are those supply and demand questions?

ED SALSBERG: Thanks Ed. There are very significant differences in the supply and the adequacy of the supply by communities. Not even by state, because within states there are great variations between different communities. Some of it has to do with the production. We do tend to have more physicians and other practitioners educated in the east coast and to a lesser extent the west coast; more problems in the middle of the country in terms of the numbers being produced. They can be a two or three fold difference in the supply and in many ways, the distribution of practitioners is a greater challenge, I think, going forward. I'm very encouraged by the increased production and the number of graduates in many health professions. Even with that increased production, we are going to face problems in rural communities and poor communities so we do need programs that address the mal distribution. Some of it is a matter of income and clearly a practitioner who has invested a tremendous amount of their own money in their education, completes their education with -- in some cases, significant debt. They are more likely to go to a community where it is easier for them to make a living. That is understandable. I think that is one of the reasons the National Health Service Corps is so important. You also need to look at where we direct our support for training and it may be that directing our support to training to communities in states that have shortages, may lead to a greater payoff in terms of the practitioners being available to serve underserved populations.

SUSAN REINHARD: I just want to choose a few of the questions from the audience. Some of the questions are really not about graduate nursing education or this program, so forgive me; I'm not going to raise them. There are a lot of different questions about entry into practice and things of that sort, so I'm going to stick to those questions that are related to this. This one is particularly interesting -- it comes from Sarah Berger, not a surprise. She is wondering what is being done to be sure our APN education and clinical experiences include the basics of geriatric care in the community and within the network. So it is Medicare funding and I'm wondering if Linda, perhaps you can address this. To what extent are you paying attention to care of older people in the demo?

LINDA AIKEN: Well, one of the major objectives of the demonstration is to open up new sites that haven't traditionally been involved in APN training. One of the great sites are long term care and hospice in particular. We in our site in Philadelphia have looked to some wonderful opportunities and large multi-site organizations that are using now a lot of APNs. And that is a whole new area. So yes, I think that is a fabulous area. Almost any specialty of APN education can really learn and be valuable in long term care settings of all kinds. Learning to do physical assessments, how to communicate with the patients,

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how to do medication reconciliation. All kinds of things. So, yes, that is a big area of expansion in all of our five sites.

SUSAN REINHARD: Great answer. This is a very interesting question: does the GNE program train APRNs through the doctoral level or only the masters level and why or why not?

LINDA AIKEN: All students that are new APRNs qualify for the GNE demonstration. So this would mean doctor of nursing practice programs that are producing a new APRN would qualify, but not a post masters program where the person is already an APRN. The object is to increase support.

SUSAN REINHARD: Linda, you talked a lot about the need to have funding for the clinical component and so during this demonstration in the five sites, have you noticed what is happening with the rest of the world in that area? Is the competition getting greater? What is happening in the field? Can you make that judgment?

LINDA AIKEN: Let me make a comment that I think is an add-on a little bit to Ed's comment about supply. Ed gave us some great statistics and showed that we have a variation in supply of all providers, but I think Philadelphia is a very interesting example because one out of every five physicians is trained at some time in their career in Philadelphia and yet we have a huge demand for advanced practice nurses. So in terms of the need and this I think is for two reasons that relate to changes in our environment -- one is new kinds of providers are coming in to improve access to primary care and Brittnee is an example because, I think you said you are in a Walgreen's retail clinic. Of course we have a huge increase in retail clinics in our state and they all need nurse practitioners. Secondly, in our market, we have a growth and integrated healthcare system and all of those integrated systems need and are expanding primary care. So, even in a community that has a lot of doctors passing through and many of them staying, the demand for primary care is very great.

SUSAN REINHARD: I think Deb wants to add something.

DEBORAH TRAUTMAN: Thank you, I wanted to add a comment about academic practice partnerships as one of the opportunities to address the challenges that we face looking for clinical sites. It's a real challenge; it's not limited just to nursing. We have had great experience building partnerships. When I said earlier that the improvements that we are going to make are not going to be restricted to one discipline, nursing alone, nor is it going to be academia or practice. It's both of us coming together and many others. When we have done this, I recently was on a visit down to Birmingham, Alabama to observe a practice partnership and the clinical experience for the students is very good. There is a strong relationship between those who are in the service community, as well as those who are in academia and education and because of either -- and some of them are formal and others are informal, but I think that is one of the critically important strategies that we need to continue advance in this country so that we can assure that students have

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more time to spend learning their roles than they need to spend in finding sites in order to get those experiences. As Brittnee said, when individuals and practices have experience with advance practice nurses, we find the pioneer first nurse is often the one that opens the door for them subsequent experiences. So I would encourage us that we need to think about how funding is very important and through many of these academic practice partnerships, there are formal funding arrangements that are established.

SUSAN REINHARD: Another question -- what is the incentive for primary care physicians to want to participate in coordinated care/delegate to APRNs? So whatever you were going to say, if you could add to that, Ed.

ED SALSBERG: The first, on the challenge of clinical placements, I think it is growing, I think it's not only that we are seeing an increase in the number of NPs that are in training, but we are seeing more physicians and PAs and others. There has really been a push and an encouragement to train in ambulatory care settings. If you think about it, that is where people are most likely to practice. The funding that we have for graduate medical education only goes to the hospital. So we have this disconnect where we are putting the money that we have only to docs and only to hospitals when we want to train practitioners and teams to work in the communities. So, I think there is a problem in finding enough placements -- good placements -- for all practitioners, particularly those interested in primary care. The second question about, what is the incentive for a primary care physician to work with an NP or other practitioners? I think the demands on practitioners are so great these days, to improve the efficiency and effectiveness, it's really logical for them to think about working with a team. It makes no sense for a practitioner that has 12 - 16 years of education trying to do something that someone with fewer years of education could do. This is not just about nurse practitioners; this is medical assistants and social workers, psychologists. I mean, the whole concept of the team is, we can use our physician workforce more effectively. So, I think from a physician perspective, the team makes a lot of sense. I think it actually makes sense economically as well. Most physicians now are working in groups. Group practices. We don't really have for the most part an individual physician practicing all by themselves in a single physician or two physician practice. So larger practices are seeing a diversity of patients and patient needs and working in a team, is really gonna, I think, improve their effectiveness and efficiency and I think just a very strong case can be made for why this really is in the interest of the individual practitioner. Let me just say, I think the vast majority of physicians in practice welcome the working in a team with NPs, NPAs and others. I think the people at the front line say, this is great, there is another practitioner I can work with that can help me deliver effective care.

DEBORAH TRAUTMAN: I would like to add on to that. I just recently had a conversation with a colleague who was a psychiatrist in a state where there is a significant shortage of psychiatrists. The incentive for that psychiatrist to work with advance practice nurses is to meet the needs of the community. He strongly recognized that despite their best efforts, they weren't going to be able to do it alone and together the care and the needs of the individuals in that community can be met and it's in a team that

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there is great respect, there is coordination, there is improvement of outcomes for the individuals and I think that is the primary driver for --

ED HOWARD: Clearly if your compensation is going to be compromised by the fact that you have a placement in your practice -- there is at least a period of time where you have a strong disincentive to put that person in that position. I'm reminded of the folks at Geisinger who said when they brought a new practice into their milieu and gave them the latest health information technology, it took that practice 18 months to get back to the productivity level that they had before they had the IT equipment. It sounds like something of the same phenomenon is at work here.

DEBORAH TRAUTMAN: I think a very good point you make and I think looking -- many of you are familiar -- Maryland, the most recent change in the waiver, so Maryland is an all payer state. I think we are going to see some wonderful examples of how by assuring you align the incentives -- the payment incentives, that indeed it does remove some of those barriers. It is a reality that that creates an obstacle and then a longer time. There is absolute evidence that when those barriers are removed, that you can have the quality of care with the team and it's not a disincentive.

ED HOWARD: We have some folks at the microphones and I would ask you to keep your question as brief as you can and identify yourself if you would.

AUDIENCE MEMBER: Florence Fee, I am Executive Director of a non-profit called No Health Without Mental Health. Our mission is to advance the integration of behavioral healthcare in primary care. So my comments very much follow on Deborah's and Ed's last comments. In fact, I would like to direct my question to you. I would like to just focus in on APRN's role in coordinated care, which has come up a number of times. What hasn't been mentioned is the need -- complex chronic conditions and the need to focus on patients that have concurrent medical and behavioral health. So my question is, right now one of the major lynchpins of primary care transformation is integrating behavioral health. There are multiple evidence based models of integrated care. Among the most robust data is collaborative care. As the head of a non-profit, behavioral health integration, I can tell you the role of the care manager is crucial, crucial and so how is the nursing profession, the graduate nursing education and the nursing profession in general going to prepare APRN's to work as care managers in integrated care settings, in primary care? Whether they come from a medical, physical training background or behavioral, what priority are you giving that and what are the types of programs to prepare these really crucial care managers?

DEBORAH TRAUTMAN: Thank you. So now I will play that card. I have been in my position seven months, so I may not tell you everything that we are doing. I think most importantly there is recognition that we need to bring together and continue to advance our knowledge with behavioral health as well as with physical. We have done a better job in the past. I think all of us, not just nursing, in focusing more on some of the immediate physical. I think with behavioral health, recognizing the opportunities when you have

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advanced practice nurses out in the clinic, like I was mentioning with this psychiatry practice that was in another state. They designed their team so that there is a vital role for each and they have care coordination conversations. Well, we are seeing the same happen in clinical environments. Some of the deans at the table can speak specifically about changes in the curriculum, but by having recognition of the importance in our essentials, which the essentials are the standards for what is most important in education and then by designing curriculum around those. I know that is a very broad answer, but that I believe are the steps that we are taking, so there is more concrete, specific, hands-on clinical experiences as well as our faculty have expertise and our sharing both -- again, the didactic and the clinical. We look at the whole person and that has been a major piece of improving. Then I think it's continuing to educate the public. We have made great progress over the course of my lifetime in recognition of mental health and how important it is, but I think there is still much more to be done. So I believe that those advocacy efforts come from all of us. So what we can do immediately in the schools, what we can continue to do for advocacy about the importance. As you know, many times it's not just having one problem. Many times there is a mental health problem as well as a physical condition.

LINDA AIKEN: Ed, could I just add on there? I think that as you see from Deborah, the nursing schools are responding to this in the curriculum, but one of the challenges that we had GNE demonstration is we don't have a lot of good examples of integrated behavioral healthcare. We are seeing that in the results of the ACO demonstrations and the medical home demonstrations that even though this is a goal, it hasn't actually been put in place very widely. So we can teach it, but what we really need is more examples to embed students in.

AUDIENCE MEMBER: My name is Heather Mora; I'm the Executive Director of the Accreditation Commission for Midwifery Education. The Accreditation Commission for Midwifery Education is the only accrediting entity that has been recognized by the United States Department of Education as a programmatic accreditation agency for nurse midwifery education programs in the United States. One of our goals is to expand the number of nurse midwives in the United States to meet the growing deficit of healthcare providers for pregnant women. When surveyed recently, our educational programs, 88% said the primary problem they face is finding clinical sites for their students. Providers who agree to precept midwifery students are not paid when they do this. Reimbursement from private and commercial payers does not reward them for their choice to train another generation of midwives. Forty percent of counties in the U.S. have neither a midwife nor an obstetrician to serve women there. It is really critical that we train more midwives to meet the patient's needs, but it is very difficult to do so when there is essentially a financial penalty in the form of loss productivity for precepting students. There is one nurse midwifery education program participating in the graduate nursing education program and they have indicated to us that the GNE program has made a real difference in their ability to attract and retain preceptors. On behalf of the Accreditation Commission for Midwifery Education, I would like to express to Congress the importance of dedicating money specifically for nurse midwifery students in terms of

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student loans and assist our programs with federal funding to support nurse midwifery preceptors and clinical sites. I believe that the continuation of the graduate nursing education program will be critical in our ability to attract and retain qualified preceptors and I thank you for your time today.

SUSAN REINHARD: Thank you, I guess there wasn't a question.

ED HOWARD: No I believe the question was, don't you agree?

AUDIENCE MEMBER: Bob Griss with the Institute of Social Medicine and Community Health. I would like to pick up on the point that Dr. Salsberg made about a disconnect between graduate medical education from Medicare going to hospitals and doctors when we are trying to encourage a healthcare workforce of integrated teams including nurses. The panel is focusing on the training of nurses as a primary objective, but I'm wondering if there is a government survey perhaps done by HRSA that looks at the efficiency and the effectiveness of the healthcare workforce at the community level throughout the country, so that the leverage from Medicare funding can actually be encouraging a workforce that gives us the prevention that we want. That gives us the primary care that we want; rather than the market incentives to overspecialize and for nurses to fit in around the role of doctors and hospitals in a residual way, rather than according to standards that can equalize a delivery system that functions at a community level throughout the country.

ED SALSBERG: There is currently no single national program that would fit that bill, which looks at each community. There are a series of programs that look at pieces, so that you have the National Health Service Corps and the State Primary Care Offices that look at primary care shortages. There is really no national program at this point. There have been a number of proposals, the ACA included two different provisions and two different programs -- one for National Health Workforce Advisory Committee that was appointed but never funded. There were also state health workforce development grants, which were funded for only one year. So yes, there is a need for it. I should say that many states are taking the lead in this and I want to be clear that states are doing a lot and in the absence of a sort of central direction on workforce planning from the federal government, more and more states are getting involved in these issues. States have to decide -- are concerned about access in general. They are concerned about supporting education. States really have a major role to play in assuring an adequate workforce, but there really is a need for national guidance on something like the shortages or the needs for clinical training sites. It really would be helpful to have the support and guidance at the national level, like the nursing demonstration -- graduate nursing demonstration projects.

SUSAN REINHARD: I have a question from the audience and then we will come here. This is to Linda. I don't know if we made it clear that there is an external evaluation. Have we made this clear that this is the third year of a four year demonstration in these five sites? Data are being collected from all five sites, they are being audited. So we have questions that -- we will have to see if Linda is comfortable answering some of these

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questions. It would be wonderful if unspent funds could go into a fifth year. So that is something that should be investigated based on findings, whether this could be permanent and beyond a demo site. But this is preliminary of course. You mentioned one conclusion of demo is a good cost estimate of educating an APRN. Please elaborate. Are you able to do that, Linda?

LINDA AIKEN: Well, I think we are going to have to leave it for the moment and saying that what we have invested -- first of all, nobody knew how much clinical education for APRNs was going to cost, so we have the first ever real cost numbers on what its going to really take. We have two years of data. We need some more data to do that and as Susan says, our demonstration got started late, like a number of ACA demonstrations, because we were trying to implement before we had the infrastructure up and I think that was a common problem that ACA wanted to see something happen rapidly, and so we really haven't had enough time to fully implement the GNE demonstration and there are monies and we have asked the CMS for a fifth year to -- for the purpose of really honing in on what it really does cost because we need a little bit more experience. Partly we have a start-up phenomena going on and we need to get some out years to figure out what it's going to really settle down as. So I think we don't want to give you a number at this point.

SUSAN REINHARD: I just got a note from [unintelligible], if staffers want to know more, please talk with Linda and the other demos here. I'm going to take a question from the audience then.

AUDIENCE MEMBER: Hello, my name is Marianne Grant, I am a nurse practitioner and a DNP and I'm currently a Robert Wood Johnson health policy fellow here on the Hill. Now I'm kind of a little more aware of the problems with the GME systems and I'm wondering that although its wonderful that the GNE program looks successful, is that a sound foundation to build upon or are some of the issues with the GME program going to be raised with the GNE program?

SUSAN REINHARD: I'm going to start and maybe Linda will jump in. I can speak for myself and for AARP that this demonstration would alter how physicians are educated also. The idea of spending this half time or whatever in primary care and really focusing on the issues of chronic conditions and what have you, that this could really move the whole education of healthcare workers, particularly physicians and nurses.

LINDA AIKER: Why don't I just add to that because I had a couple of examples, but they flew by rapidly. We think that already in the two years we have been doing this; that we have been able to do some things that have not been possible to do in graduate medical education. So maybe our example is going to help meet some of those goals. Namely, primary care. We have been able to meet our target of having at least 50% of training in primary care and we did that by opening up new sites. Now, the fact that we opened up the new sites because maybe we were incentivized to, but we also had a commitment to, doesn't only open up those sites for nurses. It opens up the sites for

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everyone. So we think that we are making some innovations also. Twenty years ago on a committee that I was on in the Institute of Medicine, a recommendation was made that we ought to think about geographically defined consortia to train health professionals. Well, this is what we have three times over in the graduate nurse education demo. So we have consortia across geographic areas, across multiple schools and hospitals and they work. So, we have already in our two years developed a couple of models that have implications and then finally, because we have some money for the first time ever to pay clinical preceptors, we have been able to jump start something that has been difficult to do, which is more inter-professional education. We are able to have advance practice nurses and physician residents training together, looking at and working with the same clinical populations. We have wanted to do this forever, but with this additional little bit amount of money, it's made that happen.

DEBORAH TRAUTMAN: I would like to follow up on that comment. I think that as we continue to advance into professional education and practice, we will see opportunities that are going to have a direct impact on the way it was. Many of you may be familiar, there is a collaborative called The Interprofessional Education Collaborative that brings together schools of nursing, medicine, pharmacy, dentistry, osteopathic medicine, with the intent -- and there has been great work that has been done over the past five to ten years -- five in particular -- in developing these faculty institutes where faculty from all of those schools come together and have training sessions and look at what the academic institutions can be doing to strengthen our interprofessional education and practice and I think our best model of it today is by no means what it's going to look like in the future.

ED SALSBERG: I would just add that the debate and the discussion about graduate medical education and financing and organization is ongoing and clearly not resolved. I think actually the GME discussion can probably learn from the experiences of the GNE experiment or demonstrations. I will also note that Congress authorized teaching health centers for medical education, which may be actually closer to the model of the graduate nursing education, where their direct grants and very, very important incentives for primary care and unfortunately that program's funding ends this year and hopefully there will be more funding for it, because it's a good model. I think its important to move beyond just the GME Medicare financing model to these new demonstrations and approaches.

ED HOWARD: We have time for these two questions if folks will be as brief as they possibly can and the panelists can respond as briefly as they can.

AUDIENCE MEMBER: Hi, my name is Nancy Faulk and I was actually a fellow on Capitol Hill ten years ago and we were talking about this exact topic back then. Linda, thank you, I connected with you back at that time. I'm currently faculty at George Washington University and school nursing. A couple folks who just spoke actually talked about the funding and financing piece and I think one of the things that I learned on the Hill when I worked for a senator who was both on the Senate Finance Committee, the

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jurisdiction of Medicare, and also on the Health Committee, is that funds aren't unlimited. We started to touch on the funding issues, but can you continue on for a moment, just talk for a moment about the vision for how this might happen. Is it a situation where there might be funds that are moved from GME to more interprofessional programs? To fund the program? Or is there a vision that there are additional funding streams that might come specifically to the nursing community? Anything about the finance piece that you can speak more about.

LINDA AIKEN: What I can say is that no matter what number we come up with and I think my colleagues will agree, it will be a rounding error for the Medicare program.

AUDIENCE MEMBER: Jesse Bushman with the American College of Nurse Midwives. I was looking the figures that Deborah had on Title 8 and it's interesting to me that \$231 million across all of Title 8 as opposed to \$15 billion on GME. So we have 1/60th the amount of money going into Title 8 as you do in GME, which is an interesting comment on what we value. My question is, Deborah, do you have data on how many APRN students there are overall and then how many of them are actually receiving funding through Title 8. Then, Ed, you may know this answer or maybe somebody else on the panel -- how many physician residents and interns are being supported through GME and in terms of our policy decisions, how well are we supporting one group versus the other in light of what is the need of the patient population? If the bulk of the patient populations need primary care or when I think about it, the bulk of pregnant women are going to have a normal delivery, they need somebody who can handle that as opposed to highly skilled person who can handle the really complex, difficult things. What percentage of our trainees, our students, our residents are receiving funding either through Title 8 or through GME?

DEBORAH TRAUTMAN: So I can answer part of your question and on that second slide that we had on my presentation, it tells the number of students currently enrolled. So for nurse practitioners, there are almost 64,000. For certified registered nurse anesthetists, the number of current enrolled students is 4,230. For the clinical nurse specialist, its 2,349 and for certified nurse midwives, I'm sure you know the number, but for others in the room, it's 1,456. I don't know out of that number fully who are receiving Title 8 funding, but we would be happy to, if we have that data, share it with you at a later time.

ED SALSBERG: And in terms of the financial support, the main federal support for graduate medical education is the Medicare program. Clearly it is more generous than the grant programs, it's a formula driven tied to in patient days and the number of residents. I can tell you there are probably about 120,000 physicians in training now. The numbers that are actually supported by Medicare is a little less than that, but you have the VA and others. So it's an interesting question. I don't feel comfortable giving an answer other than clearly there is far more support for graduate medical education because it's built into the Medicare hospital reimbursement system.

ED HOWARD: I would like to say that we have settled all of this, but clearly we have not. What we have done, I think, is raised the general level of understanding of what the mechanisms are and what is going on that might bear on some changes that are coming in the future. And for that, I want to thank our colleagues at AARP and the Robert Wood Johnson Foundation for helping us put this program together. I want to thank you for braving what is now a raging snow storm outside, to come in and listen to this program. Please, you might as well stay indoors for 30 seconds more and fill out the blue evaluation form if you would, before you leave. We could really use your input. Susan?

SUSAN REINHARD: I just want to thank everyone that had anything to do with putting this together. Let's give everybody a round of applause.

ED HOWARD: Including our great panel.

[applause]