Testimony at State House on Community Nurse Pilot

Katie Williams, RN-BSN
Community Nurse, Aging in Hartland

Highlighted sections will not be read during in-person testimony.

To the Health and Welfare Committee, thank you for inviting me here today to speak in favor of supporting the prospect of Bill S. 231.

My name is Katie Williams. I have been a Registered Nurse for fifteen years. I worked for five years at Dartmouth Hitchcock, five years with the Visiting Nurses (VNH) and have now been contracting with Aging in Hartland as one for five years.

Most people emphasize cost reduction for emergency services when they try to justify this model of care. While this is true and does matter, the benefits are far greater and difficult to quantify. Please consider that in village care models, not everything can be measured and that this programming will only prosper if it is allowed time and space for relationship and client agency to be the guiding light. The moment this model becomes involved with a medicare or medicaid billing structure, it will begin to dismantle.

Today I intend to share a few stories from my practice which I feel depict how Community Nursing is unique from existing home healthcare systems and yet exists within a broad spectrum community and regional health model. My colleagues have spoken today about the importance of a dynamic town based support structure which empowers us as nurses to meet all of the needs identified in the home. The nurse does not stand alone but she is at the front line.

Case Study 1:

Objectives:

1. To demonstrate that the community nurse can present in the home, continuously, even where there is not a justified medicare reason for VNH to be present and when long term medicaid is not an option.
2. To demonstrative a collaborative care model. The nurse works in partnership with other existing community based services such as SASH and Senior Solutions to fortify case management services.
3. To demonstrate that homebound seniors are especially at risk for ineffective cost management and case management and not typically identified as high risk by primary care systems for additional service allocation.
4. To demonstrate that the community nurse supports clients' agency to define their needs for social, emotional and physical health, often physical health isn't deemed a clients top priority.

Frank is a 75 year old man who grew up ten miles from where he is currently living. He is deeply religious, kind, never misses an opportunity to get a mailing address and a birthdate from the people he is fond of. He did not marry or have children and lives alone.

We have been working with him continuously for five years, meeting at least monthly and at times, three days a week, depending on the acuity of need and depending on what other services may also be engaged.

He has untreated PTSD from early childhood trauma. He is deeply isolated, severely obese and is considered homebound because he requires wheelchair transportation to leave his home in any way. For the most part he has been able to walk or use a walker but getting into a vehicle and traveling requires different assistance. He has a pension and social security income and just barely misses the mark to qualify for most social services. He pays out of pocket for all assistance.

Upon our introduction, he was enrolled in SASH but had no medical doctor. He had primary concerns for diabetes, cardiac disease, chronic pain, and chronic skin infections.

Immediately the community nurse requested special consideration for a home based primary care program from another hospital, the client was accepted. Community Nurse Connect provides all community nurses with an electronic platform to communicate directly with DH systems, including VNH. Because this client is unable to

leave home, he can not just schedule himself an appointment and go to the clinic. Visiting Nurses provide services if there is a medicare approved reason for being in the home. VNH has had multiple intervals of care during these last five years however, they have always had to discharge Frank once the wound was healed or the rehab goals were met. In chronic illness, the next healthcare issue is just around the corner. The community nurses' continuous care allows the next issue to be identified and addressed ahead of time. I remember one home visit when I identified a wound. I was able to call the primary care physician and send photographs. They in turn sent a new prescription for infection management and made a referral to VNH to initiate services. Over the years our interventions have been countless. The community nurse has facilitated home modification, delivery of essential goods, identification of multiple caregivers, medication education, symptom management support, transportation and friendly visitor assignment. Most recently, I have been part of a multidisciplinary approach to support the client to return home after an extended hospitalization. Frank has made the courageous decision to die at home rather than attempt rehabilitation in a skilled nursing facility which would likely result in permanent residency.

Case Study 2:

Objectives:

1. To demonstrate that the Community Nurse can be integral in end of life care and aging in place. Community nurses work in partnership with hospice nursing services, not as a replacement and not as a duplicate service.
2. To demonstrate that once client needs are defined, the community nurse can help client plug into health resources as needed.

I have an image saved in my phone of two hands, my own and that of a client. It is a picture I took when I was at the bedside of this person that I cared for, for four years, while she was eventually dying. I was honored to witness her final passing but I also witnessed the very long and difficult journey it took her to get to this final surrender. As a community nurse I supported her to find a new cat, placement for rehab care, caregiver training, a new recliner chair and a volunteer to help make modifications in the home for fall risk reduction. I spent countless hours listening to her life story, building trust and offering companionship. She decided to let go of her drivers license and we made sure she had emergency plans for power outages. This person invested much meaning into the practice of work. She was a technical teacher in the Vermont

jail systems, a mechanic, an engineer. When she could no longer use her hands, when she could no longer problem solve, she knew that it was time to let go. At one point we had a joint visit with a SASH coordinator who suggested that she might now be a candidate for hospice care. There was a two month period between that joint visit and the next. Within that two month period, the community nurse ensured that the primary care doctor made a referral to a local hospice facility: Bayada. We worked together to gradually introduce new team members. Eventually the hospice team replaced the primary care team but still the community nurse remained. We arranged final family visits, indulged in graham crackers with milk and read Agatha Christie out loud. She eventually qualified for the Death with Dignity program. The client at one point stated "I couldn't make this decision without you. You know me so well". The 100+ visits I made with her were FREE. My visits were not defined in duration or length by her medical insurance guidelines. I was integral in her hospice care. One day I came to her home for a routine visit and she and the bed were saturated in blood. She had been having recurring nose bleeds because of her COPD treatments and condition. Rather than call the rescue squad, we called her hospice team. I sat with her, gave her a bed bath, coordinated with hospice and together we triaged her care. The rescue squad didn't need to be called and the hospice team didn't need to come. By the time I left she was clean, calm and stable and the hospice nurse was planning to come for her routine visit the next day.

Case Study 3:

Objectives:

1. At times the community nurse is the only community based service in the home and the liberty to adapt a home visiting schedule according to the client and family needs provides comprehensive case management.
2. To demonstrate that the community nurse does not work with a client in isolation, but rather includes family as important factors in addressing health and wellness.

Finally and not last in my heart's awareness, is a client that really was a fighter. This woman was 94 years old when she left us, and was basically independent up until the age of 93 and one-half. I met her four years ago at a blood pressure clinic. She

attended the community breakfast and clinic that is organized weekly at our local church. Initially, she would only occasionally welcome me to her home. And, when she did, she wanted me to know that everything was fine. Truthfully, everything was fine, until it wasn't.

We were called in when she had a fall and had been hospitalized. By this time, over gentle and non-urgent introductions, we knew each other well.

The fall itself was not too bad but unfortunately, the hospitalization was extended because she contracted COVID while staying at Dartmouth. By the time she was home, 5 weeks later, her cognitive status had changed. Deep isolation will do this. She lived in a trailer that was placed in the same lot as her grandson. He and his wife had been this client's primary support system for at least ten years though throughout much of that time she had been quite independent.

She would always pick up beets at the food shelf and she would tell the nurse "If you boil the beets and drink the juice and waste nothing, you will be strong in health".

When her health turned, after her fall, it was very difficult. She was discharged first to a rehab center and met all goals there. She was then discharged home with services from our local VNA. Rehab worked closely with her but she consistently, because of her cognitive changes, refused cooperation and was discharged for not meeting progress goals set forth by Medicare. This left the community nurse and the primary care team, who, at this point, was home based. Home based primary care is only able to visit monthly. The community nurse provided three visits per week and communicated with primary care at each visit. Some of these visits were crisis management as the family felt powerless and helpless. They wanted to call 911 because they didn't know how to handle the clients increasing senility, her threats to burn down the house and attempts to disconnect the power. Calling 911 would have been fruitless, she could not receive inpatient psychiatric care and she was not yet qualified for choices for care, thus unable to be transferred to a nursing home. The community nurse was the most consistent in home service for the client and their family when no other service could be in place.

Eventually, this client chose to end her own life. While she experienced cognitive changes in the end, there were also periods of lucidity. She knew that she did not want to live in a nursing home and she knew that she did not want to live at home, requiring

significant, 24/7 care from her family. The family wanted to but could not give this level of care. Her passing was peaceful and ultimately a reflection of what she truly wanted.