THE CLASS OF 1964 POLICY RESEARCH SHOP

COMMUNITY NURSING IN VERMONT

PRESENTED TO THE VERMONT HOUSE COMMITTEE ON HEALTH CARE

Rep. Rebecca Holcombe

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PREPARED BY:
EMMA LYNCH
ELENA RACCUIA
WENHAN SUN

Contact:
Nelson A. Rockefeller Center, 6082 Rockefeller Hall, Dartmouth College, Hanover, NH 03755
http://rockefeller.dartmouth.edu/shop/ • Email: Ronald.G.Shaiko@Dartmouth.edu

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EXECUTIVE SUMMARY

Healthcare across the United States is fragmented, expensive, and inefficient; the healthcare delivery system in Vermont is no exception. In fact, due to the state's distinct aging demographic and geographic composition, Vermont experiences unique challenges in access to healthcare and health equity.[1] While Vermont's Blueprint for Health has sought to create an integrated community-based health approach, health care service gaps remain pervasive throughout the state.[2] One response to this problem has been the independent rise of community nursing programs (CNPs), which aim to meet the needs of those who are underserved by the current healthcare system. This report aims to define the scope of community nurse programs in Vermont and present the Vermont House Committee on Health Care with valuable information on the role of community nurses, the services offered by community nurse programs, and potential future initiatives that can help promote a healthier lifestyle among more Vermont residents. First, the report describes community nurse programs and identifies the ways in which they mitigate service gaps. Then, the report outlines how existing programs have been established, how they operate, and how they have been funded. Finally, the report concludes with an analysis of program alternatives and recommendations regarding what the state's role may be in community nurse initiatives.

1 INTRODUCTION

Healthcare is an expensive and pervasive problem in the United States. While the country outspends every other developed nation in the world by nearly three times per capita, healthcare delivery remains fragmented and largely dependent on individual states. As such, legislators are attempting to combat rising healthcare costs by creating financial incentives for systems to prioritize preventative and value-based care. These systems would replace the current fee-for-service model, which incentivizes providers to wait until patients are in desperate need of expensive and extreme healthcare measures. In a state with a relatively low population density and lacking service-providing county governments, a more grassroots approach involving community nursing programs offer a simple but more immediately promising healthcare strategy.[3]

Indeed, community nursing programs (CNPs) have emerged internationally as one solution to fragmented, expensive, and inaccessible care.[4] These programs lack one concrete definition because their services are profoundly influenced by the populations they serve. Nonetheless, CNPs broadly function as a preventative and educational measure.[5] Staff members include registered nurses (RNs) who typically come from the community or general area. As "community nurses," they engage with groups and individuals to provide medical knowledge, basic care, counseling, and other resources such as referrals to physicians or other institutions.[6] Their familiarity with the localities they serve allows them to advise community members on location-specific health information such as health clinics, grocery deliveries, and pharmacy options. While these services tend to be affiliated with town governments, many are provided by faith-based communities and nonprofit organizations. Lastly, CNP services in Vermont are free-of-charge, which makes these programs component in transitioning away from the profit driven healthcare industry.[7]

This brief addresses Vermont CNP organizational models and program-specific operations. It asks: How do these programs fit into the state health care service delivery? What kinds of services do they provide? How are they founded, funded, and managed? How many models of community nursing exist, and how generalizable are they? How effective are they at accomplishing their mission statements, and perhaps more importantly, at filling local and regional healthcare needs?

2 PRELIMINARY ANALYSIS

To effectively carry out an analysis of regionally relevant CNPs, one must first understand the context in which they operate.

2.1 POPULATION GENERAL HEALTH

The majority of Vermont adults report good-to-excellent general health—as evidenced by Vermont's overall statistics on health outcomes and factors that contribute to health—with only 14 percent reporting fair or poor health.[8] The state consistently ranks as one of the healthiest U.S. states and federal districts overall.[9] However, certain populations, including the elderly, people with disabilities, and people with chronic diseases, face particular hardships. This section will lay out basic trends in these three areas as they currently stand.

Vermont is aging at a faster rate than other states, and the age gap is widening.[10] Today, the median age of Vermonters is around 42 years, compared to the national median of 38 years. While the percentage of individuals age 65+ is growing, the percentage of those under age 20 declines. If current trends continue, Vermont is on track to be the oldest state in the nation by 2030, by percentage of residents over 65.[11] The healthcare workforce is also aging alongside the civilian population.[12] The rising costs of nursing school (i.e., the tuition for a B.S. in Nursing degree has risen by more than 50 percent in various schools throughout the state since 2009) mean that the healthcare workforce is not being replaced.[13] Since the counties in the state with the oldest populations also happen to be the least populated and demonstrate the poorest health outcomes, this poses a significant problem.

Another population facing hardships is people with disabilities.[14] Approximately one-quarter Vermonters are disabled, which includes anyone who reports having serious difficulty walking or climbing stairs, concentrating, or making decisions, hearing, seeing, dressing, or bathing, or who, because of a physical, mental, or emotional condition, has difficulty doing errands alone. The age aspect plays into this as well because older adults are significantly more likely to have a disability than the rest of the population. Approximately 40 percent of disparities seen in general health are reported by older Vermonters, who are also statistically more likely to delay care due to cost, experience poor mental and physical health, or report rarely or never getting necessary emotional support as compared to adults with no disability.[15]

The last vulnerable population we will mention is people with chronic conditions.[16] High rates of chronic disease, notably diabetes, cancer, and depressive disorders, are reported most frequently by older adults and those with a disability. Approximately 78 percent of deaths in Vermont are caused by chronic diseases, substantiating the value in promoting healthcare systems that target this population.

2.2 HEALTHCARE GEOGRAPHICALLY

The small, rural nature of Vermont presents problems in healthcare delivery, as rural communities face persistent inequities in health outcomes and wellbeing.[17] As the state policymakers seek to address these disparities, they must keep in mind the challenges rural communities face in terms of access to quality health care and connectivity to town centers and amenities. Factors such as geographic isolation, lower socio-economic status of residents, higher rates of health risk behaviors, greater difficulty in accessing health services due to transportation, and limited access to affordable and healthy food negatively influence health outcomes in more rural areas.

Additionally, several studies have highlighted that healthcare access in rural areas is often fragmented; in general, residents are older, poorer, and have fewer physicians to care for them. While insurance coverage is nearly universal among white people and people with the highest income, only 80 percent of individuals of racial or ethnic minority groups have health insurance coverage and a primary care provider, and 20 percent of adults at the lowest income levels have no access to health insurance at all.[18] The majority of rural communities in the state are served by one of five rural mid-size hospitals, eight Critical Access Hospitals (CAH), or by academic medical centers in Burlington and Hanover, NH.[19] As such, residents living in border towns must travel to New Hampshire, New York, or Massachusetts to access emergency, inpatient, or specialty care, and many individuals live more than 45 minutes away from the nearest hospital.

2.3 THE RISE OF COMMUNITY NURSING PROGRAMS

Across the United States, communities have grappled with how to reduce hospital readmissions, manage post discharge care, monitor chronic illnesses and high-risk patients, and help community members navigate the complex healthcare system. The CNP model, as structured in Vermont, offers a unique mode of addressing these needs. Furthermore, it is worth noting that although local non-profits and parishes have been the main drivers behind the implementation of programs to connect people to CNPs, communities in Vermont and New Hampshire have also collaborated with hospitals and other medical institutions towards this goal.[20] Today, most CNPs are located in the Upper Valley region of Vermont (*See Figure 1 on next page*). Their expansion to other, particularly more rural, communities that lack access to primary care could allow for a more efficient and proactive method to address health needs.

3 THE ROLE OF COMMUNITY NURSES IN VERMONT

The community nurse program model in Vermont is unique and relatively new. Therefore, it is important to determine what capabilities and potential limitations exist for the work that they can do, situate them within broader Vermont health services, understand how their role differs from other health service providers in the state, and reference first-hand testimonies related to community nursing before discussing their operational structure.

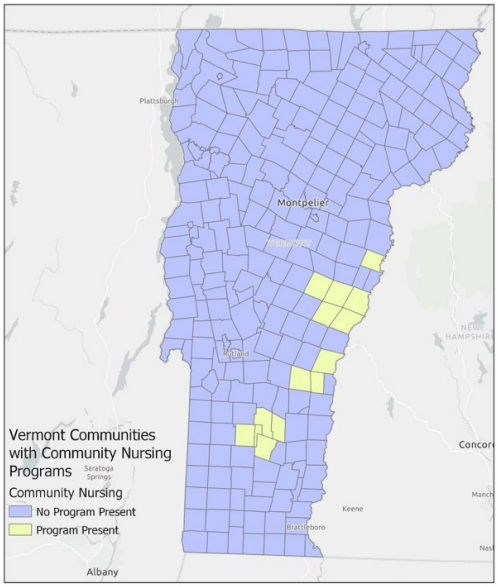

Figure 1: Map of Active Community Nursing and Community Care Coordinator Programs in Vermont, March 2023.

3.1 COMMUNITY NURSE SERVICES

Community nurse programs fill gaps in the traditional healthcare system free of charge and with no limits on their conditions of service.[21] Unlike visiting nurse services or skilled home care providers, which may be limited by Medicare reimbursement guidelines, there are no restrictions for eligibility, frequency, or duration of contacts with contacts. However, community nurse services cannot replace primary care providers or emergency services.[22] As registered nurses, community nurses carry insurance and have significant training, but they are not able to use all their medical expertise. While they can perform examinations and assist with medication management, they do not provide hands-on medical care beyond basic first aid in emergency situations.

Additionally, community nurses are trusted members of their respective communities. The nurses, who are town locals, often develop personal relationships with their patients through frequent at-home visits. By regularly visiting patients at home, community nurses gain valuable insights into their patients' living situations, which may reveal previously unnoticed issues such as inadequate food supplies or potential safety hazards in their homes that could lead to falls. These insights go beyond social and psychological concerns and can help improve overall patient care. Furthermore, community nurses play a large role in promoting public health through health education, counseling, and advocacy—they facilitate support groups, serve as referral agents for vulnerable populations, assist with health management, and initiate advanced directives.[23]

Logistically, about half of community nurse services in the state take place in person and the other half virtually. According to a most recent client tracking report conducted by Community Nurse Connection (CNC), a leading nonprofit organization, 40.6 percent of appointments took the form of home visits, 6.9 percent occurred in-person at a medical office, 20 percent via email communication, and 32.3 percent via phone call. Emotional support exceeds other community nurse services by far, which is followed by education and assistance with medications, medical equipment, and

management. Leading service outcomes include reduced anxiety or worry for patients and caregivers, reduced social isolation, and the improved ability to remain safely at home. In addition, many patients suffer chronic and critical diagnoses. Among these patients, 34.8 percent solicit community nurses for help managing their diabetes, 21.2 percent for cancer, 16.7 percent for dementia/Alzheimer's, and 15.2 percent for chronic obstructive pulmonary diseases. Many of these individuals are older, live alone, lack adequate social support, and struggle to feel safe in their homes.[24]

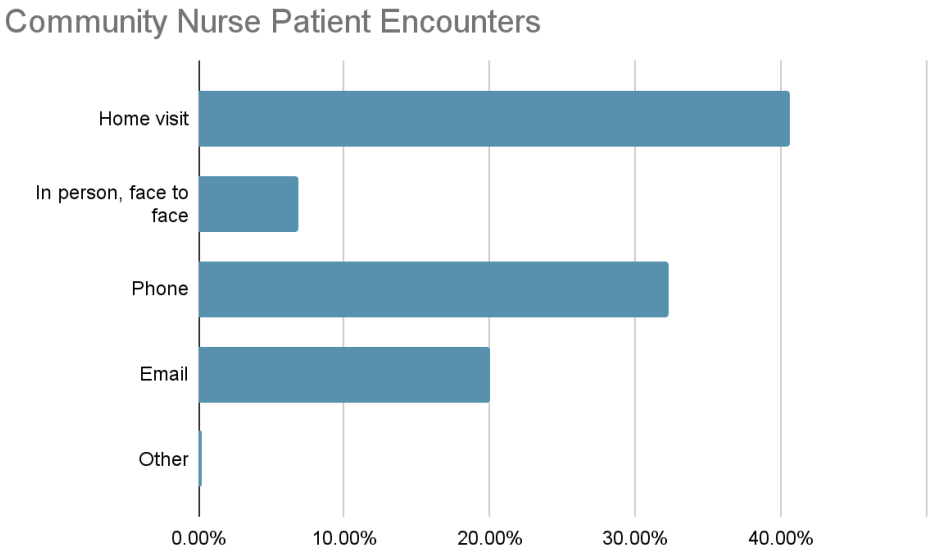

Figure 2: 1,091 Encounters over October, November, and December 2022. From Community Nurse Connection.

3.2 THE IMPORTANCE OF CONTINUITY

In an increasingly automated and bureaucratic healthcare system, providers are expected to offer continuity of care simply from reading patients' medical records. However, oftentimes there is a wealth of relevant information that even an integrated health record cannot fully convey.[25] The learned relationship between nurses and patients offers a level of continuity that the traditional healthcare system, due to numerous case managers, outpatients, and insurance providers, is unable to provide. Unlike most traditional healthcare providers, community nurses know their patients on a personal level and can better formulate care plans that cater to their patients' individual needs. Regular visits enable them to establish an informal baseline of their patients' physical and mental health and demeanor. This baseline serves as a point of reference, allowing the nurses to note even subtle shifts in the patients' conditions over time. Such consistent monitoring helps nurses to identify potential health issues early and take appropriate measures to prevent them from worsening.[26] Moreover, community nurses can build a rapport with patients that allows for honest, meaningful conversations. Patients often view their nurses as trusted advocates and sources of stability during periods of rapid change in their lives and health. This emotional connection provides patients with an added level of comfort, allowing them to discuss their symptoms and seek out the care and support they need. This stands in stark contrast to formal medical settings, where patients may experience long wait times to see doctors or specialists and frequent changes in care providers.

Finally, community nurses may be tasked with additional responsibilities that are unique to their role. For instance, they may add notes to their patients' records to remind medical providers of issues that should be addressed during appointments. They may also provide care during times when the Visiting Nurse Association (VNA) is unavailable and follow up with patients who were not admitted to the emergency department.[27] Community nurses' past experiences, combined with their familiarity with their patients' distinctive needs, give them a high level of assessment skills that are not typically found in other areas of the healthcare system. They possess the necessary skills and expertise to analyze a patient's situation and surroundings, ask relevant questions, and provide the help needed, even in situations where patients have been denied services elsewhere.

3.3 COMMUNITY NURSES IN THE HEALTH CARE DELIVERY SYSTEM

It is important to distinguish the role of community nurses from those of other players in the Vermont healthcare delivery system. As previously outlined, community nurses play an important role in helping patients navigate the healthcare system in their respective communities, providing wellness and educational services, and working with hospitals and local resource centers to set up a continuum of care. They have a deep understanding of their patients' needs and build strong relationships with those who they serve.

Many community nurses work hand-in-hand with public health nurses, who also promote community wellness. Public health nurses have a deep understanding of the epidemiology of their respective localities. Unlike community nurses, they deal with health from the perspective of populations, not individuals.[28] For example, a public health nurse would study the symptoms that develop in a community after exposure to toxic waste and then strategize how to care for them. A public health nurse does not deliver care individually in a person's home, where, in contrast, community nurses interact with patients on a one-on-one basis wherever is most convenient for them. Community nurses often report their patient observations to public health nurses to investigate public health risks and solve problems about how to preserve residents' health amid them.[29]

Town health officers also play a role in the community health ecosystem. By law, every town and city in Vermont has a local board of health, consisting of the town health officer and town select board.[30] Town health officers are responsible for investigating possible public health hazards and risks, preventing and removing these hazards, enforcing health laws, rules, and permit conditions, and enforcing orders. Unlike community nurses and public health nurses, health officers are subject to frequent reshuffling. They are unable to provide the same level of individualized care as their counterparts due to the broader scope of their work responsibilities and relatively shorter terms. Community nurses often reach out to town health officers for support in accessing more local resources for their patients.

3.4 AN INSIDE VIEW TO COMMUNITY NURSING

This section will analyze existing programs and projects currently implemented by other states to determine their fit and viability in Vermont and New Hampshire, especially in the Upper Valley area. Solutions that seek to alleviate rural homelessness must also target public health issues including drug and substance abuse, domestic violence, mental health, physical health, and health care access. There are two general approaches to working with the rural homeless: housing-based approaches with

clinical support and mobile outreach and delivery efforts. Regardless, to be efficient and effective, solutions to rural homelessness must be comprehensive in connecting the wide but often disparate network of community and governmental resources available.

One community nurse eloquently described her job using five pillars: she seeks to support individuals' *physical, emotional, social, spiritual, and financial needs*. In her view, the spirit of healthcare relies more on what happens outside of medical appointments than on what happens during them. In her patient interactions, she ensures that they understand medical instructions, know their financial options, and recognize their health needs that span beyond their physical well-being. She also noted that, while it does not stem from a lack of goodwill on the part of doctors, nurses, and other mainstream healthcare professionals, effectively maneuvering the healthcare system can be overwhelming, and even impossible at times, for patients in need. One patient with a terminal illness described that their provider lost their PCP form twice; they did not know how to go about preventing this issue from repeating itself. The community nurse was able to leverage her knowledge and connections to rectify the situation by working within the system. Without a community nurse, this burden to address failures in care often falls on patients' spouses or children. Other times, they are simply overlooked. During such detailed conversations about patient-needs and disservices, a nurse may conduct basic check-ups. Afterwards, she may converse with her patient about their well-being, medication, diet, and living situation. Not all meetings with patients take this direction, but the fact that they can is an immense boon for small Vermont towns.

The community nurse also explained that during her patient visits, she slowly explains to them the realities of their chronic conditions. She provides a space for gentle coping as the patient contemplates what treatment measures they are ready to pursue. She sympathizes with their pain and informs them about important questions they should raise during medical visits. She also walks them through how a physician may respond to their questions and the state of their condition. In emergency situations, she may even accompany the patient to the hospital or medical practice. During these conversations, she also offers patients space to share about their lives before they were sick and what aspects of this time were most meaningful to them. These conversations importantly inform next steps in patient care.

Finally, the nurse spoke about how, on another occasion, she supported a woman through an at-risk pregnancy. She helped her plan appointments and served as an on-call resource and advocate for her needs. While she no longer works with this patient, she occasionally receives pictures of her thriving child. She described that while some patients, such as this woman, only utilize community nurse services for short periods of time, many, particularly elderly individuals, continue to seek out care for the duration of their independent lives. While her patients would likely argue that her support and expertise is priceless, community nurse services pose an immense cost on towns, communities, and donors, as well as community nurses themselves, who, in many instances, are only paid for a fraction of the hours that they realistically work.

While some nurses go above and beyond their basic responsibilities and pay grade, others are forced to set boundaries due to inadequate compensation, geographic and time constraints, and the limitations of the healthcare system.

4 COMMUNITY NURSING IN VERMONT

Motivated by healthcare needs and the gradual emergence of community nurse programs worldwide, certain communities in Vermont have started programs of their own. This section will outline how successful town programs have been founded, structured, and operated. When necessary, subsections will analyze the programs first individually then identify commonalities among them. The section will also cite characteristics of nurses and the patients they serve.

4.1 PROGRAM ESTABLISHMENT

Though community nursing is a centuries-old practice, all programs considered in this research are a decade old or younger. One pivotal impetus for the reemergence of community nursing in the Upper Valley was the founding of the organization Community Nurse Connection (CNC). CNC serves as an umbrella organization that supports community nurse initiatives throughout the state and helps towns and localities launch new programs. While some programs have begun as a product of direct communication between CNC and community groups, others have surfaced independently and simply turn to CNC for grants and information regarding where to find additional funding. In most cases, to establish a program it simply took one individual—or group of individuals—to begin the conversation, commit to program development, and turn to local organizations, such as CNC, for support.[31]

For example, in Tunbridge, the town health officer prompted the program by approaching the town select board. Health officers stated it was necessary for the town to build a healthier community by promoting preventative care and hiring a nurse as a town employee.[32] Shortly after, in 2020/2021, the Tunbridge community voted on the need for a community nurse. The first nursing budget was passed at a Tunbridge Town Meeting in May 2022. The initial program was based largely on CNC's community nursing plans. Today, a group of local nurses meet as a steering committee and are working to establish their own non-profit to strengthen their program and assist others.[33]

The program in Hartland began differently. Community nursing in Hartland is run entirely by a nonprofit organization, Aging in Hartland. Aging in Hartland was established with a mission to connect residents aged 60 and older to resources and support services to facilitate them in aging in their own homes.[34] Though the organization is supported by the Town of Hartland, nurses act as agents of the nonprofit organization and not of the town itself. Additionally, the nonprofit addresses the needs of a more niche target audience, seniors, whereas most town programs serve residents of all ages.[35]

The community nurse program in Strafford began similarly to that in Tunbridge. However, it was a group of residents, not the town health officer, who brought community nursing to the fore. After several false starts, there is a warrant up for voting in the 2023 Annual Town Meeting to partially fund the Strafford Community Nurse program.[36] Community Nurse Connection supports these developing initiatives by sharing job descriptions, assisting with advertising, and advising program founders.

To reiterate, in all these cases, program establishment disproportionately came from a community level: it took one individual, or group of individuals, to go to the town and convince the board of the importance of incorporating a community nurse program to promote residents' health. Alternatively, other grassroots initiatives, such as Aging in Hartland, have emerged to fill the gap in care.

4.2 PROGRAM OPERATIONS

Although it varies by town, most community nurse programs employ one-to-two nurses who hold a B.S. in Nursing and an active VT RN license. In addition, community nurses enter the profession already equipped with health assessment skills from five or more years of experience in the nursing field. Some towns, such as Tunbridge, Norwich, and Lyme, NH have an added preference that nurses have experience with home visiting, such as VNA or hospice, prior to assuming a town community nurse role.[37]

Nurses in all the programs addressed in this research follow a self-determined schedule and work predominantly on weekdays. However, they make themselves available on weekends as well. Hours vary greatly. While most towns will advertise ten-hour workweeks, in practice, community nurses work 40-hours per week or more. These numbers grow for nurses serving more than one municipality. As mentioned above, common services include vital screenings, health care coordination, referrals, case management, patient advocacy, health and wellness education, resources and counseling, discharge planning, and facilitating discussions between patients and family members. While organizations such as Aging in Hartland focus entirely on older adults and their families, many community nurse programs serve residents of all ages.[38]

Finally, while many towns have their own individual community nurse programs, some of which are town-run and others of which are administered by local non-profit organizations, certain groups of towns (e.g., a collective including Weston, Londonderry, S. Londonderry, Peru, Landgrove, and Andover) have an umbrella organization that provides community nurses across all municipalities.[39]

4.3 AGING IN PLACE

Most individuals who use community nurse services are older adults—the median age of patients is 79—who want to live independently. For this reason, assisting with aging in place is a key part of a community nurse's role.

Determining when it is appropriate to move a loved one to a care facility, and whether it is financially feasible to do so, is a familiar challenge for many Vermont families. While, as cited in previous sections, community nurses have some limitations regarding the medical work they are permitted to conduct, their role in frequently checking-in on residents can make a big difference in families' decisions to allow their loved ones to live out their final days at home or pursue other avenues of care. Many elderly individuals may reach out to community nurses if they have concerns about peculiar symptoms they are experiencing. If they have no local or available relatives, they may rely on community nurses for help obtaining prescriptions and grocery deliveries. Finally, in many cases when patients are discharged from in-patient care or rehab facilities, community nurses help them understand discharge instructions to prevent them from returning to the hospital with the same issues.

4.4 PROGRAM ADVERTISEMENT

While much of the information about community nurse programs is spread by word-of-mouth and family and friend referrals, community nurses also use a variety of other methods to connect with prospective patients. Community nurse programs may advertise their services on town or personal websites or by posting flyers in community centers. Some of these websites are part of a broader set

of town services. Additionally, they often have relationships with local fire and police departments. If either police, fire, or EMT dispatchers receive calls about issues related to the safety of elderly or disabled populations, they typically refer them to a community nurse or contact the nurse directly for assistance. Some nurses choose to attend town events, such as town hall and local club meetings, mass, or local performances, to meet townspeople and share information regarding their services. They may also hold regular hours at popular local spaces, such as in town halls, at service organizations, or churches. Finally, given that community nurses typically enter this position after many years in the nursing field, it is not uncommon for their former places of employment to refer patients to their services for more direct, personalized care.[40]

4.5 SUPPORTING AND FOSTERING COMMUNITY NURSE PROGRAMS

Community nurse programs are structured differently throughout the state, and there are many overlaps and disparities in the ways that they are funded. Not only do the overall hours nurses work vary by town, but the number of hours they are compensated for also differ. Nurses typically work anywhere from eight to 40 hours per week. During an interview, one nurse noted that she is only compensated for 15 of the 40 hours that she works each week due to immense needs in her town and limited financial resources. On average, community nurses are paid for 12 hours of work per week at a rate of 30 to 40 dollars per hour. These costs may be balanced by the sharing of one nurse over multiple towns, but this also increases the population in need and in turn the potential workload for the nurse.

Currently, community nurse programs are primarily funded by small grants from various organizations and individual donations. Some towns have also included program funding in their budgets, but this is often contingent on funding that goes beyond their typical operating budgets. The cost of employing a community nurse is typically in the range of $20,000 to $40,000, but this amount is not feasible for every town and can vary depending on the availability of funds.

5 ALTERNATIVES TO COMMUNITY NURSING

While CNPs may provide a practical solution to contemporary healthcare disparities in Vermont, there are many other programs that provide similar services. Therefore, it is important to identify these programs to avoid duplication of services as CNP expansion continues. In 2006, Vermont passed health reform legislation that laid the groundwork for the Blueprint for Health. This program aimed to establish a highly coordinated, statewide approach to health, wellness, and disease prevention through integrated health services based on Patient-Centered Medical Homes (PCMHs) and Community Health Teams (CHTs).[41] However, despite nearly two decades of health reform in Vermont, gaps in the healthcare system persist, which has led to an increasing number of community nursing programs in the state.

5.1 FEDERALLY QUALIFIED HEALTHCARE CENTERS

Federally qualified health centers (FQHCs) are community health centers that provide primary care and preventative services to underserved populations throughout the state. They may receive federal grant funding through Section 330 of the Public Health Service Act. Centers are in schools, nursing

homes, and exist as stand-alone clinics. As of June 2021, there were 89 FQHCs in Vermont, including 22 FQHC school clinics, one FQHC nursing home clinic, and 66 FQHC service delivery clinics.[42]

5.2 PATIENT CENTERED MEDICAL HOMES

The Agency for Healthcare Research and Quality defines Patient Centered Medical Homes (PCMHs) as models of primary care organizations that deliver the core functions of primary health care. Using a patient-centered, culturally appropriate, and team-based approach, PCMHs coordinate patient care across the health system and a full range of individual needs. According to the Centers for Disease Control and Prevention, the PCMH model has been associated with effective chronic disease management, increased patient and provider satisfaction, cost savings, improved quality of care, and increased preventative care. In 2022, 75.5 percent of adults in Vermont were served by Blueprint PHMCs.[43]

5.3 COMMUNITY HEALTH TEAMS

Community Health Teams (CHTs) and Support and Services at Home (SASH) are additional programs that aim to provide comprehensive healthcare services to Vermonters. CHTs consist of multi-disciplinary personnel, including nurses, social workers, and nutrition specialists, who work closely with medical home clinicians to provide direct support to patients and families. Their services include patient management, care coordination, counseling, and referral to intensive mental health care and substance use disorder treatment support. [44] CHTs are primarily funded by Medicaid, Medicare, major commercial insurers, and some self-insured businesses.[45] On the other hand, SASH is a wellness initiative designed for Medicare recipients who wish to age-in-place. It offers free wellness workshops, social activities, exercise classes, educational events, and outings, as well as various wellness programs that respond to social determinants of health. SASH has been available since 2011 and primarily promotes preventative care for the elderly. [46]

5.4 VISITING NURSE ASSOCIATIONS

Another option that may be mistaken for CNPs are Visiting Nurse Associations (VNAs). VNA member agencies include nurses, speech therapists, physical and occupational therapists, wound care specialists, social workers, home health aides, and personal care attendants. Like CNPs, VNAs play an important role in the lives of Vermont residents by bringing healthcare services to patients' homes. However, VNAs require a physician's referral to be covered by Medicare, Medicaid, or private insurance. Without insurance, the cost of utilizing a VNA can vary and may become unaffordable. Community nurses cannot provide the same level of physical care that VNAs offer, but they conduct their services free of charge which make them more accessible to some patients.[47]

5.5 ADULT DAY-CARE OPTIONS

Adult day-care centers, such as the Scotland House in Woodstock, Vermont, play a pivotal role in allowing elderly and disabled individuals to age in their own homes rather than in long-term care facilities. Since 2016, the Scotland House has provided daytime services to seniors who are physically and/or cognitively limited and who may feel isolated at home. They offer comprehensive programming that includes social, personal, and medical support and full-time nurse supervision. The center operates from the early morning through the early evening, and patients and their families may

choose the duration of their stay. These kinds of programs offer respite to family members and give patients the opportunity to engage in activities with others who are in similar conditions. In addition, full-time staff members and medical personnel develop personal relationships with patients and can assess subtle changes in their behavior as well as potential health concerns. While this research lends a high priority to increased funding for community nurse programs, adult day-care centers have the potential to benefit many areas of the state.[48]

6 POLICY OPTIONS FOR THE LEGISLATURE AND OTHER ACTORS

As discussed, the Vermont model of community nursing has developed largely outside of traditional health care stakeholders at the state level. However, the continued growth and expansion of these programs suggest that there is a demand for services that are not currently provided by the existing healthcare model. Recently, Vermont Act 167 (2022) was passed, which details several health care reform initiatives that focus on community-based services. Further coordination and collaboration between all stakeholders, including the legislature and community nurses, could provide valuable insight and benefits to all Vermont residents. To improve access to long-term home and community-based services for more Vermonters, the Department of Disabilities, Aging, and Independent Living (DAIL) should involve community nurses in their working group and seek their input and recommendations.[49]

6.1 FUNDING AND FINANCIAL SUPPORT

The overwhelming barrier for most CNPs is funding. Since financial resources for community nurse positions are derived from piecemeal grants, donations, and town support, community nurse program coordinators and volunteers must spend a significant amount of time and resources fundraising and applying for grants. Providing financial support to these independent frontline health resources through state mechanisms could potentially be one of the most significant changes that the legislature could implement. During conversations with regional health stakeholders, this research explored three unique mechanisms for funding: an individual community nurse organization-based approach, a regional planning commission approach, and a community health conglomeration approach.

6.1.1 INDIVIDUAL COMMUNITY NURSE ORGANIZATION APPROACH

A straightforward model for the state to financially support community nurse organizations is the establishment of a state fund that distributes grants ranging from $5,000 to $150,000 to local community-based health and nursing organizations. Funding distribution could consider factors such as community size, services provided on a quarter basis, and other needs. This model must carefully balance requirements for reporting and evaluation with the resources available to volunteer-based community nurse organizations. However, it is essential to evaluate the results and effectiveness of a state-supported community nurse program. To reduce reporting demands, longer grant cycles could be implemented, beyond the current two-year cycle, to allow for more time between grant applications. Additionally, grant applications could be simplified, using clear and straightforward language that a layperson could understand. Another potential option is to require communities to match a certain portion of state support, as many communities have already approved the use of town financial resources to partially support community nurses.

6.1.2 A REGIONAL PLANNING COMMISSION APPROACH

Discussions with representatives from the Sharon Health Initiative revealed the potential for Vermont's eleven regional planning commissions to support community nurse programs. Advocates for community nursing proposed integrating these programs into municipal and regional health plans. For instance, the Two Rivers-Ottauquechee 2017 Regional Plan, Fostering Healthy Communities, recommended that municipalities invest in health care coordinator programs, including community nurse and community healthcare coordinator roles.[5] By distributing funds and other resources through planning commissions, individual community nurses could be incorporated into larger regional health infrastructure. This approach could enable regions to tailor their grant allocation processes to meet specific needs.

6.1.3 COMMUNITY HEALTH CONGLOMERATE APPROACH

Another broad movement in the field, as brought to attention by a Vermont Department of Health District Director, is the creation of larger integrated community health networks. These networks could include various groups involved in delivering mobile integrated healthcare in the region, such as community nurses, school nurses, visiting nurse associations, and visiting hospice nurse associations. The goal would be to collectively pursue larger multimillion dollar grants, which individual community nurse programs may not have the capacity to pursue alone. In addition, these networks could reduce the grant reporting burden for individual community nurses and promote their integration into a cohesive community health approach.

6.2 COMMUNITY NURSE OR COMMUNITY HEALTH COORDINATOR

As the demand for community nursing services grows and hospitals struggle to fill nursing positions, some towns in Vermont have opted to hire non-registered health coordinators instead of registered nurses. Since community nurses rarely provide front-line medical treatment, it may be beneficial for the state to shift employment from community nurses to community health coordinators. These lay people may be easier to recruit and train and should be able to fulfill client needs despite their lack of nursing qualifications.

However, there are still aspects of the community nursing model that may attract nurses to the position. For instance, the flexibility and autonomy of working only six to eight hours per week may be especially appealing to young mothers who need to balance work with family responsibilities, while also allowing them to maintain their professional licensure. Additionally, there is a growing trend for community health providers to be integrated into the fabric of their local communities, which can create a sense of shared identity and purpose with clients. Furthermore, clinical nurses who are nearing retirement or in semi-retirement may find that the part-time and varied nature of community nursing work allows them to stay engaged in the workforce while pursuing other interests. Finally, for practitioners who are passionate about making a positive impact in their communities, community nursing offers a direct way to give back and make a difference.

6.3 A PARAMEDICINE MODEL IN VERMONT

Creating a strong partnership between paramedicine and community nursing could greatly enhance the current mobile community health infrastructure, especially in areas where community health

coordinators who are not licensed healthcare practitioners are being utilized. The Vermont Department of Health investigated the feasibility of utilizing this partnership in 2016, conducting several focus groups with stakeholders across the state.[50] In other states, such as Maine, Arizona, New York, and South Carolina, community paramedics have already been implemented and have proven successful. [51]

Community paramedics could take on responsibility for delivering services that require medical knowledge, licensure, and insurance, thereby reducing costs associated with those items. As paramedics already possess these qualifications, implementing community paramedicine programs could be an efficient way to reduce costs while maintaining quality of care. For example, Rescue and Emergency Medical Services (EMS) in Sharon, Vermont initiated a partnership with the community care coordinator after identifying many cases of repeat callers. Currently, EMS refers individuals to the town's care coordinator in such circumstances. Londonderry's Volunteer Rescue Squad has also established a similar partnership with the community nurse, continually referring patients to their care. Evidence shows that paramedicine has been associated with reduced readmissions to hospitals and reduced strain on emergency services, ultimately reducing costs for patients and hospitals. [52]

6.4 MORE AVENUES FOR PARTNERSHIP

During interviews conducted with community health stakeholders, several other partnerships were mentioned that could prove beneficial if more widely adopted throughout the state. Although these partnerships may fall outside the domain of the legislature, they are still valuable for further consideration. One of the partnerships discussed was between community nurses and case managers in local hospitals. Currently, many case managers are not fully aware of the services provided by community nurses. Increased incorporation of community nurse services into the language and prescription of case managers would be crucial towards linking the independent work of many community nurses into the formal healthcare system. This would help to ensure that patients are receiving comprehensive and coordinated care across various settings.

In addition to partnerships with case managers, nursing programs with community health tracks offered by state, technical, and community colleges could also be leveraged to enhance community nurse services. Students of these programs could play a pivotal role in contributing to community nurse services. For example, by shadowing or undertaking some of the responsibilities of community nurses, students could benefit from field experience and seeing first-hand medical issues. Simultaneously, community nurses could benefit from the additional help and reduced workload. By collaborating with nursing programs, community nurses could also help to inspire the next generation of nurses to work in the community health field.

7 CONCLUSION

Healthcare delivery in Vermont follows U.S. trends in being fragmented, inefficient, and expensive. The added complexities of an aging and rural population make healthcare even more inaccessible. The goal of this research was to understand the unique models of community nursing that have emerged in towns throughout Vermont to serve this issue. We find that many programs have emerged as local resident initiatives and follow the same basic operational model. The strong relationships that community nurses foster with their patients and respective localities offer a level of trust and continuity not found in other healthcare services throughout the state. The appeal of community

nursing stems from increased resident comfort and attention to health needs as well as economic benefits associated with preemptive care. Currently, community nurse programs struggle most in obtaining the funding necessary to expand programming to all state localities and properly compensate nurses for their services. Though community nursing is not the only model that has developed to fill the extensive gap in healthcare infrastructure, it has proven to be a successful one and, therefore, deserves more attention from the State.

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