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Recent hurricanes show how hospices need to continually strengthen disaster plans

Hospices that have been there pay attention to details

If there is anything positive that comes out of the natural disasters of recent years, including hurricanes Katrina and Rita, it's the lessons hospices and other health care providers have learned about disaster planning.

The recent Gulf Coast disaster forced some hospices to enact two disaster plans back-to-back. First, some Texas hospices had to find ways to accommodate additional patients among hurricane evacuees, and then the same hospices had to engage in their own preparations for Hurricane Rita, says **Robin Kruth**, BSN, vice president of hospice operations at VITAS Healthcare Corp. in San Diego, CA.

"We received 18 transferred patients from Hurricane Katrina into our Houston program," Kruth says. "Some patients were from other hospices, and others were evacuees who, due to stress and the situation, saw their conditions worsen, and so they became hospice patients."

Several weeks later, all 125 patients served by the Houston office were under mandatory evacuation and had to be relocated, Kruth says.

"We transferred a lot of patients to sister programs in Dallas and San Antonio and Fort Worth," Kruth explains. "We transferred patients to facilities where we had partnerships."

More recently the hospice provider had to evacuate staff and patients in California because of fires, Kruth says.

Whether the disaster involves fires in California, hurricanes in the Gulf Coast or Florida, or something else, the 27-year-old hospice corporation has seen it all.

"Being a Miami-based company, we have pretty detailed procedures and protocols for how to get ready for a natural disaster," says **Mark Cohen**, vice president of communications and public relations for VITAS Healthcare Corp. of Miami.

Even so, there are some disasters that are such a surprise that only fast action afterward can provide necessary help.

For example, Brighton Gardens, a nursing home in Bellaire, TX, evacuated 53 residents in preparation for Hurricane Rita, using charter buses to take them to a sister facility in Dallas. Unfortunately, one of the buses caught on fire, probably related to patient oxygen tanks, about 16 hours into the long, slow journey. More than 20 people died in the fire.

While a VITAS hospice in the area had some patients at the nursing home, which was operated by Sunrise Senior Living of McLean, VA, a chain with hundreds of facilities across the United States and world, none of the hospice's patients were on the bus that caught fire, Kruth says.

However, as soon as the hospice received word of the fire and deaths, managers sent chaplains and social workers to the Dallas facility where the Brighton Gardens nursing home residents were being transferred during the evacuation, Kruth says.

"Our folks were in there all night, assisting with bereavement services," Kruth explains. "We played a significant part in assisting in bereavement with their staff, families, and care providers at the nursing home."

Some Florida hospices have dealt with so many disasters in recent years that disaster preparedness has become a continuous improvement project.

During Hurricane Ivan last year, Covenant Hospice of Pensacola, FL, lost its corporate and clinical offices, and 14 members of the staff had lost their homes, says **Dale O. Knee**, MHSA, president and chief executive officer.

Previous disaster had taught hospice managers to have cash on hand for emergency purposes as a hurricane approaches because ATMs will stop working and banks might be destroyed, Knee says. **(*See story on tips for disaster planning, p. 123.*)**

The money can be used for any legitimate purpose, including giving it to employees who were victims of the disaster and are in need of financial assistance, Knee says.

"The next day after Ivan hit I was standing in the parking lot distributing money to employees, and they signed and acknowledged receiving $500 or whatever I paid them," Knee says.

VITAS hospices also had cash on hand for employees' financial burdens, and managers handed out gas cards prior to the hurricane's landfall to ensure the staff had full gas tanks, Kruth says.

Covenant Hospice also will pay staff ahead of time if a storm is expected before the pay day, Knee says.

"Most of these good ideas come out of bad experiences and lessons learned unfortunately," Knee notes.

For instance, Hurricane Katrina ushered in a new problem of gasoline shortages, Knee says.

"Katrina did impact us, but not as bad as Ivan," Knee says. "But it was still significant, and we had more staff members lose their homes and more than 150 patients evacuated."

Power outages hit about half of the Pensacola hospice's service area, and the hospice in Mobile was out of power for several weeks, and this problem was compounded by gasoline shortages, Knee explains.

"We have gone together with two hospitals

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in Pensacola to have a contingency plan where if a gas station loses power but still has gas in its tanks, we can hook up the station to a generator, so we can pump gasoline for our staffs," Knee says. "It could be used exclusively for the three of us, and we're looking to do that in other areas."

Hospices have to be prepared for having patients spread far and wide during an evacuation process, Cohen says.

"We have 2,500 patients in South Florida, and there are 2,000 different answers to how an evacuation goes," Cohen says. "Some move in with family and friends who have power; some might be put in our inpatient units, which all are part of hospitals or nursing homes."

Also, Miami has critical needs shelters where people register at the beginning of the hurricane season, and those shelters are staffed with medical personnel, Cohen explains.

"If patients in Miami are in an evacuation zone, they might go there," Cohen says.

VITAS hospices recovered quickly from Hurricane Rita, thanks in large part to the careful disaster planning, Kruth says.

"After Rita we were back up the next day," Kruth says. "Our advantage was we had a lot of folks who stayed local and were able to get back in the swing of things quickly."

Within two weeks, all of the patients who were evacuated because of Rita were able to return, she notes.

The problem with Hurricane Katrina, which blew across Miami and Dade County, is that there was little time to prepare because it was born in the Bahamas, Cohen says.

"We didn't have much more than 24 hours notice between the time it grew from a tropical depression to a storm," Cohen notes.

"Generally, this time of year you're getting storms that come off the horn of Africa and travel across the Atlantic and end up in the Caribbean," Cohen says. "And we have a lot of advance notice."

The other problem with Katrina is that it moved slowly over Florida, causing some areas to experience 12 hours of tropical storm-force winds that left power outages and disaster in their wake, Cohen adds.

"My observation is that 12 hours of a 75 miles per hour wind can do as much damage as two hours of 140 miles per hour wind," Cohen notes. ■

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Hospices can do a great deal upfront to prepare for the next 'big one'

Disaster preparedness experts offer these tips

Whether a hospice is situated in a hurricane, earthquake, fire, flood, or tornado zone there's a lot managers can do to prepare for a disaster.

For one, every hospice should have a disaster plan that takes into consideration as many difference scenarios as can be imagined, experts say.

"We've had a disaster planning process in place since 1993, and we continually update that," says **Dale O. Knee**, MHSA, president and chief executive officer of Covenant Hospice in Pensacola, FL. Knee spoke about delivering hospice care after a catastrophic disaster at the National Hospice and Palliative Care Organization's (NHPCO's) 20th management and leadership conference and exposition, held Sept. 22-24, 2005, in Hollywood, FL.

"Not only do we update it based on lessons learned, we test it and have periodic drills of differing types with different scenarios," Knee adds. "Our plan is office and count specific, and each office has its own individual plan, which in turn ties into the master plan for the organization."

The plan is available on an in-house computer link, and hard copies are available in every hospice office, he says.

VITAS Healthcare Corp., based in Miami, has

hospices located in some of the most disaster-prone regions, including Florida, the Gulf Coast, and California, says Robin Kruth, BSN, vice president of hospice operations for VITAS in San Diego.

"We're very proactive when it comes to disaster planning and preparations," Kruth says.

Knee and Kruth offer these suggestions for how to improve a hospice's disaster plan:

1. Plan for everything, but know which disasters are most likely.

Covenant Hospice, which has 13 satellite offices and corporate headquarters in Pensacola, also divides potential catastrophes into three categories, including these:

- Natural disaster, including hurricanes and floods;
- Man-made disasters, including chemical spills from train derailments;
- Violence and terrorist incidents, including bombings and riots.

"We have a matrix called the continuity of operations planning that addresses all of these three categories, and with that we generate what we call a hazard vulnerability analysis," Knee says.

The hazardous vulnerability analysis is in a matrix format, and it shows the probability of something happening from one to five, Knee explains.

"So if, for example, we have an office close by a railroad track where there are a lot of chemical transports being made, then that might be a three from a hazard standpoint," Knee says.

Also, the hospice has a three-step process for hurricane planning, divided by 72 hours, 48 hours, and 24 hours before the hurricane is expected, Knee says.

VITAS hospices review their disaster plans at least annually, and many review the plans on a quarterly basis, Kruth says.

When a disaster strikes, a hospice needs to know who the key staff and managers are so they can be called to coordinate the plan, Kruth says.

"There are a lot of staff members who don't have families, and they'll step up and say, 'I'll give 100 percent during this disaster,' while others say, 'I have four young kids, and if I don't have schools to provide care, then I need to stay home with my kids,'" Kruth notes. "The key thing is to be proactive and really look within your organization to see who the key leaders in the program are."

It's a hospice's responsibility to ensure the safety of patients, their families, and staff, Kruth says.

2. Have contingency arrangements for telephone service, medications, and equipment.

"Because we are a national organization and have programs in various parts of the country, if we have to transfer phones or assist sister programs we can do that," Kruth says.

The hospice organization has arrangements with medication, durable medical equipment, and other vendors to have extra supplies on hand during the days or hours before a hurricane strikes, Kruth says.

"So we can be sure all hospices have enough medicine and supplies to protect them for a two-week period of time," she adds.

During hurricane season, Covenant Hospice stacks up on supplies, Knee says.

Covenant Hospice will have all calls forwarded to a call center out-of-state in the 12 to 24 hours before a storm is expected to hit, Knee says.

"It's a seamless process, and patients and referral services don't even realize that the calls are forwarded," Knee says.

3. Share decision-making and have communications plans.

Covenant Hospice has a safety manager who is in charge of disaster planning, as well as risk management, and adverse events, Knee says.

"She chairs a committee made up of representatives of the organization, and they periodically look at the disaster plan," Knee says. "The plan, although it's centralized and is a corporate disaster plan, the only way it can work is by decentralizing decision-making."

So each branch manager and other key people are authorized to make decisions on a case-by-case basis, Knee says.

One key aspect of disaster planning is the recall plan.

"The most important thing that happens as part of the plan is there's an overall request that as soon as possible after an incident or storm or hurricane that by 9 o'clock the morning after the storm all staff will return to their office if they're able to safely," Knee says.

VITAS hospices also include in their disaster scenarios a plan to have staff meet at a particular place at a scheduled time after the disaster strikes, Kruth says.

"That's the meeting point, and you put together what we call a disaster tree, where you have an outline of what's going to occur prior to

the disaster, Kruth says.

"In Houston, we have patient care teams and inpatient care units, and each team has a team manager," Kruth says. "One person was delegated to be the key person in charge of that particular group of patients, and it's that person's responsibility to see that they're all contacted either by phone or by care provider going directly to the home."

Communication planning during disasters should include alternative ways to reach staff and patients, Knee says.

Covenant Hospice, for example, has a call list that can be used as staff wait for a storm or hurricane.

Knee will call several people at the top of a calling list to give them detailed instructions. Then each of those people call 10 or more people on their list, and this process continues until everyone is reached, Knee says.

"Last time we used this was during the approach of Rita, just to disseminate information," Knee recalls. "From the time I put out two or three sentences of information later in the evening until the information reached over 800 people, it was just about 70 minutes."

Then the last people who receive the information have to call Knee or a safety manager or another designated manager to let the person in charge know that they've been contacted, he adds.

After the disaster strikes, the staff will communicate by cell phone if possible, and if there is no telephone reception, then everyone reverts to the planned recall list to meet in person, Knee notes.

4. Know everyone's evacuation plan.

Each patient at Covenant Hospice has to have an evacuation plan as part of the admission process, Knee says.

"While it's nice to have several days notice with a hurricane, there are too many other incidents in which you'd have virtually no notice at all," Knee says. "So each patient has an individualized evacuation plan which we work with them on."

"Seventy-two hours before the storm we double-check our evacuation plans, and we ensure hospitals and nursing homes have evacuation plans for our patients," Knee says. "We put a hospice nurse in any special needs shelter where our patients might be going."

At 48 hours before the storm, the hospice makes certain patients have all the medications and supplies they need for two weeks, and staff advisories are issued, Knee says.

And then 24 hours before the storm, the hospice reinforces its storm plan and makes certain all medical and electronic records are in a secure place.

As a final part of evacuation planning, it's important to note that no hospice has to handle everything on its own because there are many hospice providers who are willing to help during a tragedy and disaster, Kruth says.

"We're all out to provide quality end of life care and the support that people can depend on," Kruth says. ■

Motivate and retain staff through open communication

Mutual respect is essential, expert says

Hospices can improve staff motivation and retention once administrators adopt a policy of open communication and mutual respect, an expert advises.

"Mutual respect is especially important," says Denise Bauer, RN, RRT, CHPN, chief executive officer of Fair Hope Hospice and Palliative Care in Lancaster, OH. Bauer and Karl Hartmann, who also is at Fair Hope Hospice, received the Heart of Ohio awards for hospice employees, presented in late 2004 by the Ohio Hospice & Palliative Care Organization (OHPCO) in Dublin, OH.

"We respect each other for their position on the team equally, and their opinions are valued," Bauer says. "The staff feel this is a comfortable place to share and work."

Despite having to cope with the hiring and competitive wage challenges common to free-standing hospices, Fair Hope Hospice has a pretty good staff retention overall, Bauer notes.

Retaining home health aides is the biggest challenge, and the hospice's annual turnover rate is about 25 percent, Bauer adds.

However, receiving the hospice employee honor from OHPCO was affirmation that the hospice's work in motivating and retaining employees, Bauer says.

Here are some of the strategies the hospice uses to improve employee morale and motivation:

* **Use a motivation technique, such as**

FISH! Philosophy: The hospice sets the culture and tone for its staff through following the FISH! Philosophy ©, which was developed by John Christensen, chairman of ChartHouse Learning of Burnsville, MN (www.charthouse.com/)

"It's a motivational strategy for staff, which talks about open communication and respect, while having as much fun as you can in the workplace," Bauer says.

Hospice managers show FISH! Philosophy videotapes and books to staff, and they teach new employees the four key aspects of the philosophy, which are as follows:

• "Be present," Bauer says. "That's really actively listening and communicating with each other, not daydreaming when someone is talking on the phone, but listening and trying to help people."

Hospice staff are taught that it's important to be present with patients and families, showing they care and are not just doing a routine job, Bauer says.

"If a caller is talking to you, take time and listen, and if you don't have time, say, 'I don't really have time and can't talk right now,'" Bauer says. "But give people your undivided attention."

• The second aspect is "play."

"This means to allow people to give a more positive attitude about their work so they can do their work, but also smile and have positive energy in the workplace," Bauer says.

• The third point is to make their day, Bauer says.

Hospice staff need to try to do what's moral and help people as best they can, focusing on customer service, Bauer explains.

• And the fourth aspect is to choose your attitude, she says.

"People can choose their attitude on a daily basis," Bauer says. "And this also gives you permission to approach someone who has a bad attitude and talk with them about that."

* **Keep staff meetings and managers' doors open:** The hospice opens staff meetings to everyone, and there is an allotted time for workers to make announcements or to discuss important work issues, Bauer says.

"Sometimes we'll discuss information the staff need or we'll provide some kind of encouragement," Bauer says.

If the hospice has reached certain goals, then managers might celebrate by bringing pizza to a meeting or having a party for the staff, she says.

"Or if it's been a rough time lately, we'll do something special with staff, like a party," Bauer says. "And we have a surprise birthday party for the staff every year, instead of celebrating each individual birthday."

Staff also learn that they are free to bring their questions and problems to managers, who keep in touch with hands-on clinical care, Bauer says.

For instance, Bauer is the hospice's CEO, but she also continues to see patients on occasion.

"I would never ask someone to do something I wouldn't do myself," Bauer says. "One of the nurses said that the thing that helped her the most was that day I told her that if she needed to talk at any time, my door was open."

* **Provide problem-solving presentations:** "We do a case presentation during an inservice to show how to better manage patient care from physical, psychosocial, and spiritual aspects," Bauer says. "Sometimes the presentations are made up, and sometimes they come from different educational material."

The presentations are shown on an overhead projector and are printed on handouts, Bauer adds.

After they're read, the staff discuss various options.

Also, the staff have access to an ethics committee when an actual dilemma arises with a patient.

* **Use performance reviews effectively:** The hospice has routine audits and surveys of families to check performance improvement, Bauer says.

Also, there's a staff education day in November, she says.

"We try to make it fun as staff take time to do tests that check their performance and to make sure they're performing optimally on a yearly basis," Bauer says. "Each year it's based on a theme, such as the rodeo, which is this year."

Administrators for the rodeo theme dress up in

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cowboy outfits, and the hospice provides snacks, games with prizes, and the skills checklists and performance evaluations, Bauer says.

"We have the staff benefits displayed at stations where they can meet with people to learn more about them and to learn how to utilize them," Bauer adds. ■

CMS takes steps to ease emergency

The Centers for Medicare and Medicaid Services (CMS) relaxed some rules and requirements for home health agencies that provide care to patients who were relocated as a result of Hurricane Katrina.

The first step taken was to reassure agencies that the normal burden of documentation is waived and the presumption of eligibility should be made for all patients who were evacuated to neighboring states where no health records exist and no proof of coverage can be presented.

Other changes that will help home health agencies include:

- Home health agencies that furnish medical services in good faith, but who cannot comply with normal program requirements because of Hurricane Katrina, will be paid for services provided and will be exempt from sanctions for noncompliance, unless it is discovered that fraud or abuse occurred.
- Crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the programs will be paid.
- Programs will reimburse facilities for providing dialysis to patients with kidney failure in alternative settings.
- Normal prior authorization and out-of-network requirements also will be waived for enrollees of Medicare, Medicaid, or State Children's Health Program managed care plans.
- Normal licensing requirements for doctors, nurses, and other health care professionals, including home health personnel, who cross state lines to provide emergency care in stricken areas will be waived as long as the provider is licensed in their home state.
- Certain privacy requirements of Health Insurance Portability and Accountability Act will be waived so that health care providers can talk to family members about a patient's condition even if that patient is unable to grant that permission to the provider. ■

Hospices, hospitals focus more on palliative care

Even a freestanding hospice can make it work

Palliative care programs are growing in number and prominence at hospitals and hospices across the nation, as increasing numbers of health care providers want to focus on medicine used as much for comfort and quality of life as for diagnoses and cures when dealing with patients who have chronic illnesses for which there are no easy resolutions.

The number of hospital-based palliative care programs nearly doubled between 2000 and 2003 to 1,100, and now about 1,800 physicians have become board-certified to participate in palliative care, says **Amber Jones**, BA, M.Ed, hospice liaison consultant at the Center to Advance Palliative Care (CAPC), based at Mt. Sinai School of Medicine in New York City.

There also has been an increase in the number of nurses specializing in palliative care, she adds.

There are about 200 certified advanced practice nurses now, and soon there will be more, Jones says. "There also are licensed nursing assistants in palliative care, and so we're seeing a huge growth in the number of palliative care trained professionals," Jones adds. "We did a survey of hospices 2½ years ago, asking how many were interested in providing palliative care services, and 25% were already offering palliative care services, and 90% were in the process of planning it."

For hospices, the move to palliative care is a natural one, says **LaDonna Van Engen**, RN, CHPN, hospice program coordinator of Saint Elizabeth Hospice of Saint Elizabeth Regional Medical Center in Lincoln, NE.

"In order for hospices to survive with Medicare and Medicaid and insurance, we need to promote and look at palliative care," she says. "It offers people the control they want."

Chronic care

Palliative care is becoming an attractive service for patients with a wide variety of chronic dis-

eases, including congestive heart failure, emphysema, peripheral vascular disease, and end-stage heart disease, experts say.

The concept is directed toward supportive care for patients who have symptoms that are not well controlled, medication side effects that have led to a poor quality of life, and chronically ill patients who are not terminally ill.

For instance, a person with advanced heart disease might be routinely shuffled into surgery, but the palliative care approach would have a team help the patient look at the quality of life risks of such surgery and make a decision that, while not ideal, may be better suited to their needs and situation, Van Engen says.

Van Engen says under the palliative care approach, she would say to the adult child of an 80-year-old patient whose health is failing rapidly, although no one disease qualifies as a hospice referral, "Tell me about your mom. What kind of person is she? Would she want you to do everything to keep her alive like this, and can she get better?"

"When someone is facing a serious chronic or life-limiting illness, they also have a lot of emotional issues, and they need to make decisions about what they want with the rest of their life," says **Cindy Marsh**, executive director of the Hospice of Texarkana (TX) Inc., a freestanding, community-based, nonprofit hospice that provides palliative care services.

"They may need to make advanced directives and those types of things are addressed with the social worker on the team," she says.

Likewise, the social worker will help palliative care patients understand what will happen when they're discharged from the hospital."

So the biggest question hospices have with regard to palliative care isn't whether to provide these services, but how, Jones says.

CAPC answers the how question by providing educational programs that help health care providers build a business plan and gain support for the utilization of palliative care services, she explains.

One program is a two-day intensive seminar that provides a primer on building a palliative care program with lectures, small group sessions, and the goal of providing attendees with an understanding of the elements of the program, Jones says.

CAPC also offers site visits at one of the organization's six palliative care leadership centers, at a cost of $1,500 to $1,750 for four people. A health care team may visit a center over a two- to three-day period to gain hands-on experience with people who have been through it, Jones explains.

The team typically brings to the site visit data from the hospice or hospital, which can be used in developing a business and implementation plan, she adds.

As a follow-up, the visiting teams receive a year of technical support from the leadership center.

The Hospice of Texarkana formed a palliative care program after staff received training from CAPC, Marsh reports.

The palliative care initiative is two-pronged: The first and main effort involves a collaboration with CHRISTUS St. Michael Health System in Texarkana, and the other effort will be the opening of an outpatient palliative care clinic at the hospice medical director's clinical setting, she says.

"We had been working with CHRISTUS for some time in providing hospice services, and we had gained their trust in both our clinical operations and in how we conduct business with our patients there in the facility," Marsh says.

The hospice's mission was helped by CHRISTUS leaders who wanted to implement palliative care services in all of the health system's facilities, she notes.

"What made this effort extremely successful is the fact that CHRISTUS contracts from us a nurse liaison who is working with case management on a daily basis to identify patients who might benefit from a palliative care consult," Marsh says.

The Hospice of Texarkana program also involves a social worker and doctorate-level pharmacy consultants, she says.

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Palliative care contacts with patients and families involve at least two disciplines with the goal of making it a team meeting, Marsh reports.

"I think one of the real strengths of a palliative care program can be continuing the interdisciplinary approach that is so successful in hospice," she says.

For hospices that already are part of a hospital system, palliative care is a natural fit both clinically and economically.

For example, Saint Elizabeth provides some of the same comfort and support for patients and families referred to palliative care services as those referred to hospice, although the palliative care patients do not have to have a diagnosis of fewer than six months to live.

"We provide comfort care on things besides healing," says Van Engen.

Palliative care patients must meet Medicare guidelines for home care services, but they receive home care with the additional comfort and support that palliative care offer, she says.

"Medicare doesn't recognize palliative care in the home at this point," Van Engen adds.

Hospices that have home care services or are affiliated with health systems with home care services train home care staff to provide a palliative approach to their care, she explains.

"The staff don't just provide wound care, but focus on end-of-life issues, family support, and that sort of thing," Van Engen says. "With the palliative approach, the home health aide may say, 'I'm going to give them a bath, but if they insist on not getting up today, I won't push that hard.'"

The benefit to the hospital system is that referring chronically ill patients referred to palliative care services helps to reduce rehospitalizations and saves health care dollars, Van Engen and Marsh note. ■

Innovation aids nurse recruitment, retention

Re-entry RNs are untapped source

Hospices have had to deal with the periodic nursing shortages for decades, but California arguably has one of the most challenging problems, so a Sunnydale, CA, hospice has developed a nursing retention and recruitment program that tackles the problem with innovative solution.

"The pool in California of nurses is shrinking
a little faster than nationally," reports **Jane McLeod**, BSN, MA, a professional staff recruiter with Path-ways Home Health and Hospice of Sunnydale, CA.

Starting Jan. 1, 2005, California requires all hospitals to have a ratio of one RN to five patients, and this has caused hospitals to rapidly staff up with RNs, she explains.

"This leaves community health providers with a huge challenge," McLeod says. "So we looked at some of our options, and we saw that the pool of nurses that hospitals weren't actively recruiting were re-entry nurses."

Hospitals weren't recruiting these nurses because it took re-entry nurses longer to regain full competency and productivity, and they weren't a good match for hospitals' new graduate programs, she says.

"Many of them had been away from the bedside too long and were not competent in their skills anymore," McLeod notes. "The acuity of patient in the hospital is so much higher than it was five years ago."

However, these same re-entry nurses had qualities that were ideal for the hospice environment because they brought to the role a necessary maturity, independence, adaptability, and problem-solving ability, as well as the ability to handle stress and crises, she says.

"We identified that this type of nurse might be well-suited for end-of-life care, and we so we had to go out and figure out where you could find those nurses," McLeod says.

Hospice nurses need to think on their feet and understand the symptoms they observe in patients, which is why new nursing graduates do not do as well in the environment as do re-entry nurses when they're trained, she says.

The next step was to find out the state's requirements, which in the case of California meant that RNs had to have one year of nursing experience within the last three years in order to qualify for hospice licensure, McLeod says.

"So we had to apply for a waiver from the state in order to hire re-entry nurses, and we had to construct a program," McLeod says. "I worked with the state licensing board to see what they would accept as a training program and supervision program."

Hospice managers applied for waivers for each nurse who didn't make hospice nursing requirements, says **Jane Hoffman**, BA, BSN, MS, staff education coordinator for Pathways Home Health and Hospice.

McLeod also contacted the state's board of registered nursing to make certain there weren't additional requirements for re-entry nurses.

As a result the hospice's re-entry nurses complete a re-entry program and then go through preceptor training, she says.

The training program has also helped with nursing retention. The hospice has hired eight re-entry nurses within the past 1½ years, and seven of the nurses still are with the hospice, McLeod reports.

Here's how the re-entry program works:

1. Find re-entry nursing prospects.

The hospice has recruited re-entry nurses who have been out of the field for up to 15 years, and most are women older than the age of 40 years, McLeod says.

"Most women with young families are looking for per diem work," she notes. "They cannot commit to the hospice schedule because of their family responsibilities."

The re-entry nursing recruits typically are parents and sometimes grandparents who have raised their families and now want to return to nursing, but think that hospice nursing is what they'd really like to do, McLeod says.

2. Screen and interview re-entry nurses.

Hospice managers have designed a set of interview questions to assess the job candidate's personal qualities and to filter out the nurses who may not be a good fit with hospice, McLeod says.

"We require all candidates to spend one day with a hospice nurse before we even interview them," she says. "It gives them an opportunity to see if this might be a good fit for them."

Hiring preceptors also evaluate the potential employees during the tag-alone day, observing how the nurses behave in the hospice home and to see if they've asked appropriate questions, McLeod adds.

Job candidates who pass the first screening test are then interviewed by hospice managers.

3. Train re-entry nurses.

Re-entry nurses take a nursing training program of 90-plus hours, meeting three days a week for four weeks at a continuing education facility, McLeod reports.

"They go through physical assessment, medical management, IVs, wound care, nutrition, and a very broad curriculum," she says.

The re-entry nurse's orientation at the hospice then is longer than the standard orientation program, and it includes quarterly meetings with preceptors over the course of a year, Hoffmann says.

"Re-entry nurses make no independent visits for the first month and are asked to observe and put their observations in writing," Hoffmann adds.

"One thing we found out is these nurses, even though they've been through refresher courses, need extra clinical experience," Hoffmann says. "So we have them all spend some time with one of our nurses from the home health section to review clinical areas, such as wound care, phlebotomy, IV education, and pain and symptom management."

"What we're finding from the nurses we've hired is if they have a strong medical or surgical background, then they have some of the core clinical skills that it's hard to teach people," McLeod explains. "They understand critical thinking and are good problem-solvers, so we give them a lot of practical experience."

While hospice managers expect the re-entry nurses to become fully productive and competent members of the hospice team, they don't expect them to learn everything as quickly as other newly hired nurses, Hoffmann says.

So re-entry nurses are assigned preceptors who case manage the re-entry nurse as the nurse makes patient visits for three to six months, she adds. ■

Need More Information?

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Is the doc available after the initial order?

AZ addresses issues with hospital-based referrals

The hospital discharge planner calls your admission department about a patient for

whom the physician ordered home care. Sounds like it is just business as usual, doesn't it? Not if the physician who ordered the home care only saw the patient once, for a brief time, and is never available to sign the plan of care or answer questions about the patient.

This is the problem faced by Arizona home care agencies when the physician who ordered the home care service is a hospitalist as opposed to a primary care physician. A hospitalist is a physician whose practice is completely based in a hospital setting, such as the emergency department, explains **Karen Jeselun**, RN, administrator of Arizona Home Care in Phoenix.

The agency received a referral for a hip replacement patient who needed physical therapy and blood drawn to monitor anticoagulant medication, she reports. "The hospital-based physician wrote the order, but he was not available to approve the physical therapy plan of care, nor was he available to review the results of the lab work to monitor the medication's effectiveness and make changes if necessary," Jeselun says. "We had a patient who needed care, but no physician to oversee our care for her."

Because Jeselun's agency was not the only one facing this issue, a statewide task force was formed that included representatives from hospitals, home health agencies, and the state medical association. "We realized early in our discussions that there was no one, simple solution to the problem, so we've addressed it in several ways," she says.

Transient seniors

The most at-risk group of patients in Arizona was the large Medicare population, Jeselun reports. "Many of our senior citizens are a transient group of people who live part of the year in a state other than Arizona, and most of them do not have a primary care physician in Arizona," she explains.

When these people do need health care, they often enter the Arizona system through an emergency department and are treated by other hospital specialists if necessary, Jeselun adds.

In these cases, the hospital-based physician may discharge the patient with orders for home health care, but there is no community primary care physician who can follow the patient's care, approve changes in medication, or sign the initial plan of care developed by the home health nurse. **Bruce Bethancourt**, MD, a Phoenix physician on the task force, says, "We found that 30% of patients admitted to home health care without a primary care physician were readmitted to the hospital."

Primary care physicians always have been hesitant to take assume responsibility for a patient that they have not seen, know nothing about their medical history, and don't really know the reason for their hospitalization, Bethancourt says.

Not only is there a liability risk, but there is also the issue of being able to provide the best care for the patient, he says. "A physician needs all of the information on the patient to assume responsibility," he adds.

What wasn't fully understood by hospitals and hospital-based physicians was their liability in the discharge of a patient to home health, points out Bethancourt. "It was quite a shock to hospitals and their physicians to learn that if they discharged a patient on medication, they are responsible for that patient until the problem is resolved or the care of the patient is transferred to another physician," he says. Many hospitalists believed that once they discharged a patient to home health, the patient

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was no longer their responsibility, he explains.

The first step taken by the state medical association was to develop a database of primary care physicians who will take new patients when a home health agency receives a referral from a hospitalist, or when the hospitalist needs to refer a patient to a primary care physician, Bethancourt says. The association is setting up a web site to make it easy for agencies or physicians to find a primary care physician for the patient, he adds.

Jeselun's agency has developed a list of physicians who are part of a hospital-based physician group so that their admission staff will recognize the referral as coming from a hospitalist. "One of our problems had been that we did not realize the referral was from a hospitalist rather than a private physician until after we accepted the patient," she says.

By identifying the referral source early, admission personnel have an opportunity to research the patient's situation and find out if the patient does have a personal physician, Jeselun points out. "We'll actually contact the patient while he or she is still in the hospital in order to get information and put the patient in touch with a primary care physician if there is not one," she adds.

While home health agencies and hospitals in Arizona are just beginning to address this issue, Jeselun is encouraged. "There is no quick fix to this problem, but we are seeing an increased awareness among hospital-based physicians and primary care physicians that will make it easier to make sure that patients do have a primary care physician involved in their care," she says. ■