Marsha Zimmerman: An Oral History

Nursing Career, Emergency Department Leadership, *Em*STAT and Epic Technology Leadership Contributions

at Hennepin County Medical Center

HENNEPIN HEALTHCARE HISTORY CENTER

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Interviewed by Mary Ellen Bennett, RN

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At Hennepin County Medical Center, Minneapolis, Minnesota

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Direct quotations are based on recollection. The entire text has been edited for length and clarity. Portions of the text are redacted as noted due to privacy, confidentiality, or sensitivity of the content.

Mary Ellen Bennett: The following interview was conducted with Marsha Zimmerman, on behalf of Hennepin Healthcare History Center for the History Center's Oral History Project. It took place May 1st, 2024 at Hennepin Healthcare. The interviewer is Mary Ellen Bennett. Marsha, thank you for giving us this oral interview today regarding your long career here at Hennepin County Medical Center. During your time at Hennepin, you made many contributions and used your strong skills as a change agent every day. To start our interview, would you briefly share with us where you grew up and a bit about your academic history.

Marsha Zimmerman: Thank you for having me. This is very exciting and it's hopefully a nice contribution to the history of Hennepin. I was born and raised in Omaha, Nebraska, and came to the University of Minnesota for college, thinking I wanted to be a Med Tech [Medical Technologist] and quickly decided that really wasn't what I wanted to be. I have an undergraduate degree in social work and I was very involved during college. At the University I was a student senator, I was president of my sorority, I was involved in homecoming and all kinds of different activities. I was also involved in civil rights and some activities around the war. So, during that time I kind of reset and thought, well, I really would like to be a nurse. The first thing I did was teach Head Start for two years and then I went back and got a two-year nursing degree. And that's when I started at Hennepin as a cashier in the old hospital [General Hospital]. I then went on to get a master's degree in Human Resource Development Training in Healthcare at Saint Thomas.

Bennett: You said you started your employment at the old General Hospital in 1972. Can you tell us what led you to want to work at that old hospital and what specific departments you worked in?

Zimmerman: In my last year or two at the university, I really was moving into looking at social change and who I wanted to be, and I decided I didn't want to work for a capitalist organization. Where I found space in my heart, was General Hospital. I knew about General Hospital because anybody could go there and the care they got was excellent.

My goal the whole time from when I started nursing school, was to be employed at General Hospital. When I started, I couldn't get a job as a nursing assistant because I had no experience. But they said I could be a cashier in the cafeteria and so I worked for the dietary department. I got out and could interact with patients because we had paper menus and we would take them out and go to each bedside and help the patient circle what they wanted the next day on their menu. From there I was hired on Main 1 West as a nursing assistant and went on to work there in my first nursing job. At the time, we had a Respiratory ICU [Intensive Care Unit] and then I worked the MICU [Medical Intensive Care Unit] and RICU when we moved to the new hospital.

Bennett: Can you describe the environment and the culture at the old General Hospital? For instance, how you felt when you went to work and how staff and patients related to each other?

Zimmerman: In the old hospital we had wards and often times there was one nurse and an aide or two, taking care of twenty or twenty-two people. And when I started nursing school, I really thought, oh, I want to work in the OR [Operating Room], that sounds like a place to be. But I fell in love first of all, with the old men that we took care of, and then all of our patients, and also the staff. And there was one LPN who worked nights, and I think I learned who I wanted to be as a nurse from her. She treated everybody with compassion. Everybody on her shift got a back rub and they were put into bed and she made sure they were comfortable. Then she got out her guitar and she serenaded the ward. And it really

set the tone that there's the technical side of nursing and medicine, which I love, and there was the compassionate, humanistic side of caring for patients.

We would set our older patients up in their geri-chairs [chairs with arms and a tray] around a table, in the middle of the ward, that had a red and white tablecloth. We also had ENT [Ear Nose and Throat] patients on the ward. Young men who had broken jaws with their jaws wired shut. We would get them to feed our older guys. And people, because there are only the curtains between the beds, they really looked out for each other. We oftentimes got a heads up that somebody was having a problem, from another patient. It was like having a great big family of twenty people; most of the time everybody got along. And a small staff and everybody had to work together and really, do things that made sure that everybody got care because there were very few ICU beds. We oftentimes had critical patients on the wards and that's where I got my taste for ICU nursing.

Bennett: That's amazing. It's so different than it is now, but that's the beauty of nursing. It's more than just the medical part of it.

Zimmerman: Right. I've learned some really good lessons. Also, I had a man who did not want his family to know that he needed to have a hemipelvectomy because of cancer. And I just couldn't understand how anybody would not want their family to know. And so, I was able to reach out to his family. Later, I had a 'really interesting' talk with the CNO [Chief Nursing Officer] about how I overstepped. It was a really good lesson for me. I just thought of course, he just doesn't know, and I, as my nursing assistant self, would help him. And it was wrong. And you know, he accepted it. That's probably one letter in my file. But it was also one of those good lessons. We are not taking over someone's decision making; we are there to support their decision making, no matter what it is.

Bennett: After the move to the new hospital, then called Hennepin County Medical Center, you said you worked in the Respiratory and Medical Intensive Care Units, can you talk about your role there and any interesting experiences you had in that department?

Zimmerman: There were four ICU's, they were in a cluster. I worked in MICU-3 and then Respiratory ICU. We got very, very complex medical cases. We had one young man who seemed to be in a vegetative state after a suicide attempt. We worked and worked with him and his family. Well, with his family because he was unresponsive. They really wanted to take him home and we of course, thought that he should be in a nursing home and it would be too much [for them]. But the decision was made that he would go home. We taught them about feeding tubes and everything they would need to do to support him. And at that point, he was off the vent [mechanical ventilator] and breathing on his own.

About a year and a half later, a family and a young man, who was walking with a limp, walked in the unit. The mother said, 'you don't remember us?' And I said 'no, sorry.' It was that young man and his family. And despite all the testing that was done and everyone's best assessment, somewhere along the way, he woke up. He was probably not back to his original baseline, but he wanted to know where he had been in the hospital. He had some foot drop, which we were kind of disappointed to see. But it made me realize that miracles happen, medicine doesn't know everything. We really needed to support the family. I think they had moved him to a nursing home along the way. But you know, he came out of the place he was, in his vegetative or almost vegetative state, and became a lot more functioning than any of us ever imagined. So, as we gave prognoses to people and tried to support them, I always

remember that case because it was one that really shook all of us up, how wrong we were. And how sure we were, because that's what we were told, that this is what all the scans and everybody said.

Another time, a US Marshal walked in because we had a gentleman who was in custody because he was a witness in a big federal case. He [the witness] had gotten sick and so he was in the ICU. I knew the US Marshal from my days at the University, and he's like 'Marsha, wow, you became a nurse.' And I said 'yes, and you're still a US Marshal.' But anyway, we talked and he said that they didn't want to have to have a mistrial, they really needed him to testify, and was there any way they could bring the judge and the jury over? And at that time, MICU-1 was not being used as an ICU. And I'm just a person who says 'oh, there's something to get done, I can do that. Just go ahead and do it.' So, I said 'sure.' I got some chairs and I arranged them in MICU-1 and they [the Marshals] let me know they were walking over. I guess the Marshals were kind of walking around [escorting] the jury and the judge as they walked from the courthouse down to the hospital. And I think I had Security [Hennepin Security Officers] open MICU-1 for me. Somehow it [the situation] made it back up [to the hospital administration], and here they are, holding court in MICU-1. The CEO [Chief Executive Officer] and others came running in and said 'Marsha, what are you doing?' I said 'I don't know. They want to have court. I set up court.' And they said, 'well, no, you should have told somebody and got permission.' Yeah, that was another one. But it was just easy. It's just a jury and it's just a judge, and it wasn't a big deal to me. It was a really big deal to everybody else. And so that was another one of my ICU adventures.

Bennett: Well, you are a problem solver and you think outside of the box. [chuckles]

Zimmerman: Or a problem causer. [chuckles] Thank you.

Bennett: You then transferred to the Emergency Department [ED] around 1980. Can you talk about your experience as a nurse in the ED?

Zimmerman: When I transferred, it was really hard to go to the ED. I mean, you got interviewed and you had to wait until there was an opening. There were several of us that were leaving the ICU at the same time, and so I was told I could go, but I had to wait six months. Which was really hard, but they couldn't afford to have so many nurses leaving the ICU, which probably reflected on some stuff that was going on in the ICU.

I realized that having a great ICU background didn't really set me up necessarily to be a really good ED nurse. There were many more patients. There was no longer a ratio of 1:2 or 1:1. You had eight or ten patients all in various states coming in, and it moved fast, and you had to be very good at doing assessments. I always said, 'it takes six months before you were allowed to work in the Stabilization [STAB] room.' But, I thought the hardest job was being a triage nurse because you needed to quickly assess patients as they came in, and there were usually lines of patients waiting. And you learn that you need to have a picture of what someone looked like. And if someone came through the door with pursed lips, puffing away, they needed to be STAT [immediately] placed. If they could talk to you, then maybe not [roomed] quite so fast. Their vitals are their vitals, but it was the picture of what they look like.

It added on to what I learned about how much you can interfere and work with patients, you need to know where they were and what they were willing to hear. We worked with a lot of families and a lot of people whose family member was in the Stabilization room. The charge nurses worked to get their

family notified and get them in. It was fascinating and difficult and emotionally challenging to know that someone had already died, yet you couldn't tell the family that. We wanted to get them in and have chaplaincy and everybody else there. So, it took a lot of communication skills.

One time we had a Hmong gentleman who came in and actually started in the cubicles [the non-critical ED rooms] and I just didn't have a good feeling about how he looked. At some point he crashed and then he was moved in the Stabilization room and died. There was an officer with the Minneapolis Police who was Laotian, Hmong, who came in to help us with the family. He explained to me that it was tradition that the family go in and be with the person who had just died. And I said 'yes, that wouldn't be a problem.' He [the deceased patient] had been the leader of a clan who had come over and he was involved with a group of people here who considered him their leader. So family was not just his sons and immediate family. It was well over 100 people who came in and they all wanted to go in and see him. The sons pretty much uncovered him and surrounded his head and then everybody else came in to pay their respects. It was pretty disruptive, but I had made a commitment that the family could be there and again, it wasn't for me to judge who was considered family. Maybe there are different traditional families. I did promise that if another case came in, we'd get everybody out [of the Stabilization Room]. We did manage to get everyone through. I was talked to about that also. It meant a lot to that family and I think overtime we have learned to work with different traditions and different expectations.

I worked really hard so that if a family wanted to come into the Stabilization room in certain cases, we would allow them in. We ended up with a policy when I was in the ER, I don't know if it still exists. Sometimes they [the family] were the ones who did CPR. We had a dad who had done CPR on his baby, I think it would turn out to be a SIDS.[1] He couldn't understand [why he wasn't allowed in the STAB Room]. He knew what was going on, yet we were going to lock him out of the room.

And we had people who got really upset and it didn't have to be that way. There's nothing magical about what's going on, especially because people see it on TV. It's very hard when it's their loved one. I think it helps that they know that we did, respectfully and with care, everything we could do to save that person. I think it helps in their grief.

Bennett: Well, thank you for that. I'm sure that there are many patients and their families who appreciated you advocating for them.

Zimmerman: One other thing. When I was a nurse on the floor and even in the ICU, Primary Nursing[2] started as a philosophical approach on how we took care of patients. And in the Emergency Department, we had a lot of repeat patients and patients who came and got their primary care from us, or because they were intoxicated, or for psych issues. They were repeat patients for whatever the reason. I just want to say 'thank you' for the Crisis people [Crisis Intervention Center or CIC], because they had a very big, important role in all the care we gave. We started doing some Primary Nursing with some of our patients [in the ED]. I had a patient who came in frequently, often acted out, and it was very difficult for everybody. I had a Care Plan[3] for her and agreed that they [ED staff] could call me whenever

[1] SIDS or Sudden Infant Death Syndrome is the unexplained death of a baby, usually less than one year old.
[2] Primary Nursing is a model of personalized care delivery that assigns a single nurse as the primary caregiver for a patient during their hospital stay or other period of care.
[3] Care Plan – A nursing care plan is a road map for the care of a patient and a necessary tool in following the nursing process. It helps coordinate the care for a patient.

she came in. And if I wasn't working, I would either talk to them or come down and try to get her out and back into her family. This was a patient who at one point assaulted a paramedic. It was a very belligerent, acting out, kind of situation. We finally got her to the point that she stopped coming in. It took a lot of work. We had other patients in it [the Care Planning program] that were success stories. And obviously there were some patients who weren't success stories.

Bennett: You received your Certification in Emergency Nursing. Can you talk about that process and how that helped you?

Zimmerman: Yes. I had applied for a couple of jobs in the ED and didn't get them. And so, I decided that I needed to maybe do some work on me and also to stretch a little bit and say, 'what are some things that nobody else has in the emergency department.' I want to be honest, that kind of was a motivating factor. [chuckles] There was a Certification in Emergency Nursing [CEN]. I think that this was just the beginning of certifications in many specialties. The CEN was something that no one else at the time had and so I studied and got Board Certified in Emergency Nursing.

At the same time, I was working on my master's degree and I realized that we all took ACLS [Advanced Cardiac Life Support] training, but only the doctors taught ACLS. Nurses were allowed to teach ACLS, but this just didn't happen at Hennepin. So, several of us were chosen, three of us, and we became the first nurses to be Certified ACLS instructors. I always use that [story], as I did get hired into other roles and expanded beyond a clinical nurse, that sometimes you just have to say, 'what can I do for myself?' There's obviously something that, where I was, that wasn't working for these jobs. But that didn't mean I had to be stagnant or leave, I just reached out for some other opportunities.

Bennett: It sounds like that became other opportunities as well with the ACLS program.

Zimmerman: Right. Well, it was ACLS and then we did ATLS [Advanced Trauma Life Support]. It's a teaching hospital, which I love. I always told new nurses in the emergency department, that you may know that this patient needs the CBC or lytes [electrolytes], but this is a teaching hospital, so what your goal is, is to help the medical students and first-year residents know that that's what they wanted, without yipping at them. 'How stupid, of course that they need a CBC.' Sometimes, you know, you kind of lost it. But I loved teaching and actually wrote a paper for my master's degree on the role of nurses in an academic emergency department. Not everybody thought the nurses had a role in training the doctors. But when I went back and looked at what role we had, it was an important one. Because we needed to be nurturing, and do our job, and be there for them. And frequently it was, well, I have all these things ready for you in case you choose to use them.

And the Stabilization room was that way too. It was a big deal to work in the STAB room and it was great. I ran the STAB room for a while. And working with Dr. Ruiz[4] was a joy as far as what inventions he would come up with and how we would try to improve both the medical and the trauma care.

But really, what you needed to do is anticipate what the doctors are going to need. Out in the cubicles or at triage, you had to be right on top of it because you had patients that a lot of times, you couldn't get a doc to right away. We had some standing orders and otherwise just found a doctor and dragged

[4] Dr. Ernest Ruiz was the founder of HCMC's emergency care practice which was one of the country's first. He helped create the new field of emergency medicine. He was Chief of Emergency Medicine at HCMC for 21 years.

them over there. But in the Stabilization room they may say, 'I'd like to put a chest tube in, 32 French.' And I say 'yep, got it.' And part of that was knowing what they wanted, because I couldn't make the decision to do it, but I could anticipate what they wanted so it was right there. And that's what was being a really good nurse in the STAB room was.

Bennett: Nursing is the constant and it really helps to have that knowledge behind you. You were a Station Instructor and also Manager. Can you talk about the culture among the nurses and other staff, residents, and staff MD's in the Emergency Department?

Zimmerman: I think it's a great example of teamwork, of collegiality. I always felt respected and I think that we worked together well as a team. There were the normal kind of personalities and there was push and shove. But I was given great opportunities because I think I was a good partner with the physicians, and I was also knowledgeable. I knew what I needed and what to do.

As I said, at Hennepin, I think part of being a good nurse is also working in an academic center where there are many, many levels of people learning. We had paramedic students from Mankato and other places who did rotations and some of them have now moved on to being CEO's in places. I think that there were so many opportunities to teach and to learn at the same time. There were so many different aspects around disaster planning and all the things that go into emergency medicine, and working with the paramedics and being supportive of the paramedics. All of that made it my very favorite place ever. Even more exciting than Epic[5] and the things I did later in my life. I always look back on what I learned in twenty-five years in the Emergency Department. It was the best. It gave me some great opportunities.

Bennett: It never is a dull day around here and also you learn every day. Can you talk about your role with *Em*STAT and what *Em*STAT stands for and its implementation?

Zimmerman: I was working as a Station Instructor/Clinical Educator in the Emergency Department and I got to go on the vacation of my lifetime. A friend knew people who had this wonderful ranch in in Montana with horses. I knew other people who had been there and I was drooling. I love to ride. It did not include children so it was like this adult trip, and it was lovely. While I was there, four or five days into riding, they offered me, and I took the opportunity, to ride a horse they don't usually let people [visitors] ride. And part way into the ride up the mountain, he took off and I got thrown into a ravine. It turned out I had an L2 burst fracture.[6] So, then I became a trauma patient, which was very interesting and there were lots of lessons learned from being on the other side.

Eventually, Dr. Ruiz and then Dr. Rockswold[7] accepted me back at Hennepin from Great Falls and I was air evacuated back. I had my back fixed and rehab and then came back to work, but I really couldn't work as a nurse. At the same time, Dr. Clinton,[8] was a very early embracer of computer technology and I would beg for his cast-off computers as a clinical educator because I wanted to have a computer at work. He met some people from Texas who had started a company that put together a computerized Emergency Department Locator Board and System and it was also a charting tool. It was called *Em*STAT.[9]

[5] Epic is the name of Hennepin Healthcare's electronic medical record initiated at Hennepin in February, 2007.
[6] L2 Burst Fracture is a type of spinal cord injury at the second lumbar vertebra caused by an injury such as a fall.
[7] Dr. Gaylen Rockswold was the Chief of Neurosurgery at HCMC from 1976-2011.
[8] Dr. Joseph Clinton was Chief of Emergency Medicine after Dr. Ruiz serving in that position for more than 21 years.
[9] *Em*STAT was a point of care, clinical information system for Emergency Medicine in the 1990s. It preceded the current Hennepin Healthcare electronic medical record, Epic.

The goal was to have computers throughout the department, including at bedside and at triage. You would be able to see everybody who was waiting at triage and you would see a status board of everybody in the emergency department. 'Where's my patient? What are they waiting for?' So as labs came back, instead of putting little Xs on a grease board, we had real time numbers running. 'This was ordered, it needs to be drawn.' So, it was a whole different view of emergency medicine.

I really wanted that job, and before I went to Montana, they had given it to someone else. And then I got a call saying, they had changed their mind and I could be in charge of coordinating it. So, it was great. I had a fifteen-pound weight limit and I still had a leg that wasn't working very well. I was in a TLSO brace[10] for six months. And there I was, back at work and helping to plan and implement this computer program. So, it was with great thanks to Dr. Clinton and Dr. Sterner who gave me that opportunity. We were really partners in making sure that it was implemented and it was successful. We were a beta site,[11] which was an initial site and we partnered with the company. I got to do a lot of work with them and also IT [HCMC Information Technology department]. We had to put a different kind of network in to support them, so I worked with cablers. And like everything else, I was just learning so much. We were also making sure that we had a system that supported the nurses and physicians who were very concerned that this computer was going to make their job harder, where we really hoped it would make it easier. Our motto was 'where's my patient and why are they still here?' That was the goal of trying to do it. Then we moved into physician order entry and doing documentation.

Bennett: Did that lead you into your role with Epic, our electronic medical record?

Zimmerman: Yes. We implemented *Em*STAT and new modules and new things with it. I also became part of the physician's research because we had lots of data. And so, I actually learned how to query Oracle[12] and pull data. It was part of the way I converted some of our reticent physicians and staff, by helping them with their research. If I can provide you data, then you understand why we're asking you to document things that you thought were in too much detail. Then we can do studies. I can't remember what medication, there was something that came out with a black box warning[13] and it was a medication that we had been using. We pulled all the data on this medication and any complications to help show that we had a reason to keep using it [the medication]. It was data that was already there.

As the hospital started looking at 'do we want to have a hospital wide electronic health record?' I was on the team that was doing the [system] selection. It was a very broad team. I was one of many, many members. But after a couple of years of work on that, they made the selection of Epic and then posted jobs. I applied to be the Clinical Director, went through a series of interviews, and got the job. There was a Clinical Director and a Financial Director, who was Mary Kepke. And we had a person above us. Our roles changed back and forth between [title of] Director and Manager depending on what HR was up to at the moment. But basically, I was in charge of all clinical aspects of the implementation with Epic.

[10] TLSO brace is a brace used to limit motion in the thoracic, lumbar, and sacral regions of the spine. It is used to treat stable fractures or after surgery to the thoracic and or lumbar region of the spine.
[11] Beta site is the final stage in the testing of a new software or hardware product before its commercial release, conducted by testers other than its developers.
[12] Oracle is a relational database management system, widely used in enterprise applications.
[13] Black box warning, also known as a boxed warning, is a warning the FDA can issue for a medication. It is a prominent feature on a drug's packaging and the labeling alerts prescribers to side effects or other issues.

Bennett: Can you talk about the successes and the difficulties regarding acceptance of the electronic medical record? You talked a little bit about your efforts to persuade the physicians that the documentation was so important and that you could pull information back out for studies. But there are many other facets that you had to deal with.

Zimmerman: The hospital had a homegrown system called IRIS,[14] that could be used to pull up labs, radiology, and other results. I'm trying to remember now. There might have been scanned copies of the chart. You could get into the Lab [Clinical Laboratory] system and radiology had places where you could view images. There were still physicians who chose not to look at an image on a screen and wanted the actual image in their hand. That continued with a couple of doctors through many iterations of having PACS[15] systems around and there were people who still liked to see the paper copy of the charts.

But there were a lot of support systems in place. And so, as we started looking at our philosophical approach to eliminating errors and making sure we're giving good patient care, we wanted to eliminate some of the middle steps. And so instead of a lot of verbal orders, some physicians would tell the Station Clerks or HUCs [Health Unit Coordinators] 'this is what I want,' and the HUCs would translate that into putting all the detail of the order in. So, we said, 'well doctors, we will make it easy and we'll have everything you need right there, but you need to put your own orders in, because it's not really good for the Station Clerks to do that.' And it's the same way with documentation, frequently you couldn't read it [on paper charts] and it was very difficult to go back and tell what was going on. Or there wasn't the amount of detail that was required. Some of it was tied into the financial side because the government and insurers were looking for detail. And when it wasn't there, we weren't getting paid. And so there were denials and it was because there wasn't the level of detail documented that they wanted. Or the attorneys [need for detail] also on that one. We had a strong physician presence in all implementation. Dr. Gensinger and Dr. Larson, we were all partners in making this work. Dr. Belzer, all the way up to Jeff Spartz and Kathy Wilde, we had the C-Suite's support,[16] and we had great physician support. But we also had a lot of fears from doctors and nurses and everyone else, that this was taking over their lives, and this is not what they wanted, and that patient care will suffer. So, we worked really hard to have Super Users, and training, and Med students there to be right at their side when they were doing it.

Everybody had to be trained and basically, we offered classes all over the place and time to practice, and design systems. We would always say if we were in a design session, everybody had to do thumbs up, thumbs sideways, or thumbs down. And if you went thumb sideways, you had to stand up and explain why you were hesitant. We accepted if somebody wasn't going to like it, but we tried to always drive to consensus. And then once we made a decision, we didn't go back very easily because there were so many things that we had to do.

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[14] IRIS, *Integrated Realtime Information System,* is a version of an electronic medical record used by Hennepin Healthcare before Epic was launched. It was read only with no direct documentation. It held Clinical Laboratory and Radiology results, transcribed dictations, and narrative notes.

[15] PACS system is a medical imaging technology used to securely store and digitally transmit electronic images and clinically-relevant reports.

[16] C-Suite consisted of Dr. Michael Belzer, Chief Medical Officer; Jeff Spartz, Chief Executive Officer; Kathy Wilde, Chief Nursing Officer and Senior Vice President of Patient Care.

We weren't the first hospital using Epic, there were other places. But we also knew that we didn't want to make changes to Epic just to make it look like a previous system. We had SMS[17] in before and on the registration side, there were changes made, so it looked like the system that was before that. So, we wanted to go live with the model Epic system wherever possible, because that also made doing upgrades easier. Our goal was to always take upgrades as quickly as possible, because if we were complaining about something that wasn't right with the system and they were willing to change it, we had to be able to take that change.

There were lots of moving pieces and lots of work to be done. But basically, if you weren't trained the day we went live, you weren't allowed to work. And that came from up high. So, it was very easy for me to do my job and take some of the abuse I got, [chuckles] because I also knew that I was backed up for what I was doing.

Did some people get some special treatment? Yes. But that's the way it works. They maybe had gotten trained at home or in some special sessions. But basically, we had wonderful support and we made it happen. There were some moments that were very difficult like with the Pharmacy going live. But we managed to get through it and Epic helped by sending extra people out. We just made it happen and it's still going strong today.

Bennett: So, we were not the first hospital to go up on Epic, but were we one of the very first?

Zimmerman: I think they had twenty or twenty-five hospitals.

Bennett: In Minnesota?

Zimmerman: No, across the country. But I think Allina was up before Fairview. We weren't the first one. And North was coming up. So, we became a very strong regional Epic Center and we had Minnesota Epic user group meetings. The CIO's [Chief Information Officers] and some of us would meet together and we discussed common problems and issues. We had staff who moved back and forth [employed], as staff do, and we just accepted that. Epic had a wonderful training program and people got certified. Some of them left and some are still working as consultants and have moved on. But it was a great opportunity.

I just mentioned before that we were separated a little bit from HR [Human Resources] at the time, and had the opportunity to bonus our staff, and also there was a bonus at the end. So, it was a little different model to make us competitive in the marketplace to get people employed at HCMC. Mary Koepke and I set up tables outside the cafeteria to recruit. I really wanted clinical staff that we were going to train as computer analysts rather than getting computer analysts and trying to make them fit into a medical model.

So, we brought in nurses, we brought in doctors, we brought in people from the Lab. And they were trained in their modules to do the build or to do the modifications we needed to work at Hennepin. And I don't think anybody appreciated us standing outside, talking about Epic in the cafeteria. But we actually hired a few people from that process, because they didn't know what it was unless we were out there talking about it. So, we went a little bit outside the box all the way around. But it was very helpful,

[17] SMS stands for Shared Medical Systems. It was a computer system before Epic that was used for patient information, registration, system visits, and admissions.

like when we did our first build and then everybody got a monetary bonus because we met a deadline for our first 'go live.' We celebrated frequently, so it was, I think, a good place to work for most people.

Bennett: Wonderful. Can you describe how far the program developed by the time you left?

Zimmerman: I retired in 2015 and it's kind of strange that I couldn't put together exactly what year. I was hired in 2005 to start working on Epic and our first go live was in 2007.

When I left in 2015, we still were working to get the Lab on Epic and there were some other parts of Epic that we weren't on, and they were developing new ones. Doing upgrades was huge, sometimes the look and feel of something changed. And again, we tried to stay as vanilla and close to Epic as possible so we could take them all, and that required a lot of retraining. But I think they're still working on the Lab, or it's going to go live soon. They are getting off a separate system [not Epic]. So, the idea was as Epic developed modules or components, to move everything into one system. We had Ambulatory up, we had all the financial side up, and HIM [Health Information Management or Medical Records]. If a department wasn't on Epic, we interfaced to an existing system. We interfaced to the State [MN Department of Health] for Infection Control. It was always really interesting to be sending data to the State, securely and scrubbed, so they could see peaks and fevers, and peaks in things coming in through the Emergency Department, and looking for trends. And so, there was different work going on that felt very beneficial to the community.

Bennett: We were looking for influenza-like-illnesses with the avian flu worries and also when I left, they were just bringing up the Epic module for Infection Prevention. So, thank you for that. That was a big deal for us.

Zimmerman: We also participated, or I got to participate in several very interesting quality analyses of when something broke down. When a lab result didn't make it back to the right person and then something downstream happened, maybe to the patient. So doing those analyses, which were supposed to be done without any finger pointing, it wasn't looking for blame, but it was looking how the holes in the Swiss cheese lined up. Just one example, a critical value didn't make it back to the doctor who was supposed to get it. And those are always really hard because it usually meant that there was an untoward event or a critical event. I can't remember all the lingo right now. We had to come in and we couldn't just say 'no, it wasn't my fault.' But you really had to listen, and to say, 'this is how all of this lined up to happen.' Then we needed to go back and fix it and make sure it didn't happen again.

My role evolved. It was not just the Clinical Director of a staff and Epic, but also when the State showed up and they needed data. Or we were doing a quality analysis, or sometimes the courts would want something, and we'd have to work with subpoenas. So, there were lots of facets to my job.

Bennett: It changed everything, but for the better.

Zimmerman: Thank you.

Bennett: You mentioned that your children grew up at Hennepin. Can you tell us about that?

Zimmerman: I was a single mom with three kids when I started in the Emergency Department. It was really important for me to have my children understand what I was doing. And probably we were a little bit looser back then about telling stories, not really bad stories, but things that happened at work.

And I developed this practice of each of my children getting a day at work with their mom, on my day off. And we would come in and tour the Emergency Department, and go up and see helicopters, or go get a tour of the inside of an ambulance, and eat in the cafeteria, which was a highlight for unknown reasons. I introduced them to everybody and showed them, this is where I work. So that when I had to pick up overtime or I was rushing off because we had a disaster, they understood what I was doing and why I was doing it.

They became models for some of the classes. We had a pediatric trauma class and we started using ultrasound and they needed models for teaching the docs about doing an ultrasound. They acted and had moulage makeup on for the ATLS. They were on the other side of doctors and nurses learning how to do things. And sometimes they would come home and critique what they saw. [chuckles] They got really good at it, so they knew when they were supposed to start having trouble breathing. And one of my sons came home and said 'Dr. Ruiz asked me what I thought of this person.' I said, 'well, I don't know if that's a good idea.' But they really had a healthy understanding of the Emergency Department and I think most everybody knew them. They wouldn't have hesitated if you let them walk in and do something. So yeah, it was important to me that they knew, because the ED was a huge part of my life. And sometimes with the craziness that's happening in the Emergency Department, they got a babysitter and I took off. And I think I've apologized to them a few times. I sometimes probably put the ED first, but they survived and all grew up fine.

Bennett: Well, what great experiences for them. Do you have anything else that you would like to share regarding your work at HCMC? Anything you forgot to mention or you think it's important?

Zimmerman: I ended up being a different type of nurse than I expected. And so, my whole career was at Hennepin, but I had the opportunity both planned and serendipitously to do many different things. And I don't know very many people who start out cashiering in the cafeteria and then being the Director for Epic at the end. But if I look back at the most meaningful thing I did, it's when I was doing direct nursing care. And I think that influenced almost everything else I did. With all the work with Epic and all the work we did with teaching classes or working in an academic center, it was that the patient always should come first. And our goal really was, and my goal was, always to give good patient care.

And you know, we mentioned that when I broke my back, I was on the other side of being a trauma patient. I developed that into this presentation that I ended up speaking at conferences nationally named "Tail (tale) of a Trauma Nurse" about breaking my back. But patient care has to come first, no matter what. And did we always succeed? Maybe not, but that was always my goal. And it was my love for Hennepin to make sure all patients who came in, were treated with respect, and we gave them the best [care] that we could. And though I learned a whole lot about finances by the end, I hope that good patient care was always our goal.

Bennett: It has been a great honor to speak with you today, Marsha. On behalf of the Hennepin Healthcare History Center, I want to thank you for your countless contributions to the Hennepin Healthcare system, the staff and the patients, and for your tireless efforts to make change for the improvement of patient care.

Zimmerman: Thank you.

Career Summary

1. I worked at HCMC for 42 years as a nurse. I started as a cashier in the cafeteria, worked the large men's medicine ward at the "old" hospital, the ICU, and 25 years in the Emergency Department. The last 10 years I was the Clinical Director for Epic (Electronic Health Record - EHR).
2. My passion for HCMC is the mission and core values to serve the community and provide care to all who came to our facility whatever their ability to pay, whatever the circumstances. I tried to provide exemplary care to all of my patients – the victim or the perpetrator. I was an advocate for my patients and families – including the very controversial inclusion of a family member in the Stabilization Room. As the charge nurse, I learned the many ways that grief is expressed and the importance of cultural traditions of dying – despite hospital guidelines which were too often based on white community practice.
3. As the EHR Director, I advocated for and implemented Epic at the Jail and the Workhouse so that our patients had a longitudinal health record. I also spearheaded the Affiliate Program which allowed our community clinics including NorthPoint to have Epic and the patient to have complete medical records throughout the community. We stretched Epic to work with Addiction Medicine, as well as Hennepin County Public Health, Crisis, and Red Door. I could not just implement Epic, it was important to always keep the patient the center of the project.
4. I worked with our vendor and our staff to support HealthCare Homes on Epic. And, I was on the implementation committee to design and support Hennepin Health. There were many hurdles to providing a longitudinal record of health and social needs and I was proud to be part of the solution.
5. My college years at the University of Minnesota included being a Student Senator and student activist. I was involved in the Liberation Coalition and the takeover of Morrill Hall. I was also a leader of the Student Strike Steering Committee – where I led meetings with diverse groups including SDS, Socialist Worker's Party, etc.
6. I taught in Head Start before going back to nursing school and worked only at HCMC for the rest of my career.
7. I continue to receive my health care at HCMC, and after being injured in Montana, I was flown back to HCMC for surgery and care.
8. I have been a volunteer at Open Arms since 2016 and currently have over 1000 hours providing meals for clients and families with life threatening illness.
9. I was on the Board of Directors of the St Paul Jewish Family Service which serves clients along the West 7th corridor in St Paul. Previously I have served on the Board of Directors of the St Paul Jewish Community Center
10. I am the co-founder and co-Director of the Hennepin Nurse Alumni Association which provides social, educational, philanthropic opportunities for former Hennepin Healthcare nurses.
11. I live in St Paul; my children and grandchildren attend(ed) St Paul Public Schools.

I believe in Hennepin Healthcare. And, I have energy to continue my lifelong passion to support individuals and populations with disproportionate health needs. I am a good organizer. I continue to work on listening, understanding and learning.

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