MH: So alright just starting with a brief introduction, um we appreciate you being here, um participating with us today. We're just doing this project to gather information about the history and evolution of the OT practice, especially in rural, rural settings such as North Dakota and Wyoming. So thank you for being a part of it. Do you have any questions before we begin?
LN: I don't. No.
MH: Alright.
LN: Thanks for the invite, it will be good.
MH: Of course. So we just want to start with a big picture question. Um what has being an OT meant to you?
LN: Gosh, probably um all of the opportunities. I don't even think you're sit- you can sit here now and understand the opportunities you'll have in your thirties, forties, and fifties. Of the things that you can do outside of the scope of practice, I'll use that term, or frames of reference or theory as far as occupational therapy approach. There's things so far outside of that like legal, law, like medical law, that I dabble in a bit just because we need to address those things when we hire a new doctor. Or we have a therapist that needs some legal um background, like a patient gives them $1,000 can you accept that? If you can't, how do you handle that? Um so there is, it's limitless, it really is.
MH: Okay, awesome, thank you. Um so when did you decide to be an OT and how did you kind of go about that path?
LN: Sure.
MH: The adventure to be an OT.
LN: Probably the end of my freshman year at UND. Was a fall and spring year freshman and ah working with our career center, and knowing had some familial experience with long-term mental health. Triggering me and seeing some of the therapies, and I believe, and it's been a very long time, but there's like physical and occupational therapy at this facility, but observed direct care one-on-one, and then some group as I can recall of mental health and occupational therapy for someone these are very very involved, very mentally ill clients that were not functioning to be able to handle money or um prepare themselves in their appearance to interview for a job. Those types of things out of family member that piece. So observed a bit of that, realizing that I didn't have an interest in such- at the time, such acuity such as medical technology and working on biochemistry pieces or fluids and blood and or nursing etc., but having an interest still in healthcare. So the career department at that time said so here is medical technology, athletic training, physical therapy, occupational therapy, two year program LPN if you want to do something in East Grand Forks in the Northland Community Technical College. I started that path and then, I believe it would have been spring of my freshman year, it would have been 1985. Visited with the then, would be the Darlene Schapansky of the program and just visiting with her. 'Here's what I have for my transcript if you will from high school, and what I've completed in my first year etc.,' so went down a completely different path of where I had my generals.
MH: So you just, when you entered into college what did you, were you just generals? Or?

LN: I was. Yes I was, um actually probably the closest I would have came would have been Industrial Technology or Law School. Which are two completely different tracks. So that is where I landed and that was spring of 1985 and it wasn't until probably the spring of 87, just fine-tuning what what credits were going to be applicable and volunteerism and all those pieces, and still working where I was working at the time, which was nearly full-time. And realizing I probably couldn't do both and still apply to the program. So I applied, I think it was, I think my acceptance started August of 1986 would have been my fresh, my junior year which is your first day of occupational therapy. And at that time and it was a two-year with a six month, or two 12 week rotations, adult physical disabilities and adult psychosocial.
MH: Such a journey.
LN: It is, still still probably on the fence you know as you are going through pre-OT course work, until you- I had an opportunity to observe and I can recall you know, but just a couple of my observations were I wasn't filing paper, or helping just sterilized children's play toys, actually was able to see some therapies that really tipped me to the point where, all of a sudden I tipped heavily into um biomedical. The biomedical model at that time. That started my path down this journey of physical disabilities. Psychosocial was just left in the dust.
MH: So is that the area you focused on entering as a practitioners? Phys Dys?
LN: Yes, it was.
MH: Okay, and we looked you up because we hadn't received your CV yet so, and it said that you're a certified hand therapist? Is that correct?
LN: Yes.
MH: Okay so what made you decide to pursue that?
LN: Yeah that was an interesting journey because I was at, what was then United Hospital, now is Altru Health System. And uh moved back from the west coast of the United States into Grand Forks again and took a position at Altru. And the position was, uh then it was called Outreach. I went to the Outreach clinics if you will. United Hospital van, play toys, wheelchairs, feeding equipment, and traveled to the long-term care facilities we had established contracts with. So I was the first, I was the first traveler or Outreach therapist for all over United Hospital now they need about 40.
MH: That's real cool.
LN: Yes, we were just in a van and I did some pediatrics in the school systems. I did adult geriatric work in long-term care, and I did that just because I wanted to be back in Grand Forks. We had a family member that was terminally ill, and we were going to help care for her. And during that time line of doing outreach, Dr. Robert Clayburgh was a hand surgeon at United Hospital. And he was wanting to put together a upper extremity program, he wanted a program. One we could market as such. So there was one occupational therapist working at Altru that did 'hands' as they say and I had started asking her if I could observe just a few splints. For whatever reason I had nak, and continue to have a pretty good idea of the ability to take a two-dimensional and put it into a three. I love orthotics. So I worked with her and held some, you know, limbs with her during the fabrication of orthotics and she said 'You know Dr. Clayburgh wants to put a

program together, and I can't really do it alone. Would you be willing to put some hours in, and a perhaps work toward- or pursuing your certification in hand therapy?' So I did that for, that was 1993 to 2000, about 7 years of practicing and going into the operating room with Bob Clayburgh and some of the other hand surgeons. And I sat for my boards in 2000 to become certified. So Mary Lynn was certified and I was certified. So we had the largest hand center, at that time, in the state of North Dakota. It was kind of neat. And there was a hand therapist in Fargo and one in Bismarck, so we- you know there were five of us in the state, so we get together on the telephone and talk about osteoarthritis of the CMC of the thumb. We were all just like 'Ahhh, oh my gosh.' You know exactly what I'm talking about, so it was very neat, we had a little click. And then I I faded, I phased out of Outreach traveling and Mary Lynn and I were full time and we hired a .5, or halftime, physical therapist. That helped us immensely with some more core work, and upper extremity work, and shoulder type of things, and scapulothoracic type of things. So it was a really good marriage, worked really nice. Then it was called the United- United Hospital, the United Hand Center. Bob Clayburgh was our director and chair, and we had one other hand surgeon. So we had a nice little package of three therapists and two surgeons.

MH: Wow, you really played a huge role.

LN: It was nice and it was great for me because I've never been involved in building a program. Like standards of practice writing and policy writing. So if one of you were to be hired, and I were gone, or we were out ill, for you to go to a standards practice book and see the mapping or the patterning for an anti spasticity splint. And then what are the indications, contraindications, what type of fabric you should utilize. We wrote one for every splint. We wrote them for attendance and all those things, it was really neat. It was a neat journey.

MH: Yeah to establish it, that's great. Thank you for sharing that. Okay, so onto the next question. So as you mentioned you had a couple leadership roles, some say leaders are built through typical life circumstances. Were there any difficult life situations that you evolved from to sculpt you into the leader you have become?

LN: Outside of work? You're referring too?

MH: Anything. It can be within work, school, outside of personal.

LN: Sure, probably bits and pieces of it early on, when it was just three of us at the Hand Center. Because any therapist, OT or PT, that came in then, because we needed to take vacations etc. of how we, you know it was difficulty as to how much you put upon someone that doesn't work in Hand Therapy. They're an occupational therapist that does a little bit of everything in the hospital. They also, maybe, they go to some of the nursing homes and do some self feeding evaluations etc. And how we could come together in a room and determine what are going to be the, we called them essential demands. What are the essential demands to be able to practice when Bob Clayburgh, or one of the other hand surgeons calls, that you sound proficient on the other end etc. And we struggled with what that was. I was I think I probably wanted a bit of a deeper dive, like someone that said 'Sure I'd be interested in doing that.' But if I'm going to cover and hand therapy, here's what I'd like to have, like every month you come to our staff meetings and we do some skills validation with you about every 3 months etc. And others were,

just give him the low-hanging fruit, just like the basics splints, all they have to do is do that and range in elbow etc. But it never really worked out that way. It would inevitably, if you take a take a Wednesday, Thursday, or Friday off. That Thursday that therapist that has never made, like a hinged elbow brace, would get a call from Dr. Clayburgh with a patient from Warroad, Minnesota that needed a hinged elbow brace. So you set them up for failure. There was that piece a little bit. And that was probably a pinnacle of just how we can be logistic in coverage to maintain that, if my 29 year old brother came in one day for a hinged elbow brace and then three days later someone else's, that the standardization of how the orthotic was fabricated was relatively close. We were not all robots there will be some differentiation but I should be able to look at that and say 'You learned this from me' because this is how the humeral cuff looks, or what have you. And then during that time line at United Hospital and then into Altru through the early 2000s and I went into private practice it probably was another large challenge and probably the largest because we are open a private practice in direct competition with Altru Health System. And Sanford at that time moved into East Grand Forks as a clinic, and they had a couple of therapist. So then how, what do you do as a owner and still practicing in order to to make a position enticing to a three-year out graduate. You know they're like 'Oh I can't do this, this is too risky for me' when you've only been in existence as a private practice for three years. I think those are challenges that at the end of the day, you had to weigh whether you're going to spend $1,500 right out of the shoot on someone you hire. And you're saying within 90 days I need you up to attend an advanced upper extremity conference and be willing to invest those dollars realizing, they come back from the conference and say 'This just isn't for me.' And then you're out $1,500, and then you're out that orientation and training. And we have decisions like that every week, and many times every day of the week there would be something that would come on the radar, like how long would we continue to go as owners of the clinic and still do the janitorial work on Saturday mornings to try to not have someone come and clean. We do it ourselves, you know. But at the end of the day was $60 on a Saturday to have a man or a woman from a company come in, and we thought what is $60 we mean to us when we spend 3 hours on a Saturday for being away from our family, you know. It's those hard decisions when your partner's like 'Well then I'll just do it' but then there's there's a bit of animosity that they're always doing it, then what do I bring to the table? So those are, those are always on going. And now they've all they've done now in my role in administration at Riverview Hospital is blossomed into but 120 employees that I have that report to me. How how do you handle that? How do you have directors of different departments that are direct reports of those 120 staff and give them skills or tools because they're 10 years into their career and I'm almost 30. And what things I've learned that didn't work well, or worked well. Not giving them feedback in a timely fashion without it feel feeling as though it's condescending and that they're learning something rather than, that's not the way to talk to a staff member. Well how do I do it? Well not like that. You know that's not how you respond, but how do you continue to groom those therapist and now, at this point, a couple of the leaders, I work with six leaders at Riverview they're my direct reports and then they have 120 staff. And now I'm at the point of succession planning, of you

know laying everything I have out on the table to have someone succeed my position and take my role in administration in the next seven to 10 years probably. So we're starting a little bit of that now, they don't know that, but I'm grooming them. I'm grooming them all to see who floats to the top. Because they are all very good, and it's a hard decision. But I don't really need to make that for the next many years. So those are points, I think that were measurable for me that were big learning pieces. Private practice was the biggest. I have support around me now. There's six of us, there's six of us in leadership, we have a CEO and I'm involved in all our seven clinic sites and then occupational therapy, and physical therapy, radiation therapy, long-term care, and lab um- pulmonary rehab. So all those pieces, so I have all those leaders assisting me as well, and supporting. Versus in private practice it's a different-

MH: It's continuous evolution of learning and finding what works best.

LN: Yes, now I am on the end of actually being the one sometimes there's the saying 'You forget all you know.' Like you get so proficient at some things, you never get proficient at everything, which is always good. But some of the things you forget, you're even like, man I have had that hard conversation with someone that is chronically late for work. But I don't know why, but I don't know I know they can't be chronically late for work anymore. But I've had 3, or 4, or 10 of those conversations. And my new leader, who's my newest leader? She's a, she's a director of lab. She got her degree here, medical lab science. So she's 28 years old, 30. Young leader. You know to have those conversations rather then, you can't be late again or I'm going to fire you. Well that's not really the conversation, it's more as you're well aware in time and attendance you been, you're averaging to be late about 2 days per week in the last month. Tell me more about why that is, and what we can do different. Because I need you here at 8, and if you can't be, how do you see us continuing to have you employed? And I'll say, 'This is not something that I thought would affect my work, but here's what's going on.' And maybe it's something where they're like 'I did not know that' and so we maybe take her work schedule, and move 8 to 4:30 to 9 to 5:30. You know a child with special needs, don't even know the scenario. So those kind of tools for Emily, rather than, because it is easy when it's busy, to bring someone to say, I need you in my office for a couple minutes, like this is the last day you can possibly be late, or I'm going to need to let you go. Without any backstory. And there are many back stories were you look at someone and say I apologize, but this is not going to be the right fit for this position, and then you terminate anyway. You hope you can work with them.

MH: Yeah, okay. Alright, so the next one is describe the profession as you see it now, and how do you see the profession of evolving over the time of your practice?

LN: Current in the profession, is probably as we talked as when we first started today. It's just, it's even more I think in a positive way, and in a neutral to negative way, it's diluted more. I think there's more dilution to the occupational therapy degree. I think it's definitely more heavily leaning to academics versus when I was practicing early on. None of us had aspirations to be in academics, and all those those that were in academics, were only in academics. So the positive to that now is there are those that are an academic in an academic role and they also have some involvement at a professional level as far as practicing and I think that's a positive.

MH: Right.
LN: As I mentioned when I graduated there was faculty, and there were those that were on the academic side, and the rest of us, that I think the majority of the the 36 of us that graduated, were all on a track to practice. We wanted to practice and see patients, and the majority of those in that pool have continued in that realm, other than Cindy Janssen. Bonnie Haff is another, but that vast majority versus I think as you all sit here, one or both of you may have some academic exposure. It just simply, the facility may be large enough that you work at that's a teaching facility.
And they want you to be involved involved at a master's level and/or a doctorate-level as you progress along in some research. There was no term of best practice, or value-based purchasing and some other terms but best practices is probably the one that hits home to us. Why did we do a certain thing therapy wise with a patient say with a subluxed shoulder? It worked. It was what worked. Here I'll show you what works. Well now there is best practice to show evidence to that so, it's definitely has changed. But as I mentioned with that I think you know, some of the- some alternative therapies that OT is involved in along with acupuncturists, and some physical therapists, certainly chiropractics definitely changed. If you know a chiropractor that's 50 and a chiropractor that's 25, they practiced very very differently. And there's some of some of the alternative pieces as far as health care is concerned that I think the the PTs , OTs, athletic trainers, a little bit that have um infiltrated those areas that I still personally don't know how that fits. I don't know how that feels to me. I don't know how dry needling by OT or PT feels to me. When I have a very proficient, and we have one at Riverview, a master's-level acupuncturist that is also has a subspecialty in pain management. That feels like that is her work and I want to continue with my occupational therapy analysis of daily function, or analysis of work tasks and coming up with a plan of care on that.
MH: Right.
LN: That's why I see a then and currently now.
MH: A lot of blurred lines.
LN: Yep.
MH: Yeah, um kind of, I don't know where this question is but I feel like it goes into what you were just saying about how there is an academic side and then the professional side. Do you want to talk a little bit on it originally being a bachelor's degree going into a master's degree and now a master's degree turning into a doctorate degree.
LN: Sure, the you know the I don't think that there's inability anymore to differentiate the secondary education piece whether it's master's or doctorate level work with, by academics, the academics, the full-time associate or assistant faculty or Dean chairs, and those that practice now. Simply because of things such as best practice. Much of the best practice for any given standard of practice, there's best practice that that oftentimes is out of the incubator of academics. It's the you or I, I'm practicing full-time. I'm not practicing full time, I'm working full-time practicing very little but still seeing some upper extremity patients. But I'm definitely more involved on collection of data for our patients for various reasons, and we're currently were very very early in our journey of becoming credentialed, if you will, as a Center of Excellence by the

Joint Commission for Orthopedics because we have a very robust orthopedics program for such a small critical access hospital. We average about 900 cases a year of orthopedics. Beautiful for me, because I'm an OT by degree, certified hand therapist. I still get to see patients and we have a board-certified hand surgeon at Riverview, and so what I was doing when I was 24 to 40 something, I'm able to go back to doing- doing now. So I think, you know certainly I didn't feel any different when I receive my transitional master's, my TMOT in 2006. It didn't feel much different, however, that was in my practice. However, the way that I analyze literature review of best practices definitely different. Definitely gave me a much more keen eye on review of research. So when we get together and we look at it as an example this Joint Commission Center of Excellence Orthopedics, and I start to- we start to put together a learning tree in an algorithm of who's going to own what pieces of this. There are things that came out of my TMOT, as far as my ability to do analysis of even some statistical research like on best practice for, oh gosh it could be anything, strengthening of thumb that has had a joint replacement. Those types of things and to be able to filter through the data to take a look at whether this really has applicability, is important. And I think you will feel, those of this group that's going to be on board of this, this first doctorate year roll into the Occupational Therapy Program you may feel that as well.

MH: Okay.

LN: I think there is a, there's an eye academically that is probably mandated now by the therapist. Like we have two relatively new grads, one just last year, Annie, Maddi Ondoll from the program here, that her analytical skill set, like her proficiency for review of even research articles on whether we want to, or what do we want to have as our baseline intake for functional independence when we do this orthopedic piece or working through that. You know there's a dozen standardized assessments for baseline function and what do we want to use and Maddi is helping with differentiating that. I'd I think that people like me all though I went through an '06, my TMOT, but a bachelor that's sitting next to me like, it does matter who it is, you can tell that mindsets not there. Incredibly intelligent, but being able to take 3 research articles and say which one has the best validity for us at Riverview. I don't think I'll be able to do that. It's not as though they just look at it like, well that's easy enough, I'm just going to go to the inter rater reliability. And whoever has the greatest interrater reliability, that will be our go to. Well there are other factors and I don't think they could do that. I think that's what the master program has allowed for sure. And I went through it, I mean Janet was my preceptor. So yeah, if you are going to be under the wire, you are going to be under the wire. And it was on arthritis of the joints. So that helped me in my world because it was my world. You know, metacarpophalangeal arthroplasty was my world. Putting that to best practice and literature review is where Janet really helped me through that piece. Because the year before I completed my TMOT, I was seeing metacarpophalangeal arthroplasty. One a month. Very innate baseline orthopedic work as far as arthritis is concerned. But a very, very structured physical, functionally limiting postoperative protocol that, if you had a hand surgeon, he or she let you have one of his or her metacarpophalangeal arthroplasty, and you blew a joint out, you'd never get another patient from

them. So I had that just in my mind, and I had hardwired exactly how they're treated. I knew exactly the orthotics. It was about four braces during the first 12 weeks that they'd go through post-operative rehab. Then Janet asked me to say 'How is that best practice? Is that in your mind?' It is because I'm, I know that I'm probably better than 80% of the therapist in the whole area, but how to put that to evidence was important. It's beneficial.

JC: And so, the master's degree you're saying brings that evidence-based piece in and literature and stuff. What do you predict, do you think the doctorate program will just add on to that, or do you have any other specific like…

LN: Yes, I think it will add on to it. I don't know enough about the curriculum that's being laid out in our program here. But in general, I believe that it's going to weigh more to the ability to do more non patient care. The master's program for me, and the ability to take, and I had actually my flash drive that I had loaded my, I update my CV, my flash drive has my entire scholarly on it. And it's just data upon data, and I have every research article. I scanned them all in so I was just reading through them and then I would just highlight the articles that triggered me to be inclusive of what I was going to have to support my scholarly project. And when I read those I look at those differently now. I think there will be a difference with the doctorate level to that extent, but I think it's going to take away from practicing. And they'll be those that are just fine to not, and when I say practice I mean direct patient care. Even .5 I think that would be challenging if someone truly wanted to utilize their doctorate skill level. But there are other external forces as far as many programs inclusive of ours that is pushing a doctorate level. You know Creighton University, 15, 18, maybe 20 years ago was the first doctoral program in OT. And I thought, a doctorate level OT, seems like it just seems so heavily, and at that time I just said- I just used the word heavily research. Research heavy, and practice light. Now I don't feel like there's such a divergence of them. Especially since going through the TMOT program. I was in private practice at the time, working full-time, and teaching a class at UND and I had my scholarly. So the ability, that at the end of the day when I had these articles in front of me, or I was reviewing them electronically, I really became I think quite efficient in filtering through journal articles and/or actual research articles to find what is going to be able to, when I presented the Frank Low poster presentation, what's going to present me in the best light. That if an anatomy instructor, a prof comes up and asks me a question on Newtons of force in a certain um, angle of the CMC joint. Am I going to be able to answer that type of thing. That's what was going through my head. So I was like, what are going to be the most effective. So it was helpful, for sure.

MH: That is so interesting to see your perspective on that. Um, I lost my spot. Okay, so we want to look at the context of practice when you graduated. What was happening in the world in terms of social, political, economic, education, family.

LN: Yeah during that time, was probably very little exposure for us as OTs practicing. In fact my first position which was out of state, I had no interaction with my manager director other than my work as an OT in patients basically. How's it going? I recall the conversations, 'Are you feeling like four to six of these spinal cord patients is a comfortable level?' And I know we

talked through ‘Hey, if there's four patients and three are them are quadriplegic, C5 or higher, that's heavy for me. It’s intensive.’ That was our discussion, and in practice that's all we had binders on and were able to just practice. Didn't even didn't even worry about billing to any extent other than how much time did you spend with John and Jane and Joe. It was like 45 minutes, 1 hour, 45 minutes. Okay, here's John's name, 45 minutes, 60 minutes,45 minutes. The end of each day the paper got handed to our secretary and I never knew where it went. Fast forward to now and I would hope to think that and I'll use Maddi Ondoll again, the new grab ‘16, ‘17 I should say, no ‘16 grad from here, is in our staff meeting- so Crystal is our director of rehab, she reports to me. And she has 35 staff, so if I go to their staff meeting, we’re all in a big room and Crystal will put up metrics on how their last 90 days has looked, as far as therapy is concerned. Deep, deep into what percentage of reimbursement were receiving as far as our gross billables. We bill out to Blue Cross Blue Shield Minnesota. 300 patients we saw, what percentage of that dollar amount are we receiving net? And not broken down by discipline, like OT and PT, but just as a rehab. Crystal shares those things and shares what our wait times are, because we can monitor that through the world of the electronic health record. And shares what it means in the world of, you would call it a warehouse, we call it supply chain. It is basically all the tools we need to work come from somewhere, well when they come from somewhere they are a cost to our department. Crystal will talk- discuss by discipline OT and PT etc. how many dollars we have allocated and you as a group can collectively sit and discuss who should go to a three-day conference in 2017. What type of capital equipment we should be taking a look at. So there is very, very much more transparency, like day and night, truly day and night. And it's a wonderful thing and I think it's a bit of a burden, when you're just, and two of you may be one of them, I just like I just want to practice. And I can see it on some of the therapists, it's overwhelming and I don't like anything administrative, I don't have any desire. I want to practice and do literature reviews on, you know what's the current what's the current lit review information on oral motor strengthening of infants? Or it could be anything, there are so many things, so many things. That's what they want to do. But Crystal does a very nice job as a director and engages our staff because she also has each 12 months of large report card electronic. And every one of her goals directly ties to the group that's in her department.

MH: That’s amazing.

LN: It’s very different, very different. I felt as though I missed out on probably years of education when I was practicing because I was happy to have a full-time job. I had a sign-on bonus and moving expenses out to Reno Nevada. I thought it was just a wonderful- to be able to get there, and two or three weeks I think, and I was practicing with a caseload of a spinal cord patients. Only spinal cord, specialized. Making orthotics that were, you know semi dynamic with hinges and such just at 24-25, it was amazing, and not asking another question about the surroundings of where we worked. I probably would have at least have had the opportunity to think of, that at maybe 30 years old, do I want to do a third or a half of my time administratively? Or do I never want too? I wasn't even thinking that at 30 I was thinking more, ah that time I was

thinking of sitting for my hand certification because it was a monster of a test. Anything else on that? Kind of then and now?
MH: Yeah no that was a very good example. I think that sums it up for me.
LN: Do you have any other questions on that piece?
JC: I mean no, that's a big-
LN: Yeah, you are in such a great positioning coming out of this program.
MH: Yeah this is really just making me excited to…
LN: If you if you have not locked in on a facility, and you're continuing to line up interviewing and such. The interviewing process is the time for you to ask these kind of questions. If I were interviewing you one at a time, I would want you to ask ask me, just say, what do you think the most interesting best practice you came across as a group of OTs? And me interviewing you, had better be able to tell you. If I were like ah we don't really do a lot of that. You shouldn't go work there. Walk away. Don't literally walk away. Be polite, finish out the interview. I interviewed a guy a few weeks ago, and he said I should just walk. No don't do that. But those types of questions are more and more important to help us differentiate because the quality of the therapist coming out. Like when I interviewed, I honestly interviewed on the telephone. Didn't even fly to Reno, Nevada. Interviewed on the telephone and they asked a few things about, just what did I think was a pretty comfortable caseload? Am I worried about working overtime, or would I be willing to work overtime? How soon can I start? There were other questions, but it was very generic and it felt cold. Now that I think about it, then it was just like, you know get me through it, I am going to be a great hire. I am a hard working. And now our interviews, even with Maddi, were different. There were questions like that. Or I would maybe if you were interviewing with me I would pose those questions to you and say we know the position you're applying for, say it's our most recent position we had open, which was full-time pediatrics. So you know, I would know what you're applying for and I would ask a question similar to that, I would just say, 'What do you think the biggest skillset you came across the last 90 days that puts you ahead of anyone else applying for this position?' And then you'd say 'Um, some of the latest research on, we'll say oral motor strengthening in infant's'. 'Well tell me a little more about that research article.' I wouldn't know that I didn't even need to know the title. I want to say how did you come across that? And then the next person would say something very generic like 'Well I've been, I've been doing some reading on pediatrics.' Well that's good because that's what you're applying for. You know, that person wouldn't get hired. So those types of things will be very important.
MH: So be very specific and
LN: And query the person interviewing you. That's what most of our leadership and then us in administration, our senior leadership, we like to be tested. Like you could go in and say, they would say, do you have any other questions and you may have a few questions about the benefits and say I do have a question, 'What is your biggest satisfier as far as working at Riverview?' If they just say, 'Well you know, it's- I think I'm just going to retire here, it seems like a pretty good job,' that's probably not comfortable. You should be able to, I should be able to identify, you

know, why I when I was 42 went out of private practice, sold my private practice and took a leap of faith and interviewed for a director of rehab position. Why would I do that? Like what, and then why Riverview? Because there were a couple other positions open. And then why have I stayed since? Why didn't I bail in a couple years, thinking ah I don't know if this is it. And if they can't answer that, probably not a real good culture that you're hiring into.
MH: That is great advice.
LN: Yeah, I love interviewing people. You can really see someone's skillset. Because they're probably going to, you are going to have patients ask you, really obscure questions and your ability to think on your feet. And if you don't know it, to say, well we won't get into that. I mean, you just have some of the tools to be able to- the patients will query you all the time because they've never had a stroke, never. And their wife and their daughter and their son have never, and they are all in the therapy room asking all kinds of questions, and to think on your feet quickly like that, it's important.
JC: Um actually, this might be a question later on, but how do you see like the roll or the relationship between OTs and OTAs? How has that changed from when you first started to now?
LN: I think the OTAs are under utilized. We have no OTAs right now, no we have one, her name is- yeah we just have one. I think it's an under utilization. I think the relationship between OT/OTA, PT/PTA is similar to a medical doctor and an advanced practice provider, your nurse practitioners and physician assistants. There's an underutilization, like where's the handoff, like where's the best hand off? If I were to start practicing again in an upper extremity rehab, say I make a decision next year, I just want to I finish up my last 8 years practicing, miss it, and I do. But I don't want to do that. But if I did, I would want to have a COTA as my partner. Like maybe, we would share patients. It's too segmented, and you know, it is like 'Oh hey, so you're going to see my patients this afternoon, well her charts in the electronic health record and if you have any questions let me know.' That is not a patient handoff. That's a term we use, an electronic health record, should always be a face-to-face hand off. And then I prefer to just, I usually bring a laptop and we have TVs like this in Riverview. I pull a patient up on there and then we just have privacy so no one can walk by and see their information and we go through it together. I don't currently work with any COTAs but that is how I would follow that.
MH: So do, are COTAs not involved in your practice right now because of financial or…
LN: Not financial at all. I don't know. I just don't know. I think that we had a full-time COTA when I first started there 6 years ago, and she resigned to take a different position, and we just instead of filling that void with another COTA, we had more autonomous work that required some evaluation off site. And the COTA wouldn't be able to do that, so we filled it with an OT. In hindsight, I would have had one of the OTs in the facility go off site and fill the internal with a COTA. And I was the director of rehab at that time, so that was my mistake. And looking back, I would have done that. COTAs are invaluable because their hands on skill set often, because they get face-to-face and hand-to-hand with patients nearly one hundred percent. That's what they do. And they can tell a story to you in notes, if you haven't seen the patient three times a week, and you see maybe every 2 weeks. You could read, if they do a nice note, you can just read a story

line and envision. You can walk in and confirm what you read to a patient. Rather than, 'If give me a minute I'm going to looking in the electronic health records.' They won't maybe say that but, 'I'll look in your chart' and then you maybe scroll through and you just like things just aren't making sense. And all of a sudden the patient is like 'Did you talk to the therapist that works with me?' Patients should never see that on the front end so. That answer that?
MH: Yeah. Um, so thinking back on your career could you reflect on your personal growth and your professional development.
LN: Sure, I think we touch base a little bit on early, early career as far as misses. There are misses on my part that I think that I would have been far more inquisitive on 'Where does that paper go?' 'Where do my charges go?' 'Like how are you reimbursed for my services?' And I don't believe, and you're in a different world now because you certainly have at least heard, and I don't know where you're at in your curriculum, but you have at least heard CPT codes. Current procedural terminology. I didn't know CPT codes even existed, 18 months to 2 years into me practicing. Didn't mean anything to me. Yeah and it's very, it's invaluable to know. So when we get together as therapists at Riverview, and the new grads etc. We talk about what's best fit for CPT codes to maintain our validation and what we're doing we're actually reflecting on, and things like that. So early on growth-wise, those are probably things that I would have fired up earlier. As far as professional growth, probably some of the things that were the most helpful for me was working when I was preparing and studying for my certification in hand therapy because of our small department I had the ability to work with, go into Dr. Clayburgh's and Dr. McCloud's offices at the end of the day. They let me look at, look through their books. So I would get to look at, at that time it was a recorded tape to look at surgeries etc. Also I would be able to query them a bit about just professional development. Like what would they like to see out of a therapist. And they're always like 'Well treat my patients well.' Like what else, like what things would you think, if I had extra time, I should know? And they said 'Well you should definitely know like what it cost us to make this brace, and what it cost if we just take a break out of the box.' So I started thinking about supply chain, like products. Because I use a lot of products, a lot of orthotics and things like that. And it was valuable to pick their brain about that. So I think that started me to be much more inquisitive. And i've carried that now for, barely a day that I don't ask one of my leaders, one are the directors of the six areas that oversee, a question. I see them in the hall and will ask them something because they're experts. I'm not an expert a diagnostic imaging, not an expert in medical practice or our clinics. We have 30 providers doctors and advanced practice providers, I'm not an expert in those areas. But Amy our director clinics is. So we learn something nearly every day. I asked them more than I asked them more questions probably than they asked me. Just though and my response to them if they look at me as though 'Gosh he asks a lot of questions' is whenever you go on vacation or you're our ill for a day or you're on vacation for 10 days, I want it to be seamless that one of your nurses in the clinic would call me and I would know exactly what the answer was. And it happens every week, someone is out. It happened today, that Amy was actually was out of clinics and one of the nurses called and a provider was having a concern that was not going to be remedied by me

saying, ‘Check with Amy when she gets back.’ It's more drop what I'm doing to walk into the clinic, see him, shut the door and have a conversation with him about what was not working well that day, today. So those pieces as far as growth are concerned, and then leaning on the academics here. One of the positives of when I was teaching, was access to the faculty and just bouncing things off. Almost exclusively it was Jan Stube or Anne Haskins. Just because Anne was a student of mine, she worked in surgery upper extremity rehab in the Twin Cities. She worked for me in private practice, so her and I- and we've done a couple what conferences, two-day conferences on shoulders and so we have of a lot of a collegial relationship. So to keep that tie academically has always been a professional growth piece for me that, that's something I did do long ago. I started teaching here in ‘93 Intro to OT for years and years, Intro to OT and then OT Adult Phys Seminar, basically on your 5 days. Come back and write your case study, I would grade those. So that's been a very important piece, I think wherever you may land, I think it’s always a positive to reach out to the nearest OT program and go there and meet the faculty. You may not have even graduated from that program, which may even be beneficial you get to see another world. And you may not be interested in teaching at all, you just show face. And they will reach out to you, I guarantee. You introduce yourself to a few facility, you can give them your business card. They would say ‘Are you still doing predominately adult physical disabilities in the inpatient in the ICU?’ ‘Yep.’ ‘Would you ever be willing to come, like we're just talking about edema management of lower extremities like in a bed, would you be willing to present?’ Or ‘I just have a question.’ So it's a very important professional piece. If nothing else, academics, the faculty, to be able to have access to them is critical. And the more important pieces is students like you that when we have the physical disability course, that I taught, they are always pressing me. Always pressing me for ‘Why?’ Like ‘So I guess I don't get why ultrasound would do that. How would I tell a patient that?’ And they're always pressing and pushing so that always presses you all the time. I'm always doing lit reviews when I teach. To see if there is anything new out there so you're not coming over this program start working on the place say Avenue Northwest in the Twin Cities. And they’re like ‘Is that what you had in your physical agent modalities lab?’ ‘Yep.’ ‘We don't even do that anymore.’ You know that type of thing, you can't have that happen. That's an embarrassment to the program or me as an instructor, you know. So those are probably the highlights, I think, as far as the professional piece, academic tie, and there's nothing probably more valuable than an advanced practice provider or doctor that you can align with. They will tell you things you don't want to know, and many times they will steer you along. Dr. Clayburgh, the hand surgeon that was at Altru, and he's in private practice in Grand Forks, he was he was critical. He gave me the, you may or may not be familiar you have so many things in your head right now, but there's a two-volume book called Rehab of the Hand written by Evelyn Mackin it's the Bible of hand therapy. Two volume it is about 1500 pages and he handed me that. And he said ‘I’m going to give you six months to prepare for the test. So you can come into any OR with me’ but he said ‘I want you to test out in November of 2010.’ And it was around April-ish. He just said ‘You can write in the books if you want, these are the older versions.’ He said ‘but I have highlighted (he literally highlighted) areas I want you to be

proficient in.' Wound care was big. Custom orthotics, like making orthotics for infants, like a some infant fractures their proximal phalanx, how to make a- and he gave me a six-month window. And he was just push, he was a pusher. It was, in hindsight it was what I needed to have. He was good about it too.

MH: So you had a lot of accomplishments in your career, are there anything- do you have any regrets that you wish you would have pursued more in terms of accomplishing, or anything else?

LN: No, I don't think so. I probably would have, I probably would have utilized some resources in high school. Which for this interview may not even be relevant it's just too far back for any one person that's going to be looking at this data. But, you know career counseling in high school was basically absent, or I did not pursue it. You know our counselors would come if you'd had something they'd say sure, come on in. but if you didn't, you walk by their door or you never utilize them, you know so if you go through basically 24 to 30 credits of my freshman year just general's, just floating around. That was wasteful. You know, it was wasteful.

MH: So just in retrospect, something you would have changed? Alright.

LN: Yeah, I would have probably advanced my math and statistics heavier. You know for me to be, like and even in private practice, to be able to be proficient in reading statistical data. Metrics, yeah.

MH: Alright. So what is one of the best memories of being an OT you have?

LN: Hmm, boy that would probably be two patients that I had prepared for days at a time with the surgeons. One was a plastic surgeon with a little boy that had a bilateral upper extremity and chest burns from a bonfire. So we prepared looking at research on whether we'd be able to even treat him at Altru, or if he would have to stay at Saint Paul-Ramsey Burn Unit in the Twin Cities. And the satisfaction of that because I've ran into him on two occasions now tailgating at football. And he's in his mid-twenties now, and still you can still see some of the grafting of skin. But he has full use of his hands and his wrist, he has a little bit of a, he says he really can't throw that well because he has, he had a lot of webbing of scar in his axial. But the preparation with Dr. Charette the Vascular Surgeon at Altru, and then Dr. Clayburgh was a hand surgeon, because we grafted skin. That was best outcomes, like seeing a child at seven through about eight and a half. I saw him about a year and a half. Every day seven days a week for about four months. Every single day he came in on the weekends with his parents because we debrided his wounds in the whirlpool. And how, I bet you know, and then at that time I was mid-twenties, late twenties, how did I respond to a PEDS. Because I didn't like PEDS. Like I didn't know, I didn't have any, yeah I had children but they were mine, at that time. I did, yeah. But how do you treat them, and you know, diversion techniques to get away because it was nothing short of extremely painful. And you could only medicate him so much to make him not too lethargic. And then another patient as far as a below elbow complete amputation replanted. It was another that was a lot of research, with a couple of the vascular surgeons and a hand surgeon in the Twin Cities that replanted his arm. It was a Grand Forks injury so he came back and wanted to be treated here at home. And that was very, very satisfying because I still randomly see him. You know he has some wrist mobility, maybe 30% arc and probably 50% strength. And he does have some mobility in his

fingers, you know. Because he was truly just about nearly at the, just below the distal radioulnar joint, just below it. And that was completely amputated into a machine, and then he was able to withdraw, and then they retracted his arm out and they flew him to the Twin Cities and replanted. You know, so to have some prono- supination, so he could feed himself, it was amazing.

MH: That is amazing, wow.

LN: It was, it was a journey and he was about 2 years. So, it's like those longer-term patients. They were the two patients that I probably prepared more so because I knew that the boy, Toby, and then Paul I know well, I knew when they were going to land in Grand Forks, like get into therapy in the very first day. Dr. Charette there, Dr. Clayburgh's there. They're both over my shoulder, and the parents are there. He's had not a lot of postoperative pain because he had been medicated. There was a lot of rehabilitation at St. Paul-Ramsey, it's more about bracing and splinting, so here we go. And how you prepare for that, how you prepare for at that time, was basically just traumatized patients now. PTSD or PTSS, syndrome rather than disorder I hear. Anyway, we did some research on a child, seven or eight, and how I would handle that. It was a big learn, it was amazing.

MH: It has to be so rewarding to be able to see them nowadays.

LN: Yeah, it's pretty neat.

JC: So now, those two stories might align with this question because it's what are your most challenging experiences. Are there any other moments that stick out?

LN: In practicing?

JC: Yes.

LN: Yeah, I think patient wise they are probably the two most challenging patients. But just in practice in of itself, is challenging to stay current. You know to stay current, whether you're practicing full-time in medical practice seeing patients, or part-time, or for me just a patient or two at a time is all that I see, and to stay current in that. And one of the satisfiers that I already alluded to was my ability to stay academic at the program here with the modality course. I wouldn't care what course would come up again, I'd like to teach like a credit just to keep me tied in, because it keeps you current.

MH: Keep those connections, yeah.

LN: Because to keep current in OT in general, and then phy dys, and then upper extremity rehab is very defined. And then there's this role of administration. In administering budgets, and supporting your leaders when they're having a couple of employees that are very poor performers. How do you handle, how many chances do you give someone, or how do you commend someone. Like we call it re-recruitment. We try to do a re-recruitment conversation every month with our, or Crystal does, with her 30 staff. She probably has 20 of them that she tries to re-recruit the other 10. They do their job, they clock in and clock out. And she doesn't spend a lot of time on them though because they just don't, they don't go that extra, anything. You know, and to balance all those pieces and stay current in OT is a challenge. I don't know

how, you know, other than being in a department that's large enough with other OTs, how, other than having an academic tie, you would do it. It would be very difficult.
MH: Do you guys do lunch roundtable article review kind of session things.
LN: Somewhat, yes. It's a little bit more diluted down than I would like to see. Like the PED's OTs will meet. And then the PED's PTs will meet. Sometimes there will be some collaborative information. But as a whole, all of the OTs we do have a monthly OT staff meeting. A lot of it's like logistics, there's not a lot of chance to just scan in a research article and have everyone review.
MH: I see.
LN: But it should be necessary. For sure.
JC: Again, you kind of touched on this with your understanding, like your educational experience. We want to know what that's like for you. So, looking back on schooling at UND, and then also your education experiences with your administration.
LN: You mean the difference between the two, or?
JC: Or like what, so starting off with your education here at UND, what stands out for you that you were learning? So, like you already mentioned your class size, but theoretical models, your interactions with the faculty.
LN: Yeah, interaction with faculty. The more challenging the faculty were, the more I recall and remember them, for sure. Historically, and neither one of you were familiar with Dori Markin. She was a female, physical disabilities (professor), was challenging to me. She was challenging and rode me in this program. More than I believe other faculty did, by any stretch of the imagination. So, our senior year when we had our banquet in December, we graduated December 21st or something, we had a banquet just that month. And Dory and I had a real nice conversation because my parents had attended that, of just why she felt the need to push me. You know, just some of the transgressions we had as far as our communication, we didn't see eye-to-eye; yet, my senior year I was a teaching assistant for muscle function that she taught. And she had me, she wrote a letter of recommendation for me to be the teaching assistant for gross anatomy with Dr. Keck. He was a male anatomy professor. That piece of one faculty member that you can align with, and I didn't until my senior year. So my sophomore and junior year pre-OT, and then my junior-senior year, and then I of course we talked about fieldwork. But that junior, most of the junior, into part of my senior year we are adversaries in some respects. But I realize at the end that, especially in the phys dys and like anatomy lab, being the teaching assistant from anatomy lab I felt, anatomy lab I nailed. Anatomy lab like nearly a hundred percent on course work, and it was just one of those things that I just, I like three dimensional things and Dr. Keck allowed me to help set up lab with the pins for identification and things like that. And Dori and I met, like I say, after, or around the time of our graduation. I've came to realize the importance that she had when I actually felt as though there was an adversarial relationship. And I think some of the other faculty watered down to me, like she stood out. And the others were like 'I couldn't handle that' and 'I couldn't handle this' that was beneficial for me, and I've never let that piece go. Because it was outside the occupational therapy program to

me to be a TA in anatomy, felt like it was outside the program like I can do something else. And actually I mean, without upper extremity and anatomy to level that I know it now, I wouldn't be able to be a certified hand therapist. Because of the 200 questions, probably 50 of them were high-level detailed questions of anatomy. You know, like angle of the radius in comparison to the ulna in degrees.
MH: Really? Wow.
laughing
LN: Yeah, I know. That's what I mean, that's my point. So she was influential you know, and as far as professionally now, our board of directors of the board of Riverview that oversees us as administrators, that basically as a board could get together and hire or fire us. Otherwise, other than those six people, that are on the board, unanimously they would need to push through that. They've been very influential and pushing us as an administration. So our CEO, and then there's four of us that are in the senior leadership that out various departments, so the five of us run Riverview. And they push the five of us. We can either wither on the vine as a critical access hospital, meaning the hospital under 25 beds. We can't grow. We were too close to Altru Health System. We would be in competition Medicare would say, so we have to be limited to that size. And we have been for 115 years. That's how long we've been open. But whether we remain autonomous and stay independent because we're not owned by anyone, and continue investing in Crookston and that community, or we start aligning ourselves with an organization and just, ya know put the white flag up. So like if you're going to do this, if you're going to remain autonomous, we need best practice. We need evidence of, if you're going to say 'You should go to Riverview for your hip', 'well why?' 'Well all the doctors are all nice.' You know, they're realizing as a board that stuff doesn't fly. You have to have, so we have a Hip Occupational Orthopedic Survey, a HOOS that we do preoperative and then we do postoperative to show evidence of increase in functional capacity of a patient. And they, we have committees we've established at Riverview: a finance committee, governance committee, quality committee, strategic planning. And us and senior leadership are on those committees, and then we present to the board with the results of those. They ask us frequently about, you know, 'how will you get there?' 'How will you get to be Joint Commission certified as a center of excellence for orthopedics?' It sounds like a daunting task for an organization that only has 300 employees. So it falls on me as a senior leader, and then Crystal the Director of Rehab, Director of Imaging, Director of Clinics, us four are needing to task our 120-ish employees to buy into this number one, and then how are we going to get there. Versus an organization, and this often happens, it could be a larger organization, it could be smaller. Often it's a large organization where I could be the same type of C-suite, or corporate suite level work, like administrator. I could be an administrator in a large organization, where as long as we show off 4% profit every year and my turnover of employees leaving is under 10%, they don't really care what I do. That's not satisfying to me. It's the beauty of a critical access, like just a nibble little hospital, Carrie is my boss, I see her everyday. She's, I was like 'Hey Carrie, I need to be, I want to take a look at recruiting a speech language pathologist. We've had an open position for 74 days, and I'd like to

put a sign on bonus on that.' And she's like, 'What are you thinking? Why?' 'Well we've had no candidates in 74 days, here's all the things we've reached out to with Crystal our Director of Rehab.' And then we talked. She said 'Well how much?' I said 'How about $10,000 forgivable over 5 years?' And we started talking blah blah blah, and she's like 'Put it together in a request, just so I have an email. Sounds like a plan.' Shakes my hand and I go to human resources. Say 'Can you post this?' We're going to have a $10,000 sign on bonus. In about a 10 minute conversation. It's awesome. Or she'll say '$10,000 over five years.' She's like 'I'd rather just have, I don't think we're going to get anyone to commit 5 years for 10 grand.' So $2,000 a year as a bonus, isn't much, just for your knowledge.
MH: Sounds like a lot to us.
laughing
LN: No, it's not. Call me if you're interviewing, cause it's not.
laughing
JC: He probably saw our eyes, like oooooh.
LN: Yeah, where you guys want a job? 10, yeah-
MH: We're poor students, you know.
LN: Like $10,000 over 3 years. So at the end of 36 months, you decide on the 37th month, 'Thank you very much, but I'm going to take a position in the Twin Cities.' That entire $10,000 is forgivable. You don't pay a penny back. You know you have to, you're committing to to us for three years. It's like signing a letter of intent in a sport. So we talk through those things like a table like this, and I walk out with the plan. And it's just, and in our board at Riverview supports us in those decisions. They don't even get involved.
MH: Sounds very efficient.
LN: It is, yeah. It's pretty nimble. And we, us and the senior leadership and all of our leaders, are trained in lean efficiencies or Sigma 6. You'll hear some of these pieces. It's just basically about how to cut out waste. Whether it's a waste of a person, like you're wasting your time doing non-value-added things or value-added things. It's a, it's a concept that manufacturing started, actually, Toyota did in the 50s. It's like looking at something, so who's better to do this? Right, an OT. So we look at, we do something, and it take seven steps. Why does it take seven steps? Because it does. So we break down the steps, and all of a sudden we take it down to six steps, and that one step saves us 20 minutes a day. And then you do that, you do your turn on investment, and you present it to the board.
JC: It's like activity analysis.
LN: It is. But it's a lot more money. It's like talking about millions.
laughing
LN: Or tens of thousands. But it is, it's something that just comes innate to me. You know, and some of the TMOT program helps them, helps that piece.
JC: Now we have about like 5 questions left, but do you need a water or anything?
LN: No, I'm pretty good.
JC: You're okay?

LN: Yeah, I'm good. Yep.
JC: Okay. We probably should have gotten him a water.
LN: No I'm fine.
JC: Um, so, I have a list of these educational demands that have shifted across time. So I'm going to like list it, and then I want you to just tell me the impact these shifts have had- has had on the profession.
LN: Educational demands on OTs that are practicing?
JC: Yep. Just across the profession as a whole, yeah.
LN: Ok, not students only? Or not practicing therapists? But just as a whole?
JC: Yep, right.
LN: Ok, go ahead.
JC: So like, you'll catch on, it's the development of OTA programs. Like, how has that shifted?
LN: As far as an effect?
JC: So we kind of touched on it a lot in regards to, you know, the master's program and all that.
LN: For me personally, I think it's a great opportunity for those that want to be involved in the profession of OT without the commitment of 6 plus years. And there's a fit, like I said there's a, when we were practicing at Altru we had a COTA that was knockout upper extremity rehab. She was so good. I couldn't do my practice, and she couldn't do her practice, without one another. So I think that there are, you know as far as- I feel like COTAs now are more underutilized than even when I was practicing in my early career. I think it's been more diluted down too. Them, and I say them like that two-year degree, working in long-term care in an activities department, or in a REM home, or a long-term disability home doing an activity analysis, and you know setting up patients on feeding programs. But I feel like it's limiting, rather than you know a COTA working adult psychiatric, like working on group therapy involving an MOT, or an adult phys dys. I think that- I don't see that collegiality as much. I think it's a miss. I think there should be more conversation with UND and CTC. And there may be that I don't know of.
JC: I mean, the next one is movement to the master's degree. I know we've talked about it a lot. Is there anything else you want to add to that?
LN: I don't think so. I would say that at the start I would not have pursued my master's, had it not been the necessity for me to continue to be able to teach. But after not too many months into the master's program, I really enjoyed it. I loved writing my scholarly project. I loved presenting it at Frank Low. It was awesome.
JC: That's good to hear.
LN: Yeah, it was really- it was. You know, people that came up that had questions, and I recall a couple of them, it was just- it was a great experience.
MH: We just started that process.
JC: Yeah, so it's nice to hear you say that.
MH: We're just starting into that big ol' project.
LN: Yeah, it's pretty neat.
JC: And so what about the development of OT models and frames of reference?

LN: Boy, that's probably going to be my weakest response. In the fact that I still, you know Models of Human Occupation and, and like a Biomedical model. Those two running in correlation is probably how I practiced the majority of my career. Some of the other models that are perhaps less engaged, like in a patient engagement during a task, and I don't know some of them by name, seem to be outside of the realm of my use of a tool. I wouldn't use those tools. But I would definitely, I definitely can tie a biomechanical or biomedical-biomechanical model absolutely directly. If I know in my, so here's how I am wired, as I can take someone that has a subluxed shoulder, and I can put an electrical stimulator on their shoulder musculature to facilitate combined shoulder flexion and adduction. But I can also do an analysis like on the Model of Human Occupation and determine what my goal is going to be written as far as from a functional standpoint. Rather than over on electrical stimulation 15 minutes, at X hertz, and we'll look for a degree of arc of 45°. I'll skip those pieces after I just put that in the note because someone has to know what that is in case I'm out ill. But I'll engage in some form of like dynamic standing at a counter for moving food product, or capability for self adjustment for shower handles, or something like that. Just basically starting typically with self-care type things. Some, I don't, I'm weak on that conversation. From the outside looking in, it- they feel diluted. It feels like all of these frames, my heavens, how many could you use or integrate into one. And the faculty may tell you, well you'll use a hybrid of them, or you'll use depending upon your population, but it still feels to me as though there- that, a good functional initial assessment that's based on best practice, on a patient engaging each day in dressing their lower extremities when they have a, like a fair minus or a fair plus dynamic sitting on the edge of the bed, is an easy sell for me. The lines of biomechanical, like those two, I don't need the others.
JC: No, no, and I think you're way more competent in that than you realize, cause I think some therapist don't even know that they're using it. I think, that's what they tell us in class anyway.
LN: Yeah, I was trying to walk through the patient, like what they have is easy they'll say. I had a stroke. They'll say 'do you think this will ever get stronger?' And I said 'there may be strength at returns, but it truly isn't a strength issue. It's actually still affected from your brain, and here's the things that we'll do, these are the tools I'm going to use, but your engagement with your vision, and the tactile sensation, or the touch of your hand, and your ability to lean toward the chair, etc. and all those pieces of feedback sensory to you, is a, is a model that's going to get you back. It's not going to be you being at home and your husband or wife, or what have you, ranging your arm up and down 10 or 15 times.' That'll do nothing. Other than keeping you from getting a capsulitis in your shoulder, but anybody could do that. So, and it seems to have helped me along my career in selling to patients. Like, the one question that I learned in the program was you know, asking the patients like, 'so what's your goal?' And I never use the word goal anymore, I pluralize it, and I don't ever say goals. I'll just like, 'what do you envision? What do you envision in a week, in a month, in a year from now knowing you've never had a stroke?' And they'll say, 'Well realistically, I mean I'm so weak now. If I could even just be able to be on the toilet myself. Or if I could drive an automatic, we have a stick shift now.' Ya know, things that are engaging. And then I can just measure those pieces. So first of all, you can't get out of

bed. And I would never tell a patient that, but bed mobility, you know as far as just being able to go prone to supine and supine to sit, would be a 10 to 14-day goal. And we would just call it a bed mobility goal. And patients would always engage in that because they knew that if you can't get out of bed, what else are you going to be able to do. So we'd start with that.
JC: And then the last one here for the impact, or the shift impact, is the importance of interprofessional education.
LN: Like how important, or?
JC: Yeah, if you want to take it that way. Or for us now, so think of like students now, the education they give us about interacting with other professions.
LN: I don't know, I think we were hardwired to be that way. Between muscle function and anatomy, and now I'm dating myself because this was literally back in the late eighties, but we had physical and occupational therapy. And there wasn't, I felt like we, we just grew up together. Like we grew up through those programs. And I think what's most important, would probably be, just you to me, probably the most important piece, and that still is lacking quite a bit, is of the role of whether it's a two or four-year, or doctorate level nursing program in OT. If I see a discrepancy of disciplines, I won't see a PT and OT argue about a shoulder, I'll see a nurse and an OT argue about functional stability during transferring. All the time. So if you have a home care patient, they've been transferred, they had a total hip, they're at home, they require home care. An LPN or RN goes out and does an assessment, 8:30 in the morning. 2 p.m. that day the occupational therapist goes out there and they do an occupational-based assessment, which nursing has some of those pieces in there, right? They both load them into their electronic health record, and all of a sudden the chart reviewer, or the nurse that oversees the case, will look at the discrepancy and is like, how could one of you say that they're maximal assistance of one sit-to-stand, and the other has minimal? Well who's going to be the minimal? It's going to be the OT. Nurses will be max. And that was when they saw them at eight o'clock in the morning, and you should have a higher level of, typically higher level, of necessity for dependence later in the day. Particularly if you have some physiological deficits. Like you get weakened during the day. Eight, nine, ten o'clock in the morning should be your prime day. So I think between the disciplines, I think it's important. I feel like sometimes it feels forced. I think it should be a natural. But if their one alliance that I think is still weak and major is between OT and nursing, and the role between them, I think it's blurred. Tto me it's more blurred than OT and PT. And that's something to say, because I've had my battles with a physical therapy at the United Hospital in 1992-93 when I first moved back here and I wanted to do shoulders.
MH: That's really interesting to hear because, you know, in this building we don't have nursing. And so they always when they address interprofessional work, they're out- we're talking about PTs, doctors, speech. They don't really ever mention nursing. So that's a very interesting point.
LN: Yeah, we talked a little bit through- early on Janet, Dr. Jedlicka, was like 'Oh, pretty excited. You know, we're going to have some capability architecturally. We're going to have pods. We're going to have interdisciplinary interaction.' I said 'That sounds great.' I said 'What are you going to do, what's the medical- what's the nursing program going to do with that

building that they have?' 'I think they're going to stay there.' And I said 'Gosh. There's like the electronic health record, EMR, however you want to call it. Electronic medical record, electronic health. They're written, they're designed for nurses. They're built with, if you ever get a chance, what year are you?
JC: We're second years.
LN: Second years. So, yeah I don't, we don't get together this year. I speak to the organization and administration course. That's your third year. Anyway, we look at metrics. On the board about, we go into a dummy electronic health record. And it's designed and such that it has basically flow sheets that you can time at like 1:18, 1:24, 1:49, 1:38, whatever it is. And it's designed for nursing staff. So, when you integrate and you try to have interdisciplinary work with physical therapy etc., it gets to be a challenging electronic health record. And that spills out onto the department. Yeah, so I think if there's a discipline, because there's very few places you'll practice that you're not going to have a relationship closely with nursing. Yeah, it's wildly underrated. And I see it every week with our nursing staff, even inpatient nursing. And our physical therapist that saw a patient in the emergency room, and helped fit them with a wheelchair because they're going to have the necessity to be transported from inpatient to imaging, or inpatient to somewhere else, and they do a brief analysis and they actually physically go up into the inpatient unit and meet the nurse. They do a face-to-face. We call it a ticket to ride. It's a catchy term for, it's in the electric, it's an electronic health record term. It's like hey I'm going to give you a ticket to ride, like here's the patient I'm handing off. And they'll have discrepancies. And you have to talk it through, I mean it just, more opportunity there.
MH: Yeah, for sure.
JC: Um so, ACOTE has indicated that by 2027 entry level practice will be at the doctoral-level for the OT, and the bachelor's degree for the OTA. And as you think about your practice, we kind of hit on this again, like what do you see as positives about this? Or what are the more drawbacks about this? We haven't hit on the drawbacks really.
LN: Sure. Yeah, I think it will probably, as far as drawbacks, I think just the level of commitment that you're John or Jane Doe, whoever they may be at that time, is going to look at the commitment of time to that. When some of the core, I mean proficient OT, is I don't have a doctorate. To be a proficient practicing OT, to be able to get there in four, four and a half years versus seven. What does that two, two and a half years bring to you as a practicing therapist? Now, as far as a COTA moving off of a two-year to a four-year bachelor's I think that that's a miss, that two year void. We have a PT assistant, a male at Riverview. And his fit with the PTs, there's about half of our PT's are doctorate, and then the others have just been grandfathered in if you will, that relationship is just so, just congeals very, very well. So to bring that to a four-year level I think that there is, I would say if you're- if you asked me I'd say 'That sounds fine for those that are interested in doing that. And then maybe they'll be capped at this level of, we want them to work at their highest skill set, but they're going to be capped here. But I still want a two year. I think that you're you're skipping a whole piece here. And I think that piece is the ability for hands-on direct patient care, and being able to assess. Like a patient looks a little bit off that

day, they're a little asymmetrical at their pelvis while they're standing, and their foot has about a 20 degree more of a drop. That's not COTA picking up on that they've had a transient ischemic attack, that's not me as a doctorate OT standing in my cubicle assessing the next plan of care. You know you just don't even get that skill set, and to get that eye. And there's a big role for the COTA in the World of Occupational Health, like work injury. So, on the opposite end, the doctorate level mandate 2027, the pieces, if they feel like they're going to be similar, if it seems like that curriculum is going to be similar to what pushed the baccalaureate into the master's, I think that that's a positive. I don't know what else I could have squeezed out of a master's that I didn't get. I don't know what else that the doctorate is going to give me. I don't know that piece. I'd be interested to read it. But I think of the shift, that I don't like this void.

JC: It's kind of a side note question, but do you think it has anything to do with PTD, or like, and you know DPT.

LN: Oh, for sure. I think between, even speech language pathology. You know, there's fewer master's and more doctorate-level pieces there. And certainly in the nursing program, DMPs, Doctor Nurse Practitioners. So our ends, here's what we're seeing at Riverview, hired an LPN. Awesome two year LPN program. They work part-time for us because they're going to get- they're going on to get their RN four year. And they're actually not even going to come back to work after that because they're going in to a nurse practitioner program. And um, there's pieces like, two year LPN program and come out making 17 and a half to 21 dollars an hour. You have two years of monies that you need to pay off versus a six-year DNP program and you have $100,000. And they'll all say, well that's fine but working as a DNP 10 years later, when you pay all that off, here's still this LPN. Yeah, and my point being that LPN is, theres- it's hard to substitute that piece. So I think there's external pressures from many avenues including the DPT program.

JC: So next it's kind of like a card sorting questionnaire. And so, so for this class we reviewed a series of articles that looked at the values and beliefs across time. And some of the key things articulated in those articles were like technology, and occupation, and all of these. So if you just want to take a few minutes and organize these in like the most important to least important in your regards of how it has- these terms have enhanced your professional practice and development.

LN: Mine?

JC: Yes, your personally. So how would you prioritize these in terms of enhancing your professional practice and development?

LN: I would be nowhere without that, that is key (activity analysis). I can break them all down, and our, our surgeons like that. They just, no doubt about that piece.

JC: For activity analysis. And then we'll just kind of like walk through each item once they're done, so you can kind of explain your thought process to us.

LN: Sure.

JC: Awesome.

LN: So just briefly, that we'd- we talked a couple of times today as well on activity analysis. Which is just the ability to analyze task and movement. And that was important when I started practicing at 23-ish. And just this year we have been doing an analysis of- um, we're building a new clinic for our 30 doctors. And we did spaghetti mapping on exactly physically how many steps they'll go from exam room A to exam room B, how much time they'll spend in there, using using lean principles on how we can utilize examination rooms for various things, even though it just looks like an exam room. So OB-GYN, OB, morbidly obese patient, and you know just the ability to multi use the rooms and analyze how that patient would flow, how we can have a visual on the patient with them still having privacy. So it's a, I use it in my entire career almost everyday. This (occupation) just simply to be able to tie these two together. So, we have someone that has a limited motion in the shoulders as an example. We analyze what they, what they have a capability of currently doing, and what they're most likely going to be mandated to be able to do if they want to return home. And engaging these pieces while they're still being rehabilitated, whether it's with me or a COTA. We offer this (continuing education) still at Riverview. You may, when you start to interview, you may find that they say well we give the occupational therapy department $2,000. And then you think, well that's pretty good, until there's 10 therapist. You know, and then it's a $100 weekend and you have to pay for your hotel. We have a very, very robust continuing ed. And I think myself and Carrie, my boss, are probably two of the bigger drivers that we try to push about $1,000 to a therapist each. So you're talking about $35,000 of continuing ed for our therapists. It's key. You get out, you get out into Devils Lake, and it's no negative against Devils Lake, but you're working for Altru Health System, you travel to Devils Lake everyday. By the time you come back at the end of the day the OT office is closed, so your ability to interact with your colleagues, you lose skill set really quickly. These are important pieces. These are always nice to have (specialty certifications) to- it keeps you- takes you to a certain new level that you can never be lax once again. And then it also makes you very marketable. This is my CHT. Licensure just for compliance. Whether its state of Minnesota, state of North Dakota. And then the requirement for continuing education there's a number of hours for each state. Probably the electronic health records been the biggest piece here (technology). These pieces I, I put just a little bit of weight on, more so when I just see the word legislation. As far as some of the pieces that legislation has allowed for us to still retain validation of a skill set. And we still to this day have physical therapy and speech pathology in one pool, and OT is by itself just because of the robust nature of some of the evidence of best practice on functional outcomes. I mean we have a Medicare patient, and they have a cap on the dollars per year of rehabilitation. 750 for OT and PT- or em, PT and speech, and a separate 750 just for OT. Well that tells you as a profession the value of that. I read this health care team as like a, I consider it like a health care home, which is a national program now. That it's a health care team that will get patients home as quickly as they can, and then monitor them at home using wireless electronic monitoring for the nursing staff, 24-hour nurse call system, a therapist that can be doing random checks as far as home care visits etc. So I take that health care team, and I actually would take and overlap that with the actual term of like, medical home model. So

it’s called the medical home model, and it’s nationally recognized. These two pieces (adaptive equipment and arts and crafts) are just, they’re simply tools for me that I would utilize all through, all through, particularly in here. A little bit of technology. But these to me are staples that I utilize to some extent, but I use them not in typically- like arts and crafts in their nature of coming to an end game of completing a task of a craft, but how a patient is positioning and mobilizing their way through it. Like can they obtain the items to do it? Can they stand physiologically long enough to complete it? Or to participate in it? I’m not too much about the completion piece. But I use that to engage patients rather than, here’s machine X, I’m going to have you move your hand this many times. This would do, you could be talking to them and they have no- they have no transfer of training. They’re not watching this. But to engage them in a pronated position and doing this ten times, you could turn the machine off and they’d have a carry over. You can see them doing this. You do something like this with the machine, turn it off, that's it. I see it over and over and over. The plasticity. So, those would be the layout.
JC: Perfect.
MH: Yep, those are great. Great breakdown of each one.
JC: Yeah. I can take them from you now. So North Dakota is considered a rural state, obviously. And so how do you think being rural, how has that influenced your decisions? Or like on the impact of care you could provide?
LN: Sure. Probably early on just establishing a network of other therapists. That, when I know a patient is getting- leaving to the Devils Lake area, I know the therapist out at the Devils Lake area I can do a hand-off to. We can’t do a face-to-face of course just because of geographics, but to get onto the telephone and discuss patient care and then follow up on an email. So I’ll always have an electronic thread, if you will, I can follow up. So I think it definitely has required some resilience. I think that there has been gaps that I have observed over my career. Of therapists that join a facility that's large enough in nature that they have a robust outreach program where they service 15 nursing homes and 10 outpatient areas, and that one, or two, or three year grad, or new grad, is left to their own devices. And I think that's a failure upon people like me not to support them. You need to have an end of day synopsis or break down, maybe not every single day, but at least a couple of times a week. Like what worked well this week? What were your pain points? Like what was challenging? And anything inbetween. I think that because we have basically four major cities, and everything in between, so those four major cities of major healthcare facilities, and these- like a say these outreach therapists, I don't think that they're supported in the way that they should be. I think there should be more, more tele-education. We have telemedicine, right? Put a patient in front of a camera and you're talking to the physiatrist. There should be more colleague to colleague. I think that should be- I think everybody should have a mobile iPad and be able to FaceTime. And do it all the time. The end of the night at 6:30 and you shoot them an email and you’re like, ‘Ah, I don't remember. What was the patient's main concern?’ So more real, real time. Like FaceTime type things.

JC: So this is one of our last questions here. So imagine that I'm your family member who is considering pursuing a degree in occupational therapy. What advice would you give me? And how come and why?
LN: So you're pre-OT?
JC: Yeah, I'm not OT. I'm pre-OT.
LN: Yeah, I have a friend that's a physical therapist in Grafton. He's the director of rehab there. His son is applying to the program here. Unless he's in. But, Jonah Kratochvil?
MH: For OT?
LN: Yep.
JC: Jonah?
LN: Jonah Kratochvil. He's applying then.
JC: Unless he went to Casper?
LN: Yeah, I don't think he did.
JC: So then, he must be.
MH: Yeah, the name doesn't ring a bell.
JC: Cause there's only so many boys, so.
LN: I think the advice would be to re-talk to the academics here. I don't mean above and beyond Darlene, but outside of Darlene to one of the academics, as far the therapist- the OTs are concerned. And just get feedback on, as far as volunteering, before you even get to the point where you're applying. Where you're like well I need 20 volunteer hours here of this and that, I would probably have them help you. Or a colleague, if you would, find locations in which you can volunteer. Where you actually will observe a therapist. No filing paper, no sterilizing, and I reuse those examples because half of my volunteering was just that. And it was horrible. And I didn't really know at the time, all I cared about, at the time- I wanted those hours on my application when I interviewed in front of the whole faculty, at the time sat at a table and interviewed you.
JC: Glad they changed that.
LN: And you sat, you sat here as the student. And I didn't, I didn't glean hardly anything out of that. So that would be a starting point. If you, if you feel like you're more enthusiastic and empowered after volunteering probably about 10 to 20 hours in the major two or three disciplines, of we'll say peds, adult, adult and peds psych, industrial medicine like occupational health. Then come back and talk to me. And if you still feel that piece, then you're, then there will be 'Spend this 75 or $150 and join a few organizations.' That I was reluctant with, with like a state level NDOTA, and state-level AOTA, like a state-level branch of North Dakota. I really didn't have an interest, or you know just, what would that bring to me? But it may be now it's much more pertinent because I'm a member of about four organizations that they have nightly email blasts. They call them an e-blast and I can read it on my phone. And I'm just like, and one of them's on the American Society of Hand Therapists. So there's therapist like you, you know I'm working in Laramie, Wyoming, I've had a referral, I have a burn patient and they're talking about a brace or a splint. They get like 10 responses within an hour.

JC: That's awesome.
LN: Those tools are amazing. Because back if I were in Laramie, Wyoming asking that question, I'd have to wait until the next day to ask the surgeon. And he or she probably wouldn't steer me down the right path. Because therapists are better orthotics. I can make a better orthotic than a surgeon. It's just the nature. So, those pieces, that would be my best advice. Just make sure that you are invested in that piece. And then try to, try to find outliers, like therapists are doing things out of the norm. Like how am I in administration now? Practicing? Best of, best of many worlds. Wage at an administrative level, solid. Being able to, with with with the exception of this year, do some academic teaching. Still see a patient that's specialized upper extremity. And being able to be in a rural health facility that's really mobile. You know? And to find like an outlier. Like, well part of this interview is like. You know? And I know when I spoke with Janet, she said that they were- they being the group- was looking at graduates that were working in, I don't know if she used the word different administrative roles, or different, I don't even know how she titled it. But you know people that are like Cindy Janssen, or Cindy whatever her last name is now.
JC: No, it's still Janssen.
LN: Janssen? Yeah. Like how she went through her career being on like a similar pathway. You start- you're just happy moving out to California to work your first job. And the telephone interview was like 5 questions, it couldn't have been more than 15 minutes. Next thing you know, you know they send in the mail a check that I have to go cash in the bank for cash. Cause they gave me like five hundred dollars of moving expenses. Like oh my gosh, I don't have to pay this back right? No it's yours.
laughing
LN: That's all yours. Yeah, no it was five hundred dollars cash. It was all you were thinking about. But now in hindsight, I'm 51 years old. The pieces that I would have probably of- I would have asked Washoe Medical Center way more questions. Like would it be reasonable- could I, could I just have a 5 minute phone call with the physiatrist? The Physical Medicine Doctor that's the Chief of Staff? I would have liked to have met him beforehand. Because he was a bit difficult. I think I would have picked that out. Wouldn't have deterred me from taking the job, but it would have, I would have approached him differently. I was a pretty idealistic new grad. And I was, thought I was pretty solid with spinal cord. Cause I, I was pretty heavily anatomy educated. So I knew my nerve roots and I knew my cervical levels etc. But that's about all I knew, you know? So he educated me.
JC: So, last final question here. Going back, Jonah, you said his name was, right? And if he was to ask you, like what are the most positives about this degree? So what are the positives about getting this degree?
LN: Probably the opportunity to work in so many different, I call it- I'm sorry this phone is ringing a third time and I think it might be- may I step out?
JC: Yes.
LN: I don't typically get a person calling me three times.
pause

LN: So that, you know, yeah. So as far as feedback would go, that would probably be, the one single piece is the opportunity. You know, therapy, you know is he a PT that provides therapy like direct treatment to the patients? It's so far beyond that. You don't even imagine. You can't even, really. And then being in private practice for a while and understanding the ability to have- be in a for-profit clinic. What that meant, like the things you would learn from that piece, business administrative pieces, the program never taught us that because you wanted to continue direct patient care specializing in the functionality. Yeah, or you know, practice for a number of years and then decide you want to pursue your doctorate and pursue anatomy. Which I had about a one year window where I practiced in California, came back here and got this- still yearn for anatomy. Like I could have been an anatomy prof. Like, maybe that would be me right now. So yeah, the opportunities it's hard. And if you're like well that's just going to dilute your degree, but you don't. You ultimately, you're among these tracks and you drop into something.
MH: You're building upon it more and more.
LN: Yeah, so I would stay in phys dys, specialize in upper extremity rehab, still have that. And then I get to be an administrator. It's-
MH: Yeah, the best of both worlds.
LN: It is. It's really nice.
JC: And I think it's fascinating that, you know you started off with the mental health. Like going in you were mental health. I was surprised. Like they tell us that, like you know- you don't know if that's exactly what you're going to do. And it's nice to hear you say that.
LN: I enjoyed it, I enjoyed my St. Paul-Ramsey psychiatric inpatient. Which was St. Paul-Ramsey, St. Paul-Ramsey, Ramsey county. It was a county hospital, so it was a whole lot of Minnesota medical assistance. A lot of indigent, really mentally ill patients that I thought, what am I doing here? And I just loved it. Loved it. Because of, like I say, mental illness runs in my family. And you know, when you go visit a family member in a locked-psychiatric unit in the 70s and 80s, that was way different. Jamestown and Fergus Falls, I visited them both. That's when I started seeing, like why do you- I didn't even know it then, like why do you have them do anything? Why are they doing stuff? Shouldn't they be in a bed, like taking medicine and getting better. But they were engaging in an occupation. It was, yeah.
laughing
JC: Well thank you so much, I know we went a little long.
LN: Sure. Yeah, it's no worries. That's fine.
MH: Yeah, we really appreciate you coming and talking to us.