***Nightintales* Podcast Transcript**

**Episode 11 – Community Health Nurse**

**Guest:
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Jessica: Welcome to Nightintales. This podcast was created during the international year of the nurse and nurse midwife. And what a year that was. This podcast is dedicated to telling the stories of nurses from across our profession. Our goal is to introduce you to the seemingly infinite possibilities in nursing and encourage you to find your true passion within this work. I'm your host, Jessica Spruit and I'm so glad you're here.

 Hi, thanks for joining us for another episode of Nightintales. I'm excited you guys are here and I'm excited also to welcome our guests today. I have Belinda Aberle and she is joining us today to talk about the tip of the iceberg when we think about community and public health. Belinda has her Masters of Science and Nursing and Community and Public Health Nursing, and is also board certified as a public health nurse advanced. And so, she's going to tell us about her career trajectory.

I think you'll be really interested to hear about the variety of things that she's done within this specialty of nursing. And to help you think about what might be available to you. So, Belinda, thanks so much for taking your time and spending this time with us as an opportunity to share what you've done.

Belinda: Thanks so much, Jessica, for having me. What an exciting time to be able to share our passion for nursing. So, many reasons to be able to want to do that. Why I'm teaching now to be able to take what I love and pass it on. So, this is a great way to do that besides lecturing and planning classes and all that good stuff. A little bit about me. I graduated in a long time ago from Boston University with a bachelor's in nursing. And I sought that out because at the time in the early eighties, it was already being talked about is the minimal degree. And I'm really excited to be in a school had a great graduate program and a really great BSN program.

I went from there into the typical, at the time, med surge for about a year and loved it, did ICU for a little over a year and also loved that. I love the technology. I love the pace. But what I didn't love about ICU that was just me was I felt like I didn't have time to be creative and adaptive. And those are the parts of my personality that were like, not that task oriented. If you're a super task-oriented ICU is perfect for you. If you love the technology, but you don't love that tasky day long work, then you move into other directions and there are so many other directions to go.

So, I tried home care the next just a year and a half after. And part of it was because I moved and I had to get a new job because of the move with my husbands because of my husband's job at the time. And so, I was just excited to try something new and fell in love with home health care. It has evolved over these last 30 years so much, and to the point now where it is still considered a career in part of community health, but so much of what happens in community health now, I mean, in home care now is really acute care. Because patients are only given a short time by their any insurance provider to have a nurse or multiple disciplinary team, visit them at home.

And so, you're seeing them right out of an acute care situation and they're still pretty sick. And your skills, your assessment skills, your independence of practice just really has to be great. And so, if those are things that you can imagine yourself enjoying just being adaptive and creative and being in people's homes and their space and enjoying getting to know them or not, you will enjoy that. That really just an amazing part of nursing doing home health care. From there, I took a couple breaks and went back to the hospital and what I did was a little bit of med surge.

 And then, I ended up doing a little bit of outpatient surgery, which also I found a nice break from home care and a really nice, easy nursing job. Making your patients happy, going to surgery, and then making them happy on their way out the door was what I call that. So, if you need a break from something more intense, good place to go. Then I tried hospice back and forth a little bit when I was living in west Michigan and ended up doing that full time for a couple of years and loved that. I found it a very sacred way to use who I am as a nurse and my skills. Also, just a lot of independence, a lot of teamwork, really wonderful teamwork happens with hospice.

And it's, as I said, sacred to me, it's about a sacred is that experience of being with someone when a new baby is born to be with a family when their loved one is dying and to be with that dying person and help them have the best experience and the most peaceful experience, they can; is just a tip of the iceberg in terms of experiences and sacred life work, as far as I'm concerned. So, I want to encourage you to look into that as an option and also a really nice, flexible option. I've love to talk more about that. The next thing I did was when I was in graduate school, because I decided I really wanted to teach. I went back to school late in life and decided to move from the Western.

I was commuting from west Michigan to graduate school and decided I really wanted to be at U of M for a while, and just get into the, all the things that are available that I couldn't do when I was commuting. So, I got a job as a chronic disease manager in Public affair in a family medicine practice, it was actually a U of M family medicine residency practice with lots of residents running around and really cool place to be in all those ways. But my job was very unique in that it was part of a demonstration project that started about eight years ago to really display the value of RNs BSNs in primary care.

And now there are 400 practices around the state who have been through the demonstration project and continue to utilize RNs in that way. I had a caseload of about 70 patients and just got to take care of them, tried to keep them out of the hospital and the value of what I was able to do to – or that practice from a financial standpoint. I mean, they used to joke about how if I just kept two people out of the hospital a month from a readmission and all the costs that entails for your events that I made my salary. So, that was fulfilling in lots of ways. Not that I pay that much attention to the finances, but I really didn't enjoy that.

Taking everything I knew from home care and about what it's like for people to– the barriers that they have when they get home from an acute care situation and then to care for themselves and adapt to the changes, etc. I took that knowledge into this primary care setting, where then I was able to have my own caseload and help those people who were often – they were all multiple chronic disease people – patients with multiple chronic diseases and really mostly high utilizers of the hospital, where we were trying to have them succeed in being home and being safe without multiple hospitalizations and readmissions.

Jessica: That highlights the role of nursing so well. You have that really good approach thinking about what's happening to them in their homes, all of the barriers they need to overcome to safely manage their chronic illnesses, but yet you're utilizing all of your knowledge of pathophysiology and pharmacology and what it takes to care for disease processes too. That's sounds like just such a comprehensive model of what it means to be a nurse, but in a non-traditional – in a way that weren't in their home, you weren't at their bedside, but you were their partner in care. It sounds like.

Belinda: Right. It's really a part of the team now in the best practices of primary care that are looking at the role of a chronic disease manager and saying, how – we have this team, we have a provider nurse practitioner, PA physician, and then we have a team of other people on many times really good primary care practices are saying, this is a great addition to have a chronic disease manager, or sometimes it's called a care navigator, care manager. And it's a great role too that I loved and would have kept going, except that I really wanted to go into teaching.

So, here I am at Wayne State. I'm just excited about where I am now. I also did want to mention that throughout my career, I've enjoyed, and Jessica interrupt me again if you need to, I've enjoyed volunteering with lots of different kinds of I guess I would call it people who are experiencing social determines of health issues. So, I've been on mission trips in other countries. I've just paid attention to what's going on global health wise. And then, of course, in graduate school, it became really important to me to pay attention because I was really looking at public health and you can't look at public health without looking at global issues.

And so, I took some of that mission trip, passion, and a lot of those other things, and just have continued that, to have that as a passion to really understand global health and hopefully pass that passion on. So, I had the opportunity right after I graduated from grad school to – I just was looking at the CBC website about what was going on in West Africa with the Ebola crisis and saw that they were signing people up. So, I applied and was accepted.

They were only taking people that were willing to do a six-week commitment. CDC was paying a partner organization called partners in health that does all kinds of really great – we already helped around the world, mostly in Haiti and West Africa and a couple of countries in Eastern Africa. But anyway, partners in health trained us for a couple of days in Boston and then sent us on our way. They were bringing in new cohorts every week and I was there for six weeks. I took a leave of absence from my job at U of M family medicine. And it was an incredible opportunity.

And so, what I say about that, if you can't think of any questions, one of the things I want to make sure students know is that if you do want to do that of nursing, even for short term, it is something to prepare for. There are some great ways that you can get into that field. One that I would recommend right away is to look at pre disaster to call it's called basic disaster life support and regionally, these classes are taught. They're free if you look up PDLs. They're taught by actually FEMA staff from a federal government regionally, and then you can get advanced disaster life support or Tufts to nurses and other providers. I think the lowest sort of credential wise as paramedics can get that credentialing as well.

And it makes sense ‘cause they would get very involved in disaster management. And then, you can do lots of things with that part of it. I did not have that certification, but I think because I had a master's in public health and also some experience in developing countries, that was one reason why I was accepted in the groups that went to West Africa. But I always recommend peace Corps. I can't talk about that enough. It's such an amazing organization. I've many, many family members, including my son who **[inaudible] [00:13:13]** for peace Corps volunteers. And it's a great place for nurses to try out the world of global health too. So, I'm always happy to talk about that too.

Jessica: I love hearing about it. I'm curious if you don't mind, when we're thinking about global health and responding as a public health nurse to a global health crisis, such as Ebola, which you did what was that like? What did you spend those six weeks doing? What was your work there?

Belinda: So, when I arrived in January of 2015, not that long ago, the pandemic was starting to slow down a little bit. So, we were all trained to be in Ebola treatment unit, which was a very rudimentary ETU that was set up in a school way back in the beginning of the pandemic. And so, we were all taking turns being in the full PPE for a maximum time of two hours because they made you get out of there because it was, your body was about 110 degrees when he got back out. And that just wasn't healthy.

So, there were a lot of shifts going on all night, long day long. Having us go in and short shifts to take care of people who were actively sick with Ebola. I ended up doing that for a couple of weeks. And then, the last few weeks I helped with some field work where they were helping with – they had these, forgotten what they were called, but they were temporary ETUs for people that were suspect cases.

Jessica: When you say ETU Belinda, what are – Emergence –

Belinda: Ebola Treatment Unit. Yeah. So, it sounds like, so they were intensive care for people that were actively infectious and that's where you had to wear the full PPE and do really, really careful donning and doffing, especially because you could infect yourself very easily by getting those body fluids and splashing them on your eyes, getting it on your skin. And there were people that were – we had poor pairs of gloves on not one, not two but four. And taking those off, there were people that had punctures of all four and had to go home because they had potentially been exposed and had to quarantine for three weeks and all that kind of stuff.

There's actually a Wayne State grad who was with me and he was on his second tour because he had had to go home after having an exposure so. So, yeah, so that was, that's what the Ebola treatment units were. And then, they had temporary ones out in outlying places also set up temporarily where people were treated, who were suspect cases. And until they got their lab work, they – if they were showing symptoms, they were kept there. And the same thing, we would bring them their meals. They were not necessarily very sick, but we put the full PPE on to go into the, what they called the red zone to care for those patients that we were suspicious of and waiting for them to turn positive or negative.

Jessica: Right. Wow. This is such – I'm imagining such an intense experience.

Belinda: It was.

**[Crosstalk]**

Jessica: That balance, I think of caring for people who need your care so desperately, but also, I imagine it would be impossible not to be concerned about your own health and adhering to the proper donning and doffing. And do you have suggestions or feedback for people who – I mean, if we think about where we've been, right. Our country has been experiencing our portion of a global pandemic with COVID-19 for the past six months, at least our state.

And I'm just curious unfortunately, probably many nurses listening to this will find themselves in perhaps situations that feel just as intense or just as scary or intimidating. Are there things that you, based on your experience and your expertise in this would suggest or things to help us stay calm or grounded when things get so intense?

Belinda: No, that's a really good question, Jessica. I thought we had really good leadership and training in the experience that I had, because it was so important to do that. We were in a group, I would guess of 30 of us in this one location, maybe more because they were staying in housing situations. But we did hear from leadership just about every day to check in how are you doing? Are you handling this? Are you emotionally handling this? Are you physically handling this? We don't want anybody passing out when they're wearing that PPE, because you're putting yourself at risk, if that happens.

And so, what I would say, the there's so many lessons to be learned from this I'd love to, in fact, I will pass on to you that some of the blogs that some of my colleagues that were there, we, a lot of us keep in touch and there've been some really beautifully written blogs about this current pandemic and their reactions after when our memories come back. Because they're really pretty horrific memories. I've never seen a death rate like I had, I mean, we had at least half of our patients dying and I've never had it seen that in my whole career.

 But what I would say and to those of you who have experienced some of this pandemic, and I know some of our nursing students have been in acute care situations during this, that getting that support and really being able to talk about what you're experiencing and reflect about it is super important every day. Just know that you're not alone in how you're thinking and feeling and hearing and the anger that you're feeling, if you're not feeling like you're, this is being handled well find really good. And I guess I shouldn't say good ‘cause who knows what that means.

But the best ways to vent are really professional and not on social media, but really with trusted colleagues and finding a way to get your – to know that you're being treated fairly and also safely, and that you're caring for yourself in the middle of this really intense nursing work. It's super important to who you are as a person and your ability to, to care for people is something that I had to even pass on to my own child who has a tendency, like I always have to want to be on the frontline.

And then, she just went back to school after getting a bachelor's in international studies to be an EMT. And so, she went to the front lines at the beginning of the pandemic to New Orleans. And she's a little bit of a hot dog and I was like, “Honey, there is no emergency in a pandemic.”

 Remember that you – and this is what all of my friends said and what we said in and it sounds like you don't care and an emergency room nurse might differ with this, but they don't because a lot of my colleagues that were there fairly own work, our emergency room folks that the most emergent thing is for you to be safe because you cannot safely care for anyone else, if you are not safe. So, it's important that what the recommendations are and that you care for yourself. That's one of my big recommendations.

Jessica: Sure. When I hear you say that, I think too, we are not even just talking about wearing your N 95 and the appropriate gloves. But I think caring for yourself also means at the end of that shift or that day, or that assignment, recognizing as you talked about the emotional distress on top of that mental and physical exhaustion, and really taking that time to care for yourself so that you can do it again the next day. I imagine that you had to find some coping mechanisms and some ways to– you talked about venting and having conversations with trusted colleagues. But I imagine that that was pretty critical too. And when we talk about self-care,

Belinda: Yeah, definitely. And I think that one of the most rewarding things about what I did in Sierra Leone. And what I'd like to pass on to people is how inspiring it is to know people who are doing the same good work that that you're doing. And so, you use that to inspire you and to help you with self-care. It's not that you compare yourself, but sitting down and saying, look what we just did together. And then, finding out who else is doing this among your friends and colleagues and how they're feeling is super helpful. I just will never forget sitting around. We had this like Tiki hut in this Irish army camp that was set up just for us to stay in for that time in West Africa and by the Irish army.

 ‘Cause that's what they're good at and disaster management. And the Tiki hut was where we sat and talked in between our – when we got back from a shift and there were people who were serving from the World Health Organization in Geneva, there were people who were with the National Health Service just prominent doctors from England who had done this work before. A lot of people that had worked with doctors without borders in a lot of different situations. And they just kept me going, hearing their stories and their love for what they do and their passion. So, just remember those things when you're starting to lose it and remember your passions and be inspired by others as well.

Jessica: Right. Oh, I think that's such good advice and advice that truly went on the front lines you can apply. If you don't mind Belinda, I'd like to go back, you spoke I think so passionately and so genuinely about the sacred space of hospice and what that meant to be a hospice nurse. And I'm wondering if you can just talk– when we're thinking about public health nursing, community health nursing what does it mean to be a hospice nurse? And what is a day in the life of a hospice nurse look like? I imagine it's highly variable.

Belinda: It's highly variable. most hospice agencies that I know of have a couple of different team members but a regular hospice case manager who's working regularly and is not doing contingent work, excuse me, we'll have a caseload of patients that are in the community. And by that, I mean they're not in a facility, a hospice facility and they will see those patients on a very regular basis, not every day, unless the person is really actively dying and then you will try to see them more frequently and sometimes every day. But many times it's once a week in the beginning, those kinds of things.

Some hospices are set up like a lot of home care agencies where there's a team of people that do the admissions. So, you may, might not do that initial like three-hour assessment that usually takes because there's so much to talk about and paperwork and coordination between yourself and the rest of the team, etc. Usually the hospice medical director sees the patient fairly early in that process too. And so, you do a fair amount of coordinating with them, usually just by phone. “Hey, here's what's happening today.” and you develop a very trusting relationship with your medical director. And usually see anywhere between, I don't guess I would say four and seven patients a day.

 And then, usually there's some call involved. It's just depends on the size of the agency. I was with a fairly small hospice agency in west Michigan. And we took call I guess, once or twice a month on the weekends. And then, one night, a week, every two weeks or something like that. And I have to say, probably got called at least 50% of the time in the middle of the night. So, it is one of those things that that's one of the downsides, but it's certainly doable. Sometimes it was just somebody's catheter was plugged and their family member had not been trained to know what to do.

 Usually we tried hard to train people to figure that part out, but sometimes early in the process, lots of things like that happen, but even that part was usually very rewarding. **[Inaudible] [00:26:36]** get that call and get yourself out of bed and go see a patient and know that you've made a difference for them in the middle of the night. ‘cause it's also rewarding, so.

Jessica: Yeah, I think of the role that hospice nurses play in the lives of patients and families, and really in some of their most challenging and saddest days I mean, those can be some of the hardest times of their lives and yet hospice nurses can offer comfort and peace that I think it is like you say such a rare opportunity to be able to offer that to another human. And I think it's a really beautiful thing to offer. What a beautiful thing that a nurse can bring to a home fight the situation that you're in.

And I've often seen as you suggested hospice nurses become very autonomous, as you said, you come very well-trusted and are close partners with the medical director. And so, in my experience, that's probably one of the roles where I see a lot of autonomy in nursing. Would you agree with that or do you want to speak to that?

Belinda: I would definitely agree with that Jessica. I think it's one of the wonderful things about it, but it is something that takes some experience. It doesn't necessarily have to be med-surge, it needs to be some experience in doing great assessments and really understanding pathologies because your patients will have lots of questions. I also did in the hospice I was in went to hospitals because we didn't have at the time – the hospital system I was with didn't have hospital staff that was either palliative care or hospice trained. So, I would see patients in the ICU when the family wanting to make a decision or for med surge floor.

And so, I saw quite a few patients and that was rewarding too, to be part of that process of helping a family and a patient aside this person's had a stroke they're not going to come out of this those kinds of decisions that have to be they're really hard. And now we have palliative care teams that help a little bit in most hospitals that help with that, but still hospice nurses can go in and admit a patient and in an acute care situation and then help with the transition to home or to a facility.

Jessica: Do you have Belinda? Because I think no matter what we do in nursing, we will find ourselves in situations where we have to have difficult conversations like that, or we have to facilitate a conversation that will lead to decision-making for families. And I'm just curious, and I know there are curriculums dedicated to this and certifications, but do you have any tips about if you're maybe a newer nurse or less experienced in this field and you have to help a family engage in a difficult conversation, is there anything you would suggest a way to approach it or something that tends to work well?

Belinda: Oh, wow. That’s a really big question, Jessica. I think one of the biggest things is to listen to people really well and validate their concerns because that's one of the things that is hardest – one of the hardest things I think for us to do to learn, to be good listeners and to really hear what people are saying and then help them sort through the barriers that that they're facing to making good decisions. Because that's often what's happening in the decision-making is if you don't hear what's behind the patient, even in any change or decision-making that they have to do. Hearing them and validating what they're saying and what is really going on behind their struggle is a big one.

I remember that a lot with people, ‘cause sometimes it was a bigger spiritual issue when it came to making a decision to say to start hospice. Sometimes it was – well hospice means you're giving up. So, there was a lot of having to clarify what that, that wasn't true, but if you, if you start out with, “Well, that's not true Mrs. Smith.” it doesn't come up. It isn't what Mrs. Smith is ready to hear. This is Mrs. Smith's belief system. And for whatever reason, validating their beliefs and then helping them see that there are other ways to think of this is a really – I just remember utilizing those important listening skills and important conversational skills a lot.

Jessica: I know that was a really big question. And as I asked that, I started to feel guilty for asking that because I do not, it was, but I think you answered it really well. Belinda, I think that you did give us something to think about and a tool to have in our back pocket when we find ourselves in situations such as that. So, I want to thank you for answering that despite how big and perhaps vague it was. It does make me think of how well positioned when I think of the education of a nurse and our theoretical foundation in the person and medicine. So, this whole really holistic approach, it just seems like who better to do that than a nurse.

And so, I would also encourage people listening to remember when you find yourself in those intimidating situations, who better to do it, then you though. It might be hard and you're going to have to put yourself out there and in an uncomfortable position, but who is more poised to do that than a profession like us right? I mean, and that's sort of what I think is so truly beautiful about this profession and what I think drives so many of us.

Belinda: I think that's so true Jessica. I mean, you often do feel like you're wearing a lot of hats and you'd like to just say let me just call the social worker and talk to you about that but there you are in that room or in that home. And then, you have the resources within you to listen and to help people get to the next step. What decision maker in in those kinds of tough situations, whether it's behavior changes or hospice decisions, or caring for their family member and how, and whether they can sometimes that's one of the biggest things that we did in hospice was helping families see that they're capable of caring for their loved one in this time.

And it took all my skills to say here's what you can do with your body and your home, and here's what isn't going to work, and here's how we can make this work. And so, it was a really great way to use all the creative, adaptive parts of your brain and your nursing knowledge at the same time.

Jessica: Yeah. Wow. How rewarding it must feel to empower families at such a difficult time who are in such a vulnerable space and yet you still empower them. So, you've described the value of creativity and liking technology and tools, but using them and perhaps unconventional or less conventional ways. Are there any other things that you would say if someone really recognizes this quality about themselves, or if somebody feels they have a real strength in X, Y, or Z, then maybe they should look at public health or community health nursing. What other qualities do you think would really translate well to this specialty?

Belinda: No, that's a good question. When thinking a little bit more about my public health nurses that I know well, and again, haven't been directly in that field, but I now know it really well because I have had clinical student groups at both the Oakland County health department and the Detroit health department for five years and have gotten to know the staff there really well and understand that role. What I see in many of the roles there are similar because there are several roles, especially at the Detroit, I mean at the Oakland County health department where they're doing a lot of community visits.

So, they have case managers doing both children's special health care services, and they carry a caseload of a similar caseload size, like 60 or 70 kids with special needs and in all over Oakland County. And they really, they need to have good organizational skills. I mean, it's not my top forte, but I know how to do it pretty basically. And I know how to follow some good guidelines in that way because you're having to prioritize and plan your own days and get out of conversation so that you can get onto the next patient's house and all those kinds of things. So, I would say that it you don't have to know all these little tiny details about yourself in nursing, if you're still just starting out.

But if you know that you have some good desires to just be that person who understands what's going on with people and can coordinate things for them, those are great things. And I think the other piece really is a passion for the – here's what I want to call it; health determinants. And what your role as a nurse is in helping people best care for themselves. And so, in the hospital, you are often stymied and that does not, I'm not saying that isn't a great place for a lot of people, but if you're frustrated in the hospital, like Mrs. Smith could, did not have to have this hospitalization.

If someone had only taught her this, or if someone had only intervened here, or if she had only known how to really care for her asthma or whatever. And that is driving some real frustration for you, those kinds of passions will also be important because that's a lot of what you end up doing in any of these fields. One of the girls that I have gotten to know well at Oakland County goes to homeless shelters and they have a homeless shelter in Pontiac that is set up for people who are really sick. And so, she spends a lot of time there and does some other homeless advocacy program is what they call it.

And so, that role is also one of those just have a passion for the determinants that get people in those situations and what you as a nurse can do to, to advocate for them and really make a difference in their lives too.

**[Crosstalk]**

Belinda: – advocacy. You want to advocate and you have a passion, and then you want to find a place to do that.

Jessica: Right. I love listening to this because as I think about the trajectory that you described and the way that it shifted and changed with what was going on in your life and what your needs were and where you were living, or when you were attending school. And then, you think about if you have a passion for determinants of health, if you have a passion for global health, if you have a passion for keeping people out of the hospital, I mean, it just goes to show you, or at least it's showing me how many things we can do in nursing that are truly tailor – it feels tailored to us, right.

Tailored to what travel does us and what motivates us and makes us tick and look, there's a job for it. I love hearing that because it really illustrates again, what I continue to say is what feels like infinite opportunities.

Belinda: Yeah. Exactly. Great.

Jessica: Oh, that's exciting. Well, Belinda, thank you so much for taking this time and spending this with us today. Your journey was a really exciting one to listen to, and I'm definitely inspired by the passion that you have for healing individuals and families and communities and looking at things from that perspective. And I'm just really grateful for you talking to us.

Belinda: You're so welcome. And my pleasure to say the least. Yeah.

**[Crosstalk]**

Jessica: Well, thanks so much. Thank you for listening to this episode of Nightintales. As you do, we encourage you to consider the unique nature of each person's journey through this profession. The views shared on this podcast are those of an individual, not the academic institution that they graduated from their employer or the professional organization that they're active in. The stories of their career path and progression are not intended to suggest that there is a uniform approach to achieving similar accomplishments, but to open your mind to all that is available to you. Each journey in nursing is as unique as each individual that we serve. We hope you'll listen again, next time.

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**Duration: 41 minutes**