Betty Irene Moore Speaker Series
Jennie Chin Hansen in conversation with Heather Young
April 10, 2012

CHAPTER 1: THE DRAW OF COMMUNITY NURSING

So I'd like to start Jennie, how did you end up deciding to become a nurse? What was that like for you, your path into nursing?

it's been interesting to think of all the sequence of events that came into where I am in nursing. But probably, one of the key things that led to choosing nursing was the opportunity to volunteer at a hospital when I was a teenager. So I was a --

Heather: Candy striper?

Jennie: -- a candy striper except that we wore these salmon outfits and not the candy stripers' but yeah it was -- it's watching at that point with my -- the lens that I had as a teenager, the whole sense of caring for people and helping people heal and that's kind of the lens I had but I have a different story as I got underneath the covers so to speak and you know and how I thought about it but that's what really led me into choosing this. I also grew up in a time where we didn't have that many role models in other fields as well and so given my age, the two options most women went into were either nursing or teaching at that time. I knew I didn't have the patience to stand in front of six year olds for all day long, but the opportunity to really see this experience and the care giving side of it was just -- probably resonated very deeply

Jennie: Well, we were asked to share some materials and in one of the articles I think that you have as a reference is some of my experiences when I was in my baccalaureate nursing program and working in the Safety Net Hospital in Boston. I started to see the hospital from a very different perspective as a trainee

I ended up instead of going into acute care and especially for those of you who are in my decade area, it was just unthinkable that you graduate from nursing school and not go into two years of med surg before you do anything else. But it was such a fundamental sense of thinking about people, caring about people, helping people but differently from that kind of environment that I did not go into acute care so you know when we talked about this earlier, that many of you who are nursing students and fairly recent grads that it happens to be unemployment time where it's difficult to get perhaps a direct position. But there are other ways to learn about nursing,

Jennie: Well, you know there are programs called community clinics now. They're formally called FQHC's, Federally Qualifying Health Centers. In those days, this is like the entire poverty war that was going on and so one of the original sites was here in San Francisco called Northeast Medical Services. So I ended up working there, working as part of a team. Right off the bat, I was a community health nurse. I had community aides who were a part of this team and so the ability to go to people's homes and understand their circumstances, the environment they lived in, the circumstances they faced and you know not just my brochure that I was bringing to educate people.

You certainly realize what health and well being and health and illness and the kinds of socioeconomic determinants that really were about health and well being. That was something I found that I liked. I was not always the one who was going to be the expert. Some of these

family members caring for adult disabled children knew a lot more about care than I certainly did as a young nurse. So you start really seeing that partnership really early and that was great.

CHAPTER 2: LEARNING FROM MISTAKES

Heather: So Jennie, I can't imagine you've ever failed at anything but could you sort of dig deep in your mind and tell us about a situation

I was a community health nurse in -- a public health nurse actually in Moscow, Idaho and I was a -- this is a farming and a logging community. Can you imagine me there? But anyway, it was and I was fresh out of my graduate program and research was on my mind you know so I did all my research because I had seen in the course of my home visits there was child abuse and pregnancies that were going on in this community.

So I collected all my data, had my report ready. I knew who made decisions, I went to the school board, I present -- you know I got ready with my information, I sat in front -- you know I stood in front of the school board of basically in those times, we're talking about 1972, 73 and these are all middle-aged white men and there was me talking about pregnancy and child abuse. I had already figured out too what their budgets were and thought that gosh, they spent so much money on football uniforms I think. You know one dollar is only one dollar you know a student per year that they could have a part-time nurse. You know it wasn't even having to be me but then I could see when I appeared you know, all shiny with my data and information, I could see this kind of mental headpathing that I had here.

So I presented but I knew that nothing had stuck and so I realized I was totally ineffective and so I realized like you know this is where me the expert coming to give you the information that you need, no way. So that was not it at all and I found that in the course of the year and a half I worked with many families, many parents and it was the parents ultimately, mobilizing the parents for them to really come to it and they decided this is what they wanted so it wasn't me. It was really what their needs were and if it was important to them that it flipped around. But yeah, I failed miserably. I kind of walked out there with my tail between my legs. I knew I was just totally ineffective.

Jennie: But I think part of it is knowing that we're going to fail and that's one thing I actually would like to say about us in nursing, you now in hospitals this whole thing of not making errors. Not making errors cause us to really try to do things "correctly and perfectly". Sometimes that inadvertently gets in our way when you're taking risk because these are different concepts. One is safety and accuracy and the other one is risk taking where you will fail. So one, you shouldn't fail and the other one, you actually are being asked to fail.

So our need to bring these two concepts together to understand when you have to be absolutely accurate say in medication safety and other times you take the risk where you're not sure that you're going to succeed but you know it's an important thing to try to reach. That when -- you're right, when you fail those memories are actually important to learn from or those experiences are important to learn from so that it you know teaches you for the next round. So I think it's one of the things that we have to do in healthcare, that there's perfection of no mistakes but if we're going to change things, we have to allow ourselves to make mistakes.

I think one of the areas of pride for those of us who do focus in geriatrics is understanding people's core preferences and values and some difficult choices that people might make that might not be quite the same that comes out of our textbook. So the ability to use judgement and discernment and hearing other people rather than our eagerness to tell people what's best for them. Again, when we do tell people what's best for them it comes out of a good place because we want the best, safest care based on "evidence". But sometimes our values are not based on evidence. Our values are what our beliefs are about and what's important to us.

So we have to be able to integrate the sense of the hard and the soft in a way to really have the ultimate best outcome. You know people who choose to not use some device that we might recommend and it puts them at risk. In some ways that whole question that has to be discussed to weigh out the dignity of being able to make that choice because that's what's important to them. So these are not easy discussions, these are not black and white and this is where our ability to manage ambiguity sometimes as well as exploring how to think about a problem, the fact that this is not an evidence-based cookbook.

CHAPTER 3: BUILDING ON LOK

The whole thing about On Lok, it was started by the community and what was interesting is here is what is now today considered a fully capitated at-risk Medicare Medicaid program for frail older individuals really dealing with great complexity. But what’s interesting is the people who started it, the two key leaders who had started this program were a social worker Marie Louise [Phonetic] [0:27:35.8] and Dr. William Gee, a community dentist. So they really looked at this as a community systems issue of how to care for individuals who are certified to be in a nursing home but they couldn’t get into a nursing home. So that was the genesis of it but over you know -- fast forward, the ability to have a program grow around the person and Marie Louise was just brilliant in her portrayal of the fact that the focus she had was really you know kind of on a napkin drawing of having the person in the middle and having a cross disciplinary team helping people stay in the community.

So that sounds like pretty common sense you know. Now we talk about it, community-based services, home and community based care, these kinds of things but the essence was understanding that people really probably despite frailty want to stay in their normal environment for as long as possible. AARP has done studies you know, people aren’t kind of waiting to go to a nursing home. It’s nursing homes, as much as we say that nursing homes do have a particular and very important place in the continuum of the care but that’s not what most people aspire to necessarily and even if you have a great assisted living, not everybody wants to go to an assisted living facility even though there are -- this is great as a resource.

Heather: In context at that time, the only publicly funded alternatives were really nursing homes right?

Jennie: That’s right.

Heather: So you're in a hospital and if you needed care following, you ended up in a nursing home and other than that, the community services just simply weren’t there at that time.

Jennie: Right and even for San Francisco at that time, if you needed a medical bed place for people who are poor, people would get placement but they would get placed like 30, 40 miles

away. So here are people you know and our core population that we had when it started was in San Francisco's North Beach and Chinatown location. At that time, we're talking about 40 years ago, the three core populations were Chinese population, Filipino, as well as Italian and each -- especially the Chinese and the Italian populations didn't speak English necessarily so people got sent so far away, broke all bonds you know in terms of cultural context, the food that people enjoyed, that got broken.

So that whole model started On Lok into that role and over time, we ended up having medical care because we found out that without the physicians as part of the team you know, people would disappear into kind of Neverland if something happened over the course of the weekend. So it's a full nine yards and if you don't know about the PACE On Lok program, I highly recommend it because that's where the future is beginning to move. It just you know took 40 years but it's the concept of really integrated care delivery coupled with managed care in the best sense of the word. In other words, we could provide services that were never normally paid for; hearing aids, dental care, podiatry, services like recreation. These were things that were possible.

Long story now, it was passed into federal legislation in 1997 with bipartisan support which is a very key concept for us to think about. You always have to kind of think from the various perspectives whether it's the Democrats or the Republicans were able to get support from both sides because they hit their core important values. For Democrats, it was access in vulnerable populations. For the Republicans, it was simplifying regulation and saving some money. But you know again this was not about scrimping on care, it was spending the money differently. All of us know you know that this goes on today. So now, there are 29 states with programs like this with about 80 some programs. I think about 11 of them have rural health sites as well.

CHAPTER 4: MOVING TO AMERICAN GERIATRIC SOCIETY

I ended up being recruited by a search firm to really consider this and I had to admit that I didn't know that much about the American Geriatric Society other than I thought it was a physician's organization and it was actually true though. Our organization had been founded by geriatricians, people focused on care of complex older people but about 12 years prior to that, the board of directors had really decided the organization, because it was geriatrics really should be cross-disciplined. I mean this is what geriatrics is about and so I ended up interviewing and I saw that the whole area of those of us who are in this field of aging and gerontology and geriatrics, that this is not kind of like a go-to place you know. This is like not kind of a babe magnet discipline.

So this organization is really focused on workforce and guidelines of care and systems of care. So I thought this would be a real opportunity to you know hoist up where this issue of care complexity and having people better prepared in their competency, not only as specialists in geriatrics but in really infusing a core modicum of competency across all of our disciplines because that's who the population is. I think 75% of our healthcare dollars goes to chronic disease and so really it is about -- the future is about chronicity so that's where I decided I'd role up my sleeves to try to do this even though when I knew that the pipeline of geriatricians is shrinking.

You know it's an oxymoron that as we need more people, whether we're talking about faculty who are nursing faculty who are knowledgeable about geriatrics and aging, same thing with physicians. This has been going downhill for a long time for lot of reasons of incentives and finance and income and all this but it's just wrong. I mean this is one of those things where it's kind of like a battle cry to say this -- we should be preparing for what this is today let alone the future and so something has to be done.

Jennie: Right and what we don't know -- because everybody will do this in different parts of medicine and all, they'll say "Oh, I work with old people. I really know about old people." So this is something that people do work with older people but they don't really know about older people. You know with people with the poly pharmacy, the risk of hospital-acquired disability, the delirium that could be preventable. I mean you know the geriatric syndromes that are there, preventing falls, making sure that we stay healthier for as long as possible and not just "do excellent care" when we're in the hospital but understanding what is quality of life as compared to just the technical aspects of it.

So I think the reframing of all of this as we are here and knowing you know we're spending so much money, almost twice. Some of our closer developed countries and what do we get for it you know and we're still worried about understandably medical mistakes, transition fragmentation. Think about if we stayed on the healthier side for a much longer better time. We're using evidence and knowledge that we have, I mean society would be so much healthier.

I am extremely proud about brings together all the disciplines. In other words, it's physician, nurses, pharmacies, social work PA that develop these tools whether it's in this case the medication list that we have to be that much more careful about with older people and then also new guideline -- a new framework of thinking that if we have people who have multiple conditions and we're also you know eager to do evidence-based practice as we call it today. But what if you have six or eight conditions? You have guidelines for congestive heart failure, guidelines for diabetes, guidelines you know for arthritis. How do you begin to deal with that especially when some of the guidelines, when you put them all together conflict?

So we've had an expert panel that crossed-discipline to really think about the principles of how to think about complexity and how to prioritize how we choose guidelines. So it's one of those areas of building knowledge-building evidence working with the national quality forum on this so that we begin to do this because it's not good enough to just do check lists and think that we've done quality. It's really understanding the context of the population.

CHAPTER 5: NURSE LEADERSHIP

I know many of the audience members are thinking about the future, thinking about their own futures as professionals and also thinking about the incredibly changing dynamic healthcare environment that we're in where the labor markets are kind of iffy at times. No one really knows where healthcare reform is going to land in the end. There's a tremendous amount of uncertainty and I'm sure Jennie will say opportunity at the same time and I was wondering if you could comment and maybe think about some advice for the audience about the future of nursing.

Jennie: Well, you know if our careers are any guide, you know it's so wide open relative to what we can do. Many of us who choose our initial profession you know think about really the direct care of individuals.

But as we go into places and I think those of you who work in hospital systems or other institutions, you know there are things that come up that you notice and that both bother you or don't feel right or could be actually done better.

Nursing just is at this point wide open for that kind of leadership opportunity so it's not you know -- it's so awkward in some ways being in front of you thinking, oh gosh, this is somebody who you really want to hear about from but in many ways those -- the issues that got me going are the issues that I was confronted with. Much like that you know horseshoe bedside experience that I happened to have and it bothered me enough to really think about you know what should be done about the respect and the regard of people and being informed about things or being involved about this. So everybody you know because one of the recommendations is having nurses assume leadership roles and it doesn't mean leadership with a capital "L" necessarily. It's like doing something that makes a difference on your unit, doing something that you speak up on behalf of your patient and families and when you find some moral distress about these issues that you have, having somebody to talk to about how do you begin to think about these issues.

So you could do it at any point.

There are different opportunities to participate as "leaders" to understand how decisions get made, how a community comes to decide what's important, those of you who choose to be active in a political activity. You really discover different things that can help us be that much more effective in our carrying the banner of what's the best about healthcare for people and with people. So that's one of the recommendations that came out that we thought it was so much more important. Here we are you know, we have the Gallup Poll that we all know that nurses for the past decade have been really always on one of the top three so you have an opportunity for the public at large who already has a great deal of trust in our sense of ethics and our participation and coupled with learning to help lead and we are the biggest workforce. I mean we are three million plus strong. Our ability to shape how healthcare is there, possible can come from two venues. One is what we can do in our own system and then secondly, our thinking about the public at large.

Heather: And as we think about it what suggestions do you have for nurses in practice about how do we affect the change that we want to see? Imagine you know people say working in a hospital now, how can they influence?

Jennie: Well, I think that the opportunity to participate in improvement in your system is just a wonderful place to start in terms of quality and safety because that's something you see and if we're working on floors and units, we see stuff that gets messy. We also see how unergonomic some of the design is. So there are places to be able to think about this. There's a wonderful film that was done that was shown on PBS about just how much waste goes on. You're looking for wheelchairs on floors and you know hoarding supplies because you want to be able to have them. I mean those things could be redesigned. Technically it's not rocket science but it's the ability to participate on those working committees that make life simpler you know.

One example in this particular PBS show was why were all these people waiting for admission sitting in the hallway with on waiting to go upstairs. I mean how undignified, how stressful and somebody said why do we have to that, you don't realize -- they didn't have to. It just was culture you know. So these are some things that can make a difference where you wait until you need to go upstairs and you know because it's stressful enough. We're again talking about of course selective admissions. But there are things that you wonder, why do we do that rather than just falling into the patterns of doing it? You could get involved there.

Heather: So you're saying lead from where you are.

Jennie: Definitely.

Heather: That you don't have to be the one with the top title in an organization, that everyone in their practice with what they observe and the issues they encounter, the situations have an opportunity.

Jennie: Right. Well, it's like you know wearing a -- in fact the metaphor they used, using a different lens to take a look at this. Sometimes we may actually need to go see somebody else's unit or somebody comes to our unit because we get so used to what we do and we have done workarounds forever. So we don't under -- actually probably appreciate how we have figured out a way to manage and put it back whole, but it's not probably the most efficient system**.**

Jennie: I think we're all driven to make things better you know and to leave something or to have a situation be improved because you were there. You know I say part of it is having footsteps that when you've left something has improved because you were there. So that's probably as basic as it is. Have I made it better? Sometimes it's making it better for the person, the patient; sometimes it's because you've made it better for the team; sometimes it's because of a process that you've been a part of. So I feel that's basically whether for me it was __unlock_ and the fact that I had the blessing of having both my parents and incidentally my brother was in the program as well who had very advanced Parkinson's.

I thought gosh, I'm so lucky that I had something like On Lok and I think everybody should have something like this, you know the ability to make it better because sometimes we take on a leadership role because there's been like a real problem, you know. That something is like I don't want -- Megan's Law. These laws they get passed because we don't want another child to have that experience and we're going to make it better from something that is a tragedy. The flipside is wow, I've had a great opportunity to have something good. Other people should have this too which is another way to do it.