Introduction

Enrollment in nursing education programs almost doubled between 2002 and 2012 (Auerbach, Buerhaus, and Staiger, 2017). Numerous sources report that the overall number of registered nurses in the United States has stabilized and is now projected to meet the national need (Auerbach, Chattopadhyay, Zangaro, Staiger & Buerhaus, 2017; Buerhaus, Skinner, Auerbach, & Staiger, 2017; U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis, 2014). This national level aggregation hides regional and setting differences. Auerbach, Buerhaus, and Staiger (2017) detail regional differences in RN workforce growth projections between 2010 and 2030. When these differences are matched with the age of the population, notable problem areas emerge. The New England region (Maine, New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island) is expected to age the fastest with the least growth in new RNs, while the West South-Central region (Texas, Oklahoma, Arkansas, and Louisiana) is expected to see the reverse; an increase in new RNs by 40% with only a 5.4% increase in the population over 65 years-of-age. These variations underscore the local nature of the workforce and mitigate the positive news suggested by national data.

Data specific to the RN workforce in home-based care is rare. The Bureau of Labor Statistics (2015) projects that health care and social assistance “are expected to have the fastest employment growth and to add the most jobs between 2014 and 2024”. Further differentiation in the sector specifically identifies home health care services, with a projected increase of 4.8%, as second only to construction in wage and salary growth between 2014 and 2024. Hospitals are only expected to see a 0.8% increase during this time. In a national analysis of workforce demands in various long-term care settings, including home health, new RN jobs are projected to increase between 59% to 73% by 2030 (Spetz, Trupin, Bates, and Coffman, 2015). These projections, coupled with the regional differences in population and RN growth, lend support to the concern expressed by home-based care leaders about the growing challenge of workforce stability and availability.

Home-based care is a broad term used to encompass all kinds of clinical care provided in the location the individual identifies as “home.” The traditional definition of home-based care includes home health and hospice. Although home-based care is rapidly expanding beyond these traditional Medicare-defined benefits, they remain the largest and most well-defined segments of the industry. Clinical and operational leaders in home health and hospice agencies increasingly worry about recruitment and retention, reporting growing problems with nurse retirements, lack of applicants, and growing patient needs. Concerns about meeting patient needs are growing, and many are voicing a need for new models to manage their workforce.

Project

Members of ElevatingHOME and the Visiting Nurse Associations of America (VNAA) are committed to innovative, collaborative problem solving to meet the health care needs of people at home. The availability of registered nurses is a critical cornerstone of all healthcare delivery settings. In home-based care, it is a significant limiting criterion to service delivery. Ensuring a vibrant, professional workforce of RNs starts with nursing education. To that end, ElevatingHOME and VNAA invited nurse
leaders from home health and hospice agencies and from nursing academia to explore the intersection of home-based practice and nursing school.

The following report summarizes numerous interviews and multiple group conversations. As an exploratory conversation with experts in the field, it offers insight, guidance, and opportunities for next steps.

Summary of Findings

**Goal 1: Assess the perspective of home-based care nurse leaders and nurse educators about new graduate nurses in the home setting.**

**Agency leaders hiring new graduates**
The group agreed that hiring new graduate nurses in home health and hospice is generally discouraged. Many reported that this has been a general industry position for over 30 years. The rationale supporting this principle includes the isolation of home-based practice, the need for reliable assessment skills before entering homes, the complexity of home-based practice, the maturity needed for end-of-life care, and the generalized belief in nursing culture that “everyone has to do their year in med-surg.” In some states, this is encoded in state regulations, disallowing new graduate nurses to practice in home health. (Department of Health and Hospitals Office of the Secretary, Bureau of Health Services Financing, 2001).

Several members of the group reported active hiring programs for new graduates. There was general agreement that this is rare across the industry and over-represented in this group. Leaders who hire new graduates reported doing so in response to significant and long-term problems with the RN workforce. They reported long-term vacancies, lack of experienced applicants, high turn-over, and high costs related to the problem. Agencies hiring new graduates described a variety of programs developed to orient new nurses.

Designs ranged from extending the standard orientation program all the way to agencies employing a dedicated nurse educator who leads a full-year Nurse Residency Program, built on the curriculum of the American Association of Colleges of Nursing. Leaders with more intensive programs report positive early results, but these programs are generally only one to two years old, and retention rates will be evaluated over time.

New graduates were reported to be generally eager, moldable, positive, and “full of energy.” They also need more time and commitment from a mentor during orientation. Success with retaining new graduate RNs was subjectively related to the investment in their orientation. Agencies with dedicated educators, reduced productivity expectations, and longer, more customized orientations report more positive results; but this observation has not been quantified by a side-by-side comparison.
The challenges of investing in specific programs for onboarding new RNs were noted as “just different issues.” The common challenges with hiring experienced RNs were mitigated with new graduates. Notedly, new graduates do not demonstrate the same struggle with time management, travel between visits, and documentation that many experienced nurses struggle with in home-based care.

Leaders shared observations of nurse-specific variables as predictive of success. Second career, older nurses, and those who live in the community are more interested in home-based care and more likely to accept the position as a new graduate. Nurse educators concurred, reporting that traditional college students, those right out of high school and away from home only for college, are less likely to consider the long-term and community nature of home-based care. Alternatively, those who are grounded in the community and pursuing an RN degree as a second career, or as a career development opportunity, are more likely to find value in the environment of home-based care.

**Nurse educators and home-based care**

Limited exposure and involvement with home-based care in nursing school was identified as a concern. Home-based care is most likely to be included in the curriculum under the general framework of “community nursing.” Community nursing is used as a generic term, without clear definition. It may represent nursing care provided in homes, ambulatory settings, public health offices, schools, churches, and a variety of other locations. Practice anywhere outside of a hospital could fall in this category. It is rare that case studies and examples used in class and simulation are set in homes. Most educators report having home-based care clinical rotations for at least some RN programs. Clinical experiences vary based on the length of and degree awarded by the program; geography and availability of appropriate educators also impacts the availability of these experiences.

When home-based clinical experiences are integrated in curriculum, they are generally limited to “shadow” experiences. Coordination and access to RNs able and willing to supervise students in homes, one patient at a time, significantly limits the independent action of the students. Although some schools do send students in pairs to see patients without a direct supervisor, their actions must be limited to interviewing activities and often are perceived as “social visits.” When students have experiences partnered with the home nurse, much of the nurse’s critical work is unobserved. Home-based nurses invest considerable time assessing and care planning. This work involves extensive time thinking, documenting, and communicating with other team members; unlike in the faster pace of a hospital, these activities are often spread out over time. Care planning in home-based care is typically completed over days, not minutes, employing multiple communication methods and delays while information is gathered. If the nurse is not invested in explaining and articulating this work, it is almost impossible for the observing student to understand. The sporadic nature of a student’s clinical scheduling impedes the ability
to see the full cycle of impact born by the nurse at home. These structural barriers pose significant challenges for nursing educators who seek to design engaging learning experiences for students.

The diversity of electronic medical record systems is another systematic barrier to students in home-based care. The complexity, variability, and security of these systems impede easy access to patient records. Since many home-based care agencies have limited Information Technology support staff adding, deleting, and training students and instructors is not prioritized. The diversity of systems utilized is greater in home-based care than in hospitals as is the cross over between paper and electronic records. Paper records in home-based care are often hard to access and discerning what is paper vs. electronic becomes complicated.

The workforce of nurse educators is under pressure in general; additionally, nurse educators expressed difficulty recruiting nurses with a home-based care background as mentors, instructors, and faculty. This combination leaves a void in connecting the curriculum with home-based care.

Numerous questions about the current state of home-based care and nursing education represent opportunities for action.

**Curriculum**
Core curriculum requirements heavily focus on hospital-based experiences and the perspective of acute illness, which is no longer reflective of nationwide health needs. Multiple comorbidities, long life expectations, and cost-reduction efforts moving care out of hospitals are radically changing post-graduation practice. Practice in home-based care is highly dependent on care planning, holistic assessments inclusive of the environment, long-term relationship building, and independent practice. Although these concepts are in curriculum currently, emphasis remains on skill-based practice and needs of the acute care setting. Simulation suites and adoption in nursing schools was identified as a significant asset to expanding experiential learning. At this time, simulated home-based scenarios are rare, they could be designed with relative ease and shared quickly.

The variety of different programs as an entry into practice is a gap to be explored. It was unknown if home-based care exposure changes in relation to the program degree.

Numerous competing factors in education were discussed as influencers of the curriculum. It was noted that more discussion about what foundational skills are in the practice of nursing and how they are best developed will be useful given changing demographics, payment reform, and the continued shift from illness- to wellness-care.

Leaders in practice will need to better articulate the skills new graduates must have to successfully join home-based practice. The industry is challenged...
to breakdown barriers to student experiences. Clinical experiences are generally lacking in student engagement. These experiences are key opportunities for students to make work plans. Agencies are unprepared to utilize them for recruitment and development.

Many opportunities were raised to utilize home-based practice to develop a focus on family caregivers, cultural needs, and community level skills, which are not prioritized in acute care practice. Safety issues for both patients and staff in home-based care were recognized as significantly different than what is typically covered in curriculum. Safety discussions are strongly embedded in the hospital setting and will need to be reexamined for the home.

**Orientation**  
The “one year in med-surg” adage was referenced as a substitute for the development of the conceptual skills required in home-based care. The challenge to develop these skills during an orientation period is multifocal. The need for planned educational content, organized learning exercises, and an opportunity to grow these skills in a safe practice environment requires resources (time for lower productivity among staff and nurse educators) which are not commonly found in home-based care agencies.

**Structural**  
It was identified that at least one state expressly bars new graduate nurses from working in home-based care by regulation. At the opposite end, the home health conditions of participation (CoPs) allow for a student nurse to perform billable visits, a practice state boards of nursing have not supported. A full inventory of what regulations exist where, and how they fit together, is critical to national initiatives.

Retention length, recruitment rate, and vacancy length are all common measures already in use, but they are not reliably aggregated within home-based care. There is currently no large, central repository for data about nursing practice in the home setting. A structure for tracking and disseminating data is needed.

Numerous questions about how the NCLEX exam could support a shift in curriculum were raised. The test drives nursing curriculum and is an important aspect of any change efforts.

A gap was noted in the sharing of knowledge and experience about practice in home-based care. There are grant projects, residency programs, programs with developed clinical experiences, and home-based care discussions in schools, but there is a lack of knowledge sharing. There are home-based care agencies successfully recruiting and supporting new graduates; and several programs who gave up trying to hire them after multiple failures. These cases need to be studied and shared.

**Summary**

These discussions explored two key questions: what is the current relationship between home-based care nursing practice and nursing education, and is there room to improve it? The clear answer is yes, there is room to create more effective, higher value connectivity between nursing education and home-based care.

The nation has already begun what is expected to be a radical shift in care delivery away from acute care and institutions and into homes, focused on wellness, and maximizing person-centered choices. This shift is changing where and how nurses’ practice and places demand on different aspects of the profession.
Looking Ahead

ElevatingHOME and VNAA look forward to working with nurse leaders to breakdown these barriers, share knowledge, and affect change. Based on these findings, we will work to:

• Identify role model home-based care agencies already hiring new graduate nurses and develop case studies for sharing
• Identify outcomes measures to monitor the nursing workforce in home-based care
• Develop mechanisms to implement a national database for the nursing workforce in home-based care
• Initiate discussion with the National Council of State Boards of Nursing and the American Association of Colleges of Nursing regarding home-based care content

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