Michelle Jerome RN, BSN has been doing home visits the majority of her 35-year career. She comes to our community with experience in home health, hospice, public health & maternal/child care.

The Story of the Chelan Valley Community Nurse

The year-round population of the Chelan Valley (Chelan. Manson and Chelan Falls) is around 10,000. The Valley has one small community hospital, two family practice clinics, one Assisted Living facility and one Adult Family Home. Skilled Nursing and Memory Care are located 20 to 50 miles away. The local Skilled Nursing Facility was sold and moved to Wenatchee (50 miles) in 2016. About three years ago a group of concerned citizens began meeting, calling themselves the Senior Living Initiative. They were fueled by both philanthropic concerns for the aging population who were looking at having to leave their valley home in their last few years, and also by a selfish concern, as most involved with the Initiative are looking at waning years themselves, talks began. A community survey was done which identified numbers of the aging population, income levels, and number of available spots for seniors to age in place. Not surprisingly, a significant gap was identified. The survey also looked at how people would like to spend their last years. The overwhelming majority surveyed wish to remain in the Valley in their own homes and have specific requests for what might be available when they can no longer stay in their own homes.

The Senior Living Initiative group put on a Summit for the community in September of 2016. Out of this Summit came two Task Forces: one to create a Campus of Care, a physical grouping of facilities to cover the continuum of aging; and the second to look at services to assist the aging to stay safely and comfortably in their own homes as long as possible. The Chelan Valley Community Nurse Program is an offspring of the second task force. Lake Chelan Lutheran Church offered to and became the 501-C3 fiscal sponsor for the nurse ministry. Application was made to United Health Care for a grant to fund a half time nurse, and was funded as a demonstration project beginning August 1, 2017. The program targets frail and vulnerable adults living at home with the goal of education, coordination and referral to services that will augment the situation in the home. The goal also is to supplement, not duplicate, existing services.

At this writing, the nurse is utilizing the database from Henry Ford McComb and has over a hundred clients. The need to create every form necessary (referral, HIPPA, assessment, report to MD, etc.) became onerous and the nurse applied to the Lake Chelan Community Services Council for additional funding to support a part time administrative assistant. This funding has allowed the nurse to get out into the field more.

Referrals come from physicians, nurses, social workers, family members, clergy and concerned neighbors. The nurse is conducting frequent blood pressure screening clinics after church services at various congregations and at the Senior Center and Community Meals Programs. She also volunteers twice monthly at the Food Bank. The public visibility is increasing the comfort of community members in seeing and confiding in a nurse. It is also increasing the comfort of professionals in referring clients. An additional small grant was awarded by the Lake Chelan Health and Wellness Foundation to increase the number of screening clinics available to citizens through this nurse/program.

Here is a sample story of what can be accomplished by this unique role of the nurse. A client, with severe COPD and continuous O2 is living at home with his wife. A bright, intelligent man, he has always managed all his medications and treatments and this has worked well for them for many years. This winter, after dental work, he developed a jaw infection which became septic and he then developed pneumonia. Because of the sepsis, he lost the ability to direct his care. The wife called the nurse, who arrived at the home to assess him and promptly sent him to the ER, where he was admitted for IV antibiotics and treatment. After discharge, the nurse received a call from the wife to come and teach her about his condition and how she might asses him in the future. This was a very fertile visit, with the husband helping with the teaching. The wife stated at the end that she felt much more capable. Sure enough, a few weeks ago the nurse got a call from the wife requesting a visit. The nurse went out and he was indeed heading into respiratory difficulties and went to the hospital. This time, the medical staff at the hospital complimented the wife on getting him there sooner. He was in the early stages of pneumonia and his hospitalization was significantly shorter. In this scenario, the client was not eligible for home health or any other nursing services. The education could have been done at the doctor's office which is in Wenatchee and would have required a half day trip there and back, which is taxing on the patient. The same can be said for the assessment in the home by the nurse.

Rural populations have a long drive to specialist care which is often booked weeks or months out. Having a skilled nurse available for the education and assessment needs of this population is invaluable. Because this program is funded by grants and donations, there is no need for insurance prior authorizations trying to fit a client's needs into specific and narrow requirements for reimbursement.

There are so many success stories, and few can fit into one single category of need. Frequently, as in the case of the COPD client, the spouse or caregiver is really the one in need of services and support. Recently the nurse has been receiving greater acceptance from the Hispanic Community and has begun providing blood pressure screenings after local services. This is particularly important as a number of uninsured is significantly higher in this population, and cases of untreated Stage I and II hypertension are particularly high. The opportunity to provide education and referrals on the spot is invaluable.

Currently there is effort to create a fundraising team that will look at sustainability options for this program as the funding ends July 31, 2018. The nurse is requesting skilled assistance as fundraising is not her forte.

That this program is making a difference is not the question. The question is how might it continue.