KENNESAW STATE UNIVERSITY ORAL HISTORY PROJECT

INTERVIEW WITH JANICE M. LONG

CONDUCTED BY THOMAS A. SCOTT

EDITED BY SUSAN F. BATUNGBACAL

INDEXED BY THOMAS A. SCOTT

for the

KSU ORAL HISTORY SERIES, NO. 58

WEDNESDAY 6 DECEMBER 2006

Kennesaw State University Oral History Project
KSU Oral History Series, No. 58
Interview with Janice M. Long
Conducted by Thomas A. Scott
Edited by Susan F. Batungbacal; indexed by Thomas A. Scott
Wednesday, 6 December 2006
Location: CIE/CETL House, Kennesaw State University

TS: Janice, let's just begin, as we do with everybody, by talking a little bit about your background, where you were born, where you grew up, where you went to school and things like that.

JL: I was born in central Texas, Temple, Texas, a Texan by birth. I grew up there and went to the public school system there, graduated from Temple High School. The big hospital on the hill was in view of me all the way through my life, and that was the Scott and White Hospital. I knew from being very young that I was going to go there to work. I wanted to be a nurse.

TS: Let's see, the Scott and White Hospital is where you actually got your diploma in nursing.

JL: Scott and White Memorial Hospital. I got a diploma in nursing.

TS: So you were looking at that your whole life.

JL: Yes.

TS: How did you know that this was what you wanted to go into?

JL: It's kind of unusual, I guess, but when I was in the second grade there was a girl who was a good friend of mine, and her mother was a nurse, and she came in her uniform—her crisp, white uniform, and talked with my second grade class. I just loved Ms. Stephens. I wanted to be like her, so that's when I first really kind of thought about nursing. Now my mother would tell me I was always a caretaker—I was always trying to take care of everybody. So I may have been born with some inclination of being a caregiver of some sort. But Ms. Stephens definitely spurred me to understand what a nurse was and to want to be a nurse, and that was just second grade.

TS: I was going to say, it's unusual that you know what your future is at that young of an age.

JL: Yes, I latched on to it and I held on to it. That was all I ever wanted to do. I just kind of knew.

TS: Did you work in the hospital along the way?

JL: Yes. I worked my first year in college—you had to be eighteen years of age to work in the hospital—so as soon as I was able to get a job, I got a job as a desk clerk. In fact it paid my bills to get through junior college, which met the core that I needed to get into nursing school. I think I had $80.00. I mean, back then, you know, it was a long time ago, I had $80.00 as a gift for a graduation, and that took care of my first semester, and then my work at Scott and White, as a desk clerk, paid for the rest of my tuition.

TS: What was the junior college?

JL: Temple Junior College. I think it's now called Temple College, but it was Temple Junior College at the time.

TS: Is that a public or a private college?

JL: It was a public college.

TS: So you got an associate degree from there?

JL: I didn't get a degree from Temple.

TS: You just took the courses?

JL: Yes, I just took the courses I needed to get into Scott and White.

TS: What year did you start there?

JL: I started in '66.

TS: And that's when you were eighteen years old and you started right out of high school.

JL: Right. I could walk to the campus from my house [laughter].

TS: That's convenient!

JL: It was very convenient. It was a small town.

TS: And then how big a hospital was Scott and White? For a small town it couldn't have been too big.

JL: It was about a 150-bed hospital. It was large for that town. It was kind of considered a center of health for the central Texas region. Waco was thirty-five miles away. That's nothing here, but there it was a big thing. So anyone who lived in any of the surrounding counties came to Scott and White. It became

known as an international hospital, and we had folks from other countries coming there because of the diagnosticians. It was often called the "Little Mayo of the South" because they mostly hired Mayo docs and it was a teaching institution.

TS: Lucky for you to have such a prestigious hospital right next door.

JL: It was wonderful. I loved it. I felt like I was in heaven the minute I walked in there to be a ward clerk [laughter]! I learned from some of the best the ropes of care, the logistics of labs and doctor's orders and things like that from working right there with the nurses and doctors. It really did help me in nursing school.

TS: I would think so. Now you got a diploma in nursing. How does that differ from getting a bachelor's or is it the same as getting a bachelor's?

JL: No, it's not. It's a degree that is very functional in that you're in the hospital working the whole time. The first six months we were in the classroom, but beyond the first six months we were on the floors working constantly. We would pick up shifts. We pretty much ran the hospital on weekends and nights, the students did. There was always a registered nurse there, but we were the caregivers, and they counted on student labor very heavily. It was a good thing. It was a great experience.

TS: Right. So what would be your title when you graduated from there?

JL: I was a registered nurse.

TS: Okay, a registered nurse.

JL: The Associate Degree program began in our area about the time that I graduated from Scott and White. But Scott and White went on to partner with Mary Hardin-Baylor University which was in Belton, Texas, about eight miles from town.

TS: Mary Hardin-Baylor, is that different than Baylor University?

JL: Yes, yes it is. It was a woman's college originally. Mary Hardin-Baylor, I guess, was her name. I don't know the whole story of the background of the college, but they wanted to have a bachelor's degree in nursing and wanted to develop it. Scott andand White had wanted their diploma program to go on to be bachelor's, so a lot of the faculty who were teaching in the school of nursing then at Scott and White, the diploma program, went on to be the faculty at Mary Hardin-Baylor. I was the next to the last class to graduate from the diploma program before it went to be a bachelor's program.

TS: I was just thinking, in terms of the associate, that Kennesaw's nursing program started in '68 or '69, so I didn't realize that that was kind of a new thing at that time.

JL: It was in our area. I'm not sure how it came to be around the country, but in our area associate degrees—we didn't have one in central Texas until, the early '70s in Killeen, Texas a junior college put one in. There the students just came in, they did some core courses and they went straight into a two-year, and they were finished in two-years. For the Diploma program at Scott and White Hospital, I had a one-year prep time to get into nursing and then started in September of '67. We went straight through, summers and all, and we finished in '69. But it would be similar to Baptist's diploma program here.

TS: Georgia Baptist Hospital?

JL: Yes, they had a diploma program. They were pretty popular because they helped staff hospitals with these programs.

TS: Well, it looks like you ought to know your stuff after two years straight on the floor.

JL: You didn't come out of school with anything you hadn't done. You had all the skills down. It wasn't something you just learned in the lab; you did it all. We also were in class Monday through Friday mornings for the full two weeks. During the first six months it was all day, then the clinicals began and we worked on the floors as students. That was the good side of it. Now, we didn't have all the core courses that a bachelor's degree would have, so we didn't take a lot of theory, we didn't have community health.

TS: And that's one of your main areas.

JL: Exactly. I had to go on to get that.

TS: So you get through in '69; any mentors along the way? You mentioned Mrs. Stephens earlier, but any other mentors along the way?

JL: In the nurse's school it was Dr. Gallman. She was my very first clinical instructor.

TS: Do you know what her first name is?

JL: LaVerne, LaVerne Gallman.

TS: Was she a doctor, MD, or nursing . . . .

JL: She was Ms. Gallman at that time, I think. I think she went on to get her Ph.D. shortly after I graduated because she was teaching at the University of Texas in Austin in the nursing program, and she finished her doctorate there. She was the most incredible instructor, the kindest, most engaging person. If I said I want to

be like anyone it would be like Dr. Gallman in terms of the way I practice. She was just a consummate professional. She read and studied. There were many things that she admittedly did not know and was quick to find ways to help us find that information.

TS: Has she been a role model for your teaching?

JL: Yes.

TS: You got through in ’69 and then there’s a huge time gap between ’69 and ’95 when you got your master’s.

JL: I was in school almost all the time. I wanted my bachelor’s degree, and so I heard that Mary Hardin-Baylor had one, and that was the next step. All I knew really initially was that I wanted to be a nurse, and the program that was in my hometown was a diploma program, and that’s all I knew. So I didn’t do a lot of investigating because it was in my backyard.

TS: Sure.

JL: So when I heard then that there was this higher level, I wanted to get it. But at that point I was already married and had children, and so I just kept every year taking a course. So I would take one course a year just to keep myself moving forward with all the humanities. I loved literature, and I loved history, so I got all those things done. Computers were coming down the pike, and I wanted to learn that, so one year I just took courses in computers to understand how to use them better, how to type better, do all the things I would need to do. I wrote a paper, at least, one paper in that time, trying to press myself to be a better writer and think methodically. It was a terrible paper, it was horrible!

TS: At least it was a paper! So did you get a bachelor’s degree somewhere along the line?

JL: No. Actually in ’93 when I had finished all the core courses, we moved to Georgia. In Georgia I was going to go to Georgia State [University] and get my bachelor’s degree at Georgia State because I’d had all the core. They were going to make me retake a lot of things that I had already taken because you have to have so many hours to get it. They told me because of my experience and because of my work, the publications I had done—I would probably be a better candidate for the RN to MSN program. So I came back to Kennesaw and took a course in management that I needed and one in organizational behavior.

TS: At Kennesaw?

JL: At Kennesaw. Those were the only two things I needed to get into Georgia State’s MSN program. So it was a nice fit. Eighteen months later I finished with

my master's. I was closer to a master's degree with my course of studies that I had been doing over the years than I was to a bachelor's. It didn't make a lot of sense and it's hard to explain, but . . . .

TS: No, that makes perfect sense.

JL: Several people have those programs. Emory has a program like that, an RN to MN programs. But it only takes people who have met most of the core and who have had over ten years experience.

TS: Did you stay at Scott and White hospital all that time before you came to Georgia?

JL: I stayed at Scott and White most of the time. I went to the VA hospital—I had opened the first renal clinic at Scott and White—renal dialysis clinic. In 1973 there was a lot of talk about people having renal disease and not being able to be dialyzed and people dying from renal disease. So there was a movement to submit at least to Medicare or to the government to seek funding for people who had end-stage renal disease because of the cost of the treatment was so high. I had been working in ICU and doing dialysis, just the peritoneal, and I knew all the nephrologists. So when they wanted to open a unit they asked me if I would open up this unit and learn how to do dialysis. I didn't know anything other than what I had seen, and it was very intriguing because it was my hardest subject to learn. I guess I asked the most questions of any of the nurses who worked there. So I started studying and went to Austin and saw how they were doing dialysis there and met Dr. Jack Moncrief. He actually taught me how to do dialysis. He's pretty famous in dialysis. He had a partner, Dr. [Robert] Popovich—I didn't get to meet Dr. Popovich. They went on to develop this CAPD [Continuous Ambulatory Peritoneal Dialysis] program with Travenol, which is now Baxter [International, Inc., Deerfield, Illinois]. Those are all renal treatment areas. I have a certificate later that was signed by Dr. Moncrief as being trained in CAPD. I saw the first hemodialysis. I trained with him. I went to Breckenridge Hospital to do that, but it was with his program, and he was the main person. I worked with him and his nurse to learn the procedures. Then I came back, set that up at Scott and White, the program with the technician there, and later went to the VA and did the same thing at the VA. I worked at the VA for about two years. It was a little bit better pay!

TS: So that became your specialty then, I guess.

JL: Yes. I set the CAPD program at Scott and White and the VA, where we train people to do peritoneal dialysis. This is really my first home community care. I train people to do hemodialysis, to do peritoneal dialysis. I work with the families and the individuals. I think that particular area of experience is where I grew to understand that we don't give care to people. We give care with people. So we work with people, not doing something to them. If we don't have that

collaboration with the individual and the family, with the patient becoming our partner, really, we don't have as good an outcome because if they don't get it, it doesn't happen after they go home. I saw my work and my life's passion shift from being a procedure oriented, skill-oriented expert nurse to being someone who educated, worked with others to learn what they needed to know to protect their own health, to promote their own health and to provide care in their home setting.

TS: It sounds like a very time-consuming thing that maybe a lot of hospitals don't do because they've got too many patients and they're too busy.

JL: It's very time-consuming.

TS: Did you just kind of develop this on your own or was there a model for what you were doing? How did you get into this?

JL: There really wasn't a model at the time. I found one book that some nurse had written. It was kind of a rough copy of a booklet that a nurse had written on dialysis. It was a very informal booklet, but it was a beginning. But mostly I used medical nephrology texts and what I recalled from my teaching time with Dr. Moncrief and his group and the time in ICU watching the MD's because the MD's did it all before. So first we opened a three-bed hemodialysis unit, and that was in 1973, and we went on to provide acute dialysis in the hospital. So I dragged this big tub across the street. It was 120-liter tank that had a little side unit on it, which you'd put a coil in. Now, nobody would use a coil any more, but the coils were the first way that we performed hemodialysis. We'd take this big tank across the street to the hospital from where we were situated with our new unit that I opened. If a patient was in ICU, then we'd go in, and if they were in acute renal failure, we could go in and do their dialysis for them there. Before I started doing it at the hospital, it was only the doctors that could do it, so I was the first nurse that was trained right there in Temple, Texas, to do that procedure. But the resources weren't many. I learned about—it was an early kind of group of people who were in the same kind of throes that I was in learning that got to know each other and network across the country. So I met people from Washington that talked over the phone. Austin, Texas, had someone that I could always call and get them when I did training there. Waco hadn't started at the time, but I had folks in Houston and Galveston. So I went to Houston, I went to Methodist [Hospital System] and Methodist was doing some work. I went over to Ben Taub [General Hospital]. They were doing it with children in Houston, and then I went to Galveston and saw the Galveston units. I actually worked down in the Galveston units at the Galveston VA for two weeks to get better trained. The training, literally, was trial and error. A study came out that we could reuse the dialyzers because they were so expensive, these coils. So I did a lot of research in the literature. The docs came to me and said, "Let's try this." Before I started doing it I got the literature search and understood it a little bit better. We were storing our dialyzers in brine. We would create this big tub of distilled water and

dump salt in it until it was a super-saturated solution. Then the coil itself would be filled with distilled water, which would cause an osmotic pull and diffusive pull of the salt into the area where the blood would go and keep it free of infection because there were infections and we abandoned that pretty early.

TS: But the coil, you were just using one at a time before then because it could pass a disease on to a different person?

JL: Right. Well, it was only used for one person. We didn't use it on different people. Say, if you came in, and you had acute renal failure, and you didn't have any insurance. We were getting funded—the law HR1, that's the law that passed it. I know there are a lot of HR's every year, but this was 1973. That law was passed and it provided funding, but it didn't provide a lot of funding. But it got us started so somebody could get dialysis. So we were trying to figure out how we could keep this program going and not lose everything and not lose the program. There were modifications, and the end stage of renal disease regulations went on to pay better. Then it paid at cost. Whatever we billed we got, so it was pretty expensive to the Medicare system.

TS: And the coil was very expensive, I gather?

JL: It was the most expensive part of what we did.

TS: So if you could use it many times on the same patient you could save a lot of money.

JL: Yes. Now there were a lot of problems with those coils. They could rupture in a heartbeat. The blood would be going through them at about 300 cc's a minute. That's not quite a pint, but that's pretty fast movement. If one of those membranes—they were cuprophane was the name of the membrane—it's in the cellulose, cellophane family, but it's very permeable, semi-permeable, and it didn't allow the size of molecules that blood are to go through, but it would let the small molecules go through. But the membrane—we didn't know a lot about it, never had been reused before—but the membrane was sensitive enough that when it had been used a lot of time and you had a lot of high pressure going through that, so the blood was going through it very fast and there'd be a lot in it then it could break. With the size of those membranes, those coils, if one broke we'd have blood all over the ceiling and everywhere. It really made nurses—we would say in order to work in dialysis you had to be fast on your feet, quick draw on your clamps, and be able to swim because we had floods periodically with all the water we used! It was a 120-liter tank, so it would sometimes leak.

TS: Wow. Just doing my math real quick it looks like you were only about 25 years old when you were on the cutting edge of all of this, which is remarkable.

JL: I seemed to be in the right place at the right time. I think a lot of people at that time didn't want to do something different. They were afraid to do something that would—maybe they'd go do it for a while and then they'd be taken away if it didn't work out. But it was so exciting, so new, and it just was so challenging, I felt like I just had to do it. They gave me the opportunity, and I was just really impressed that they thought I could do it. It was a real compliment to me that they would ask me. I couldn't have said no [laughter]!

TS: So you were kind of in on the ground floor in the early '70s, and you continued to work in that same area for the next several decades then.

JL: For thirty years, really, I spent working in renal. I moved through the specialty from direct care delivery to teaching people to do home dialysis. As time went on, reimbursements were reduced and clinics had to be tighter and tighter and tighter about how they managed the clinics. So instead of having this hospital having a chronic unit and this hospital having a chronic outpatient unit and that one, there became centers of large chronic units. So Temple might have one or two, Scott and White maintained theirs. But you really had to partner, and it came about that over time the large corporations like BMA, BioMedical Applications, was probably the first big organization that I'm aware of. Then there were others that followed: Fresenius [AG, Bad Homburg, Germany], and there were many others that followed, Gambro [AB, Stockholm, Sweden]. Fresenius is still very active and very strong. BMA is not. I think BMA sold all theirs out to Fresenius. But there are a number of Fresenius clinics around nowadays. There wound up to be just a few.

TS: So when you train somebody to do it at home, they take all the equipment to their houses?

JL: I taught them to do hemo at home. About 1 percent of patients who are on end-stage renal disease treatment are at home. It's a pretty small number, but when you think about how many people are on dialysis, it's a pretty high number. I think at Scott and White I trained about twenty-five people to be on home hemodialysis in different places around the metro area that I would travel.

TS: I bet they were very grateful to be able to do it at home.

JL: We would go out to their homes and watch the first treatment at home, and then always we had a person on call. It was me most of the time at first, and then we hired other people to work with me as the program grew. I trained other people to do it.

TS: I would think after all those decades you're probably running the program by the time you left Texas.

JL: Yes, I did. I left Texas to go to Louisiana to open their CAPD program. The doctor who was working with me at Scott and White was moving to Louisiana with a new partner out there, and he wanted to open a CAPD program out there. So he called me up and asked me if I'd think about moving; and, of course, I was always looking for something fun and different to do.

TS: What part of Louisiana?

JL: Shreveport.

TS: Okay. What year would that have been?

JL: That was in '78.

TS: Relatively early.

JL: I opened their CAPD program and set it up, and we started the program there. It became a very active program. Dr. Steve Youngberg was the doctor that moved there and then Dr. Sheldon Kottle. I only stayed there a year. I got them all set up, but I had gone through some life changes and been divorced. There, I met my husband, who was my husband twenty-three years. He only died a few years ago.

TS: What was his name?

JL: Jay Long.

TS: So you met him in Shreveport.

JL: I met him there. He was actually one of the administrators. He was one in the national office who would come down periodically to see them for the company that managed, basically, the books. Apparently, we had been at a meeting together in 1973, and I didn't know it. I had been at the Little Rock conference and he said, "Oh, I was in Little Rock." But I met Jay there. His aunt was working in the office. Actually, the reason I met him was because his aunt was working in the office and she kept saying, "You need to meet him, you need to meet Jay."

TS: Nice to have matchmakers [laughter]!

JL: Yes.

TS: Okay. So you only spent a year there, and then did you go back to Texas?

JL: Well, no, when Jay and I got married, when he asked me to marry him, first he said he had a unit out in Georgia that he said he wanted me to come out here and open the Douglas unit. It sounded pretty exciting because it would be opening a

brand new unit. He flew me out here. I met Dr. Luchana Chaya and some of the other doctors. He had the first clinic in Marietta that he later sold to BMA. He had that clinic, his company did, and they had several here. But anyway, he flew me out here to talk to the folks about opening this clinic, and I guess by this time we were getting to know each other better, and the CAPD program was going. I'd already trained somebody to run it in Shreveport, so he wanted me to open this one and do the same thing here. So I moved to Georgia.

TS: That would have been '79?

JL: That was '79. I moved to Georgia, lock, stock, and barrel, my little kids, and my sister came with me.

TS: What part?

JL: We moved to Douglasville. The clinic was in Douglas, and we found a house to rent and brought everything out here and rented a little house. It was kind of exciting coming this far away from home. I never had been [laughter]! Of course, then I went on to move to D.C. a little time later.

TS: To D.C.? What year was that?

JL: That would be '80. We got married in '79, and I stayed out here and worked for awhile, and I think the comment he had, right before we got married was, "It's easier for me to find a nurse than it is a wife! How about being my wife?" His aunt had been working on us so long, so we got married, and then I moved to D.C. I worked here, but I never did open the clinic. So that's when he said, "I can find somebody to open that clinic."

TS: So you went where he was.

JL: I went where he was. It was actually in Maryland, Waldorf, Maryland.

TS: Right outside.

JL: Out of D.C. I worked in D.C. though. I got a job at Greater Southeast [Community] Hospital. I did some work for him just going down to his units and somebody opening up a new CAPD program or setting up a new unit, I'd go help them out. I became very good with the regulations and understanding the regulations, so I was kind of handy for different clinics. People would periodically call me to see if I could help out if they had a problem with passing the state surveys or inspections. Then I'd go and problem shoot for them and set up a plan for what they needed to do. At Greater Southeast they had a dialysis program, but it had been run by a physician, and they wanted to move it under a hospital and make it part of their critical care. So I set it up under Critical Care at Greater Southeast Hospital. They had some of the best training I've ever had in

my life. They really mentored me. Joann Duffy was probably the most influential person there. She is now Dr. Joann Duffy. She was in school then, studying. She was the manager of critical care, nurse manager. She was a hands-on manager, she was in there with you, but more importantly the hospital considered itself to be career builders—they were well-known for that, Greater Southeast. They would have us attend all these conferences and attend sessions. We had to be active and really be responsible for our budget and everything, but they had us really working on developing ourselves as leaders, not just as managers. It was more about motivating, moving people, finding common ground. It was excellent, excellent training. And Joann Duffy had this thing that she did with the nurse managers over the critical care. She had this monkey; you had to wear it on your shoulder if you had taken somebody's monkey. Well, the thing was, if I had someone working in my department, and they came to me and said, "Janice, I've got this problem," and then I went and fixed this problem for them because that was the way I tended to operate: "Oh yes, I can solve that. Sure, let me fix that." She would make me wear the monkey all week. Then you're embarrassed around your peers if you've taken somebody else's monkey, and that was considered taking a monkey.

TS: That's a good teaching strategy.

JL: She trained us to be good delegators. "Tell me about what you're doing. How you're going to solve that problem, let me know how you did, you know, I'm interested in your problem," just great, wonderful.

TS: So you, basically, tell them how to learn how to do it themselves.

JL: So you really build a bunch of self-empowered people, and their confidence grows, and they become, later, better leaders for having worked with you. So I guess I was in a middle management position, but I really feel like I developed more managerial skills than I had ever had, even though I had done management.

TS: So do you stay in Washington . . . .

JL: Six years. My husband needed to move here to oversee some of his clinics here better. When I came here I felt like the area I didn't have the most experience in, in all the renal experience I had, was in transplant, and I really wanted that. St. Joe's [Saint Joseph's Hospital] was opening a new transplant program, so I went there and interviewed, and I got on board. I worked for a year, and they were going to have the transplant program, and I wanted to do it so bad, and then they didn't get approval to do it right away. I guess I could have gone to Emory [Healthcare], but I had an opportunity. Someone called me. They heard I was going to be leaving St. Joe's and—I could have stayed and done acute, but I'd gone there to do transplant and wanted that experience. They were opening—they needed a nurse administrator over the Northside facilities, and that was over a unit that had 200-something patients. It was huge, and it was a step up for me, it

looked right. I felt prepared as a leader, I felt like I could do it. There, I really learned "AR/AP" business management and at the same time, remember I'm building my arsenal of knowledge from my ongoing school at every place I'd been.

TS: Right. Was St. Joe's already out at the Perimeter by that time?

JL: Yes. Right across the street from Northside [Hospital].

TS: My wife's been doing some research on St. Joe's when it was down right on Peachtree Street.

JL: The person at St. Joe's that was most influential over me was Dr. Susan Hill. She is just phenomenal. She's a nephrologist—she's the first nephrologist I worked with that I felt was my peer. The first time I felt the doctor was my peer. I always felt that they somehow were superior to me.

TS: Up on Mt. Olympus, or whatever.

JL: Yes. I think she helped me feel that, and maybe she wanted me to feel that; I don't know. But she is the most engaging, cared about what my opinion was, [and] recognized that my years of experience meant a whole lot. While I may not have always made the best decisions in things we discussed, most of the time I was pretty close to "on" and that brought some reinforcement back to me, too. I think that helped me grow in my confidence, which is an area on which I think I needed to work.

TS: So you did that for several years and then was it about '93, that you enrolled in Georgia State?

JL: Yes, And I was at Northside as an administrator at that time. The time at St. Joe's, I was going to Kennesaw doing some of the work at Kennesaw.

TS: Where were you all living at that time?

JL: In Marietta.

TS: Okay, so Kennesaw was convenient then.

JL: Oh, yes.

TS: All right. It makes sense to take those business courses, I guess, given what you were doing.

JL: Yes. It was perfect timing. I needed it really.

TS: You're obviously doing teaching all along at least in the hospitals, themselves.

JL: And a lot of teaching with the different colleges in the different areas where I worked. Now, I didn't so much after I came to Marietta until probably I was at WellStar [Health System], and that was after my master's degree. Then I came and taught the Critical Care course here, the renal part, with Dr. Vanice [W.] Roberts. Then also I would come and do the renal lectures for the different baccalaureate degree student courses.

TS: I was going to ask you how you got to Kennesaw as a faculty member. Let's see, it's '95 that you got your master's, and I guess it's an MSN degree from Georgia State, Master of Science in Nursing, and so after that is when you're teaching part-time here?

JL: Right. They would call me and say, could I do the renal lecture, and I always loved to teach, so I came and did that.

TS: The renal lecture?

JL: The renal lecture. So I would only come and do a class.

TS: For Dr. Roberts?

JL: Yes. Dr. Roberts, then for Dr. [Janice B.] Flynn, Dr. [Jane D.] Brannan, different things that they were teaching, but for Dr. Roberts I taught in her continuing ed. course, the critical care course. I did the acute renal failure and the chronic renal failure lectures, I think those were two or three sessions, I forget.

TS: When did you start working for WellStar?

JL: In '96.

TS: So the year after your master's. Was that at Kennestone?

JL: I came on board as the clinical nurse specialist to develop their disease management. They were trying to do the development as discretely and easily as possible to not rock anybody's boat. They wanted to do it in a way that we could do a lot of research, do a lot of planning, get our material together and ready to go, get our physicians on board, and then present it to all the workers and all the people who are part of the WellStar Health System. So while I was hired into the medical management division I was first given the childhood asthma project to develop, pediatric asthma.

TS: So you're working in all of the WellStar hospitals then?

JL: Right, five hospitals, all the physician offices, all the acute care centers and the long term care facilities.

TS: Where was your office?

JL: At the main campus. First, when it was called Promina Health System, we were over by Cobb Hospital in an administrative office over there. It was where the head of the Promina organization had his office. Then they built the big center down on Sandy Plains, the big administrative center, and then moved us all down there. So disease management, medical management, all went to the administration building, and we worked from there. I'd get pediatric asthma, and then that program turned out to be pretty successful, and I built the adult asthma program. I was assigned a chronic disease to work on and I facilitated a task force and worked with developing the program.

TS: What was that first one?

JL: Pediatric asthma, then adult asthma. Then from the adult asthma it was just kind of the next step, we did COPD, which is chronic obstructive pulmonary disease. I facilitated the task forces that developed these projects and managed the outcome data from that. I coordinated the education session for the health system, getting physicians up to speed with what best practices were in these particular areas. I was learning the lingo and learning all of that myself, too, which was very positive. Then when the school health project came along and needed to be done, because I had done the ped.'s asthma and had worked there, they asked if I would consider working with Dr. Gloria [A.] Taylor, who was from Kennesaw State University. So Gloria, then I would have to say, was my next greatest mentor, and she may not even know that! I'll have to tell her, actually. She and I worked very, very closely on the school health project. She was just remarkable. I was the medical management person assigned to the school health project, and we worked with all the public schools in Cobb, Douglas, Paulding, and Cherokee County. I think those are the main ones that we targeted. We wrote a book, and I facilitated the task force that did that. She oversaw the nurses and was the KSU contact. So the two of us—me inside WellStar and her inside KSU—really moved that school health project forward. There were wonderful collaborations from the community and great opportunities for health promotion and disease prevention in the community, for a large community. Gloria was wonderful to work with. She was working on her doctorate, so I got the bug to want to get my doctorate from Gloria. She still is a mentor to me, I can tell you!

TS: Great. So what makes you decide that you're going to teach full-time at Kennesaw after doing all these great things already?

JL: After the school health project I began working with the diabetes project. Let me tell you why I got diabetes, because I had been working in renal for so long and looking at people, the reasons they came to renal was to get dialysis. I had come

to understand in 40 percent of them—it had been 20 percent in 1970, and by 1993 it was 40 percent—were there because they had diabetes. There was another 35 percent there because they had hypertension. Diabetes and hypertension are just liked married. They go together. I felt like somebody needs to be working on preventing renal disease rather than all of us in the renal specialty area working on preventing complications of end-stage renal disease. So I talked to the professional organization that I was a member of, and I said, "We ought to have a special interest group for preventing end-stage renal disease." At that time they weren't ready to talk about that; they didn't think that was so important.

TS: Okay. A special . . . .

JL: Interest group. We had a special interest group for hemodialysis, we had a special interest group for peritoneal dialysis, we had one for transplantation and we had one for conservative management, but we didn't have one. I was the regional representative for the hemodialysis special interest group and served several roles in those special interest groups, but I wanted to do one on prevention and nobody was quite interested in it. That's really the thing that sent me to WellStar to work in disease management. And I went there wanting to do diabetes, and they weren't ready to do diabetes. They said that wouldn't come first. So when the opportunity came along that there was a need for a diabetes one, I asked, "Please let me do it." They felt like my hands were full and I didn't have the time, but I really, really wanted to do it, so they let me work with diabetes. So I established the diabetes program there. We did education for patients. We did education for providers. We did the whole thing plus a case management program.

TS: When you say a special interest group, does that mean a group of professionals that want to give voice to the needs inside the WellStar System?

JL: That was inside the professional organization for nephrology nurses. We had people from all over the country who would be involved in it. I'm in this region, they're in that region; we're in different regions and we're trying to get policy issues, we're trying to look at everything. I really didn't find my heart and soul there any more. I really felt like I started in nursing because I was just a baby, and there was something that drew me to it that made me feel like it's more of a calling than it is just a choice to make money. When things occur to me in the course of my experience, I feel like I need to move on them. So I started to working with diabetes, and we just did a wonderful job in developing it, and the team was awesome. And here again, I'm not saying I developed—when I say, "I developed," I facilitated a team that developed it, and it was awesome. We got certification by the ADA [American Diabetes Association], recognition for our physician providers, it was wonderful. WellStar is well known for that. But I looked at all the outcome data for all of these projects, and as I watched the populations and did my reports on who gets referred where and who are we seeing and why isn't this group getting in and why are the numbers so high here—the ER is high, but the office visits are not. The referral to education is low for Latinos,

but the ER visits for diabetes-related diagnoses is high for Latinos. Why are they not going to education? Because if we can teach them—all of these other people that we're teaching are doing well, we're having great outcomes—but we're not getting the people who are hitting the ER.

TS: Do they not have any money or insurance?

JL: We often did not receive payment for services provided so we had to "write off" the amount and take a loss as there was no reimbursement.

TS: So are they just waiting until it's just an absolute emergency?

JL: Don't know, we didn't know. I really wanted to do research, so I could understand it. I wanted to ask the questions and be able to do the research and look and find out. My need to learn, myself, was strong, but my need to want to serve a population that was not getting care was even stronger. So my personal "guiding missile" here that takes me through my career, pushed me in the direction of wanting to do that—Dr. David [N.] Bennett had been on my task force for school health, he had been on the task force for diabetes and all of them. So I talked to him. He said, "Well, we've got some positions open; why don't you come up and interview?" One of my girlfriends was coming up to interview as well. I wanted to go get my doctorate and filled out the application for it. So she said, "You go to interview with me at KSU, and I'll go with you to get a doctorate." So Trish Hart—who is now Dr. Trish [Patricia L.] Hart—and I started at Georgia State at the same time in 2003, spring. We started at KSU together in 2002, August. So we kind of did the same. She stayed a year and left KSU and went back to WellStar. I stayed a semester at Georgia State and left and went to Western Michigan University [College of Health and Human Services, Department of Interdisciplinary Health Studies (I.H.S.) Ph.D. program] for my doctorate. So that's the irony of our little switching out.

TS: Western Michigan?

JL: Yes. I'm getting my doctorate from Western Michigan. And there was madness in that too, I tell you. Their program is interdisciplinary, and everything you do in disease management, everything I've done in developing programs in communities, a nurse can't do it by herself; a doctor can't do it by himself. It really takes this community collaboration of different agencies, different specialties, and you have to come to understand those people's specialties before you really can collaborate because you still kind of do silos. I wanted it very much, so that's why I switched from a nursing Ph.D. to an interdisciplinary health studies Ph.D. But I came to KSU because David Bennett talked to me about coming and working here, Trish Hart talked to me about it, and I wanted my doctorate, and I'd been an educator always. I'd already been doing it. I guess I'm an educator at heart.

TS: Well, you'd been teaching and you'd also been doing research.

JL: Yes.

TS: By the way, what did you find when you did the study of why the Latinos were going to the emergency room, but not to the clinics?

JL: They hadn't heard about it.

TS: They hadn't heard?

JL: They hadn't heard about it. Nobody had told them. The doctors didn't refer them to it. They weren't getting referred. A lot of them, when they went to the ER it didn't come up.

TS: So the ER doctors either didn't care or were just treating one after another?

JL: They're so busy, and they can't do it all. They're doing a wonderful job at what they're doing, but there's no point that education becomes an important part, or "Did you know there's a diabetes program here?" The flyers that we put out, we put out in English. We had some printed in Spanish, but they weren't everywhere, and they weren't real easy to see. So part of it was the way we communicated. I was trying to find, how do we do something that changes it? How do I make a difference, and that's how Project IDEAL [Initiative for Diabetes Education Advancement of Latinos] came to be.

TS: Did Project IDEAL start before you started teaching at Kennesaw or after?

JL: No, at the same time, really. The first day I came here to work I was on the phone with Robert Wood Johnson [Foundation] trying to get a grant to fund the research, and I had it in my mind what I wanted to do. Trish Hart had managed the case managers and all the day to day operations of the projects that I did at WellStar, so she knew how it operated, and she knew it inside and out. She was onboard with me to do it. So she and I wrote that first grant application to Healthcare Georgia [Foundation]. We didn't fit with Robert Wood Johnson. We couldn't use that one, but Genie [B. Regina] Dorman and David Bennett and Richard [L.] Sowell told us about Healthcare Georgia, and they said, "You need to put your application in with them." So we wrote a letter of intent—actually Genie Dorman helped us draft the first draft of it, and Dr. Bennett and Dr. Dorman were very active in helping us get it started. So Trish and I—Dr. Carol [S.] Holtz helped us—and we wrote the first letter of intent, got that out. That got picked up pretty quickly, and on December 23 they asked us for a full proposal on January the fifth.

TS: There went your Christmas break.

JL: Christmas, 2002, I wrote a grant with Trish Hart, and we pretty much did it all.

TS: How big a grant was it?

JL: It was $200,000.00. We were funded, I found out in March. I was in shock because I'd written grants before and didn't get funded! That was dreamy!

TS: So then you had to administer the grant.

JL: Yes. And that's when Trish decided to leave and go back to WellStar, and so it left me to run it and administer it. About that time my husband died, so it was a pretty difficult time. But the support of the college was amazing. Richard Sowell, David Bennett, Carol Holtz, Annette [L.] Bairan—I'd come to know Annette and Carol, I'd come to know quite a bit of faculty, and they were all great, but I felt like Carol was a perfect fit to be the person who was going to help me do this because I can't do this by myself. I really knew I needed somebody who knew the system here. Carol Holtz was doing her work with Latinos, [and] she was Spanish-speaking. Annette Bairan, a sociologist, really understood people, and was a nurse and a nurse practitioner and active on the IRB [Institutional Review Board]. So I thought about them and talked to both of them and they were open. I talked to Richard and he thought it was a good idea, and David Bennett, so that's how it happened.

TS: I've also got an interview with Annette Bairan. I didn't mention her earlier.

JL: Oh, she's awesome. She's an amazing woman. I send her an e-mail wanting something, a question about IRB, and just like that I get it back. Phenomenal.

TS: Okay. So you've got a $200,000.00 grant and I hope it gave you some release time to do something.

JL: Well, it didn't during the year, but they gave me a reasonably lighter load that first spring because I was going to school. So I taught in Community Health and I took clinical students. Gloria Taylor helped me learn to be a better teacher, and I learned a lot from her. All the different faculty would let me come and sit in their class, too, when I first came. I sat in Dr. [Christina] Horne's class. I really learned a lot watching her teach. I learned a little bit from the different faculty that I watched teach. Teaching one-on-one with individuals, teaching to families, teaching to communities and people that are paid by the organization that you work for, is different than paying students who pay you to teach them. It's a very, very different thing. It took me off-guard for a while that these people, they weren't altogether appreciative of everything I said [laughter]. It took me a little while to learn how to relate to the students, the young learners—most of them were very young learners. I'm still learning, and I think I'll probably be learning forever, new things about how to teach. I hope I do.

TS: I guess we all will. So it was a very different type of teaching, and you had to grade, too [laughter]. So you're doing that and you're teaching Community Health, anything else that you were teaching?

JL: I think I'm a good clinical person, so I taught complex health, and that includes renal disease, which is a good thing. I've taught leadership; I'll be teaching leadership again. I loved teaching leadership and I've learned a lot from Dr. Mary Ann Camann in that course and Dr. Jan Flynn in the other course. I had so many mentors here I could probably just name all the faculty because I've learned something from all of them.

TS: Well, you were in a very fortunate situation that you knew the faculty before you came here, too, and they knew you.

JL: Yes, I did, I knew quite a few. So that was really awesome. We also taught, I can't remember, I taught several other courses, but I think those are the main ones.

TS: So you get this grant, and then you've got to find people to help you do the grant. What exactly did they fund? What was the $200,000.00 supposed to go to?

JL: It was to fund the development of a program initiative for diabetes education for Latinos. Now, we wanted to understand what made people not come or come to an educational program. We wanted to understand what modifications or alterations needed to be made in teaching materials or programs to reach various sub-ethnic groups. It's very different teaching a Mexican population than it is teaching a Colombian population, so we broke it into four groups to narrow it down a little bit. There was a huge population of Mexican-Americans here. There's also a very large population of Colombians in school here, so we thought that's another group that we should use as a target, Colombian-American. Puerto Ricans are very large. They presented a little bit of a different view because they're citizens and might have different issues compared to Mexican-Americans, who might be less likely to be insured. Puerto Ricans have higher likelihood to have benefits that a citizen would have. Not to say that our Mexican-Americans weren't all citizens because we really don't ask, so we think there are a lot who are because we know they work and have been here many, many years. Then the final group that we wanted to look and consider was really brought about because of Dr. [Alan V.] LeBaron's work here, and that was the Maya. There is a huge population of Maya here—nobody really knows much about the health conditions or concerns or issues that they face—their languages are so varied. We felt that because of the high population we would like to understand is there a high risk for diabetes in this group, and so do we need to modify our work and materials to accommodate this group? So those four groups was how we targeted it.

TS: So the largest are from Mexico and then Colombia and then Puerto Rico.

JL: Really in that order.

TS: And the Maya were both Guatemala and Mexico, I guess.

JL: Yes, they were combined. But they are uniquely different from just the Mexican-Americans.

TS: Right. Okay, so you have four target groups and your goal is to find out, I guess, what you need to do to get them into educational programs?

JL: Yes. And then we wanted to establish a program and start to educate, start to teach, start to give them the tools they needed to self-manage the disease. And to start a ground swell of education that could be passed on community to community, person to person. Because we believed if we could get a grass-roots effort going that might help change the health behaviors and make for a healthier community overall. So the education classes—we learned so much in that first six-month phase of just learning and understanding. We did focus groups and called other clinics and talked to people who had expertise in working with Latinos to find out what they were doing and what they thought was important, a huge lit review of everything we could find that had been published. Then started in January 2004, the first classes, when we hired Dr. Astrid Rozo-Rivera. If you ask me one person that is the one person now for Project IDEAL, it's Dr. Rozo-Rivera because it's kind of a transition, the front-line work transitioned from me to her. She's Colombian, she's a medical doctor, she's bi-lingual, she's seen as "one of us," instead of a professor. So she and I are just really close in the way we work and communicate. She's my professor of Spanish, and I'm her professor of English!

TS: Have you learned Spanish?

JL: Yes. I've been learning Spanish all my life since I was in high school, but I have learned to be more proficient or more confident in speaking with her. She really has helped me in that way.

TS: So you started classes and who were in the classes to begin with?

JL: Mostly people referred from MUST the first time. We started on the MUST Ministries campus in a little, bitty trailer. We didn't have a place to wash our hands. There were no bathroom facilities, and we shared it with several other groups. So we'd really have to come in and clean before we could start because we'd have the remnants of somebody else's meeting. One time they had the AA in there doing haircuts, so we had to find a vacuum to clean before we could have our patients come in. We outgrew it very quickly and then the Tommy Nobis [Center]—Astrid and I were trying to decide how are we going to come up with a better place to accommodate the size of the groups we were getting. So I went over and just looked through different community agencies and ran across the

Tommy Nobis Center. It was a long shot, but we thought why not, let's just call them.

TS: That's about two or three miles from here, I guess on Bells Ferry [Road, Marietta].

JL: Yes. It's like three minutes from the MUST Ministries. So we went over and talked to Linda Mosher, and she said, "I think this will work for us because we've wanted to outreach to Latinos and we haven't." They made available—that if we had people who were disabled they could get them into computer training, and they had some jobs periodically and could help us with placement of folks who needed jobs. It's just been a wonderful relationship. It was like moving into the Taj Mahal for us. We have water. We have a faucet!

TS: It does look like a nice building over there.

JL: And now we have so many people that come. Tonight is our support group, so we have so many people that come sometimes up to eighty people for these support groups. We start with exercise. Then the next part will be a time with a little bit of education and just to talk about issues, "Does anybody have any issues we need to talk about?" But not only do we have the families and the people with diabetes, but we have the children of the families. So now I play with kids and do my own little kid education with the children, and we do exercise and play music. They are mostly all English speaking except the real little ones. So my challenge right now is to develop some more formal education programs for the children, so that while they're there in our support groups they are doing some fun learning games. It's not my strongest area, but I'm talking to people who know and have that, so it's good.

TS: IDEAL, did that stand for anything in particular? Where did that name come from?

JL: Initiative for Diabetes Educational Advancement for Latinos. It started to be "DEAL" and we were like, "No, that doesn't work, IDEAL works."

TS: Right. Okay, so you're doing classes and support groups. You're doing exercise, you teach them how to deal with diabetes, how to, I guess not prevent if they've already got it but to . . . .

JL: Right, to keep from having the complications of it, though. We really do work hard on that. Dr. Rozo-Rivera has been really great in some of our latest developments. But our focus groups helped us right on the front end to develop ways to teach. Dr. Rozo-Rivera has come up with some really neat mnemonics. We use the hand—first of all, everything we do goes back to the person's hand. She came up with the idea that everybody learns, when they're learning their Spanish, this ma, mi, me, mo, mu thing—we do a, e, i, o, for our vowels and she

said they use, a lot of times with the children, ma, mi, me, mo, mu for vowels. So we took those five components, and they are the mainstay of how we teach. So if I have ten minutes with somebody, I'm going to do my ma, mi, me, mo, mu. We use our hands for the size of the meat serving, we use it for the size of an apple, the amount of rice you can have, just different—we use the hand for the amount of salt you can have. We refer everything to the hand to keep it simple. We use a lot of colors because color is very important to the Latino culture. Green stands for hope, so we use a lot of this very bright green color in a lot of things we do. We always add the green to it.

TS: You brought a . . . .

JL: Yes. These are the placemats we developed to reinforce. We call it "My IDEAL Meal." That's the Spanish version on the other side, and this is the English version.

TS: I better turn to the one I can read then: "My IDEAL Meal."

JL: We are having that actually copyrighted at Kennesaw, so Kennesaw owns it. We have been presenting in different places around the country. A number of folks are wanting to buy our placemats, so we had to go and talk to Flora [B.] Devine and try to formalize how we do it.

TS: About the copyright?

JL: Yes.

TS: So this is just kind of the . . . .

JL: This is the synopsis of what we teach right there. This is the ma, me, mi, mo, mu at the bottom by the hand. Those stand for Spanish words: ma, maintaining a healthy life style.

TS: And me for medications as you need them; mi, measure your meals and plan well; mo, monitor your blood sugar; mu, move and exercise.

JL: Yes, that's right. And the headings make more sense in Spanish. But it helps to do it in English as well. We got involved with the CDC [Centers for Disease Control and Prevention, Atlanta, Georgia] about a year and half ago or two years ago. Dr. [Timothy] Akers knew some folks there, and he got a session for us. I knew the doctor who was over the National Diabetes Education Program. He and I had been in some meetings together and presented together. Dr. Akers knew tons of folks over there, so he said, "Let's go meet them." So we went over and did a presentation for them, and then they came to KSU. They were very impressed with Project IDEAL, and now they are full partners with us in the project for the next phase in the work site.

TS: The CDC?

JL: Yes. And they also fund Dr. Rozo-Rivera's salary now.

TS: Oh. Well, that helps.

JL: Yes. Dr. Rozo-Rivera went to Colorado and presented at their big conference earlier this year, and then I'll be presenting at their big conference next year in February. We're both invited speakers in the CDC conferences now. Really, we're tickled to get that.

TS: Where is the conference in February going to be?

JL: In Atlanta.

TS: Oh, okay, at their headquarters?

JL: No, it's going to be in a hotel downtown, but I'm not sure where. It's February 27, I think, and I'll be presenting our new research, the one that they're partners with us on with the poultry plants. So it's taking IDEAL to a work site.

TS: How many people have come through the program, would you guess?

JL: Oh, my goodness, we've seen probably over 1,000 people between screening and classes. But we have in the database, which we maintain, around 400 people who have been through our education classes. In community settings we see a lot more than that and in our support groups, adding those in. We started out having to call doctors and offices and ER's and really going out—churches, schools, going out and doing screenings, educations in those sessions. Dr. Rozo-Rivera and I were out constantly in those locations trying to tell the message of, "We need to reach Latinos." Now, we just go and they just kept coming. We have a class set up, and I think it's that network of communications, that grass roots communications that occurs in the Latino community that moves things a lot faster than us going and talking. We do have another contact that we just made up at Northside-Cherokee Hospital in Canton, so we'll be going up there and doing some classes up there.

TS: Are you still operating on the original $200,000.00 grant?

JL: No, that money's gone. I think we were finished with that in April of this year. We have an extension on it, received a little bit more from them on it, I think an extra $70,000.00 or $80,000.00 to keep on going, looking at that population longer. Dr. Rozo-Rivera's salary is covered from CDC, but everything else is no longer funded. Our members are helping us do the work inside. We can't do A1C's, but we're doing those through other partner . . . .

TS: Can't do what?

JL: The blood test that measures the blood glucose average over three months. It really is our best outcome indicator that we've used.

TS: What's that called?

JL: A1C. Hemoglobin A1C, in the grant that paid for that test and we did the test. We now get all our monitors for free and we give out the monitors for free to participants. The Home Diagnostics [Fort Lauderdale, Florida] is the company that provides us the free monitors for all of our participants, and they will provide them for us for the new research.

TS: Good for them!

JL: They've been great to us! Even if we didn't have the service commitment we'd still be doing this because it's the right thing to do—we just love the people and they appreciate it so much, what you do. Tommy Nobis gives us the space free, so we don't have rent. The labs—we're getting either through the MUST clinic or through the Good Samaritan Clinic over in Austell. It's all free now. We're looking for more funds to help sustain it, but a lot of our participants, the ones who did really well in managing it, the ones who really do the best, have kind of risen up as leaders. We've done some training now with the CDC helping us, training those folks as lay health leaders. They go in and help us do weights and heights. We bring student nurses mostly to do blood pressures, but they help us with heights and weights just to help everybody stay up to date with where they are.

TS: I was going to ask if you were involving KSU students?

JL: Oh, yes, all along, they were involved in focus groups. They've been involved every month in some education with support groups. We bring them in to do blood pressure screening and community screenings for blood glucose. They go with us when we go to Expo, when the American Diabetes Association—who is another one of our great partners—has a huge Expo every year downtown. We take students down there, and they do labs and blood pressures and paper work and interview people and do feet assessments. Nursing students, we couldn't have done this without nursing students. They've been awesome. The faculty sends us our students now from the different courses, but those early courses—we send them to learn to do blood pressures and we work with them there.

TS: I think the latest census statistics are that 12 percent of the population in Cobb County is foreign born, and it's not going to get any smaller any time soon, I don't think, so there's always going to be a clientele out there.

JL: Yes.

TS: So you see this as something that will go on permanently now?

JL: Yes, I think so. I don't think it can end. I know research is research, and research has a starting point and an ending point, and the research part of it did have a starting point and an ending point. The service part of it—the need that was filled by the program that was developed to provide the vehicle for the research, has filled such an empty place in this community that I don't think it could stop. I think it's a snowball that's rolling so that it won't. There are so many volunteers all the time that come in and help. It's mostly students and faculty—Dr. Jan Flynn has been down there, Dr. Bairan, Dr. Holtz, of course, Dr. Astrid Rivera and I are there most of the time. If Dr. Rivera is not there, I'm there. Most of the time both of us are there.

TS: Are you able to use this for your dissertation?

JL: My quality of life data will be my dissertation topic.

TS: So you were saying earlier you had done the research; you just have to write it out now. Have you presented any papers; you say you're going to do one in February; have you been presenting any papers?

JL: Yes, we've presented everywhere we can, really. We present on involving students, presented that with Sigma Theta Tao, our honor society in nursing—that was in Indianapolis. I think we've presented just about every year over at Savannah at the Georgia Nurses Association. We presented there and we usually present on how to involve students in the project. I had a student with me one year presenting. We presented to the CDC several times. I've presented at the Mini-Medical school at Morehouse. I've presented in San Diego, [and] Los Angeles. We're invited speakers to the American Association of Diabetes Educators [Chicago, Illinois], that was a big deal! I was not able to go. Astrid and I were both supposed to go. I couldn't go, but Astrid went, Dr. Rivera went and did the presentation for us. We presented at the state diabetes conferences for two years. Locally, either Dr. Rivera or I has presented numerous times. I'll be presenting in February, of course.

TS: Sounds like a great thing to tell to the service clubs like Kiwanis and Rotary and so on.

JL: We haven't done the service clubs and we should. Now, we have made some calls to the Kiwanis because of the eye opportunities. In fact, the leading cause of adult onset of blindness is diabetes. So we really do work hard with our population, educating them about maintaining good control to protect their eyes, to protect their ability to work.

TS: Right. So you think you're going to finish your doctorate maybe hopefully this summer, and I guess as long as you're staying in university teaching it's pretty important.

JL: Yes. I love teaching. I was scared to death that first semester. I was scared out of my wits. But it grows on you, and I always have loved educating. It's just that it was so different. At Western, this Ph.D. that I'm getting there has to be balanced in scholarship, policy, and pedagogy and teaching—and they expect us to come out strong in all those areas—scholarship, including both our ability to write and our ability to research. So it has a huge research component, and incorporated into the program is several courses on pedagogy and andragogy. Those courses were so helpful for me. From the first course, I could see a difference in the way I felt in the classroom and the way I work with students. I love it. I just really love it. I don't ever want to quit teaching.

TS: How did you get your course work done at Western Michigan? Did you do it in the summertime or what?

JL: We had summer intensives. I went up three times a semester for intensive weekends and online. It's a residential program with an online component. There were a lot of on-line components. It's a pretty heavy program of study with, I'm told, a heavier comprehensive requirement than most Ph.D. programs. There were, as I understand, four universities that were funded to do these interdisciplinary programs. In order to fix the health care system that's broken we needed health professionals who were really savvy on policy, savvy on research and joining those two together, and strong models in the academic community. So they have really had to try a little harder to bring us up to a level of functioning that could prove their ability to do this because they've got money to do this. Western was one of the four. I don't know who the others were, but I understood there were four.

TS: Do you see Kennesaw moving in that direction some day with doctoral programs?

JL: Yes, I would love to see that. Having been through this program and still learning from this program, I expect I'll continue to learn this interdisciplinary concept. I don't know how any one discipline can go and work here and solve their problems and the other disciplines solve their problems without really understanding each other. I just think it has to overflow those boundaries. Those doors have to be kept open, so that communication goes, and not only communication to work towards something together, but understanding each other's roles and working, so that it's synergistic—it becomes an explosion instead of a small stream to make a difference. I think we're going to see a lot more of that. I'm hearing that we're getting into that more here at KSU. I'm excited about it! I hope some day to be involved in teaching in one of those programs, not now, but some day in the future.

TS: Well, it may be kind of a leading question and a bad question to ask in an oral history is a leading question, but it seems to me that our nursing faculty does more applied research than anybody else on this campus. It's just amazing what all you're doing. I just wondered if you could talk a little bit about what you see the intellectual life of the campus as being, the students for instance, as well as faculty.

JL: I think this is the cream of the crop. It's not because I grew up here as a teacher and this is only five years of growing up, it's not because of that. It's because I've been around and I've seen a lot of different ways people do what they do. Kennesaw has some fine professionals, and I think we get the best students. I know we do in Nursing, and it looks like we do in all the other schools. They are the top academic achievers. We have some of the best minds of people who can come together to learn to be nurses. We have some of the best pass rates on our NCLEX [National Council Licensure Examination] as evidence of that. I think KSU is so situated, and I think we're going to see KSU as one of the leading universities in the country in the next ten or fifteen years, if not already. I think we're being known for a lot of things right now that are just—when we hit that point that everybody else knows, we know [laughter]!

TS: Right, right. That's been kind of our history. We were a little bit ahead of what the perception out in the public was.

JL: Way ahead, and way ahead of a whole lot of universities. And expecting integrity and expecting performance, expecting academic excellence, you know, I think we have set the bar. It would be real hard for folks to try to catch up with us!

TS: Are you excited about that new $60 million dollar building they're talking about?

JL: Oh, man, I am! It sounds so exciting!

TS: I guess they're going to do ground breaking this summer for that?

JL: Beautiful blue prints. I've seen the sketches.

TS: So maybe a year and a half or two years from now you'll be in the building?

JL: Yes. We'll be ready!

TS: I bet you will! It seemed at the time that that old Science building would be a good place to hold nursing and now you're all over creation aren't you?

JL: We've outgrown it.

TS: In fact, some of you are going to be going over to where my office is now in the Pilcher Building when we move to the new Social Science.

JL: Yes, I've heard that some of our faculty is going to be there. I heard it in the meeting yesterday, actually. But we've been using the auditorium in the Science building, and we use the Convocation building all the time for classes. I've taught several classes over there. It's very nice.

TS: It'll be great to have that building on campus.

JL: Yes. It's a great campus, too. One of my faculty members from Western came here, and she was like, "This is an awesome campus!" I said, "Yes, it's beautiful."

TS: What haven't we talked about that we should?

JL: I'm sure I wish I would have said everybody's name that has been so incredible.

TS: You can always add later when you see the transcript if you want to.

JL: Okay. There have been so many people who have made Project IDEAL come to be that I would hate it if I left anybody's name out.

TS: When you get the transcript just add any that you think need to be in there.

JL: Our community partnerships have been phenomenal, too, so between WellStar Health System, CDC, Tommy Nobis Center, the MUST ministries, local churches and organizations, the Latin American Association, the American Diabetes Association, Diabetes Association of Atlanta, HPS [Department of Health, Physical Education, and Sport Science], Dr. Lucia Ribeiro, and Dr. Rosana Ayala in the Department of Foreign Languages, HHS [WellStar College of Health and Human Services], Dr. Anne Hicks-Coolick, the Wellness Center—the exercise program here, they're the people who do the exercise. They give up their time. Sherry Grable, the director of the Wellness Center, was on the advisory committee that developed Project IDEAL, and she's the one that designed the exercise programs. It didn't' come from us; she did it. And Sarah Brooks [the coordinator of the Wellness Center]. When you get a group of people together who really are motivated and sincere, with even a little bit of money to get something done, I think you can move mountains. I think we've pretty much moved some mountains with this project. I'm expecting a lot from the future because I think we've got a little ball rolling, and I think it's going to do more.

TS: Right. Well, it's remarkable in just four years or five years how much you've gotten involved in the whole campus.

JL: I do. I've worked with the Spanish department and Dr. LeBaron ….

TS: Alan LeBaron has an office across from mine.

JL: Oh really? He's just been awesome. And we work right now with a couple that need some help in the Maya group, and then that hooks us in with Emory. It's tightly woven, and one thing leads to another, and you build another, and maybe it's like this and woven.

TS: Right. Well, you really fit the definition of what a metropolitan university ought to be, that you've come in and you've done your teaching, but you've also done a ton of service while you were doing it for applied research purposes as well.

JL: Yes.

TS: I don't know when you sleep. It sounds like you're very busy.

JL: I stay busy! But I sleep good.

TS: Well, I've about run out of questions, I think.

JL: Thank you so much. This was such an honor to speak with you.

INDEX