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## Second Acts: Reflections from Nurses to Inspire the Next Generation of Nurses

Welcome and overview of the Report: Anne Llewellyn .....	4
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### Contributors

1. Cathy Kauffman-Nearhoof BSN, RN, CCM. ....	7
2. Robin Boltz MPH, RN .....	39
3. Beth Boynton MS, RN .....	42
4. Elaine A. Bruner MSN, RN-BC .....	47
5. Carol Canada BSN, RN .....	50
6. Stefani Daniels MSNA, RN, ACM, CMAC .....	53
7. Linda DeBold ARNP, MSN .....	56
8. Maria Dias RN .....	58
9. Kim Fabis, RN .....	61
10. Mary Ellen Gervais Ph.D., RN, CCM .....	64
11. Tina Kowlsen MBA, BS, RN, CCM .....	68
12. Barbara A. Buono Kuritz B.S, RN, LHCA, CCM .....	74
13. Linda Lamb RN, CCM .....	78
14. Margaret (Peggy) Leonard MS, RN-BC, FNP .....	84
15. Sheilah McGlone RN, CCM .....	99
16. Maureen Orr BS, RN .....	105
17. Laura Ostrowsky RN CCM .....	111
18. Mary Reidy RN, CCM .....	118
19. Gail Snow RN, CCM, HIA, MHP, ACS .....	121
20. Marilyn Van Houten, MS BSN RN CCM .....	123

### Closing thoughts: Will Case Management Be Your Next Act? By Deanna Cooper

Gillingham RN, CCM .....	129
--------------------------	-----

Thank You .....	131
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## WELCOME

Welcome to *Second Acts: Reflections from Nurses to Inspire the Next Generation of Nurses!* This report has been a goal of mine for some time, and I am happy to share it with you. Please take time to read each of the articles and allow them to inspire you to move forward in your career. Take in the spirit and the passion each author has shared. This report is our gift to you, the next generation of nursing!



A Second Act is something a person devotes his or her later life too, after retiring or leaving a former occupation. Second Acts can take place at any age, but most happen as we enter our retirement years.

As I move into my own Second Act, I wanted to leave behind positive thoughts to the next generation of nurses and case managers as they take up the mantle and lead those who follow them.

I hope this report inspires you and invigorates your career. Are you doing what you love? Is your role making a difference? Do you have a career path you want to follow? Are you making plans to get to the next level of your career?

The Second Act Report is a compilation of stories from friends and colleagues that I have met throughout my career. As I thought about how to write this report, one thing I realized I did not want the report to be about me, but wanted to showcase those who have inspired me to be the best that I can be. So I sat down with a pen and paper and thought about the people who have touched my life and my career. Once I had my list, I reached out to each person on the list and asked them if they would write an article to share how/why they became a nurse, and how their careers took shape over the years. Each responded to me that they thought the idea was exciting and they would like to participate!

As you will read as you move through this report, you will see similarities between the writers. As you read through this report, you will come to know the type of people who go

into nursing and how by following the opportunities that happened to them they moved into directions that shaped their lives.

It is my hope, these stories inspire you to grow in your career so that as you move into your Second Act, you can look back on your career and are proud of what you accomplished.

Each person who contributed to Second Acts is a nurse and has advanced forward in their career in their own way. Some are still working full time, and some have retired, but all are contributing in multiple ways. I hope you will read this the report and pick up a few nuggets of advice that will inspire you to make the most of your careers.

Nursing is a challenging career, and it is not for everyone. For those who choose nursing and work to make it a successful career; it is the most rewarding career you will ever have. Those who are successful in nursing are because they care, are curious, have perseverance, want to help others and are committed to improving the system. They don't give up when the going gets tough but find ways to work through the challenges they face.

Nurses make healthcare work. Nurses empower patients and families to get through the most challenging times of their lives. They help the healthcare team work together to deliver safe, quality care to meet the specific needs of each person who they touch.

Moving forward, I would like to see the culture of nursing change so that each nurse realizes the value they bring and are proud of the work they do. Today there are four million nurses in practice in the United States. Imagine if we used our power in one voice? Imagine how we could transform the healthcare system to work for the people who enter from the various entry points. Just imagine what we could do!

As a nurse of over 40 years, I am proud to say that I am a good nurse and have had an incredible career. I provided the best care I could to those I had the privilege to care for in my various roles. I learned, shared, mentored and effected change. It was not easy, and I ran into many obstacles, but I moved forward and found my way with the help of my family, friends, and colleagues.

I invite you to take the time to read this report and learn from the professionals who contributed to this report. The information shared is meant to empower and give you strength when you are stressed, confused or looking for a way out. You worked hard to earn your degree and your license. If the area of practice you are working in today is not inspiring you, find another area of practice. Nurses have multiple options as they move beyond the bedside. Use your experience, harness your passion and find the area of practice that you love.

Enjoy the book! Feel free to pass it onto your nursing colleagues or to those who are looking for their career options. I hope this work provides you with insights that will inspire you to move forward.

Best wishes,



Anne Llewellyn, MS, BHSA, RN-BC, CCM, CRRN  
Nurse Advocate

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#### **Editor's Note**

I would like to thank *Cathy Kauffman-Nearhoof* for her contribution to this report. Her chapter, *The Way We Were*, provided insight into the history of nursing and will allow all who read her words to have a glimpse into how far we have come as nurses. She went over and above in her writing and research so she could share the history of both practices and weave how their work has impacted the work we do today.

## THE WAY WE WERE

By: *Cathy Kauffman-Nearhoof, BSN, RN, CCM*



Do you remember Metal Lunchboxes? 45 RPM records. S+H green stamps? Candy cigarettes? Home milk delivery in bottles? 35 cent/gallon gasoline? 29 cents for a loaf of bread? Party Lines? Telephone numbers that started with a word prefix (Windsor-2731 was mine). The twist.

Well, if you do, you grew up in my generation –and became a nurse in the 70s like me, you probably have a plethora of memories relating to funny and sad events, changing healthcare insurances, pharmaceutical and an explosion of technology advancements.

You probably have a few war stories tucked away as to “this is the way nursing used to be.”

Do you remember when:

- Taking temperatures used to take at least 5 minutes per patient?
- We checked diabetic glucose via urine samples and dip sticks?
- IVs were calculated using your watch and an algebra equation?
- When hospital beds were raised up and down using a crank at the bottom of the bed?

As for me, I graduated from Penn State University in March of 1975! It seemed only yesterday, I was a student nurse attending my first clinic. Here I am, 44+ career years later and looking back on the diverse nursing roles, changes and advances I’ve witnessed.

When most of us applied to nurse school or college, we were asked: "Why do you want to be a nurse?" While there was a brief time when I wanted to be a Veterinarian (my guidance counselor in 1967 said girls don't do that), I easily answered this question stating that "I want to help people." I'll bet you answered this question the exact same way!

My desire began early in my life where I can remember a hospital visit as a 4-year-old. My father snuck me into the hospital, up the back stairs, and to the room where my grandmother was. I remember wearing a fancy dress for this visit and sitting on her high bed.

When I was asked why I chose to go to college to become a nurse instead of attending a local hospital program, my reply was that by having a degree might be able to advance my career to become a "head nurse." Such a microscopic perspective of the nursing profession! I had no idea back then as to the multiple career paths that would be available to me and to all nurses over the subsequent 40 plus years.

Others have attempted to "compliment" all of us at some time or other by commenting with a soft touch and a smile: "'You're too smart to be a nurse.'

What they don't know is that we chose the nursing profession because we wanted to be a nurse and not because we wanted to be a doctor but was too intimidated or frightened to try.

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Many nurses in my generation faced many challenges, including but not limited to gender bias, professional invisibility, poor pay, and confusing often confrontational educational paths. But the profession of nursing has changed as we have slowly benefited by a progressive paradigm shift by transitioning a position of powerlessness – where "nurses" scrubbed the floors as well as the patients — to a time when the practice of nursing and professional value has found a voice in the seats of Congress.

On any given day, we can turn on the news and listen to pundits expound upon historical comparisons of conflicts, presidents, changing national and global politics, wars and rumors of wars, natural and man-made disasters, global warming and the rapid and complex evolution of our national society and culture.

Despite events the global events that fill up 24/7 news, Nursing has been engaged in its own dynamic and hard-fought evolution. We must remember to be appreciative of the nursing pioneers who preceded us, who had a vision for the future of nursing, and who had the courage and stamina to advance the value, quality, and role of nurses everywhere.

### **Looking Back – Clinical Nursing**

According to the annual Gallop poll, nurses have been included at the top of the list for the 17th year in a row as the most trusted profession in America. Just think about where we started – in some cases from a perception by some in the early years that only women of questionable repute would expose themselves to the shocking sights and smells of the sick and potentially unclothed. This caused me to explore some of the histories of nursing and healthcare that opened the door to my nursing adventure. (1)



Three days after graduation in 1975, I started my first job on the night shift in the local emergency room. And I worked full time for the next 44 years in various nursing capacities

1. **White Uniforms** – Hospital dress codes back then required that nurses wear white uniforms.
2. **The Cap** – Back then, most hospitals required that we wear our nursing cap. To not comply with this policy would result in being “written up” by your nursing supervisor. (I was)



*My Penn State Nursing Cap*

3. **Expansion of pharmaceuticals** – From medicinal plants to the discovery of Penicillin, the pharmaceutical industry has become a more and more critical component our healthcare delivery systems. Nurses must be committed to continuous learning about the constant barrage of new and advanced drugs entering the market and furthermore, must learn how to both safely administer these advanced drugs and how to educate our patients best.

An example of deficient drug-related education I experienced happened as follows: I was working in the ER on the night shift when we discharged a patient with Compazine suppositories in hand.

The patient's wife called us later in the night, asking if her husband could cut the “pills” (suppositories) in half since they were too big for him to swallow!

4. **Diagnostic testing became more complex** – X-rays became too nonspecific in many cases, and were replaced by MRI, CT and PET scans that would have seemed like science fiction in the 60s and 70s.
  - a. With the introduction of more complex testing, education and preparation of our patients became a mandatory component of our care plans.
  - b. Barium enemas were the preferred procedure used to explore colon symptoms.
  - c. Exploratory surgeries were on nearly every daily OR schedule since this was the only way to assess and diagnosis many diseases.
5. **Patient length of stay in hospitals has been considerably shortened.**
  - a. In the 50s, my mother spent 10 days in the hospital when I was born.
  - b. 40 years ago, my patients having cataract surgery could expect a 7-day hospitalization would be confined in bed, where their head was positioned using sandbags placed on both sides of their heads to hold it still. Today it is an outpatient surgery!

- c. A cholecystectomy patient could anticipate at least a 7-10-day hospital stay, attached to all sorts of suction equipment and sporting an NG tube for days. Today, a chole is predominately an outpatient or a one-day length of stay.
6. **Intravenous infusions were delivered from glass-bottles.** Just watch MASH to confirm the administration of IV fluid and blood.
- a. Smart IV pumps came on the market about 30 years ago, enabling medications, patient-controlled analgesia, and medication dispensing systems.
  - b. As a Nurse Manager in the surgical unit in a small VA hospital I met with a medical device representative and became excited about this new equipment. So, in the interest of healthcare progress, I took the liberty to arrange for a trial testing of an "electronic IV pump" on my surgical unit. Unfortunately, I failed to complete all the necessary paperwork for this trial, causing a bit of a crisis in the administration! A learning experience from which I was forgiven.
7. **EMR** (does not stand for Emergency Medical Record).
- a. The electronic medical record was introduced. The goal is to connect all providers, physicians, institutions and nurses to an electronic patient medical record intending to enhance interdisciplinary communication and care coordination
- (REMINDER: Healthcare practitioners still **MUST READ** the documentation.
8. **Regulations and standards were non-existent.**
- a. Nurses did the best that they could with the knowledge and tools that they had.
  - b. There was no nursing practice consistency from institution to institution.
  - c. Beginning in the 50s Nurse Practice Acts began to standardize basic regulations and ethical codes as developed by the Joint Commission.
  - d. **Licensure.** Today, advances are finally being made by standardizing nursing licensure standards from state to state through the [National Council of State Boards of Nursing](#) and the Nurse Licensure Compact.
9. **Professional Liability** - We have become a litigious nation. Some studies estimate that 1 in 10 hospitalized patients have experienced some type of treatment or assessment error.
- a. **Legal Protection:** As a new nursing graduate, our instructors encouraged us to purchase nursing malpractice insurance. So, I did. It cost \$10.00 a year. We lived and died by the Kardex, a folded card-stock roadmap to all things for the patient, completed in pencil and continuously crossed out or erased and updated.
- Assessment Error: During my first clinical experience as a student nurse in a small hospital in Pennsylvania, I was assigned to care for a patient with one functioning eye; and a glass eye in the other. While prepping my patient summary for my instructor's review, I was stunned to see, documented in the physician's ER assessment, that the patient had "equal and reactive pupils."

10. We lived and died by the Kardex—or at least we were supposed to. The Kardex was, a folded card-stock roadmap to all goals and interventions for the patient, completed in pencil, and continuously crossed out or erased in order to update.
11. Universal precautions didn't exist yet, i.e., No gloving for IV insertion or blood draws.
12. Closet or wall "machines" s on each unit created a warm-water-bath to warm metal bedpans by using warm flushed water in order to improve patient comfort
13. Nurses used the second hand of a wristwatch to calculate I.V. drip rates using a complicated algebra equation. No IV pumps for a few decades.
14. White oxford lace-up shoes were the required foot attire for students and some hospital nurses.
15. Only operating-room (OR) staff and physicians wore scrubs.
16. Vital signs and nursing note documentation required a three-color pen to differentiate between events the three different shifts. (green, red and blue).
17. Nurses mixed antibiotics and other IV drugs on the unit without pharmacist assistance.
18. Nurses became more proficient in I.V. sticks by practicing on one another.
19. Supply requisitions were completed on typewriters.
20. Public health encompassed well-baby check-ups at the new mother's home.
21. Grandma died alone in the hospital – the family waited in the waiting room where they were informed of the death of their loved one. Valium was on hand for any family member who might become hysterical.
22. Patients heading for the OR had their body hair shaved by nurse aides with hand razors.
23. Most surgical patients were admitted to the hospital the night before their operation.
24. The Physician's Desk Reference and the U.S. Pharmacopeia were chained to the desk in the nursing station and were the only drug information resource.
25. Nurses carried trays with little paper cups of pills and along with patient med cards.
26. Cancer was a death sentence.
27. Staff and patients smoked in the hospital.
28. Back injuries were the most common work injury to nurses as there was no way to lift a patient other than by brute nursing strength.

### **Nursing Pioneers**

But advances in the practice of nursing advances were slow to take hold and were often hard fought for. Nurses hoping to advance their profession always did so with the goal of finding ways to improve patient care.

But none of the nursing's advancements happened by accident. When challenged to earn the respect in a predominately male physician-dominated field, a few heroic nurses bravely stepped up and initiated decades of the struggle for nursing education, purpose, respect and power. It was through their blood, sweat, and tears that these nurses fought opposing administrative forces,



*Before Hoyer Lifts. Nurses suffered twice the number of back injuries as construction workers.*

waged war against the segregation of nurses, and worked to eliminate antiquated perceptions of nurses and the unwarranted limitations.

When I graduated in 1975, these were some of the 1970s "current events."

- *The first Apple® computer is developed.*
- *The Supreme Court allows removal of life support for Karen Quinlan.*
- *Elvis Presley died.*
- *The disposable razor is introduced.*
- *Capital punishment is deemed constitutional.*
- *Oregon decriminalizes marijuana*

Our professional progress was slow and often frustrating. We have been challenged with gender bias, professional invisibility, poor pay, and confusing confrontational educational paths. In the scheme of history, nurses have fought hard for their professional "voices" and to be taken seriously.

Our best-known nursing pioneer, Florence Nightingale, was not our only heroine. "While we cannot deny a professional history of marginalization, invisibility and gender biases, we can (also) celebrate the extraordinary achievements of other frontier nurses such as Lillian Wald, the founder of the Henry Street Settlement house and public health nursing, and Mary Breckenridge, who brought nurse-midwives to the mountains of rural Kentucky." (2)

Nursing registries were created around the turn of the 20th century. These organizations were owned and operated by various nursing associations including eventual association with the American Nurses Association. Registries formed the backbone of a more formal system of finding and hiring nurses for the purpose of delivering services to families in the community.

Eventually, the registries became significant in setting up some of the first nursing standards that initially addressed hours of work, fee schedules, and a set of minimum criteria needed in order to enter the nursing practice. These (private duty) registries remained a popular and a preferred means of obtaining nursing private duty assignments through the lean years of the Great Depression and into the post-WWII era. Over time, the registries began to fade as American hospitals assumed the full responsibility for nursing the sick. (3)

Years before women gained the right to vote, a Registered Nurse at the Farmingdale TB Preventorium for Children in rural New Jersey from 1909 to 1930, Jessie Palmer Quimby resided at the institution and worked or was on call 24/7. In fact, all nursing personnel were required to live at the facility to ensure their availability. In the pre-antibiotic era of the "White Plague," the country experienced high rates of morbidity and mortality. Eventually nursing leadership reorganized and advocated for the importance of caring for and protecting children from TB. A public health emergency was identified and a strategy to improve care was developed.

In addition to providing scrupulous nursing care of children at the Preventorium, the nurses also ordered food and supplies, scrubbed floors and did all the laundry. These women managed all aspects of this complex health care institution. As TB declined in the United States most of these institutions were closed around 1940. But in their time, the Preventorium nurses represented the leading edge of not just one popular reform movement, but two, child-saving and TB prevention. (4)

### **Nursing Segregation**

It was not until 1946 that the boards of both the American Nurses Association (ANA) and the National Association of Colored Graduate Nurses (NACGN) endorsed the principle of ONE integrated professional association fighting for the rights, the respect, the prerogatives and the privileges of all registered nurses in the US. In January 1951, the NACGN formally dissolved. But what many of today's nurses have forgotten, is that the official position of desegregation by the ANA marked only the beginning, not the end, of the battle for professional integration of nursing. (5)

The last southern state to desegregate, Georgia, finally capitulated in 1961; and the last southern district, New Orleans, finally accepted African American nurses as members in 1964. (6) North Carolina was among the first to integrate, and in their adoption of desegregation, they were years ahead of communities where they lived and practiced.

A decade later, Estelle Riddle, a renowned pioneer of nursing desegregation looked back with pride of the progress integration had made, while she was privately saddened by the lack of real integration progress among American Nurses. (7)

I lived and worked in a small city in central Pennsylvania. While working my first job at the hospital as a new graduate in 1975, there were no African American Nurses on staff. Further, there were no African American in any of my workplaces until 1997, when I moved to Pittsburgh.

Today, I live in Georgia – the last state to adopt integration of African American Registered Nurses Today, I work side by side with my African American Colleagues.

### **Critical Care Nurse**

Critical Care units are places where patients and technology first collided. As a student nurse intern, I spent a semester in a 6 bed Intensive Care Unit I found the machines and equipment in the winter of 1974 - 1975 to initially be intimidating. The hisses and buzzing of ventilators and EKG alarms was the original surround sound in new ICU units. Not long into my internship I was exposed to my first cardiac arrest up close and personal – mouth dry/heart thumping; praying that I didn't have to do anything, I was handed the arrest clipboard and was told to record every intervention occurring during the arrest! I was scared!

One of my patients was a man suffering from a self-inflicted gunshot injury in his attempt to commit suicide.

New experiences every day. What would cause someone living in my community to try to kill themselves in such an egregious manner. The family was devastated as they suffered in the waiting room hoping for good news behind the swinging doors of the ICU. I was able to follow my patient to the OR and observed the surgical procedure of craniotomy to remove the bullet. I remember standing there, watching as the brain beat to the same rhythm of the heart monitor. The bullet was never retrieved. The patient never recovered. I never knew that the brain beat to the same rhythm as the heart. My own naivety at the time caused me to be quietly try to understand the pain someone feels that would drive them to suicide.

But historically, ICUs were not newly created in the 20th century. British nurse Florence Nightingale was the first to have used an intensive care unit (ICU). In 1854-1856: during the Crimean War Florence Nightingale pioneered a concept of separating injured soldiers by the severity of their illness

ICUs in the United States eventually had their origin in the postoperative recovery room around 1923. The Johns Hopkins Hospital in Baltimore created the first three-bed unit for postoperative neurosurgical patients.

Tank-like ventilators enabled the survival of some patients by maintaining the respiratory function of thousands of patients suffering from Polio. The iron lung, invented in 1927, helped people with polio to breathe. In the 1940s and 1950s, there were whole hospital wards full of polio patients in iron lungs.

Global polio epidemics were, in fact, a definitive moment in the development of critical care units due to the emergence of several paralytic polio myelitis epidemics which included the United States. In the 1950s, these epidemics resulted in a rapid expansion of ICUs across the United States and led to improvements in mechanical ventilation.



Rapid advances in technology from the mid-20th century provided monumental opportunities to improve the chances for the recovery of critically ill patients. But it was important during the 50s and 60s to recognize the role that nurses played regarding the promotion and organization of specialized critical care services. They became outspoken proponents by proposing that by grouping patients together by acuity and complexity in these new units, patient recovery was further enhanced due to the receipt of intensive nursing services... and not just the functionality of new-fangled machinery. (8)

In the early 1970s, most large medical institutions had ICUs constructed in their hospitals. Physicians and nursing staff recognized that skilled care and increased vigilance could improve outcomes.

Working in a hospital ICU is serious business; it takes an in-depth understanding of complex conditions, quick thinking, and the self-driven dedication to achieve the advanced skills necessary for the job. The ICU can be difficult for many nurses to handle. It was once said that nurses experienced ICU burn out in 2-5 years. Today. Specific intensive care standards,



hospital supported advanced education, mentorship programs and supportive teams find nurses spending their entire careers in this stressful but rewarding healthcare environment.

It is my opinion that ICU nurses are probably the most respected, highly trained and skilled nursing providers of patient care that exist. Since these patients have exceptionally unique and complex needs, these nurses must be equipped with exceptional, confident and expeditious clinical and critical thinking skills.,

As my career progressed onto the early 80s, I discovered a nurse who stood above all the rest. She was an Army RN Veteran. Her colleagues and I could not help but respect and admire her. Always calm; never flustered; As the ICU manager Nancy ran a tight, efficient and highly effective Intensive Care Unit. She was a healthcare warrior. Many patients were blessed when she brought her knowledge and clinical skills from the war to the hospital bedside. Nancy was my nursing hero.

I learned more in that semester than through my entire student experience. Technology became a tentative friend but to be totally honest, I've always been a little intimidated by biomechanical advances. But it was not the equipment that cared for these patients and their families. This tightly knit partnership of ICU nurses and dedicated physicians often achieved patient recoveries when situations proved to be hopeless...impossible. They created the miracles of the ICU.

Thank you to my ICU mentor Chris and the amazing and caring staff of the ICU who prepared this young and naive nurse for graduation in a week and for the beginning of my career.

### **Emergency!**

Hungover by the excitement of my ICU experiences, when I graduated from college in March of 1975, I went to work 3 days later in the Emergency Room of the same hospital I interned in. It was my first nursing position and it was on the night shift in the ER. With my 25 cents per hour shift differential, I earned around \$6,500 a year. (I bought a set of contact lens with my first paycheck.)

My mother always referred to the emergency department through her entire life as the Dispensary (a kind of advanced first aid room) ...a term which would likely annoy most ED professionals today.

Following huge advancements in emergency medicine during the late 60s and throughout the 70s this level of care first became officialized as the Emergency Department. Explosive advances in science, medicine, emergency transportation, and technology have led to the creation of specialty emergency care, physician certification, and certified emergency care nurses.

While attempts to provide emergency care are arguably as old as medicine, the history of emergency medicine as a specialty is only around 65 years old. Along with England, Canada, and Australia, the United States was one of the early adopters recognizing the specialty of emergency medicine.

In 1960, typical hospital emergency "room" staffing patterns used residents, interns (often foreign), general hospital staff physicians, and rotating on-call specialties. Believe it or not, back in the early 60s, at least half of all ambulance services were run by morticians or funeral directors because they had vehicles that could transport people horizontally. (9) How do I know this? My grandfather who lived with my family my entire childhood had begun having a series of strokes; his last and fatal CVA occurred in January 1975. He missed my college graduation.

As the U.S. medical science pioneers moved forward, they received a lot of support in the form of the 1966 National Academy of Sciences "White Paper": "Accidental Death and Disability, the Neglected Disease of Modern Society." The paper described the poor state of emergency care in the U.S., which led to the 1966 Federal Highway Safety Act. For the first time standards were established for ambulances and emergency training in the U.S. At the same time, the Vietnam War further confirmed just how poor civilian trauma care was in comparison to that received by soldiers in the field (10)

Other developments that influenced the establishment of emergency medicine in the U.S. were the introduction of CPR as a resuscitation measure and the implementation of ER coverage by Medicare and Medicaid.

In 1972 the American Medical Association (AMA) recognized emergency medicine as a specialty and created the AMA Section of Interest on emergency medicine. But even this was not easy. The early leaders of this recognition needed to overcome physician arguments against the specialty, including that there was "no unique body of knowledge" for emergency care, there was no research base to support the specialization, fear that the ER physicians would steal away their patients", and an argument that "we have too many specialties already".

By 1973, the passage of the federal Emergency Medical Services Systems Act (Public Law 93-154) funded regional and local EMS (Emergency Medical Services).

Further public knowledge and expectations were advanced by the television show "Emergency" which publicized both the new Los Angeles paramedic ambulances, the doctors who received and cared for these patients, and the many pilots returning from Vietnam. It was these incidents which triggered an expansion of aeromedical transport services.

Anita Dorr (ER Nurse Heroine) had served as a U.S. Army nurse in both Europe and Africa during WWII, and she had risen to the rank of major. Having witnessed the effects of many of the infamous horrors of that conflict, she was committed to helping trauma victims as quickly and efficiently as possible.

Enlisting the aid of her husband, Dorr designed and built a small, red, wooden cart that had wheels, a laminated top, some shelves, and a clipboard. She arranged materials on the top according to where on the patient's body they would be needed. Intubation items, for instance, were at the head, medications in the middle and intravenous materials at the foot. The invention, which was dubbed the "crisis cart," and was an instant hit. Soon the entire hospital was full of them. (12)



Was Anita Dorr the inventor of the crash cart as we know it? She never obtained a patent, so in the meantime, others laid claim to the title. But there's no doubt Dorr was among the first. And that was just one of her many accomplishments in the field of emergency nursing, a specialized discipline she helped create.

Anita Dorr rose to become the supervisor and the director of the emergency department in a Buffalo, New York hospital. Noting that her profession lacked both official recognition and standards as a sub-discipline of nursing, she co-founded the Emergency Department Nurses Association (EDNA) with Judy Kelleher in 1970. (12) The EDNA (now called the Emergency Nurses Association, or ENA) began publishing the Journal of Emergency Nursing and also created a series of certification courses reflecting the highest degree of expertise.

As a former ED Nurse, there are specific characteristics that that differentiate emergency nursing from other departments and specializations. The variety of duties, procedures and treatments are unpredictable, and the pace changes moment by moment. During a busy night, we could be called upon to deal with every unplanned and imaginable type of health issue, including but not limited to managing rowdy intoxicated patients, baby deliveries, cardiac arrests, vehicle accidents, intubations, drug overdoses, homicides/suicides, heart attacks and strokes, and multiple complains of pain.

While working as an ER Nurse, I was exposed to a plethora of these emergent and not so emergent situations.

My ED nurse mentor was close to or past retirement age; stood about 5 feet tall, chubby, and had unbelievable patience. These diverse experiences provided me with more confidence and skill to pass my nursing board. Thank you, Kathleen.

On the lighter side, night shift seemed to attract some of the more "interesting" patients such as:

1. *The young men usually came to the ED in the middle of the night to have their pubic lice diagnosed and treated.*
2. *The city drunks (\*or to be politically correct, intoxicated patients). These patients generally arrived with the police.*
  - a. *Amazingly, nearly every fall-down intoxicated patient confessed to having had only two beers.*
  - b. *I once took a fist to the left side of my face by one of our regulars when the physician who had been agitating him ducked just in time – his name was Benjamin, and he was a regular.*



3. *The ER doctors. Some of our ER doctors were educators; some were our partners; some were nice and personable, others were cranky, and one particular doctor was just "hinky."*

- a. *We had a female ER physician who always treated the nurses with respect; appreciated our insight; and gave us a lot of latitude to proceed in implementing standing orders, labs and diagnostic tests before we woke her. The ER doctors then worked 24-hour shifts, and either slept on one of the litters in the ER or in the cast room where there was a bed.*
  - b. *Dr. B. was a Korean Vet ER Physician who tried to run the ER like a MASH unit. He was probably the most stress-inducing ER doctor at that time, always keeping us on edge.*
  - c. *Our most incompetent ER Physician was from Asia where women were little more than his personal "slaves." He never trusted either our assessments or suggestions.*
    - i. *For example, any nursing student or physician intern would take a close look at a young man in the ER with a high temp, nausea/vomiting, and rebound abdominal pain. He sent this patient home twice before he finally admitted the 20-year-old boy to the hospital on his 3<sup>d</sup> ER visit and allowed us to telephone the on-call surgeon to operate and remove his appendix.*
  - d. *I'll bet you're curious about the "hinky" doctor. To be honest, this doctor was our most excellent diagnostician...but he had a few strange and unusual habits.*
    - i. *We once had a male patient come in who was in cardiac arrest. It just so happened that his girlfriend surprised him early in the shift by bringing him some home-made dinner for later, so she was an observer to this event. The two stood at the foot of the litter, while the doctor ordered that the patient is placed on a mechanical cardiac compression machine – for an hour. During the mechanical treatment, he while he explained to his soon to be wife the intricacies of medicine and his exceptional skill.*
    - ii. *In the ER, we kept a green composition notebook to document all our long distance calls. Unfortunately for him, Dr. T. kept a very personal diary in the exact same type of journal, which he left in the ER on the same shelf one night. (Why he brought it to work was beyond our understanding!)*
    - iii. *One night I grabbed the long-distance book to document a long-distance call, and low and behold, the notebook was not our call registry... it was his diary! Of course, we all read through it and had a good laugh.*
    - iv. *Most of his entries documented his chronological exploits with his girlfriend. Such as the first kiss, the first French kiss, vertical necking, then horizontal necking, a lot of fondling, and even the first sexual exploit with his girlfriend. Further, each entry was rated from fair to excellent.*
4. *During slow times during our shift, the ambulance crew practiced IV insertion on the nurses. No gloves.*
5. *Working nights in the ER, the nurses typed up the admission paperwork, wheeled the patient to the ER treatment room, assessed the patient, documented, assisted the*

*physician, implemented any prescribed treatment, and filled out the billing statements at discharge. Band-aids were \$1.00 each.*

**6. Nursing salaries have also drastically changed.**

- *When I was a nurse working the night shift, I earned just over \$6k/year.*
- *As of August 2018, the highest paid nurses in the United States can be found in San Francisco. Nurses working there in acute care can earn a median hourly rate of \$65.68 an hour or an annual wage of \$136k/year!*

## Hospice Home Health

The term “hospice” (from the same linguistic root as “hospitality”) can be traced back to medieval times when it referred to a place of shelter and rest for weary or ill travelers on a long journey. The name was first applied to specialized care for dying patients by physician Dame Cicely Saunders, who began her work with the terminally ill in 1948 and eventually went on to create the first modern hospice—St. Christopher’s Hospice—in a residential suburb of London.

Saunders introduced the idea of specialized care for the dying to the United States during a 1963 visit with Yale University. Her lecture, given to medical students, nurses, social workers, and chaplains about the concept of holistic hospice care, included photos of terminally ill cancer patients and their families, showing the dramatic differences before and after the symptom control care. This lecture launched the following chain of events, which resulted in the development of hospice care as we know it today.

**Table 1: HOSPICE TIMELINE | Hospice Leaders**

<b>1965</b>	<i>Florence Wald, then Dean of the Yale School of Nursing, invites Saunders to become a visiting faculty member of the school for the spring term.</i>
<b>1969</b>	<i>A book based on more than 500 interviews with dying patients is published, entitled, <b>On Death and Dying</b>. Written by Dr. Elisabeth Kubler-Ross, it identifies the five stages through which many terminally ill patients progress. The book becomes an internationally known best seller.</i>
<b>1972</b>	<i>Kubler-Ross testified at the first national hearings about death with dignity, which are conducted by the U.S. Senate Special Committee on Aging. In her testimony, Kubler-Ross stated, “We live in a very particular death-denying society. We isolate both the dying and the old. We can give families more help with home care and visiting nurses, giving the families and the patients the spiritual, emotional, and financial help to facilitate the final care at home.”</i>
<b>1974</b>	<i>Florence Wald, along with two pediatricians and a chaplain, founded Connecticut Hospice in Branford, Connecticut, the first hospice in the US.</i>
<b>1978</b>	<i>After several failed attempts at legislation, a U.S. Department of Health, Education, and</i>

	<i>Welfare task force reports that “the hospice movement as a ... is a viable concept and is the proper subject of receiving federal support.</i>
<b>1980</b>	<i>The Joint Commission on Accreditation of Hospitals (JCAHO) was asked to develop standards for hospice accreditation.</i>
<b>1982</b>	<i>Congress includes a provision to create a Medicare hospice benefit in the Tax Equity and Fiscal Responsibility Act of 1982.</i>
<b>1984</b>	<i>JCAHO initiates hospice accreditation.</i>
<b>1991</b>	<i>The Commission on the Future Structure of Veterans Health Care released a report recommending the inclusion of hospice care in the veteran's benefit package.</i>
<b>1993</b>	<i>Hospice was included as a nationally guaranteed benefit under President Clinton's health care reform proposal.</i>
<b>1997</b>	<i>Congress passed legislation barring taxpayer dollars from financing physician-assisted suicide.</i>
<b>1997</b>	<i>The growing end-of-life movement focuses national attention on the quality of life at the end of life as well as the need for increased public awareness and physician education.</i>
<b>1998</b>	<i>Hospices nationwide report rapidly declining average and median lengths of stay. The percentage of hospice non-cancer admissions decreases dramatically, reflecting the problems associated with determining a six-month prognosis for these patients.</i>
<b>1999</b>	<i>The U.S. Postal Service issues the Hospice Care commemorative stamp in February.</i>
<b>1999</b>	<i>The Office of Inspector General (OIG) releases the Draft Compliance Program Guidelines for the Hospice Industry.</i>
<b>2000</b>	<i>Research from the Department of Health and Human Services, shows statistically significant findings supporting the provision of hospice care for residents of skilled nursing facilities.</i>
<b>2002</b>	<i>The Department of Veterans Affairs launches a program to <u>improve veterans' access</u> to hospice and palliative services.</i>
<b>2002</b>	<i>Federal court upholds Oregon's physician-assisted suicide law.</i>
<b>2004</b>	<i>More than 1 million Americans with a life-limiting illness were served by the nation's hospices in 2004, the first time the million-person mark has been crossed.</i>
<b>2004</b>	<i>Elisabeth Kubler-Ross, a pioneer in the field of death and dying, dies at the age of 78.</i>
<b>2005</b>	<i>National dialog on the importance of advance care planning increases as the case involving Teri Schiavo—who dies in March—escalates in the media and within public policy debates.</i>
<b>2005</b>	<i>The number of hospice provider organizations throughout the country tops 4,000 for the</i>

	<i>first time.</i>
<b>2006</b>	<i>The American Board of Medical Specialties (ABMS) recognizes hospice and palliative medicine as a medical specialty.</i>
<b>2007</b>	<i>Research published in the Journal of Pain and Symptom Management reports that hospice patients live an average 29 days longer than a similar patient that did not have hospice care.</i>
<b>2007</b>	<i>The Alliance for Care at the End of Life, a 501(c)4 organization is created to provide the hospice community with a more comprehensive, strategic voice on Capitol Hill.</i>
<b>2008</b>	<i>Florence Wald, a pioneer in the field of hospice care in the U.S., died peacefully at her home in Connecticut on Saturday, November 8. She was 91.</i>
<b>2009</b>	<i>The number of hospice volunteers continues to grow with a record 550,000 people serving as volunteers.</i>
<b>2009</b>	<i>Advance directives become available online.</i>
<b>2010</b>	<i>We Honor Veterans, a pioneering campaign to help improve the care Veterans receive from hospice and palliative care providers, is launched by ... the Department of Veterans Affairs.</i>
<b>2012</b>	<i>LIVE—Without Pain, a new public awareness campaign from NHPCO's Caring Connections, dispels myths about pain and empowers consumers.</i>
<b>2014</b>	<i>Forty years after the creation of Connecticut Hospice we celebrate 40 years of hospice care in the US.</i>

## Hospice Nurse

In 1973, as a student nurse I was assigned to work on the medical-surgical unit, where I would provide the nursing care and develop a care plan for a terminally ill patient who was dying of metastatic breast cancer.

When I walked into her room, it was dark—the curtains were pulled shut; she was alone in the room. During shift report, I was told that she was lonely and that she had discontinued her chemotherapy. Family visits were infrequent and sometimes tense.

What was I supposed to say to this lady? I was 19 years old. What did I know?

But what I learned is this: just because a person is dying, does not mean that they have lost all interest in life; they are the same person they were before the cancer. During her bath, dressing change, and an injection for pain, we talked about everything. About her cancer diagnosis and the subsequent treatment; her favorite recipes, her family's denial, and their refusal to accept her "no more chemo" decision. We laughed, and we cried a little. Mrs. S.

changed my perception of the needs of the dying patient. She created in me a passion for finding a way to better care for our dying.

**In 1974,** I took college nursing elective course entitled Death and Dying. This became additional education which fueled my interest in this unique patient population.

**In 1977,** I was teaching medical nursing in an LPN nursing education program. I included a subset nursing training regarding "Death and Dying" in my teaching plan. We wrote our obituaries, visited a funeral home, and debated the pros and cons of patient awareness of their terminal diagnosis. To tell or not to tell.

**In 1981,** I was hired as a Home Health Hospice Nurse. This position was without a doubt the most rewarding clinical experience in my career. Lessons learned from these amazing and brave patients carried over into the rest of my career and in even my personal life.

1. I learned that pain management was a paramount concern for dying patients whose families and doctors were afraid of addicting these patients to narcotic pain medications. In fact, pain is often a patient's primary fear of the dying process.
2. We were vigorous in our education of families, physicians, other nurses and team members regarding pain management strategies. We carried our hospice message to groups, churches and other education forums to spread the word and garner support.
3. Early pain interventions Brompton's Cocktail had grown in popularity for the management of severe pain, coke syrup could be used for nausea, and sugar could be applied for the treatment of severe decubiti.
4. But a. before physicians gained comfort with prescribing straight morphine, Brompton's was our "go to" drug. (Addiction of their patients was a common concern among physicians.).
  - a. Coke syrup for nausea could be purchased at the pharmacy, and sugar was an old but effective approach to healing decubiti when insurance did not cover prescription treatment.
  - b. Adding a few heaping amounts of instant milk to any mild based drink or food added much-needed calories before the days of Ensure.
  - c. Bran can be sprinkled on cereals, oatmeal, and many other foods to help to resolve constipation. Beer was also a solution for a few of my patients.
7. Educating families. Keep dark brown towels on hand if there is any possibility that the patient will hemorrhage. Brown towels minimize the amount of blood when the blood blends into the brown fabric. This became a useful intervention for the family of my patient who was dying of mouth and throat cancer, the cancer gradually encroaching toward the carotid artery. He did not hemorrhage but died quietly at home with his family at his bedside.

8. Almost every nurse can identify one or two things in our profession that they had trouble doing or just could not do it. I could not take care of our baby or toddler patients. A two-year-old toddler suffered with an untreatable brain tumor was too close to home. I had a 2-year-old at home. Our team was close, and we were flexible. One of my colleagues kindly agreed to “trade” patients with me, thus ensuring that this baby and his family received the best-skilled care and emotional support they needed.
9. I still have to laugh at the cleverness of some of our caregivers. Mr. J. wore an external catheter, which fell off one weekend. Rather than “bother” the on-call nurse, Mrs. J. rigged up an ingenious system to keep her terminally ill husband dry while collecting the urine.
  - a. Her system included: the cellophane tube wrapping around a long tube of disposable cups; duct tape; an empty milk carton.
  - b. Using your imagination, I’m sure you can picture the cellophane attached to his penis with duct tape; and the tube of cellophane then running down the side of the couch into the milk carton.
10. Bargaining patients were not uncommon. Fear, desperation, unresolved issues – all contribute to prolonged bargaining among dying patients.
  - a. One such patient offered to take my family and me to Florida on vacation in his RV if I could find a doctor that could cure him.
  - b. Many prayed to live just long enough to see a baby born; at graduation; a wedding. Their passion often seemed to work...and then some even tried a 2<sup>nd</sup> or 3<sup>rd</sup> time.
11. Hiding diagnosis of terminal illness became the mission of some families which is the only way they knew how to “protect” their loved one. They did not want their loved one to know that they were dying. On the other hand, you might be surprised to know that many of the dying conversely believed it was **their** responsibility to protect their family from the reality of pending death. So, the game of secrets, empty conversations, and suffering tore at apart those who were dying and those who would be left behind. Always remember: the family is losing one person—the dying are losing everyone.
  - a. Some families set up intercom systems in the patient’s bedroom which was monitored by the family sitting in the kitchen after warning the nurse “don’t tell him he is dying.”.
  - b. Sometimes families would not leave us alone with the patient since this might impair the ability to maintain the secret.
  - c. The family assumed the role as an encourager to the patient, so he would not “give up.” “Keep fighting. God is not ready for you yet. We need you around till Sharon gets married.”
  - d. When this secret thrives, families and friends could not have honest conversations; they were reluctant to talk about their lives outside of the patient’s bedroom; and they absolutely could not cry in front of the patient. So, remember: Crying can be a tremendous release for both patient and family It



can be a moment of clarity, honesty, love. It is an opportunity to mend past grievances; to forgive and ask for forgiveness.

- e. As a side note...I never met a hospice patient who did not already know he/she was dying.

They played an exhausting emotional game. This secretive coexistence was one of our challenges; our goal was to find a sensitive path to break through the denial so that both the family and the patient could be open and honest; they could resolve lingering family issues, they could openly take care of their affairs; and they could express their love and say their goodbyes. Most of the time, we were successful. We made a difference.

I could go on and on about the stories and memories of my hospice experience. Some are funny. Some not so much. My patients and their families were amazing people. They laughed and cried. Some could still tell questionable, a lewd and funny jokes. Some had regrets they wanted to express. Others expressed the love that might have previously been withheld.

In the end, I can only express a heartfelt thank you to those patients and families who allowed me to be a part of their family for a little while. I was honored.

## Nursing and Education

The tradition of formal training for nurses is only about 150 years old. Before the 1870s, most people were cared for at home by family members, "largely because nursing was not considered by polite society to be a respected profession."

In the eighteenth century and the early nineteenth century women were without formal training, unpaid and relied on family and /or folk remedies for their provision of patient care. During family illnesses, it was most always the women-folk (wives, daughters, nieces) who were expected to care for their family members and neighbors who were ill or unable to care for themselves.

**Table 2: A PEAK INTO THE NURSING EDUCATION CONFLICTS**

<b>1798</b>	<i>Dr. Valentine Seaman at the New York Hospital was the first to teach nurse attendants in America.</i>
<b>1839</b>	<i>The Nurse Society was formed in Philadelphia which advertised the need for "females with good habits, a sense of responsibility, and patient dispositions." The nurses were taught by the physicians in the lying-in dispensary to provide community nursing visits to pregnant and newly delivered women. (Watch the British series "Call the Midwife" for perspective)</i>
<b>1856</b>	<i>Florence Nightingale demonstrated the value of military nurses during the Crimean War.</i>



<b>1859</b>	<i>Nightingale published "Notes on Nursing," the first instruction manual of any kind for nurses</i>
<b>1872</b>	<i>The Civil War became the turning point for the establishment of nursing schools in America. In 1872 Linda Richards graduated after one year of training and was considered America's first trained nurse</i>
<b>1873-1889</b>	<i>Three hospitals established the first nurse training schools in America. The New York Training School at <u>Bellevue Hospital</u> was the first 1-year nursing school in the U.S. founded on the principles established by Florence Nightingale. (14)</i>
<b>1893</b>	<i>The World's fair in Chicago introduced Americans to hamburgers, the Ferris wheel, the Pledge of Allegiance — and the <b>idea of higher education</b> for nurses. "Nurse leaders of the time — including Nightingale, argued for an educated workforce with standards of practice, as opposed to one in which nurses served as apprentices in hospitals."</i>
<b>1893</b>	<i>Nursing (apprentices) students were unpaid and required to work 12-hour shifts in their school hospitals, providing the hospitals with a source of free labor. "Students worked with little or no clinical supervision, classes were irregularly scheduled and were often canceled when students were needed to staff the wards." This hospital staffing practice existed well into the 1960s.</i>
<b>1889-1900</b>	<i>By the turn of the century, there were over 400 hospital-based nursing schools in the U.S. There was no standardization: programs range from six months to two years in length, and each hospital sets its own curriculum and requirements. These schools existed primarily to staff the hospitals that operate them.</i>
<b>1909</b>	<i>The University of Minnesota School for Nurses became the first university-based nurse 3-year baccalaureate program.</i>
<b>1909</b>	<i>The American Red Cross was asked by the Geneva Convention to fulfill the requirements for nurses during wartime.</i>
<b>1910</b>	<i><b>Practical nurses</b> were recruited to serve in <b>World War I (WWI)</b>, educated by the American Red Cross, the US Army Corps, and Navy Nurse Corps. A lack of supply and a great demand again called for educational programs that would crank out nurses in accelerated programs.</i>
<b>1923</b>	<i>In 1923 a study known as the Goldman Report was the first to conclude that nurses should ideally be educated in a university setting. In 1948 The Carnegie Foundations issued a study agreeing with the Goldman Report.</i>
<b>1941</b>	<i>The National Association for Practical Nursing Education and Service was established.</i>
<b>1952</b>	<i>A project at Columbia University introduces the concept of <b>two-year, associate degree</b> nursing programs.</i>
<b>1955</b>	<i>All states developed standards of educational training, regulations, and laws for both the licensed practical nurse and the registered nurse. Nursing exams were standardized by</i>

	<i>each individual state.</i>
<b>1960-1975</b>	<i>Diploma programs began to decline and were increasingly replaced by 2-year associate degree and 1-year LPN programs.</i>
<b>1982</b>	<i>Even as the ADN Registered Nurse remained the most common degree held by working RNs, the National League in Nursing (NLN) released the first position statement to affirm the BSN is most desirable as the minimum educational level for entry-level nurses.</i>
<b>1990</b>	<i>Fears of worsening <b>nursing shortages</b> put a damper on efforts to require the BSN as an entry to professional practice.</i>
<b>2003-2008</b>	<i>Several studies demonstrate that patient outcomes improve when a higher percentage of nurses on staff hold a BSN.</i>
<b>2010</b>	<i>The Institute of Medicine issued a landmark report called “The Future of Nursing,” which compiled extensive research recommending that 80 percent of the nursing workforce hold a BSN degree by 2020.</i>
<b>2012</b>	<i>New York and New Jersey considered controversial legislation known as the “BSN in 10” law. It required ADN-prepared nurses to obtain a bachelor’s degree within ten years of entering nursing practice. However, fears of another looming nursing shortage prevented the BSN from becoming a national standard for entry-level training. But by this time, many employers are creating incentives for nurses to go back to school.</i>

#### **Timeline Resources**

(14) <https://www.americansentinel.edu/blog/2016/09/06/a-timeline-of-nursing-education/>

(15) <https://www.nurse.com/blog/2012/11/12/history-lesson-nursing-education-has-evolved-over-the-decades-2/>

Excellence the quality of nursing education has become a common theme given the rapidly changing health care culture of the past decades. Education eventually became mandated in most states in the US.

*When I graduated from Penn State with my BSN in March of 1975 and went to work in the Emergency Department 3 days after graduation. At that time. I was one of 3 BSN prepared nurses in the entire 300 bed hospital (the other two were administrators). As a BSN nurse, we struggled in those early years to prove our skill and our value. We were often challenged by our Diploma peers who consistently insisted that their training was far superior to that of any BSN program. However, it was up to each newly BSN prepared nurse to take accountability for their readiness to care for our patients and to prove their own capability to their colleagues and their value to the hospital and pave the way for the BSN prepared nurses who would follow.*

However, passionate arguments continued throughout the 20<sup>th</sup> century as to what level of education a nurse should have. LPNs entered the scene with mostly one year clinical and theory educations; AD nurses initially became a viable solution especially during wartime shortages to move RNs into the profession faster and with the necessary skills obtained from a 2 year community college preparation; RN diploma nurses had been the core of nursing programs and hospital staffs for years and the students were also a valuable solution for

staffing hospitals with free labor; and BSN nurses with both clinical and a core of advanced college coursework were said by healthcare leaders and studies to bring a higher level of critical thinking along with clinical experience to the nursing education around the late 60s and early 70s. But for years, leaders of the profession, doctors, and administrators fought passionately as to the level of education absolutely required to create a competent nurse.

All nurses are educators in some capacity. New nurses learn both good and bad practices to their mentors and peers. I was more fortunate than most. I was fortunate to have had the opportunity to teach in a LPN program. In 1977 I was hired as an LPN instructor where I worked for 4+ years. Our program was fast paced as it ran two overlapping classes each year graduating about 60 LPNs annually. I was responsible for teaching both classroom and clinical subjects where I prepared nursing students with the skills and knowledge to competently function at the bedside; to safely conduct patient procedures such as – but not limited to – dressing changes, catheter insertion, bathing, enemas, med administration, and professional nursing documentation.

LPNs became the eyes and ears of the RNs due to their constant presence on the unit floor and bedside patient care. Class selection for our program was strict. But as a result, we graduated class after class of student nurses who achieved a 100% board pass rate. I'd like to give a *shout out* to our LPN nurses everywhere!

*Teaching has a lot of interesting moments related to student experiences. During my teaching tenure, here is what our LPN program looked like during the late 70s and early 80s. LPN Instructors were not required to have a BSN. But the diploma nurse instructors were required to be enrolled in a BS program and demonstrate progress toward achievement of their degree.*

- *Our students were required to wear their gray and white dress uniforms – no uniform pants! (Our very esteemed elderly Program Board President did not believe that pants uniforms were feminine.)*
- *Students were not permitted to wear any jewelry, except for a wedding ring.*
- *We were required to be referred to the students then as Miss, Mrs., and Mr.*
- *The students wore their uniforms all the time; even during classroom education. No street clothes except for the occasional class holiday party.*
- *Every nurse was required to wear the classic oxford clinical nursing shoe and a fitted custom-made student uniform.*
- *Successful students were capped in 6 months with much celebration and fanfare. From that point on, caps were also required student attire.*

*As instructors, one of our favorite exchanges consisted of sharing the funny or surprising things that students said or did. In fact, we kept a running steno pad of these actions and comments. I don't know whatever happened to that steno pad. It may in fact be long gone in view of the retirements of my colleagues...or maybe one of them was able to snag that notebook on the way out the door. But my memory is still able to conjure up a few student gaffs. Here are a couple of recollections that are still stored in my brain.*

1. *I was assisting a nursing student with a very lean and tall male patient so that he could use the urinal. (He could not "pee" when in bed) The elderly gentleman was a bit frail*

*and leaned heavily on me, as the student and I held him up into a safe standing position. The nursing student proceeded to position, sight unseen, the urinal in the right spot beneath his hospital gown "positioned" the urinal beneath his hospital gown, so he could "pass his water." Unfortunately, the urinal placement was not quite right, which I quickly realized as I felt a warm wet stream of urine running down me leg and into my shoe. All I could do was let 'er flow or risk dropping our patient by adjusting the placement of my shoes! The students found the whole episode to be funny!*

- 2. I was assigned to be the lead instruction for Obstetrics, so I attended many vaginal deliveries, C-sections, and circumcisions with the students. They were not permitted in the delivery room without an attending instructor. Most deliveries were uneventful and always gave me chills. I had my share of students who passed out during delivery, one who passed out before the action even started, and many of our females who joined with the new mother in her "pushing. "It was their simulated pushing that caused many to leave the room after "birthing" their internal menstrual protection.*
- 3. Circumcision was a part of every newborn boy's welcome into the world. We had a special room where the doctor performed this procedure. It was about the size of a supply closet, included a small procedure table, and was further crowded by 2 tall filing cabinets. We often crammed 4-5 students into this room to observe the circumcisions. On this spring day, the sun was baking the room through its one window. The OB unit and this "closet" did not have air conditioning back then. Usually the students persevered through the procedure...except on this day. Then CRASH! One of my chubby female students passed out, fell sideways, and ended up tightly lodged head first between one of the cabinets and the wall. The most difficult intervention was safely "unwedging" her so she could stand up, brush herself off, and assume a somewhat embarrassed demeanor. She was not hurt, and the students found the whole episode to be funny when we gathered at the end of the day for our regular clinical meeting.*
- 4. An older student in her 40s was assigned to care a post-op woman in her 60s who had surgical placement of a cardiac pacemaker two days before. (These patients were often in the hospital for a week). I was paged (no cell phones then) by a student who I met at the patient's bedside to oversee her performance of an uncomplicated dressing change. The Hard of Hearing patient was lying comfortably in her bed while the student was nervously chattering away. It was after the successful completion of the dressing change when the student, in her most sincere voice, complimented the hard of hearing patient on her "amazing recovery since having her heart transplant.". The patient sweetly nodded and smiled while the student was completely unaware of their gaff! (She never graduated)*
- 5. A critical component of nursing education is ensuring that the students are thoroughly taught to document legibly, accurate observations, spell correctly and in a timely manner. We can all agree that some terms were difficult for the students to spell – such as purulent draining. Pussy wounds were often found the student (and even*

*some seasoned) nurse documentation. — “The infant was circus sized.” “On the second day, the knee was better, and on the third day it disappeared” (????).*

On a serious note: When it comes to nursing documentation, knowing how to accurately document on a patient can literally mean life or death. Some of the most common medical documentation errors can also be the most disastrous. Plus, improper documentation can open an employer to liability and malpractice lawsuits. For nurses, who are on the front lines of defense in the medical field, being adequately trained early on proper documentation can help avoid such medical errors, save lives and help protect their employers.

[http://nursingeducation.lwww.com/blog.entry.html/2018/02/22/nursing\\_documentatio-S5hF.html](http://nursingeducation.lwww.com/blog.entry.html/2018/02/22/nursing_documentatio-S5hF.html)

6. *One day I was paged to assist a student who had already been signed off on performing patient enemas. But on this day, the patient was to be positioned on her back for some reason I don't recall. The student was near to tears in that the repeated attempts to perform the enema had not produced the expected results. Upon observation of the student's technique, it turned out that she was giving the patient a douche and not an enema.*

By 2020, an estimated 12 million older Americans will need long-term care (Medicare, 2009). The aging of American will seriously impact healthcare by the baby boomer generation. About 70 percent of licensed care in nursing homes is provided by the LPN/LVN workforce. Based on these facts, there is a compelling, urgent need for a stable, educationally well-prepared LPN/LVN nursing staff, in long-term and chronic care settings. (16)

The National League for Nursing fully supports the critical role of licensed practical/vocational nurses (LPN/LVN) in providing quality patient health care. The NLN's mission statement promotes a *strong and diverse* nursing workforce, guided by dynamic and integrated core values regardless of their level of education, including integrity, diversity, and excellence. (16)

Nursing advancement has not come to an end. All nurses, regardless of their title must support and promote a unified nursing profession. It is up to every nurse to that we unite together as essential who are partners on the front line who are required to meet the varied needs within today's complex health care system. (16)

*I am deeply respectful of the valuable contribution all nurses but as a former LPN instructor, LPNs will always have a special place in my heart. To Peggy, Shirley, and Joan ... we many a formidable team of unified and effective instructors. Working with this team was one of my most enjoyable colleague experiences during my career. Thank you.*

## **Doctors and Nurses**

What would nursing memories be without the inclusion of the love/hate relationships between doctors and nurses?

Since the 18th century, the nursing profession's focus has shifted from servitude to educated care. A nursing journal once described that the Florence Nightingale view has given way to an

"understanding that nurses contribute to all aspects of health care and do not exist merely to serve physicians."

Throughout history, doctors and nurses have shared a sometimes-fragile relationship; one that was often influenced by their social status, our gender, their power, and inaccurate societal perspectives. Doctors' opinions of nurses were likely influenced by the status of nurses during the pre-Nightingale era. Nurses, during this era, were not afforded a respectful reputation. Nursing was 'arduous and ill-paid,' attracting people who were regarded to be unfit for other occupations. These unsavory people included female criminals and vagrants, and "immoral" women.

In a 2013 study by the Institute for Safe Medication Practices found the following in 2012:

- 87 percent of nurses encountered physicians who had a "reluctance or refusal to answer your questions, or return calls,"
- 74 percent experienced physicians' "condescending or demeaning comments or insults," and
- 26 percent of nurses had objects thrown at them by doctors.
- Physicians shamed, humiliated, or spread malicious rumors about 42 percent of the surveyed nurses.
- And a New York critical care nurse responded that "Every single nurse I know has been verbally berated by a doctor. Every single one."

In my small-town hospital in central Pennsylvania, physicians ruled. The doctors held all the power and were very well-protected. The assumption was that nurses were more easily replaced than doctors. A blind eye was turned by hospital administration when these bully physicians were unrelenting in their verbal and physical abuse; when their repetitive and unwanted touching was deemed as "accidental" or just excused as "that's just his way." and when surgical instruments and other objects were thrown at a nurse.

A few of my observations.

1. Demeaning Physician Behavior.

- a. In the 1970s and in some hospitals, well into the 1980s, nurses were still required to stand up and give their chair to the doctor...even though they too were performing essential duties. My first interaction with the battle for chairs occurred in the latter 70s while I was charting my nurse's at the nurse's station.
- b. The highly annoyed physician commented: "Are you going to sit there all day or are you going to get up and give me this chair!?" I got up. Such was the culture of acceptance of physician inappropriate behavior at that time.

2. Projectiles...

- a. I was the nurse manager in the surgical unit when the resident was trying unsuccessfully and through multiple attempts to insert a central line at the patient's bedside. He was becoming increasingly angry and frustrated after a 3<sup>rd</sup> failed attempt when he picked up the used bloody central line tubing and needle and threw it across the bed landing against my uniform.



- b. The throwing of soiled dressings was a favored tactic of one well known surgeon., I was in the process of changing an abdominal dressing on a patient when the surgeon walked in. He who found it necessary to snatch up the very soiled abdominal dressing and threw it directly at me. And then he walked out. I never knew why he was so angry that day. His reputation of disrespect and bad behavior toward nurses and our nursing administration was well known. the nurses.
3. Nurse Intimidation. Dr. H. was an incredibly talented and successful orthopedic surgeon. He was also one of the meanest doctors on staff at the hospital who harbored a special disdain toward bachelor prepared nurses. My new ED colleagues assigned me to assist Dr. H in the application of a Spica cast and sent me to the "cast room." The cast room was windowless and not air-conditioned. I was so nervous I was shaking. I did as he asked without comments or questions hoping to get through the experience without becoming the target of his verbal attack. I held the patient's arm in place while he applied the cast. After the application, he stood up, and told me to stay put, holding the patient's arm in place; and "don't move until I come back to check on him." I stood over the seated patient for over an hour without moving – scared half to death. What if I did something wrong? I'd only been on the job for 2 weeks.

When he returned to check on the patient, he said with a laugh ... "I guess you passed." I was one sweaty and panicked orientee. "I later learned from my new colleagues that Dr. H. loved to "test" all new nurses. As it turned out, he had a specially built frame available in the cast room that he could have used to support the drying cast. (On a side note, his daughter went to Penn State a few years later to get her BSN...)

4. More Nurse Intimidation.  
One day when I was on the unit with students and their post-partum patients, he walked purposely out of the labor and delivery room unit, picked up an RN he had had words with, and dropped her butt first into the large laundry can on the unit. can. I forget his exact words, but they included "incompetent and stupid." We didn't bother to report the episode. Dr. B was the best obstetrician on staff.
5. Patient Intimidation.  
Dr. B., a well-known and excellent obstetrician had a notorious reputation of treating unmarried pregnant girls with blatant disrespect and hostility. A very scared teen girl was in the delivery room one day, legs and arms strapped down. I was observing the delivery with two of my students. Here is what we witnessed: Dr. B. refused to provide the girl with pain relief as she yelled and screamed with pain. His response to her pain was: "maybe she'll learn her lesson!"

When the baby was delivered, he told the attending nurse loud enough for the patient to hear, to "get this bastard out of here and don't let her see it."

So, why didn't we report these doctors? As the study revealed, there was a justifiable fear by the nurses that they could lose their jobs or that others would see them as a "tattle." That unacceptable reporting behavior would inevitably affect their experience at work.

Bullying by physicians still exist today. But as nurses have gained a higher status in their professions through education, stronger code of conduct policies and advanced NP degrees most agree that they receive more respect and generally have a more harmonious relationship with most doctors.

While workplace disagreements may cause occasional friction, as in all industries, most nurses and physicians seem to recognize today that value of one another's contributions to the health care field deserved mutual respect in all interactions.

### **Nurses Today.**

- Nurses are among the top 10 most respected and trusted occupations in the US.
- Nursing care is highly specialized. Hospital patients are grouped in units by disease or acuity.
- Computed tomography (CT) and magnetic resonance imaging (MRI) scans are the first order of business before a definitive diagnosis is made.
- The average length of stay in acute-care hospitals is 4 days (down from 11.4 days in 1975).
- Scopes and lasers are used to treat numerous bleeding conditions.
- I.V. infusions are regulated with sophisticated pumps run by safety software.
- Plastic shoes, clogs, and sneakers are common footwear for nurses.
- Pharmacists and pharmacy technicians prepare, compound, and deliver drugs and infusions following rigorous safety checks, sometimes involving preparation in special hoods.
- Automated beds are used to weigh and reposition patients.
- Ceiling-mounted lifts transport patients from bed to chair.
- Nursing caps can now be found in museums.
- More than two-thirds of patients exceed the 5-year survival rates for most cancers.
- Online references for pharmaceuticals, nursing procedures, and evidence-based practice provide instant information at the point of care.
- Home-care nurses provide acute- and critical-care interventions and teach family members how to perform these techniques in the home.
- Elderly patients undergo invasive procedures at the request of the family, even when healthcare professionals know such care is futile.
- Low-birth-weight babies have a survival rate of 90% (up from less than 50% in 1960).
- Nurses provide a growing percentage of primary-care and chronic-care patient management.
- Nurses are leaders in every aspect of healthcare delivery, education, research, politics, and policy formation." (11)



The Future of Nursing

<https://alliedstaffingnetwork.com/7-modern-healthcare-trends-every-nurse-needs-know/>

### **Nursing is Adapting to Changing Demographics**

Baby boomers are now retiring from nursing in vast numbers. Unfortunately, the supply of new nurses just isn't keeping up with demand.

### **Nurses Are Playing a Greater Role in Care Provision**

As a result of the changes pushed through by the Affordable Care Act, hospitals are now paid based on the entire patient experience and outcome. This makes the input of nurses more critical than ever.

### **Technology is Becoming Increasingly Important**

[Technology](#) is changing every area of the nursing profession. Some student nurses, for instance, are already using sophisticated simulators to practice care provision before being granted access to real patients.

### **Nursing is Moving Away from Hospitals**

There is now a concerted effort within the healthcare industry to keep patients in their own homes for as long as possible. (Back to the Future – huh?) As a result, there is a growing need for [nurses to work in communities](#) — providing care and monitoring the health of patients away from hospitals.

### **Nurses Are Becoming More Educated**

As the nursing profession continues to change, the need for a more expansive knowledge base amongst nurses becomes greater.

### **The ACA is Driving Demand for Nurses**

Between the Affordable Care Act's approval in 2010 and April 2016, the number of [Americans without health insurance](#) fell from 15 percent of the total population to just 9.2 percent.

### **Case Management**

According to the Case Management Society of America (CMSA), case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes." This definition should be familiar to all of us in this industry...but it was not always the case. (17)

*Case management became my non-clinical passion around 1990 when I accepted a position with Crawford and Company as a Worker's Compensation Nurse Case Manager. I can honestly tell you that I was not even sure what my job would entail. But before long before I*

*fell in love with the challenges of care coordination, the rewards of optimal recovery and RTW (return to work), the field independence, and the collaboration between providers, employers, lawyers and case managers.*

Ever since the early 1900s case managers have been contributing to health care. There is evidence of case management in the 1860s, where such techniques were used in the *settlement houses* occupied by immigrants and the poor. "Patient care records" consisted of cards that cataloged the individual's and family's needs and treatment, all aimed at ensuring that the patient/family received the services they needed for maintenance of optimal health. (18)

Just like the Nursing Profession, case management roots in public health nursing, social work, and behavioral health. The original public health nursing models in the 1920s and 1930s used community-based case management approaches for the provision of care in the home. Unbelievably, this model remained mostly the same as a community setting between the 1930s and the 1980s,

Long before hospitals were considered the "bees' knees" of the healthcare universe, case management was used for a variety of purposes in order to meet the needs of diverse populations of patients. Long-term chronically ill patients, the poor, pregnant and newly delivered women were a few populations we served.

At the conclusion of World War II, many nurses were employed as case managers to help to returning wounded veterans receive the appropriate interventions required as part of their rehabilitation. To date, this remains a significant area of practice with case managers playing a key role in the [Wounded Warrior Project](#). (17) "For the first time, the "continuum of care" was labeled, relating to the myriad of community health services that these injured warriors required and used." (18)

By the late 1980s, community-based case management programs were emerging in many parts of the country as a mechanism for managing patients and resources in workers compensation and capitated insurance environments.

The mid-1980s were witness to a flurry of activities, all designed to figure out how to improve the quality of healthcare while *reducing costs*. On the payer side, we saw the introduction of the prospective payment system with the diagnosis-related groups (DRGs) as the reimbursement model. (18) Enter...HMOs.

*It was in the mid-1980s when I was promoted from my surgical manager role to the very first Veteran's Administration Utilization Management nurse. I was taught how to maximize care coding through thorough documentation, the professional collaboration required between the payor's Utilization Management Nurse and the hospital, and my first exposure to an electronic healthcare system which assisted in DRG and optimizing reimbursement assistance. I scanned the charts for missed opportunities to maximize our payment and to appropriately use our facilities resources.*

The next significant change also occurred in the mid-1980s when health insurers developed *case management* programs targeted at the coordinating care for the catastrophically injured

or ill population. Again, the case management goal was to focus was cost containment due to a double-digit unsustainable inflation rate of medical costs.

*In 1990 when hired as a Worker's Compensation Case Manager with Crawford I was responsible for managing the day-to-day care coordination of injured workers while collaborating with the healthcare team of providers and attorneys.*

*In 1993, I was promoted to the position of Manager of Crawford Healthcare and Rehabilitation for Central Pennsylvania. In this role, I maintained an active caseload, marketed our program, grew the number of clients and staff, conducted educational sessions for client employees and managed our case management staff. I reviewed every employee case on a monthly basis for quality and participated in the decisions with Adjusters and Employees regarding surveillance recommendations. Admittedly, this was often a fun experience when we reviewed the footage of our back injured workers, especially during the Pennsylvania hunting season. One client was filmed dragging his big ol' buck from the woods and another was in the video pulling his boat from the lake and hitching it up to his truck. When working with the attorneys, this "short movie" evidence was often the segue to a claimants RTW, their exit from their company, or a final settlement and case closure.*

*Between 1993 and 1995, we quadrupled the size of our office staff and client base by creating an energetic, outcome driven, and skilled team of nurse case managers and social workers and achieved measurable positive results for our accounts, claim adjusters and employers.*

### **Managed Care Case Management**

In 1995, a friend called to tell me about a director position at Blue Cross. The position was to manage both utilization and case management services for over a million employees of both state and national employer accounts. I was eventually offered the Blue Cross position and began my orientation in early July 1995.

Thus, began a long tenure in program management by working for three different Blue Cross organizations in Pennsylvania (Pennsylvania was the only state that had 4 Blue Cross Plans), a large national Medicaid Disease Management Company, several Medicaid Insurance programs, and a Medicare-Medicaid program both in South Carolina.

Our health insurance case managers received patient care information from hospital case managers, home health care companies, physician's offices, social workers and other health care providers. In a few organizations, the nurse case managers traveled to the hospitals to visit their assigned patients on site for the initial assessment.

Insurance case managers can often assist providers and families cut through the red tape and could occasionally reach beyond the covered benefits and obtain approve items or services that weren't normally covered by the member's health insurance policy, but could be proven that care could be delivered more efficiently through a benefit exception, thus saving money in the long run. Insurance case managers provide two critical functions for their organizations; their priority is to meet the patient's individual needs while at the same time watching the bottom line and working toward established long-term goals.

During my first position as a Director with a Blue Cross organization, the practice of Case Management, and the Case Management Society of America were growing in their professional roles for the optimization of patient outcomes. However, unlike general nurses, case managers were working without consistent standards of practice. But in 1995, though, CMSA became the first organization to begin the development of Case Management Standards of Practice.

I am proud to say that I invited to participate in this endeavor. I was thrilled to accept, and I sat on the committee in Washington DC with an impressive group of national case management leaders, to assist in the development of these standards. I met life long colleagues during this experience with whom I've remained in contact through most of my career – many of whom are renowned authors, speakers, and educators of case management. I was so honored to be a part of this endeavor and included within this amazing group of professionals.

Thank you URAC for including me in this project and thank you to the many professionals on the committee who opened their arms to include me in this awesome opportunity.

## **IN CLOSING**

The healthcare industry is changing at a faster rate than ever before. Advances in technology and a shortage of student nurses and instructors needed to educate professionals are just two of the issues that could change the profession forever.

In 2001, a federal study predicted a nursing shortage by 2010 and a severe shortage by 2020. Nursing shortages occur on a cyclical basis, but the fear was that this time would be different, and the shortfalls might be permanent.

Compounding the situation is current evidence of a shortage of nurses with the retiring baby boomers. Government predictions believe that the available RN jobs will jump from 2.7 million in 2012 to 3.2 million in 2022. The numbers can't be fudged [source: U.S. Department of Labor]. There will be a nursing shortage in the coming years. It's not a question of if, just when.

I retired in November 2017 on disability, missing my retirement goal of retirement in December 2018. I have been in treatment for 19 years as of today for Rheumatoid Arthritis and its comorbidities. It is amazing as the years have passed the number of comorbidities connected to this immune deficiency disease. I did my best to circumvent the stress of working my way forward through these health issues without anyone around me in the workplace noticing. It was a challenging strategy I implemented; and it was not sustainable.

My retirement was short. quickly tired of 24/7 TV news, Sudoku puzzles, and walking the dog. Today, I happy to say, that I work prn for several non-medical personal care agencies as their assessment RN. My vision comorbidity is not nearly as negatively impacted from computer glare when documenting in a paper-based chart. I document at my own speed and

can use magnified visual devices as needed. My schedule can be set around my flares and symptoms. Once again I feel the value of making a difference. My career has come full circle, as I engage once again with my patients and their families face to face. As I filled out on my application to nursing school, I am helping people. I love it. Back in the day ... becoming a nurse was thought of as being a step down from a doctor, but the tides have finally turned. As one of the most important roles in the provision of healthcare, today nursing is considered being the backbone of the industry. After years of the relentless conflicting demands for better education, legislation and job conditions, we are now engaged in a profession that is valued and respected. (20)

Although healthcare industry developments related to access to care, society, medicine, and technology will continue to change the healthcare landscape, they will never replace the true essence of nursing-- helping people.



Cathy Kauffman-Nearhoof BSN, RN is a retired RN case manager. She is a graduate of Penn State University with 44 years of nursing/case management experience. Her active career years reflect multiple levels and types of healthcare, from Emergency Department to Hospice; and a variety of Care Coordination roles including worker's compensation, health insurance, Medicare and Medicaid case and disease management.

Today, she works a few hours a week for nonclinical in-home care agencies on a contractual basis as a RN Nurse Assessor.

She is the mother of two grown and successful sons.

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## CASE MANAGERS: THE GUIDES IN HEALTHCARE

By: *Robin S. Boltz, MPH, RN*

Like many other significant aspects of my life, I didn't choose to become a case manager, I randomly tripped into it. But, in retrospect, it was a natural role for me. Case management is the perfect role for clinicians such who view themselves as helping people, families, and communities move towards health.

Straight out of college, I was a cardiac intensive care nurse. My view of nursing was narrow; the good nurses worked in hospitals and the best nurses worked in intensive care. My patients often were fully sedated and their bodily functions – breathing, heart rate, caloric intake, and waste excretion – were adjusted based on protocols and physicians' orders.

If I had been older and wiser, I would have realized that being a highly technical ICU nurse was inconsistent with my granola momma, outdoors-loving personality. Deep down I've always believed that nutrition, exercise, and literacy are the basics for good health and many days I left work feeling as if I had contributed nothing.

This was the early 90's when hospitals were struggling to survive under the DRG prospective payment system. To reduce costs, nursing care underwent time and motion studies. Our efficiency was measured with stopwatches by strangers in suits who watched us give bed baths and IV medications. Alas, many of the things we nurses did were deemed technical tasks that could merely be "supervised" by nurses. Luckily, I never had to figure out how to supervise these tasks, while being out of sight and busy with my own "real" nursing tasks, because it was soon decided that the last hired 1/3 of the nursing staff would be replaced by patient care technicians.

But before my last day of work, I was approached by our chief cardiologist whom I had a great working relationship with. He described his current congestive heart failure (CHF) research and invited me to apply for a nursing position in his program. He gave me the details of an informational session which was occurring in just a few days. I promised him I would attend.

On the day of the informational session, I arrived to find an interesting array of highly credentialed cardiac clinicians. A PharmD specializing in CHF and a nurse practitioner launched into a detailed presentation on the actions and applications of several new and very promising heart failure medications. Being a mere RN, I was flattered that they thought I was worthy of this information. After all, I made no medication decisions, I just administered what the doctor ordered.

Soon the curriculum moved onto nonmedical factors, such as diet, and exercise, and stress, things that I had never included in an ICU care plans. Then a very passionate social worker presented aspects of family, community, and the environmental infrastructure of our city as components of care. I felt like I was the only realist amongst aliens. Sure, we had included these things in our academic care plans, but they had never been mentioned in the hospital.

Suddenly, I got the concept – these patients are at home! In my nursing career, I had never seen the human side of my patients. Of course I thought, outside of the hospital, they do eat, talk, walk, work, and love! I was enthralled to learn of highly advanced health care happening outside of the hospital, in real life. I had found a place where both my holistic view of health and my clinical knowledge were equally valuable.

Over the next five years, I learned to educate and motivate people to manage their CHF. We – our patients and the clinical team - designed and set up progressive walking programs in high crime neighborhoods. Before food desserts were ever defined as a primary community health factor, we persuaded neighborhood grocery store owners to stock whole wheat bread and vegetables; we started a group exercise program at the YMCA; and, very importantly, we connected their primary care physicians to the CHF program and collaborated with them on the new CHF medications and exercise treatments.

As a case manager, I felt responsible for the patients' whole health. But one patient taught me that while I could intervene in every aspect of her life, I could not impose my own or the program goals on her. My patient had been recently hospitalized and through conversation, we had identified the precipitating events. When I started to list actions to reduce her risks, she stopped me. "My goal is not to be well. . . that's your goal . . . I just want to be comfortable and have my kids visit me more often." Her frankness made me realize that when she was hospitalized, or recuperating from hospitalization, her kids were more attentive. I could list all the dos and don'ts on managing medications and meals that I could think of, but until I figured out a way for her family to be more present, my patient would end up hospitalized again.

After our very successful heart failure program lost research funding, 9-11 happened, and our country went to war. Being in proximity to the Dept. of Defense, my region was immersed in the urgent care and rehabilitation of injured service members. Contracts were awarded, and teams were formed at lightning government speed. Both leadership and expertise were needed yet the typical formal structures of authority were absent. For those of us who realized that there were no designated swim lanes, this opportunity for unbridled innovation fueled us. The nurses and social workers who did not thrive in our unstructured frontier left quickly, and the brave remaining team dedicated ourselves to the challenge and even quipped a working mantra which was stated daily, "hard, smart, and together."

And the work was hard. Due to technological advances in equipment and combat medical care, very high numbers, of the wounded military were surviving the type of bomb injuries that previously would have killed them. But we were blind to many of the injuries – sure we saved and treated the limbs, eyes, and other organs that were damaged by IEDs but still invisible to us were the traumatic brain injuries and hearing loss caused by just being in the vicinity of the blasts when no physical injuries occurred.

The count climbed of service members who had undiagnosed brain injuries with dysfunctional depression, and their subsequent self-medication with drugs and alcohol. For a couple of years, we also missed PTSD, with its consequential violence and suicide, which is now a



presumptive diagnosis for returning combat service members. And there *were other hidden injuries, odd and mysterious to us because frankly, we knew little about the Middle East* - inhaled toxins from burning oil fields and bombings of building materials unknown in the U.S., and odd, persistent skin infections.

We were not hired as, or ever identified as, complex rehabilitation case managers but the urgency and the complexity of the injuries required us to define this as our role quickly. We identified and split up the growing list of special needs, each choosing a specific condition to become the designated expert. With little research available, we partnered with military hospitals and orthotic/prosthetic specialists to learn the existing and newly advancing therapies, building relationships along the way to maximize our patients' opportunities to participate in all available care. During this time, Walter Reed and Bethesda Naval hospitals were continuously, with long waiting lists for both inpatient and outpatient rehab.

We did not accept the status quo of no access to care, but continuously compiled and reported on the number and location of patients who obtained or lacked outpatient physical and mental health therapy. Aside from our clinical coordination, we also learned about V.A. health care and its disability ratings, to demonstrate the urgent need for systems and policies to be updated from the peace era. Together, the civilian, military, and contractor case managers figured out how to do many things that we never did before. Examples include, what trigger words needed to be included to link a chronic condition to a military injury or how to advocate for a service member to be transferred to a civilian hospital so they could be near family; how to enter and approve claims in the military and Veteran's claims system, getting providers paid so they would continue to take our cases; how to research backward in time to document a combat event that would qualify our patient for continued V.A. care.

Yes, all of my case manager roles had few boundaries, and a never-ending need to learn and do more. But I am thankful for the case manager mindset that I maintain still. I hope always to have a sense of urgency, to learn because the more I know, the more I can do to improve my own and other's lives.

I've always thought of case managers as the expert pathfinders – the Sherpa guides of health care. And, like Sherpas, we must know multiple ways but can never learn all the methods on our own. We are educated, trained, and guided by other generous and seasoned health care experts, until, one day, we are the experts. And we lead and teach, and encourage, and pass it on.



Robin S. Boltz, MPH, RN - Using her guiding philosophy that people and organizations are always both the same and different from others, Robin improves health care outcomes by embracing both the traditional tried and true methods as well as unproven, new approaches.

# WE TEACH WHAT WE NEED TO LEARN: MY 2ND ACT NURSING CAREER AS A MEDICAL IMPROV TEACHER

By: *Beth Boynton, MS, RN*

At 63, I am very excited about becoming an elder resource for younger nurses and others. In this essay, I'll share with you my vision for the next generation of healthcare professionals, some highlights of my life and nursing career path, and an introduction to the emerging field of Medical Improv.

First, it seems important to share how powerful Improvisational Theater has been in my life. It has and continues to contribute to my abilities to:

- Trust how I feel and what I think. I don't have to be right or perfect to share an idea, concern, or desire.
- Be a confident speaker, teacher, and writer.
- Respectfully and confidently set limits and to honor those of others.
- Listen with an open heart and mind. Even when I am hearing criticism or points of view that I am strongly opposed to.
- Recognize when am feeling threatened or vulnerable. In doing so, I can gauge my ability to work through any anxiety and the need to attend to my own safety and how either may impact my ability to communicate that point in time.
- Say "No" and speak truth to power.

These kinds of skills and behaviors are fundamental for all of our interpersonal, interprofessional, and therapeutic relationships. When our relationships are healthy so too are our teams and systems. And the healthier our teams and systems, the better the care we provide. As such, I have a lofty vision for the next generation of nurses!

## A Vision for Next Generation Nurses

Nurses interface with the full spectrum of humanity, pretty much all over the world. The opportunities for us to spread compassion, empowerment, love, and healing are endless. And, there are a lot of us. So, the rippling effects of such efforts will have local and global significance in a world fraught with fear, violence, and hate.

Our individual and collective ability to spread these ideals calls upon us, not only to develop clinical expertise but also to foster high emotional intelligence and effective, respectful communication skills. This skillset often referred to as 'soft' skills supports our capacity to be self-aware, reflective, confident (even when we don't know the answer) moderate behavior (our own and other's), show ownership, honor alternative perspectives (even when we disagree and even when we feel vulnerable), listen with non-judgement, manage conflict, share power with physicians, peers, patients, and families, speak up to power, and take care of our own health and wellbeing.

These skills are the foundation of respect for self and others. They are essential for:

- Eliminating bullying behaviors.
- Creating and sustaining cultures of safety.
- Building a system that is responsive to dependence while empowering independence.
- Modeling dignity.

They can help us in healthcare to provide safer care and optimal patient experience while experiencing more joy and meaning in our work. And, as lofty as it may sound, they will contribute to the wellbeing of our societies and world.

So, I am passionate about helping nurses and others develop 'soft' skills and using Medical Improv as a safe, effective, and fun strategy for doing so! Next, I'll share some of my story that has led me here and follow with an introduction to this unique form of applied improvisation!

### **Career Path & Life**

I already had a BS in Biochemistry and minor in Theatre and Communication before beginning an AD Nursing program in 1985. Unlike some nurses, I didn't have a strong calling to become a nurse. Rather, jobs were scarce, I was interested in healthcare, nursing schools were enrolling, and the papers were full of work opportunities for RNs.

Given my strong science background and to some extent the public image of the nursing profession, I thought a career in nursing would be easy. **WRONG!** I was totally surprised by how demanding it was.

To this day, I don't think people realize how smart nurses are!

Nevertheless, I found myself inspired by my teachers and classes. I graduated with honors and was very excited to begin work as a Med-Surg RN at a small community hospital. It wasn't long before I experienced some of the overt and covert abuse that nurses are often subject to. I remember a patient withdrawing from morphine backing me up against the wall in his room and trying to choke me and a surgeon who humiliated me while I was trying to assess an infiltrated IV in a patient's room early in my practice.

After a year or so, I left the hospital and took a job as a clinical director at a women's health center. There I found myself questioning my sexuality and falling in love with another woman. I was surprised and a little confused because my previous relationships had been with men and I was generally happy with that! This relationship flourished, and we did the typical next steps of living together, buying a house, and starting a family. In 1991, my partner gave birth to the most amazing baby boy, and I became his non-bio Mom! (Curran, now 27, is by far my biggest blessing.)

From the women's health center, I moved to work in Occupational Health and Home Health. The role of Case Manager was emerging in both areas. I worked closely with a variety of organizations on their workers' compensation cases and often found myself in the position of advocating for injured employees while trying to appease concerns of managers and supervisors. I liked and was good at this advocacy work and could see how relationship and power dynamics between injured employees and supervisors often made a difference in how successful recovery and modified work efforts were. I also enjoyed the autonomy and was good at bridging relationships.

My first attempt in starting my own business was in the mid-nineties when I tried to build a consulting firm to help business leaders avoid adversarial relationships with injured workers by improving communication and relationships with them. Alas, it wasn't meant to be. We needed money, and so I went to work as a nurse liaison for an occupational health clinic. This was an excellent job for me, and I loved working with the medical director and therapy team to facilitate employees' recovery and return to work. We didn't call it Case Management back then, but it was an early form of it, especially when there were problems.

Things were going pretty well until shortly after my son started first grade, my partner left me for someone else. I didn't see it coming, and as you might imagine, this was a pivotal and painful period in my life. I was devastated by her betrayal and really scared that my relationship with Curran would be in peril. This was back in the day when same-sex parents were not typical in elementary schools in the northeast.

I got into counseling and struck up another of the most important relationships of my life....with my therapist! "You have to stay visible in the school", she said in one early session. This wasn't easy. I didn't have a lot of family support for my role as Curran's Mom, but the school and teachers were excellent. In retrospect, I think they could see my fierce love for him and that he needed my stable influence.

Part of rebuilding my life, as I was learning in therapy, involved developing healthier relationship and communication skills. While I had been a great advocate for others, being assertive for myself was unfamiliar. I had learned growing up that looking for ways for people to be dependent on me was a way I formed relationships. Caretaking at its finest! This is a very complex co-dependent pattern and took years of work to understand and break out of it. I often found myself a small step ahead of my son, in teaching him about assertiveness as I was learning and practicing it myself.

I changed jobs a couple of times trying to accommodate a schedule that worked with being a single parent. Very determined to be home every minute that my son was with me, which was, thankfully, 50% of the time.

Being a Home Health nurse gave me the flexibility I needed which was great. However, practicing my new assertiveness skills was not well-received in the culture. Saying "No" to one more patient visit upset my peers and supervisor and needing help when none was available was frustrating. I came to see how difficult being assertive was in a culture that

didn't support it. Feeling frustrated with my work as an RN I decided to go to graduate school for Organization & Management.

Around the same time, my son, now in middle school and I took a community improv class together. He loved theater and although somewhat shy, shined in that environment. I had a little bit of a theater background, and it worked for our schedule. We had a blast, and I started to see how improv activities could help me become a better communicator. I've been hooked ever since.

In graduate school, I built a model that used theater games to teach emotional intelligence to children. The model was for younger kids, so Curran helped me teach which was good for him and them and me! I was on the fence about my nursing career back then although continued to practice in home health part-time.

Shortly after earning my Masters, I had a chance to teach a class of healthcare administration students working on a certificate program at Antioch College. We used the Institute of Medicine book, "Crossing the Quality Chasm" which made it very clear that communication problems were at the root of many patient safety issues.

I realized that all of the work I was doing with kids could be useful to us in healthcare. Over the next decade or so, I began to write and teach workshops that focused on building emotional intelligence and communication skills for healthcare professionals. And the more I teach these skills, the more I see that integrating experiential activities from improv is the most powerful and effective way to build these 'soft' skills. There is nothing like having an experience of being heard to value and develop skills associated with listening!

Around 2011 I presented a workshop at a public health forum at New York University using improv to teach communication and collaboration skills. One of the activities I did for a small group of theater education and healthcare students was an activity called "Overload" which requires one person to count to 100 by fours while answering simple personal questions from one person, figuring out simple math questions from another, and mirroring the physical movements of a third person.

Watching these students do this activity struck me as an extremely powerful way to raise awareness about what nurses experienced when multitasking and relentlessly interrupted and to spark discussion about limit-setting. From here I created a workshop that led to a YouTube called, [Interruption Awareness: A Nursing Minute for Patient Safety](#) and shortly after attending the first "Medical Improv" train the trainer session at Northwestern University. These experiences sealed my decision to focus on improv as a teaching tool.

### **Teaching Improv is My 2nd Act!**

Over the next few years, I wrote the industry-first book on Medical Improv To explain the links between communication-related skills and key outcomes like patient safety, patient experience, and workforce health and prepare healthcare leaders to teach fundamental

activities. Locally, I founded the Portsmouth Improv Learning Lab (PILL) where I teach classes that help people grow personally, have fun, and meet new people. I get a chance to try activities and tease out learning opportunities such as this recent post about [perspective-taking](#) reveals. PILL has also brought together a group of students who have become part of an improv troupe called the "Out of the PILLbox Players" and play an important role in train the trainer work I do.

You can see us [here](#) in an activity called *Same Time Story* adapted from Viola Spolin's *Theatre for the Classroom*, that can be used to teach attentive listening and empathy.

Currently, I travel around the country teaching medical improv workshops. I also, direct filming sessions that provide video included in a growing library of train the trainer resources. I am also working closely with friend and colleague, [Liz Korabek-Emerson](#) who teaches mindfulness. We've been combining meditation and improvisational practices as a teambuilding and stress management workshop for all businesses. We call it, Fiercely Human - Crazy Wisdom.

I have recently unveiled my new business and website, [Boynton Improv Education, LLC](#), which houses my work in medical improv, the learning lab, and collaborations. I am also volunteering on the content committee for the 2019 Applied Improvisation Network Conference in Partnership with the Alan Alda Center for Communicating Science at Stony Brook University, New York, USA! I can't wait to attend and possibly present at this conference. I have recently joined the education team of the HumanDHS (Human Dignity and Humiliation Studies), a global transdisciplinary network and collaborative community of concerned scholars, researchers, educators, practitioners, creative artists, and others. This is an honor and aligns with the deepest roots of [what improv experiences can be](#). I am also under contract with F. A. Davis Publishing Company to co-author the 3rd edition of "Complexity Leadership: Nursing's Role in Health Care Delivery" with the original author Diana Crowell, PhD, RN, NEA-BC. Diana has been a pioneer of this topic and of self-care for nurses and I'm delighted to be working with her.

I feel very blessed in my life and work as a mom, nurse, writer, and improv teacher. If you would like to know more about my work, please don't hesitate to reach out to me at [beth@bethboynton.com](mailto:beth@bethboynton.com). And good luck to you in your own life and work. I wish you a safe, joyful, and inspiring path!



Beth Boynton, RN, MS is a nurse consultant and author specializing in respectful communication, collaboration, and culture in healthcare and other businesses. Her books, blogs, videos, and other publications build on the idea that respect for self and others is essential for healthy relationships, teams, cultures, and all human systems. In healthcare, respect is critical for safe, compassionate care of patients and families and for the wellbeing of the workforce. Beth has written 3 books on communication in healthcare, is the creator of the Teach Medical Improv [train the trainer ebook series](#), and a member of the Human Dignity and Humiliation Studies Education Team. [Learn more.](#)



## CASE MANAGEMENT: COMPASSION AND CARING WITH A PURPOSE

By: *Elaine A. Bruner, MSN, RN-BC*

My path to a nursing career was pretty direct; I don't recall wanting to do anything else. As a teenager, I volunteered as a candy striper for two years, in a large academic hospital. I was attracted to the multiple roles for nurses, mainly in acute care.

During my undergraduate studies, I was able to work as a nurse extern, between my junior and senior years. This experience, with the University of Virginia (UVa) Medical Center, solidified my interest and I completed my BSN in 1982 during the advent of the AIDS crisis, the early years of managed care, and a nation-wide nursing shortage. Relocating 700 miles away from my hometown, I started as a new graduate nurse with UVa.

My nine years with UVa included roles in an oncology unit, as a nutrition support nurse and completing my MSN in Home Health/Case Management. After finishing my graduate studies, it was time for a change, so I moved to work in Richmond, VA where I joined a hospital's home infusion team then transitioned to home health care practice followed by working with an Area Agency on Aging (AAA) as their home care coordinator. From the AAA, I continued to work in community-based care, leading to a role as a hospital-based home care coordinator. This is the job that piqued my interest in case management as a specialty healthcare practice.

I returned to acute care as a nurse case manager for an orthopedic unit then moved to a traumatic brain injury (TBI) rehabilitation program. After moving to Texas, I continued in rehabilitation case management and then moved to critical care case management for several years.

Returning to Virginia, I joined a military hospital as their TBI case manager for three years then two years as a primary care case manager with a large hospital system. Recently, I have returned to military CM as the Nurse Case Manager for Special Warfare.

When I reflect on what led me to a case management career, it certainly was a natural progression from my previous nursing roles. Like many case management colleagues, on the job training "OJT" came from co-workers, supervisors, and my studies. Case management practice combines the best of clinical knowledge, system-wide engagement, and life-long learning. Case management has allowed me to become an educator and mentor as well as an author. I suppose I shouldn't be surprised since I was voted "Most Likely to Teach" thirty-seven years ago by my undergraduate classmates.

The diverse CM roles I have worked have allowed me into individual healthcare journeys where compassion and caring are central to successful outcomes. As a case management educator, I am invested in colleagues who are pursuing case management certification or those entering the case management field where an experienced nurse case manager offers resources and coaching. Mother Teresa said it best, "Not all of us can do great things...but we can do small things with great love."

Case management has offered me several life lessons involving self-determination, advocacy, and unconditional love. Here are a few examples. During my home health jobs, I met an older



woman who lived alone in a rural county outside Richmond, VA. Mabel was blind, with several chronic medical conditions plus a lower extremity amputee. It seemed that her dog, Scrapple, was her only companion as I never met anyone else in the five years I worked with her. Soon, I came to know Mabel's son who infrequently appeared with groceries and supplies. I suspected he was diverting her food stamps and Social Security checks, but Mabel would never agree to pursue legal action. She reasoned that if she got "involved with the system," she would lose her home. Mabel tolerated her son's behavior to preserve her autonomy and way of life. To be honest, Mabel and Scrapple did better than many other families on my caseload.

My experience with Sue and her husband, Chris reminded me that unconditional love overcomes adversity and supports you in the worst circumstances. Sue was a young artist with dilated cardiomyopathy. Her condition worsened to the point of introducing hospice care. The conversation where Sue and Chris met with me to discuss continuing treatment options, including hospice, is embedded in my mind. Chris was adamant that more could be done to extend Sue's life even though she required maximal assistance with personal care and was becoming more fatigued. Sue turned to Chris and essentially shared that she was suffering more each day and that she knew that he loved her enough not to extend her life. She asked him to agree to turn off the implanted defibrillator and stay with her until her last breath. Chris agreed, with tears running down, holding Sue tightly. He loved her enough to let her go.

Finally, advocacy is critical to CM whether I am the advocate or coaching others to advocate for their needs. Families and caregivers for mild traumatic brain injury survivors face life-long challenges involving psychosocial issues, prolonged symptoms, and living with an invisible wound. This is especially true of our young veterans whose lives have been profoundly altered due to their military service. Ann and Mike are one example of the tenacity and advocacy required to continue in life. Mike was medically retired due to Traumatic Brain Injury and Post Traumatic Stress Disorder. Throughout the medical retirement board, his wife, Ann was by his side taking notes, asking questions, and contacting me frequently. Other TBI team members considered Ann a nuisance; however, I knew how fortunate Mike was to have his wife. Ann never let up in her campaign to access services or pursue all the benefits Mike was entitled. Five years later, when his permanent disability was denied, Ann and Mike appealed, without legal counsel, and won. Ann refused to accept that her husband's service was not deserving of full benefits. She was relentless in gathering evidence, working with me, and Mike's behavioral health providers for that reversed disability decision. Their future as a family depended on that disability appeal, and Ann was willing to do whatever it took. Ann's actions remind me to never give up despite unfavorable odds.

My CM practice has followed many amazing people who forged a path for me, and others, to be successful in this specialty. As I reflect on what the next generation of case managers needs to know and be prepared for, here are my thoughts:

\*You care for people. As the Internet of Medical Things and artificial intelligence increase their presence, you must remember that you care for people, their healthcare decisions, and not the machines, the numbers, or the money.

\*Be mindful of your moral compass. You live with every action you take; ensure they are grounded in your values and beliefs.

**\*Embrace lifelong learning. Our healthcare environment changes too rapidly to rest on what you knew last year, last month or even yesterday.**

**Facing retirement in 7-8 years, I know that I will remain engaged in nursing and CM practice, most likely as a mentor and educator. My thought is that many Baby Boomer Case Managers can share their knowledge with those entering CM practice. My family will ensure that I balance professional activities with travel, volunteer work, and learning new cake recipes.**



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## A CATASTROPHIC INJURY LEADS TO A CAREER IN CASE MANAGEMENT

By: *Carol Canada RN, BS*

I always wanted to be a nurse; I was a candy striper in high school. I believe we all have a calling if we would only listen to our inner voice. I was not a nerd in high school; it was during the late sixties and early seventies, so my grades were good but not stellar because I loved to go out to concerts with my friends and listen to rock-and-roll. After graduation, with no scholarship in sight, I became a nurse's aide. Eventually, I saved enough money to go to LPN school and studied hard to become top of my class.

I loved working in the hospital and started in Pediatrics. I dreamed of someday being able to go back to school to become a registered nurse; I wanted the black stripe on my cap! It was in my early twenties I fell in love and married, I thought all my dreams were coming true. By my latter-twenties, I had two beautiful children and single again. I reflect now and see that when one door closes another will open.

I decided I needed a change, so I moved from Arizona to California where my sister was living in Los Angeles. I found a job, but soon found out my salary of 176.00 dollars a week was not going to cut it. I had a toddler and five-year-old and barely enough to keep a roof over us. One night I was praying and seeking answers and direction, and I will never forget an overwhelming peace came over me, and I knew I must find a way to go back to school.

I applied for grants and got them, I was grateful and enrolled in school. The next few years were an endless time of study, caring for my children and having faith that I could keep the lights on. One time I broke down and called my Dad and said couldn't do this anymore, his sweet voice replied, "Your tough Carol I believe in you, you can do this." The day finally came, I will never forget my graduation, standing on the podium looking at my babies and feeling a real sense of joy and accomplishment. I made it; a new chapter was to begin.

It was time for another life decision and knew I must move back to Arizona to have my kids closer to their grandparents. So off we went again, I got a fantastic job and began working in the Cardiac Unit, shortly after that I floated to the Emergency Department and soon found out this was my calling. I took every available course and certification that would enhance my knowledge; it wasn't long before I was moving up into leadership roles and I loved my profession. The years were passing, and I was content, little did I know my life and career would take another turn.

In the summer of 1989, an offer came my way with the hospital I worked for to spend the summer working in emergency services at Grand Canyon National Park. The hospital system and the National Park Service had an agreement that would provide services at the Grand Canyon Clinic. I was excited, and my children were thrilled since they were out of school. Off we went and set up house in a tiny cabin provided for us with by Park Service at the south rim of the Grand Canyon.

The clinic was bustling 24-hours a day, three nurses and two doctors handling cardiac emergencies to simple squirrel bites. My experience was pushed to the limits as we life

flighted people to Phoenix or Flagstaff. With limited resources, no CT scan, no MRI, we handled it all. You must imagine the nearest hospital was two hours away and the nearest Level1 was four hours away.

My children and I loved the starry nights, the cast iron stove that heated our cabin, and the wonderful people that lived there. Rangers, park police, wranglers that managed the horses and mules. We were a tight-knit community; our time was spent exploring all the Canyon has to offer: cookouts with friends, hay rides in the woods and the smell of pine cones.

The summer was ending, and we decided to stay on for another year. The winter was harsh, and soon it was Christmas, I decided to go home to Phoenix for the holidays and return Christmas day because I had to work the following day. It was a great week, and as the time came to return, my mother said she would keep the kids until New Year's Day. I did not know what a blessing that was until days later. While traveling back to the Canyon the weather got ugly, and we hit black ice, the vehicle rolled over several times landing us in a ditch. I remember it all, mostly though that I could not move and was losing consciousness, it was not very long before I thought my life was ending. I had a near-death experience and felt comfortable as I whispered: "who will care for my children?" After about two hours emergency services reached us and I was flown to a trauma center in Phoenix with spinal and head injuries.

It was touch and go for a time, but eventually, I could move my legs! After a very long recovery and rehab, I could walk. Then the reality of my career hit me, what was I to do now that I could never lift patients again. Everyone was telling me to file for disability except for my wonderful doctor, who encouraged me and pushed me to find anything in nursing.

So, this began my journey to Case Management. I finally acquired a position at a newly opened HMO clinic as a nursing supervisor. It was the 90's, the era of HMO's coming into Arizona and this was a large multidisciplinary center out of California. The center was bustling with patients, and we grew and expanded. Soon after I received a call from the corporate headquarters which conveyed to me, they wanted to start a Case Management operation in our clinic. They explained the focus and that we would be a test sight, I accepted the challenge.

I had a wonderful mentor out of California, Sherry Aliotta RN, she was the Director of Case Management for the Health Plan. She remains a leader in Case Management and a peer I highly respect. We were both on this journey. She provided the process development and what we would focus the big three: heart failure, COPD, and diabetes. She provided a format for initial assessment and practice guidelines and introduced me to the standards of practice and CMSA. I reached out to the surrounding hospital discharge planners, and we started to monitor those members admitted and discharged. The physicians were noting improved compliance with patients and fewer re-admissions. The hospitals were noticing less denial for payment, and the patients were healthier and happier, it was a win for all of us.

I continued to make connections in the community with individuals striving to develop and grow case management programs. I received an offer from a hospital to come on board with full support and to develop a Case Management program. I was so excited to accept this

challenge, a little apprehensive but excited. We built the program with its core based on CMSA Standards of Practice, regulatory guidelines, and reimbursement.

This was an early stage of HMO or managed care contracting with acute care. It was a massive transition for acute care hospitals and a wakeup call when it came to delays or denial of days. The program had to encompass discharge planning, utilization, and reimbursement. Education in Case Management was a priority for my staff and myself, I reached out to other hospitals in Arizona, and we started a small group that met after work to share ideas. It wasn't long before we decided to contact CMSA and ask to start a chapter in Arizona. It was an exciting time, and I was honored to be the first president, our chapter grew quickly. Vendors were eager to be part of the chapter, and soon we had 100 plus members. Our luncheons at times had 150 attendees comprised of members and guests from outlying areas. In that year, the Arizona chapter was chosen the fastest growing chapter for CMSA.

During this time, I met many wonderful individuals from across the country involved in growing and standardizing the practice of case management. Leaders from CMSA came to our meetings provided invaluable education to our case management community. We also reached out to Social Service professionals as they were also getting involved as case managers. It wasn't long before we could realize the considerable impact the profession of case management had across the healthcare continuum.

I continued to grow in my profession traveling to conferences and eventually being part of the national board at CMSA as part of governmental affairs committee. I acquired positions as Director of Case Management, also web and content development for healthcare web-based programs. Later in my career, I had the opportunity to travel and consult in Case Management in hospitals, educating and improving models.

I've long realized that Case Management programs need to evolve as healthcare changes. I firmly believe the core practice of case management must stay the same to protect the integrity of the profession, the patient and the institution you work for. Keeping yourself open to new challenges will keep you on the forefront, engaging with your peers and sharing ideas. Now that I am in my golden years, I want to continue to act as a mentor, educator, advisor for program and process development. It has been a great career!



Carol Canada, RN, BS, is the founder and president of "Case Manager Care" featuring a software product for collecting case management outcomes. She is a founding member of the Arizona Chapter of the Case Management Society of America and served in the past at the National Level. She is known for her continued effort in education and development of Acute Care Case Management. For the past several years her passion has been to develop and demonstrate the contributions hospital case managers make in the delivery of quality cost effective care. Currently, she is available as a mentor, advisor, educator and program enhancement provider. She can be reached via email at [carol.canada@gmail.com](mailto:carol.canada@gmail.com)

## TRAVELING THE ROAD TO IMPROVE HOSPITAL CASE MANAGEMENT

By: *Stefani Daniels RN, MSNA, ACM, CMAC*

I always wanted to be a nurse. Chalk it up to the Cherry Ames books I read as a kid, but the desire never left me and eventually led me to Hunter College in New York City. Marriage and children interrupted my plans, but I got back on track and graduated from Albert Einstein Medical Center School of Nursing in Philadelphia.

I had to talk myself into my first job as a cardiovascular care nurse when I was informed that new graduates are never hired to work in critical care. My persistence resulted in three great years in the CV surgical unit at Cooper Hospital in Camden, New Jersey. Not only was I able to broaden my clinical knowledge and gain a greater appreciation of patient-centered care, but it was also the first opportunity I encountered and learned to adapt to the 'politics' of health care. It was during my tenure at Cooper when I began to envision a more definite sense of a career path; one that would lead me to seek further education and positions of increased responsibility in hospital administration.

The ensuing years found me at Stockton State College in New Jersey, Villanova University in Pennsylvania and several nursing leadership roles till I landed a position as Executive Vice President for business systems at Graduate Hospital – a division of the University of Pennsylvania, where I participated in executive-level operational management and financial planning.

When the CEO was replaced, I landed a position as a chief nursing officer and assistant administrator in a 150-bed community hospital in Margate, Florida. It was then that I came across several articles describing a new nursing care model developed at New England Medical Center (NEMC). It was an innovative change in the way nurses coordinated the care of their patient and involved the nurse accompanying her patient as the patient transferred from the originating care unit to another care unit. The resulting face-to-face hand-off by the newly minted "nurse case manager," meant that the receiving care team had current information about the patient's diagnosis, treatment plan, the patient's response to medical and diagnostic interventions, the initial post-acute plans, and the family's preferences for a transition.

Coincidentally, the leadership team at our hospital, which was part of a national, for-profit hospital system, was charged with developing new strategies to reduce the costs of care, reduce the fragmentation of patient care activities, and streamline organizational quality improvement efforts. Using the concepts introduced at NEMC and insights gleaned from related articles, I created a team of case managers at Northwest Regional Hospital who would work with the medical staff to "coordinate the patient's journey through the acute care continuum by means of resource conservation; seamless delivery of prescribed services; timely communication among providers, payers, families and patients; and discharge planning." I recognized that it may not always be feasible for a nurse to leave her 'home' unit



to accompany her patient to another, so the new team was not part of nursing, but were integrated into a new Quality Resource Management department. The experience was published in the National Association for Healthcare Quality's Journal for Healthcare Quality in 1996.

Our case management team emulated the goal of the NEMC model by coordinating care across inpatient units as the patient journeyed through acute care services. We were quite successful and met all our goals but I soon realized that only a certain personality had the skill-set to make meaningful inroads into the coordination of care since it meant establishing a close partnership with members of the medical staff. Our attrition rate was high at the start, but once the 'right' people were recruited and oriented, we had a dynamic team of savvy professionals who knew how to gain the respect, and, I might add, the admiration of the administrative and medical staff.

After the hospital system was acquired, I found myself out of a job but started getting calls from doctors and colleagues of doctors who wanted to learn more about the case management program I developed at Northwest. I started visiting those hospitals to offer advice and guidance, and before I knew it, I had a business. That was the start of my Second Act. I recruited some former colleagues to help me, and we slowly grew together into Phoenix Medical Management, Inc. (PhoenixMed). No, it wasn't named after the Arizona city, but after the mythical bird who rises from the ashes for a second chance.

Soon after, I was asked to join a national consulting company to help them expand their case management consulting division which I did willingly thinking that I could learn a lot from the business activities of a national consulting firm. Unfortunately, it didn't take long before I realized that this company was sought after for its management engineering expertise and its success in creating case management departments by consolidating utilization review and social work. There was no evidence that care coordination was on the minds of any of these hospital leaders nor the firm's principals; their mutual goals were to reduce overhead costs as quickly as possible. Those goals generated recommendations ranging from switching from two ply bathroom tissue to single ply, and eliminating social workers as superfluous with short lengths of stay. I left the firm shortly thereafter and returned to the work I started doing at PhoenixMed in 1994.

Over the years, PhoenixMed has been engaged in projects to develop new case management programs as well as transforming old ones. In every case, I know that it is essential to make sure the leadership team has a mutual understanding of what care coordination is all about. Too many C-suite occupants have little appreciation of the value of coordinating care as they did at New England Medical Center all those years ago. I'm hopeful that the current marketplace will force their hands without constraints of hospital case management leaders who fail to see the forest for the trees.

In preparation for my retirement, PhoenixMed is no longer accepting long-term case management transformation engagements. But I still have a Third Act ahead of me and shall remain an assertive voice for care coordination in the hospital and through the entire



continuum. I've accepted several invitations to provide education on hospital case management best practices and some short-term consulting gigs, but it's time for the next generation to take up the cause of hospital care coordination and tear down the walls resisting change. The entrenchment of ideas that has perpetuated hospital case management as a functional department to perform discharge planning and utilization review has deprived hospitalized patients of a pro-active advocate to coordinate care.

Looking back over my career, there are many 'lessons learned' both in the field of hospital administration and case management. My top three, in no particular order:

1. When embarking on a project – any project – make sure that among those who will be evaluating you and the project you've designed, there is a consensus about the vision and goals they anticipate. In my experience, especially in the field of hospital case management, I have found that the CFO may have a vision entirely different than the CMO and unless they are in harmony from the outset, there is bound to be challenged.
2. Successful hospital case management requires – no, - demands self-confident, self-assured clinicians who accept the role of a proactive patient advocate. Without assertive advocacy, the average patient rarely has a voice in the hospital environment.
3. The hospital is the only American corporation with a dual governance system. Understanding the politics that influence the relationship between these two divisions is essential to be successful. Case management leaders must study the 'politics' of their hospital and use their new knowledge to move hospital case management programs forward.



Stefani Daniels, RN, MSNA, ACM, CMAC is founder and managing partner of Phoenix Medical Management, a national case management consulting company. Ms. Daniels is a member of the editorial boards of Lippincott's Professional Case Management journal and HCPro's Case Management Monthly. She is the co-author of the 2<sup>nd</sup> edition of *The Hospital Guide to Contemporary Utilization Review*, the text *The Leader's Guide to Hospital Case Management* and a contributing author to the 2<sup>nd</sup> & 3<sup>rd</sup> editions of CMSA's *Core Curriculum for Case Managers*. If you would like to reach Stefani, feel free to email her at [daniels@phoenixmed.net](mailto:daniels@phoenixmed.net)

## HOW CAN I HELP

By: *Linda DeBold ARNP, MSN*

Dreams of becoming a nurse began in High School. The science of the body fascinated me. I've always been steered to the medically complex patients. I started my career in nursing in 1983, with oncology patients both adults and children. Then onto a GI station where I found the gut was not so simple. It seemed every 3 to 6 years I moved to learn more in-depth knowledge. Lucky I was to be able to stay within the same large hospital system. After completion of more studies at Barry University, I entered the world of critical care, specifically medical intensive care "MICU."

By 1995 as an ARNP/MSN I began to care for the complex pulmonary patients, on vents. Leading a multidisciplinary team that included physicians, pharmacy, Clinical Nurse Specialists, dietary and nursing. Together we worked wonders for our patients and the hospitals' bottom line.

As my world continued to turn up new opportunities the term "CASE MANAGER" reared its head and I jumped in as a case manager of ventilated patients. Before long I entered the world of management. First as a coordinator, then as a manager, an eventually a director, yes in case management.

What I had learned from my years of working was that leaders come in several different aspects. My goal was to take all the good and great leaders qualities and merge them into my style of management. Early on I truly learned that knowledge is power and every day you can learn something. The Clinical Nurse Specialists role was one that always fascinated me. My mentors came from that group. Expanding your role in nursing was important; risk-taking and accepting change became my traits for accepting new and challenging things.

Nursing continues to expand its knowledge; the major concern is NOT to forget "the patient" and to ask "How can I help." Perception of needs and knowing when to intervene will be the next generation's conquest. Ethics continues to drive my interests in caring for patients. A patient advocate is what I want to be known as. One CFO I worked for would always say "Yes I know Linda, it's about the patient." He finally got it!

Now after 35 years of full-time nursing within the hospital, I've settled into teaching at the college level. New nurses and continuing education for currently employed nurses are my students. In addition, I do some consultations for assessments and evaluations of case management systems.

My favorite post-retirement work is in the simulation lab. Working with resident physicians as

they learn to perfect their assessment skill so they can become proficient physicians is a good day.

My family is important and the time spent with them is what I do best!

The curtain is not coming down on my nursing knowledge. Friends and family keep me busy with listening and guiding them within this ever-changing web of health care...

My jobs were exciting, and my patients made going to work every day something to look forward to.



Linda DeBold ARNP, MSN - My career as a nurse has been very rewarding. Starting with Graduation in 1985 from Broward College. Working as an oncology nurse certified for 5 years. I returned to classes for the BSN/MSN track at Barry University, graduating in 1995. Medical ICU nurse and from there I entered into the world of case management. Managing ventilator patients, saving patients and saving dollars was my specialty. Soon after a national recognition at NTI, I entered the leadership role in case management. Upon retirement I've been an adjunct professor at Broward College, using my skills to foster the role of simulation with nursing and medical students. As I look back, I'd change nothing. Looking forward I hope to continue to contribute to the profession for a few more years

## NEVER STOP LEARNING AND GROWING

By: *Maria Dias, RN*

In 1965 I was a junior in high school and taking a business curriculum. My two-year-old nephew/godchild was sick, and my sister asked me to go to the doctor's with her since she was somewhat squeamish when it came to blood. The doctor sent us to the hospital as Tommy had a ruptured appendix. He was very sick and we didn't know if he would make it through the night. I prayed to God to let him survive and told him I would become a nurse to help other people if he would spare Tommy. As Tommy got better, I took the time to talk to the nursing staff. They thought I would make a good nurse and told me about an LPN program as a beginning step.

After I finished the program, I worked as an LPN on a major surgical floor at a teaching hospital in Connecticut. Back then, we had to rotate to the night shift, seven nights out of the month in which I was in charge of a 46-bed unit with one, or if lucky, two aides. That was a lot of responsibility for an LPN!

In 1971 I moved to Florida with my husband and started working at a local hospital. I hated it! I couldn't believe how demeaning the RNs were to the LPNs. The LPN'S weren't allowed to count narcotics without an RN. We couldn't draw up Heparin or insulin without having an RN check the dose. I thought it was just the new environment and forced myself to stay for six months. One day a tracheostomy patient was transferred from ICU to my floor. None of the RNs knew how or wanted to take care of a trach. Since I had worked on a major surgical floor, I took the patient and instructed the RNs on trach care. This provided me with a little more respect from the RNs. A new hospital was built in the area, and I went to work there. This was a very friendly atmosphere. The nurses encouraged me to take a class with them to help with hospital emergencies. I said sure, not realizing I had just signed up for EMT 101. Although the class was held at the hospital, we had to go to Broward Community College to sign up. Since I was enrolled in the college, I started taking prerequisites for the RN program which had a two-year waiting list. After my son was born, I continued to take classes and was ready when there was an opening in the program!

I graduated in 1977 and started working at a local hospital through the hospital pool. Due to a new hospital policy which forced me to work weekends, I had to leave since I didn't have a sitter for my son. I started working at an Osteopathic Hospital through the pool which didn't require weekend duty. The staff and doctors were great, and we worked as a team. I gained an array of experiences working on every floor of the hospital including ICU, ER, and the Recovery Room.

After having 25 years of hospital work, I felt it was time for a change and joined the largest Asthma & Allergy practice in South Florida. The practice was sold, and the new owners felt we were overstaffed with RNs and let me go, only to call me back two weeks later for their corporate office to become their Internet Allergy & Asthma nurse on their website Breathingzone.com. I answered contact questions on the internet in real time. This was quite the computer education. They put me in an office and purchased two books for me, Internet Explorers 5 for Windows for Dummies and Word for Windows 95 for Dummies. I started on page one and taught myself how to use the computer so I could do my job. Unfortunately, the company went out of business after one year.

Shortly after leaving the company, I ran into one of the doctor's from the practice who wanted to know where I was working. When I told her I was unemployed, she insisted I return to the office and contacted administration to get me back. I became the charge nurse for three offices with all the responsibilities and stresses of that position.

After twelve years of working long hours, my husband showed me a postcard that had come in the mail. It was for an open house for a Utilization Review/Case Management position. The supervisor who interviewed me felt Utilization Review would be a good fit with my past experience. I no longer was in charge of a staff of nurses, only myself. I LOVED IT and worked there for 8 years until the company decided to change all the computer programs and go paperless. This sent me into a panic, and I decided it was time to retire.

I felt working in Utilization Review/Case Management taught me time management and organizational skills along with additional computer skills. I was very detail oriented, and a supervisor once told me, "why wash the kitchen floor with a toothbrush when you can use a mop?"

My career has taught me the confidence to go after what I want and find a way to do it. Everyone loves to get together with like-minded friends, but you need someone to take the initiative. I am the person who always takes the initiative and gets things done.

Currently, my "Second Act," is to organize trips for my church senior citizen group of close to 200. This includes day outings, overnights and multi-day cruises or excursions. I also arrange lunches for my Red Hatters group and keep in touch with my Utilization Review coworkers by arranging dinners several times a year. Life has been good!

I've met such wonderful and interesting people over the years. My lessons learned over the years have been two-fold. To learn to listen and to value our elders as they have much to offer us as we continue to learn!



**Maria Dias, RN** - I was born in Hartford, CT. to Portuguese immigrant parents. I was widowed after 37 years and have a son living in Jacksonville, FL. with his family. The loves of my life are my two adorable grandsons and look forward to visiting them as much as possible. They make my life worth living. I enjoy traveling with my sister and church group, and I try to fly up to CT. yearly to visit with family. I enjoy water aerobics and in my spare time, love to garden.

## THE COBALT BLUE PRINT JACKET

By: *Kim Fabis, RN*

I enrolled and was accepted into the Nursing Program at Broward Community College, graduating with Honors, Phi Beta Kappa in 1985. It was a long and hard road, working full time as an LPN and attending college. I was blessed to have Michael at my side who supported and encouraged me!

Many saw my passion, potential, and dedication to grow and progress as I went through the RN program. I was so very blessed with staff RN's, charge nurses and great Unit Managers/Directors that mentored me along the way of my education and training. They supported, mentored and facilitated my professional growth and development! I was even awarded the LPN of the Year recognition for my outstanding dedication to the Nursing profession in 1984!

I was offered an Internship to the ICU/CCU setting upon passing the RN NCLEX in 1985 and spent six months in a preceptor/advance skills career ladder training program. The program was professionally and personally fulfilling. The Internship helped me put my new critical thinking skills, clinical knowledge and advanced skill set into practice. I even earned my "cobalt blue printed jacket"! I was blessed to be part of the "old school" of Hospital practices where specialty Nurses are "Homegrown"; trained, mentored and become proficient providers of care!

For six months I provided bedside acute nursing care for patients and families that were critically ill and were facing life-changing events with my assigned preceptor ever at my side. Her name was Lynn, and she was the best of the best! I did pass my 6-month internship and was on my way!

I worked as a bedside staff CCU/ICU RN for 10 more years. I proudly wore my "cobalt blue print jacket," continued to perfect my skill set, gave my very all to bedside care, patients and families and continued to grow professionally. I was fulfilled and committed.

I learned so many lessons about life during those 10 years that are still a beacon for me professionally and in my personal life. I learned that life is fragile, life is not fair, and to always trust your moral compass. I learned that no one should die alone and that mistakes are stepping stones. I learned that you have to forgive yourself and learn from your mistakes. I learned to never ever assume and still have the grace to accept and embrace that which we cannot change. I have held the hands of the living, the dying, and the families of both.

My personal journey also echoed with growth and change! Michael and I got married, bought a home and began raising our family. We were blessed with two beautiful children, a daughter, and son; Anna and Michael.

Through the rest of my tenure at HMC, I continued to climb the clinical ladder of professional growth. I was promoted and served as the ICU/CCU Charge Nurse, Clinical Coordinator for ER and ICU/CCU and then as the Director of Critical Care and Dialysis services from 2001 to



2007. I have witnessed and participated in so many positive changes in healthcare, including, National Patient Safety Goals developments, Rapid Response Team's, advances in disease management, clinical practice initiatives, technology and many changes in patient care models.

I have been blessed to have worked aside and learned from many dedicated physicians, nurse and healthcare team members. I have as a professional nurse assessed, planned, implemented, evaluated, lead, supervised, improved, educated, mentored, measured, investigated the root-causes of mistakes and advocated, listened, laughed, cried and learned from each step of my nursing practice or what I feel was my calling.

I still remember a few patients that will always hold a special place in my heart; participating in their care was...moments that still take my breath away. That "cobalt blue print jacket" journey served me well, and I believe I also served it well!

In 2007 I became the Nursing Administrator of Moody Manor Foundation, a Long Term Care Rehabilitation facility founded in 1991 by Patricia Moody who's youngest of 10 children sustained a closed head injury in a boating accident her Junior year in High School. Pat's vision and mission was to provide an alternative to an extended care "intuitional" setting for her beloved daughter and other women who had sustained and survived Traumatic Brain Injuries.

My journey was now to continue to fulfill the passion and dedication of Pat, calling on all my years of experience with both the art and science of nursing. I found the work most rewarding and very humbling; the value of my work in the Critical Care arena all those years now realized!

I was challenged in that the Residents needs were not related to acute illness but instead were focused around their physical, neurological, cognitive, emotional and psychosocial disabilities and deficits. I was responsible and successfully managed the 24/7 operations of the facility, the staff and the residents. I embraced and learned new skills; medical case management, rehabilitation nursing, human resources, and facilities management to name a few. I was truly dedicated to my "new" family and enjoyed my work in this very unique setting with this very special population of survivors.

In 2016 the Foundation merged with another Community Organization. The residents, staff, and families continue to thrive in this caring, supportive and stimulating "home" environment today. And for me, I've started a new leg of my journey as a nurse!

Today I work as an Independent contracted nurse case manager providing services to injured workers, insurance companies and employers. I find providing medical coordination of care for quality and cost-effective outcomes a welcome challenge in my advancing my career. I have begun the journey of preparing for a certification in case management through home study and web learning. I continue to learn the multiple complexities of our healthcare systems, insurances, benefit programs, and disability plans as they are today.

My toolbox as a case manager is no were near filled; there is still much to learn in this labyrinth. I do not offer any advice yet as a Case Manager, but check back with me in a few years! I'll be on it!



Kimberly Fabis, RN is a Professional Registered Nurse with almost 4 decades of clinical and management knowledge and experience across multiple healthcare settings. She received her Associates in Science Nursing Degree from Broward Community College. She is currently working towards a certification in case management. Kim is a native Floridian and lives in Davie Florida.

## PROFESSIONAL JOURNEY

By: *Mary Ellen Gervais Ph.D., RN, CCM*

This is a little bit of a funny story about how I initially considered nursing. When I was 17, I entered a convent – right from high school. I left after only four months and spent the next few years trying to figure out where I wanted to go with my professional life. In the midst of this exploration, I lived with a friend who was a nurse, completing her master's degree in nursing at Yale University School of Nursing. She would invite her nurse friends over frequently, and they would sit around and talk in "initials" – PRN, OD, QOD, CABG, etc. As those conversations were going on, I would say "I'm going to go to nursing school just so I can understand what you are talking about!!" That joking led to my exploring the reality of going in this direction. There was a lot to consider including what kind of program I should enter - A diploma program? A university nursing degree? At that time (the early 70s) a university degree was still not the main approach to becoming a nurse. I also needed to figure out how I could ever afford it. After a lot of thought, I decided I was going to go to a four-year nursing program to become, eventually, a midwife. I was accepted and attended the University of Connecticut. It was a great program and the area I enjoyed the most was not midwifery but home health. When I graduated, I knew that at one point I would go beyond a bachelor's degree, but I had to get into the workforce to earn a living. I started working right away in neurosurgery at Yale-New Haven Hospital. That job and my colleagues, nurses, and physicians, inspired me always to provide high-quality care with compassion. Between that job and my move into care management I practiced in the hospital, in med-surg after neurosurgery, and then many years in home health. I have now been in the care management field for more than 30 years. I worked first for one of the companies that trained many care managers in the beginning of care management history, Intracorp. From there I moved into care management for a special program for Maryland Medicaid. I worked for the University of Maryland department that oversaw the program and supervised about ten CMs and developed a training program. The program was moved from the University to private care management companies, and in moving to one of these, I expanded my role to vice president. During this time I completed a Master's degree in nursing and started a doctoral program in health-related science. Combining all of these experiences I spent a number of years as the key professional designer of a care management software that is still in use today. The software was designed to do several things – 1. Standardize approaches to managing our populations, 2. Drive appropriate follow-up based on what is known about the participant, 3. Capture outcomes for the nurse to review on a regular basis, and, 4. Allow for measurement of impact. It eventually also was developed to provide appropriate supervisory oversight of the care management staff. The development of this software has been a passion of mine for almost 30 years. The software evolved to integrate with the data that became increasingly available. I completed my doctoral degree during this time and using data to drive effective outcomes was the focus of my dissertation. The software was one of the first to be URAC certified for case, disease and utilization management.

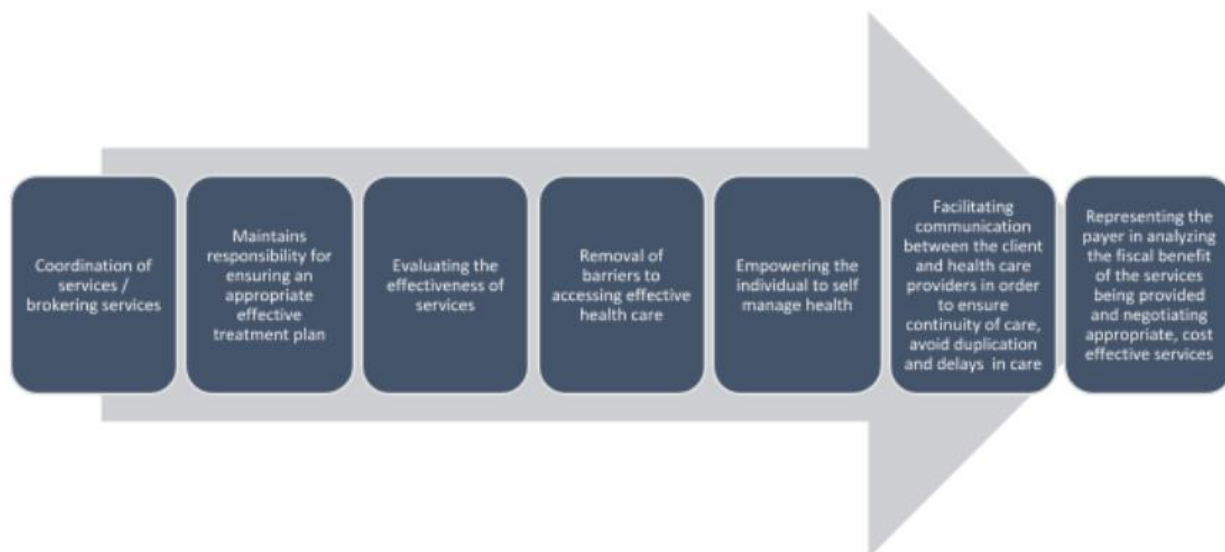
## CARE MANAGEMENT INITIATION

In the mid-1980s, I was looking for a new experience in nursing when I was returning to work after giving birth to my second child. I was introduced to care management through IntraCorp. The minute I started I felt like I had “arrived” in terms of nursing. My initial exposure to nursing was in primary nursing in which I was responsible for a person in a holistic way. Care management was the ultimate experience in primary nursing for me. As a care manager I was responsible for coordinating all the care for my patients; scheduling team meetings; identifying all factors that impact their health, and coordinating solutions. Beyond that, I learned about the associated costs of care and how changing behaviors ultimately impacts health and corresponding costs. At the time we worked with only acutely ill individuals, but over the years we evolved to supporting individuals at different levels of need.

A few years ago a nurse left our employ and posted on Facebook that she was leaving to go back to a “real” nursing job. Having felt in my career that care management was the fulfillment of nursing to me, I was a bit annoyed. According to the definition of nursing established by the International Council of Nurses, care management is clearly “real nursing”.

*“Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (ICN, 2002)”*

In graduate school, I conducted a study and a literature review on the role and function of care management. This study confirmed my experience that care management has a broad range that affords the flexibility I have valued in practice.



As a result of my studies and experiences, I created a model of care management that supported the health of individuals across the continuum of need, instead of breaking a person into conditions or into case/disease management. This model is called personal health

management, and the practitioners are called personal health nurses. This is the model that my team practiced for more than ten years. This model leads to significant clinical, behavioral and financial outcomes. It also leads to very high nurse satisfaction which is a significant variable in the success of the programs.

## **LESSONS LEARNED**

Multiple lessons were learned through the years, but two overriding ones stand out that I believe are pertinent for future practitioners.

The first is that we need always to make what we do meaningful. I recently went to a conference about "courageous inquiry." Courageous inquiry in my profession has always meant that we never stop asking the questions that lead to excellence and that add meaning to what we do. I used to tell the nurses I trained that we are not in this to simply pick of the phone and complete a task or check off a box on a form. We are here to uncover the obstacles to success and put solutions in place to overcome them.

The second has to do with leadership. We ARE leaders regardless of where we are in an organization. We are leaders with our clients, in the communities where we work and in the organizations we are associated with.

Overall nursing leadership takeaways:

- Leadership occurs from the bedside to the boardroom
- Nurses are FULL partners with other health professionals
- Nurses are accountable for their own contribution

Some of the leadership competencies we bring:

### Communication and relationship management

- Seeing the participant's needs through their eyes
- Advocating for the participant's goals
- Collaboration

### Knowledge of the healthcare environment

- Clinical practice skills necessary to effectively provide personal health management
- Care delivery models that can be employed to impact positive outcomes
- Continuum of care needs

### Business skills and principles

- Plan management
- Strategic management
- Staff management
- Marketing

### Professionalism

- Personal and professional accountability
- The ethical practice of nursing

### **MY SECOND ACT**

I am committed to the model that makes what we do meaningful for ourselves and for the populations we serve. I left the position I was in to start a consulting company. My role as a consultant is to help others ensure the delivery of effective population health/care management services. As a consultant, I also am working to ensure that data drives actions and there are tools in place to ensure that outcomes are core to practice. I have been told I bring a unique skill to the industry – one that integrates technology with care management actions. My hope is that I can mentor others to develop these skills.

I have also started a book, and I hope to complete it in the next year – we shall see.  
AND I continue to enjoy children and grandchildren.



Mary Ellen Gervais Ph.D., RN, CCM, President and CEO of Hyacinth Health Consulting Inc. is a Registered Nurse with more than 20 years of care management experience. Her Ph.D. in health-related science focused on the effective and meaningful practice of care management. Throughout her doctoral and Master of Nursing programs she has studied outcomes research and measurements in care management.

## MY... SECOND ACTUS

By: *Tina Kowlsen, RN, BS, MBA, CCM*

Life is an interesting journey, because simple events can change our lives. As a young teenage girl; I had my first air flight to NJ with my best friend for a summer vacation; staying with one of her older sisters. Carol was a young nurse married to a young resident, and they opened their home to us for a beach vacation. This young experience was life-changing and was when I decided "I wanted to become a nurse"...so as to marry a doctor, like Ray! Ha...ha...

However, many years later, right after graduating from high school and getting accepted into several nursing programs, I selected a three-year diploma nursing program at Phillipsburg School of Nursing in Phillipsburg, PA, which was affiliated with Penn State University in State College, PA. Three-year nursing programs were prevalent back in the mid-1970s, and very affordable, but are almost extinct today.

My nursing career has taken me down many paths, from hospital nursing (medical, surgical, psychiatric and OB/GYN); to community nursing in home health care, then hospital supervision. It later took me to medical case management (MCM) in the insurance industry....during the very early years of case management in the mid-1980s and where I continue to practice to this day.

I recall in my early years in home health care; a patient/woman, during an initial assessment verbalized how she depended completely on her husband, as well as, her doctors for everything. During that assessment, she shared her anger related to her husband passing away from a massive heart attack. She shared this anger because she was left alone to have to pack her own luggage and purchase her own clothes, which were things her husband always did for her. She also shared anger toward her dependency on her physicians given her medical problems and limitations after falling and fracturing her hip. This member was an example of total dependence of her environment, healthcare professionals, lack of accountability and "missing links" in the health system.

I developed a passion for case management during those early years after realizing in home health care that there were missing links in the health care system for patients (between the patient, payors and the providers). I saw case management as "filling in the missing links" and started on my long journey advocating for patients, the process of case management, and later; the profession of case management.

In the early-mid 1980s, as a part of a small core group of healthcare professionals at Intracorp; a subsidiary of Cigna Insurance, I was given an opportunity to set up a medical case management (MCM) model program. My role on this team involved setting up their MCM plan in the Northeast Florida region. Their program was initially designed to address private rehabilitation for the injured worker; and then evolved to members with catastrophic injuries and illnesses in group health plans, reinsurance companies, and others with associated risks.



A little over a year later, I was recruited by Blue Cross and Blue Shield of Florida (BCBSF) to assist in developing their case management program. BCBSF's initial program was designed to address catastrophic illnesses and injuries but later evolved also to include chronic illnesses. Catastrophic illnesses and injuries were defined as members with diagnoses (ICD-9 codes) and associated inpatient hospital claims of \$100,000.00 or more per each admission. Chronic diseases were characterized by ICD-9 codes with related readmissions that together totaled \$100,000.00 and above.

After several years of learning about the group and commercial health insurance business, reinsurance business, I ventured out on my own and started Case Management Choices (CMC), Inc. in Jacksonville, Florida with my late husband. CMC evolved into a managed care company for group health and workers compensation. We developed operational policies and procedures. We trained case management professionals and developed our own case management/managed care software program. We partnered with Third Party Administrators (TPAs), Provider Networks and bundled our services to offered insurance plans for predominantly self-funded groups.

Many healthcare colleagues in similar positions of developing, implementing and operationalizing new case management programs around the country during that same time period were looking for one another to share ideas and experiences. Many of my early colleagues found one another through the Individual Case Management Association (ICMA); the earliest case management organization. An intuitive young man during those early years; named Tom Strickland, founder and former President of Systemic Corp., a private rehabilitation company started this early trade organization. ICMA was a forum where industry colleagues met; shared program experiences and started writing about case management in this organization's first professional publication called; "The Case Manager."

Also, many involved in the early years of case management were involved in local and state efforts of organizing; and I served as a local and state president in Florida aligning our organizational efforts to CMSA in the early 1990s. Many of us that were involved as early industry leaders and healthcare colleagues also assisted in co-founding the Case Management Society of America (CMSA); which differentiated itself as the professional association versus ICMA as the early trade organization for case management.

CMSA was focused on defining case management, and the Standards of Practice for case management. This professional organization has advanced the case management definition, established standards of practices and collaborated with other well established National professional associations and organizations developing professional certification(s), ethical standards and advancing the industry and much more over the last 30 years.

Another exciting part of the journey during these early years for me was taking on the role as the first national legislative chairman in CMSA; I was also involved in tracking related legal and regulatory activities around the country, related to managed care and quality as it related to case management. Several of these organizations included the National Committee for

Quality Assurance (NCQA), Utilization Review Accreditation Committee (URAC), and Healthcare Quality Certification Board of the National Association for Healthcare Quality (NAHQ) to mention a few.

Also, in the mid-1990s, educational opportunities occurred for speaking and writing about case management. I was approached by McGraw-Hill to write a case management training guide for a new national education program which they sponsored. Per that request, I wrote the "Essentials of Case Management" for McGraw-Hill/Business Network in 1996. I traveled around the country as an educational consultant for a Seminar entitled: Essentials of Case Management supported by Irwin Professional Publishing. The purpose of this seminar was for educating healthcare colleagues in early case management programs from the insurance industry, hospitals, and rehab, HHC, etc.

The focus of this seminar and educational training guide was to educate case managers and managers of case management programs of the definition of case management; the process of case management and resources available at that time. It was important to note the description that defined the process was similar for case managers employed by healthcare providers or payers; however, the focus and workflow for case managers were different depending on the work setting. These same similarities in the process are portrayed in the definition of case management today. Also, the focus of case management still varies depending on where case management is practiced.

Life changing journeys continue to shape our lives and careers. My life changing event came when I lost my husband of 24 years and business partner of 13 years in 2002. After running our business alone for 3 more years and losing my mother to complications with Alzheimer's; I took a sabbatical for a couple years before returning to my profession as an RN and case manager.

Sure enough, the case management industry continued to evolve into a profession; with national recognized Standards of Practices and certifications. Case management; also referred to as care management and care coordination was evolving into legislation for states workers compensation statutes, Medicare, and Medicaid. Case/care management continued to develop into new program models such as disease management models; Accountable Care/Patient-Centered Medical Homes Models; Care Coordination Models, to today's Population Health Models.

As I re-entered the workforce, I returned as a case manager, a volunteer research assistant and then a Compliance manager at University of Pittsburgh Medical Center (UPMC) Corporate Care Management Department. I was interested in learning how hospital case management was evolving in the healthcare system. I worked at UPMC during the early years of the Recovery Auditor Contractors (RAC), Medicare Auditor Contractors (MAC), Medicaid Auditor Contractors (MIC), etc. Hospital case managers and Directors of Case Management within the UPMC healthcare system were dealing with these new regulatory players who impacted their care management roles, responsibilities and program operations.

Later, I accepted a case manager position back in the insurance industry initially with Aetna, in their new case management model called In Touch Care (ITC); a telephonic population health model. Most recently, I work for Magellan Health, initially as a Lead Care Coordinator then promoted to a Care Coordination Manager. My role and responsibilities include managing, mentoring and coaching a regional team of registered nurses, social workers and license behavior health professionals. These efforts support the rollout of an integrated health care program; a new population health model in Medicaid, in the state of Virginia. This model is an integrated care coordination model including medical and behavioral health and involves telephonic and field care coordination. Their care coordination program rolled out initially in the long-term support services (LTSS); then was followed by Medallion 4; a Medicaid expansion populations in the State of Virginia.

I have learned many things over the last 40 years, practicing as a registered nurse and a professional certified case manager. However, the most important thing I have learned is the important roles registered nurses and certified case managers' play in addressing people's health care needs. Patients have always been the primary focus; however, these models continue to place patients in the center. They also impact the delivery of care with the age of technology, informatics and data analysis, quality of care; and strategy changes of healthcare.

I have also participated in and witnessed the impact nurses have made visiting their legislative offices in Washington, DC influencing their local legislatures on the value of case/care management and care coordination. I continue to see nurse and case management executives as National presenters at National Healthcare Forums speaking as experts to other healthcare executives, physicians, legal and regulatory executives.

With that being said, looking back at some of those experiences, as a registered nurse (RN) working in different healthcare settings such as the hospital and in home health care settings, patients are at the center with their ongoing care needs. However, treatment protocols, standards of practices, length of stays have changed due to technology, regulations, and healthcare coverage issues.

With that in mind, the RN role has evolved from a caregiver, working at the patients' bedside into case managers, care coordinators, patient advocates, educators, to.... managers, executives, and expert consultants in many different areas of healthcare.

Many clinicians are seen as industry leaders in case management, care coordination, and other aspects of managed care. Nurses are included in this group of clinicians around the country; and are seen in hospital systems, the legal and regulatory systems, academics; as well as, the insurance and financial systems. Nurses and case management professionals are involved in informatics, research, data analysis, stratification of diseases, documenting their experiences and expertise in many publications; as well as, speaking at national and international forums.

As an early case manager, I have worked the healthcare systems to the extent where I have taken health care insurance benefits for inpatient hospital care and demonstrated to insurance executives how utilizing them for home care services instead of repeat admission; would

promoting quality of life and cost-effective health care. With that being said; I want to share a story of a young man that I provided case management services, and it has stayed with me over the years and had an impact on my career.

This young man was a member/patient diagnosed in the early 1990s with multiple medical complications associated with AIDS, before confirming the AIDS and AIDS-related diagnoses. This member/patient was referred to my case management/ managed care company by a health insurance company that sub-contracted us for field case management services. I worked collaboratively with an internal case manager within the national health plan that was my client. After meeting multiple times with this patient and his mother in their family home, this member moved home to be cared for by his mother. He had gaps in care which required additional healthcare providers; such as home health care, home infusion, the Northeast Florida Aides Network (NFAN) to mention a few; with all collaborating together around this patient's plan of care. After reviewing clinical review criteria for an inpatient stay, and completing a detailed cost-benefit analysis, this patient/member's health plan was willing to be innovative to use his inpatient hospital benefits for HHC services (which were exhausted at this time). This cast scenario promoted quality of life for this member and his family, quality of care; as well as, provided a cost-effective plan of care until he passed away at home.

What I learned from both patient experiences; was compassion, creativity, and new career pathways. This member/patient and many others had an impact on how valuable the case management process was to advocate for them and their quality of life. It was a true win-win for all those involved with this patient, member, family, and health plan.

I learned how important it is to think outside the box and go to bat for individuals in need; at the same time, taking risks to share creative thinking and demonstrating the value of case management. I have always said, one of the most important things I learned was we may not be able to change the whole complicated healthcare system; however, every now and then we get to change one person's life and/or fix one problem within the business of healthcare, and that has to be enough!

As indicated earlier, I continue to work in the business of healthcare; now a Care Coordination Manager in a Medicaid expansion program in Virginia. This is a population health model for Magellan Health; a health plan from Arizona. This medical model is the latest care coordination program design which is an integrated health care model of medical and behavioral health, stratifying diseases, engaging members, utilizing motivational interviewing and mindfulness techniques through care/case management and care coordination.

I would like my second act to be a part of mentoring and coaching young and new health care clinicians and business professionals to:

- Assist in better understanding the value of care/case management, care coordination to people and health systems;

- Educate the importance of the process, policies, regulations, and certifications related to care/case management and care coordination;
- Encourage case management professionals to think outside the box; be forward thinkers, and use critical thinking skills as new young healthcare professionals within the business of our healthcare industry.

I would also like my second act to play a role in creating resources and education related to medical models of care coordination, the importance of engagement, motivational interviewing, mindfulness, and quality improvement efforts. I believe this role in my second act will be an important responsibility toward advancing the profession of case management.

"This medical model is the latest care coordination program design which is an integrated health care model of medical, behavior health, and pharmaceutical; stratifying diseases, engaging members, utilizing data analytics, IT solutions and care coordination skills including motivational interviewing and mindfulness techniques through...."



Tina Kowlsen, RN, BS, MBA, CCM is a Care Coordination Manager at Magellan Health, Virginia's Medallion 4; integrated health and population health program. Tina is a past founding member of CMSA and served multiple national board terms in the early 1990s and from 2012-2015.

## THE WHITE HAT

By: *Barbara A. Buono Kuritz BS, RN, LHCA, CCM*

I became a registered nurse in January of 1971, or perhaps it was earlier, let me explain.

Many mornings I watched my young mother with rheumatoid arthritis struggle to get out of bed. I remember feeling so helpless as she started every day in pain. I wanted to make the pain go away for her. I just didn't know how. Then one day I watched my pediatrician's nurse help a child on crutches walk. There she was with her starched uniform and equally amazing white hat fastened to her dark Brunette hair. Her presence was inspiring almost magical.

I think it was at that moment the calling to be a nurse wondered into my heart.

I knew right then how to help my mom. All I needed was a white hat. I was convinced the ability to help others had something to do with that white hat. So, I would run for my white Kleenex and pin it to my head and help my mom get out of bed.

Maybe it was my imagination or just the mere image of a child with a Kleenex on the head that seemed to help my mother smile more as she coped with the pain. Whatever the reason for her smile I would like to think I made a difference.

I was hooked, and I wanted to be a nurse when I grew up.

I soon learned the privilege of helping people with injury and illness would require years of medical study passing tests, sharpening procedure skills and professional dedication.

And although being a nurse is no longer associated with the white uniform and cap, it still represents someone with compassion and caring. It still means helping people, making a difference and impacting the patient care experience.

### **Jobs along the way**

I graduated in August of 1970 from a three-year diploma school with an associate degree.

In 1970 graduate nurses were in high demand.

I decided to start my nursing career as a staff nurse at a community hospital.

I remembered my first interview and listened intently as the head nurse stated the importance of following the floor rules.

- We work as a team.
- The patient bell must be answered immediately and the call bell always at the patient's side.
- Bed rails must be up when the patient is in bed. No one falls out of bed on this floor.
- Medications and procedures are to be done on time and documented.
- All written orders are to be taken off immediately and implemented.

- Morning care needs to be done by 10 am before the doctors make rounds.
- Nurses are to accompany doctors on rounds.
- Listen, understand and spend time with the patient.
- Explain things to the patient.
- Follow policies and procedures.
- Ask questions if you do not understand.

I shook my head yes and agreed to the job. And so, I started my nursing career on a 35-bed medical-surgical unit. The hospital employed a team of new graduates from the Philadelphia area to staff the floor.

As graduate nurses from multiple nursing schools we worked and learned from each other. We bonded together determined to make a difference in patient care. We studied together, sat for our nursing boards and became registered nurses.

I learned from that first job the importance of good documentation, teamwork, active listening, patient safety, empowering the patient through education, and being efficient.

After ten years of medical-surgical nursing, I needed a change and transferred to the maternal child health department.

I became a certified Lamaze instructor and conducted prenatal education classes. I worked all three maternity units (delivery room, postpartum and nursery). My role expanded to include well baby home visits to reinforce infant care.

It was during newborn home visits that I developed a deeper understanding and appreciation for different cultures and traditions. It was one of the most rewarding experiences for me because it taught me the meaning and importance of the continuum of care.

As my personal circumstances changed so did my career. I became a single parent with two sons to raise. The rotation of shifts played havoc with my work-life balance.

I entered the business world unprepared to what would follow next.

It was the 1980s and the beginning of managed care. I transitioned into an insurance-based setting and was given a new hat to wear. My hat was in the form of a headset attached to a phone. I became a utilization review nurse and reviewed cases for medical necessity, and certified inpatient hospital days. I spent my days talking with hospital discharge planners.

One of the hardest things for me was sitting at my desk for eight hours. I frequently could be seen standing at my desk. This behavior made the business world nervous, and I was asked to sit down.

I missed the interaction with the patient and family and soon found my way into case management. I felt right at home. I became one of two pilot nurses for telephonic case management. We designed the program and wrote processes for others to follow. I learned from this experience the importance of design and paying attention to the details.



My family would ask if I was still a nurse. I assured them that I was. I explained that this new role gave me an opportunity to work with more patients and advocate for them in new ways.

To learn more about the business world, I returned to college and completed my degree with a concentration in healthcare administration. I held various management positions and worked with some of the most talented people in the field of case management.

As a manager, I learned the importance of good communication, follow through and the importance of quality management.

My work took a new turn as I transitioned from people management to program design, content development, and training. Designing programs and content development gave me the opportunity to transfer my organizational and planning skills. I learned the importance of getting content right the first time before developing the training.

As the Greek philosopher, Heraclitus said, "There is nothing permanent except change."

As health care continues to evolve, I believe certain fundamental behaviors that guided us in the past will continue to serve us well in the future.

That said, I would like to share what I learned during my health care journey with you.

- Do things for the right reason you will sleep better at night.
- Follow the policies and procedures of your organization they were made for a reason.
- Enjoy what you do and approach everything with a sense of heart, caring, and compassion.
- Add value to each situation leaving it better than you found it.
- Don't become extinct, embrace changes.
- Appreciate our differences and celebrate diversity.
- Promote quality pay attention to the details. It will save you time in the end.
- Keep your skills updated learn something new every day.
- Say yes to new opportunities they enter your life for a reason.
- Play it forward and share your knowledge with others.
- Advocate for those that need support.
- The biggest part of caring is to pay attention to what matters to others.
- Observation is one of the most important skills you can develop.
- Grow where you are planted. Serve as you are needed whether it be a leader or soldier.

Most importantly pay attention to the laws that govern health care. Question things that may impact each person's right to timely and cost-effective care.

I think that all skills are transferable. When looking for a career change believe that you can take your skills such as organization, communication, time management into the next job or life circumstance.

There are many opportunities for nurses and case managers. Give your best along the way, be open to new opportunities and put on the new hats.

**What will I be doing for my second act?**

I am still writing my second act. However, I am committed to doing my best to embrace the change that is certain in the next chapters of my life.

I will remind myself to enjoy the little things more than the big things in life. Things like the beautiful sunrise and sunsets, the coolness of water when you first enter a pool on a hot summer's day. That first cup of coffee in the morning. That special kiss goodnight.

I experienced my share of successes and failures in my career and learned lessons from each.

As I move to my second act and pass on the baton to the next generation of health care professionals, I urge you to take the time to evaluate your experiences. Assess things that go well and those that do not. Learn from both and make it part of who you become. Offer the world the best that you can be. Be the role model for others because you never know when a future little nurse will be watching and looking at the hat you are wearing.



Barbara A. Buono Kuritz BS, RN, LHCA, CCM, has held various roles in health care for over 30 years. Her focus has been case management, education, and leadership. Barbara is a past MidAtlantic chapter president of Case Management Society of America.

## BEING A NURSE CASE MANAGER: ACHIEVING GOALS BY LISTENING AND THINKING OUTSIDE OF THE BOX

By: *Linda Lamb, RN, CCM*

I wanted to be a nurse for as long as I can remember. Even as a little girl I would tell people I wanted to be a nurse when I grew up. I was confident and convinced that's what I wanted to do after having three hospitalizations when I was thirteen years old. I watched the nurses carry out their duties asking them many questions when I had the chance. I loved watching and observing them as they genuinely helped people. They worked hard to provide care, relief of pain and give comfort to their patients. From that time on I worked hard in school along with selecting science classes in high school to pave the way for college and a nursing scholarship.

I graduated from college and nursing school in 1970. I took the RN boards in June of that year and passed. That was a thrill that I will never forget! I was a young nurse about to start an enriching career in an occupation that I had dreamed about for many years.

My first RN job was in a small hospital working on a med-surgical floor as a staff nurse. I loved it! After several months my husband and I moved so he could attend pharmacy school and I took a staff position at the VA Hospital. I was assigned to a post-surgical floor where I quickly discovered that my nursing education had just begun. I learned so much working there. We were responsible for so many things, including complex wound care and dressing changes, mixing IVs including TPN when the pharmacy was closed, drawing blood for lab work on the evening and midnight shifts and the list went on and on. Many veterans had complex wounds including amputations which required a great deal of care. I was the only RN on the evening and midnight shift and worked a 35-bed ward with an LPN and two nursing assistants. It was arduous work, but we always provided the best care possible.

I worked there for twelve years and had no intentions of leaving, but a good friend convinced me to broaden my experience with home health care nursing. I had two small children at the time, and I liked the idea of doing home care visits while they were in school and not having shift work. So, I left the hospital setting and took the home care job.

Again, just as with the VA Hospital I learned a great deal. Providing nursing care in the home was a big challenge. Providing wound care, IV administration, medication management, was complicated in a patient's home. Our home care agency also provided lifeguard flight nursing coverage which I did for several years. I would tell people that delivering nursing care in a 'sardine can' was the biggest challenge I had ever had. We flew patients from one hospital to another for higher acuity care. We also had several transplant patients that we transported to the transplanting facility.

I advanced to the home care supervisor position and eventually to the director. It was stressful to say the least and very time-consuming with very little nursing in my day to day routine. After several years of being on call 24/7, it became too much for my young family, and I left the position.

I made the decision to return to hospital nursing, and I took a staff nurse position at the small hospital near our home. I was assigned to the med-surgical floor, and again, I loved it. I realized that bedside nursing and hands-on care was the reason I went into nursing in the first place. But working midnight shifts again wasn't an easy thing to do. I had been away from hospital nursing now for 8 years and had enjoyed working during daytime hours.

After several months my good friend telephoned again stating she had the perfect position for me working as a case manager. She was the director of a local Third-Party Administrator (TPA) for self-funded insurance groups. At the time I had never heard of case management, TPAs or self-funded insurance companies and kindly turned her down. I also explained that I couldn't imagine being a nurse tethered to a telephone, computer and sitting in a cubicle. How could I possibly provide care and help people that way! She encouraged me to think about it and to give her a call if I changed my mind and we left it at that.

Several weeks went by, and she called a second time. She was really trying to convince me telling me that she had just the group that I would be perfect for with my extensive background and experience in home health that included setting up care, pricing, supplies, and equipment. I thanked her again for thinking of me but stated I couldn't imagine sitting in a 'pen' all day and being tied to a telephone. No way could I be a good nurse over the phone.

After a particularly rough midnight shift, I had just gotten home at 9:30am and was very tired when the phone rang. It was my friend, and this time she asked me to just come out to where she worked and observe the three case managers that worked there. She said I should see and hear how they worked and observe the involvement they had with their patients. The third time was the charm, and I agreed to see what this new term 'case management' was all about. We set up a time a couple days later for a two-hour observation session. I had no idea what to expect and felt it was going to be a waste of my time and theirs. I soon discovered how wrong my preconceived assumptions were!

The three nurses sat in a room together but had individual cubicles for telephone privacy. They were making telephone calls to physicians, home care agencies, equipment companies and patients including family members. I was astonished by how in-depth their conversations were and the closeness they had with the patients they were managing. I honestly sat and listened in disbelief. They explained their role and all three stated it was the best 'nursing job' they had ever had.

I guess at this point I could say the rest is history. I accepted the case management position and was told the first company assigned to me would be a new company coming to the TPA, Walmart. Talk about jumping into the fire immediately. I was scared out of my mind that I would be the cause if this huge company left the TPA.

It took several months for me to get the 'hang' of it and to finally settle into the role of a case manager which was to provide quality cost-effective health care to our members. It was amazing, and I soon got over my timidity when calling total strangers and offering help with their care needs. I quickly learned and discovered that I could help people to a much greater extent than being a staff nurse in a hospital.

After a year or so I advanced to a catastrophic case manager and was given many large groups including Burger King, Chiquita, Nucor Steel, and numerous others. I was told that I had a 'knack' for being able to engage and connect with patients and families to the resources they needed and an ability to figure out what was those resources were. This also included negotiating with providers to demonstrate costs savings. My experience in home health care was really a plus.

I had fantastic experiences and established lifelong friends telephonically. My nursing world had expanded more than I would have ever thought possible. Eight years passed very quickly, and I truly loved case management. I really enjoyed what I was doing and had contacts all over the country.

Then the bad news came. Our small company was being sold to a large national chain and was being relocated to Arizona. Within six months we either had to move to Arizona or find other jobs. I was literally heartbroken. Moving to Arizona was not an option for my family. I had to come to terms with applying for another job. Even though I loved hospital nursing, I wasn't eager to return to shift work, and I knew I didn't want to give up case management.

I was very fortunate that a case management position was available at a local commercial insurance company. I applied and got the job. I was relieved of course knowing that I could continue my career and profession as a case manager.

Working for the commercial insurance company had many differences from what I had been doing at the TPA. The company was a part of an integrated healthcare system that included physicians, clinics, hospitals, home care agencies, and their own DME provider. I found there was very little if any negotiation needed for care unless a patient was out of the service area and needed emergency care. From my role at the TPA which I often referred to as 'in the trenches' case management, this new role required more learning and experience as a different type of case manager.

There was a great deal of education of patients regarding their coverage and benefits included in their plan. I took the case management certification (CCM) examination in 2001 and became the first case manager in our company to be certified. Our company had a career ladder system and after becoming certified was put at a level II case manager and had the most difficult cases referred to me. I was thrilled with how much help and assistance I could provide from my desk via the telephone. I spent 20 years with this company and retired from there January 1, 2018.

Do I miss being a case manager? Immensely.

Early on in my case management career, I had a particularly difficult case. It was an eight-year-old little girl with a brainstem glioblastoma. It was inoperable, and her prognosis was extremely poor. She was placed on steroid treatment to reduce the mass and slow down the growth of the tumor. When she was referred to me for case management, she had already been in and out of the hospital numerous times during the previous 6 months. I've never been a pediatric nurse and wasn't confident I could handle this case. It was always very hard for me to see children sick and suffering.

I started investigating the case and found that she was currently in the ICU in a Cincinnati Ohio hospital. She had been trached and was on a vent due to the size of the tumor. I remember sitting at my desk wondering how tough can it get! I wanted to cry out loud just thinking about this poor little girl.

My motto has always been 'never give up'. I started making phone calls to get as much information as I could regarding the little girl's current status and acuity level. I had numerous conversations with the ICU nurse who kept telling me she would never leave the hospital, even though when awake that was her request over and over again. I had conversations with her parents which ripped at my heart and left me in tears after each discussion. They wanted desperately to take their little girl home.

I made up my mind that I would do everything I could to get this to work out. This was before home ventilators were readily available and other equipment she needed. I had been working with a great home care agency in the area on other cases and made numerous calls to the director to see if we could basically set up an ICU in the girl's home. The agency was willing to do all they could.

I had to make a call to the benefits administrator of the company the girl's father worked for presenting to him what I wanted to do. One of his first questions was would it be cheaper than leaving her in the ICU. I explained that setting up this kind of care would likely cost just as much and perhaps more than leaving her in the hospital. I was prepared for him to tell me 'no', but he didn't. He knew this family and gave me permission to proceed.

It took several days to get everything arranged, the equipment delivered to the home and then transport for her from the hospital which had to be via an ambulance. The home care agency guaranteed qualified nursing coverage 24hrs/day, 7 days per week along with respiratory therapy coverage a couple times per day. This was huge, especially back then.

I remember the ICU nurse telling me she thought I was gutsy, but she admired me for making it happen. She cautioned me several times stating this little girl required a lot of care which would be difficult at best in a home setting.

The day came, and her transport home went smoothly. An ICU had literally been set up in the living room of her home. I had several conversations with her physician, and she was entirely on board with this plan and reassured her parents and me that she would visit the girl often and write orders as needed. I remember one afternoon she called me after the little girl had been home a couple days and her statement to me was: "you don't work for an insurance company, do you? No one does this that works for an insurance company"! I've never forgotten how that comment made me feel knowing I stepped out on a big limb to help this patient and her family. Her parents called and told me how happy she was to finally be home where she could see her younger brother and her friends. They could see her often which was terrific for patient and family. Having her in the home had challenges for sure, but the parents didn't have to spend their time in the hospital and could have more time together. She had a month and a half at home before she passed away. The parents are still in touch with me after all these years; friends forever.

I have helped train and mentor many nurses new to case management. I always told them my motto, 'never giving up! To me, that is the key. Along with that is developing good listening

skills and to do your job with genuine compassion and caring that can even be felt during telephone conversations. If you can't envision this, then case management is not for you!

Also on my list was being a good P.I. To investigate and determine what is really needed, wanted, or might be important to your patients and then put together a plan including goals that will work. In my initial conversations with patients, I always asked the question: what concerns you the most about your diagnosis, injury or illness? And then I listened. Often their answers would be, how much is this going to cost me? That's when I would discuss their benefit plan and give them what I called my insurance 101 discussion. If they were so concerned and worried about paying large health care bills, I knew they wouldn't be focused or able to give their all for recovery.

I often told new nurses that case management included 'everything and anything' and to explore all avenues. If you run into a roadblock, back up and try a different path. Obviously, there are times when things just don't or can't work out or when the benefit plan doesn't cover something. Often the case manager then becomes the bad guy and has to deliver the bad news. But exploring resources, local organizations, state funding, and other alternatives can at times assist when benefits are limited. Another avenue to pursue is an exception to the benefit plan. Putting together a cost analysis and listing reasons why an exception should be made can be addressed and presented to the member's insurance company, director of healthcare benefits.

Case management has changed considerably since I started my career in the profession (before it was even recognized as a profession) almost 30 years ago. Care is more available in most areas which makes things easier to arrange and provide. There will always be challenges and difficult cases that will test a case manager's abilities to 'think outside the box'. My advice be inventive, creative AND never give up!

I haven't really moved forward to my second act yet. Retirement is definitely an adjustment after rushing out the door to go to work for all of my adult life.

I have a number of house projects that I would love to do now that I have time. I've been extremely busy for the past 4 months due to my husband having foot reconstructive surgery. Providing hands-on care again 24/7 pushes everything else to the back burner.

Eventually I would love to work or volunteer at the local senior center. With my background and knowledge in health insurance I'm confident I could provide needed assistance to seniors that are struggling to get their healthcare needs met and understanding what is covered with their insurance. The same might be possible at the small hospital that is close to our home. Helping patients with the confusion of insurance coverage is an on-going need for most people.

Good luck to the new generation of case managers. Healthcare is constantly changing, especially now. Keeping up with all of the changes will present additional challenges to the new generation of nurses and case managers.





Linda Lamb, RN, CCM became a registered nurse in 1970 earning an ADN Degree from Weber State University and began a forty seven year rewarding career. After an interesting career Linda retired January 1, 2018 from her level two position as a senior case manager for a local healthcare insurance company. Linda is a certified case manager and active in her professional organization, the Case Management Society of America. She has attended every year since 2002 (even after retirement) as she found the networking with other case managers important. Linda was voted the most valuable employee three times from two different healthcare companies. This achievement from her peers was a great honor.

## THE LEONARD EXPRESS

By: Margaret (Peggy) Leonard, MS, RN-BC, FNP

Choo! Choo! All aboard the Leonard Express. Everyone on board will take this magical ride with me to the Second Act. I hope you enjoy each stop along the way.

First stop "Dream Land".



*(Leonard R. L., 2008)*

As a child I always dreamed of being a nurse, getting married and living happily ever after. I started out attending Long Island College Hospital School of Nursing. One of the top Nursing Schools and one of the first to offer a Bachelor of Science in Nursing degree though its collaboration with Long Island University. The best of both worlds a fine University and an excellent Hospital based nursing program. I dreamt of helping people, caring for people who couldn't care for themselves. A later day Florence Nightingale in my starched white uniform, white cap, white stockings and highly polished white shoes. Oh,

OK now you realize how far back the mid-60's were! As fate would have it, I fell in love, left school and got married, had two wonderful children and planned to live happily ever after. Well, sometimes the best laid plans don't work out. I didn't return to nursing school for 15 years.

This Second Act journey is a chance of a lifetime for me and I thank Anne Llewellyn for inviting me to share my story in hopes that others can explore, absorb and perhaps laugh at the lessons learned from my journey.

**Next stop,** on the Leonard Express is "Actualization Village."

Here we see how reality and dreams meet and come to fruition. You have to love people, and nursing. You need to plan a path and be realistic about what you can and cannot be, and what you need to do to make your dreams come true. How much do you want this, can you be a one-on-one practitioner and a visionary? Are you willing to be a mentor and bring others along and share your learnings in order for you to inspire others' journey in this wonderful profession called Nursing? First: Which schools do you want to consider? Which schools are good? What degree do you want? What is the time commitment? What are the costs? If applicable, how will I do as an adult



*Margaret A. Leonard, 1985*

learner. I knew I wanted to take the quickest, easiest, least expensive route. I decided to go to my local community college, Nassau Community College at night, I loved it. I went to school at night and worked as a real estate broker during the day. (I still have my Broker's license, you never know!?!?) I graduated with honors and got the first job I applied for at South Nassau Community Hospital. It was on a Medical Surgical Unit. I immediately started to take Coronary Care courses and in a few months was offered a position in the Coronary Care Intensive Care Unit. I then took advantage of the hospital's tuition reimbursement benefits and began to pursue my BSN at Adelphi University. Once I had my BSN, about two years later, I was eligible to work in Community Health at the Visiting Nurse Services. The next rung on my career ladder.

I loved Home Care Community Health. At that time though the New York State Nursing Association (NYSNA) was battling to keep the legislation requiring Community Health Nurses to have a BSN. It was then that I became involved with NYSNA's Legislative Council. I served for 8 years, five of those were as Chair. We had a major lobbying campaign to keep the BSN as a minimum degree required for Community Health Nurses but our adversaries, Home Health Agencies and the Commissioner of Health felt a nurse, was a nurse, was a nurse and they didn't require a BSN. However, the Associate Degree programs curriculum did not contain any Community Health courses. Really, they didn't. Well, unfortunately we lost that battle. Fortunately for me VNS, too, had tuition reimbursement. So, I enrolled in a Master's Program at Adelphi. I loved Community Health Nursing. I learned more about people, cultures, individuality of care, that all care is local, and you had to be politically savvy. I learned a great deal about myself. From my second month of nursing school, I knew I was drawn to certain issues and to becoming an advocate. I became active in NYSNA (although I was never represented by their Union arm). I became a Charter Member of their Leadership Program and their Leadership Institute, Chair of their Legislative Committee and a NYSNA delegate to the American Nurses Association. I also served for seven years as President of NYSNA's District 14, which represented Nurses in Brooklyn, Queens and Long Island. I was also instrumental in forming a Political Action Committee (PAC) in collaboration with NYSNA's District 13. (Manhattan and Staten Island).

**Lesson Learned:** don't get too full of yourself.

I went to a NYSNA convention and it was an open forum for Members to express their views on creating or adopting a statewide PAC. As I approached microphone number 7 and was acknowledged by the Chair, I spoke to the issue from the PRO side rather than the Con side. Afterwards, many of the NYSNA leadership, especially the head of the Leadership program came over to congratulate me on a job well done. My head swelled. The next day, I went to the microphone and made a complete ass of myself. I was mortified. That evening the President of NYSNA was hosting a cocktail reception in her hotel suite. I didn't want to go because I was so embarrassed, but I had to. When our hostess greeted each of us, I apologized for my poor performance at the voting body. She smiled, hugged me and said, "the good thing about being a leader is you get to do it all again tomorrow." Words I have lived by and passed on to a thousand others over the years!

Once working at Visiting Nurse Service, I became even more involved in lobbying. Lobbying is not a dirty word. It is another word for advocacy and I loved that role.

Feeling good about education and professional involvement I enrolled in Adelphi's Doctorate in Nursing program. After my first three courses (9 credits), Adelphi launched their post masters Family Nurse Practitioners (FNP) program. I jumped at the opportunity to get my FNP certification. It just fit and defined what I wanted to be. The Dean allowed me to take a break from the Doctoral Program to enroll in their FNP program and they would even let me use nine of the FNP credits as my electives. Great deal, by the way, VNS agreed to give me tuition reimbursement for the FNP program. Unfortunately, Adelphi's Doctoral Program closed, and I had no way to make up the courses because they were not offering them anymore. (A few years ago, Adelphi reopened its doctoral program. YAY!) However, my future plans did not call for me or require me to have a doctorate.

I left VNS to explore the latest health care phenomenon, managed care. The Centers for Medicare and Medicaid had contracted with Manage Care Organizations (MCOs) to manage the utilization of services and later the case management of their enrollees. Institutions like hospitals, clinics and home health agencies now had to go through these middle men, MCOs for authorization of services they wanted to deliver. This caused a great deal of hostility and consternation for the MCOs, but they were controlling the payments and as the saying goes, "follow the money".

Fidelis Care in New York was my first foray into managed care. I started as the Director of Quality and Clinical Care. After three years I moved onto Hudson Health Plan (known then as Westchester Prepaid Health Services Plan for 18 years and then spent my last years with MVP Health Plan as their Vice President of Medicaid Government and Community Initiatives.

**Lesson learned:** Strike while the iron or your proclivity to something is hot. You never know what might happen.

My FNP certification gave me even more freedom in choosing positions. By the way, do not ever let your licenses lapse. Keep up on your professional affiliations and certifications. During this time, I also had the privilege of working with colleagues to co-author my first book, Klainberg, M., Holzemer, S., Leonard, M., Arnold, J., Alliance for Community Health: An Assessment Model. McGraw Hill Publications: New York, (1998). I was on a roll and wanted to give back to my colleagues, so I met with the Dean of Adelphi College and created a Nursing Program for the returning nurses for their BSN, called Vision. I also had the thrill of myself and a colleague creating, producing and hosting the first prime-time, drive-time, half hour radio program produced and hosted by RNs. It was on Monday nights from 6-6:30pm.

All of this was exciting we had top academics, business and community leaders and politicians as guests.

**Next Stop** – Academic Path. When choosing your academic path do your research and be practical. Now while I was a strong advocate for BSN in 10, for me the most economical way

was to get my associate degree first from my local Community College. With two children in tow, my only logical choice was Nassau Community College. It was only a few miles from our home. It was less expensive than the four-year schools and at the time you could get a hospital position with either degree. My school advisor helped me find scholarship monies to ease the financial burden. When I say burden, I believe my tuition was \$150-\$300. a semester. I know you're saying NO way, but YES way.

Here is a little background story that I still have a hard time believing myself. It wasn't until my mother was in her mid-eighties when she told me my Great Grandmother was a nurse. Unbelievable I know, but you had to know and love my mother, Virginia Brolly, she was a strong and loving woman who was married to the most wonderful man in the world my dad, Cornelius Brolly. I was so blessed to have such wonderful parents. As far back as I can remember I wanted to be a nurse. How different my life's journey may have been, if I could have proudly announced to anyone who would listen that my Great Grandmother was a nurse. I can't imagine not mentioning it in every presentation, lecture and acceptance speech I made over the years.

**Lesson Learned:** really explore why you want to become a nurse and make sure your life's partner shares and supports your dreams as well as theirs.

As an adjunct instructor at the College of New Rochelle for almost two decades I would always ask each student that I taught why he or she wanted to be a nurse. The class was for second degree students and RN's returning to school for their BSN. The returning RNs usually told of how they cared for a family member at home when they were ill or their Mom or relative was a nurse. Most of the second-degree students said that they couldn't find work with the first degree and heard there was work in the field of nursing and decent money. Both choices made sense. What is your reason for choosing nursing as your career?

**Next stop:** Certification County

In addition to your degrees, it pays to explore certification.

"Although the terms licensure and certification are used interchangeably, it is important to understand the difference. Licensing is an official and legal form of validation required by the professions. Generally, the state government issues licenses, and either the state department of education or the state department of health oversees the process. Licenses are issued to ensure that the public will not be harmed by the incompetence of practitioners. Licensure tells the public the practitioner is knowledgeable and competent and possesses the skills required to practice safely. There is usually a required educational level that must be attained before someone can sit for the exam, and a certain passing score must be achieved before a license is issued. These exams are appropriately named entrance exams because practitioners must pass these exams to gain entrance into their profession.

Case Managers hold licenses in their specific disciplines: nursing, social work, medicine, physical therapy, pharmacy, so on and so on. Nurse Case Managers obviously hold licenses as a nurse so why should a case manager seek certification, if he or she is licensed to practice? Certification affirms that the case manager possesses knowledge in his or her specialty. It reflects commitment to the profession of nursing, and it demonstrates accountability to the public. Certification should also be recognized as a career enhancer. It makes you much more valuable in the workforce, and in many organizations, certification is rewarded with increases in salary." (Llewellyn, 2009)

"Certification is a designation earned by a licensed professional to assure that he or she is qualified to perform a job or task according to sound principles of practice." Nurse case manager's certification is one such certification. Certifications generally are earned from a professional society and usually need to be renewed periodically or may be valid for a specific period of time. As a part of a renewal of an individual's certification it is common for the individual to show evidence of continual learning - after termed continuing education." (Llewellyn, 2009)

There are many certifying bodies that offer certification in case management including the American Nurses Credentialing Center (ANCC) which is the credentialing arm of the American Nurses Association and the Commission on Case Manager Certification (CCMC) for example. A list of agencies can be found on the Case Management Society of America's website, <http://www.cmsafoundation.org/>.

I was appointed to the ANCC first expert panel on Nurse and Case Management, worked to create their first credentialing exam, the first online review courses, taught the review course to many in the veteran's administration (VA) and other institutions. I was invited by Anne Lewellyn to co-author with her the third edition of the ANAs Nursing Case Management Manual and the fourth edition with Elaine Miller. I now sit on the ANCC Commission on Credentialing.

"The term certification is confused regularly with the term certificate for obvious reasons. Earning certificates; however, does not require that an individual have a professional license, does not require testing and does not reflect competency, but instead proves attendance or participation in a training or particular educational experience." (Llewellyn, 2009)

Some tips on how to prepare for your certification exam: Control your own anxiety - (don't listen to exam gossip). Set expectations that are realistic. Prepare mentally and physically and tap into your current knowledge base, it is more in depth than you imagine. Create a study plan and personalize it. No one knows better how you study, than you. There are many study guides available, make sure you get one. Good news, all certification exams are multiple choice and only one answer is correct. Remember, pacing your time is important. Lesson learned: Certifications in all your specialties is doable and desirable in the Human Resources Space.



## **Next Stop – Volunteer Land**

Volunteerism - the use or involvement of volunteer labor, especially in community service. (Wikipedia) One of the most important activities is volunteerism. It does several things: it helps people who need help; it helps certain organizations stay in business, it gives you an opportunity to network with like minded people, and when you do help others you get a feeling of warmth and satisfaction. For many years I volunteered on nursing and health care committees and I learned so much. Volunteering to be on committees, task forces, commissions and boards has always been important to me. For years I went to meetings, conferences, conventions, summits, seminars and educational dinners on my own time and my own dime. Later in life when my position called for me to be involved in many collaboratives, my expenses were covered. Then I began to be invited to speak at these different venues and was paid honorariums. It pays to hang in there.

**Lesson Learned:** Volunteerism develops character, expands your horizon, your knowledge and your network while you are helping others. It's a win-win.

## **Next stop: Mentorville**

Mentoring: Most successful people have had a great mentor or two in their lives. My first mentor in nursing was a good friend of mine and future sister-in-law, Joan who started nursing school when I did the first time. But she didn't drop out. She encouraged me to go back to nursing school and realize my dreams. Along the way I was blessed with several fine mentors. Instructors in Nassau Community College (NCC) who encouraged me to go for my BSN. Professors in my BSN program who encouraged me to volunteer for my first committee. A Community Health Committee which met at Malloy College and included members from different local health care institutions and parish nurse groups. The work was fascinating. I enjoyed it and I enjoyed working with others on the committee. I couldn't believe that I was sitting with some of my professors and CNO's and CEO's and having the same level of input. I continue my Committee work to this day. I have served at every level – Member, Executive Committee – Chair, Boards of Directors and several Committees. Chapter Organizations and then the Organizations themselves. From being a member on my first Community Health Committee, to now chairing the New York State Board of Nursing, my commitment and dedication is the same.

We may all have had instructors or bosses who have had the whole "alphabet soup" after their name and it felt as if they were saying "I've got mine, now you try and get yours" or the preceptor who you imagined was saying "oh boy, they burdened me today with this student or this newbie". You need to decide what type of mentor or preceptor you will be. I prefer to be one who says this is how I got to where I am, let me show you how to get to where you want to go.

**Lesson learned:** mentors are great gifts, always treat them with respect. Develop your mentoring style early in your career. Do what you need to do to get your job done. When you



are able to help or mentor “the newbie” do so with the best of intentions and a smile. You never know who your nurse will be when you are ill.

**Bullying: Bullying doesn’t only happen in the school yard.**

The first experience I had of bullying happened on day one of my first job as a nurse and I had just graduated with my Associates Degree. I started on a Medical/Surgical floor in a local hospital. The floor was manned with mostly LPN’s. They were great nurses and knew their stuff but didn’t like the “newbie” who was an RN. I was given what they call in our business, 9 “completes”. That meant those patients needed help with everything - moving and Activities of Daily Living, it was heavy work, the kind that puts a lot of pressure on your back and usually requires two people to move these patients. Unfortunately, I couldn’t find anyone available to help me most of the time and when they did help me it was clear they were annoyed by my request. They ostracized me for weeks before I could break through their clique. I would get in early and try to help the Ward Clerk and the LPN’s prepare for “report”. I would volunteer to help when someone needed it. I acknowledged their expertise, I even brought in donuts. I finally broke through and we began to work as a team.

**Lesson Learned:** Don’t let the bullies get you down. Don’t let them win. If you witness bullying step in.

**Next Stop – Success Town**

By working diligently, volunteering, mentoring, and always being willing to learn, you can be at the top of your game in no time (a decade to two). Oh now, don’t cry. That just sounds like a long time but take it from someone who knows “tempus fugit”. I believe that my volunteer work for the state, the Church, for NYSNA, ANA, American Nurses Credentialing Center Commission on Certification, Sigma Theta Tau, Adelphi University, the National Transition of Care Committee, The National Quality Forum, CMS Technical Expert Committee looking at readmission rates, the NYS State Health Improvement Project looking at the labor force, The Case Management Society of America, serving on committees and Boards of Directors nationally and on the State level, I was very into my volunteer work and it filled a hole in my soul that was not satisfied by my bill paying jobs. One enhanced the other. Some of the projects I implemented at work were a direct result of cutting-edge systems and models I learned of from my volunteer work. I went from staff nurse to a senior VP of a Managed Care Organization (MCO) with all the benefits and salary enhancements equivalent to my skills. Don’t let anyone tell you, you can only make so much money as a nurse. Nursing can be rewarding and lucrative. Some nurses are making seven figures for their talents.

To be successful at your position you must have a strong team behind you. Make sure you treat staff with respect. Make the job site a pleasure to be in. Support your staff and make sure they know that you support them. When I first began with Hudson Health Plan, I was able to convince other members of our Executive Council that certification and professional involvement were important to the professionalism of our staff and should be supported by administration. As a result, staff were encouraged to get certified. Books, applications, and

review courses were paid for by Hudson Health Plan. Once they passed their exam, they became certified by a recognized authority. In addition, they received a \$3,000 bump in salary. This not only helped existing staff but made recruiting easier.

So obviously this suggests that improving your knowledge base and expanding your credentials can only help you get to the “top of your game”.

**Lesson Learned:** Remember the better your staff are the better your team works and the better you look.

#### **Next Stop – Awards City**

There is really something special about being acknowledged by your peers for your work in our profession. As Sally Field said on stage as she accepted her Academy Award and held her Oscar – “You like me, you really like me!” I have been blessed with dozens of awards from local organizations for my work in the Community to National awards for programs I created and implemented, to my ½ hour prime-time, drive time, radio program that I produced and hosted for 6 – 7 years with a nursing colleague at Adelphi University; and later with my hubby for the next 3 – 4 years Nassau Community College Station. The original show won a national media award from Sigma Theta Tau. I also received the CMSA Case Manager of the Year Award and their Life Time Achievement Award. Naturally, I was humbled and delighted. God and my career have been extremely good to me. While each award takes up only one line on your resume, they represent work that possibly took years to complete. What I consider another acknowledgement of my work was grants received from CMS or the State to support projects or research. Most of us know that for the most part Grant dollars don’t always cover a projects expenses but when you can prove your model of care works, patients are happy, are getting the care they need and are saving your organization dollars through lower ER rates, lower admission and readmission rates, Administration will usually agree to support the program going forward. Take some time to evaluate the programs you are working on – should they be assessed for their effectiveness? The answer is probably yes. Don’t be afraid to bring your ideas to your boss. You may be sitting on a program that will bring you and your organization awards and a return on their investment (ROI).

**Lesson Learned:** Acknowledgement from your peers for your work is extremely gratifying.

#### **Next Stop – Publishing Plaza**

You may have heard the term “publish or perish”. It is a main stay of academia. It is too bad other branches of nursing see little need to write and publish papers, reports, articles or even a book! When I travel around our Country to speak to groups of people, I always encourage them to consider writing an article about what they are working on. People actually shutter at the idea of writing. I don’t know why but I guess they are afraid of rejection or failure. They also have no experience writing; they don’t feel readers would be interested in what they have to say. They don’t know where to begin; they are embarrassed to share their thoughts in writing in fear that the reader or editor will laugh at them. I am here to tell you

that publishers are starving for good articles about the interesting work you are doing. Editors are our friends; they are willing to help us go through the process. If you have an idea for an article, don't be afraid to reach out to one of our Case Management Publications or any Journal you think might be interested in your topic. You will be surprised how helpful these folks can be. I think I began with writing the Presidents Column for District 14 of NYSNA Newsletter. I almost wanted to give up the Presidency because I had to write the President's Column, I shuttered at the thought. However, I took on the challenge I wrote about the things I felt were important to the readers. A clinical issue, a political issue, an announcement of something or a tip on how to keep your physical and mental health in tip top shape. The Newsletter led to articles, led to contributing to other authors books, to co-authoring books. I met several very interesting people along the way. I have to tell you that there is a very special feeling which comes over you when they say, "she is a writer and an author." WOW! Try it – you'll like it!

Remember to research your work thoroughly, cite each quotation in your list of references. Check your facts; you'd be surprised how simple it is to write down a key piece of information, a date or a data grid wrong. Make sure if you are going to be referencing a project that you are involved with it at work that you have permission to write about it and they approve of the publication.

The feeling of accomplishment is tremendous, and it may not be like having your name up in lights but it's pretty close.

One of the articles I had the pleasure of co-authoring with two of my beloved colleagues, Sheilah McGlone and Alan Boardman, "Taking Integrated Care Management to the Street", Journal of Ambulatory Care Management, Lippincott Williams and Wilkins, (January 2011). (Leonard M. M., 2011)

Ask for help in choosing a publication that best suits the work you want to write about. Don't pigeon hole yourself or your work. If your project has great results you may find that your administrators are already in contract with certain journals and are planning on submitting the story themselves. If that is the case, offer to help with research or data collection. Be a part of it even if your name won't appear as an author, they will remember you for the next time and you may get your name listed next time as one of the authors.

I have been a nurse reviewer for the Journal for Case Management and now for Case Management Advisor. I am very fortunate to be able to review so many articles written by colleagues and by professionals I would love to meet. Let me tell you what I look for when I review an article – is it interesting, is it timely, (there is nothing worse than reading about a model of care that has been around for ages and uses old industry buzz words – except maybe plagiarism). I look for articles to be of help to the reader, articles with appropriate references. None of these considerations should pose a problem to you. Broaden your network to include folks that like to write or are in the publishing business. If you are still in school, your academic advisor can be a big help. Hopefully you have an advisor you can communicate comfortably with. If not, ask for a new advisor.

When I was in my short-lived Doctoral Program, there was a gentleman in our class of six who seemed to have no problem dealing with our assignment to create a report on the classes' subject matter, which at this time I can't remember what it was. He submitted his paper to find out that he had not only plagiarized the work, but he plagiarized the work of the professor. Now that was a big No- No! Sometimes it is hard to absorb the words, devour them and "spit them out in your own words" but it can be done. Also, just remember to use quotation marks and citation appropriately and always assign credit.

Feedback – one of the first articles I submitted came back with more red ink than I thought existed. My first impression of the edited version made me feel "stupid". Oh no, how could anyone write this bad. However, when I read the edits, they all made sense to me. The edits were on style, phrasing, and my not carrying through appropriately with verb tenses. There was no critique on content. I was so relieved; I made my changes and resubmitted only to get back more edits. Version four made it through the whole process and got published in "Nursing Spectrum". The Editor and Assistant editors were fabulous to work with. Today, I have had dozens of articles and three books I have contributed to- published.

I also worked with my husband, Ron, to write and publish his two children's books based on our wonderful granddaughter, Caroline and his book on Irish Music and Heritage called the "Merry Hearted Boys" about the Clancy Brothers, Liam Clancy and Tommy Makem. That was fun as well. So, you take that next step on your career ladder and get published.

**Lesson Learned:** Don't plagiarize your instructor.

**Next stop:** Anxiety Ville

Mergers - In today's fast paced health care world, mergers and takeovers are common place. You need to understand the world of mergers if you are to survive one if it hits you. I want to share my experience with you. Mergers and/or takeovers affect everyone in both companies from frontline staff to the C-Suites. In my case MVP Health Plan in the upper part of our state, a larger plan than Hudson Health Plan, 600,000. Vs 120,000. (democratandchronicle.com, 2013). MVP carried many products including Medicaid, Medicare, and Commercial lines of business. Why merge, for HHP they were a small plan in a state where it was desirable to the state to have less not more MCOs. MVP wanted to grow its Medicaid business. All Federal and State business indicators were predicting that Medicaid was going to be expanding and would be producing profits. So I imagine MVP's senior staff and Board of Directors considered the best route to increase their Medicaid membership –hire extra provider relation's staff to go out and build a network of Medicaid providers and then hire enrollment staff to sign up Medicaid patients (not an easy or quick fix) or buy a Medicaid Plan with a solid and extensive network and a hearty number of members. HHP had approximately 120,000 members, a solid provider Network and HHP was number one in Quality among all the state Medicaid plans. In addition, HHP was number one in member satisfaction for 14 years. The decision was easy, buy HHP, if they could strike the right deal, and they did.

To make this merger happen it was important to get Executives on both sides to agree they would work together and put a good integration plan in place. Most mergers cause anxiety

among staff, our merger was no different. Staff had so many questions and who could blame them. Will they keep me or let me go, will I have my same position, my same boss, will I stay in my office or be transferred to one of the new offices, will my hours be the same, will my benefits be the same. Will my hours or my money be affected? These, of course, are all normal fears and anxieties. You need to prepare yourself. I can't stress enough how important your people skills and political savvy are during this process. It is tough. Developing a good working relationship between you and your team and the folks in the new company's integration team is vital. Reality is, if there is a Vice President of Case Management in your shop and their shop, only one Vice President may survive the merger.

It is also important to protect your team from rumors and insensitive talk. In my case, my senior staff would be more than stoic during the combined policy and procedure assessment meetings, which were designed to decide on whose policies would be followed, which system would survive and which model of care. All very important issues and very proprietary. When the day was done, I grew to expect both Directors (these two women helped me and the company all the way) to wind up in my office in tears. It was important to listen carefully to their concerns and work with them to develop a survival plan. Sometimes it felt like neither side won because neither side had but, in the end, we came out on the other side one strong company and team. Not everyone survives a merger but if you want to, you can. Get to know the staff on the merging company that is purchasing the other company. Mergers take a lot of work and people skills.

**Lesson learned:** Don't burn your bridges behind you because you are bound to run into the same people after a merger that you worked with during the merger activities. You DO run into the same people repeatedly. The nursing world gets smaller the longer you are in it.

#### **Next stop: Political Park**

My love for advocacy and politics also helped me realize my potential. Not only did I teach the Politics of Nursing and HealthCare at the College of New Rochelle, but I was on the New York State Nursing Association's Legislative Council for 8 years, 5 of them as Chair. Then founded the Case Management Society of America's Public Policy Committee and served as Chair for 8 years until they didn't know what to do with me, so they made me the first Chair Emeritus for the next 6 years. I still participate on the committee. In all those years I saw many changes for nurses and case managers. The New York State Nurse patient ratio bill passed, the BSN in Ten bill passed after being on NYSNA Legislative Agenda since 1965!! Nurse Scholarship Act was passed, Nurse Practitioner Direct Reimbursement from CMS, the term Case Management found its way into the integrated model of care language of the Case Management Model Act which was inserted into many health care bills, and many pieces of Federal and State legislation and regulation. The number of health care professionals who became active advocates was very rewarding. I was asked to speak at many different forums about politics and the importance of being politically savvy at home, at work and professionally at local, state and national levels. Now as I move through my Second Act, I am becoming active internationally. Public Policy is one of my ways of giving back to my profession.

**Lesson learned:** Politics is not a dirty word. You must be politically savvy to move your health care and professional agenda forward.

**My Second Act may not be my last Act**, but it is one in which I have been able to expand my work to give back to my profession. As my volunteer work continues and my speaking engagements, I decided to take on a new gig. I have just accepted an offer to do some consulting work for MVP Health Plan. It will be fun to see a lot of my dear colleagues again. I have made many friends through the years. People you don't have to see every day to call them friend. You can just pick up the phone or text and pick up where you left off with them. One colleague, dear friend, caring nurse, excellent leader and brilliant informatics nurse was Margaret (Peggy) Annecchino. Margaret was my life saver when she stepped up to the plate and agreed to fill in my spot as VP for Medical Management when I was first diagnosed in 2015 with Stage 3C plus colon cancer and was out for 9 months. She kept the ship afloat and projects moved forward beautifully. She worked very hard really covering her own position and mine. Hats off to you Peggy! She, of course, had help on the business side and the emotional side from our award-winning Director of Case Management, Sheilah McGlone and our Medicaid Medical Director, Dr. Carolyn Leihbacher. My Three Amigos as they inscribed on the plaque on a new bench, they had dedicated to me and my contributions to our profession at one of the parks in my town of Niskayuna, New York. What a humbling experience that was. They arranged this surprise gift through my daughter, Denise who is a member of the Niskayuna Town Council. When the Three Amigos asked Denise for some advice on a unique and cool gift, Denise jumped at the opportunity and said, "no more pocketbooks or jewelry", I have a good idea!', Ha!

Of course, being diagnosed with cancer was devastating to me but my family was right there for me. My son and daughter were there for the first appointment with the surgeon through my "all clear" many months later. My Son Billy and my daughter, Denise coordinated second opinion visits in Boston and helped select the right oncologist for me. My treatment consisted of being at the oncology center for 6-7 hours every other week and 46 hours at home with a portable infusion pump. I had all the expected side effects, nausea, diarrhea, neuropathy, nose bleeds, mouth sores and fatigue. I hated the fatigue.

MVP was very understanding of my circumstances and were extremely helpful through the whole disability process.

All my friends responded with calls, texts, visits, some of the funniest get-well cards I had ever read, flowers, gifts, food and goodies. I remember sitting on my front porch one night with my son and saying it was like watching my own wake and funeral and waking up the next day alive. Pretty cool.

My involvement with the State Medicaid part of the business was needed and requested of me when I returned. So, Margaret Annecchino agreed to stay on as VP of Medical Management and I returned to a new position, Vice President of Medicaid Government and Community Initiatives, I was happy, because I felt relevant. Sheilah and Margaret left MVP in



Nov. of 2016 and January of 2017 respectfully. I missed them tremendously. Eventually, I realized the time had come to retire. So, on July 28th, 2017 I retired with an absolutely fabulous send off which was choreographed by my Executive Assistant, Lea Domestico. She had loving help from many others including Geminesse Williams and Gini Velez. The party was of course the best I had ever been to. All the HHP Executive Team was back together in one room with all the best people at HHP and MVP. The gifts were hilarious, beautiful and meaningful. The food was delicious, the candies (my favorite part), the desserts and the cake were just great.

After my retirement party on Friday, I left on Saturday for Hawaii for two weeks with my son, his wife Hanne and my two youngest grandchildren Piper and Beckham. We had the greatest vacation ever on Maui in two waterfront condos. My loving and beautiful cousin, Loren lives on Maui and has several travel and hospitality venues as clients, so we went first class all the way. Ain't retirement grand!

In October. I went on a Viking River Cruise to Austria, Prague, Vienna and more. My husband, Ron's illness, Chronic Inflammatory Demyelinating Polyneuropathy had gotten worse, so he had to cancel his voyage. That was a shame because the trip was magnificent. Fortunately, he was able to stay with our daughter, Erica and her husband Nick while I was gone. Elise our oldest, helped out as well.

Back home I continued my volunteer work and had the power to arrange for meetings to begin 11 am or later. Again, what a great thing this Second Act is.

I got to visit my granddaughter, Caroline a few times during her first semester at Catholic University in Washington, DC. She is a star, she won so many scholarships and was one of the ten Girl Scouts from across the Nation to win the National Gold Award for an environmental project her and her Scouting Leader and scouting friends worked on. She also lobbied for and received \$300,000 in funding for the expansion of the project state-wide from the NYS Legislature. The apple doesn't fall far from the tree. Her mother, Denise is a Town Council Member and a lobbyist. My son said I have visited Caroline more times in her first semester than I ever visited him in four years... I find that hard to believe.

In May of 2018, I was re-diagnosed with cancer this time it is Stage 4 colon cancer with Metastasis to my spleen and the lining of my abdomen. I am on a new targeted drug but the same chemo regime, 3 days every other week. My family and friends continue their prayers and support and my Denise is right by my side again. Her husband David has also been a great help, he does all my shopping. Good guy!

Ron is now in a nursing home on Long Island near his girls. He has severe Alzheimer's Disease. It is the saddest thing in this world. Erica, Nick and Elise visit every day and are coordinating his care expertly. They love their Dad very much and he and I love them.

One of the ways I fight back the tears is visiting my two youngest grandchildren. I get to see them the most because they are the closest to me. Piper and Beckham light up my life and make me forget all things upsetting.



Next week I leave on a Caribbean Cruise with my Saint Vincent Ferrer grammar school friends. Yes, I am talking friends since we were 5 – Ann, Arlene, Carol, Cathy, Denise, Jane, Mary and Peggy. Love these women. A good social network of friends can keep you smiling. I must also mention my local friends, The Breakfast Bebies and my Cella Chicks –Agnes, Beverly, Coleen, Creve, Christina, Elly, Fran, Gail, Loretta, Mary Jane, Nancy N., Nancy W., and Patti. Remember to take time to stop and smell the roses, keep humor and music in your life and then to take care of your physical and mental health, the profession needs you.

When I return, I will start working on some conference presentations I have coming up. I did retire from the CMSA Foundation Presidency. It was time. The Foundation needed new life at the top and I knew just the right person to take the foundation to new heights – the talented and award winning case manager extraordinaire – Debborah Gutteridge and she with the blessing of the CMSA Executive Director, Kathy Fraiser and the Board of Directors of both organizations and the Foundation Executive Director, Rebecca Perez and their Executive Administrator Michele Lee, the Foundation will flourish. I have made a commitment to continue to support the Foundation and pay my success forward through a Public Policy Research Grant for at least the next 5 years. Unashamedly, I say donations can be made to the CMSAF at <http://www.cmsafoundation.org/>.

Remember, I restarted my nursing career in my thirties as a single Mom of two, working full time. Got remarried, started working as a Med-Surg nurse and then moved up my career ladder, went on for my BSN degree at night continued with my master's degree, tried a doctoral program lucked into my post master's FNP program. Received scholarships and tuition reimbursement most of the way. I learned to be a good student, mentor, preceptor, teacher, writer, speaker and leader. I learned to give back. Every day is a gift!

Who knows if there will be a Third Act, but I sure am enjoying this Second Act. Please get in touch with me if you have trouble staying on this magnificent roller coast ride, I call nursing.

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Case Management Society of America Foundation: <http://www.cmsafoundation.org/>

New York State Nursing Association (NYSNA): <https://www.nysna.org/>

American Nurses Credentialing Center (ANCC): <https://www.nursingworld.org/ancc/>  
Commission on Case Manager Certification (CCMC): <https://ccmcertification.org/>



Margaret (Peggy) Leonard, MS, RN-BC, FNP is nationally recognized for her work in Quality, Case Management, Care Coordination, Transitions of Care, Certification and Public Policy. She is a published author and has written extensively on these topics; including the American Nurses Credentialing Center (ANCC), Nurse Case Management Review and Resource Manual. Peggy was the creator, producer and host of “Community Nurse On-Call”, a national award winning prime time, drive time radio program in NY for 10 years and is the recipient of dozens of awards including the Case Management Society of America’s Lifetime Achievement Award.

Peggy Chairs the New York State Board of Nursing and is a Commissioner with ANCC’s Commission on Certification. She is past President of the Case Management Society of America (CMSA) and its Foundation. Peggy also chaired the New York State Nurses Association Legislative Council. She was past Chair of the National Transitions of Care Collaborative (NTOCC) Public Policy Task Force; Founder and now Chair Emeritus of CMSA’s Public Policy Committee and a member of the NYS Workforce Workgroup - in support of the NY State Health Innovation Plan (SHIP).

## **BUILDING BRIDGES TO INNOVATIVE CASE MANAGEMENT PROGRAMS: SHARING MY CONTINUING SUCCESS STORY**

By: *Sheilah McGlone RN, CCM*

As I sat down to gather my thoughts about my lifelong career in the health care field, I thought about when this dedication to case management really began. As I began reflecting on my own life, I realized that, as with most of us, the practice of case management actually started right at home – caring for loved ones, a father, mother, husband, and child. We know that the path of life is often driven by outside social forces, but I still believe that fate, one quickly made a decision and even a bit of luck, can change the course of ones' life. I have been fortunate to have crossed paths with several people who have influenced my career and "dared me to be more than I ever thought possible." I am forever grateful to all of my mentors, especially Peggy Leonard, who have inspired me and touched my career in so many positive ways. But I will forever be indebted to the dedicated home care nurse who – while helping me care for my terminally ill mother – encouraged me some 40 years ago to reach for the stars and go to Nursing School. The building of the bridge began all of those years ago. I was 33 years old, a wife, a mother of two children, and a new graduate Registered Nurse.

I loved bedside nursing. I joined a new community of friends and staff wholly dedicated to helping people. As a new graduate in a large hospital, I found it at first frightening, chaotic, and challenging but – as I gained confidence – very rewarding. I developed strong clinical skills, working at first with experienced, dedicated preceptors as I traveled throughout the medical-surgical, diabetic and orthopedic units. I was soon ready to take additional courses to earn an intensive care/coronary care certification and status. During this time I was exposed to new viewpoints of my patients regarding their overall health, wellbeing and socioeconomic situations. Even with small windows for patient engagement within direct care nursing, I never lost sight of how important it was to kind, empathic and comforting to even the most complex and challenging patients. There were many enlightening situations where I was able to apply my life experience and – in some cases – to "step into a patient's difficult shoes." I had the faint hope that I could help them overcome external barriers to care in such a short time, and I knew that many of them would become familiar faces as they returned through the revolving door.

Transition to a utilization review position was unexpected, but life-changing circumstances made Monday through Friday, 9 to 5, essential. My husband was diagnosed with a life-threatening cardiac condition that required me to have a more reasonable and structured schedule and work closer to home. I was very surprised when I was called for an interview and immediately hired as a Registered Nurse Healthcare Analyst for Empire Blue Cross/ Blue Shield, a leading health insurance company based in New York. My first challenge in the new role was to embrace technology and overcome my fear of the computer. It certainly didn't take long. It was the early 1990s, and the birth of precertification for inpatient hospital admissions was a new consequence of ever-rising health care costs. I gathered and evaluated clinical information to authorize medical necessity for medical and behavioral health admissions. The process was not well received by providers. My new environment was radically different from bedside nursing and involved a different and often difficult kind of communication with providers and subscribers. After one year, I transitioned into a supervisory role, becoming responsible for the daily operations within this large managed

benefit program. I learned many new skill sets. I felt like I had been launched into a new planet of call center service levels, quality assurance reports, and the writing of policies, procedures and performance appraisals. Daily life consisted of the application of medical necessity criteria, ensuring corporate compliance, meeting state-mandated time frames, and processing appeals.

Most importantly, this position was my first exposure to organized, complex patient identification. I quickly learned to step up and overcome the challenge of gaining respect from an over-burdened team. I understood the importance of team building, the need for ongoing staff training and motivation and open communication. I began to feel like and be regarded as a calm, thoughtful leader with high staff expectations. Then, after six and a half years, changes in the larger health care arena led to the closure of my well- established high-performance unit! But the valuable experience had brought me closer to building the bridge to case management. I was ready to move on and take with me a set of leadership skills I would use in the years to come.

It was a fateful day in my career path when I received a call from my former manager from Empire Blue Cross /Blue Shield. She had transitioned to a small New York community-based, government-funded Medicaid Managed Care Organization, later known as Hudson Health Plan. Managed Care was a brand new concept in the world of Medicaid. I still fondly remember the phone conversation hearing her say, "come work with me; New York State confirmed that I need a case manager!" She was hesitant about defining my responsibilities and advised me that I would have to create my own job description. The ambiguity of the position was disconcerting, but I took the road not traveled to learn something fresh with more positive patient contact. Sitting in a small cubicle next to Claude, our energetic and dedicated mail clerk, I started my telephonic outreach to Medicaid members with complex medical conditions. I was able to engage some patients and help them move forward to a healthier outcome, but the outreach challenges to an underserved population were overwhelming. The majority had health issues and social challenges related to poverty and poor access to care. My career transformation had begun, and I was getting closer to building that bridge.

I had made a somewhat impulsive career change decision in my life by heading to Medicaid managed care, and now "luck" came my way. As Hudson Health Plan expanded, new leadership arrived. I was so fortunate that Peggy Leonard, a pioneer in the world of case management would oversee the small case management department. She became my trailblazer, mentor, boss, and friend. It was refreshing to be surrounded by a circle of strong women in leadership roles at Hudson Health Plan who believed that quality patient-centered care – not the "bottom line" – was the priority for improved outcomes. This was an unusual philosophy in the managed care arena. As I worked my way up the ladder to Senior Director of Case Management, my world became dedicated to serving the most at-risk, vulnerable population. Hudson Health Plan became a well-respected health plan at the local, state and even national level. We were on a crusade to provide excellent healthcare for "underprivileged" populations, but I knew we had to learn some new case management strategies to meet that goal.

Peggy introduced me to the Case Management Society of America (CMSA) in the late 1990s. Being part of CMSA was and continues to be a wonderful educational and rewarding experience that has helped me to grow as a professional case manager and to obtain certification in a field of growing importance. By sharing CMSA educational materials and programs, I was able to expand the knowledge of my staff and help them to develop into truly expert case managers who – in turn – became well-known and respected in the industry. I became very involved within my local chapter and soon assumed leadership roles, including treasurer, educational chair, public policy liaison, president, and Board member. I also helped to create a much-needed chapter in the NY Capital Region. The networking and establishment of lasting friendships with my CMSA colleagues are unsurpassed. I found it rewarding to attend several CMSA Public Policy “Hill Days,” which allowed me to join my colleagues in getting the word out to my local house and senate representatives on Capitol Hill regarding our Standards of Practice, our Case Management Model Act and “who we are and what we do.” These trips awakened emotions, making me feel proud to be an American who might be able to make a difference with health care reform. I quickly realized how politics are shaping our professional roles within this ever-changing world of health -care.

It was 2008, and our case management model was about to change exponentially. I was invited, along with my colleague and friend Alan Boardman from Hudson’s behavioral health vendor, to participate in the beta testing of a new training program through CMSA called “An Integrated Case Management Model.” I was aware of the so-called “silos” in current models, including those within my own programs, and understood the need for physical and mental health service integration. Although we worked very well with Beacon, I recognized that more needed to do. I was energized thinking about attending the training. Alan and I read the required manual and went nervously to the two-day sessions. It was intense training. I will never forget my friend Becky Perez standing with Deb Gutteridge in front of our group saying, “this may not be for the faint of heart.” I knew it was a major shift in previous case management philosophy and communication strategies, but it was time to take action and assign “one case manager” to link and integrate patient care coordination across all domains of health – physical; psychological and social – for health care “navigation.” This innovative program was swirling within my mind as I went about my days. I was inspired. The Hudson Health Plan architects were beginning to build the bridge

Hudson Health Plan was ambitious and innovative, always looking to improve programs to promote better patient outcomes for the underserved. In 2009, the New York State Department of Health (DOH) announced approximately seven million dollars in grant funding to six different organizations, for the creation of a three-year regional Chronic Illness Demonstration Project. The purpose of the “CIDP,” as it was called, was to address the needs of chronically ill Medicaid recipients, improve their health outcomes, and show cost savings to the Medicaid system. After the initial announcement, there remained one un-announced award for Westchester County, where Hudson Health Plan was based. Although it was late in the game and unusual for a health plan to apply for a CIDP, we partnered with Beacon Health Strategies and diligently worked to complete a seemingly endless application and jumped into the game. The main focus of our planned submission was the implementation of a “feet to street” fully integrated case management model, with a core design based on the CMSA integrated training. We were selected! We then created an

interdisciplinary team consisting of experienced Registered Nurses, Social Workers, Integrated Care Coordinators, and a Peer Support Specialist with access to both medical and psychiatric physicians for consultation. Our team was empowered with knowledge to succeed after completing the in-person Integrated Case Management Training with Becky Perez. We were off and running to meet our goal to find, engage and provide integrated care coordination for 250 “lost,” high cost, fee-for-service Medicaid recipients. Our challenges were beyond belief, but we continued to be the only CIDP program in the state that met its ambitious outreach and enrollment goals. This new team, called Westchester Cares Action Program (WCAP) was not “faint of heart.” They were willing and able to head to the streets to help break the mold of despair that continues to have a hold on vulnerable, marginal populations. Awards at the community, state, and national level were for WCAP, including the CMSA Research Award in 2012 for demonstrating successful outcomes. One of my proudest moments was when I stood on the stage at the 2013 National Case Management Society of America Conference in New Orleans to accept the CMSA Award of Service Excellence (AOSE). I dedicated this distinguished award to many, but most importantly to a phenomenal “street gang” of professionals whom I was privileged to lead. In 2012, the WCAP Team transitioned into one of the most successful New York State Health Home Case Management Agencies. I have participated in several presentations at the local and national level to share the strategies that led to our success, and proudly became a CMSA trainer for the integrated model.

I continued to break routine patterns of our standard case management programs. I was driven to expand integrated model techniques and face-to-face for the most complex patients within the Hudson Health Plan Case Management Department. With the help of data analytics and patient profiling, we were able to identify such patients easily and, after case stratification, the new approach was successfully launched. All of our programs, including our renowned maternity program, were revamped with a new approach that was recognized and well-received within the community. My 20 years in a leadership role at Hudson Health Plan was not just a journey, it was “great run,” and the bridges we built are still standing!

Hudson Health Plan was acquired in 2014 by a large “commercial” insurance company. After two years working for the merged company, I retired from my Senior Director position, leaving behind the rewarding but chaotic days of government-funded managed care.

I am very proud of my accomplishments and the personal and professional relationships I have established, but I have more to accomplish. The circle of life can certainly change one’s course. Getting a bit older, the loss of a husband several years ago, a year of breast cancer treatment and the recent loss of a beloved son all caused me to take a step back to focus on the simple poetry of my life. It was now time for my “second act” as an expert independent case management trainer and educator.

As an experienced leader in the field of case management I was aware of the need to train and empower case managers to help patients move across the continuum toward better health. Training is essential, so I too have hit the streets and embarked on a mission to share my expertise with all levels of staff working in the healthcare field. Through my training classes, I am making many new friends who are dedicated health care workers from different cultures, different communities and all walks of life. I travel to large hospitals in New York’s “inner cities” and local and rural Federally Qualified Community Health Care Centers to train



and share my knowledge, success stories and lessons learned. I am so pleased to see staff make changes within their practice and daily routines by embracing the motivational interviewing techniques I present and accepting the concept of patient-centered integrated methodologies to promote patient engagement. I receive enthusiastic promises that their newly learned motivational interviewing strategies will be applied to promote the health behavior change of patients; many of my trainees even tell me that their new skills are helping them to navigate challenges within their own busy personal lives. I am continually amazed and energized to be in the company of so many who are committed to improving the health outcomes of those who are most at-risk. My schedule is busy in 2019 with new requests to provide case management training focusing on the CMSA Standards of Practice. I will continue to be available to assist with CMSA's Integrated Case Management training program, which helped create the path of my career, improve the lives of so many, and in which I still fervently believe it. I continue to train front line staff, and try every single day to make a difference. I continue to evolve, as I learn from those around me. My second act is not my last!

As I work through my profound grief over the recent loss of my son due to an accidental Fentanyl overdose, I am preparing to add a third act. Some may call it a "mother's story," which there are so many these days; others may call it a crusade, a campaign or just a healing process. I am marshaling my courage and convictions, and getting ready to pound the pavement – again – this time to work the stigma of mental illness and addiction, and call for immediate access to quality care and the prevention of the illicit sale of Fentanyl and other illegal drugs. John was a social being, a free spirit with a big heart. He was at times like a well-loved mayor in a subculture called the world of survival and addiction of which many are not familiar: a subculture that does not have socio-economic or educational level boundaries. He was also desperate for treatment, and – despite my personal advocacy and intervention on his behalf – the "system" failed him.

To start, I will incorporate into my current training programs emphasis on the need for a specialized case management skillsets to help create a path to recovery as we all experience the challenges of the current opioid crisis in our personal lives and careers. I hope to become a familiar face and voice at community and state meetings promoting awareness of the need for this specialized practice of case management

I remain passionate about my work and I am still moved by CMSA's philosophy and guiding principle of Case Management that states: "The underlying premise of case management is based on the fact that when an individual reaches optimum wellness and functional capability, everyone benefits, the individual being served, their support system and the health care delivery system." I will always continue to be a part of CMSA, remaining committed to many additional years of learning, teaching, networking, making new friends and participating on the CMSA Foundation Board. I encourage anyone entering the practice of case management to become a professional and to get certified. Join CMSA to learn new ideas, keep abreast of clinical skills, learn about new technology and hear success stories from those who have traveled the path before you. Abide by the CMSA Standards of Practice. Be aware of the state of healthcare reform through public policy. Jump into the political game and come to "CMSA Hill Day." Our healthcare system needs you!



Don't be afraid to build your bridges and implement new innovative techniques to empower your patients to move towards change in this tumultuous world of health care. In all of this, don't forget to take care of yourself and those you work with every day. As Peggy Leonard always says: "Together we can make a difference." It's time!



Sheilah McGlone RN, CCM, is a well-known leader in the field of case management and a winner of the National CMSA Award of Service Excellence. She has over 30 years of case management experience with a primary focus on underserved populations. She is dedicated to the philosophy and delivery of fully integrated care coordination. As a Senior Director at Hudson Health Plan, her innovative programs have won awards at local, state and national levels. She is presently sharing her expertise by working as a case manager educator focusing on the basics of motivational interviewing, CMSA Standards of Practice, leadership strategies and implementation of the Integrated Case Management Model. She remains active with CMSA and was recently appointed to CMSA Foundation Board of Director.

## WHY I BECAME A NURSE AND MY VARIOUS CAREERS IN NURSING

By: *Maureen J Orr, RN, BS*

I graduated from Johnstown Mercy Hospital School of Nursing in May of 1965, with a Diploma in Nursing. At that time, Diploma Schools were the most common institutions for women to obtain a career in nursing. Note that I said, women because at that time there were no men in nursing.

Since I was the oldest in a large family with nine children, the "Little Mother/Nurse" role was given to me by my family. I loved my siblings and enjoyed helping them and recall times when all the kids had measles or mumps, and my mother would turn one of the larger bedrooms, into a "ward" to care for all at the same time. There were few vaccines at that time, and infectious diseases would run through the entire family. I recall one summer when the girl next door died of polio, and we were kept inside and were not permitted to play outside due to the concerns of catching polio. One of my beloved uncles was a Mayo Clinic, graduate surgeon. In high school summers, he employed me in his office to help, and I enjoyed reading his journals between patients. His wife, my aunt, was also a nurse and both of them strongly encouraged me to become a nurse, so it seemed inevitable. Fortunately, I was able to receive a loan from the Hospital to enable me to attend because my parents were really unable to help me at all.

Upon graduation, I headed to the big city of Pittsburgh, since they paid the best salaries at the time (\$5400/year). I started at the large county hospital and learned the basics of Intensive Care-a new concept in caring for patients. I later transferred to Pittsburgh Children's Hospital in the Infant Surgical Unit and loved the challenges of caring for babies who often returned from open heart surgery wearing a Band-Aid on their chests. Working was my job, but my life outside the hospital included dating, attending concerts, reading, and development of hobbies such as sewing. One of the physicians I worked with had recently returned from Viet Nam, and he described some of the conditions in the country and the work he had performed. Concurrently, I had been reading the books of Dr. Tom Dooley, who described in detail the medical care he was administering to the peasants and wounded in the jungles of Viet Nam.

Intrigued, I began planning to try to obtain a nursing position overseas. I considered the military but honestly did not think I could care for young wounded soldiers. I wanted to concentrate on childcare. Soon, I noticed an ad in the paper for nurses to work with the USAID (United States Agency for International Development.) This was a new agency developed by President Kennedy to provide development care overseas in Third World Countries. Resources were being provided particularly for Viet Nam to "win the hearts and minds" of the locals. I applied, was accepted, and in July of 1967, I left home for Washington, DC for orientation. Subsequently, our group of 24 nurses flew to Hawaii to learn to speak Vietnamese. Three months later we flew to Viet Nam.

I was assigned with two other nurses to the Khanh Hoa Provincial Hospital in the city of Nha Trang, Viet Nam on the coast. Initially, this hospital had been built by the French. In addition to the main wing, there was a communicable disease ward divided in two by a flimsy wall. One side had patients who were diagnosed with tuberculosis, and the other hand had patients with bubonic plague. My assignment was to turn the one small room with the only 4 hospital beds in the hospital into a recovery room/intensive care unit and teach the nurses

recovery and intensive care. It would take a book to describe all that occurred during this best job of my life, but suffice it to say, it was also the best nursing experience of my life. I would have stayed much longer except for the Tet Offensive, which made it impossible for civilians to continue working there. During the Hawaiian training, I had met another USAID employee, who worked as a Refugee Officer. He asked me to marry him and thus began another rich chapter of my life. I always tease that I married a gypsy, since my subsequent career was anything but usual, but indeed rich in experiences as my husband accepted many consulting positions overseas.

We returned home, got married, my husband underwent surgery to have shrapnel removed from his lungs (thanks to a claymore mine explosion while in Viet Nam), and I began working at Colombia Hospital for Women in Washington, DC. I continued my work with children, this time working in the Neonatal Intensive Care unit until our first child, Sean was born.

While recovering from surgery, my husband became associated with a language training program, and they transferred him to New York City. I stayed at home with Sean until he was about 9 months old then began working part-time at St Vincent's Medical Center in the Bowery section of New York City. I worked in the Charity Wards with as many as 20 patients per ward. Ensuring all patients received their medications was a challenge in this overcrowded ward of injured and ill patients. In our home life, it was a joy learning the city, and we spent weekends exploring the many beautiful neighborhoods in the town from our sweet apartment in Greenwich Village.

Subsequently, my husband decided to return to school, and we relocated across the country to Tucson, Arizona. A new Medical Center was being built for the brand, new medical school and I was delighted to assume the "Head Nurse" position in the gorgeous new Infant Intensive Care Unit. As lovely as the place was, the challenges of opening a new unit were many. I recall dashing to Walgreens on opening day to purchase diapers, thermometers and other essential baby items that had not yet made it to the unit!

Many advances were being made in the care of critically newborn children, and I was proud to be a part of that progress. However, the concentration on preventing neonatal mortality sometimes conflicted with common sense. For example, all newborns, All Newborns, even perfectly healthy 10 Apgar babies were admitted to the neonatal unit for the first 8 hours of life for observation. Naturally, this certainly conflicted with bonding with mothers and initiation of breastfeeding. I recall numerous meetings with physicians concerning these challenges that had little effect at that time. This experience I believe affected my decision to have a home birth for the birth of our second child. Fortunately, I had a wonderful obstetrician who had a jeep completely outfitted for any emergency and Brendan was born at home with the assistance of a medical student, a nurse, and my beloved obstetrician.

Upon completion of his education, my husband was offered an excellent opportunity to work with the Arizona Medical Association on a project to reduce infant mortality on the White Mountain Apache Reservation in the mountains of Eastern Arizona. I had never adjusted to the dryness of the desert and the lack of greenery, despite the stark beauty and was delighted to move to a place that was perfectly green and lovely. Every day while looking out the windows of our living room, I would marvel at the vision of mountains, rivers, and wildlife.

While my husband worked on training aides and nurses to do outreach to pregnant Native Americans to help reduce infant and maternal mortality, I was hired by the White Mountain Tribal Authority to work with high school students to encourage health careers. In the 1970s there was only one Native American physician and very few nurses. My students were eager to learn, and I taught them a basic Nursing Assistant program, which enabled them to be hired in the local Bureau of Indian Affairs Medical Center as Nurses' Aides in the summer while applying to colleges to obtain careers in the medical field. It was a privilege to work with Native Americans and to see the challenges of their lives as well as their triumphs. It was a wonderful experience for our children, also, to learn to live with another culture and to understand that not all children had the same privileges they had. My husband's program was very successful, and as a result, he was offered a position in South America.

Sadly, we said goodbye to our wonderful friends in Arizona and headed south for more adventures. In preparation for living in Colombia, we had to undergo a lot of training in New York and based on my passport, (which I resented) that stamped me as "housewife" meaning I was not permitted to take a job away from a Colombian. The unemployment level in Colombia was very high at the time. However, upon arrival in Bogota, I connected with some women who had worked with the Peace Corps, and I took over their program of teaching English speaking women childbirth classes. In effect, the classes, plus support while hospitalized and postpartum, I acted as a doula. Basically, I taught what I had learned in the birth of my second child, which was the Lamaze method of "Husband-Coached Childbirth." Concurrently, I was learning to speak Spanish by taking classes while my children were in school, but I still did not feel comfortable enough to be teaching courses in Spanish. Following each group of successful childbirths, we celebrated with potluck parties at our home so that everyone could see the new babies. Many friends were made in these wonderful classes. However, life in Colombia became more challenging, due to the increasing drug trade and my husband's office was transferred to Miami, Florida.

Our family arrived in Miami at the same time thousands of Cubans flooded in, during what was termed the "Cuban Crisis." I knew that with my school-aged children I could not accept work in the hospitals, so I looked for a daytime opportunity and accepted a position with the Florida Public Health Department. Speaking Spanish was obviously a benefit as I began my career in public health. While the work was gratifying, lack of resources was a constant problem. Duties seemed overwhelming at times. All nurses were assigned at least 10 schools to service, in addition to clinic duties for prenatal care, newborn care, vaccinations, infectious disease, home visits for postpartum follow-up, and communicable disease follow-up. All of this while the city was convulsing. One of the schools I was assigned to in a Little Havana neighborhood had to have a special counseling session for children who had witnessed people murdered during their treacherous journey from Cuba to Florida. An abandoned car was found in front of our children's school with a murdered body in the trunk, leaking blood onto the road. Mentally ill patients who had been flushed from the hospitals in Cuba were sent to the US by Castro, and they walked the streets, with many of them actively hallucinating. Crime soared, and many citizens fled to the northern parts of the state. If that was not enough, the AIDS epidemic hit the streets. Needless to say, the times were challenging for public health nurses. I loved the work I was doing and ultimately was assigned

to manage the high-risk maternity clinic. Concurrently, I obtained my certification as a Community Health Nurse.

While my husband had succeeded in increasing his education, I became more determined to improve mine. Working full time while managing an active family and working on my degree was challenging to say the least. I recall many days when I set the alarm for 4:00 a.m. to start a few loads of laundry while studying before heading to work. Ultimately, I was able to complete a Bachelor's Degree from the St Joseph's College in Maine, taking classes via correspondence (before the internet) until fulfilling the last requirement of 3 weeks on campus in the summer. How proud I was to achieve this degree finally.

As my family responsibilities grew and the boys were entering college, I needed to assist them more financially. Salaries for the public health department were the absolute lowest in the entire country. I began looking for positions with better income but with daytime hours. A friend informed me of the joys of case management. (Thanks Yvonne)!

I interviewed with American International Health and Rehabilitation Services and was given a position of case manager for interfacing with the insurance company and injured workers. A whole new world opened up to me! Although I thought I had kept up with nursing and medical changes, I learned that work-related injuries had a lot to teach me. I could still apply the skills I had learned as a public health nurse with interviewing and counseling patients while learning to connect them to the most appropriate health care provider to ensure their ability to return to work. Mental health issues also required learning more about some of the problems that prevented them from a successful return to work and life as before their accident.

Concurrently, while learning to work with insurance adjusters, I began learning new skills concerning medical-legal issues. At that time, adjusters had very little knowledge of medical issues with numerous claims. The American International Group was one of the largest insurance carriers in the world at that time and provided insurance on Workers' Compensation, Auto claims, Medical Malpractice claims, Home and Auto Insurance. They even insured Michael Jackson and other entertainers! Our supervisor at the time, Pat Murphy was very supportive of any of our ideas; therefore, when I learned of a new organization, called the American Association of Legal Nurse Consultants (AALNC), I was thrilled to become one of the charter members and also obtained certifications as a Legal Nurse Consultant. Soon, our organization learned of the unique role that nurses could play in informing carriers about medical issues that could impact the cost of the claim and the welfare of the claimant.

In addition to medical-legal issues, case management was another new field that I was learning. Certifications soon became available through the Case Management Services (CMS), Commission for Case Manager Certification (CCM), and Certification of Disability Management (CDMS.) It was exciting to be learning new methods of interaction with patients. Many times, the business of insurance and the welfare of patients required a new level of skill to ensure the ethics of our nursing responsibilities would not conflict with the desire and goal of the insurance company.

When my husband retired from his international work, we decided to move out of South Florida, since the pace of life seemed overwhelming at times. Our oldest son had relocated to

Jacksonville, and after a long road trip exploring potential places to retire, we relocated (again) to North Florida. We were sad to be further from our youngest son but knew we did not wish to live in Key West. I accepted a position with the State of Florida in the Bureau of Rehabilitation and Reemployment and enjoyed more opportunities to perform case management duties. The level of poverty in the area was striking, and on occasion, folks would stumble into our office and report not having had any food for 4-5 days. I quickly developed lists and phone numbers of agencies able to assist those without resources. Fortunately, there was a food bank close to our office, and I made many trips there to secure food and connect clients with resources. This was also a way to learn more about the city and its wonderful people.

I would still be working for this wonderful organization if Governor Rick Scott had not dissolved it a "cost-cutting measures" five years ago. In a part-time venue, I still performed some case management work for a dear friend, but at the age of 74, I am now enjoying the gifts of retirement. I belong to a wonderful quilting guild, and I volunteer at a local museum as a docent.

I believe what I have learned in my 56 years of nursing is that it remains a wonderful vocation for people who still want to assist humanity at a very personal level. Case management has helped remove me from the frontlines of hospital nursing to a more personal and in-depth means of connecting with clients and teaching them methods of health care on a one to one basis. Although caseloads were at times challenging, learning the skills of time management, interaction with physicians, and attorneys and yes even courtrooms at times helped expand my knowledge and my skills as a nurse case manager. Coordinating services, connecting clients with resources, communicating with folks at many levels were also terrific skills to become not only a better nurse case manager but also a better person.

My daughter-in-law and my nephew's wife are both nurses, working high-stress positions in Coronary Care ICU and Emergency Departments. I hear their stories and challenges and learn from them of the technological changes in patient care. Today's nurses have many challenges, and I hope that my younger grandchildren might consider a career in nursing, too. If that happens, I hope that they can learn from the past experiences other nurse case managers and I have had and continue to put the patient/client first above all. Their challenge will be to learn the increasingly complicated technological skills while making sure that the person who is at the center of their work is never forgotten.

A few years ago I learned of a Nurse, Hildegard of Bingen. She was born in Germany in the year 1098 and became a Benedictine Abbess, supervising nuns who worked in hospitals run by the priests. At some point, she decided she wanted her own abbey and asked the order to allow this. She was denied and became very ill in her struggles. However, she never gave up and petitioned the local bishop who ultimately allowed her to establish her own abbey. There she wished to teach her nuns/nurses how to care not only for the ills of the body but also of the spirit. She composed and played music and poems that helped her patients relax and have their spirits lifted as well as their bodies healed. I hope that in the future, nurses will have more time to address the spiritual needs of the patients/clients through known practices of yoga, tai chi, music, and poetry. Because if I have learned anything in my long career, it is that if the spirit is ill or crushed, the body will not completely recover.



In looking back over the 56 years of my career, I am filled with gratitude for my career, despite it being very atypical of most of my nurse friends. Now, I am in my Second Act as a nurse, caring for my husband who has health challenges. Hopefully, the skills I have learned in the past will be applied to help us both as we progress in the winter of our lives, especially using the tools of kindness and empathy to guide us on our journey.



Maureen Orr is a Registered Nurse with experience in various fields of nursing, including Pediatrics, Recovery Room, ICU, Neonatal ICU, Public Health, Legal Nurse Consulting, and Case Management. Roles have included supervision and teaching. Overseas experience included establishment of a Recovery Room in Viet Nam, where she instructed Vietnamese nurses in their own language, and development of a childbirth education program for expectant parents in Bogotá, Colombia. Ms. Orr has worked in areas of cost containment and quality control for a large insurance company and was national educational director for their medical-legal consultant program. She has worked as an in-house Clinical Research Associate for a large Miami law firm. Since 1997, Ms. Orr established Orr Legal Nurse Consultancy, Inc, as president and owner. In this capacity, she

performed medical legal reviews of complex litigated cases for attorneys and adjusters in areas of product liability, toxic tort, auto liability, workers' compensation and medical malpractice. Additionally, she worked as legal nurse consultant for Thomas J. Goldschmidt, M.D., Neuropsychiatrist, while also performing case management.

Ms. Orr was a charter member of the American Association of Legal Nurse Consultants (AALNC) and the co-founder of the Miami Chapter of the AALNC. She achieved certification in the first program developed by the AALNC for Legal Nurse consultants (LNCC.) Other certifications included Certified Case Manager (CCM,) Certified Disability Management Services (CDMS) and State of Florida Workers' Compensation Provider (QRP). Publications include the January 1992 Journal of the American Association of Legal Nurse Consultants and a chapter in the Principles and Practices of Legal Nurse Consulting. Ms. Orr has made more than fifteen presentations throughout the country concerning nurses and legal nurse consulting for various groups. On a personal note, she is married, with two children, six spectacular grandchildren, and one great-grandchild.

## **JOBS END, CAREERS CONTINUE: ENTERING ACT TWO**



By: *Laura Ostrowsky RN CCM*

I went to college straight out of high school (no gap year), not having any idea what I wanted to do with my life. My mother used to say I was the only child she knew that never expressed a specific desire to be anything when I grew up. In college, I took my requirements and put off picking a major for as long as I could, eventually choosing a double major in elementary education and sociology. I decided I didn't want to teach and went to work in market research for a few years.

During that time, I grew up, and thought more about my career goals and eventually decided to become a registered nurse. I rationalized that nursing was a secure career with lots of options and the chance to do some good in the world. My sister remembers being somewhat surprised when I went into nursing. She thought it made sense as a practical career goal but said she had a vivid memory of me screeching and gagging when I reached into a bag from the supermarket and found that a container of chicken livers had opened and disgorged its contents into the bottom of the bag. Obviously, that is no longer an issue and wasn't when I began my nursing studies.

Since I already had a Bachelor of Arts, I decided to accelerate the process and enrolled in an Associate degree program at a local community college, while continuing to work. I did well in the courses, was able to skip many of the requirements, enjoyed the clinicals and graduated in 1979. My first job was at Montefiore Hospital as a nurse in the specialty division which included Neurology, Neurosurgery, and Oncology. I started on the night shift on Neurology and remained on that shift for three years. While primarily assigned to Neuro I was trained or credentialed to float as needed to the other services in the specialty division.

I found I enjoyed the mastery of the skills I was learning and was becoming adept at inserting IVs, NG tubes and catheters. The physical work felt good. I'd arrive home tired, sometimes a bit achy but feeling fit and competent. As I became more comfortable with my professional duties, I began to think about my long-term future in health care. I read articles about community and public health. When the Sunday paper included a special insert on education, I would pour over the graduate programs and request information about health-related programs, such as a Masters in Nursing, Nurse Practitioner programs, Health Planning and Policy, Health Administration, Public Health and others.

Late one morning following a tough shift, I was awoken out of a deep sleep by the phone ringing. Groggy but coherent I reached for the phone and managed to answer it without knocking anything over. The caller was a professor from Hunter College who was responding to my request for information on the master's program in Urban Planning. The program included a specialization in health policy and strategic planning. The professor was the advisor for the health planning concentration and suggested I come in to meet with him and discuss the program. I managed to check my calendar and schedule an information session and went back to sleep. In brief, we met, I applied and was accepted. I began the fall of my second year

as a nurse working nights full time and attending graduate school part time (9 credits) during the day.

Two days per week I would finish my shift at 7:30 a.m., change clothes, race for the subway, pick up breakfast and head for class. The courses were stimulating, the students had diverse professional backgrounds, and the faculty was supportive. It was a 60-credit degree designed to be finished in two years if attended full time. I completed the program in three years since I had a full-time job. The school helped me get an administrative residency in my third year with Montefiore's Vice President for Planning. The residency was fascinating. I attended high-level strategic planning meetings, worked on a variety of projects including a certificate of need for obtaining a Nuclear Magnetic Resonance Scanner (NMR), the original name for the MRI (Magnetic Resonance Imaging machine). The word nuclear was considered controversial hence the name change.

I also provided staff assistance on a project to develop a Medicaid HMO, the first in this area. It was modeled on the California MediCal program and eventually evolved into the Bronx Health Plan which later became Affinity Health Care. During and after my residency I participated in the administrative on-call program. It consisted of spending a minimum of two nights per month in the hospital as the onsite administrative "go to" person. Weeknights required a start time of 5 p.m., weekends and holidays, were a mandated 24-hour shift. Administrative on-call programs are excellent training for anyone in healthcare management at the entry and mid-levels. It is a great growth and networking opportunity. If you have an opportunity to do this, I recommend it highly.

My administrative residency was cut short when the QA (quality assurance) coordinator was promoted, and I was offered the position. I accepted. The position reported to the Director of UR (utilization review) and QA. The year was 1983, and this was my formal introduction to the Joint Commission and the State Department of Health and their associated survey processes. I worked with medical staff on audits and programs to improve care delivery, identify opportunities for change and I also learned about pushback and non-compliance to a much greater extent than I had ever experienced as a staff nurse.

In 1985 my boss left Montefiore, and the position of Director of UR and QA became available. I applied and was promoted to that position. I was now dealing with a staff of UR nurses, clerical support staff and the responsibility of hiring a new QA coordinator. It was an abrupt leap into management with staff oversight and coordination accompanied by managing and eventually growing a program that was destined to become more integral to hospital finances and efficiency.

It was 1985, and significant changes were taking place in health care. We all know that case management is about *the right care in the right place at the right time*. Time and place apply to careers as well. The Federal government had changed the methodology for payment for inpatient care to case payment or DRGs rather than per diem rates. It was the dawn of medical case management. We moved from passive utilization review to active utilization management of the patient's stay in the hospital. Review information began to be used for performance improvement, focusing not only on efficient, cost-effective delivery of care but

consumer satisfaction via improved quality. Efficiencies in transitions of care became critically important. Suddenly, hospitals were losing money even when beds were occupied and sometimes *because* the beds were occupied. Length of stay in the acute care setting began to drop, same day and ambulatory surgery increased dramatically. Managing patients' time in the hospital became critical to financial survival.

A significant milestone was reached in 1990 when CMSA was founded dedicating itself to the support and development of the profession of case management. We became a recognized specialty with a clearly defined mission and standards of practice.

In 1988 I was offered a position at New York Hospital (now known as New York Presbyterian). The title was director of Patient Case Management, a relatively new term for the time. New York was now an all-payer DRG state with exemptions for designated specialty hospitals including Psychiatry, Acute Rehabilitation, and Oncology. I accepted the position and began working with the individual services to decrease the length of stay while maintaining quality, not a concept that was readily recognized, at the time it was perceived as a controversial concept and consequently provided a great challenge.

I worked very closely with Financial Planning analyzing DRG lengths of stay against high volume diagnoses and procedures. We focused on specific services starting with elective admissions. Eliminating preop days was initially a struggle but when doctors saw that admit day surgery worked it was an easy way to cut a day. We looked at standardizing care with clinical pathways. Doctors resisted what they described as "cookbook medicine" but eventually learned to accept standards when developed with their input using evidenced-based outcomes data. Working with Finance and Biostatistics and creating regular reports resulted in credible data for their review and analysis and consequently change began to take place. I may be making it sound easier than it was, it was frustrating, an ongoing struggle. I used to tell staff it's like water on a rock, over time the water will wear a groove in the rock's surface. For those who say that nothing ever changes a look back at the last 3 or 4 decades serve to prove them wrong.

I spent 11 years at New York Hospital/NY Presbyterian; eight as director of Patient Case Management and the next three in Information Technology. The IT job was a corporate position where I worked as a project analyst responsible for selecting and then implementing a healthcare information system which would be rolled out to seven network institutions. The system was an integrated program with applications for CM, QA, Risk Management and Credentialing. I learned a tremendous amount about system selection, purchasing, configuration, and implementation as well as the best climate for gaining user cooperation. I also learned that I was not really an IT person. That was when I received a call from a headhunter for a job as a CM Director.

Despite that fact that I didn't "love" the IT world I debated whether changing jobs was the right choice at that time. My children were young, and I had flexibility in the current position. I discussed it with my husband, and we reviewed the pros and cons. He said it all boiled down to one question, do you want a job or a career? He was right, I chose the career, and he supported my decision, he always has.

Changing jobs, accepting new challenges can be a risk, it also means proving yourself all over again. It means accepting a level of discomfort, sometimes even inconvenience to your work life balance. There is the need to build up your vacation bank, gain seniority, etc. You need to decide what you want, what you are willing to do to achieve it, what is important to you. Make a list, review your options and if it is right for you then take the plunge.

I decided it was time to return to my roots. One of the things about case management is that no one else really understands what we do even if they won't admit it, so being a CM director usually means that no one else in your institution knows more about what you do than you.

It was late 1999, Y2K was looming. A good time to leave IT. I was recruited for the position of Director of CM at Memorial Sloan Kettering a DRG exempt cancer specialty hospital. It was a fledgling department, but the institution was committed to the growth and evolution of a program designed to meet growing institutional and patient needs. It was the turn of the century and to provide 21<sup>st</sup> century clinical care as an institution a 21<sup>st</sup> century case management program was essential, a program that helped to provide cutting-edge quality cancer care and patient support across the continuum, longitudinal case management.

We expanded from inpatient only case management to the emergency department, pediatric day hospital and ambulatory clinics. An aggressive denials and appeals program was created along with an advocacy program to provide access to covered care despite network restrictions. I had a table of organization of 23 positions when I started and now have over 70 employees, 40+ RNs, 8 LPNs, administrative and clerical support staff. This is where we ended up but let me tell you a little about where it began.

Convincing a DRG exempt institution of the need to decrease days was a challenge. I did a presentation where I spoke about that challenge and opened with the following tongue in cheek story.

*Once upon a time in the last half of the last decade of the 20<sup>th</sup> century, there was a specialty hospital. It was DRG exempt and had no managed care contracts. Patients had indemnity plans, plans without network limitation, straight Medicare and Medicaid or the ability to pay out of pocket. It was good.*

*The problem was more and more employers were limiting employee insurance options, and traditional plans were becoming cost prohibitive. Insurers were contracting directly with hospitals to provide in-network services at negotiated rates, but this hospital was not jumping on the bandwagon.*

That hospital is a thinly veiled description of Memorial Sloan Kettering Cancer Center but not far from the reality of that time. When I was hired, Memorial was contracted with only one major insurer, but up until then, that had been enough.

While there were plans with out of network (OON) options, that option was becoming cost prohibitive for many people, and Memorial was losing market share. More and more plans were eliminating the OON option altogether. Numbers of new visits were declining, DRG exempt rates were higher, length of stay (LOS) somewhat elevated compared to DRG

facilities. The value of specialty care was not clearly defined. This was the situation facing me when I was hired.

I worked with Finance, Marketing and Managed Care Contracting to look at ways to make Memorial Sloan Kettering more attractive to payers. Using analytics Finance was able to demonstrate that the overall cost of care for diagnosis, treatment (with and without surgery) was lower despite the higher per diem costs. Due to our ability to identify the right diagnosis and treatment choices, to expedite care and having specialized staff able to quickly recognize rare and common cancer diagnoses, we were able to dramatically decrease LOS through efficiencies, optimization of transition plans that provided patients with home infusions, advanced wound care and more options for outpatient chemotherapy and surgery. As the program and staffing grew, I was able to place case managers in ambulatory care and encourage the use of the term transition planning to replace discharge planning (a limiting concept). The case manager in the clinic was able to prevent unnecessary admissions or jump-start transition planning and shorten the required admission. While this is common now, it wasn't in the first decade of the 21<sup>st</sup> century.

While we made strides and the department grew the feeling of frustration continued. My staff and case managers in general often felt misunderstood or underappreciated. My solution was to look outside the institution to my peers in the industry. Anne Llewellyn then at PRIME, invited me to join with a group of people from the health care industry, physicians and case managers to write a consensus paper on case management and physician collaboration. It was an eye-opening experience, and I began to seek more opportunities to share best practice and interact with other like-minded professionals. I became involved with my local Case Management Society of American (CMSA) chapter and submitted articles to Case in Point, CMSA Today and other industry periodicals. Some were published providing a real sense of accomplishment. Entering the Case in Point Platinum Awards competition resulted in nominations and honorable mention in the areas of Discharge Planning/Transitions of Care and Utilization Management and a Platinum Award for Hospital Patient Advocacy added to our organizations credibility. I spent a weekend with a group of case management professionals organized by the Commission for Case Manager Certification (CCMC) to review the case manager's roles and functions and required knowledge for the CCM certification exam. These efforts and activities boosted my confidence, made me more passionate about the work and tempered the frustrations of the daily routine.

As I became more involved in my local CMSA chapter, I joined the board of directors and attended my first CMSA national conference. The atmosphere was stimulating, I loved the networking, the sharing of ideas and experiences, akin to the local chapter but multiplied. In late 2011 the board of the local chapter announced that they would like to nominate me for CMSA's case manager of the year (CMOY) for 2012. My immediate response was..." That's a lot of work, we should really devote the energy to someone that can win." They pointed out my published articles, my leading-edge program which had more than doubled in size over the first 10 years, my work with the chapter. I was doubtful but mined my files and worked with them to provide the metrics and other requirements for the application. To my shock, I was awarded the 2012 CMOY designation. Receiving the award at the conference required that I make a speech to an audience of over 1000 people. I survived the experience and found

that I was exhilarated by the recognition. So much for being shy and retiring, I was out there, and I loved it. I started submitting abstracts to conferences and presenting a few times per year to a variety of audiences. Someone asked me a year or so later if I liked public speaking. My response, I love having spoken, the questions, the feedback from the audience are the reward for the speaking experience. Speaking is a skill you develop over time, and I now relish both the speaking experience as well as the aftermath.

Speaking is part of my second act. I have joined the speakers' bureau of a drug company and present to a variety of audiences but mostly case managers several times a year. I plan to do more public speaking next year when I leave my full-time position at MSK which will also enable me to speak for organizations that I currently have to turn down to avoid a conflict of interest. I am very focused on CM education, sharing of best practices, promoting the profession and see my retirement as the opportunity to devote more time to those activities. I am currently teaching an online CCM certification prep course to assist case management professionals to prepare for case management certification.

Another part of my second act is teaching group fitness classes. I started going to a gym in my fifties to improve my strength, endurance, and balance and found I enjoyed it. A few years back, I saw an opportunity to improve my fitness skills and incorporate my case management goals. I responded to a request for volunteer fitness instructors from a group called Shape Up NYC. They provide free fitness classes seven days a week in all five boroughs of NYC. They were accepting applications from people interested in training to assist with their program, I applied and was accepted. Most of the participants were younger than me, but not all. They put us through an intensive 12 session training followed by a test. We had to commit to six months as volunteer instructors. That was three years ago, and I am still teaching a one-hour class every Monday night following work. I love it. It keeps me fit, hones my presentation skills and utilizes my case management background. I teach ways to incorporate exercise into my participant's lifestyle, we set goals and achieve them, discuss nutrition and general health.

In addition to my work-related writing, I have been exploring other formats. MSK has a free writing program for patients where you are partnered with a professional writer to coach/mentor you. In the last year, I was diagnosed with cancer, had surgery, radiation and am basically cured with ongoing surveillance. I wrote about my experience and found the process very therapeutic, and I am now writing stories and essays. When Anne made the request for my input on the Second Act project, I saw it as a perfect segue to my current transition from full-time hospital CM Director to a writer, teacher, speaker, and semi-retiree.

I think I started preparing for my second act a decade ago as I became more involved with professional to activities outside of my immediate workplace, challenging myself to publish, to engage in public speaking. Is it a second act, an evolution, a chapter in a journey? I don't know, but I can't wait to see what happens next.





Laura Ostrowsky RN, CCM will be leaving her position as Director of Case Management at Memorial Sloan Kettering at the end of March 2019 to actively transition to her second act. She is writing, teaching group fitness classes and speaking to health care audiences about CM, oncology, end of life and other related topics. Her 40 years in health care include, staff nurse , QA coordinator, Directorships in the areas of UM and CM at 3 major teaching hospitals. She also spent 3 years in information services. If you want to know more read her chapter, check out her LinkedIn page and there's always the internet.



## WHY DID I BECOME A NURSE?

By: *Mary Reidy RN, CCM*

It all started with 2 little 5-year-old girls playing with their pals in the neighborhood.

Because we were girls, I suppose we were the nurses, and the boys were the doctors. For short, while it was fun but then the children in the neighborhood started coming to us with real and not imagined ailments. One child had terrible abdominal pain, and when we told his mom about it, she took him to the hospital for possible appendicitis. The mom was thankful that we reported the severity of her child's symptoms to her.

We were becoming pretty good at this, but then something started to happen. We both enjoyed being in the "thick of things." We never shied away from bloody noses etc. We began to visit a severely handicapped bed bound child in the neighborhood. Her mom started to notice we were the only ones attending and her mom saw we were not uncomfortable with the appearance of her contracted body or her undecipherable speech. We started with trying to assist with therapy as directed by her mom.

For me strange as it seems I have always wanted to be a nurse. I was interested in not just helping people, but I really wanted the knowledge of knowing how the body functions and what the first action should be in response to a critical event.

My dear friend and I both went on to be nurses. My friend worked throughout her career in the emergency room, and I went on to med-surgical units.

I worked in male and female wards. That was quite interesting. Forget about HIPAA in those days. I worked on a hemodialysis unit; a supervisor in a nursing home and presently as a case manager nurse.

Working with renal transplant recipients and donors, was and to this day continues to be the most rewarding and challenging position I held in my career.

I started working as a utilization review nurse when my husband and I decided to start a family. At the time, there was no testing for CMV and AIDS. I did not want to run the risk of exposing my unborn child to these illnesses so I thought UM would be a good idea.

In a large level 2 teaching hospital, we rotated units. The UM rotation included acute and chronic psych units including locked units. Maternity and newborn and high-risk nursery, general med-surg, oncology, and orthopedics, as well as all the ICU's including respiratory and in those days "shock and trauma" or shock 'a rama.' It was truly a wonderful experience to be exposed to all the specialty units in the hospital. I was grateful for this experience as well as the valuable information about the various conditions of patients. Had I not worked at a university hospital I would not have had exposure to all the specialties in such a short period.

However, I did not find reviewing charts and providing information to a third party to be an enriching experience.

Luckily for me, the role of the UM nurse started to grow into case management. By that time I had many years of experience and at all levels of the spectrum of patients and so I took this experience and moved into a more formal style of case management and UM.

By this time, our roles as case managers became focused on reimbursement as well as optimum patient outcomes. A challenge like no other and also improve patient satisfaction scores as well. Many of the nurse case managers that I worked with daily always emphasized it was not the time to enter into the role of a case manager nurse without any case management experience. I readily agreed.

I have learned so much in my 45 years of practice. That is to say that honestly, nursing is really the only career I have ever known. How would I feel if I was downsized and then had to learn a trade in finance for example? It is likely I would not survive. I like to think of what I have learned through the years with this analogy. Nurses are the first line of defense for patients. When the first line of defense or integrity is broken just like with skin integrity, there is a chance of an opportunistic infection. In the role as case managers loss of integrity results in the chance or opportunity for communication breakdown. When there is a communication breakdown, there is an opportunity for missed information, lack of trust, readmission risk, and failure for optimum disease management for our patients. To be our best means to always advocate for our patients so that our goal should always be a seamless transition from hospital to home or to rehab or to another acute care facility. It is indeed a tremendous amount of work, but it is not for the weak or unreliable.

For the new generation of nurses to take over and become successful remember: there is no substitution for empathy and simple kindness. First be human yourself. How this person must feel who has had a delay of treatment or told insurance has denied needed equipment or a procedure. To this day, I do not: Text in front of my patients, or tell them all my personal woes. Advocate for your patient and empower them with knowledge for them to advocate for themselves as well. Try to locate the land mines before they do. For example, anticipate what the care needs may be before they occur. Plan ahead as best as possible for discharge and communicate to the third party whether it be a nursing agency or for durable medical equipment. Develop a team approach with your peers, and work collaboratively with providers of care. Acknowledge every kindness shown to you when someone goes out of their way to help no matter how small. Never stop learning.

For my second act I would like to volunteer at a children's hospital and simply rock the babies, and hopefully, they will feel less afraid and vulnerable. Each of us has a role in this life, and to this day I am thankful that the role I chose was to help people at a time when they needed me the most.



Mary Reidy has been a nurse since the age of 18 years of age. The path to this career choice was embedded at a very early age. Having professed the idea that nursing was not as much a profession as a calling, her career in nursing began after completing high school at the age of 17 years old. She graduated from St. Mary Hospital School of Practical Nursing in 1973. It was in this hospital and in this program, where to this day she maintains the philosophy that she truly learned to become a nurse at St. Mary. "Nurses are trained very quickly today and frequently the basics are overlooked. Nursing measures are left by the wayside and not utilized as efficiently as they should be in today's technological society." The

program for practical nursing was adopted from the former registered nursing program. Many of the registered nurses from these former diploma programs were recognized at being the most efficient and knowledgeable of all the diploma programs in the Philadelphia area St. Mary's being one of them, having adopted the Franciscan philosophy of nursing and care.

After graduating from the associates degree program at Hahnemann Hospital in 1978, Mary remained at Hahnemann Hospital and found her career choice of caring for people with renal disease including transplants and donors and later hemodialysis nursing. She married the love of her life in 1981.

Mary has worked in rehab facilities, hospice nursing, utilization review, and case management.

Mary enjoys life with her loving husband, three grown children, as well as a new grandson. A sweet little rescue named Blaise completes the mix.

Mary is currently working as a certified case manager for a New Jersey Medicaid company. "Poverty continues to be the barrier to care for many Americans." "Many of these individuals are unable to navigate their complex care needs and the most critical of care needs are often met with long wait times to see specialists and the authorization for the care for the appropriate level of care becomes a complex process as well."

Mary resides in the Bucks county area with her husband and rescue dog Blaise. The challenge to implement a workable health care delivery system for all in America remains a mystery to her to this day. Mary remains dedicated to facilitating care to those with the greatest need.

## ONCE A CASE MANAGER, ALWAYS A CASE MANAGER

By: *Gail Snow RN, CCM, HIA, MHP, ACS*

My mom was a nurse and ever since I can remember that is all I ever wanted to be. I even gave a speech on IV's with examples in high school! I worked as a nurse's aide while I was in school (the dormitory was right behind the hospital).

When I graduated, I went to work on a medical-surgical floor at St. Mark's Hospital. I worked there for 8 years spending time on medical-surgical, psych, OB, and eventually in intensive care and coronary care. I then moved to Santa Cruz, California and got a job at the Community Hospital of Santa Cruz, working as a team leader on the intensive/coronary care unit where I worked for 9 years. While I was there, I also rode on ambulance transfers to a larger hospital in San Jose. I then moved back to Salt Lake City and went to work at Jordan Valley Hospital when it opened its doors in West Jordan, Utah. I started working there in the Emergency Department and the recovery room as a staff nurse and worked a few shifts in the newborn nursery when they were short of help.

After a year, I was asked to set up a 4-bed intensive/coronary care unit at Jordan Valley Hospital and became the head nurse of that unit. When the head nurse of the emergency room left for medical reasons, I was asked to become the head nurse of both the emergency room and intensive care/coronary care units.

As my boys got older, I felt the need to be at home in the evenings. I started looking for a position that allowed me to work day shift. I found a job at Intermountain Health Care's Health Plan as a Utilization Review Nurse working five days week 8-5. I worked as a review nurse with clinics, who wanted their physicians to do reviews.

As the health plan grew, the name was changed to SelectHealth. It was at this time that the leadership decided that case management was a more effective and patient-friendly way of managing cost and providing quality care for our members, so I began doing case management and obtained my case management certification.

It became apparent that there was a need for disease management of specific diseases, we added a disease management program to the mix. I was the Team Leader for the case management/disease management team, the clinical education director, and I also did case management and disease management for Heart Failure, Asthma, and Hepatitis C unit until I retired in 2010.

When I first moved into utilization management, I found that I felt a great loss for direct patient care which I dearly loved. I was even thinking of going back and doing direct patient care part time, but being a single mom and raising 2 growing boys that didn't seem to be a good option. When I started learning about and doing case management, I found that it filled my desire to work with patients and their families and to be a help and resource for them at a time when they needed it most. Often it was just a person for them to vent to without fear of judgment.

Case management allows you to do the things you became a nurse for – taking care of people in need, proving support, and compassion. Sharing resources that will make their lives easier, being a nurse, and a friend. It is working with people from all walks of life, loving them, and helping them. It is the most fulfilling work that I have ever done.

Now that I have retired I found that I missed working and I am working a few hours a week for a friend, who has started her own company. I am doing some case management, some utilization reviews, timeline reports, and usual and customary reports. I loved being a case manager, and now that I have retired, I find I still have that role with friends and neighbors at times. Once a case manager, always a case manager.



Gail Snow, RN, CCM, HIA, MHP, ACS: I grew up in Idaho and graduated from Grace High School in Grace, Idaho. I graduated from St. Mark's School of Nursing with an RN Diploma. I attended Westminster College my first year of nursing school. You can reach Gail at [gsnowrn@comcast.net](mailto:gsnowrn@comcast.net)

## LESSONS LEARNED AS AN ADVANCED PRACTICE NURSE THAT HAVE CARRIED ME THROUGH ADVERSITY AND CRISIS

By: Marilyn Van Houten MS BSN RN CCM

When I was a senior in the School of Nursing at the University of Miami in 1969, I had a strong desire to enter the Army Nurse Corps. My dad was an officer in the US Army, and I would have entered the Nurse Corps as a commissioned officer. I saw my future there, making my Dad proud, and satisfying my sense of adventure and love of traveling. I stood in line in the University of Miami gymnasium, filling out all the forms and feeling sure the physical exam would be a piece of cake and I would fly through the last hurdle to a guarantee of a lifelong Nursing profession while serving my country. The medic looked disappointed as he informed me that I was 11 pounds underweight. He told me to "eat lots of bananas" and come back as they would be doing physicals at the University a few more days. I did exactly what he recommended and came back hoping I had gained enough weight that they would take me. I was still 10 pounds under, but I had heard they were desperate for RN's so thought they might slip me into the group. Unfortunately, the height/weight ratio was not negotiable, and I was turned down for what I envisioned as a wonderful opportunity.

One of my classmates was selected. He went directly to a MASH unit in Vietnam. I learned later he died young with a neurological disease. Other nurses I have worked with over my 50 plus years of nursing also served in Vietnam. They are some of the greatest clinical nurses I knew, but some had psychological scars that were difficult to erase. Was I fortunate or unfortunate? I will never know but suspect I would be a very different person today had I served in Vietnam.

So off I went to Orlando, and was recruited to a large hospital in the downtown area. There was a huge nursing shortage going on in 1969, and only 1% of the RN's had a bachelor's degree, so many were promoted to administrative positions quickly. I found myself a little deficient in some of the clinical procedures, compared with my colleagues, mostly hospital trained nurses, many of whom were "used" as staff in their clinical training in hospitals. Most of them had done procedures multiple times in their training. Many of the BSN nurses were given lots of responsibility immediately, managing other nurse's, aides and clerical staff, but what I needed was more bedside nursing.

Along came a job to help create something called "Creative Nursing" units, a new concept putting RN's back at the bedside, in an Adventist Hospital. Pantsuits for nurses were just coming into vogue, but the Adventist Hospital system prohibited pantsuits and insisted on RN's wearing modest white starched uniforms covering the knees, white stockings, bleached white shoelaces and our nursing school caps.

We weren't allowed to wear make-up, and NO smoking was allowed from the minute you drove onto the Adventist campus. We looked very professional and were treated with respect. On my unit, the RN's were doing direct patient care, and the aides were assisting with paperwork and as needed for an extra hand. The patient outcomes were terrific, but the cost of an additional RN to patient ratio made it an expensive experiment that benefitted the patient but not the hospital corporation.

After getting my skills up to par, I was enticed into Public Health Nursing. I was always fascinated with how other people lived and was soon exposed to the stark contrast of pathetic slum housing to penthouse living on Miami Beach and everything in between. I even put an Unna Boot bandage on a diabetic patient who was classified as "homeless." His address was a "lean-to" (a piece of wood, propped up on a tree) in a poverty-stricken area right off US 1 in Miami FL. Another time I was called to a mansion, to insert a Foley Catheter in an older, very wealthy man, who now has a County beach name after him!

I loved being "on the street" and meeting all kinds of people in the most unusual settings. Most of these situations I had not been exposed to as a child growing up protected in Lutheran school in Lafayette IN but despite being scared, I loved it! My Public Health made a smooth transition to the Home Health setting where I moved up to into a management position, supervising over 120 people.

Following the home care experience, I moved into my favorite job that of creating another new model of care know as a Hospice program. I was the first paid employee in the company, as everyone else in those early days were volunteers. I went to Tallahassee & Washington DC to promote this "new" program to state and federal officials. Once the funding for Medicare and private insurance came through, the program for terminally ill became widely accepted. I loved the grassroots Hospice program; the enormous multi-billion-dollar Medicare program it became, not so much.

In 1982 my husband, Skip Van Houten a brittle diabetic since 13, became very ill and ended up on dialysis. In 1988 after working a few years for a Rehabilitation company, helping workers compensation patients get the correct medical care and assisting them to get back to work, Skip encouraged me to start my own Case Management Company. All I had was a desk, typewriter, carbon paper and my skill set which was complementary to this brand-new profession! All I had to buy was a fax machine, and I was on my way, working out of my home, directly for workers comp insurance companies.

I started hiring employees, who would come to my newly added addition, bringing reports, in the late afternoons. This became intrusive as I was making dinner and had employees knocking at my door. So my next big step was purchasing office space, a condo office in a newly built office building near Tamiami airport. After the first 5 years, I needed a larger space and moved down the hall to an office with twice the space. Shortly after that move, Hurricane Andrew hit Miami, and the roof of the building was breached causing water to pour into the computers & phones, basically ruining everything.

As my home was devastated, I moved to my mother's house (her first floor was dry) and worked on her dining room table with my assistant. As if I was in a dream I kept working, with many of my customer's unaware of the horrendous situation South Florida was in. My mother seemed very traumatized by the damage and soon developed a respiratory infection. We rushed her to the hospital where she was placed in the ICU. After 2 weeks, she succumbed to Acute Respiratory Distress Syndrome. My husband, himself very ill, did her eulogy at the funeral home and asked the funeral director if he could make his own arrangements while we were planning Mom's funeral. The director told him he was probably just upset with her death and the severe storm and felt it wasn't appropriate. Within 3 weeks Skip was hospitalized and began getting weaker. One day after sprinting up 6 flights of stairs,



I found him unresponsive in his hospital room. They called a code, but it was too late; I was back with the same funeral Director, arranging a second funeral for my husband.

I vividly remember attending a Miami Chamber of Commerce meeting just a few weeks before, advising how to get Miami business's back to full operation. The speaker said something very prophetic that always stayed with me, "some of you are dealing with the destruction of home and office, but just imagine there are families out there planning funerals and going through the grieving process while still coping with the largest natural disaster in the U.S."

My daily life, as I had known it, was turned upside down! My mother was relatively young; the exact age I am now. My husband was just 49. My mother had no idea she would be part of what they called "collateral damage" from Hurricane Andrews aftermath. She seemed unable to cope with the tremendous damage she saw all around her. The hospital and ICU were basically being run by these fantastic experienced RN's; we saw very few MD's coming into the hospital the week after Andrew. Most of the orders were done with the nurses over the phone, not in person.

My husband had many of the long-term effects of 10 years of dialysis and diabetes. His fistula arm access became infected, and an emergency amputation had to be done to save his life. He continued to live his life as best he could attending Dolphin and Heat games and ordering gifts for the family on QVC when shopping was difficult. He knew he was dying and wanted to make it easier on me by making his arrangements while we were at Mom's funeral. A week after he passed, I received another QVC package in the mail with a thoughtful gift.

This horrible life experience taught me to treasure every moment with family & friends. This category 4 Hurricane showed me how unimportant "things" were and how delicate life's balance really is. I learned that Registered Nurses were the heartbeat of health care institutions. Hospitals couldn't have run without them, and there were many emergencies as people tried to put back together their shattered lives. Although the RN's had their own damaged homes and children to deal with, most of them were finding a way to get to work and devoted their shift plus more, to human beings in terrible need, suffering both physical and emotional trauma.

People ask me how I was able to cope with losing two immediate family members while putting back together a damaged home, my mother's property and my office space. I felt like things were not real, like I was in a "dream-like state" while attending patient appointments, coordinating injured workers medical care, along with making insurance phone calls, filling out forms, meeting with catastrophic claims adjusters that the property insurance companies had flown into Miami.

During this time, I was expected to deliver exceptional care and get my numerous Case Management reports in on time. Whoever thought that my training and experience in case management would help me in recovering from a major hurricane and become an independent woman alone, running a growing business!

From my Hospice nursing experience, I knew the grieving process is different for everyone. For me joining water aerobics classes once the pool was functioning, helped me immensely

physically and emotionally, since I had always found water very soothing. To this day I still prioritize my water aerobics classes.

In 2005, just when things started to normalize, I found a lump, high on my chest, pushing through the skin. After my diagnosis of triple negative, locally advanced stage 2B breast cancer I found myself in the second most stressful time of my life. This is the year I now know was the beginning of MY SECOND ACT!

I was 58, in good physical condition but soon I was putting my body through harsh, lifesaving treatments of dose-dense chemo. The first dose of chemotherapy totally knocked down my ANC, (absolute neutrophil count) and I found myself shivering beyond my control, with a very high fever in two different ER's (the first one had no beds). I was admitted with neutropenic fever. During my admission, Miami experienced Hurricane Katrina which went on to replace Andrew as the most destructive Hurricane on record. The hospital went on emergency power only. My hospital bed was stuck in the upright position so it was very uncomfortable. At one point during the night, the emergency lighting & my life-saving IV antibiotics shut down, and windows began shattering in the room across the hall from me. I was totally alone in the dark as I heard the emergency codes being called and all visitors were told to leave immediately. I remember hearing the Nurse's making sure all the IV's were plugged into emergency plugs and escorting anxious visitors down the hall to the stairways.

Within that week I was home & trying to help out around my home where many branches and trees had fallen, but none thankfully fell through our roof!

As I gained some strength and my numbers went up enough to undergo chemo again, I was back at the hospital on the dose-dense chemo regime. At this point, my nursing education helped me immensely. I used my research skills and searched for information on the newly discovered breast cancer phenotype, Triple Negative, which had no targeted therapy. Only 10% of patients had this aggressive type of breast cancer, so I knew I had to educate myself to give me power in decision making regarding the rest of my treatment, type of surgeries, radiation, etc.

Along with my physicians, we discussed options as case managers do daily, decided on a quadrantectomy (wide excision lumpectomy) followed by another surgery of total axillary node dissection, since testing showed the cancer had advanced to my lymph nodes. I did my own extensive research, so much so that I was advising some of the physicians on what was being published. I emailed one doctor to ask a question about the research I had just read, and she immediately called back and wanted to know where I saw her research. She was not even aware it had been published!

Ever since my public health and home health nursing days, I had always tried to educate my patients, feeling they were much more in control if they had more knowledge of their diagnosis that too often physicians had no time to discuss.

I have managed to survive the most aggressive form of breast cancer and even feel I have thrived by joining The Heroines Choir, a breast cancer choir in the past 13 years since my diagnosis! Today I am doing the daily management of the choir and the presentations along with running my busy Case Management company.

I feel very thankful that 2005 was the beginning of my "second act" in Nursing. I feel so blessed to have chosen a field that is so diverse and has taught me so many lessons that have carried me through adversity and crisis.

As we move further into 2019, I am attempting to work fewer hours, spend more time with my precious granddaughter, and "smell the roses". That early morning breakfast on the patio with my Golden Retrievers, enjoying my garden, gives me renewed energy to guide new nurses in case management, share my 50+ years of nursing experience, advocate & coordinate medical care for injured workers, helping injured workers back to productive lives!

As I was writing this article, I realized that my original desire to "serve my country" has come full circle as my companies' largest customer is the Federal Government, injured employees. All of my career paths in Nursing have really involved the principles of Case Management and now I have the opportunity to share my knowledge with the RCM Team of skilled Nurse Case Managers.



Marilyn Van Houten is a Registered Nurse with a Bachelor of Science in Nursing and MS degree. She has 50 years of nursing & administrative experience. Marilyn has achieved the CDMS National certification as a Disability Management Specialist, and currently holds the national certification as a CCM, Certified Case Manager. She founded a Case Management company, in 1988, Rehab Case Management, Inc. RCM has successfully helped rehabilitate workers comp & catastrophic injury patients for the past 31 yrs.

She is a past President of the local chapter, South Florida Case Management Network and has served on the National CMSA Board as a Directors for two years, and State Chapter of Florida Board for 8 years. She was awarded the "Case Manager of the Year" by the local CMSA chapter for her advocacy of breast cancer patients. She has served on the inaugural PFAC (Patient Family Advisory Council) of the Baptist Hospital Breast Center & the Miami Cancer Institute (MCI). She also assisted with the design of the MCI building which opened in 2017.

Diagnosed with aggressive Triple Negative Breast Cancer in 2005 she found herself on a pathway to research the recently discovered phenotype and became very interested in the rehabilitation of breast cancer survivors, assisting them to become "thrivers" (not just survivors), through choral music with The Heroines Choir. She is currently the Assistant Director of The Heroines Choir for women who have been diagnosed with a life-threatening illness, injury or friend/caregiver.

As an RN with national Case Management certification & a "thrivers/survivor" herself, Marilyn is keenly aware of the importance of advocating, supporting and guiding patients & families,

who face an on the job injury or major catastrophic accident or severe long-term illnesses.

Currently, her company Rehab Case Management, has 19 Certified Registered Nurse Case Managers in 8 states, who work with Workers Comp, Group Health, Litigation Support Services, and Long-Term Care Insurance companies and attorneys. RCM also provides private Case Management Services for individuals and families.

Marilyn recently contributed to a chapter in Experts in Pink: Your Guide to Breast Cancer Health. Her chapter is titled: Heroines Harmonize to Heal: I Found My Lump and Then My Voice. The book is available on Amazon at <https://www.amazon.com/Experts-Pink-Guide-Breast-Health/dp/0692146733>

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## Will Case Management Be Your Next Act?

By: *Deanna Cooper Gillingham RN, CCM*

I always wanted to be a nurse and started my journey as a candy striper. But I let the influence of others sidetrack me from my dream. Family friends who were nurses warned me about all the negatives and I listened to their warnings. So I entered college pursuing a degree in Medical Technology. It didn't take me long to realize that was not the career for me. Not knowing what to do next I got married and had a baby. I always wanted to be a mother and had the privilege of being a stay at home mom, but I wasn't satisfied. Then one day I woke up and realized I wanted to be a nurse and was determined to make it happen.

I found out that I was accepted into a very competitive nursing program and that I was pregnant with baby number 2 all in the same week. Everyone asked what I was going to do and I responded "Have a baby and go to school." I decided not to think about it but just do it, something that has served me very well in my life. Looking back I realize the times I decided to "just do it" and work it out as I go along were where I have accomplished the most.

My nursing career took me down many paths. After graduation I began working in Home Hospice before landing my first hospital staff nurse position on a Med-Surg/Dialysis/Detox unit. I then moved to an Oncology position where I worked for four years becoming chemo certified and oncology certified through the Oncology Nursing Society. From there I went back to home hospice and homecare nursing. Then in 2000 I moved to South Carolina and took a position in SICU (Surgical Intensive Care Unit), eventually moving to LDRP (Labor Delivery Recovery Postpartum) where I worked for over 9 years as a staff nurse, per diem nurse and travel nurse. My next stop was the VA where I worked in the GI lab followed by another brief stint as a home hospice on-call nurse. I absolutely loved being a nurse and the variety of areas nurses were able to work in but I honestly didn't see nurses working far from the bedside.

Then everything changed as it often does. I had left labor and delivery, the area of nursing that I loved the most, because of an injury that prevented me from working on my feet for any length of time. When I moved to the GI lab things were better for a while, but eventually that was too much. I needed a desk job. A friend of mine had been telling me about case management at an insurance company. I had no idea what case management was, but I knew I had to do something so I reached out to the department manager and the next thing I knew I was offered a job. I was hesitant to accept the position because I still didn't know what case management was, but my soon to be boss Brenda El Dada assured me that I had what it took to be a great case manager and she had just the right people to teach me the ropes.

And she was right! I had wonderful mentors and learned case management from them but it was not easy. Case management builds on the knowledge nurses have from their acute care experience but there is a lot to learn from insurance principles to social determinants of health

to the case management process and so on. I knew there had to be a better way to learn case management than just getting thrown into it.

I now have my own business providing resources and education to case managers. We realized through our Facebook Group "Case Managers Community" that others are having the same frustration with learning case management from overworked coworkers as there was no comprehensive training program to teach case management available. We also heard from nurses who want to enter case management but need to build their knowledge and skills required to land their first case management job and had nowhere to turn.

To fill the need we created the "Foundations of Case Management" Course. If you believe case management is for you I invite you to check out [CaseManagementInstitute.com](http://CaseManagementInstitute.com) where you will find resources to help you decide if case management should be your next act, and if so how to prepare yourself for the practice.



Deanna Cooper Gillingham, RN, CCM, has been a Registered Nurse since 1994 and a Case Manager since 2011, working both complex and transplant case management. She has worked in a variety of clinical settings as an RN, including med-surg, dialysis, oncology, hospice, SICU, LDRP, L&D, and GI Lab. She has also worked as a travel nurse, agency nurse, and patient service representative.

As co-founder and CEO of The CaseManagement Institute, Deanna has impacted thousands of case managers with her company's products and resources. Deanna has served on the Board of Directors of the CMSA Foundation and is a member of The Case Management Society of America, Registered Nurse Innovators Influencers & Entrepreneurs, The National Nurses In Business Association, and Rotary International.

Deanna is currently living her dream life on the beautiful Caribbean Sea in Puerto Aventuras, Mexico. From there she is able to run her online business, learn a new language, and live in a culture where everyone is happy and relaxed.

To learn more visit these two websites, <https://casemanagementinstitute.com> and <https://casemanagementsstudyguide.com/ccm-certification-made-easy>

# Thank you!

Thank you for reading Second Acts! On behalf of my colleagues who contributed to this report we hope you enjoyed the stories and that they provided information that will enhance your career. If you would like to reach out to any of the authors, please let me know and I can connect you.

I would love to hear from you and learn about your plans for your Second Act.

Please feel free to share Second Acts with those you think would benefit! Best of luck in your career.

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