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CHARTING NURSING'S FUTURE
REPORTS ON POLICIES THAT CAN TRANSFORM PATIENT CARE

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IN THIS ISSUE

"People desperately need long-term services and supports (LTSS) to remain in their homes and communities. Nurses, because they have the trust of families and expertise in problem-solving, are improving LTSS and the lives of older Americans and the family caregivers who provide the bulk of their care."

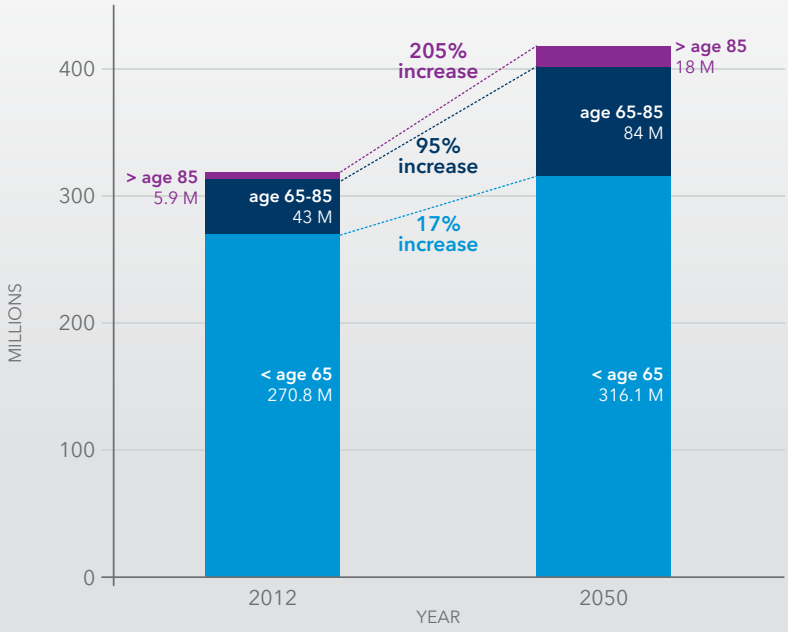
–Susan Reinhard, PhD, RN, FAAN
Senior Vice President for Public Policy; Director, AARP Public Policy Institute

Addressing the Looming Demand for Care as Americans Age: How Nurses Are Reshaping Long-Term Services and Supports

By 2050, the number of Americans age 65 and older is projected to almost double to about 84 million. With 70 percent of older Americans expected to seek assistance in maintaining their health and well-being, policymakers, insurers, health care providers, and consumers must find effective and affordable ways to harness the health care workforce to provide long-term services and supports (LTSS) to this population.

Nurses have developed many creative, sustainable, and compassionate ways to care for individuals who, because of disability, frailty, or illness, cannot care for themselves. Through advocacy and education and by spearheading and implementing novel programs, nurses are making it easier for older, chronically ill individuals to stay healthier, remain in the community with their families, and avoid developing expensive debilitating conditions. This brief describes some of these LTSS programs, their potential to reshape the future of care for older Americans, and policies that could facilitate their widespread adoption.

Figure 1.
Who Will Care for the Aging Population?



Currently most older adults—those age 65 and older—who require assistance receive care in their homes from unpaid family or friends who are part of the baby boom generation. The oldest boomers are now older adults themselves, and they will soon swell the ranks of those most needing care while the population of potential caregivers grows only modestly.

Data Source: U.S. Census Bureau, 2014. *An Aging Nation: The Older Population in the United States;* AARP Public Policy Institute, 2013. *The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers*.

How Nurses Are Increasing Access to Long-Term Services and Supports

In 2013, 12 million Americans could not live independently because of disabilities or chronic conditions. That number is expected to rise as the population ages, swelling to 27 million by 2050 and dramatically increasing the demand for LTSS. Alzheimer's disease is one of the major drivers of this trend. By 2050, about 13.8 million older adults are projected to be diagnosed with Alzheimer's, up from 5.2 million in 2014.

At more than 3 million strong, the nursing workforce will be central to meeting this growing demand for LTSS. In addition to providing clinical care, nurses can assess the long-term health prospects of individuals with physical and cognitive impairments, develop customized care plans, monitor individuals' responses to care, coordinate care across providers and settings, and oversee the quality of the assistance older adults receive.

This brief highlights nurses' roles in the design and implementation of programs that are already improving LTSS options for older Americans. These include programs aimed at:

- improving care transitions (see p. 3),
- enabling older adults to live in the community (see pp. 3, 4, and 5),
- preventing physical and cognitive decline (see p. 5),
- coaching and supporting family members (see p. 5), and
- making institutional care more homelike (see p. 6).

This brief also describes new curricular resources and policies designed to increase nurses' knowledge of caring for older adults (see p. 7) and explores state and federal policies that could improve access to care for aging Americans (see p. 8).

"Almost every day, I hear of an older adult's increasingly complex and debilitating physical health and need for individualized, person-centered assistance. Professional nurses can and do make a critical difference. There is an important and urgent need to expand the nurse's role in long-term services and supports to help ensure the health and safety of our nation's older adults."

–J. Taylor Harden, RN, PhD, FAAN
Executive Director, Coordinating Center at the National Hartford Centers of Gerontological Nursing Excellence

What Are Long-Term Services and Supports (LTSS)?

The term LTSS typically refers to a broad set of options for people of all ages, who because of ongoing disabilities and chronic conditions require assistance for 90 days or longer with tasks essential to their health, well-being, and safety. These include help with activities of daily life, traditionally defined as bathing, eating, preparing meals, shopping for necessities, managing money, and the like. As changes in technology have allowed people to perform health care activities at home that were previously performed by nurses, LTSS has come to include support for medication administration; bowel and bladder care such as enemas and tube feedings; as well as wound and colostomy care.

LTSS can be delivered in settings that range from private homes, to adult day-care centers, assisted-living facilities, or nursing homes. Although LTSS are critical to meeting the needs of all individuals with disabilities, this brief focuses on nursing's role in meeting the LTSS needs of people 65 and older.

Who Provides LTSS?

APRNs – Advanced practice registered nurses are RNs with graduate degrees and national certification who practice in several roles, including that of nurse practitioner (NP). NPs often provide primary care to older adults living in the community and sometimes coordinate care for high-risk older adults transitioning between care settings.

RNs – Registered nurses are educated at the diploma, associate degree, or baccalaureate level. They are licensed to evaluate a patient's health, coordinate and deliver clinical care, and provide health education, health counseling, and emotional support to patients and their family members. RNs are key players on the health teams that help older adults remain independent in the community. At nursing homes, an RN must be on call at least eight hours a day, and some states require RN coverage 24 hours a day.

LPNs – Licensed practical nurses receive one year of post-secondary vocational education and must pass a licensure exam. LPNs work in nursing homes and extended care facilities, hospitals, physicians' offices, and private homes. States determine which care activities LPNs may provide and which of these require RN supervision. Some states allow experienced LPNs to supervise unlicensed personnel such as CNAs and home health aides.

CNAs – Certified nursing assistants must complete a state-approved education program of at least 75 hours and pass a competency exam. In nursing homes, CNAs assist patients with feeding, bathing, dressing, grooming, and mobility challenges, and along with LPNs, provide the bulk of direct care. CNAs also work in residential care facilities, primary care offices, and hospitals.

Home health aides – No formal education is needed to become a home health aide, but some employers require aides to have a high school degree or formal training. Those who work at Medicare-certified home health agencies must complete at least 75 hours of training and pass a standardized test. Home health aides provide companionship and help with domestic and personal activities. They provide the bulk of paid care to aging adults in the community.

Other caregivers – Unpaid family and friends provide the majority of LTSS received by older adults living outside of nursing homes.

To learn who pays for LTSS, see p. 3.

Affordable Care Act: Pilot Programs Encourage Frail Elders' Independence

The Affordable Care Act (ACA) addresses LTSS for those 65 and older in several ways and includes provisions that shift some public LTSS dollars from nursing homes to community-based services. Through the Center for Medicare and Medicaid Innovation, a newly created center within the Centers for Medicare & Medicaid Services (CMS), the ACA is funding pilot programs, several of which depend on nurses to provide care that allows chronically ill older adults to live safely in the community.

Medicaid is the principal payer for LTSS, and Medicare is the principal payer for the health care of older adults (see graph below), giving CMS—and taxpayers—a strong incentive to experiment with programs that can keep beneficiaries healthy and reduce costs.

Independence at Home Demonstration

Helping homebound chronically ill Medicare beneficiaries remain independent is a goal of the ACA's Independence at Home Demonstration project. The pilot program tests a delivery and payment incentive model that uses primary care teams led by physicians and nurse practitioners (NPs) to coordinate home care for up to 10,000 beneficiaries.

NPs take the lead in Louisville, Ky., at primary care provider MD2U. MD2U has enrolled more than 1,000 beneficiaries, each of whom is assigned an NP, who makes house calls and brings all the necessary medical equipment to the home, and an administrative care coordinator, who schedules appointments. Each NP cares for 120 to 180 patients.

"When I first started MD2U in 2004, I thought I'd hire physicians for house calls, but this population requires a lot of attention and education," says Michael Benfield, MD, the founder of MD2U. "Nurses are educated in disease management and self-care. They have experience working with the equipment, like a catheter or IV. Physicians just aren't trained that way."

"NPs are the best-trained people to take care of the chronically ill."

–Michael Benfield, MD
Founder, MD2U

Each pilot project is expected to meet a 5-percent annual savings target and demonstrate that its patients are receiving high-quality care. If MD2U maintains a high standard for quality of care and achieves savings for the demonstration as Benfield anticipates, the provider's strategy of taking advantage of the strengths of NPs may eventually be used to extend access to scarce primary care services to many more older Americans.

Community-Based Care Transitions Program

Researchers estimate that 19.6 percent of the Medicare beneficiaries hospitalized in 2004 were readmitted within 30 days of discharge, in part due to the failure to adequately attend to the care transition at discharge. Researchers estimate that 90 percent of those readmissions were unplanned, costing Medicare about $17.4 billion.

Nurses have long asked how the transition from hospital to home might be handled differently. One of the first was Mary D. Naylor, PhD, RN, FAAN, Marian S. Ware professor in gerontology at the University of Pennsylvania, who pioneered the design of a transitional care model that uses APRNs to coordinate care for high-risk older adults within and across health care settings. The model has been shown to reduce readmissions through 12 months following hospital discharge, improve patients' quality of life, and save money. Another model, developed by Eric Coleman, MD, MPH, professor of medicine and head of the Division of Health Care Policy and Research at the University of Colorado Anschutz Medical Campus, uses RNs and has also produced impressive results.

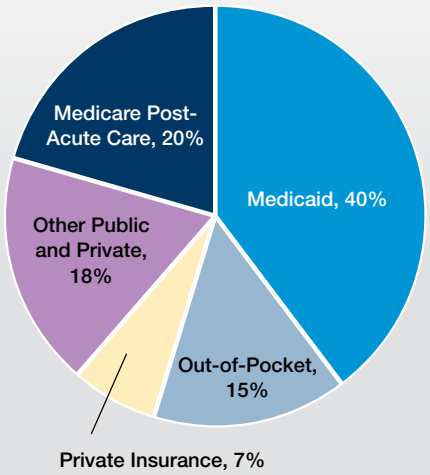
This evidence led lawmakers to allocate $500 million through the ACA for care transition programs, with a goal of reducing readmissions by 20 percent. The Central New Jersey Care Transitions Program (CNJCTP) is one site taking part in the ACA-funded Community-Based Care Transitions Program. Six hospitals in the CNJCTP region work with RNs and social workers, who together act as health coaches to teach self-care strategies to high-risk, chronically ill Medicare beneficiaries. RNs focus on beneficiaries' symptoms and health care needs, including medication management, while social workers attend to socioeconomic needs that may lead beneficiaries to return to the hospital. "The collaboration of nurses and social workers has been an essential approach to addressing all the needs of each patient," says Marie Perillo, RN, BSN, director of the New Jersey program and director of care coordination at the Visiting Nurse Association Health Group.

Within one to three days after discharge, a coach conducts a home visit and then checks in weekly by phone for 30 days. One week after discharge, the coach helps the beneficiary get to an initial, follow-up appointment with a primary care provider.

Since August 2013, more than 2,000 patients have received care through CNJCTP. Perillo says the program is on track to meet the CMS goal for reducing hospital readmissions.

Figure 2.

Who Pays for Long-Term Services and Supports?



Source: Kaiser Commission on Medicaid and the Uninsured. Estimates based on 2012 CMS National Health Expenditure Accounts data.

Integrated Managed Care Models: Addressing Costs and Quality

In addition to creating new programs to coordinate care for chronically ill older adults, the ACA recognizes the unique needs of individuals over the age of 65 who are "dual eligible"—meaning their incomes are low enough that both Medicaid and Medicare pay for their health care. Dual eligibles often have multiple chronic conditions, and half have cognitive problems such as dementia.

The ACA created a new entity, the Medicare-Medicaid Coordination Office, to streamline care for dual eligibles, ensure safe transitions between care settings, and eliminate cost-shifting between the two federal programs. Nurse leaders have developed two established LTSS programs—one national and one in Wisconsin—that can serve as models for policymakers looking for ways to help states meet these same goals.

Program of All-Inclusive Care for the Elderly (PACE®)

Twenty years ago, Jennie Chin Hansen, RN, MS, FAAN, recognized the potential of a pioneering local initiative serving San Francisco's low-income frail, older adults and helped turn it into a federally funded Medicare program. Today Hansen wears a different hat, CEO of the American Geriatrics Society, and PACE programs have multiplied to serve 30,000 beneficiaries through 104 programs in 31 states.

PACE provides health promotion, health maintenance, and full medical and social services to adults 55 and older who, based on state criteria, qualify to be in a nursing home due to a combination of cognitive, functional, and medical conditions. At the time of enrollment, individuals must also be deemed capable of living safely in the community. Most PACE members are eligible for Medicaid and entitled to Medicare.

Each PACE program uses a PACE center as a focal point for providing services. Enrollees spend two to three days a week at the centers, where they can see a primary care provider, receive physical therapy or personal care, refill prescriptions, and engage in socialization and related activities. PACE provides transportation to and from the centers. PACE also provides care from a home health aide when necessary and evaluates members' homes to ensure a safe living environment. Interventions range from removing such hazards as poorly placed electrical cords to installing assistive devices.

Nurses have a high degree of clinical autonomy within the program, and they often operate as leaders of health care teams that include physicians, other nurses, social workers, dietitians, nurses' aides, drivers, and physical, occupational, and recreational therapists.

PACE receives a blended, capitated fee averaging $5,500 per person per month from Medicare and Medicaid to provide care to enrollees. Researchers have found that Medicare expenditures on PACE enrollees are comparable to those of their fee-for-service counterparts, but that PACE reduced hospitalizations by 30 percent. "Because the program receives a preset fee that covers participants' complete health and medical care as well as their social, emotional, and environmental needs, PACE is incentivized to provide the best possible care to help its enrollees maintain their fullest functional, cognitive, and medical stability," says Hansen. "This is what comprehensive prevention with a frail, medically complex person looks like when you really do it well."

PACE is currently an optional program within Medicaid. Requiring states to offer PACE through their Medicaid programs could make the program available nationwide. For now, federal lawmakers have proposed legislation that would give PACE more flexibility to enroll additional beneficiaries.

Nurse-Led Care in Wisconsin

Another program enabling dual and nursing home eligible adults to remain independent is the Family Care Partnership Program, a public-private initiative in the state of Wisconsin. The program, spearheaded 20 years ago by Barbara Bowers, BSN, MSN, PhD, associate dean at the University of Wisconsin, integrates hospital transition services with health and wellness care, and long-term services and supports for 2,900 Wisconsin citizens.

Three managed care companies oversee the program in conjunction with the state, and as with PACE, each program member is assigned an interdisciplinary health care team. Partnership Program teams include a primary care physician, an RN, a social worker, and an NP who coordinates care between the enrollee's health care team and any outside care providers. Nurses from the team also provide transitional care when a member leaves the hospital.

According to Karen Musser, MNA, president and CEO of Care Wisconsin, a Partnership Program, getting Medicare and state Medicaid programs to work together is challenging. She is hopeful that policymakers at the Medicare-Medicaid Coordination Office will do more to enhance collaboration between agencies so more dual eligibles can be served by managed care programs.

According to a 2011 audit, Wisconsin's Family Care Partnership Program contributed to a decade-long drop in the growth of the state's Medicaid long-term care spending, in part by shifting expenditures from nursing homes to the community.

"PACE continues to provide patient-centric care to many of the frailest members in our society and keep them in their homes and communities. Nurses are one of the keys of the coordinated care team that results in PACE remaining one of the most effective, compassionate, responsive, and responsible health and well-being initiatives ever. It is important that successful models of care like PACE be made available to more older adults and their families."

–Rep. Chris Smith, R-N.J.
Lead sponsor of the PACE Pilot Act of 2014

Initiatives to Prevent Physical and Cognitive Decline

Aging is often associated with physical and cognitive decline. The most common cause of cognitive decline is Alzheimer's disease, which almost always necessitates LTSS, but at a cost too steep for most families. Nursing homes charge $84,000 to $90,000 a year for a private room, according to federal government and health care industry sources. The cost of home health care, about $20 per hour, quickly adds up.

Delaying physical and cognitive decline, and supporting family caregivers are two strategies for postponing the need for paid LTSS. Nurses have taken the lead in creating three innovative programs that employ these strategies. Expanding these programs could help reduce the growth of LTSS costs.

Interprofessional Effort Prevents Decline and Supports Families

Access to primary care is essential to slowing the pace of decline in older adults with chronic conditions, and so is supporting caregivers. With these points in mind, Claudia Beverly, PhD, RN, FAAN, director of the Hartford Center of Geriatric Nursing Excellence at the University of Arkansas for Medical Sciences College of Nursing, facilitated the launch of the Arkansas Aging Initiative in 2001. The statewide network of nine aging centers serves an estimated 1,200 to 1,600 older adults.

Each center is owned and managed by a local hospital and employs a geriatrician, an APRN, and a social worker to provide both primary care and education about chronic conditions. The team also supports people as they navigate various health care settings and provides care in the home when needed.

The centers also offer programs to family caregivers, health professionals, and students on how to assist people with LTSS needs. In addition to coping strategies, family caregivers learn the proper use of such assistive devices as hospital beds, walkers, canes, lifts, and transfer equipment.

Hospitals fund the primary care clinics and the interprofessional geriatrics team. Funding for the education component is provided by the state's tobacco settlement fund and other sources. According to Beverly, recent reductions in Medicare funding for hospitals in the state have cut into the primary care centers' operating budgets and pose an obstacle to the centers' expansion.

Nurse-Designed Project Aims to Slow Cognitive Decline

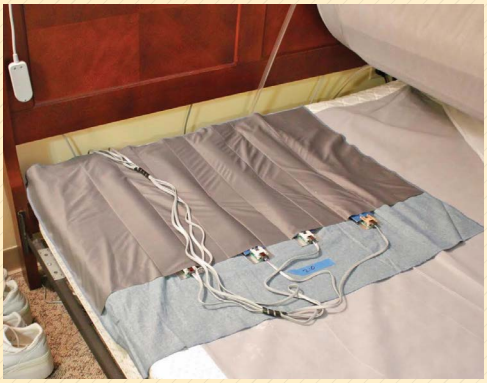
In a suburb of Milwaukee, Wis., Beth Meyer Arnold, RN, MS, a specialist in gerontology, and Lyn Geboy, PhD, an environmental gerontologist, have developed "Optimize: Your Brain and Health." The eight-week program for people with mild cognitive impairment aims to slow the course of their decline and to support their care partners.

The curriculum emphasizes a healthy lifestyle and physical and social activities that engage the brain. Once a week for two hours, individuals with mild cognitive impairment meet in a group. They exercise, learn about cognitive functioning, and work on creative artistic projects to keep the brain challenged. Participants learn about diet, communicating effectively, and other strategies for managing cognitive deterioration. The emphasis is on continued learning, as well as on developing peer relationships with those facing similar cognitive challenges.

An RN or social worker meets separately with the individuals' care partners to teach them about the progression of dementia, coping strategies, and community resources for support. So far, Optimize has served 250 individuals and their care partners. Geboy's preliminary evaluations of the program indicate that about half of those with cognitive impairment scored higher on cognitive tests after completing the program, and 55 to 58 percent of the caregivers felt a "decrease in burden."

As of 2014, the classes have only been available in the Milwaukee area, but Arnold and Geboy, owners of Cygnet Innovations Group, are developing an implementation manual to train nurses and social workers to deliver the model elsewhere.

The Value of Sensor Technology



Unobtrusive sensors placed under a mattress can measure heart rate, respiration, and bed restlessness. Other sensors placed in kitchen cabinets, over bathroom doors, near toilets, and elsewhere, detect changes in routine behaviors that can signal physical or cognitive decline. Residents of TigerPlace in Columbia, Mo., a retirement community, can opt to have their apartments outfitted with the remote monitoring technology. Automated computer algorithms look for patterns in the sensor data and alert a nurse or clinical social worker if those patterns indicate early signs of a health issue.

Photos: Katie Bell

For frail elderly adults, even small problems such as a urinary tract infection can flare into a health crisis if left untreated. Nurse faculty at the University of Missouri Sinclair School of Nursing helped develop the system, and they are now conducting a cost analysis to determine whether the technology saves money by preventing hospitalizations. If, as expected, the results reveal a cost savings, the researchers would like to see policymakers consider the use of the technology as a benefit for Medicare and dual eligible beneficiaries.

Culture Change: Reimagining Nursing Home Care

Approximately two-thirds of the Medicaid and Medicare dollars spent on LTSS go to the nation's 15,600 nursing homes, which care for 1.4 million people each day. In 1987, lawmakers' concerns about the cost and quality of care in these settings led to passage of the Nursing Home Reform Act. Contained within the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), the law created a statutory blueprint for improving the quality of nursing home care.

OBRA '87 created requirements that elevated residents' rights and quality of life to the same level as their clinical care. The law also directed nursing homes to make residences more homelike and mandated that individualized care plans be based on a comprehensive assessment of each resident. It promoted increased flexibility regarding meals, accommodating residents' natural sleep/wake rhythms, and honoring residents' choices related to bathing and other activities—practices associated with what is often referred to as person-centered care.

OBRA '87 laid the foundation for a growing "culture change" movement—a shift from institutional- to person-centered care. However, 20 years later, a survey by the Commonwealth Fund found that 43 percent of nursing homes still operated along traditional lines, and only 5 percent of nursing homes operated according to the new paradigm.

Nursing's Changing Role in Long-Term Care

Culture change has benefits not just for residents, but for nursing homes and their employees. Culture change facilities typically try to be less hierarchical by employing a more collaborative approach to providing care. CNAs often cross-train to assist residents with a mix of personal, household, and health care needs. The direct-care staff is also encouraged to work in teams that manage their own work throughout the day. RNs function in more of a leadership capacity, deploying their expertise and other resources to enable the work of the direct-care team.

The Commonwealth Fund's survey reported that as facilities embraced culture change, they experienced increased staff retention and decreased absenteeism. Such gains are significant. In 2007, nursing homes faced average annual turnover rates of 38 percent for directors of nursing and 66 percent for CNAs.

Levers for Change

STATE SURVEY AGENCIES

Nursing homes are highly regulated environments, but according to Mary Jane Koren, MD, MPH, a geriatrician and expert in long-term care, nothing in state or federal regulations prevents culture change. In fact, she points out, "Nursing homes are the only health care setting that has a statutory *requirement* for individualized, person-centered care."

Despite this mandate, institutions often fear that changes will make them vulnerable to financial losses or to citations for regulatory violations known as deficiencies. For example, one nursing home had to address regulators' concerns that it might be forcing residents to work or exposing them to contaminated food when it proposed planting a vegetable garden that residents could help maintain. Some states have addressed these issues by revising their survey instruments and training site surveyors to recognize the person-centered care practices that exemplify culture change.

MEDICAID DOLLARS

According to a study published in *The Gerontologist* in February 2014, states may also have some financial leverage in encouraging culture change. Researchers found that between 2004 and 2011, the probability of adopting culture change was higher in states that financially rewarded culture change or paid higher Medicaid per diem rates. However, the researchers cautioned, Medicaid incentives alone are unlikely to trigger widespread adoption of culture change.

EDUCATION

Research also shows that older adults who receive care from nurses with a background in geriatrics are healthier. According to Christopher Langston, PhD, program director of the John A. Hartford Foundation, Medicaid and Medicare could use their leverage as payers to require that people working in nursing homes and assisted living facilities have education in geriatrics. Koren agrees, and she would also like to see nurses acquire team-building, communication, and other skills related to delivering person-centered care.

The Value of Culture Change

In this skilled nursing facility at Orchard Cove in Canton, Mass., nurses dress in street clothes and share meals with residents, underscoring the homelike feel of the community. To achieve this quality of life for both residents and staff, Debora Symonds, MSN, RN, director of nursing, engaged the Paraprofessional Healthcare Institute (PHI) to facilitate culture change. PHI trained Orchard Cove's RNs, LPNs, and CNAs in how to seek resident input in care decisions and work more collaboratively with each other, permitting direct-care staff more autonomy in problem-solving within their scopes of practice. The training resulted in lower turnover and increased job satisfaction for staff, and a reduction in bedsores, urinary tract infections, and falls among residents.

Orchard Cove has 45 residents in its skilled nursing unit, who, on average, are 98 years old. The facility continues to provide communications training to staff every six months with a focus on building relationships.

Photo: Becca A. Lewis Photography

Educating Nurses to Care for Older and Frail Adults

As the American population ages, all nurses will need to know more about caring for older adults. Yet as of 2008, fewer than 1 percent of RNs were certified gerontological nurses, far fewer than are needed. This shortage led the Institute of Medicine to recommend that nursing schools do more to educate students about issues specific to geriatric care, such as managing cognitive impairment and multiple chronic conditions.

Historically, few RNs have chosen to pursue a career working with older adults, in part because the salaries tend to be lower in long-term care settings than in hospitals. But the looming shift in demographics points to the need for change. Nurse leaders at universities and professional associations have created a spectrum of resources to help educational programs retool their curricula and enhance the capacity of licensed nurses to address the needs of older and frail adults.

Pre-licensure: Geriatric Nursing Education Consortium (GNEC)

In 2005, the John A. Hartford Foundation made a $2.48 million grant to the American Association of Colleges of Nursing (AACN) to form the Geriatric Nursing Education Consortium, aimed at helping faculty increase geriatric content in senior-level undergraduate nursing courses. To date, 808 faculty members at 418 nursing schools have received training, and 344 nursing schools have reported adding or enhancing coursework focused on caring for older adults.

Post-graduate: The Merger of Adult and Geriatric Nursing Certifications

Given the likelihood that there would never be enough NPs specializing in geriatrics, in 2008, nursing education, credentialing, and licensing groups reached consensus on a plan to merge all graduate nursing programs in adult primary care and acute care with specialty nursing programs in geriatrics. By 2015, any nurse pursuing an advanced degree in adult primary or acute care will be educated in treating the full spectrum of adults—from young adults to the frail elderly—in order to receive certification. This change is intended to increase the pool of nurses with geriatric knowledge, enhancing the profession's readiness to care for the growing population of older adults.

Faculty: Advancing Care Excellence for Seniors (ACES)

The ACES Project, funded by the John A. Hartford Foundation and established by the National League for Nursing in 2009, aims to increase geriatric training for nursing school faculty who teach in associate and baccalaureate degree programs. A collaboration between the League and the Community College of Philadelphia, ACES has educated about 1,500 faculty throughout the nation. The course covers teamwork, care coordination, evaluation of older adults during hospital stays, and transitions between care settings.

Continuing Education: Nurses Improving Care for Healthsystem Elders (NICHE)

NICHE, which has been funded by the John A. Hartford Foundation and the Atlantic Philanthropies, is a learning collaborative operated through New York University's School of Nursing. The program provides nurses working in hospitals and health care systems with educational resources, project management support, clinical protocols, and access to a community of learners made up of NPs, gerontological nurses, and health coaches working in acute care facilities. Participants, in turn, train fellow staff on the health needs of the frail elderly. More than 575 hospitals and health care facilities in 46 states, Canada, Bermuda, and Singapore belong to NICHE.

Policy Opportunities: Funding Graduate Nursing Education (GNE)

The ACA authorized $200 million over four years for the Graduate Nursing Education Demonstration to increase the number of APRNs trained to provide primary care to Medicare beneficiaries. Five teaching hospitals have received funds to partner with nursing schools and community-based clinics to prepare APRNs in such areas as care transitions and chronic disease management. Data on this demonstration project will not be available until 2017, but Suzanne Miyamoto, PhD, RN, senior director of government affairs and health policy at the AACN, says GNE has expanded collaboration between hospitals and nursing programs. The AACN, AARP, and professional organizations representing APRNs will be working together in 2015 to engage lawmakers on the benefits of the program.

"Nurses are at the heart of the care Americans receive every day and play a critical role in our changing health care system. They are key to making sure all Americans, including older Americans, have the care they need, not only when they get sick but also to stay healthy in the first place."

–Sen. Tom Harkin, D-Iowa

The Value of Nursing

The University of Portland School of Nursing pairs its students with an older adult living in the community to learn about the health, life experiences, and the challenges of aging adults. The relationships continue for one semester and inform students' understanding of the geriatric content in their courses on population health, nursing theory, communications, and foundational nursing skills.

Photo: Andrea Lonas Photography

Policies That Could Improve Access to Care for Older Adults
Momentum Builds for Scope-of-Practice Reform

As the population ages, a growing number of older adults and their families could benefit from the wide range of services that APRNs, especially the nation's estimated 154,000 nurse practitioners (NPs), can deliver. These nurses have advanced degrees and are clinically prepared to provide much of the care coordination, disease management, and primary care that older adults need.

Yet federal regulations and, in many cases, state laws hamper NPs' ability to exercise their full practice authority. More than three-fifths of states require NPs to enter into a collaborative agreement with a physician in order to diagnose and treat patients. Federal regulations and, in some cases, hospital policies also prevent APRNs from engaging in such practices as ordering tests or medical equipment, admitting patients to a hospital, approving home health care, signing death certificates, or prescribing drugs, especially the controlled substances on which many older adults rely to manage pain or dementia.

Although these laws were originally put in place to protect patients, the Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*, cites numerous studies showing that NPs provide care that is equivalent to and sometimes better than the care provided by primary care physicians. Consumers with chronic diseases may also gain an additional benefit from NP care. A study published by the Centers for Disease Control and Prevention in April 2014 shows that NPs and physician assistants are more likely than physicians to educate their patients on how to manage chronic conditions.

A patchwork of restrictions related to reimbursement also hinders consumers' access to APRN services. For example, NPs must seek physician approval before Medicare will agree to pay for home health services for their patients. The ACA added an additional requirement that physicians must certify beneficiaries' eligibility for these services and for durable medical equipment. These inefficiencies can reduce the amount of time NPs spend with their patients and result in care delays, especially in remote settings.

In 2012, the National Governors Association recommended that states ease their scope-of-practice laws and retool reimbursement policies to expand access to NP-delivered primary care. In March 2014, the Federal Trade Commission added its voice to calls for reform. The agency characterized requiring APRNs to obtain a contractual agreement with a physician in order to practice "anti-competitive," and urged states to change their rules. In 2008, the National Council of State Boards of Nursing (NCSBN) adopted a model that allows for full APRN practice authority. The Consensus Model for the Regulation of APRN Licensure, Certification, Education & Accreditation was developed by 23 nursing organizations that agreed to implement the model by 2015. NCSBN has also assisted state boards of nursing in adopting the model. To see the progress of state legislation, visit https://www.ncsbn.org/5397.htm.

Scope-of-practice reform has also experienced setbacks. In September 2013, the Veterans Health Administration proposed granting full practice authority to its 6,000 APRNs, but momentum stalled when some lawmakers expressed opposition to the idea.

Other Policies That Enhance Care for Older Adults

To ensure access to affordable, high-quality LTSS for the growing population of older adults, policymakers and service providers can:

- Expand effective and innovative programs that use nurses to improve care for older adults and support their caregivers (see pp. 3 and 5).
- Make access to the Program of All-Inclusive Care for the Elderly (PACE) a mandatory state Medicaid benefit, and consider legislation that would increase the flexibility of PACE to provide services (see p. 4).
- Encourage regulators to provide support to nursing homes engaged in "culture change" and other efforts to improve the quality of institutional care (see p. 6).
- Encourage CMS to require staff at long-term care facilities to have more education related to caring for older adults and culture change (see p. 6).
- Support continued funding for the Graduate Nurse Education Demonstration program (see p. 7).

> *"[S]tates may want to consider easing their scope of practice restrictions and modifying their reimbursement policies to encourage greater NP involvement in the provision of primary care."*
>
> **–National Governors Association, 2012**
>
> ***Source:*** Maria Schiff, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care* (Washington, DC: National Governors Association Center for Best Practices, 2012).

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