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An Exploratory Study of the Role of the Town Nurse

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AN EXPLORATORY STUDY

OF THE ROLE OF THE TOWN NURSE

BY

LYNN P. BLANCHETTE

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OF

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Abstract

The Patient Protection and Affordable Care Act (PPACA) was designed to expand and refocus health care delivery to a more preventative mode as opposed to a curative one. Despite being a highly industrialized country, the United States of America (USA), ranks 37th in the world in a number of health outcomes including life expectancy, universal health coverage for core services, maternal outcomes and obesity rates among adults. Public health nursing is being called to respond to this need. What is missing from the literature is a description of the role of the Town Nurse.

A descriptive, exploratory study of the role of the Town Nurse was conducted to explore the roles usefulness in meeting the goals of the Patient Protection and Affordable Care Act through the Community Transformation Grants; that of health promotion and disease prevention. There is little known about the role of the Town Nurse and its relationship to these goals.

This study, including in-depth interviews with ten Town Nurses, was used to obtain a description of the Town Nurse role, identify barriers and facilitators for further role development and the impact of the role on the community. Ten female, Caucasian nurses who had been employed in the role between 6 months and 50 years in the New England region were interviewed at their places of work or a café in the community. Data were collected and analyzed using Schatzman and Strauss' field notation system and included transcription of the audio taped interviews along with intra case and cross case analyses.

Descriptions of the Town Nurse role included a core set of expectations: a

population focus, the responsibility for identifying and meeting the health needs of the community, inclusion of needs across the lifespan, collaboration with others and performance of work within the context of a multi-level system. They met these expectations by being autonomous, being members of the community, being flexible and doing home visits. This required that the Town Nurse have a skill set that reflected clinical competency. Three sub-types of Town Nurses were identified, one with a focus on individuals, one with a blended focus and the last with a focus at the population level.

Implications for theory include that the model will be useful for increasing understanding of the role. Research implications include the need for empirical testing of the outcomes for the Town Nurse in addressing the goals of the Patient Protection and Affordable Care Act (PPACA). There are also implications for education, including the need to incorporate the Town Nurse model into the current textbooks and literature. The role as compared with current competencies and standards in public health nursing is more wide ranging and perhaps novel. Official job descriptions and socialization into the role was generally lacking. Facilitators for the role were identified as the professional roles of the TN, the nurses' autonomy, the PPACA, the location of the Town Nurse office, being a member of the community and the nurses' own characteristics. Barriers included the nurses' education level, difficulty communicating the role to community members, the location of services, the lack of opportunity for skill development, lack of resources and community preferences.

In terms of future research, further identification and empirical testing of the outcomes for the Town Nurse are needed, especially in relation to the goals of the

PPACA. Implications for education include the need to incorporate the Town Nurse model into the current textbooks and the nursing and public health literature. Practice implications include the need to evaluate a return to the blended role, consistent with historical models.

Acknowledgements

I would like to begin my acknowledgements back to my earliest days as a student and a Visiting Nurse. I met Carol Shelton when I was completing my undergraduate degree and knew then that I had found my place in nursing. My first preceptor in Community and Public health nursing called herself the "Glocester Town Nurse" and I wanted to be one ever since. I was then fortunate to be employed at an organization which was headed by a woman who was truly a staunch supporter of nursing, its independent and autonomous capacity, to reach those who make up a community, where they live, work and play. Jane MacKenzie and others like her at the VNA of Providence, Cranston, Johnston and North Providence inspired in me a desire to care for people in their homes.

During my years making Maternal Child Health home visits I met Janet Hirsch. Her persistence that I needed to go to graduate school sent me to the University of Rhode Island to become a Nurse Educator. It was there I first met Donna Schwartz-Barcott and Diane Martins. As a team, they helped me to discover the theoretical basis for community and public health nursing, to participate in the national discussions about its standards and competencies and develop a pedagogy to inspire new nurses.

I am fortunate to work with incredible, amazing women who teach Community and Public health nursing and who were always available to support me. Mary Byrd, Joanne Costello, Kathy Gremel, Jeanne Schwager and Pat Thomas have been my mentors, cheerleaders and substitute teachers and I cannot express my gratitude to them. I want to also thank Claire Creamer, colleague, classmate and friend.

I would be remiss if I did not acknowledged all of the faculty and leadership at the University of Rhode Island College of Nursing. They have guided by learning for many years and I am grateful for their guidance and perseverance.

Dedication

This research is dedicated to all the nurses who care for individuals, families, groups and populations in the community. In particular, those who do so as Town Nurses. The Town Nurses who participated, both in the study and in the preparation for the study assisted me to describe for everyone the special, unknown ways they care for their communities. Their honesty and willingness to invite me into their work and to share their love of their role created a starting point to show the nursing world how this model could work towards a healthier US.

My dissertation journey was challenging, exhausting and energizing. The time it took to complete this dissertation saw many changes in my life. Along the way, there were many people who supported me. My family and friends were there while I was studying and writing, and best of all, there at my defense. My sister Donna has been my rock, never leaving room for me to doubt myself or my ability to complete this dissertation. I am lucky to have my mother and two more sisters as part of my support team. My sons, Craig and Jeffrey are a constant source of inspiration, they are such smart, strong men, and I need to work hard to keep up. They have brought lovely young women into my life and for that I am grateful.

To my friends Patt, Gina, Ellen, Sue, Carol, Sue, Lisa and Lori, words cannot express what it means to have you in my life during this time. Your constant support, unfailing friendship and the silly nicknames (Dr. Nurse), I thank you. Many others have contributed to my successfully completing this degree by covering classes, reading and editing and just generally holding my hand and cheering me on.

I have already acknowledged Donna Schwartz-Barcott but now I need to

dedicate this work to her. Her unfailing memory of the history of public health

nursing, her unwavering belief that I could tell this story and her sheer pleasure in my

accomplishment are just some examples of the amazing woman she is. She has been

such a part of my life for many years, I cannot imagine it without her! Your

contribution to nursing science and to the lives of those nurses you have touched is

immeasurable. I am honored to call you colleague.

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Chapter 1: Introduction

Despite being a highly industrialized country, the United States of America
(USA) ranks 37th in the world for a number of health outcomes including life
expectancy, universal health coverage for core services, maternal outcomes and
obesity rates among adults (Organization for Economic Cooperation and Development
(OECD), 2013; Center for Disease Control, 2013). Other published reports have
highlighted the increasing number of adults and children living with chronic illnesses,
lack of access to primary health care including preventive screenings related to being
uninsured, poor maternal outcomes, health inequalities and poor choices for health
promoting behaviors as contributing to the problem (Wilper et al., 2009; CENTER
FOR DISEASE CONTROL, 2013). Previous models of delivery of health care in the
USA have contributed to these outcomes, and the need for a better model has led to
the current plan, the Patient Protection and Affordable Care Act (PPACA).

The PPACA was designed to expand and refocus health care delivery to a
more preventative mode as opposed to a curative one. Health care in the USA has
primarily focused on individual care, with people entering the health care system only
after they have become ill. According to the US Department of Health and Human
Services (USDHHS), the PPACA creates an opportunity to focus on prevention, which
will improve the health of Americans, reduce costs and improve the quality of care.
The PPACA includes a Prevention and Public Health Fund intended to provide
resources for expanding the health care system in the USA to better prevent disease,
detect it early, manage conditions before they deteriorate and support communities to

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develop the resources to promote healthy living. The PPACA emphasizes a focus on prevention as well as a focus on the community and a move away from primary care. This dual focus is greatly appreciated by those in community health. Also appreciated is its differentiation of population health and prevention versus primary care and prevention; primary care focuses on treatment of individuals as producing prevention. Community and public health nurses (PHNs) have the same concerns as other public health workers, believing that health is achieved through population- and prevention-focused activities.

Koh and Sebelius (2014) have explained how the PPACA is responding to the gaps in the current health care delivery system. They identify that many people in the USA do not reach their full potential for health because of preventable conditions, and that preventive services are accessed by only a little over half of the Americans for whom they are recommended. Four initiatives in the act were developed to address these gaps. First, there is an initiative which is aimed at increasing access to clinical preventive services. A second initiative promotes well-being in the workplace by offering employer incentives. Third, the act provides support for the vital role of communities in the promotion of prevention. And, lastly, it elevates and thus draws attention to the notion of prevention as a national priority.

Public health nursing, according to Kelly (2014), while acknowledging the impact of these changes, continues to identify the social determinants of health as an ongoing concern. While increasing the number of citizens who have access to health insurance is likely to improve health outcomes, particularly those arising from conditions related to lack of access to primary care and prevention, it does not directly

address the social and environmental disparities which are linked to many poor health outcomes. These outcomes have often been linked to poverty, and attempts to mitigate them have been directed through social programs such as Medicaid, Food Stamps or Supplemental Nutrition Assistance programs (SNAP) and Women, Infants and Children (WIC). In addition to those governmentally sponsored programs, there have historically been nurses in communities responding to the needs of the individuals, families and groups in communities. Programs such as the Nurse Family Partnership have been demonstrated to meet these disparities, but are not directly funded through the PPACA.

In response to the PPACA, major leaders in public health nursing called for the involvement of PHNs to address the gaps. Swider, Kulbok and Levin (2014) produced a report from an invitational forum on the role and future of nurses in public health. The forum, which was sponsored by the Quad Council of Public Health Nursing organizations, was held to develop a consensus among leaders in Public Health Nursing on action steps which will promote the ability of PHNs to be involved in the improved health of the public. They identified three priorities, one of which is to identify and support current and emerging roles of PHNs. In a brief summary of the history of public health (PH) nursing, Kulbok, Thatcher, Park and Meszaros (2012) related that PH nursing developed as a distinct nursing role, arising from the public's reaction to poor urban living conditions which ultimately gave rise to a distinct practice which is population-oriented and prevention-focused. PHNs practice in diverse settings in the community, including homes, workplaces and schools. Early in their history, PHNs were primarily focused on the resolution of social conditions such

as poverty and the negative impact these conditions had on health outcomes, addressing needs and implementing interventions that were focused on the environment and public policy.

The publication by Kulbok et al. (2012) has brought forth some long standing fallacies in the history of the role of the PHN. They describe district nursing as the first defined role for PHNs, emerging at the same time as Florence Nightingale was professionalizing nursing. The practice of Public Health Nursing included an understanding of how culture, economics and other social sciences, along with sanitation, influenced health outcomes and the lives of the families. In general, PHNs' primary role should be the nursing of groups or communities, particularly vulnerable groups, primarily for the purpose of alleviating illness or preventing it, not necessarily for the promotion of health. This is consistent with the role of the Community Health Nurse up until the 1990s, when there was a shift away from community-based nursing to one of institutional, i.e. departments of health with nurses serving in specific programs such as Maternal Child health, Communicable Disease or other disease specific programs and School Nursing. One potential exception to the movement away from community-based prevention may be the Town Nurse (TN) although little is known about the role.

Lillian Wald is credited with coining the phrase "public health nurse" as a new role for nurses who visited the homes of the sick poor (Buhler-Wilkerson, 1993). Over time, this interest moved to a focus on the neighborhood and all who lived there, sick or not. According to Wald, "Our basic idea was that the nurse's peculiar introduction to the patient and her organic relationship with the neighbourhood should constitute

the starting point for a universal service to the region" (p.1777). Her statement is consistent with the expectations for community health nursing.

This model moved into other areas of the country, including rural areas where poverty and other threats to the health of members of the community lived. This included rural health nurses, Maternal child health nurses and frontier nurses. Visiting nurses (VNs) at this time were doing both sick nursing and health nursing guided by their English colleagues and the writings of Florence Nightingale (Buhler-Wilkerson, 1993).

The current role of TN is likely a vestige of earlier forms of community nursing. There are examples of communities which integrated PHNs and VNs (Weierbach, 2007). Frontier nursing is also an example, best described by the creator of the role, Mary Breckenridge, who stated the goal of Frontier Nursing as "providing a community-supported, family-centered nursing approach to primary health care"(Raines & Wilson, 1996).

The TN role may be particularly good to meet the goals of the PPACA because it is grounded in a politically designated community (geographic) and not housed in a hospital, ambulatory care setting or health department. However, there is no empirical description or evaluation of this role. The basis of this research was to address this weakness. In this study, Role Theory has been drawn on to describe and explore the role of the TN. What is needed is an exploration of the role as it has become actualized over time and the factors which influenced the role, both positive and negative.

Purpose and Research Questions

The general aim of this study was to obtain a current description of the

professional role of the Town Nurse in the Northeast. This exploratory study sought to answer the following research questions:

1. How do Town Nurses describe their role and responsibilities and the focus of their interventions? How did the role develop over time?

2. What facilitators and barriers have influenced the role?

3. What impact do the Town Nurses think they have on the community?

A descriptive, qualitative design incorporating semi-structured interviews based on the work of Rubin and Rubin (1995) was used for this study. Rubin and Rubin (1995) used the term "conversational partners" to describe the interview method which was used here.

Significance

The research being described here will contribute to nursing knowledge. Its significance is related to the further development of a nursing typology described by Kim (2010). Kim (2010) described a nursing typology which includes four domains: client, client-nurse, practice and environment. The phenomena of nursing work or practice, located in the person of the nurse as nursing care is delivered, are considered for this domain, as nurses relate to clients and in addressing clients' health-related experiences are of interest. Kim (2010) specifically stated that nursing practice is related to how nurses work as agents of health care provision to individuals and groups, and is referred to as the philosophy of professional work. Knowing the phenomena within this domain, an understanding of how nurses make a difference for clients and their health can be achieved. She provides a philosophical orientation for practice and describes it as being made up of three components: the philosophy of

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therapy, the philosophy of care and the philosophy of professional work.

Practice concepts can be further delineated by deliberation and enactment. The process of deliberation is understood to refer to phenomena in the nurse-agent, as he or she is mentally and intellectually addressing the clinical situation in anticipation of the delivery of nursing care. The process of enactment refers to the phase in which the nurse actually performs activities in nursing. Describing this process for the TN will begin the process of understanding the role.

The term "professional nurses' role" implies that there is a single role which is used in all health care settings and context. Kim (2010) has acknowledged that there are many roles and much of the knowledge of this is prescriptive not descriptive.

Role theory, described by Biddle and Thomas (1966) and expanded by Hardy and Conway (1988), contains a number of concepts which align with Kim's explanation of practice, including the concepts of expectations and behaviors. The TN's deliberations should be expected to include an understanding of the expectations of the community and the behaviors chosen to inform the role.

There is little currently known about the TN. In pursuit of a description of the TN, this paper will include my personal and professional interests in this role, developing an awareness of it since my early days in nursing while still a student and progressing to my current position as a volunteer in a small, non-profit organization. While it is possible to make some initial comparisons to other forms of community nursing, the historical development of the role, its meaning to the nurse and to the community, is unknown at this time. The methodology, research findings, and discussion will be presented. The paper will conclude with a summary, followed by

conclusions, limitations and implications, including ideas for future research.

Chapter 2: Literature Review

Despite being a highly industrialized country, the US ranks poorly in the world for a number of health outcomes including life expectancy, universal health coverage for core services, maternal outcomes and obesity rates among adults (OECD, 2013; Center for Disease Control (CDC), 2013). A number of published reports highlight the increasing numbers of adults and children living with chronic illnesses, lack of access to primary health care such as preventive screenings related to being uninsured, poor maternal outcomes, health inequalities and poor choices for health promoting behaviors as contributing to the problem (Wilper et al, 2009; CDC, 2013). Previous models of health care delivery in the USA have contributed to these outcomes and the need for a better model has led to the current plan, the PPACA.

The PPACA was designed to expand and refocus health care delivery to a more preventative mode as opposed to a curative one. Health care in the USA has primarily focused on individual care, with people entering the health care system after they have become ill. The USDHHS (2011) identifies that the PPACA creates an opportunity to focus on prevention which will improve the health of Americans, reduce costs and improve the quality of care. The PPACA includes a Prevention and Public Health Fund was designed to provide resources for expanding the health care system in the USA to better prevent disease, detect it early, manage conditions before they deteriorate and support communities' ' development of resources to promote healthy living. The PPACA focuses on prevention and its emphasis on community is greatly appreciated by those working in community health due to its differentiation of population health and prevention; primary care medical care focuses on treatment of

individuals in lieu of population health to produce prevention. Community health nurses have the same concerns as other public health workers.

Koh and Sebelius (2014) explain how the PPACA will respond to the gaps in the current health care delivery system. They identify that many people in the USA do not reach their full potential for health because preventive services are accessed by only a little over half of the Americans for whom they are recommended. To meet these gaps, Koh and Sebelius identify four initiatives in the PPACA which were developed to address these gaps. First, the act contains and initiative which provides increased access to clinical preventive services. A second initiative is focused on promoting well-being in the workplace by offering employer incentives. Third, the act will provide support for the vital role of communities in the promotion of prevention. Lastly, it will elevate and thus draw attention to the notion of prevention as a national priority.

Public health nursing, as described by Kelly, (2014), while acknowledging the impact of these changes from the PPACA, continues to identify the social determinants of health as an ongoing concern. While increasing the number of citizens who have access to health insurance is likely to improve health outcomes, particularly those outcomes arising from conditions related to lack of access to primary care and prevention, it does not directly address the social and environmental disparities which are linked to many poor health outcomes. These outcomes have often been linked to poverty and attempts to mitigate them have been directed through social programs such as Food Stamps or Supplemental Nutrition Assistance programs (SNAP), Women, Infants and Children (WIC) and Medicaid. In addition to those

governmentally sponsored programs, historically there have been individual nurses responding to the needs of the individuals, families and groups in communities. Programs such as the Nurse Family Partnership have been demonstrated to meet these disparities, but are not directly funded through the PPACA. Kelly believes that historically, public health and public health nursing have had significant roles in addressing social determinants of health and should continue to do so. Impacting the places where people live and the ways in which they interact with one another and the environment are just a few of the areas where opportunities exist for community and public health nursing.

Community and public health nurses have a long, illustrious history of being present and responding to social change, population movement and medical improvements. These nurses work and often live in the communities they serve and have demonstrated a capacity to develop programs and meet community needs quickly. Encouraged by the PPACA, there is a movement in the health care delivery system in the United States which is looking to move away from secondary and tertiary care as the primary focus for health care interventions and instead focus on prevention and health promotion (Swider Levin & Kulbok, 2014).

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statement is consistent with the expectations for community health nursing.

Public health nursing, Wald's model, moved into other areas of the country, including rural areas where poverty and other threats to the health of members of the community existed. This model was taken up by organizations including rural health nurses, maternal child health nurses and frontier nurses. Visiting nurses (VN) at this time were doing both sick nursing and health nursing, guided by their English colleagues and the writings of Florence Nightingale (Buhler-Wilkerson, 1993).

The current role of town nurse (TN) is likely a vestige of earlier forms of community nursing. There are examples of communities which integrated PHNs and VNs (Weierbach, 2007). Frontier nursing is also an example, best described by the creator of the role, Mary Breckenridge, who stated the goal as "providing a community-supported, family-centered nursing approach to primary health care" (as cited in Raines & Wilson, (1996, p. 123).

Community Health Nursing

Nursing care has been delivered in the community throughout the recorded history of nursing. The effort to understand and describe how delivery of that care differs from the care offered in the acute care setting has been documented in several ways. To begin, a brief historical overview of the role and its transition to current practice will be provided.

As with many professions in the early 1900s, nurses working in the community were making efforts to define, describe and explain the rationale behind their work. A debate among the community health nurses centered .around the naming of an association. The title "National Visiting Nurse Association" was seen as too narrow

and a more inclusive, the "National Organization for Public Health Nursing"

(NOPHN), was ultimately was selected (Abrams, 2004). The group thought the term

"visiting nurse" varied in different parts of the country, thus would not aid with

understanding. Public health nursing, on the other hand, was more inclusive, including

the work of the nurse in the community providing bedside care to sick individuals,

care in schools and workplaces and those providing specific disease related or social

service programs (i.e. Maternal child health). With the new name, the NOPHN (1929)

wrote a new definition of the role as follows:

> …an organized community service rendered by graduate nurses to the
>
> individual, family, and community. This service includes the
>
> interpretation and application of medical, sanitary and social
>
> procedures for the correction of defects, prevention of disease and the
>
> promotion of health, and may include skilled care of the sick in their
>
> homes. (as cited in "The objectives in public health nursing," 1931, p.
>
> 439)

Additionally needed was a guideline for practice. In 1931, general and

specialized objectives were developed by the Field Studies Committee of the NOPHN.

General objectives included education of individuals and families for protection of

health, assistance in adjustment of conditions that affect health, correlation of health

and social programs for the welfare of both family and community, and community

education for the development of public health facilities ("The objectives in public

health nursing," 1931, p. 439; Abrams, 2004).

Changing the language of the model was significant. Public health efforts had

been focused on control of environments through sanitation and control of communicable diseases through isolation and eradication, whereas community health supposedly reversed the "restrictive" concept of public health (Subcommittee on Functions, 1949, p. 67). Public health was understood as population-based--that is, less focused on individual education and change of individual behaviors. Community health, on the other hand, emphasized the dissemination of medical benefits and scientific advances of the postwar period. Looking at interventions in the community health paradigm, one can see they involved (a) care and rehabilitation of the sick and disabled, (b) promotion of healthful living and (c) prevention and control of disease (Subcommittee on Functions, 1949). PHNs had always been employed to care for the sick and to work in specific control programs that were disease-focused, but nurses had demonstrated how effective their services could be if, while they were there treating the sick and enforcing public health controls, they also provided for all of the services that a family unit needed (Subcommittee on Functions, 1949).

Instead, the 1949 statement from NOPHN, Subcommittee on Functions attributed to public health nurses an independent and highly skilled role in community health. Examination of selected responsibilities illustrates the transformation from helper to colleague. In the area of individual and family care, the first of the three classifications, nurses were said to be responsible for providing part-time care to patients while educating family members, guiding families to recognize their needs, and counseling them in those areas of need. Under the second category, the nurse was to interpret medical information and teach individuals and communities to manage complex medical regimens, guide individuals with social and emotional problems,

make referrals, perform diagnostic testing, and interpret findings for families. Last in this category, nurses were responsible for working with families to ensure that their environments were safe and healthful. Although nurses had done all of these tasks with family units for many years before 1949, the responsibilities were stated in substantively different ways, reflecting a move away from the assistive model toward autonomous practice. Guidance, teaching, interpretation, and social and environmental management were viewed, at least by NOPHN leadership, as within the independent purview of postwar public health nurses.

By the mid 1970's, nursing care in the community moved to a more primary care focus. Williams (1977) has described community health nursing as more than just family-oriented care outside of an institutional setting, but also as a specialty with distinct knowledge and outcomes. Additionally, the focus of intervention varied in the community setting, with a focus which appears to be a combination of individuals and groups or populations, the nurse needing to determine which foci will produce the desired outcome, again asserting the nurse as an independent agent, able to make decisions within the scope of nursing practice to respond to identified problems.

As the delivery of health care shifts from the individual client to a more population- and prevention-focused one, the role of the community health nurse will become increasingly important. A national act, PPACA, has provided guidance to the health care system in the United States to increase the availability of workforce in the community, including PHNs (APHA, 2011). As part of the act, funding has been added to create nurse-run health centers in the community and to fund Community Transformation Grants which provide support for evidence-based, community-based

activities to promote health and prevent chronic diseases, such as smoking cessation or prevention programs, or enhanced access to nutrition or physical activity, all of which are problems on which nurses already focus and are ideally suited to continue.

During the last five years, several major reports have addressed the need for expansion of the role. In each of these reports, nurses working in the community are referred to as both public health and community health nurses. According to a report issued by the Institute of Medicine (IOM, 2010), *Care in the Community,* expanding the role of the nurse in the community and developing content for education of nurses who will work in the community are important considerations. As leaders in healthcare, nurses must act as full partners in redesign efforts, be accountable for their own contributions to delivering high-quality care, and work collaboratively with leaders from other health professions. Being a full partner involves taking responsibility for identifying problems and areas of system waste, devising and implementing improvement plans, tracking improvement over time, and making necessary adjustments to realize established goals.

At a presentation at the Forum on the Future of Nursing in 2009, an event sponsored by the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine (Care in the Community, 2009), Sullivan-Marx offered seven recommendations for the committee when considering the future of home health, community, and public health nursing. Significant for this movement towards health promotion and disease prevention, they are listed below with an explanatory statement. Each item will additionally be highlighted for its value to the importance of the nurse in the community.

1. *Establish professional nursing roles in places where people live and work.*
   Students need to learn and seek jobs in these settings. Many of the nursing
   roles in the community are not visible to those who are not directly exposed.
   The identification and a clearer explanation of the enactment of the role of
   the town nurse could provide the opportunity for student experiences and a
   link to more well established roles for nurses in the community

2. *Maximize benefits and minimize costs.* This requires reframing care not by
   place, but by skills and services. Skills should not be limited to a particular
   setting. In this recommendation, there would be a pairing of traditional,
   skilled nursing care with population-focused interventions.

3. *Enable nurses to control practice.* Payment for nursing services needs to be
   visible, transparent, fair, and based on outcome incentives. Historically,
   nursing care has only been reimbursable when it was delivered to
   individuals or families or subsumed in overhead costs. There are examples
   of this reimbursement status changing, particularly in some primary care
   practices where nurse care managers are creating a funding stream by
   documenting the improved the health of the population of the practice as a
   result of nursing interventions.

4. *Foster and recognize independent decision making by basic and advanced
   practice nurses.* Nurses need to be practicing at the full extent of their
   license, at all levels. Many missed opportunities for identification of health
   education needs, needs for community resources and interdisciplinary
   activities occur when nurses maintain a subservient or order-taking role.

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5. *Establish quality in community care as a core competency for all nurses.* This recommendation would imply that all nurses should have a minimum baccalaureate degree, as, in most educational programs, concepts related to population and community care occur in the senior year and are not traditionally part of the Associate degree education.

6. *Embrace family- and patient-centered care with a team of providers with nurses as leaders in care.* This recommendation is supportive of the nurse-led health center as well as community based initiatives which support healthy choices by families.

7. *Lead the return and renewal of public health nursing.* Public health nursing has created a vision for itself which includes the rebuilding of its workforce. For many years, the number of nurses who deliver care in this model has been diminishing.

During that same forum, Carol Raphael, Chief Executive Officer (CEO) of the Visiting Nurse Service of New York (VNS of NY) identified six skills that community health nurses will need in the future. Nurses need the ability to:

- Assess risk levels, functional impairments, and the medical and support needs of individuals;

- Partner with the patient and the patient's family to develop a reasonable and achievable plan of care;

- Manage a cross-disciplinary team, including informal caregivers;

- Coordinate care with other providers across settings;

- Aggregate, synthesize, interpret, and act on clinical data and

- Communicate effectively with patients and caregiving teams

In the final report by Swider, Levin and Kulbok (2014), the Quad Council of Public Health Nursing Organizations described an invitational forum held on the *Role and Future of Nurses in Public Health* in Boston, Massachusetts. A plan was developed for the expansion of the role of the public health nurse, given the changes in the healthcare environment, driven by the opportunities offered by the PPACA focus on health promotion and prevention. The group consisted of 25 members, representative of the Quad Council on Nursing, along with other groups supporting community health nursing in practice, education and research partners. Representatives from Robert Woods Johnson participated as well. The key recommendations for action highlighted in this Quad Council report include:

- Priority 1: Identify and support current and emerging roles of PHNs.

- Priority 2: Create and secure innovative models for sustainable funding of PHN practice and PHN interventions.

- Priority 3: Develop and support leadership skills in PHNs at all levels of practice, and education and research.

Each of these reports identifies the need for clarity of the role of the PHN, expansion of care provided by these nurses and the development of new models of delivery of care. One strategy which could be employed to meet these goals is to look at models which exist or have existed historically to see if they are aligned with the current need. These expectations will be used to guide the discussion on TNs.

Current Definitions of Practice

As previously mentioned, the role of PHN in the United States has changed

over time as the expectations of the public have changed. There is a current focus on populations as the client, focusing on health promotion, prevention and environmental causes for disease. Tthis focus includes the community in the decision making. In the past, the focus was on providing care to individuals with illness and injury, case finding and responding to needs identified in the community. Describing the work of these nurses is important to guide the practice of current PHNs and inform the practice for the future, in particular, the role of the town nurse.

The American Nurses Association's (ANA) *Scope and Standards of Public Health Nursing* (ANA, 2013) presents standards for nurses with a focus on assessment of the health of the general community, care which is delivered in collaboration with others describing the role of the nurse in the influencing and development of public policy as a primary intervention. This document defines public health nursing practice as focusing on population health through the use of continuous surveillance and assessment of the multiple determinants of health with the intent to promote health and wellness. The emphasis for the PHN is to focus on primary prevention with the goal of achieving health equity.

In a document used by nursing education, the *Essentials of Community and Public Health Nursing* (Education Committee of the Association of Community Health Nurse Educators (ACHNE), 2010), it is proposed that nurse-client interactions at individual- and family-levels of care provide a foundation for effective communication with the community and population. Intervention at the community- and population-level strengthens the individual and family capacity for reaching personal health goals. The Education Committee of ACHNE do not provide clarity

about how the nurse would make the decisions about which focus for intervention would be most effective and appear to value those interventions focused on populations versus individuals.

Internationally, the World Health Organization (WHO) commissioned a review of the literature on community nursing. This commission confirmed the notion of extensive role confusion (Edgecombe, 2001). The findings revealed at least 23 terms are used to describe the nurse, including public health nurse, community nurse and health visitor. Nic Philbin, et al. (2010) also noted a previous survey in which the researchers identified two main models of community nursing care, the generalist and the specialist, referring to nurses who care for populations and individuals.

The role of PHN can also be determined by organizational expectations. Competency models may be used to identify the interventions and expected outcomes employed by PHNs. The core competencies for an entry level community/public health nurse have been identified by the Association of Community Health Nurse Educators (ACHNE) and their education committee (Education Committee, 2010). These competencies include concepts related to individuals, families and communities along with consideration of health disparities, global health, disaster management, reemerging diseases and environmental health. It is not clear from the report if the intention is that an individual nurse will be involved in each of these areas, or if they are intended to be managed by an organization of nurses or other public health professionals. In addition, expectations may be driven by job descriptions.

Researchers Smithbattle, Diekemper and Leander (2004a, 2004b) also attempted to describe the knowledge that can be derived from those with experience as

PHNs, or the "clinical know how" related to practice. In their findings they describe the movement of the nurses through an understanding of their practice to upstream, population-focused activities. This notion of using clinical experiences provides a source of situated learning and clinical reasoning. The authors study emphasized the importance of support and guidance from experienced PHNs beyond a task-based delivery of nursing care and external guidelines. Much of the role is not well elucidated and is developed by the nurses themselves, supported by experienced nurse supervisors or peers. In this research, the authors argued that what is needed is the development of these relational and perceptual skill sets that provide the stage for seeing the "big picture" and for thinking and acting upstream. While asserting the value of sophisticated data gathering and analytic skills, this serendipitous identification of an unmet community need emerged "naturally" from the nurse's organic relationship with the community. Much like Lillian Wald, in her comments about public health nursing being "organically connected" to the neighborhoods, this finding reinforces the value of the PHN in the community, not outside, making decisions from an outside place.

Using Role Theory to Describe and Explore the Role of the Town Nurse

Given the variations in the role of the community or public health nurse, based on program or location, how does one act on the role? In particular, the TN has no formal role behaviors defined by organizations which guide the PHN practice. In addition, it appears that the TN practices in isolation, as no information has been found to indicate a professional organization or structure to which they all belong, and there is no inclusion or discussion of the role in current nursing education. Role

Theory may be useful to describe and explore the role of the TN as a subset of the PHN.

In the pursuit of scientific knowledge, Reynolds (2007) explained that concepts are necessary for the provision of a classification (typology). The relational statements for the concepts are necessary for scientific knowledge which can be used to explain, predict or provide a sense of understanding. The concepts should be defined clearly, with agreement on the meaning among the users of the concepts. For this paper, the concepts related to Role Theory (Hardy & Conway, 1988) will be defined. Following that, relational statements will be proposed.

The theoretical framework to be used in this program of research is Role Theory. This theory was proposed by Biddle and Thomas in 1966. According to these authors, the fact that human beings behave in ways that are different and predictable depending on their respective social identities and the situation is an important characteristic of social behavior. They based their theory on the following underlying assumptions:

1. Role theorists assert that "some" behaviors are patterned and are characteristic of persons within contexts (form roles);

2. Roles are often associated with sets of persons who share a common identity (social positions);

3. Persons are aware of roles and to some extent roles are governed by the fact of their awareness (expectations);

4. Roles persist because of their consequences (functions) and because they are often embedded in larger social systems and

5. Persons may be taught roles (socialized) and find joy or sorrow in the

performances thereof. (Biddle, 1979)

Brooks, et al. (2007) provided a summary of the theoretical frameworks from which Role Theory emerged. According to the authors, Role Theory is based on three theoretical perspectives. The first, social structuralism, was introduced by Park in the 1920s, who theorized that roles are linked to structural positions, with the self playing multiple roles within the confines of the position. Linton added that there was a difference between the social structures of the network of positions, status and expectations and the individual. Roles serve the social system. The second, symbolic interactionism, was developed by George Herbert Mead, who theorized about role taking, in which others could influence both the behaviors of an individual or their own. Roles are relationships between what a person does and what others do around them. The third perspective, dramaturgical, was developed by a social psychologist, Jacob L. Moreno in the 1930s. He believed that the notion of role playing allowed the actor to begin to experiment with the role. Moreno contributed the notions that the genesis of role goes through two stages called role perception and role enactment (Biddle & Thomas, 1966). This perspective has also been noted to be useful to professionals and professional groups as they explore, refine and redefine roles.

Hardy and Conway (1988) discussed the question of whether Role Theory is actually a theory or a collection of concepts and hypotheses. In this edition, they described Role Theory as being used by many other disciplines, some with a functional perspective and some with a symbolic interaction. They also identified Role Theory as being used for socialization into adult roles. The functional

perspective was defined as being a primary mechanism serving essential functional prerequisites of the social system and that there was a relationship between the role and the social structures.

Those who identify the symbolic interactionist perspective think that the interpretation of roles and role behavior focus more on the meaning of the behaviors (acts) and the symbols of the actors during interactions. This perspective maintains that structure or function influences the behavior of the actor, but does not completely explain it. Two perspectives have been posited in the interactionist view, one by Goslin (1969) which conceives of social action as a "learned response," driven by authorities such as parents, teachers or employers (as cited in Hardy & Conway, 1988, p.79), and the other by Bolton (1967) is more focused on the interpretation of cues from the environment as a basis on which to make decisions (as cited in Hardy and Conway, 1978, p.18).

Concepts within the theory include role occupant, role sending, role negotiation, role expectation and role sender. See Figure 1. A role episode involves the cycle of role sending, the response by the focal person and the effects of that response on the role senders.

Role Sending

- Social norms
- Personality
- Personal skills
- Interpretation of role expectations

Role negotiation

- Social norms
- Personal expectations
- Anticipated responses
- Organizational needs
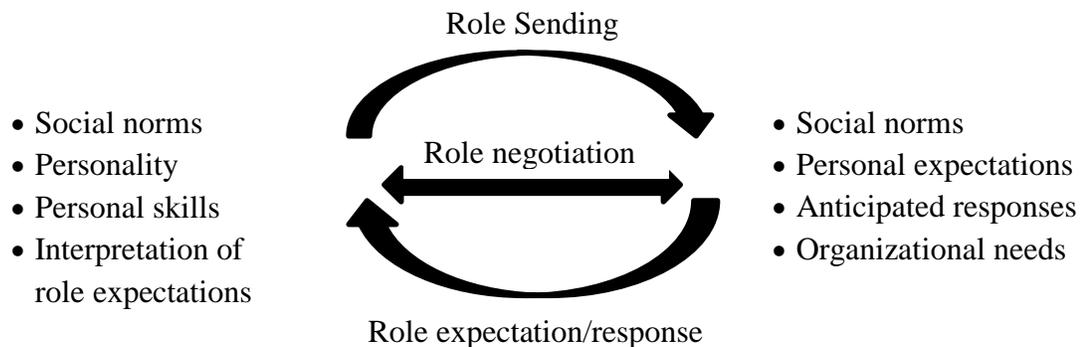
Role expectation/response

Figure 1: Diagrammatic representation of a role episode (modified by L. Blanchette)

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The role occupant in this representation could be the nurse in the community. The role sender--the public or the individual or family, for example--would be those who have expectations of the role occupant. The performance of the role occupant is influenced by a number of factors as identified in the model. For example, one might expect that the nurse brings the role of TN to the community and its members, along with all the expectations associated with that role. In addition, the nurse uses assessment skills and critical thinking to identify new needs and locate or create interventions. The choices the nurse makes about which clients to attend to are likely influenced by the nurse's own work experiences, the identified needs of the community and resources available. It is expected that the nurse in each community is actually providing varied nursing care, but using a similar model of decision making about the needs of the town.

Brooks, et al. (2007) have proposed that Role Theory could be used as a framework for investigating the role of the community nurse. The table below demonstrates how role theory could be used to clarify many questions and concerns for community health nursing. Additionally, the table defines some of the concepts associated with Role Theory such as role ambiguity, conflict, overload, identity and insufficiency.
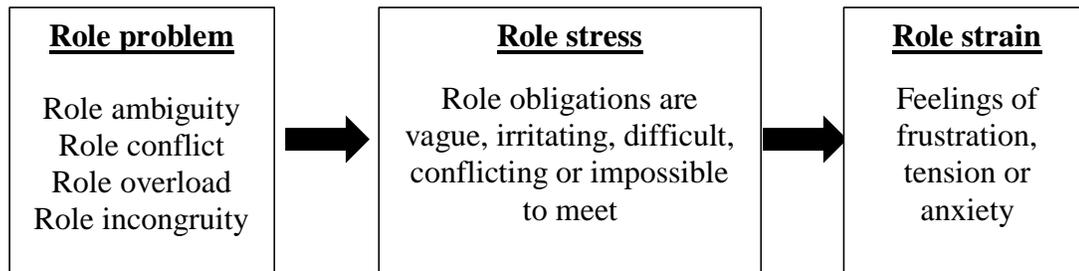
Table 1

Definition of role constructs and operational examples

Role Construct	Definition Derived from (Hardy & Conway, 1988)	Community Nursing Examples
Role Ambiguity	Disagreement on role expectation associated with a lack of clarity of those expectations.	Uncertainty about current role expectations as evidenced by the community nurses decreasing primary health care role and increased post-acute care role.
Role conflict	The focal person perceives existing role expectations as being contradictory or mutually exclusive.	Competing role expectations such as the role of administration and data collection versus role of clinician and carer.
Role overload	Inadequate resources relative to possibly excessive demands.	Increasing acuity of patients who are either managed solely as an outpatient or discharged earlier than previously from acute care settings who contribute to extra demands on the nurses' time.
Role identity	The individual's interpretation of role expectation, that is, position specific norms, identifying the attitudes, behaviors and cognitions required and anticipated for a role occupant.	The expectation of the role and behaviors of the community nurse by the individual, other community nurses and individuals such as acute care colleagues, general practitioners, clients, the community, hospital managers and academics.
Role insufficiency	Disparity in fulfilling role expectations, obligations or goals as perceived by self or significant others.	Increasing emphasis on the measurement of outcomes but difficulty in demonstrating outcomes from nursing intervention.

(Brooks et al, 2007, p. 151)

Role stress and strain were described by Hardy and Conway as being caused when a social structure creates demands on the occupants which are difficult, conflicting or impossible to meet (as cited in Hardy & Conway, 1988). Figure 2 demonstrates the manner in which role problems can precipitate role stress and lead to role strain.

Role problem

Role ambiguity
Role conflict
Role overload
Role incongruity

→

Role stress

Role obligations are vague, irritating, difficult, conflicting or impossible to meet

→

Role strain

Feelings of frustration, tension or anxiety

Figure 2. Relationship between role problems and role stress leading to role strain. (Modified by L. Blanchette)

Hardy and Conway (1978) also identified the concepts of role expectations, role taking, role making and modification and role negotiation. They defined role expectation as "position-specific norms that identify the attitudes, behaviors and cognitions that are required and anticipated for the role occupant" (p. 76). This will be an important consideration for the TN role, considering if there are similarities among the nurses who are working as TNs. Role taking was described by Turner (1962) as "the reflection of an understanding of the generalized attitudes of others in one's actions" (as cited in Hardy & Conway, 1978, p.112). Role making is considered a process and refers to the conscious strategy employed by the nurse to actively modify the role. According to Hardy and Conway (1978), this is a tool used to make certain aspects of the role explicit. Role modification or re-definition, occurs as new knowledge is made available. Town nursing is not a role which is defined in the literature, there does not appear to be an organization which brings the TNs together, nor are there specific standards or competencies which directly related to this work.

Role theory has been used to both explore and describe the work of the PHN and will be used to describe the TN and the ways the role is enacted.

The Town Nurse: What We Do Know

The TN is a type of community health nurse for which we have very little information. A search of Cumulative Index of Nursing and Allied Health Literature (CINAHL) reveals a single article on town nursing, which describes the evolution of a nurse in a small community, from volunteer service to her neighbors, to a paid position, which eventually included reimbursement from Medicare, much like a Visiting Nurse. She continued to provide nursing care in the community, including emergency preparedness, communicable disease prevention and home visiting (Kelly, 1973).

Kelly (1973) described the nurse, Eileen Nielson, as developing her own practice, one which started out as providing nursing care to elderly neighbors and friend's family members in addition to her work at a local hospital and advanced to include patients whose care could be reimbursed by Medicare and Medicaid. Ms. Nielson altered the care she delivered and added additional services as the need arose. She eventually established a durable medical equipment program, both lending and renting the equipment. In addition to caring for her patients, she taught classes in the community related to first aid, attended workshops to develop new skills for herself and writing numerous reports.

In order to gain some initial information about the role, a web-based search was completed. This search revealed websites for TNs in the New England and nearby New York state areas. The websites were downloaded and saved for review and updates. The data was reviewed using the following strategy: target of intervention, reimbursement/funding, affiliations, and presence of job description, educational

background and full- or part-time status. The data allowed this researcher to identify a description for the TN. The role is limited to those nurses who are employed by a municipality, not associated with a public health agency or a non-profit organization with a board.

Two TNs, one at the Tamworth Community Nursing Association (TCNA) and the other, Charlene, who works as a TN in community in Northern Massachusetts were identified by this strategy were eliminated from the population for this study. The nurses at TCNA because they are a non-profit organization with an advisory board. Although the nurses there appear to have a role similar to the TN, they deliver their nursing care in a manner unlike any other TN identified. Two nurses are available to the town and to visitors 24 hours a day (Tamworth is a vacation destination in New Hampshire). They provide primary care, sick visits, do telephone and in-person triage as well as community focused care such as immunizations. These nurses were the focus of a year-long study by the University of New Hampshire health policy (Tamworth Nurses.org). A visit to their office and attendance at an annual meeting revealed that the nurses work in their primary care role with standing orders from a local physician and collaborate with a local health department to deliver immunizations. All other client work is delivered based on the limitations of the nurses' licenses. Much of their time is spent in triage, making referrals and health education. In an email with the Executive Director (Personal correspondence 4/17/2012), she stated, "we consider ourselves a model for rural nursing which could be easily duplicated across America. We act like a public health office for our town at large, we educate folks, deal with their diseases or injuries. We provide training on

CPR and recently purchased AED's for our town. We do lots of assessments and confer with primary care providers. We see pre-natal patients as well as elders and everyone in between (one fellow is 103)!"

According to the study, while there are a number of significant financial outcomes which demonstrate the effectiveness of this model of nursing care in the community that TCNA brings,

> what numbers cannot denote is the value to the residents of Tamworth when a nurse comes to someone's home to treat them, or when a patient can drop into the offices versus driving dozens of miles for care, or when someone needs a loan of medical equipment, or when someone just needs someone who cares to talk to. This is what makes TCNA unique, and an integral part of the fabric of Tamworth. (p. 1)

Discovering what it is that the TN brings to the community and its members is the focus of this research.

The other nurse who was eliminate, a TN in Massachusetts, is Charlene. She is Master's prepared nurse in community and public health nursing. She was eliminated from the study related to her "expert" status and concerns that her enactment of the role would be greatly influenced by current PHN standards and her involvement with a number of PHN organizations. She is the recent Lillian Wald Service Award from the PHN section of the American Public Health Association.

During a visit to the Senior Center where Charlene enacts her role, she was observed in her daily work activities. Much of her day is spent in contact with seniors in the community--those who attend programs at the Center, such as the lunch and

recreational activities, but also those who make appointments with the nurse for health coaching, education and follow up on medical visits. She makes regular rounds within the Senior Center, keeping an eye on participants who have significant medical problems or who have been identified as having a recent decline in their medical status, including changes in cognitive functioning.

Charlene reports that she initially assumed this role in the community on a part-time basis. She worked full-time in a local community hospital. There had been a nurse in place when she started who primarily assisted with communicable disease outbreaks. They partnered with the local primary care physician to provide in home care to homebound residents and follow up care after hospitalization. Over time, she notes, the work became more highly structured based on program funding opportunities. It explains her current role at the Senior Center. While a portion of her salary is paid for by the town, most of the money comes from grant or government funded sources.

These nurses did allow some initial contact and beginning understanding of some components of the role. Significant in both cases is that while there is a job description, there is little or no specific direction for their daily decisions about nursing care delivery.

Additionally, there is information on the websites for the TNs who have been identified. The data from the websites has been placed into a table and reviewed by this researcher and her academic advisor. From the data, we have learned about the individual nurses who are identified as a TN, but also some information about them as a group. Services offered range from blood pressure and other screenings to

immunization and home visits. In many communities, the TN is involved in emergency response or disaster management. In some places, the TN has a shared office space in a municipal office, but is often co-located in the town's Senior Center. Websites reflect flexibility in the scheduling of events and availability, a participation in town events outside those which would traditionally be considered health care related and little affiliation with traditional medical models, i.e. no medical director or co-location in a medical facility.

From what little knowledge we have, it would appear that the TN model is ideally aligned with a major recommendation from the Swider, Kulbok and Levin (2014) report. This report is a result of an invitational meeting, held in Boston in November of 2013 with the purpose of developing consensus among PHN leadership for action steps to enhance and promote PHN. Priority 1 is to "Identify and support current and Emerging Roles of the Public Health Nurses" (p. 5). Under this priority, the organizers identify 20 actions and 6 expected outcomes. Action items related to TNs include the development of the role of the PHN as part of a community health team, conducting comparative effectiveness studies for public health interventions across provider/health type, identification of knowledge and skills for PHN practice the facilitation of PHN use for self-management skill in populations with chronic illness. Given that the TN is already located in a community, using her professional license to provide care to the people in that community, these items could easily be incorporated into the planning for the future of PHN.

Given what we know about the needs of the public for nursing care in the community, it is possible that the TN may provide a model for much of this work. One

of the biggest strengths is a return to a nurse for each community. In the Northeast, we have communities which are small enough to allow for the model to function well at a community level. A small group of nurses have continued to identify themselves as TNs with little written about them. It is possible they may be a good model for enacting the role as designated in the reports and the PPACA. Based on a review of websites and some data from nurses who work in related ways, TNs appear to be working independently, at both the individual and population level and focused on health promotion and disease prevention. There has been a demonstrated financial value in their work, as evidenced by the Tamworth Community Nurses Association. What is missing from the literature is a description of the role of town nurse. Questions which need to be answered in this research are as follows: Can a single nurse accomplish the goal of meeting the nursing needs of the community or population and the individuals in those communities? What are the skills used/needed by those nurses? Is this consistent with current scope and standards for practice? What strategies were used by these nurses to enact a role with so little definition?

This nurse is important to the discussion about public health nursing and the health of Americans, as it appears that the TN is managing a population at what may be the ideal size for maximum outcome, is likely to be both individually focused and population focused and that the positions are likely to be filled by nurses with expertise developed from years of holding the position. Well stated by Sara Abrams (2004),

> both historical function statements and the current competencies illustrate that
> public health nursing is something more than either population-based or

individually focused, just as it was more than performing disease-specific or

age-specific interventions. Public health nursing, as defined by nurses for

nurses, has always melded understanding of the conditions that shape health at

the global, national, or community level, and detailed attention to the

individuals who require care at the personal level. (p. 509)

Given that TNs appear to provide care to individuals, families, groups and

populations, their work may be the ideal example of a PHN.

Chapter 3: Methodology

The general aim of this study was to explore the role of the Town Nurse as described by nurses assuming this role in communities in the Northeast. More specifically, the research questions were:

1. How do Town Nurses describe their role and responsibilities and the focus of their interventions? How did the role develop over time?

2. What facilitators and barriers have influenced the role?

3. What impact do the Town Nurses think they have on the community?

This qualitative, in-depth and descriptive study was conducted using interviews with 10 Town Nurses with the aim of describing the role and its evolution.

In many of the studies reviewed in Chapter 2, the researchers used a combination of interviews and observations to understand the role of Community or PHNs, incorporating multiple methods of qualitative research. Qualitative methods for research are ideally suited for describing previously unknown phenomena, and thus were a good fit for this exploratory study of the Town Nurse. Interviewing in particular is best used when the interest is in understanding other people's experience and the meaning they make of that experience (Seidman, 1998). The intent of the research with the nurses should be considered when deciding on a method. Seidman (1998) separates interviewing from other methods by asking the purpose of the study; if the researcher is interested in knowing what it is like to be a Town Nurse, the subjective understanding of that experience, then interviewing is the ideal choice. Participant observation was an alternative which was considered and discarded. Based on this researcher's earlier experience in observing a Town Nurse, it was determined

that it was difficult to capture an in-depth understanding of the nurses' work, mainly due to the active nature of the work and the lack of time to set aside for formal interviewing.

The Interview

In this study, Rubin and Rubin's (1995) form of qualitative interviewing was used to structure the interview and its conduct. The author's conception of the use of the term "conversational partners" to describe the role of the interviewer and the interviewee suggests a way in which the interview will be conducted, as a conversation. Rubin and Rubin's (1995) form of interviewing was particularly valuable here because the semi-structured dialogue is based on a collegial relationship, which allows the researcher to gain a more in-depth understanding. The interviews for this study followed Rubin and Rubin's model. Participants entered into the conversation as collaborative associates, sharing what their experiences and understandings were to better understand a particular phenomenon.

Fontana and Frey provided additional support for interviews to gather data, describing interviews as "active interactions, leading to negotiated, contextually based results" (as cited in Denzin & Lincoln, 2000, p. 646). In particular, they identify the value of the gendered interview, one which steps outside the usual format of the interviewer as the outsider, and recognizes that the interviewees can be responsive and engaged.

Conversational partnership as a type of interviewing is frequently used for qualitative work, especially with personal or sensitive issues. This type of interviewing method can be used with an individual or group and is used when the researcher

believes he or she may know something about a phenomenon but needs more information to explore or describe the phenomena. The purpose of this type of interviewing method is to allow the individual to describe or reconstruct his or her experience with some structure from the interviewer. Semi-structured interviews allow for the conversational partner to reconstruct an experience and explore the meaning of the experience from his or her perspective. It allows for deeper exploration with the individual as it relates to the area of interest. Another benefit of using this type of interviewing is that it allows the voice of the conversational partner to be heard and meaning is explored from the conversational partner's perspective (Rubin & Rubin, 1995).

This researcher relayed to the participant that the expectation is that all ideas are welcome and not being judged. Strategies used to facilitate this attitude were (a) to establish rapport with the conversational partner, focusing on the interviewer's role as a learner and a collegiate relationship; and (b) to share the interviewer's own clinical background and interest in the topic. The interview was conducted using the Conversational Guide identified earlier, which is used to assist with focusing the interview, and includes primary questions, suggestions for probes and follow up questions. Contact information was documented on a contact summary sheet (Appendix C) which also included background information.

This researcher was primarily interested in the nurses' descriptions of their role and responsibilities, particularly focused on the target of their interventions. As these nurses work in the community, data related to the extent to which they work with all members of the community or the population was elicited. In addition, the research

sought to understand how the role was developed, gaining some historical perspective on aspects of the role the nurse may have altered. This required that the nurse tell the story in her own words as that pre-dates the work the nurse is presently engaged in. Interviewing was the chosen method, as it allows the nurse to share previous experiences. In previous descriptions of the PHN, the challenge of providing both population- and individually-focused care has been described. One of the research questions has been designed to elicit this information. Given the lack of a formal description of the role via current standards or identification in nursing education, the research questions were also designed to obtain a description of the role and the nurses' evaluation of the role.

Of further interest is gaining an understanding of the facilitators and barriers to the role of Town Nurse. It appears that this role persists over time in certain communities, and gaining an understanding of how that has been possible, within the changing contexts of health care delivery, would assist in providing needed insight to the role and its potential to meet identified community health care needs. Evaluation data was also elicited, if available.

Finally, giving the Town Nurses an opportunity to identify their impact on the community would lead to a deeper understanding of the value of the role and strategies in use to meet town health needs and also provide insight into the objectives of each nurse. Ultimately, there would be an effort to understand if all Town Nurses function in a similar manner.

As previously mentioned, unstructured interviews (also referred to as "focused") work best when the researcher knows something about the phenomena of

interest, but further exploration is needed. With a semi-structured interview, areas of

interest or questions are prepared ahead of time around a specific topic. During the

interview, the goal is to allow the conversational partner to talk freely and provide as

much detail about the areas the researcher is exploring. With a semi-structured

method, it is suggested that a guide for the interview be developed. The benefit of this

guide is to not lose track of what the researcher is seeking to explore regarding the

phenomena; it allows for some flexibility if the conversation leads to information that

the researcher may not have thought of (Gillis and Jackson, 2002; Rubin and Rubin,

2005). Conversational guides (Appendix B) should be created to guide the interviews,

but they should be reflexive and able to change as new information is discovered.

Probes were used during the interviews to allow the researcher to explore new ideas as

they appeared. The conversational guide for this study was developed in conjunction

with a faculty advisor from the University of Rhode Island, College of Nursing with

experience in both public health nursing and the use of qualitative research methods.

      Interviewing the conversational partners. Identification of the Town Nurses

for the purposes of this study began with an internet search engine (Google™) using

the key words "Town Nurse." The websites identified via the search were screened for

evidence of the nurse's funding source. Only nurses who were directly hired by a

municipality were included in this study. This ensured that the nurse was not an

employee of a Health Department (HD), subject to the job descriptions and clearly

identified role of PHN. This web search identified eighteen potential candidates for

interviewing in the Northeast; nine of the interviews came as a result of this search;

one participant was referred by one of the Town Nurses.

The participants were contacted via a letter which introduced the study and

provided them with the researcher's contact information, along with a copy of the

informed consent form. Many of the nurses responded after receiving the letter, either

by call or email. Contact with three of the nurses occurred after a phone call was made

by the reseacher, offering to answer questions and to schedule the interview. One of

the nurses in the study was identified by her colleague during a phone call to schedule

the interview. All of the nurses expressed great interest in sharing their role, which

they believed to be relatively unknown outside of their community. They also

universally expressed interest in reading the findings of this study for their own

growth and understanding.

The first participant. The first participant agreed to be interviewed at her

place of work, which was a nursing office in a Town Hall in New England. Informed

consent (see Appendix A) was obtained, along with an agreement to allow for audio

taping of the interview. Time was allowed for questions about the consent form. The

interview began with a brief introduction of the researcher, including her work,

volunteering, and academic background. A conversational guide (Appendix B) as

recommended by Rubin and Rubin (2005) was used to structure the interview. The

Guide included interview questions and probing questions. The researcher's

background was shared to establish rapport, to provide a baseline from which

conversation could begin, and to allow the interview conversation to explore concepts

more deeply. This interview was aimed at answering the researcher's questions: what

is the current role of the Town Nurse and how did that role develop over time, what

facilitators and barriers have influenced that role and what impact did the nurse think

she had on the community.

The initial question prompted the interviewee to discuss her own professional background, including education and previous employment history, and to describe her own beginning as a Town Nurse. The probe asked the nurse to identify any information she could about how the role had been enacted when she began in it and to identify any changes made during her time in the role.

To answer the second questions regarding barriers and facilitators, the participant was asked to discuss any direct supervision or job descriptions which may assist to inform the nurse's work. The nurse was probed to identify outside forces which might play a role in the decision making related to the distribution of nursing services and to identify what those forces were.

For the third research question, the nurse was given an opportunity to share examples of how the nurse interacts with the community or its members, to describe programs with which she collaborates and to identify any gaps in services provided to the town in the current role.

During the interview, a notebook was kept for making short notes related to overall demeanor and the environment. The notes assisted with further exploration of topics brought up by the nurse. The interview with the first nurse lasted approximately 90 minutes and included a tour of her office and some information about the history of the town.

Immediately after the interview, at a nearby location, field notes were written, as guided by Schatzman and Strauss (1973). They included observational, theoretical and methodological notes. Observational notes recorded items such as the

participant's general demeanor, facial expressions and gestures. For example, the nurses were universally excited and engaged in participating in this research. Theoretical notes included the identification of ideas and themes which came from the observational notes. These notes allowed concepts and observations to be linked to one another, describing themes and ideas. Theoretical notes aided in identifying a description of the Town Nurse through the identification of 10 aspects of the role. The methodological notes were used to improve the researcher's interviewing skills. After review of the audio tapes and notes, it was found that the researcher was disclosing too much personal background and creating a situation where the nurses felt obligated to speak to my interests. These notes assisted with improving the clarity and logical order for obtaining the data as well as helping to reduce the amount of time needed to complete the interviews.

The first interview was recorded and saved to a laptop and to a password secured online storage site. Once the field notes were completed and reviewed, the audio tapes were also listened to several times. The tape was then sent for professional transcription.

Subsequent interviews. Additional interviews were completed using the Conversational Guide, audiotaping and writing field notes. The audiotapes were listened to multiple times for more in-depth understanding. These tapes were also transcribed and reviewed.

Data Analysis

Data analysis included several steps, beginning with listening to the recorded interviews in order to begin identifying common elements. This was followed by the

review of the interview transcriptions. The notes of the interview and observations were read for data addressing each of the research questions. Each nurse's data was reviewed and a summary statement written related to current practice and its evolution. The data was analyzed in regard to current role expectations and behavior as it related to the nurse's focus on the entire community, in relation to the nurse's description of expectations or behaviors that reflect individual client- and population-based care. This reading was conducted to look for specific strategies the nurses used to manage both the individual and population needs of the community. The next reading focused on facilitators and barriers to the practice, seeking to understand internal and external forces which impact the nurse. Further reading identified the nurses' understanding of their impact on their community. Lastly, data from each nurse was compared and contrasted for cross interview analysis.

Insiderness

There is a risk in using this research method and it is called insiderness. Schatzman and Strauss (1973) discuss it in this way, "both the field (or the object within it) and the researcher are inextricably linked to other 'fields' and social situations-any or all of which impinge upon his research. Indeed, the researcher may consciously use these resources." Messerschmidt (1981) explains the basic premise as when one is a member of the group being studied, one needs to proceed with acknowledgement of the insiderness. This insiderness has many advantages, particularly with interviewing, when the questions can be altered as data is revealed. Knowing the topic can assist with adding questions. Several researchers (Costello, 2006: Asselin, 1999) have written about the need to specify the level to which the

researcher is an insider. Costello (2006) discussed in her dissertation the impact of insiderness on the collection and analysis of the data collected in this type of interview. She identified herself as having subjective knowledge of her topic of interest, diabetes, and therefore explained the benefits and challenges due to this insiderness. As indicated by Costello, acknowledging this researcher's own related experiences of working as a PHN and volunteering in a community in a town-nurse-like capacity allowed the researcher to give a perspective during the interviews, adding to the depth of questioning possible and gaining deeper insights. It was considered with caution and was not allowed to color the findings with preconceived notions.

Recognizing that while the researcher's shared knowledge of nursing work in the community was useful to bring depth of understanding to the interviews, caution was used to keep this from unduly influencing the results. During these interviews, the researcher's ability to share with the nurses her own professional experiences allowed both participants to share understanding of their role. In some instances, it allowed for deeper questioning. For example, as data emerged about the role and a sense of the sub-types developed, purposeful questions could be asked related to the role and its relationship to individual versus population focus. The nurses often acknowledged the researcher's understanding of their work, based on her professional history.

Field notes were used to identify both negative and positive aspects of insiderness. These field notes were shared with the researcher's major advisor following each interview, along with a discussion of the notes to identify areas of concern and need for development.

Credibility

Efforts were made to enhance the credibility of this study by attending to its transparency, consistency-coherence and communicability, three criteria proposed by Rubin and Rubin (1995). According to the authors, transparency means that details of how a qualitative study is conducted are presented in a way that the reader can see the process of data collection. Hunter (2007) described transparency in her study as being achieved by maintaining thorough records of the interviews, as well as of the observational and theoretical notes. A log was kept to track how the transcripts were made and verified. The path of analysis included notational coding strategies that were made clear to the reader. This study enhanced the transparency by record keeping which includes notes on which comments are direct quotes and which are paraphrasing. In addition, it included notes about the general tone of the interview and the environment.

Consistency-coherence has been described by Rubin and Rubin (1995) as the examination of themes for contradictory data. This requires that the researcher ask deeper level questions during the interview, then identify inconsistent data which cannot be explained. Review of the data must occur prior to the follow up contact, when the researcher has an opportunity to check for consistency with further questioning. Credibility is not necessarily demonstrated by consistency of the data, but rather by the researcher continuing to ask questions which can explain the inconsistencies.

Finally, credibility requires communicability. Rubin and Rubin (1995) explained that communicability comes from the reader being able to feel real to the

readers and the participants. Those who are familiar with the area being written about should recognize the findings as real, and those who are unfamiliar should be presented with enough evidence to convince them it is real. This is conveyed in the richness of the writing, the inclusion of details and vividness of the text.

Every effort was made in this study to maintain credibility. The support of a faculty advisor aided in this effort. All materials produced for this study are available for further review.

Confirmation from the nurses was obtained. Each of the ten nurses were sent the description, 7 of them responded to the request to confirm the description, each of the 7 agreed with the description. Tammy represented the group by stating, "I agree with your statement in full & appreciate the way you captured the essence of the role concisely".

Protection of Town Nurses as Conversational Partners

The participants are protected by following the Institutional Guidelines of the University of Rhode Island, Office of Compliance. Transcribed documents are stored in a locked cabinet. Institutional Research Board approval for the research was obtained prior to completing the research.

Chapter 4: Findings

As noted earlier, the general aim of this study was to obtain a current description of the professional role of the Town Nurse in the Northeast. It included the following research questions:

1. What is the current role of the Town Nurse? How did the role develop over time?

2. What facilitators and barriers have influenced the role?

3. What impact do the Town nurses think they have on the community?

This chapter will present the characteristics of the Town Nurses along with a discussion of the current role of the Town Nurse and identify the purpose of the role, its core activities, the skills needed and how it is enacted.

Characteristics of the Town Nurses

Ten nurses who are employed as Town Nurses in the New England area were interviewed over a five week period from December 2014-January 2015.. The initial interview with a Town Nurse was conducted at her place of work and lasted approximately one and a half hours. The remaining nine nurses were then interviewed in a similar manner, the nurse choosing the time and place. All but two nurses were interviewed at their place of work; the remaining two chose to be interviewed together in a local diner. Each of these nurses was interviewed individually, one after the other, and then encouraged to comment jointly. These two nurses have been colleagues for over 30 years, working in adjoining small communities (less than 500 permanent residents) and often cover for each other's vacations.

The 10 Town Nurses covered the range of educational backgrounds and

clinical experiences. Of the ten nurses, one was a Licensed Practical Nurse (LPN; she worked as an Assistant Town Nurse), two had diplomas in Nursing, one had an Associate's Degree in Nursing, three had Bachelor of Science degrees in Nursing, two had Master's Degrees, (one in Nursing, one in Public Health) and one had just completed a PhD in Nursing. All were Caucasian women who had been in the position anywhere from 5 months to 50 years. The Town Nurses also varied in the length of time they had been nurses, from 10 to 52 years. Their clinical experiences included acute care, pediatrics, a medical office, administration and emergency rooms. Two of the nurses had significant experience with global health nursing. Beyond that, only one nurse worked in another community/public health role prior to taking up the Town Nurse position.

Of the ten nurses interviewed, five reported that they were recruited into the role, either by the nurse who held it before them or a colleague who knew the position was becoming vacant. The other five reported they had taken on the role after volunteering to assist a previous Town Nurse with a clinic and then later applying for the position, or that they had moved to the town and found an opening for the Town Nurse when looking for work. They reported that they accepted the position for a variety of reasons: believing the role was a good one for a nurse raising a family, beginning to think about retirement or trying to get away from the rigor or dissatisfaction of hospital nursing.

The nurses are employed in a variety of ways. One of the nurses is employed by an Associated Board of Health which provides services to 15 communities. That Board employs two nurses, one social worker, two dental hygienists and two

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sanitarians. Another community employs a full-time Town Nurse and a part-time Assistant Town Nurse. One of the nurses works full-time for a home health care agency, but only works half of the time as the Town Nurse. The other nurses work between 10 and 40 hours a week. Some agencies collect donations for the services, but most are paid from the town budget.

The majority of Town Nurses had offices in governmental buildings or buildings associated with a Council on Aging or other senior services center. In one of the towns, the Town Nurse's office was located in a municipal building used only by providers of health services, sharing space with dental hygienists, sanitarians, a social worker and two nurses. The nurses had access to space in which to conduct physical assessments if needed or to administer vaccines in a private area. Their offices included a desk with a telephone and computer as well as other resources such as reference books. With the exception of one nurse, Penelope, who is an assistant Town Nurse, they managed vaccines, storing them in a refrigerator in their office. Health education materials were noticeable in each office. Announcements of services available or programs to join were the most frequently noted types of information available.

The Town Nurse Role

The current role of the Town Nurse covers a broad range of services delivered by nurses. The nurses were able to provide some perspective on the role prior to their taking it, but little was learned during this research about the historical development of the role. Overall

Few of the nurses had much to report about historical information on the

enactment of the role prior to them taking it. Charlene reported that she was given a list of nursing duties by the nurse who held the position before her. She, like all the other nurses had little or no contact with the Town Nurse who held the position prior to them taking the position. Although several nurses spoke about "doing things the way they were," many of the nurses received little or no orientation.

Janine offered that in the 50 years she has been doing the role, it has varied a bit. She said:

> I was told, as part of the job, you will have to visit school once or twice a
> week. It's not written in any kind of legal form or contract, but, and she told
> me a little bit about what she did and I had known because they had always
> had a town nurse. It was a lot at first, because it was before Rescue. So I would
> get a lot of calls that, you know, Rescue should've had, they called me at
> home. And I, you know, would just leave home and make home visits. It was a
> lot of hours, though. (personal communication,

She also recalled when she used to charge $.50 per home visit. Her role in responding to emergent situations changed when the rescue and the Visiting Nurses came in. Karen offered:

> It was primarily surveillance and injections, it was vaccines for – I started in
> June, April, actually, and then April to June I did surveillance stuff and then
> starting in June I did like back to school kind of vaccines for kids and then not
> a lot. But enough that I had to figure out what I was doing. And then flu
> vaccines in the fall. And then I do a one clinic a week for elders. And then I
> had a couple of elders that were on a once a month or a once every other month

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visit.

They were able to carry out the role based on their license, "do nurses work."

Although the question was not anticipated prior to beginning the interviews, it

emerged that the nurses had little contact with one another; thus, they do not influence

each other to a great extent. Job descriptions, when they existed, provided little

guidance about the work. Tammy shared, "the previous manager was here for 36

years, she was an LPN actually. She had a lot of experience but things kind of stayed

status quo."

The job descriptions which were available, the nurse's report, were very

general and lacked clear objectives. There was little evidence of the nurses using them,

as, in almost every case, they had difficulty locating them. They did not identify with

other established community health nursing roles, such as Visiting Nurse or PHN.

Pressures from the community around emergency management or disaster

preparedness have shaped the role.

The purpose of the role did not clearly emerge from this data. There was some

agreement that bringing public health to the community and meeting the health care

needs of the town was the purpose. Even attempts to get a copy of the Town Nurse's

job description did not prove to be a good data collection method. Almost every one of

the nurses said they had one, but couldn't locate it during the interview. For the ones

who did, the job descriptions were very general and global.

Some of the nurses implied a purpose, Lori for example, offered an

explanation of the role:

What it is is a community resource for people in the town to come to when

they have a problem that they haven't been able to figure out a solution for on their own. Or when they want to have someone with some medical experience that they can check in with and feel like they're doing what they need to do to keep themselves healthy.

Some communities have explicit expectations of the Town Nurse. Nurses were able to articulate for each town specific nursing interventions which the communities they serve expect from the nurse.

General Aspects of the Town Nurse's Role

There was agreement from the 10 Town Nurses about 10 major aspects of their role: what the nurses do (i.e., a population focus, responsibility for identifying and meeting the health needs of the community, addressing needs across the lifespan, collaborating with others and working within the context of a multi-level system), how the nurse do it (i.e., by being autonomous, being a member of the community, being flexible and doing home visits) and a required skill set (i.e., clinical competency).

Expectations for the Role.

Population focus. A population focus, consistent with the role of PHN, was evident in all of the Town Nurses. Public health at the population level is focused on health promotion and illness prevention. For example, all were actively involved in following up on communicable disease outbreaks or providing immunizations to the community, activities which are traditionally believed to meet population needs. During the recent Ebola outbreak, most of the nurses spoke about being involved, either attending or offering training for their community members. Substance abuse and prevention work was also apparent as a focus. Nurses described participation in

regional or local coalitions, grant funded projects or local opportunities to provide education related to the topic. Karen spoke about being part of a $50,000 opioid abuse grant. Karen stated:

I look at public health as being population-based and not so much individual based. So whereas you were talking about primary care, you're bringing it to the population, not to the individual. You need to facilitate so that the individuals can get the care, but you're meeting the need of the population, not individuals. Now there's a fair amount of individual work in this job. I'm not saying that there isn't, but what I'm saying is that my job is to focus on the population. So in this community, we have a growing elder population. People come here to retire, and it's a beautiful community and they can, you know, afford it, and then they're here for ten years and life's, they don't have their support, their family's somewhere else, they came here to sail and now it's hard, a lot of hard to work to get in a boat, and they need other supports. So we don't take care of our elders well.

Another population focused activity, emergency management, was identified by all the Town Nurses. Three of the nurses are the community's designee to the Medical Reserve Corps (MRC) and one of the nurses, Randolph, is Director of the regional MRC.

Being Responsible for identifying and meeting health needs. This was talked about by the nurses as "filling gaps". Town Nurses see themselves as being responsive to "gaps," creating or identifying programs to meet needs or by meeting them themselves. They consistently spoke of their work as changing all the time. They get referrals from a wide range of sources: medical providers, first responders, community

members and town officials and refer to a broad array of other organizations. Penelope explained, "we do home visits for B12 shots or one time assessments, find other problems and then we tell them to get more help from their doctor or send them to another agency." Janine stated, "I have cooked breakfast, run to the market, done laundry. One time I went to the home of a laboring mother and ended up taking her to the hospital, the baby was born in my car!" Charlene offered some insight into filling gaps: "The community used to be mostly Caucasian, but now we have a lot of immigrants and they have different needs. I am working with a lot of community groups, there is a need to embrace the multicultural community." Jane confirmed this by stating, "But we're always happy to plug in around what's another reimbursable service has to offer."

The gaps varied from town to town. Often they related to the lack of local services. Another nurse, Tammy, discussed the community members' needs:

by the time they have already called 50 million other people, they have already tried contacting others, and because we stand in the gap and are that safety net in trying to just bridge and get them where they need to be, a lot of it does end up with me, being crisis management.

Working across the lifespan. The role of Town Nurse crosses the lifespan. Much of their focus is on older adults in the community. They are often affiliated with a Councils on Aging and providing many services to the elderly and the home bound, some Maternal Child Health support, pediatric or school based care such as immunizations and screenings as well as clinics for specific risk factors were identified. There was evidence of nurses bringing their own preferences to the work.

Many, such as Lori, spoke of "carving out the position to serve the older adults in the community. My interest area is the older adult." At the same time, she recognized that she needed to see all members of the community. In general, she sees other adults at immunization clinics or employee health fairs.

Others, like Charlene, responded to the needs of others beyond the older adult and created screenings for firefighters related to their risk for developing bladder cancer. One nurse spoke about the changing ethnic and racial make-up of her community and how many of the health issues are now related to immigration and poverty, crossing all ages. She sees this group as needed a great deal of intervention, related to health promotion and illness prevention. As another example of crossing the lifespan and focusing on the entire community, Karen described her assessments:

So what my role is I see myself as both doing assessments of the needs, but also doing advocacy, both in terms of meeting current need and projecting, where are we heading? You know, what are you thinking about? I don't do it only for the seniors.

Collaboration with others. Essential to the role, collaboration with other agencies or communities allows the Town Nurse to offer better responses to community needs or prevent duplication. Often, the Town Nurse interacted with School Nurses. In one case, the Town Nurse was also a School Nurse as part of her role. Many of the nurses also relied on nurses in neighboring or regional towns for support during large-scale immunization clinics or for coverage during their absence. All nurses recognized that they needed to be knowledgeable about available resources. For example, Charlene discussed understanding that there is a need for substance

abuse intervention, but that her town is part of a large outreach grant and so she is only involved peripherally. She said, "I am on a steering committee, I don't really have the time to go to the meetings, but I still go, because I am committed to the larger picture of health in the human services."

Working within a multi-level system. Many of the Town Nurses spoke about their interactions with their municipal governments to make decisions related to health for their town. The mechanism for supervision and reporting varied widely among the nurses. In some towns, the nurse reported to a Board of Health, either for the town or region. More often, there was a single Director of Health to whom the nurse reported. Several communities had their nurse reporting directly to the municipal government, either the Town Council or Town Manager. While the majority of the nurses submitted an annual report, only three of them reported to their municipality on a monthly basis.

The Town Nurses were also involved in regional or statewide activities, such as ordering and administering vaccines and serving as the contact person in their community for the reporting of or following up on incidences of communicable disease outbreaks. They all interacted with their local emergency response or disaster management response programs.

Managing a budget, accounting, and planning were also a part of many of the nurses' experience. They spoke of writing grants or being part of grant-funded projects.

Lori explained that her position is a regional one, a 26 town consortium health district with a Board of 10 member towns. She also gets support from a regional

council of governments. Her contract is different depending on which town she is

working for. Karen explained her work with others:

> there's some regional stuff that goes on. I inherited a group, the health access
> group in New Bedford, which I've continued on, and they're doing the
> program, the problem that they've been working on this entire time, this post-
> partum depression, trying to come up with a community-based intervention for
> Fall River to Wareham that would help us identify people in the communities
> who are at risk for post-partum depression and get them connected to
> resources. We don't have any resources, so I need to work with them to gain
> access.

Enactment of the role. To carry out the expectations of the role of the Town

Nurse, the nurses use specific strategies: being autonomous, being a member of the

community, being flexible and doing home visits. Each of these was used by all the

nurses to meet the nursing needs of their community.

Being autonomous. Autonomy among the Town Nurses was highly valued.

The nurses receive little or no direct supervision. They generally report to their

community about their activities only once a year and make decisions about the

provision of nursing care on their own. This autonomy is demonstrated by the nurses

altering the expectations of the community to better fit the nurses' beliefs about what

is good for the health of the community. Lori talked about the expectations of the

community, to offer weekly walk-in clinics, but she has "carved them out to be more

chronic disease management focused," believing she can be more focused on

prevention of complications. Penelope said, "we're kind of autonomous here. Nobody

questions what I do. But I know that under my scope of practice, I know what my limitations are."

Being a member of the community. All the Town Nurses saw themselves as being members of the community even when they did not live in the town. They all spoke of its value to the work that they did. There were numerous examples from the nurses demonstrating the value to the community that the nurse is accessible in common places such as church, schools and the supermarket. Joyce discussed this:

Oh, yeah, everything's better when it's closer to home. It's just that intangible thing you know about home and people's homes when you're part of that community. It's what brings comfort. To patients, as well as to those of us who are providing the service.

Being flexible and creative. Being a Town Nurse allows the nurses to be flexible and creative. Practicing outside of the limitations of an institution such as a public health department, these nurses can meet the needs of the community members in innovative way. One of them mentioned creating a drive-through flu clinic. Since many of the activities conducted by the nurse are not scheduled but come from a request by a community member, the days are varied and unpredictable. Lori described meeting a need in the community by creating a *Healthcare File of Life*. It is a document which is left in the home, containing a medical history.

Doing home visits. Home visiting was evident in the role for each of the nurses. There is some variability among the Town Nurses about the effectiveness or purpose for the home visit. In fact, with the exception of the one nurse who works for a home care agency for part of her full time position, they agreed that the role of home

care or Visiting Nursing is vastly different from the role home visiting plays for the Town Nurse. A number of nurses described the value to the community of assisting town citizens to age safely in place or to provide support for families as they care for chronically ill and aging family members. Tammy described leaving a local home care agency when she learned the Town Nurse position was vacant, as she thought there were more opportunities to impact the health of the members of this community in the Town Nurse role. She does carry a case load of home bound and fragile community members, but sees these home visits as

> another part of our health promotion program, which we kind of define health promotion as being home visits for assessments, general well and safety checks, and then typically it's for the frail. A lot of times it's elders, because that's just the biggest need population.

Karen discussed how she sees home visits as a necessary tool. She uses them for wellness checks. Joyce stated, "it's nice to be able to visit who we want, whether we have a referral from the doctor (for the home visit) or not, we don't let people fall between the cracks."

An additional advantage of home visiting is becoming aware of clusters of problems. One nurse identified a neighborhood at high risk of developing tick-borne illnesses through visiting residents with Lyme disease and noted their proximity to one another.

Skills needed.

Clinical competency. The Town Nurse role clearly requires clinical competency. At least one type of primary care walk-in clinic was offered in each

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town. Some included clinics for special populations (e.g., women's health, blood pressure). Completing medication reconciliation for individuals, responding to the community's concerns about recent infectious disease outbreaks and creating programs which respond to the specific needs of the community such as "bone builders" classes are evidence of the Town Nurses' understanding of health promotion and risk reduction. The Town Nurses spoke of being stopped in the community to be shown rashes and asked about other concerns, to which they were expected to have the knowledge to offer the community member current, reliable information.

Town Nurse Sub-types

One major finding of this study was that there was a single role for the Town Nurse. Another major finding was the identification of three distinct sub-types of the Town Nurse role, each characterized by a different central focus: individual, blended and population.

In the first, the central focus is the individual client. Penelope, Janine and Kay are members of this group. In this sub-type, the nurse primarily works as directed by a Board of Health or health director, focused on one-on-one meetings with individuals. These nurses offer walk-in or primary care clinics for things like blood pressure screenings or the vaccinations. Little or no involvement is seen with population-focused care or program development. There are no active assessments going on in the communities where these nurses are working. These nurses tended to be at work during set hours and had a clear sense that their responsibilities to the community were limited. Penelope, the LPN, discussed not knowing how to order vaccines or manage the reporting system, and described herself as an "order taker." She stays firmly in her

scope of practice, knowing what limitations she has. Penelope described her focus in this way:

> I think here in the office is the main focus. The main job of it, what we do. And
> it's only a little bit of outside stuff. We go to a safety day in the fall.
> Sometimes another person will call here looking for help, like the school nurse,
> if someone needs vaccinations.
>
> In the second sub-type identified, there is a blended focus, a balance between

individuals and populations. As with the sub-type previously reviewed, these nurses
attend to individuals in clinics and through home visits. In addition, these nurses
conduct active assessments and participate in collaborations or committees to identify
community needs. For nurses working in the blended role, the focus is more often on
identification of the specific need for resources and then stepping in when the resource
is unavailable or working to create a solution. Lori, Jeanne, Tate and Joyce are
members of this group. This group of nurses continue with a focus on individuals, but
blend it with a population focus. They did raise questions about the effectiveness of
the interventions at the individual level and propose possibilities for change. The
changes proposed focus on moving to a more population focus. Lori stated:

> the position could probably be more population focused, but through the
> contacts I make, I think it achieves those larger population goals pretty well.
> Are we meeting all the needs, no, but I think we are pretty steady on really
> good work for the community and its making a difference.

The nurses in this sub-group also identified gaps in care produced by their current
system of delivery. Lori described it this way, "we have farm workers, immigrants,

lower income pockets who might be served by a safety net that exists out there, but I'm not working directly with them and I know there is a great need."

Finally, in the third sub-type, the central focus is clearly population-focused planning and interventions. Karen, Charlene and Tammy are the nurses who are in this sub-group. They spend time organizing immunizations and communicable disease response in traditional PHN role. Clinic times are adjusted to meet the needs of special populations. These nurses manage the budgets and ordering of supplies and make home visits for the purpose of referral and family support, but generally link those families to other service providers. They attend meetings in the evening, serve on coalitions and are involved with disaster response or MRC, usually in a position of authority.

In addition, there is evidence of creativity and ingenuity. The nurses expressed great value in the opportunity to bring new ideas to the work. For this nurse, the work day is not prescribed by the clock. They are able to respond to the community's needs on weekends or evenings. They are able to utilize electronic communication to keep in touch with members of their community, both providers and community members. While they expressed frustration with the gaps in services to meet the needs of their community, they were actively engaged in partnering with others to create services or they provided them on their own. For example, Nurse Tammy sought out resources for managing the lives of community members who are hoarders. She was able to create a coalition through a grant she wrote to manage this as well as convince the town officials to hire a Town Social Worker to provide social support and education related to the topic. She spoke about wanting to do more population focused work:

I'd like it to be more equal and be able to stand back and think I've always had

an interest in you know, what I consider some of the public health nurses is

looking at policy. Taking that voice, you know, to the next level. Which I am

actually doing now, so it's exciting.

What is apparent at the blended- and population-focused level is a more

consistent and self-directed emphasis on community preparation and prevention

activities. Seven of the nurses were involved with disaster response and emergency

management at the management level, not just as participants. This difference was

consistent with the blended and population sub-type.

The Future of the Role

While not specifically a research question, in discussions about the history and

current role, data emerged about the future of the role. Concern for the future of the

role was discussed by a number of the nurses. While some of the nurses have a plan

for their community to continue the role and are actively working to provide

evaluation data which would support the continuation, many of the nurses are relying

on the good faith of their community to see the value and continue the position. One

nurse, Tate, described rallying the community to a town budget meeting when a

proposed cut in funding was imminent. Janine described the current position as being

held for her, until her retirement, then she thinks the town will merge with the

neighboring community to provide essential services. Several nurses spoke about

efforts in their community to hire a nurse from a Visiting Nurse agency seeking to

save money. Tate described her thoughts about the position:

There is a risk that this position will go away, I've probably got about another

10 years to work, but if everyone gets their hands in the prevention pie, we might not need it. Some mandates from the state will still be in place, but I don't know how that will look going forward. Maybe we can keep the local stuff, the one on one care that comes from knowing your patient and then join alliances to meet the others.

Facilitators and Barriers

Each of the nurses was asked about the availability of resources and if they could identify any unmet needs in their town due to lack of resources. Many of the nurses had ideas about programs or interventions which would benefit their community, given additional resources. They were able to articulate these needs, but also were aware of the barriers to filling the gaps. Among the identified facilitators were the professional roles of the TN, the nurses' autonomy, the PPACA, the location of the Town Nurse office, being a member of the community and the nurses' own characteristics. Each of these was noted across the role, regardless of sub-type. While present in each sub-type, the facilitators did vary in the extent to which it facilitated the role.

Facilitators for the role.

Professional role of the town nurse. The Town Nurses were quick to articulate the value of their autonomy in responding to current issues and concerns in their community. Nurses worked within the scope of their practice, yet unlike in some practice settings, they did not have specific written orders from a physician or another provider for the majority of their interventions. Being a nurse grants them access to many places and people where entry would be difficult for others. While in some

communities there is direct supervision, it does not appear to limit the nurse to a specific goal or program and is often not provided by a supervisor who is a health professional. The supervision appears to occur more around the hours of work and some of the tasks related to carrying out the public health assignments, while the remainder of the nurses' time is hers to fill.

In those nurses who focus at the individual level, this autonomy facilitated their ability to flex clinic times, alter the schedules for home visits and respond to the communities need for health information. In the blended sub-types, there was evidence of creative response to needs such as her initiation of a research study to identify school children at risk due to hypertension. This decision arose from data gathered at a health fair in the community. For the nurse with a population focus, autonomy allowed the nurse to expand the role of the Town Nurse to incorporate programs grounded in public health concerns such as hoarding in several communities. In one community, a hoarding task force was created, merging first responders, sanitarians, health educators and mental health staff from a nearby hospital system.

The PPACA. The PPACA was mentioned as a facilitator for opportunities to expand the role. It was identified as providing access to primary medical care, including screenings and immunizations to more people, freeing up the nurse to do more health promotion and risk reduction focused activities. Tammy explained:

> We used to do a lot of well adult clinics. And that's its interesting, because that
> has really shifted over the years. Um, I would say it used to be you'd get 20,
> 30, 40 people coming for blood pressure, immunizations, different things. Well
> it's changed, because now people have you know with the Affordable Care Act

and health care system changing, people typically have primary care providers.

Location of the town nurse office. This is seen as both a facilitator and a barrier. Depending on the location, it can encourage access to the Town Nurse. In the communities where the office is co-located with a Council on Aging or a Senior Center, the population which uses those agencies is likely to have contact with and benefit from the presence of the Town Nurse.

Characteristics of the nurse. The Town Nurses described themselves as outgoing and energetic. They are invested in their community and willing to go above and beyond to meet their needs. Penelope described the Town Nurse she had worked with in the past as a "go getter." Tammy talked of her strategy as being to "approach them as a friend, rather than a nurse, rather than dealing with a state office, they like to come to someone friendly, someone they know. You have to have a personality to want to help people, you have to care."

Barriers for the role. Town Nurses expressed many ideas for programs or changes in the delivery of care which they would undertake if barriers were removed. Barriers identified include the nurses' education level, difficulty communicating the role to community members, the location of services, the lack of opportunity for skill development, lack of resources and community preferences.

Education level. While not specifically identified by the nurses, a barrier for full enactment of the role is linked to the education level of the nurses. Nurses without advanced degrees, even as low as BSN, were less likely to be involved with population-focused activities. Those nurses who were categorized as being focused on the population had a minimum education at the Baccalaureate level, one of them had a

Master's degree in Nursing, the other a PhD. This is likely connected to the content of their educational program. Content related to population health is generally offered in nursing education at the baccalaureate and higher level.

Difficulty communicating the role. The Town Nurses also pointed to the difficulty of communicating the role as a barrier. Communities value the role, but are not always clear about how to use the nursing work effectively or understand the full capacity of the role. The extent to which nurses identified this as a barrier is related to the sub-type. Those in the blended- and population-focused groups were more likely to have identified this as a barrier. Tate expressed her concern, "you know, one of my problems here is people don't realize even now, 20 years into this, they don't realize how many things they can come to me for. It's so funny." Tate also acknowledged that by stating:

> Another community is going to hire me to provide 4 hours a week of nursing. I will do their blood pressure clinics and flu shots, along with home visits. But I also hope to be able to go into their senior center to identify needs, although that is not specifically what they are asking for.

> Even when interacting with their governing bodies, the nurses felt the need to explain their thinking. Tammy explained:

> I have a little bit of a different vision in terms of wanting to be a voice. And last night, we were actually at one of the board of directors meeting explaining our important taskforce program and where we're at. And part of the reason why I think that was important was because I think it's time that we as nurses give a voice to what we're doing.

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When Jeanne was hired, she was told the Town did not want the old model of Town

Nursing, which included a great deal of home visiting and running of clinics. She

explained what they wanted:

> So, the town didn't want the old model. And I said, well, that's fine because I'd
>
> rather do, you know, real public health. Look at what the town needs. You
>
> know, broaden immunizations and teaching, and do some research studies.
>
> And they were all for it, you know? Well I don't think they had a clue what any
>
> of it meant, to be honest with you. And, I still don't. Yeah. I don't think they
>
> know what public health is.

Karen talked about it this way:

> So it was not the way I envisioned a public health nurse role and so it kind of
>
> makes for some interesting dialogue, like this is not what the role is, but it is a
>
> piece of the role. And so there had been great openness from them for me to
>
> help guide the blossoming of the role. But on the other hand, the requirement is
>
> we preserve flu vaccine.

Nurses also report that despite their various means of communication--

websites, blogs, local papers and newsletters--to let the community know what the

Town Nurse is doing, there remain many members of the community who are not

aware of available services.

Location of service. As previously mentioned, the location of services is both a

facilitator and a barrier. When located within a Council on Aging or Senior Center, it

encourages use of the nursing services for those populations, but it discourages other,

non-elderly community members from seeing the Town Nurse.

Lack of opportunity for skill development. There is a distinct lack of opportunity for skill development and this presents a barrier to fully developing the role. No organizations exist for sharing knowledge of the role. Nurses, particularly those who are focused in the role at the blended- or population-focus, were members of a PHN association, but did not think that organization was always a good fit for them. The nurses rely on their own interests and tasks they are required to carry out to form the role. Kay spoke of relying on the nurse in a neighboring community for updates on practice. Lori talked about meeting with other Town Nurses, but the meetings are quite a distance away and the role is enacted in different ways in other towns. Going back to school has helped her to feel more knowledgeable about her role. Charlene articulated how she manages the lack of available resources for skill development, "I go to things that I've been doing forever and I don't have to think about, and I just know."

Lack of resources. There were many examples provided by the nurses of how the lack of resources is a barrier. More could be done if there were more resources, including more nursing time or funds to carry out programs. Many needs are unmet within the community as a result. Tammy stated a desire to spend more of her time developing programs and not "checking blood pressure." She would like to focus more of her time on population-focused activities where she could reach more people. Penelope talked about homeless individuals living in a motel. She noted, "There are lots of children, helping them out would be an asset, although I don't know what we would do for them." Charlene spoke of doing a lot of "administrative stuff. If I had someone working for me, I could get a lot more done. I think I could seek more

funding to get programs that would enhance the rest of the community."

In discussing missed opportunities for care to the community because of the lack of resources, Jeanne identified her interest in conducting some research to more clearly identify risks in the community:

There's probably an opportunity to do more with research. I'm looking for grants now with the Barnstable county grant writer on--the big thing I've been working on for like two years is fall prevention. Because we see so many people...you don't understand that falls are a slippery slope at a certain age. I just have too many other things to do.

Charlene also added:

I wish I had time to do more, I could do more health promotion in the community, for the whole population. We miss the needs of those in the middle, there are programs for babies, programs and money for seniors, but not much for beyond high school until 65.

Community preferences. Community preferences were also mentioned as a barrier. Nurses spoke of their attempts to help the community members to understand the value of population-focused activities in order to reach more people, but many communities are insistent that the current (and old) way of doing things remain. They valued the walk-in clinics for blood pressure checks and immunizations and were less clear about the value of having the nurse focus on population health.

Potential Impact of the Town Nurse

The Town nurses assumed they have a major impact on the community they serve. Positive feedback was received from community members and reported during

the interviews. Impact, however, was not, however, an easy thing for them to articulate. In talking, they implied that they were able to meet many of the health needs of the members of their community. They could give examples of the types of things they do. Among those, they listed that they are able to keep people in their homes, provide community education in a local, rapid manner and vary their role depending on the need in the community. They believed they are able to respond to new needs quickly and effectively.

While six of the TNs reported that they submit an annual report, a review of those reports identified that they included only items such as the number of vaccinations administered or the number of home visits made. No other evaluation data was available. The TNs did not have goals or objectives which were identified and then measured.

The implied outcomes for the Town Nurse include early detection and recognition of community health needs, including changes in individual community members or at the population level, such as the need for information about the Ebola outbreak or concerns over measles for the unvaccinated community members. Lori talked of being able to get her community vaccinated because she "has a history with people. They trust me and listen to what I think they should do." This knowledge of the community was critical to the accomplishment of the goals of the Town Nurse. Tate stated, "a big part of my job is finding problems it's no one else job to do."

From their discussions, it is clearly an expectation that the Town Nurse make home visits. In several communities this case load is logged or recorded in an electronic health record.

Discussion of the Findings

As noted earlier, little has been written about the role of the Town Nurse. Only a single article was found in the literature that described the activities of a Town Nurse and it is more than 50 years old. Preliminary contact with the nurses who did not qualify for the study but worked in ways that were likely to be similar to the Town Nurses, such as nurses at the Tamworth Community Nursing Association (TCNA) and Charlene, along with a review of information available through website searches, gave the researcher an initial understanding of the role. Many aspects of the work, while similar to other roles in the community, appeared to be more wide ranging and perhaps novel. Using standards currently available regarding public health nurses, a comparison in roles will be included here. Additionally, the role will be looked at in relation to Role Theory, by Hardy and Conway (1978). And finally, the role will be looked at for its potential to meet the needs of the public as identified by the PPACA.

Current standards and competencies. Recently published new standards for Public Health Nursing (ANA, 2014) guide nurses who work in the community. These competencies are focused on nurses who work within organizations, generally public health departments where their focus is on a specific program with a targeted (sub) population. While these competencies are valuable for nurses in that kind of role, the Town Nurse role seems to contrast with regard to the focus primarily on populations. The Town Nurses in this study population focused interventions and but less extensively than implied in the public health nursing standards. In using this focus, the TN believed that it does assist them to manage some of the health promotion and illness prevention activities in this way. However, at the same time, there is much

evidence in this research to support the idea that being completely population focused may leave individual needs unmet. This raises questions about the current standards of public health nursing which does not mention any individual health needs or issues, particularly clinical needs.

Role theory. Hardy and Conway (1978) used the term role theory for those who seek to describe and explain phenomenon related to role within a social context. Of particular interest to this research is the idea of socialization or learning of social roles of adulthood, such as occupational roles. Role socialization (Hardy & Conway, 1988) described as the learning of social roles which allow the participant (the Town Nurse) to adopt the role according to the society's expectations. Generally, there would be a job description and formal orientation. In some cases, the Town Nurse was able to produce a job description, but even when they could, it was evident there was little reliance on the document to guide their practice. Given their comments, the nurses used other mechanisms to socialize into the role. In the situation where the Town Nurse had access to the previous nurse or a neighboring nurse, they socialized into the role with a standard orientation. Informal socialization occurred based on community members input about expectations for the nurse.

The relevance of three additional role concepts, role ambiguity, role overload and role conflict were also noted. Role ambiguity, as defined by Hardy and Conway (1988), is disagreement over role expectation, associated with lack of clarity of those expectations. Role ambiguity was noted by the researcher in relation to current competencies and the TN. If they are to be considered Public health nurses, then they would need to meet the identified competencies, yet the nurses describe their role in

ways which are not consistent with the competencies.

Role conflict was expressed earlier by nurses in the discussion of barriers to the role. Role conflict is defined by Hardy and Conway (1988) as occurring when the focal person perceives existing role expectations as being contradictory or mutually exclusive. The members of the community, those with authority over the nurse and those coming to the nurse as consumers, have expectations of the nurses' behavior, which may not be consistent with the nurses' preference for carrying out the role. This requires role negotiation, ultimately leading to improved outcomes for the community. In addition, it was observed by some of the Town Nurses that they struggled with splitting their time between being population focused and individually focused.

Role overload was identified by the Town Nurses, in the lack of needed resources to meet all the needs of the community. Role overload is defined as having inadequate resources relative to possibly excessive demands. Expressed by several nurses as a barrier to meeting their role expectations, nurses identified the need for more nursing care in the community. Concepts from Role Theory were useful for understanding the Town Nurse role and should be explored further.

Usefulness for meeting the goals of the PPACA. Town Nursing has been proposed in this paper as a possible response to the call for increased focus on health promotion and illness prevention. Little of the nurses' role, even in the sub-types focused at the individual level, is related to management of acute illness. Community members who required this level of care were referred to a Home Health Care or Visiting Nurse agency. The Town Nurse generally maintained their focus at identification of risks and early symptoms and responding to those changes.

Prevention programs aimed at avoiding future illness such as "bone builders", health screening and health education, along with immunization clinics were offered by all of the Town Nurses, at varying levels.

This role is a good fit for the objectives in the PPACA, as well as recommendations made by Swider, Levin and Kulbok (2014) in their previously addressed report. Swider et al have established a priority goal for public health nursing to "identify and support current and emerging roles of public health nurses". The description of the Town Nurse role will assist with the identification of this role as a viable addition in public health nursing.

As Public Health nursing continues to make efforts to define the role, enumerate the nurses who are part of the public health workforce and prioritize health promotion and illness prevention as nursing objectives, the Town Nurse role is one which should be supported for its alignment with the goals of the PPACA. It is grounded in a politically designated community, has at its core both individual and population focus and seeks to meet the health needs of the community for health promotion and illness prevention.

As guided by the Quad Council report (Swider, Levin & Kulbok, 2014) which set as a goal, seeking to identify and expand new and innovative roles which can meet the PPACA objective, this research is useful for identifying and supporting current and innovative roles for public health nurses. A description of the role of Town Nurse was obtained. The Town Nurses in this study described a base of ten common aspects to the role. Eight of these have been identified in the Public Health Nursing literature and will be reviewed here. Two new aspects were identified in this study and will be

considered for further examination. Additionally, there were 3 sub-types identified, one which focused on the individual, one which has a blended focus, and one which focused on populations. Conclusions related to the relevance of the sub-types will be presented. The barriers and facilitators were identified and facilitators will be discussed here.

A single description of the role of the Town Nurse was obtained. The description includes 10 aspects of the role. What the nurses do (i.e., a population focus, responsibility for identifying and meeting the health needs of the community, addressing needs across the lifespan, collaborating with others and working within the context of a multi-level system), how the nurses do it (i.e., by being autonomous, being a member of the community, being flexible and doing home visits) and the required skill set (i.e., clinical competency).

Population focus is a common theme in the Public Health nursing literature. A number of researchers identified this nursing action as being useful in health promotion and disease prevention and generally carried out by governmental organizations such as public health systems. Radzyminski (2007) described the concept as being "governed by the physical, social, cultural and economic environment in which we live and work. It is the greater understanding of macrolevel trends in health status (lifestyle, attitudes, values and behaviors), how macroeconomy (public policy, media and economy) and health are linked and the performance of health care systems." (p. 40). Population based nursing is also a critical aspect of the ANA Scope and Standards of Public Health Nursing (2014), where it is stated that elements of the practice include a focus on the health needs of an entire population and

assessment of population health. The description of TNs is consistent with other nurses practicing in the community.

Being responsible for identifying and meeting the health needs of the community is more commonly referred to as community assessment. It is commonly used by public health nurses when discussing the needs of populations. When used by the TNs, however, it is also referring to meeting the health needs of individuals or families. Lundy and James (2016) identify that community assessment is an essential component and a core competency for all nurses working in the community. The author's discussion of community assessment includes the application of the nursing process at the individual, family, community and systems level.

Public health nurses address needs across the lifespan. As noted by Caroline Williams (1977), care provided by nurses in the community needs to address all members. Commonly referred to as aggregates in the community health literature, the focus can be on members who share a particular characteristic, such as infants or homelessness. Williams advocates for the recognition of needs of all members of the community.

Collaboration with others in community and public health nursing is widely considered to be an essential skill. The Minnesota Wheel of Public Health Interventions (Keller, Strohschein, Lia-Hoagberg, & Schaffer, 1998) defines collaboration as "committing two or more persons or organizations to achieving a common goal through enhancing the capacity of one or more of them to promote and protect health." Schaffer et al (2010) suggest a framework for population based competencies for Public Health nursing called the Henry Street Consortium

competencies and identify that the nurse "use collaboration to achieve public health goals", (p. 79). Collaboration and the required communication skills are also identified as Core Competencies for Public Health Professionals by the Quad Council.

The Town Nurse description includes working within a multi-level system and doing systems level work. The Henry Street Consortium competencies (Shaffer et al, 2010) also identify that Public Health Nurses must work within the responsibility and authority of the governmental public health system and that they effectively communicate with communities, systems, individuals, families and colleagues. Consistent with the findings from the Town Nurse, who identify that in order to be effective in their role, they are frequently reporting to governmental public health institutions and reliant on programs provided by those institutions to assist their communities to meet their health needs.

Autonomy in nursing practice was recognized by nurses during World War II, when many veteran nurses returned to the workforce at home and identified dissatisfaction with the loss of the previously achieved independence. During this time, according to Barnum (2011), many nurses recognized that the practice of Public Health nursing, particularly for those with a Bachelor of Science in Nursing, was a good model for a return to the autonomy of war time nursing. Discussions related to autonomy in nursing is generally tied to the Nurse Practice Act, which governs the nurses' actions.   Autonomy has also been linked in the nursing literature to job satisfaction, particularly in the areas of rural health care and public health nursing. Joyce Zurmehly (2007) has also identified autonomy as a having a great role in the practice of community health nursing, and associated it with independence,

confidence, competence, being alone and being responsible.

Doing home visits is well documented in the public health nursing literature. Home visits have been found to be useful in maternal child health (Byrd, 1997, 2006), for the relief of asthma symptoms in children (Bracken et al, 2009) and for the optimization of functioning and the prevention of disability worsening (Liebel, Powers, Friedman and Watson, (2011). The TNs in this study primarily reported that they used home visiting for the purpose of early detection of changes in physical states, aging in place for older adults or to relieve social isolation for those community members who were not able to leave their homes independently.

The identification of being a member of the community as part of the description for the Town Nurse is a new finding. Although the Public Health Nursing literature does refer to the nurse engaging the community, developing relationships within the community and establishing trusting relationships within the community, it is not an expectation that the nurse become a member of the community (Shaffer et al, 2010). The TN did not necessarily live in the community where they worked but did identify themselves as valuable members of the community and were told by community members that they were considered a part of the community. Previous researchers (Long & Weinert, 1989) in rural health nursing have noted that 'outsiders" are not well received as providers of health care. Since many of the communities in this study are rural in nature, the value of the nurse being known and a member is reinforced.

Being flexible is also identified as an important aspect for the TN but is missing from the existing Public Health Nursing literature. The nurses spoke of this as

it relates to control over their schedule, primarily, but also linked it to decisions about where and how to place their emphasis on nursing interventions. While this aspect is linked to the concept of autonomy, it appears to be something additional and needs to be more closely studied. Other concepts which may be related include versatility and adaptability. Versatility is identified as a theme in a study of PHNs in Colorado (Joyce, 2015). Rosenthal (2000) describes the Rural Nurse as needing to be both flexible and adaptable, related to the wide scope of nursing problems which the nurse may face in a given work day. The community health nurse and adaptability as a value is also identified by Meadows (2009). This concept should be explored as well.

Finally, clinical competency was identified as a skill needed for TNs. Although PHN competencies are often identified at the population level as core public health knowledge, (i.e., knowledge of epidemiology, community assessment, policy development, and concepts related to environmental health), these nurses identified being able to use individually focused clinical skills as a facilitator. It was often during an immunization clinic or office visit that additional concerns were identified. The TN used these clinical skills to identify both individual and population focused needs in the community. A review of several Community and Public health nursing textbooks revealed no identification of the need for development and use of clinical skills at the individual level except for home health care, the identification of communicable diseases and administration of vaccines (Lundy & Janes, 2016; Nies & McEwen, 2015). Skills identified for the management of chronic disease include primarily health education and behavior change, but not assessment of physical findings. Facilitators which were identified include were the professional role of the TN, the

nurses' autonomy, the PPACA, the location of the Town Nurse office, being a member of the community and the nurses' own characteristics. The notion of the professional role of the nurse as a facilitator is described as credibility by Joyce et al (2015). The authors identified this in a previously mentioned study of PHN's in Colorado and describe it as being established in the community as a result of the public's trust of nurses. The nurses' autonomy facilitates the role in its adaptability. Being a member of the community facilitates the role in that the nurse is highly available to meet needs by being known to members of the community. It appears that both professionals and community members refer for services, rather than the nurse only doing case finding.

Chapter 5: Summary, Conclusion, and Implications

The health of Americans was ranked 37th in the developed world for a number of health outcomes despite health care spending of 2.9 trillion dollars in 2013, (OECD) In response to this concern, a focus on health promotion and disease prevention is believed to be needed to improve these health outcomes. An effort to alter and improve the way health care is delivered in the US is being directed by the PPACA, supporting health promotion and disease prevention interventions. This act seeks to identify innovative strategies to meet this need. Public health nursing has responded to this opportunity and gives direction to nurses to participate in the dialogue.

One group of nurses, Town Nurses (TNs), appears to already be meeting these needs. Until now, there was little known about the role of "town nurse." In a review of the literature, only one article was found. The general aim of this study was to obtain a current description of the professional role of the Town Nurse in the Northeast. This exploratory study answered the following research questions:

1. How do Town Nurses describe their role and responsibilities and the focus of their interventions? How did the role develop over time?

2. What facilitators and barriers have influenced the role?

3. What impact do the Town Nurses think they have on the community?

This descriptive, qualitative study was completed using semi-structured interviews based on the work of Rubin and Rubin (1995, 2005), who describe the specific type of interviews used as "conversational partners." The researcher for this study identified herself as a member of the group, sharing roles assumed, work

experiences, and educational background in order for the interviewees to have confidence that the researcher could relate to much of what they discussed.

Findings from this study included 10 aspects identified by the TNs, describing the role. The role also appears to be enacted with sub-roles, individual focus, blended focus, and population focus. There are implications for the current competencies for public health nurses (PHNs). The current competencies are focused on meeting the needs of populations. However, the TN role demonstrates a broader ranging focus, that of individuals and a combination of individuals and populations.

Conclusion

This research described the TN role and has identified the role as a strategy to meet this new objective in the PPACA. TNs reported that they deliver health promotion and illness prevention interventions at the individual, blended, and population level. The role needs to be further studied in order to better understand how the decisions for delivery of care made and to evaluate the outcomes for communities with a TN.

Limitations

The research sample consisted of 10 Caucasian women in the New England area. The findings of this study only have implications for the nurses who participated. The pool was limited to 18 nurses who had been identified via a web-based search. The data from the study is deep and rich and was useful in answering the research questions, but there may be more information to find if all TNs were interviewed or the parameters on participants were changed.

This study is the beginning of a trajectory of nursing research which seeks to

describe and understand the role of the TN. There are a limited number of nurses who meet the definition of TN. Although this limited the data sources, the researcher was able to interview a majority of them. The intention of this particular research was to build a basis for further study, including but not limited to participant observation and possibly group interviews. It is possible that there are nurses who work like the TNs elsewhere in the country, but the role is identified by another title. A broader search may have revealed more nurses who work under another title, in diverse locations.

As discussed earlier, every effort was made to avoid insiderness, a possible limitation. No conflicts as a result of insiderness were identified in a review of the field notes or by the nurses.

Implications

Research Implications. Contrary to the explosion in nursing research in general, there has not been an equal increase public health nursing research, particularly as it relates to the role. The role of the TN was described in this research, and three sub-roles were identified. At this point, there are no empirical measures related to effectiveness of the role or its sub-types and further investigation is needed. One hypothesis which needs to be investigated is if the blended sub-role is the most effective to meet the varied needs of the community, including those of individuals. This research provided some insight into positive outcomes for the recipients of nursing care that should be studied further. A study looking at the health of a community (e.g., health knowledge or immunization compliance) with a TN could be compared to a similar community without one.

A new report from the NACNEP (2015) titled "Public Health Nursing; Key to

Our Nation's Health" summarized the historical and current roles that public health nursing plays in the health of Americans. The report concludes with four recommendations, including one which would support the advancement and further understanding of the role of the Town Nurse. Recommendation 3 states, "The Department of Health and Human Services and the Congress should identify and remedy the gaps in the cost effectiveness of public health nursing" (p.3). Included in the rationale for this recommendation is the lack of documentation of the outcomes for the work of PHNs and its cost effectiveness. This would support outcome research around the TN role.

Further investigation via concept analysis would also be of use to evaluate further the identified essential aspects of TN practice. While some of the aspects have been described in the literature, there are additional concepts which need further investigation and none have been explored specifically with TNs.

There is also a need to consider whether there is a larger target population. In the initial search of the literature and internet and through contact with a national organization for PHN, a TN was identified only if the name "Town Nurse" was associated with the role. However, there may be some nurses in a similar role, but using another name. One suggestion is the role called "rural health nurse" It has also been suggested that the relatively new role of "Nurse Care manager" may be similar.

Education. Concepts related to community and public health nursing are taught at the baccalaureate, master's level, and doctoral level. These programs are generally using the Essentials of Baccalaureate or Graduate Competencies when designing and delivering their content. While this research did not fully explore the

relationship of delivery of care to the academic level of the TN, there is a relationship with advanced education level and the likelihood of focus at the blended or population level. However, given that the current standards for content in a specialty degree program are guided by a population-focused framework, it would appear that there could be some essential components of the TN role which would not be included in the programs currently available. The addition of the blended model, in which nurses are skilled at delivering nursing care to both individuals and populations, would be needed if it were to improve outcomes for communities with a TN. What makes the TN special is just this, the ability to work with both foci.

There is a need to consider inclusion into education the 10 aspects of the TN, particularly flexibility and being a member of the community, as those two appear to be missing from current curricula. In addition, the notion of clinical competence should be further explored and evaluated in public health nursing education.

Practice. A return to a blended level should be evaluated for practice. It was formerly based in community and public health nursing, prior to the division of nursing in the community into individual focus (Visiting Nurses) and the population focused (PHNs). In the blended role, one would see a return to an old model, in which a single nurse is delivering care at the individual- and population-level in a community or neighborhood, focusing on health promotion and illness prevention through educational activities. This is the kind of discussion which could be productive for the PPACA, which advocates for a distinct, blended strategy for health care delivery.

Reimbursement for nursing care is essential in order to maintain effective levels of care. Current policy related to home visiting requires that the recipient of care

be qualified as homebound and in need of skilled intermittent nursing care. If policy related to reimbursement were to be changed to support home visiting for aging in place, health promotion and education, and management of chronic illness, this role would become viable for replication in additional communities.

Perhaps the TN is doing just that, a combination of the two perspectives, the ideal melding of a focus which is local, responsive, and informed. It is this researcher's own theory that the blended sub-type will be the most effective to meet the objectives of the PPACA. As mentioned in the research implications, clearly outcomes should be measured to continue to develop this role for practice.

As stated by Sara Abrams (2004):

both historical function statements and the current competencies illustrate that public health nursing is something more than either population-based or individually focused, just as it was more than performing disease-specific or age-specific interventions. Public health nursing, as defined by nurses for nurses, has always melded understanding of the conditions that shape health at the global, national, or community level, and detailed attention to the individuals who require care at the personal level. (p. 509)

With this in mind, it appears that the blended focus may indeed be the ideal way to deliver locally focused nursing interventions, keeping the relationships with individuals and meeting the health care needs (health promotion and illness prevention) of the population.

Best said by Town Nurse Tammy:

that's the one thing that's unique to the Town Nurse, is it's personal, you really

know the town and the people of the town. If you have their trust, what a great opportunity you have to impact someone's health and safety. After all, isn't that what we're there for?

An Exploratory Study of the Town Nurse

Consent Form for Research
Version 1.0

Introduction to research

You are being asked to volunteer for a research study. It is important that you know the following:

- Your participation in this study is entirely voluntary
- You can ask questions now or anytime during the study
- If you join the study, you can change your mind later and quit the study at any time

Before you decide whether to join this study, the researcher will explain:

- The purpose of this study
- What is expected of you during the study
- Any risks you may face while being in this study
- Confidentiality of your study data
- How the study may help you or others

You have already been determined fully eligible for this study. This document is the informed consent. You will need to indicate that you voluntarily agree to participate in the study by signing this document. All of your questions will be answered before you sign.

What is the purpose of the study?

The purpose of this study is to obtain a current description of the professional role of the Town Nurse in the Northeast, including the development of the role, its emergence over time and its potential impact on the community.

What are the requirements to be in this study?
The requirements to be in this study include being employed as a Town Nurse, speaking English and a willingness to be interviewed

How long will the study last?

This is a one-time interview visit which will take approximately 2 hours and a phone call or email follow up to clarify any questions.

Who is conducting this study, and where is it being conducted?

This study is being conducted by Donna Schwartz-Barcott, PhD, RN, who can be reached at (401)874-5339. You will be contacted by Lynn Blanchette, PhD(c), RN, a doctoral student from the University Of Rhode Island, College Of Nursing. The interview will be conducted at

a site determined by the interviewee.

What do I have to do if I am in this study?

If you choose to take part in this study, you will complete an in-depth interview.

Interview

The investigator will conduct an in-depth interview with you that will last approximately 11/2 to 2 hours. The interviewer will ask you about your role as a Town Nurse. The interview will be audio-recorded to ensure that we capture everything that you say. You will may also be contacted via email or telephone after the study visit by the interviewer.

What are the risks and discomforts associated with this study?

There are minimal risks to your participation in this study. Some of the topics covered in the interview could make you feel uncomfortable. For the interview, you are free to skip any question that you'd rather not answer. You are also free to stop participating in this study at any time.

Although the risk is low, a break in the confidentiality of your research records may occur. Only members of the research team will have access to your study records. Your records will be securely stored in a cabinet in the investigator's locked office. For more information see the section: *How will my confidentiality and privacy be protected?*

What are the benefits of participating?

Although it is not likely that you will personally benefit from taking part in this study, you may find it reflective and insightful. The researcher hopes to learn more about Town Nurses and their role in keeping the community safe and healthy.

Will I receive any payments?

No, no payments are available

How will my confidentiality and privacy be protected?

Your confidentiality and privacy are our top priorities. To maintain privacy, this study visit will be held at a site agreeable to you. We will keep all the information you give us confidential as provided by law. Access to electronic and hard copy files is restricted to relevant study staff. All study records will be kept confidential and stored in a locked cabinet. Data will be identified by a unique participant code only. A password protected electronic document linking names and codes will be kept but only study staff have access to this document. Any document with your name on it will be stored separately from research data.

All information disclosed to the researchers will remain confidential. No individual identities will be used in any reports or publications that may result from this study. The study will maintain all study documentation for at least five years after the completion of the study.

What if I decide to end the study visit early?

The decision to take part in this study is voluntary. You do not have to participate. If you decide to take part in the study, you may decide to withdraw at any point during the study visit, just let the investigator know. Researchers may continue to use information already collected to protect the integrity of the study.

Who do I contact if I have questions or problems?

If you are not satisfied with the way this study is performed, you may discuss your concerns with the major professor of my dissertation committee, Dr. Donna Schwartz-Barcott (401-874-5344) anonymously, if you choose. In addition, if you have questions about your rights as a research participant, you may contact the office of the Vice President for Research and Economic Development, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

Consent

You have read the Consent Form. Your questions have been answered. Your signature on this form means that you understand the information and you agree to participate in this study.

_____   _____
Signature of Participant   Signature of Researcher

_____   _____
Typed/printed name   Typed/printed name

_____   _____
Date   Date

I give my permission to have the interview audiotaped.

_____   _____
Signature of Participant   Date

Please sign both consent forms, keeping one copy for yourself.

Conversational Guide

SAMPLE ANTICIPATED INTERVIEW QUESTIONS
GAINING AN UNDERSTANDING OF THE ROLE OF THE TOWN NURSE

A. INDIVIDUAL INTERVIEW CONVERSATIONAL GUIDE, INTERVIEW 1

The intent of this interview is to

1. Describe how you began in this role and what guided your initial practice

> PROBES
> - Were you familiar with the role before you accepted the position?
> - Was there something in your clinical background that prepared you for this role?
> - Can you share with me your best example of how this type of nursing is different from other places you have practiced? I'd like to hear a story or two.
> - What changes have you made in the way the role is carried out since you started working?

2. Describe to what extent your practice reflects a focus on the Town as a whole versus one on one nursing care

> PROBES
> - How is that focus reflected?
> - Could you share with me an example of each?
> - Is there an additional focus?

3. Discuss the impact of external forces on your daily practice

> PROBES
> - Is there a job description?
> - How is your work impacted by financial constraints?
> - Reporting to a Board of Health or other administrative body?
> - Have you been in contact with other Town Nurses? In what way?
> - Were there specific community expectations and in what way do you enact those?

4. Additional thoughts about your work. How would you describe your work to a new Town Nurse?

> PROBES
> - Tell me about the impact of your work on your community

Appendix C

Contact Summary Sheet

#	Nurse's Name	Address/Town	Phone number	Email	Background
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

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