Project: Nursing America's Veterans

Name of person interviewed: Renee Pate

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Nurse, military, Army, Army reserves, dental specialist, LVN, reservist, Alzheimer's care and dementia care nursing, assisted living, hospice care, geriatric care, ADN, RN, dialysis nurse, home-based care, adult daycare, inspections, respite care, clinical documentation improvement nurse, coders, utilization management nurses, case management nurses, nursing operations, COVID-19, humanitarians, detail, Remdesivir, convalescent plasma, ministry, pandemic, PTSD, quarantine, Chi Eta Phi, patient experience, transformational leadership, mentor

Abstract

In this interview, Renee describes how she joined the military at a young age and the path she took to become a nurse. She walks through the various nursing roles she held and explains how these roles have shaped who she is. Renee details how she obtained additional nursing degrees and discusses the different roles she's held at the Veterans Administration (VA). She also vividly describes the impact COVID-19 has had on her, both personally and professionally. Renee concludes by sharing the most rewarding aspects of working at the VA and highlighting the VA's current focus on patient experience.

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[0:00] Renee talks about how she wanted to become a nurse from a young age, how she ended up in the military as a young woman, Renee's first husband.

[4:20] The path Renee took to become a nurse, nursing as a reservist, the jobs Renee had after leaving the active reserves.

[9:41] Renee begins to describe a typical shift in the various roles she's held, how Renee got her ADN, dialysis nursing, the difference between being a hospice nurse and a dialysis nurse, how Renee's various nursing roles have shaped who she is, the death of Renee's father.

[16:20] Renee shares why she prefers home-based dialysis, how Renee ended up working at the VA, Heart House.

[23:05] Renee explains what adult daycare at the VA is like, Renee's role in conducting inspections, a typical adult daycare patient, how adult daycares obtain contracts with the VA.

[27:31] Renee describes a typical day as a nurse in the adult daycare program at the VA, how Renee got her BSN, her Master's in organizational leadership, and her Master's in nursing education.

[32:32] Renee outlines her role as a clinical documentation improvement nurse, the importance of empowering nurses with information.

[38:43] Renee shares how she became the assistant nurse manager for the clinical documentation educators, the utilization management nurses and the case management nurses, the impact COVID-19 has had on Renee's role and the role of her nurses, why Renee's role during the COVID-19 pandemic was very difficult for her.

[46:18] Renee talks about her experience as a nurse in San Antonio during the COVID-19 pandemic, Renee's personal experience contracting COVID-19.

[50:05] Renee details how COVID-19 affected the VA overall, the false sense of reality held by some people,

[54:53] Renee describes how COVID-19 affected health care more generally across the US, the positive side effects of the COVID-19 pandemic.

[57:54] Renee shares the most rewarding aspects of working at the VA, how nursing has changed over the course of Renee's career.

[1:02:23] Renee highlights the VA's current focus on patient experience, the professional mentors that have contributed to Renee's success in her career.

[1:06:55] Renee shares where she sees herself in the next 5 to 10 years.

[0:00] Hi Renee. Thank you so much again for taking part in these Library of Congress oral histories. Can I ask you to introduce yourself?

RP: Yes, yes. My name is Renee Pate, and I'm originally from New York, currently living in San Antonio, Texas, where I've resided for probably about 29 years now. I have two children, grown children, 31 and 29, and I have one little grandson that's five, and I'm very proud of him [laughs].

AG: Oh, that's nice. You said you're from New York originally?

RP: Yes. I'm from the Bronx, actually.

AG: Oh, are you? Oh, wonderful. What was your experience like growing up? Did your parents work? What was that like?

RP: Yeah, my mom and dad both worked. I grew up in the projects, Forest Projects. My mom was a nutritionist for Cornell University, and my dad was the head of security for a building in Chinatown. It was a little interesting growing up in New York, but I left quite early. I finished high school a year early. I got married young. I was actually married when I was 17, and then my husband and I went into the army together. Yeah [laughs]. I didn't spend a lot of adult time in New York. When I turned 18, I was already in the military.

AG: Oh, wow. Do you recall when you were growing up, were there school subjects that you really enjoyed or any extracurricular activities that you did?

RP: Yes, yes. I was always intrigued with the medical profession. I can remember telling my mom, "I'm gonna be a pediatrician." That was always a big thing. Then as I got a little older, I wanted to be a nurse, and that was the big thing for me. I was gonna be a nurse. Right before I joined the military, I had actually been accepted into a program, but then some life changes happened and my husband and I decided to go to the military. I said, "Well, maybe I'll get to pursue that in the military."

AG: What made you decide to pursue a career in the military? How did that come about, especially so young?

RP: Right. Well, this is what happened. I was married young, and my husband at that point, at that time, unfortunately became addicted to drugs, and it was a situation where he felt like he needed to do something different to get out of the environment. I didn't have any intentions on going to the military. That was never my intention. He had been accepted to law school and I had been accepted to nursing school, and that's what we were supposed to do. But when he felt like if we left, he would have a better chance of doing better with the drugs, then that's where we went. When he said he was going, he came home one day, I thought, "Oh, I'm not gonna stay here by myself," so, I joined too [laughs].

AG: It sounds like that was a pretty wise decision in terms of like..

RP: Looking back now [laughs]...

AG: Not easy, I'm sure for you as a young woman, but very level-headed thinking to kind of give yourself that much structure. What kind of military service were you in? What branch of the armed service?

RP: I joined the US Army, and I joined the Army. The job that I selected at the time was a dental specialist, a 91 Echo. I spent the majority of my time in the military as a 91 Echo.

AG: How many years were you in the military?

[4:20] RP: I was in the regular Army for six and a half years as a 91 Echo, and then I was very fortunate. I really wanted to be a nurse, and up to that point, I had only been able to take classes here and there. It's funny how that was the goal, and then I kind of didn't get to do it right away. I made a decision to get out of the Army, because when I finally did get accepted in the Army to the LVN program, we were at a point where we had what they call stop loss, and there were a lot of things going on. We had the war, we had everything going on, and they wouldn't let one job be under strength because another job needed somebody. The job that I was in, had I left, it would have been under strength, so they wouldn't let me out to go to the LVN program. When they wouldn't let me go to the LVN program, I decided to go ahead and take an early out. What was so wonderful about that was I went over to the reserve side of the house and I was going to sign up to do the reserves, and found out that they had this contract LVN program, and they were gonna accept one more person to that program, and then that was gonna be the end of that program. A really nice Colonel that was over the program, he said, "I'm gonna do your paperwork, and I'm going to make sure that you get in on this program. You just have to pass the entrance exam." [Chuckles] I'll never forget him. It was just such a blessing. I was so excited. So, I literally went from active duty Army one day to active duty reserves the next. It was something else. Then, I went to a civilian school here in San Antonio for a year and became an LVN, a 91 Charlie. I was finally a nurse.

AG: Because you were in the Army reserves, you were still-- you had a rank and ongoing responsibilities.

RP: I was still active duty. They kept me on active duty status for that whole time. So, I spent a total of eight and a half years in the military, active duty service, whether regular Army or reserves.

AG: While you were in your LVN program and active reserve duty, were you nursing, or was it like a working while you're going to school scenario, or were you primarily studying? How did you balance all of that?

RP: Another blessing. This program was amazing, because I got my same rank and pay as active duty Army. I didn't have to report. I just had to go to school and show my grades every month and pass my PT test, of course. As long as I did that, I was good. Then after the program was over and I graduated and got licensed and stuff, I stayed on a little longer with the active reserves, and then I went to the inactive reserves.

AG: What is it like nursing as a reservist? What was that job like, after you were credentialed?

RP: Yeah, it was good, because I got exposure to hospital nursing, which I hadn't done. I had been in nursing homes and things like that for my regular-- when I'd be out in the community, but when I do my reserve time, I'd be in the hospitals and I'd get that experience as well, and that was very nice.

AG: What did you do after you ended up leaving active duty reserves? Then you sought another kind of job in nursing?

RP: Right. After I got out the reserves, I had several different jobs as LVN. I've worked as a nursing home nurse. I've also done Alzheimer's care and dementia care nursing. So, several areas in the community or facilities in the community I've worked. I've been the executive director for assisted livings, different chains here in San Antonio. That's where I probably spent the bulk of my nursing as an LVN, as being in the assisted living realm, because that just really spoke loudly to me. I really enjoyed it. I had a lot of buildings that specialized in Alzheimer's care, and since I had that in my background, that was nice. Then also having the regular clientele for the other assisted livings. So, that was something big. I've also as an LVN spent a lot of time in hospice care.

AG: When you're in those roles in either hospice or geriatric care, what is the typical shift like? You know, back then when you were working in those capacities.

[9:41] RP: Well, I've worked on a number of different shifts, and I'll have to say, I think I've been blessed all the way around because I've always-- I may be the longest running person to get a degree, to finally get all my degrees done, because I had to take a class here. A lot of the times, I was a single mom, so I had to take one or two classes here and there. But I've worked two 16-hour shifts in a weekend and been paid for 40 hours. I've worked 12-hour shifts. The worst shift in the world, graveyard shift. I've worked that shift, and I don't even know how-- I did that for eight months, and then I was going crazy. Then in those executive director roles, I had more of a nine to five, eight to five, roles like that, 'cause that was more leadership-based. I've worked all kinds of shifts.

AG: You've sort of done the gamut, run the gamut [unintelligible]. Did you say you went back to school again throughout that period? When did you go back to school and what was that for?

RP: In 2007, I went back to school. I got my ADN, my Associate's Degree in Nursing. I wanted to be an RN. My ultimate goal was to be an RN, but because of the jobs that I had in executive director roles and stuff, I didn't have time to go to school. There was an opportunity. I had gone through a divorce and there was opportunity. I said, "I'm just gonna take some time and do something for me. I'm gonna get in school". So, I did. I enrolled in the San Antonio College and I did their ADN program, which was a year, a year and a couple months. That was 2008 when I completed that program.

AG: After you got the ADN, did you switch jobs? Did that lead to a different role professionally?

RP: Yes, after I became an ADN, I spent a lot of time as a dialysis nurse. That was the area that I chose to go in. I still continued to do some hospice, but primarily I did dialysis.

AG: What is that role like? I know a bit about dialysis, but what is your typical shift like? What are the patients like?

RP: Those were very long days, dialysis days, because typically, I was there at four o'clock in the morning, and I probably wouldn't leave until four or five o'clock in the evening if I was working the day shift. If I was working the evening shift, it would be even later than that, coming in and leaving. I worked for both companies, DaVita and Fresenius, and we basically putting people on a [unintelligible]. We ran three shifts of dialysis patients a day on certain days of the week, and other days, it was two shifts of patients. 25 patients to about two nurses and a medication aide, so it was very hectic. I feel like I went from one spectrum to the other. I think as a hospice nurse, I dealt with death and dying, and I had to figure out how I felt about that, because as a nurse, we are always trying to save life, and then as a hospice nurse, I had to come to grips with, “You're not going to save life here. You have to make people comfortable as they transition.” That took a little bit for me at first, and then as a dialysis nurse, it was if my patients didn't have dialysis they would die, and so, it's kind of like trying to get them to take their meds, eat right, so that if you wanna be here, you got to do the things to be here. You kind of went from cheering on one thing to cheerleading on the other thing. But, what I found over time is that all of my roles have helped me tremendously just become who I am and my value system and what I found important. I know you asked me one question and I'm going to something else. My father passed away about 11 years ago and I had to rush to New York because he had gotten sick. When I got there, my mom, she was upset, everybody was upset. [Unintelligible] he had cancer, so what I figured out, once I finally figured out what was going on, I had to come to grips with a lot of things. It was because of my hospice training and my dialysis training, because there was that one point where I was asked a question as, "Will you try dialysis? He's not responding to this thing and that thing." I had to think about this. I'm good at everybody else's stuff. Now I have to think about it on my own, my own dad, and which is dear to my heart. I'm a daddy's girl. I had to put all those pieces that I had learned along the way into practice,

and I'm saying, "Ok, do dialysis, but we're not gonna do it too long." Then when I realized dialysis wasn't going to be the answer, then I had to go to hospice and I had to put that into play. I'm thankful to God that I had the experiences along the way to help me to guide my choices and my selections. Although it was a painful time, I think it was made easier because of the road that I had traveled along the way.

AG: Absolutely. It sounds like you had experience and expertise that many people wouldn't in that situation.

[16:20] RP: Yeah. It was definitely a journey. As a dialysis nurse, I got the privilege of working with people in the center. I also ended up taking a job with Fresenius for peritoneal dialysis, where they do it through a person's stomach membrane, and they carry food around kind of all day. So, two totally different things. This is home dialysis versus in-center dialysis. I found that I really enjoyed that a lot better, but it was two totally different things. I got to learn a lot, teach. You would go to people's houses and teach them things at their homes, and I really liked that a lot better. But again, met some really great patients that became my family, and so I was blessed there as well.

AG: Was it the home-based aspect that you preferred about the-- Is it called Licinius?

RP: That was the company that did the dialysis, yes. I preferred the home-based because it seems like you just had more of a connection with the families because I was in their homes. They would come to see me. They would call me and say, "Hey, I'm having this problem or that problem. What to do?" and things like that. I liked the 1-on-1 instead of having 25 people that's pulling at you all at once [laughing].

AG: Absolutely. I can totally imagine. How long would an average patient remain on dialysis, in your experience? Would you go to their home once a week for years, or was it shorter-term typically?

RP: I would go to their home during training times, and then I didn't have to go to their homes anymore, but average lifespan on dialysis kind of varied. I had patients that had been on dialysis for 15 years, 20 years, and then I had some-- some of them, they got transplanted, which was really nice, and some people who were only on dialysis for a couple months and they passed away or something, decided that they didn't want to do dialysis anymore. It was too stringent on the body.

AG: Yeah. So, it really varies.

RP: It really varies. Yes.

AG: How many years were you working as a dialysis nurse?

RP: I did dialysis for six years. I really, really enjoyed that job, and I did that until I-- What made me change was I applied for a job with the VA here in San Antonio, and when I got the call for an interview, I thought, "Oh, man. Working at the VA would be a good experience for me as a veteran because all my time would count. I can buy back my military time towards my retirement." That was really the kicker for me because we're all trying to get to retirement, so that and the pay was probably about 15,000 more dollars, so that worked out really well too. I went and interviewed and it was just so interesting, because, I don't think I told you but one of my prides in life is that I used to own an assisted living. I loved working in assisted living so much. I had gone to visit a patient that-- The owner had called and said, "Hey, I have a patient that I need to transfer to a facility that can offer more assistance," and so she called me at the larger facility and I said, "Okay, I'll come out and I'll assess the patient." I drove out and noticed that this is in a neighborhood, this was a house, and I thought, "Oh, okay. Well, this is interesting." It's a little house, and so when I go in, this house is huge and I'm thinking, "Man, this is really good," and she has like seven or eight patients in this house and whatnot. I thought, "Oh, I love this house. This is so nice." From that point on, I told my husband - I had remarried - and I told my husband, I said, "Oh, my gosh. I just went to this house today and I really want my own little assisted living," and he was like, "Really?" I was like, "Yeah, that would be so neat." So, anyway, I did take that patient to the larger facility. I made a connection with the lady that owned the house, and it just so happened, maybe eight months later, the lady called me again at my work and she said, "Hey, Renee. I have a really bad blood disorder and I'm gonna have to sell - Heart House is what it's called - and I just wanted to know if you were interested." Oh my goodness. Right then I called my husband and I was like, "Oh, my goodness. This woman wants to sell it. Let's buy it," and he was like, "Wait a minute, wait a minute. Are you sure?" I was like, "Yeah, yeah, we can do it." So, we bought it, and it was just the biggest, best thing ever. We got it together and we did our little tweaking to it for the first three months. That's all I did, and then I turned it over to my husband who, at that time, he was a nurse, too, and he ran the day-to-day stuff, and I would come and do meds and all different stuff like that. I went back to work in the community. So, back to the VA. When I got a call at the VA and I went to interview with the VA, it was for the adult daycare program, and I was just so excited, because that's all I dealt with was adults, adult care. When I heard everything that they were wanting me to do was stuff that I had done all along in my profession, I interviewed and I was called for the job. In 2013, I started working at the VA with the adult daycare program as the nurse.

AG: Wow, that's terrific. Do you also still own Heart House? Or did you...

[23:05] RP: I don't own Heart House anymore. I am in the house now that was Heart House. This house is totally huge. It's six bedrooms and really nice. My husband at that point in time, my husband and I, we divorced. I know, another divorce, right. But anyway [laughs], we did. We divorced. Then, because I was becoming a single parent again and I really had to get out and work and I couldn't stay at home with the patients and stuff, we decided to send our patients to places that we thought were appropriate for them to be, and me and my kids came here and lived in this house.

AG: Oh, that's nice that the physical house is yours.

RP: Right.

AG: That's wonderful. So, you moved into the adult daycare program at the VA in 2013. Is that kind of like a long-term living facility, or what is the adult daycare at the VA like?

RP: The adult daycare program is kind of under an umbrella. In the umbrella, adult daycare is really like you would think about a daycare for kids. The people go to the adult school there in the daytime, and they're provided meals and activities and medications, and then they go home at night. But we're on an umbrella where we also had the assisted livings for the VA, which was something that I was familiar with. So, I did inspections. I was the one that would go out and do the inspections for the assisted living portion. I worked seeing the patients for the adult daycare program, but I would go do the inspections, which were similar to the state inspections for the assisted living communities, because I had experience in assisted living.

AG: What's a typical patient like who comes to the adult daycare?

RP: The patients at adult daycare are typically about 75, excuse me, 65 years or older. They normally have some chronic conditions where they need assistance. They're not able to do all their ADLs by themselves maybe, or they need medication supervision, or socialization, and some of them may have dementia. We had certain facilities in the city that specialized in dementia care, and so, we would have patients that would go specifically to those. Then basically, from a VA standpoint, it was just to have a need, one of those needs, and if you had one of those needs, the VA then pays for that veteran to go up to five days a week for those services.

AG: Do they get them there? They transport them to and from the daycare?

RP: What happens is the VA will pay for a VIAtrans bus card, so they can be picked up on a bus service, or most of the facilities have their own transportation vans, and they would pick up the patients and they would bring them to their facilities.

AG: How many facilities like this do they have in the San Antonio area?

RP: Say that one more time.

AG: Oh, sorry. How many facilities of this kind do they have in San Antonio?

RP: There's several of them in South San Antonio. We were contracted with 16 of them. There's several of them in the city, but what would happen is they would have to fill out an application to contract with

the VA, and then we would have to go do an inspection of the facility to make sure that it was up to standard. If they met all those requirements, and they did all the things that they needed to do, then we would make the decision to award them a contract with the VA. They would have to pass their inspections annually and keep up to code and everything to keep that contract going.

AG: I see. So they have veteran patients, but they also have the broader population.

RP: Yes, yeah. They had everybody.

AG: What was a typical day for you like in that role?

[27:31] RP: In that role, I had facilities that spanned from San Antonio, Uvalde, Beeville, Texas, so that may be-- Victoria-- two and a half hours out and back. I kept the schedule, I saw my patients. I had to see them every other month at least. I would basically decide what adult daycares I was gonna go to for the week, schedule with them, and then I would drive out, see them. I would sit and visit with each one. At some facilities, I had up to 10, 15 patients at one facility. I would sit down and spend one-on-one time with each of them doing my assessment, "How are you doing?", talking to the staff, "How are they eating? Are they interacting?", because I needed to get the full picture of my patient so that I know that this setting is working for them as being beneficial to them, how the family interaction was going. I would check all those different aspects. Then I would go back and I would make my notes based on whatever was going on. If there was something I found out in my visit that I could get a social worker involved in, I would advocate to the social worker for the patient, or whatever they may need someone to help them out. If they couldn't get a benefit that they needed, they didn't know where to go or who to talk to, I would normally find that contact for them or the family and hook them up with that. I also dealt with the respite program at the VA. It was really good because I had the respite program and under our umbrella, we had the adult daycare and then we had the assisted living. If I found that when I was talking to a veteran or a family, or the staff told me something about, "Oh, Mr. Smith's daughter, she just looks so tired. She's so worn out," then I knew we had a respite program and I could call and say, "Hey, do you feel like you need some respite days? He has x amount of respite days available, and we could put him in a nursing home for a few days and give you time to rest." All the programs worked well together. Or if it was getting too much for them to handle at home, the staff might say, "Oh, Mr. Smith keeps coming with soiled clothes," or, "He's not eating. He hasn't eaten. He's very hungry," then I might say, "Hey, you know what? We have an assisted living at such and such an address. Why don't you stop by and see if that might work for you?" All of the programs kind of went hand-in-hand.

AG: It sounds like it probably wasn't uncommon for people to kind of graduate from the daycare to more of a long-term living facility.

RP: Right.

AG: How long did you do that role? You've left the VA right?

RP: No, I'm still at the VA. I'm at the VA but I do a different job now. I did that for five years, and during that five years, I went back to school. I got my AND and I got my BSN, and I got my Master's in organizational leadership while I was in that job, so I kind of was working on schooling. I was kind of getting the hang of this school thing. Then, once I got my Master's in organizational leadership, I thought that's when I was gonna stop, but then I found out that in order to get promoted, I needed my Master's in nursing. So, then I was like, "Oh my God. My brain cells are dead. I don't know if I can do another program.". I thought, "I have a Master's. Does that not work well?" So, I went back to school and completed my Master's in nursing education. Once I finished that, I started looking at some other jobs. I applied for clinical documentation improvement nurse. I had really no clue as to what that was, but I know I needed to do something different now, because I had reached where I could go. I couldn't go any further where I was, and I wanted to do more. Now I had my education, I had everything going, I wanted to do something more. This was something new to the VA. We had never had a clinical documentation program, and it was just getting started off the ground. When I came to the program, it had been going for a year, and we were still in our infancy stage. We really didn't know what we were doing. We were figuring it out along the way. I interviewed for that and was hired, and I did the clinical documentation program for three years.

AG: What is that?

[32:32] RO: What we do is we review concurrently the patient or the patients in the hospital, we review their days concurrently from the doctor's notes. We're trying to make sure that what the physician did or what's in the documentation accurately reflects what the doctor did. Maybe the doctor might say, "The patient had heart failure." The coders will only pick up heart failure, so we bridge the gap between the doctors and the coders. So, I'm gonna go back and ask the doctor, "Hey, Doctor So and So. You said heart failure, but can you specify for me what type of heart failure it was? Can you tell me if it was diastolic, systolic? Was it acute, chronic, acute on chronic?" We are constantly reading all the notes to ensure that what the patient's chart represents an accurate state-- accurate picture of the patient's state and their risk of mortality and their severity of illness. That has been very interesting to me. I really enjoy doing that. The physicians are really, you know-- They've gotten used to us now 'cause they-- we're there, but at first it was kind of like, "Well, I don't need you telling me what to do" [laughs]. This is just a suggestion. So, doing clarifications, that's basically our job. We are like little detectives, going through the chart saying, "Did you really-- Well, was this acute renal failure or was this, you tubular necrosis?" or we're kind of asking those questions. The doctor can say, "What I really meant was this, but will you please document it in the chart?" Coders are not clinical, so they are not going to be able to ask you the clinical question that a nurse would be able to ask you. So, as nurses, that was what we did.

AG: Then you passed on the clinical notes after you revised them and got all the missing pieces to these coders?

RP: Once we get all the pieces together, what the doctor really meant, and do the clarifications, we all work in a system together, the coders and the nurses. We have separate parts of the system, but we all work in a system. They can see everything we've asked and they can put it all together. By the time the patient discharges, we have clarified the chart, and the coder doesn't have a reason to ask a question after discharge, because we've clarified it all the way. Now they can just pull the information that we've gotten for them.

AG: Do you know, do they need that information for billing purposes, or...

RP: Yes.

AG: Reporting purposes, or some combination of that?

RP: Yeah, they need that for all of that. That's how we get paid. That's how we tell how sick our patients really are. Because a patient, they have comorbid conditions and major comorbid conditions, and all of those things go into factor resources that are used to treat that patient, if they are sicker patients, and that goes into dollars for our reimbursement, how we get funded and all that stuff.

AG: Wow, it sounds like a really fascinating position. How did you manage the shift away from more sort of patient interaction to this kind of, like, detective role?

RP: Yeah, well, it is strange not to have patient interaction as a nurse, but what I've found is, if you're going to be a well-rounded nurse, you need to not only understand the patient care aspect of it. You have to understand how what you do affects the financial aspect of the hospital. If you plan to go higher in your career, you definitely need to understand those aspects. It wasn't until I got into this role that I understood what VERA, which is how the VA hospital gets paid. This is totally different from outside. It has its own set of rules and regulations and things like that. But as a bedside nurse, you never understood and understand that. My thing is, I feel like if we spend more time educating nurses about the big picture, I think you would see a difference in performance, because they would have buy-in. They would understand how the things that they do, the things that they say to the provider, and how they help the provider helps to provide resources, that they have more staffing, that they have bonuses, that they have the different things that they need. We have more equipment, different things like that. I think how we empower our nurses to know more, to learn more, will have an effect on the whole facility.

AG: Right, especially, like you said, I'm sure within the VA it's very complicated, and it's hard to know what's happening with the finances and the budgeting, but having some insight about that would certainly be beneficial, I imagine. Is that the role that you're currently doing now?

[38:43] RO: Also about a year ago, I got promoted to the assistant nurse manager for the clinical documentation educators, the utilization management nurses and the case management nurses. I'm the assistant nurse manager for those three departments. [Laughs] That's been a blessing to me, so I am thankful for that. I got a new job as the assistant nurse manager and I've got promoted to nurse three, which was nice. It's been great. Things that have really affected that, I've been in that position now a little over a year, but really COVID has greatly impacted my position and my nurses' positions, because we are what we call nursing operations. My three departments, we are part of nursing operations, and so we're kind of like the heartbeat of the hospital with those three areas. I have a lot of nurses that have critical care experience, med surg experience, things like that. When COVID hit, we were one of the first ones to get detailed to the floor. Our regular jobs just stopped, and we were in scrubs on the floor, trying to remember what we used to remember [laughs]. We literally came to work one day. We were in our regular clothes, our regular clothes, and by 10 o'clock that morning, we were on floors in various areas separated. We were all separated, and it was so much anxiety, tears, because you didn't know what to expect. I was back on the dialysis floor, as I hadn't done dialysis in I don't know how many years, and I'm like, "Oh, my God, I got to try to remember. What do I do?" People who hadn't been on med surg floors in years, they were like, "I got to even learn the medication system," because we're administrative nurses now. Then, within the year, we got detailed. Then when it seemed like things were getting better, we went back to our jobs, then we got detailed again because we had another surge, then we came back. We got detailed three times in all. All of my staff were back from detail this past April. We had been detailed ever since March on and off, so it really affected us quite a bit. Now, it's a lot of fear about being detailed again, because our numbers keep going up.

AG: I see. When they detailed you, it sounds like you said literally, you showed up for work expecting to do the role you'd been doing for months and years, and then you were deployed across units. How long, for example, did you work then in the dialysis unit? Was it for months or was it just for a couple weeks and then they moved you again?

RP: I worked in the dialysis unit for two months, and then when things kind of seemed to be leveling off a little bit, then we came back to our normal jobs. Then the surge happened again, and that time I was detailed somewhere different. I counted all the COVID patients, and if they were high intensity or low intensity, they were on ventilators, if they were on BiPAP. That was a very hard job for me. It wasn't so much hard because I was counting people, but I was counting people, I was counting deaths, I was hearing stories. I would be on a call. We had a lot of humanitarians from Loredo, different places. We were a big hub. That was our fourth mission. We were a big hub for humanitarians. I can recall a time having a husband and wife that came from Laredo, non-English speaking, and they both had COVID. I was on the call, the hospital call. We had a call twice a day in the morning and one in the evening to run the list of patients so that we can know what was going on, what the treatment was gonna be and things like that. The husband was worse off than the wife, but they both were very sick, but the husband was worse off. I would hear them say, "Mr. So and So is not doing well. We're gonna try to do this with him and that with him. Mrs. So and So, she's doing better, but still not so good." Then they would do the

iPad for the daughters to be able to talk to them, but they were in Laredo, and so we had to bring a translator in to be able to speak sometime if we didn't have anybody that could translate for them. Then I remember the day when they said he died, and everybody on the phone-- you could hear weeping, these doctors, everybody, because we'd taken care of them, and we were just hoping and praying. We had given the Remdesivir. We had given the plasma, convalescent plasma. We had done all these things, and it was just-- it's like a moment of silence please for Mr. So and So, and we're there and then I have to go back and document my death. Once the wife found out, then she gave up and then she died too. Then these daughters are without both of their parents. During COVID, that was my hardest, hardest job. I was glad when that detail was over, and I did that for probably about six to eight weeks. It may have been a little longer than that. That job during COVID was very difficult for me. One day we had, like, four deaths in one day. The morgue was overfilled. We didn't know where to put the bodies. What were we gonna do? It was just mentally draining, it was emotionally draining, and everybody was tired. I remember a physician getting on the phone and he's saying, "I just need one minute. I just need one minute. If we could just stop them from coming in for one minute so I can catch a breath." He was just at his wit's end, and it was the saddest thing. Then we lost some of our physicians. We had one that got COVID and died. We had a staff member that died. After we got to a point where it seemed like we had the patient situation under control, we had an outbreak of our staff with COVID. We had COVID staff left and right. They were getting sick, we lost some. It was bad. I've never seen anything like this in my life.

AG: Oh my god. That sounds so painful and exhausting. It sounds like San Antonio was really hit very hard.

[46:18] RP: We got hit really bad and they just kept coming. They just kept coming. It was so scary. I mean, the ventilator situation, the humanitarian situation, we were getting so many. It was so many coming, because the other hospitals in other areas, they weren't equipped to handle the situation. Then we thought it was done. We thought we were not done, but we thought things had gotten better. We go back to our routines again, and then, I believe it was in December, we all got detailed again. That time for COVID, I ended up doing calls to the home COVID people, so not the ones who got admitted, the ones who were sent home on COVID. I'll never forget, I was at home making my calls to my COVID patients and I got COVID. I don't know how I ended up getting COVID 'cause I was at home. I was so very sick. I was so very sick, but I wanted to call my COVID patients because they were sick too. I remember just my head was hurting. I felt like I had been beaten. I didn't have any taste or smell, and I'm calling my patients and they're saying the very same thing: "I can't taste. I can't smell." But I didn't want to not call or let somebody else do it because we wouldn't have enough nurses. o, I would call my patients and I would literally go back to the bed and get in the bed and lay down and try-- But even that, listening to all the people that were at home, some were very sick, some had been sick for a long time, some of them had the same symptoms but a different reaction. It was crazy.

AG: How long were you sick with COVID?

RP: I went and got my first vaccine on December 3rd. December 26th I was sick. I thought I was just sick from the shot, you get a little achy, but it kept getting worse. One day I had a headache, then the headache stayed, then I had body aches. Then the body aches and the headache stayed, and then I-- When I lost my taste and smell, I knew I had COVID. I went and got tested and it was positive. For three weeks I was quarantined, my husband in one area and me in the other area. It was just a mess.

AG: Oh my goodness. And in these circumstances, because you have to quarantine even from your family, there's no one to take care of you.

RP: No! My husband is a little older than I am. It was so cute. He would make food and he'd put it in the kitchen on the island and he would call me. He'd say, "Your food is ready" [laughs]. Then I was so sick. I was like, "Ok, I'll go get it." And so [unintelligible] stick the little plate out the door, and he got Lysol and everything [laughs].

AG: Oh my gosh. Well, it's so nice that you had him and that you're feeling great. But what an ordeal to go through in the midst of all this, as you said, after being in the hospital for months and months and then you get sick.

RP: Oh yes. Yeah, difficult.

AG: I wonder, how do you think that COVID affected the VA overall, sort of as your experience? How did it affect the organization and the workers there?

[50:05] RP: I think it had a major effect on all of us, and I think we all have a measure right now of PTSD from COVID, because now here we are-- Just as an example, I left work on Friday and we had nine COVID patients in the hospital. When I got back to work on Monday, we had 17. Today, there were three in the ED when I left. So, everybody's on edge. Everybody is just on edge because they see the handwriting on the wall. People, they know, they've lifted the mask ban. They lift this thing and that thing, social distancing. We the health workers, we're the ones suffering, because we're the ones having to take care of the people. We're the ones having to be careful with our family members and things like that. I think that as far as the VA as an organization, we realized some areas that we can improve. We realized some education maybe that staff could have that would better help in a situation like this in the future, going forward. We also realized our strengths and not only our weaknesses, that we do come together when needed, and I think that was a very good thing. We have a very good leadership at the VA, our nursing leadership, and our director is a very good director, and they were very concerned with the staff. We had brought in a lot of contract nurses. We had a lot of contract nurses to come in, to help with fatigue for our staff to give them a break. They were as mindful of those things, I think, as they could be in the situation. I mean, nobody likes to be detailed, but at least you felt like your leadership were thinking about you. Our executive nurse leader, she would come check on me. They were sending

food to us. They were doing whatever they could do to let us know that they appreciated what we were doing. I think we've learned a lot of lessons. I think that we are better and stronger now because of what we're going through, what we've gone through. No one's looking forward to this to continue, but I think the realistic side of it is that COVID is not going anywhere. It's here to stay, and it's not just gonna magically disappear. I think we have to learn how to live with COVID and what to do, but I think that if people would just allow us to get to a point where we're safer, we probably could handle it a little bit better.

AG: Yeah, I was going to ask if there were any lessons that you're taking forward from the COVID pandemic, but in many ways, it's like you said: It's still ongoing, even though for some people it feels like it's behind us. It's really not, and that kind of false sense of...

RP: Yeah, it's not. Me and my husband went to an event maybe a few weeks back, and the gentleman was saying a prayer, and he was thanking God for allowing COVID to be over and that we can resume to our normalcy. I'm looking at my husband. I held my head up from the prayer and I'm like, "Where's he living at?" I'm like, "What the heck?" Some people have a false sense of reality. I'm not sure where they're living. Maybe they haven't had anybody that died or was very sick, or maybe they don't believe that so many people did die. I'm not sure where the disconnect was. We've had a lot of things going on in the world with-- politically that has not helped the situation, but people need to realize that this is not going away. This is here to stay, but we can live our lives and still enjoy the freedoms that we are accustomed to if we do things that we need to do now and keep on thinking of each other and being safe with one another.

AG: Absolutely. Do you have a sense as well, from your position, of how COVID affected health care more generally across the US, or how it affected people generally speaking, just from your experiences or expertise?

[54:53] RP: I think overall, I think that COVID has allowed a lot of people to realize that you don't have the luxury of just thinking you're going to be here another day, or that the United States or the world is not vulnerable to something. I think it has allowed people to understand that we are vulnerable. We're a vulnerable world, and things that you might have seen in a movie have now become reality. This is really our true reality at this point, and that, hopefully, people are taking a way to value family time. I think that many people focused on the fact that they had things taken away from them that they could no longer do, and what they did not focus on was that some of those things you really didn't need to be doing anyway. I think it forced people to spend family time together, to save money. COVID is bad, but what good came out of COVID? Did you realize that now you're sitting at the table with your family eating together? Are you praying together now when you didn't pray together before? Do you now have money saved up that you would have been spending frivolously on different things? Are you in a better economic situation? Are you better physically? Did you start going to the gym? Did you start eating better? Did you start a garden and grow your own vegetables? All of these things. Sometimes we focus

on all the negatives, but I think that we need to spend more time focusing on the positive. Did the strength of your family structure get better? Were you able to help others? What were you able to do? So, when I hear people talking about negatives, negatives, I tend to ask them, "What about the positives? What can you tell me that happened good about COVID-19?" Because I know people that died. I can name all the bad things, but let's talk about some of the good things.

AG: Sorry about that. I had a phone call coming in on my computer. That's a good point. Like you said, all the kind of unexpected positive side effects that people don't realize. I wonder, we've been talking for about an hour. Do you have a few more minutes to talk about, like, thinking back over your career as a nurse and taking stock, that kind of thing?

RP: Yeah, yeah.

AG: Okay, great. I was gonna say, for example, what would you say are the most challenging and rewarding aspects of being a nurse in your experience?

[57:54] RP: Oh, man. Well, for me, let's go with most rewarding. For me, I got to be something I always wanted to be. I got to accomplish my goal to be a nurse, and there's nothing better than achieving that. I got to touch lives at different points and times in people's lives. I got to touch lives, to preserve life. I got to touch lives when people were transitioning out of this world. I got to make a difference. To me, if you're gonna be a nurse, you should make a difference, and I feel like I've been blessed to do that. I'm part of a sorority, Chi Eta Phi [unintelligible], and our motto is "service to humanity". I believe I live “service to humanity”. I believe that I've been able to touch the lives of other people, and that's the greatest reward of them all. Yes, I've had challenges. I've had days when I didn't think I was gonna make it when, different jobs, you feel like, "What am I doing here?" Just when I always think about, "Oh, why am I doing this?" God would provide somebody to say something or do something that let me know, this is why I'm doing this. This is why it's important. Maybe this sounds simple, but I've been in a situation with just putting my hand on top of somebody else's hand made them feel good. Sometimes as a hospice nurse, I realized that it was a ministry, and I realized that sometimes you think you're there for the patient because the patient is who you are assigned to, but there are so many people-- family dynamics that a lot of times, I was there for family because they needed to hear something, they needed some support and things like that. My challenges, I want to say, have become my rewards, and that's what's important to me. That's why I love what I do.

AG: That makes a lot of sense, especially in, like you said, the hospice setting and working with elderly patients, and really sort of getting those benefits of attending to people in these transitional periods.

RP: Yes.

AG: I wonder, how, if you have, how have you seen nursing change over the course of your career, if it has?

RP: I think we've experienced lots of changes just in the way we do things. The way we care for patients, the technology has just gone from one end of the spectrum to the other. Like I said, when I got put on the floor, I'm used to passing a med cart with medications on there. They got all kind of systems that think about your medications for you and distribute them. It's like you're not even needed, and so technology has come a long way. When I did my preceptorship in my nursing educational program, just to see how the nurses were being trained as opposed to how I was being trained, I'm like, "Oh my goodness. They are on a whole different level. They're learning things that I probably didn't know until recently," and so, nursing has definitely come a long way. I mean, the communication, the expectation, all of that has evolved.

AG: When you think about your current role, are there any services that you would like to see provided or expanded for veteran patients in particular?

[1:02:23] RP: Currently right now, a big thing is about patient experience. We are doing a lot of rollouts about patient experience. I've taken a big interest in that because I'm a veteran as well as a nurse, and I've been to outside hospitals, the VA hospital for care. It's all about your experience. Your experience drives how you feel about something, how you think about it, how you value your care, what you think--what you tell other people about your care. I think that I like what I'm seeing now, as far as the focus being on the experience of the patient, not what just occasionally happens, that this is the experience every time you come. This is the norm, this is not just today. This is when you come every day. It's not just when you talk to the nurse that's taking care of you, but it's when the pharmacists, you talk to the pharmacists, it's when the clerk is addressing you to make an appointment. You're getting consistent experience every time you interact with us. I think that, at least at where I work, I think that at the VA, they are doing a great job of trying to get the frontline staff involved in this process by doing different exercises, going to classes to learn more about patient experience and how would you feel about the sensitivity trainings and things like that, which are important. I think if we continue in that way, I think that we'll find that our patients are truly having a great experience and they feel good about telling you what's wrong and trusting that you're gonna take care of it and that you care about their situation.

AG: That makes a lot of sense. You know, I'm wondering, I have a couple more questions. Is there anyone that you think of as a professional mentor or role model, or multiple people maybe over the course of your career?

RP: I've had several people and instructors as well that I think have contributed to my success. Nurses. Pat, my pastor. I think because I like transformational leadership, and I think that when you find those people that are doing transformational leadership and you understand the vision, you understand how that works, you see that you want to emulate those things that you see in other people. I've had Renata

Rashaan [check spelling], some of the nurses, other nurses, Lisa Mendez, some of those nurses at my facility. I've had several of the nurses in my sorority, those nurses, we have a lot of people that have their doctorate and things like that. They have shown us along the way-- I remember when I was an ADN, and I'm thinking, "Oh my goodness. I really want to be a BSN. Look at my sisters," and stuff like that. They mentor you along the way. They've always been helpful, there to guide you along the way. I've been very blessed to have people in my life that have poured into me. So, for me, my goal is to pour into someone else, and that's how I go about things. I try to help others, show them how to do things. I try to never be too busy to help somebody or to answer a question, or if I can't answer right there, I try to make sure I get back to somebody, because if no one ever showed me, where would I be? If I don't take the time to show somebody else, then I may be keeping them from their blessing.

AG: That makes sense. I wonder, where do you see yourself or your career in the next 5, 10, 15 years?

[1:06:55] RP: I hope I'm retired somewhere along those lines [laughing]. But there's a position that's coming available here in the next couple of weeks that I plan to apply for as a nurse manager. I'm currently the assistant nurse manager. It looks like we're having a realignment of our department, and my-- I told you I had three departments under me. Two of those departments, which are the utilization management nurses and the clinical documentation nurses, are being realigned under quality, value and service as opposed to nursing, and they're gonna need a nurse manager for that. Because those have been my programs that have been near and dear to my heart, I want to apply for that position. That's my next adventure. There's a lot of things that I don't know, and I'm a little nervous about that, but I just trust and believe that God will provide people in my pathway to help me along the way, and I'm excited about it. I feel like I have a good chance at it. That's what I want to do for at least the next five years. I'm not sure past that. I can't really tell you, but I got at least 10 years until I start thinking about really retiring, so we'll see what happens.

AG: Oh, wonderful. That sounds terrific. Good luck. I hope it works out. It's a very suitable role for you. Renee, I want to thank you so much for participating again. Is there anything that you wanted to add before we say goodbye?

RP: I just wanna thank you. This has been a wonderful opportunity. Thank you for allowing me to be part of this, and I can't wait to see how it all comes out. And yeah, please reach out to me anytime anything is needed.

AG: Wonderful. I will. Thank you so much.

[1:09:04] End of recording.