Yale Nursing Matters

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The reason that nursing is so exciting, so challenging and so effective is that we see people in context. It is impossible to give good nursing care without considering a person's occupation, family or culture. Because nurses see the importance of context, we have always concerned ourselves with broad societal issues that affect our patients. To the conscientious nurse, everything matters.

At the Yale University School of Nursing, we pay a great deal of attention to policy. The policy arena is often perceived as remote. In fact, it is just the opposite. We define policy as thought and action that transcends the situation of the individual patient, but ultimately circles back to affect his or her health. Great figures like Florence Nightingale and Lillian Wald are recognized for their policy work. But we also acknowledge the policy related work that goes on everywhere nurses practice—the program to educate parents about infant car seats, the letter writing campaign to save a school breakfast program, the study to determine how needle sticks occur on a hospital unit. It is all policy. And the nurses who spearhead such efforts are all reformers, in the very best sense of the word.

Because we are scientists we have a great love for truth and knowledge, which are the foundation of all positive social change. I have always been struck by how much the scholarship of this one, relatively small, professional school has helped inform and shape public discourse. This issue gives you a small sampling of recent work in the policy area, including my predecessor Judy Krauss's insightful scholarship at the Institute of Medicine on the state of safety net providers, the work of a team of Yale nurses to empower their Chinese colleagues to build a safer workplace and the myriad efforts of our faculty and students to improve the health of children.

This is our second issue of Yale Nursing Matters, a magazine that we hope will never stop evolving to better encompass the depth and breadth and height of this community's work. With this issue we unveil a new feature, "The truth of the matter," in which a member of our faculty discusses how we strive through ongoing scholarship to find solutions for patients. In this first edition, I write about Linda Schwartz's zealous pursuit of the truth on behalf of her fellow Vietnam veterans. I look forward to other faculty taking up the torch in coming issues. Public discussions of research tend to focus on findings, for obvious and understandable reasons. But the questions we choose to ask say much more about us than the answers we ultimately find.

The questions being asked at ysn show us to be a community that cares about giving voice to the voiceless, that cares about equity and that cares about putting resources to work for people.

I am, as always, proud to be a part of the ysn community as we work toward improving the health care of all people.
A brief sampling of policy activity in the YSN community

Workforce issues
Through her work in various groups, Dean Catherine Gilliss steers health professions education to take an interdisciplinary approach toward contemporary issues ranging from managed care to provider shortages in rural areas. She is a member of the advisory board for the University of California San Francisco Center for Health Professions and the State University of New York Center for the Health Professions. Both organizations examine nursing workforce issues.

As Gilliss puts it, they try to see that the supply of professionals meets “societal needs rather than hospital demands.” She specifically addresses preparation for advanced practice and the supply of APRNs through the American Association of Colleges of Nursing’s Task Force on the Costs of Clinical Education for Advanced Practice Nursing and the Technical Advisory Board of the National Organization for Nurse Practitioner Faculty’s NP Program Analysis Project.

Gilliss also serves on the National Advisory Committee of Partnerships for Quality Education. PQE is a Robert Wood Johnson-funded program to shape the education of health professionals to better prepare them to maximize care in a managed care environment. Through her membership on the Executive Committee of the Health Professionals National Service Program, she was able to move the fellowship opportunity from strictly medical to interdisciplinary. The program creates post-graduate opportunities for practice and scholarship in underserved areas for teams of physicians and advanced practice nurses.

Donna Mahrenholz, specialty director for nursing management and policy, is principal data analyst for the Connecticut Colleagues in Caring Project, a Robert Wood Johnson-funded initiative to study the nursing workforce, assess the need and demand for licensed nurses in the future and evaluate whether the education system prepares nurses with the needed skills and knowledge. The project consortium is led by the Connecticut League for Nursing and includes nurses involved in practice and education, employers of nurses and other interested persons and organizations. Mahrenholz produced a report on behalf of the group in 1998 that was widely distributed in the state. She is also a member of the Connecticut Nurses Association Task Force on Nurse Shortage.

Doing more with less
Through a $30,000 Robert Wood Johnson Foundation Partnerships for Quality Education grant, YSN will collaborate with the Fair Haven Community Health Center to develop strategies to serve clients covered by public sector managed care programs as well as clients who are uninsured. In the fall of 2000, YSN students practicing at the Fair Haven clinic will also participate in a web supported course that uses case studies of clinic patients to discuss managed care issues. The content from the pilot course will then be incorporated into YSN’s master’s curriculum for all students.

“A lot of us are down on managed care because it’s generally not about care at all, but about shuffling money,” says Lynette Ament, the director of the program and head of YSN’s nurse midwifery specialty. “But what we’re asking
P. Minarik

is, “How can you best care for your patients given the resources that you have?” For example, home care is very important in diabetes, but managed care organizations won’t pay for it. Fair Haven simply takes a loss on home visits. Maybe that is the best solution, or maybe we can come up with a creative way to provide those same services. Teaching our students to solve these problems in the patient’s best interest is at the heart of this program.”

**Giving providers a patient’s perspective**

Karina Danvers, a YSN community outreach worker and a woman living with AIDS, recently received a Commissioner’s AIDS Leadership Award from the Connecticut Department of Public Health. Danvers was cited for her volunteer work on a project to educate providers about HIV counseling and diagnosis. She held a workshop for health care providers on the topic and shared her own diagnosis experience in a video. In 1989, her doctor informed her over the telephone that she was HIV-positive. Though he was very supportive and sensitive, Danvers explains that the doctor simply didn’t know how to convey the news. “I was his first case,” she says.

As part of YSN’s Athena Project, Danvers recruits people with HIV to participate in a program aimed at helping patients to properly take the antiretroviral medications that can control the virus. In nominating her for the award, her YSN colleague Jane Burgess praised Danvers for “going beyond her job requirements to provide emotional support and linkages to medical care.” She also called Danvers, “a tireless educator who has spoken to hundreds of health care providers, sensitizing them to the patient’s perspective and bravely sharing her own experiences and feelings.”

**Scope of practice**

Obviously, YSN faculty take an active interest in legislation affecting advanced practice nursing. All the letter writing, calling and testifying paid off in 1999 with the passage of Senate Bill 333. This bill changes the practice relationship for APRNs in Connecticut from “under the supervision of a physician” to “in collaboration with a physician.” The legislation also broadens the controlled substances that APRNs can prescribe. All of these changes are focused on increasing access to care and increasing independent practice for APRNs. Through her leadership role in the Connecticut Nurse Practitioners Group, Assistant Professor Ivy Alexander worked with other executive committee members to shape the language of the legislation and define negotiation points.

Associate Professor Pamela Minarik continues to work on scope of practice issues for clinical nurse specialists in particular as a member of the National Association of Clinical Nurse Specialists Legislative and Regulatory Committee.

**Building sound partnerships**

The school is collaborating with Connecticut Public Radio to produce a series of stories of chronic illness care and aging though the Robert Wood Johnson and Benton Foundation’s Sound Partners Program. The series, which will be aired beginning in August, will be coordinated with community outreach health activities in YSN’s own Hill

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neighborhood. YSN research in chronic illness care will be prominently featured. "When I heard that the Robert Wood Johnson Foundation was offering grants to get health care organizations working with public radio stations, I immediately called John Dankosky, the news director at Connecticut Public Radio," says YSN Director of External Affairs Colleen Shaddox. "Having spent many years as a journalist, I understand why reporting is so focused on the newest pharmaceutical magic bullet. Given the constraints reporters have on story length and on their own time, it is difficult to cover the complex business of managing illnesses. This is obviously a great way to introduce YSN's work to some of the best journalists in the country. Once reporters learn about nursing, they will see how compelling the work is and will translate that to their readers, listeners and viewers."

Standards of care
YSN's mission—better health care for all people—has many policy implications. One of the most obvious is developing good standards of care, an activity that many faculty members embrace.

Lawrence Scabell, an associate professor in nursing and child psychiatry, has been appointed to a national panel of nurses that will develop practice guidelines for the assessment and treatment of children and adolescents with Attention Deficit/Hyperactivity Disorder. He will represent the International Society of Psychiatric-Mental Health Nurses on this Expert Panel convened by the Center for Mental Health Services. In addition to his teaching responsibilities, Scabell is involved in clinical research at the Yale Child Study Center in ADHD, autism and Tourette's Syndrome.

Lecturer Jessica Coviello is working to write standards of care for heart failure patients under the auspices of the Connecticut Society for Cardiac Rehabilitation. Coviello wants to see standards that reflect the Healthy People 2000 and 2010 guidelines as well as the American College of Cardiology Consensus Report for CHF and the AHCPR guidelines. Coviello practices at the Connecticut Heart Group and works closely with nurses from Regional VNA, South Central VNA and Priority Care in delivering care to heart failure patients in the community with a goal of reducing hospital admissions.

Have bones, will travel
Linda Pellico, director of the Graduate Entry Prespecialty in Nursing, is known for her dynamic teaching style. Nowhere is that more evident than in her Have Bones, Will Travel classes. Pellico takes YSN student volunteers into local schools to give hands on anatomy classes featuring real bones and organs. Pellico's class draws sighs of wonder and the occasional "Eeew, gross!" from elementary school children.

There's more going on in the classes than a simple lesson in anatomy, however. "I believe that knowledge is power," says Pellico. "Just say no doesn't work. Teaching kids how their bodies work makes it a lot easier to explain to them why they need to wear bike helmets and sunscreen and why smoking is dangerous. I want to give kids the ability to make good decisions about their own health."
On the home front
Yale School of Nursing Associate Dean for Academic Affairs Paula Milone-Nuzzo was recently named a Fellow of Hospice and Home Care by Home Care University, a non-profit organization dedicated to advancing research, education and credentialing for home care and hospice. She also serves as board president of the Regional Visiting Nurses Association. Through her work with the Yale-China Association, Milone-Nuzzo has helped colleagues in the People's Republic of China to make use of home care to further their public health agenda.

As a fellow, Milone-Nuzzo will advise Home Care University on health care issues, guide special projects and research, and support education initiatives in the field. Home Care University is a non-profit affiliate of the National Association for Home Care (NAHC). Founded in 1982, NAHC is the largest trade association serving the nation's home care agencies, hospices and home care aide organizations that provide health and supportive services to more than seven million patients receiving care in their homes.

Health discrepancies
At the turn of the century, a man from the Passamaquoddy tribe in Maine had an average life expectancy of 45. Today, males from the same tribe have a life expectancy of 46. Prejudice is to blame for this and the many other horrible statistics that combine to form a picture of Native American health, according to Deborah Chyun, director of the Adult Advanced Practice Specialty.

Through a Health Resources and Services Administration initiative, Chyun is exploring various ways to improve the health of Native Americans in New England. Strategies include mentoring programs, tribal clinical placements and diabetes clinics.

Capitol work
Research Scientist Linda Schwartz has testified twice before Congress this year. In March, she informed Congress about important scientific flaws in the only major study to examine the effect of Agent Orange on veterans' health (see The truth of the matter, p. 28). She also presented compelling evidence that exposure among those who served in Vietnam may be far more widespread than previously believed. More recently, she testified in support of legislation introduced by United States Representatives Lane Evans and Shelley Berkley to increase compensation for veterans who have had mastectomies.

"This is not the first nor will it be the last time advocates for women veterans will encounter policies, regulations, or legal barriers, which constrain VA ability to respond to women veterans," Schwartz told Congress. "... There is no question that changes to the VA system will continue to evolve as the needs of veterans—men and women—emerge in this new age of military technology and the toxic environments of today's warfare."
“Adult smoking in the United States is on the decline as tobacco’s tragic consequences have become more widely known. And so the tobacco industry, which we subsidize with our tax dollars, must replace these smokers. They have done it by targeting children. It’s an eminently sensible strategy. After all, very few reasonable adults would take up a habit whose deadly effects have been so thoroughly documented.”

“In Teaching Our Kids to Smoke, We’re All Guilty,”
by Margaret Grey and Ruth McCorkle.
The Hartford Courant, January 25, 2000

“In every argument conventional medicine uses to bash complementary or alternative approaches to healing, the claim is made that these practices are not safe or effective because they have not been scientifically proved through clinically controlled trials. How hypocritical is it, then, for physicians to make the essentially unethical choice to dispense a treatment (stem cell transplant) that is not proved through the very method they argue is the bedrock of their profession?”

Letter to the Editor,
Amanda Dworski, YSN ’01.
New York Times October 4, 1999

“As nurses we need to be much more clear and assertive in letting the public know about our services. Then we need to work with our patients to knock down the barriers that keep us apart.”

“Nurse Practitioners Can Cut Costs, Provide Increased Care,”
By Sally S. Cohen.
The Hartford Courant, December 28, 1999

“Like social work and teaching, nursing bears the burden of being a helping profession. The romanticized and patronizing notion persists that we chose our careers and succeed in them not because of our brains and abilities but because we are ‘nice.’ And what woman need be reminded of the dismissive power of that four-letter word?”

“Women’s Work”
By Ellen Shaw YSN ’97.
Barnard, Winter 2000

“While we spend next to nothing on prevention, the tobacco industry spends $63 million annually on advertising in Connecticut alone. Without decisive action on our part, 56,000 Connecticut children alive today will die as the result of their tobacco addiction. They will die because the tobacco industry was more willing to invest in our kids than we were.”

“Save the Future with Tobacco Settlement,”
By Catherine L. Gilliss, Margaret Grey and Ruth McCorkle.
New Haven Register, May 17, 1999
Cohen's book examines America's child care policy

Who's looking after the kids?

Sally Cohen's forthcoming book, Championing Child Care (Columbia University Press) examines the political struggles to improve child care for the millions of American families with working parents. The players include Presidents Nixon, Bush and Clinton, and a host of legislators and organized interests who for 30 years struggled to reach a common ground on this compelling issue. But she found that along with progressives like United States Senator Christopher Dodd, who wrote the book's forward, child care has attracted unlikely advocates.

"For example, some of the largest strides in federal child care policymaking came under a GOP president (Bush) and a Republican Congress (1996)," says Cohen. "While some women's groups have been steadfast advocates, others have been reluctant to engage in child care politics for fear that they will reinforce the idea that women are solely responsible for the care of children."

The debate, according to Cohen, is shaped by broad ideological themes: federalism, tax policy, the role of women in society. What is conspicuously missing from that list is the welfare of children.

"We've got about thirty years of research offering evidence about what's best for children. There's been a lot of publicity about early stimulation and its role in brain development," says Cohen. "But even the research gets politicized. One side will tell you that the research supports the need for high ratios of well educated staff taking care of our children. The other will tell you that the research supports mothers staying home."

For Cohen, a pediatric nurse practitioner whose doctoral work combined public health and political science, the politics of child care are as fascinating as they are frustrating.

Conservatives tend to label any government support or regulation of child care as, "the bureaucratization of motherhood," Cohen says. "There is still tremendous resentment of mothers of young children putting their children in child care."

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"We don't even have federal child care standards in this country," she says. "We regulate hairdressers and dogcatchers more than we do child care providers, which tells you a lot."

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The theme surfaces again and again in Cohen's book as she traces the evolution of child care policy from the 1970s through the present. She looks back at the defeats of the 1970s and renewed efforts in the 1980s, a period when, according to Dodd's forward, "children's needs were more typically an afterthought in federal policy."

Child care won new legislative support with the welfare reform of the 1990s. "Policy makers want moms to stay home, but not if they're on welfare," says Cohen. With the effort to move mothers of young children from welfare to work came an infusion of billions of federal dollars to subsidize child care. The money went to the states to increase access, affordability and quality. Different states have administered the funds very differently. "It's a patchwork thing, not unlike health care," Cohen says.

As with health care, there are serious gaps. "It's a complicated system that doesn't always work best for those most in need," says Cohen.

She adds that good quality day care is very expensive. So low and even middle income families are often forced to settle for lower quality child care.

Cohen has traced an influx of support for child care, often falling outside the standard nine-to-five care that allows parents to work. "The definition of the problem has evolved over time," she says. Now the "Fight Crime, Invest in Kids" organization has succeeded in building support for before- and after-school care under the rationale that children in structured activities will not be committing crimes, smoking, having sex, etc. Some children's advocates have suggested using tobacco settlement funds to support such programs. School readiness is also a rallying cry for programs, particularly those aimed at children from low income families. In Connecticut, school readiness has lead to tremendous growth of pre-kindergarten programs, many of which are coordinated with local child care programs.

"At least now there is bipartisan consensus that there is some role for the federal government to play in the child care arena," says Cohen. "There continues to be debate over what that role should be."

Throughout the debate on child care, nurses have not been vocal. Cohen believes that the profession has a clear role.

"We haven't been key players in child care legislation, which is hard to believe," says Cohen. "Child care policymaking is a logical area of interest for us because of the family and community orientation of nursing care. Years ago, nurses were at the forefront of advocacy for families with children. It's a good time to reclaim that role."
Crowley sees child care as a vehicle to better health

Missed opportunities

Angela Crowley loves being a pediatric nurse practitioner, making a difference in the lives of children and their families. But she's also very aware that it can be a long time between office visits. "I value my role in clinical settings," says Crowley. "But I have very limited time that I can spend with children and families. Child care, on the other hand, affords an extraordinary opportunity to reach children and families. From a health care perspective, that's been a missed opportunity."

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As a consultant to Healthy Child Care Connecticut (HCCCT), Crowley is working to strengthen the link between health and child care. The U.S. Department of Health and Human Services, Maternal and Child Health Bureau is funding similar programs in 61 states and territories. HCCCT has sponsored such initiatives as development of a database of child care health consultants, HUSKY (the Connecticut health insurance program for children) outreach to child care providers and the creation of a medication administration training program for child care staff.

Crowley is particularly interested in the role of child care health consultants and has served as an advisor to First Lady Hillary Rodham Clinton on the subject. Although Connecticut is the only state that mandates weekly on-site visits from health consultants to child care centers enrolling infants and toddlers, many states are providing health consultation to child care programs independent of regulations. Crowley completed a study of Connecticut child care health consultants in 1998. Of the 133 child care directors who participated, 85% reported that health consultants were important or very important for the management of their programs. In her sample 99 percent of the health consultants were nurses. “This is clearly an emerging area for nurses and advanced practice nurses,” she says. As a matter of fact, during the next three years, the Maternal Child Health Bureau has directed states to develop an infrastructure of health consultants as part of their grant activities.

“Child care health consultants play many roles. Ultimately, their goal is to improve the health of children and families in child care settings,” says Crowley. “They bring health expertise and services to programs and act as liaisons and translators of health information among child care staff, families and the child’s primary care provider.” For example, health consultants are responsible for ensuring that all the children have immunizations, access to primary care and health insurance. They educate child care staff about health issues and offer parenting classes. Child care programs find health consultants especially helpful in their efforts to accommodate children with chronic illnesses and special needs. For example, when a child with diabetes enrolls in a program, the health consultant not only provides staff training, but also confers with the parents and health care providers to ensure a consistent plan of care. Crowley sees the health consultant’s role as valuable but believes that the role requires further definition. “The ideal role for the health consultant is whatever a given care setting needs it to be. In essence, that requires an assessment of both the program’s health needs as well as those of the children and families it serves. As this role is further developed it will be important to study the relationship between health consultation interventions and child and family outcomes.”

One of her current projects with HCCCT is the implementation of a staff training program in the administration of medications in child care programs. A student thesis that Crowley supervised revealed that inaccessible staff training was one of the barriers to medication administration in child care settings. “Parents of children with asthma or other chronic illnesses need to know that their kids are getting the medications they require to stay healthy,” says Crowley. “The research base laid by my student, Stefanie Catanzaro ’99, demonstrated that child care providers are not comfortable giving medications. That’s a problem we can solve.”

To address this need she chaired a Medication Administration Subcommittee through HCCCT that developed a medication administration training curriculum. This collaborative effort brought together representatives from the Connecticut Department of Health, the Connecticut League for Nursing, school nurses, child care providers, health consultants and Head Start health coordinators. This curriculum is currently being piloted state-wide through a grant from the Department of Social Services and the Child Health and Development Institute of Connecticut.

Good training for child care providers and high staffing levels are the gold standard for good care, says Crowley. But because they are expensive, many centers must settle for less. Crowley would like to see nurses and other researchers investigate, however, whether subsidies for child care might not actually be cost savers.

“We need to look at interventions that prevent infectious diseases and reduce injuries through healthy and safe child care environments and support access to
"When you think about the cost to the child, to the parent and to industry, then investing in health programs within child care programs does not sound so expensive," says Crowley.

services," says Crowley. "These efforts will reduce parental absenteeism, which is extremely costly to industry."

She cites the example of a Stamford, Connecticut child care program that benefits from School Readiness funding and has the first on-site clinic in a preschool setting. Through legislation passed in 1997, the Connecticut School Readiness initiative provides funding to communities to improve the access and quality of child care for low income families. Crowley visited the center when a four-year-old complained of ear pain. In most child care centers, teachers would suspect an ear infection and call the parents to come pick up the child. But this child was examined by the nurse practitioner right at the child care center. She determined that there was no infection, treated the child for pain and sent him back to class. The boy received immediate comfort and didn't miss an educational experience, nor did his parents miss work.

She's now in the midst of a program to provide vision and hearing screenings for New Haven preschoolers. The School Readiness initiative requires that all children have these screenings. Young children with vision and hearing problems not only have difficulty in school, they can potentially lose sight or have delayed language development if they don't receive care, says Crowley.

The findings of two of her thesis students, Leslie Allsopp '92 and Keryn Rausch '94, showed that many children in child care settings did not have evidence of these screenings on their health forms. "In fact these studies and others revealed that even children who do have access to a primary care provider may not be receiving hearing and vision tests as part of their well child visits," Crowley says. Child care centers wanted to provide the screenings, but often lacked the resources. When a New Haven Head Start nurse asked her for help in providing the service, Crowley saw the Graduate Entry Prespeciality in Nursing (GEPN) students as the ideal group to provide the help the centers needed.

GEPN Director Linda Pellico agreed to make screening sessions part of the GEPN pediatric rotation, allowing hundreds of New Haven children to get free screenings and giving the students the experience of working in a community setting. Crowley worked with the New Haven Board of Education School Readiness initiative to get the program going and consulted with Prevent Blindness Connecticut in its design. "Using reliable and valid instruments that are simple for children to understand and yield clear results are vital," Crowley says. To precept the students, Crowley and Pellico enlisted the services of PNP clinical faculty, Monica Roosa Ordway '98 and Veronica Mansfield.

She notes that in most large screening programs, there is little input from parents and no contact with the primary care provider. When VSN students do a screening, they first review parent histories to understand each child's needs and to determine the best time for screening. Then the report automatically goes to the child's primary care provider. If the child does not have health insurance, the students can provide teachers with information to help the parents connect with coverage.

Ranbir Bains, a current PNP student, will be studying this initiative for her research praxis. The team is interested in examining the effectiveness of this intervention and how such a program can augment primary care services.

"The development and implementation of this initiative was an enormous project, but a very exciting one," Crowley says. "We're providing an important service for New Haven children and an excellent clinical experience for our students."

It's an opportunity too good to miss.
The truth

Diers takes
her data mining
expertise
down under
Any hospital that expects to get reimbursed for its services needs to document the care given to each patient and the cost of that care. Donna Diers, former YSN dean and Annie Goodrich Professor of Nursing, was among the first to realize that there was clinical wisdom “lurking” in all that administrative data. Working with teams of clinical, financial and operational experts, she has managed to mine mountains of existing data to extract telling information about the work of nurses and its impact on patient care.  

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"I argue that the reason for the existence of the modern hospital is to provide nursing care, and, therefore, we need to understand our work better than the payers or regulators and sometimes even the administrators," says Diers. "If nursing practice is to be held accountable for the quality, quantity and cost of our practice, we have to have the tools to understand and make decisions about it, to bring the clinical and operational capacity to the policy table."

Diers has a joint appointment with Yale-New Haven Hospital, where she works with the Resource Information Management System. RIMS is exceptional in the way that it merges financial and clinical data, showing the value of nursing care as a resource. Diers and her RIMS colleagues publish their work and are sought after as consultants both nationally and internationally by hospitals that want to better inform their policy by looking at the data they are already collecting for other purposes. For Diers, that has often meant trips to Australia, which she describes as "a lot like (her home state) Wyoming." She is currently spending a sabbatical at the University of Technology, Sydney. Her work in New South Wales includes running training programs to teach health care workers to manage large data sets.

"The Aussie nursing community is quite a long way ahead of the American nursing community in developing applications of 'casemix'—Diagnosis Related Groups-based information for nursing," Diers says. "They are not quite so well along in developing health services research capacity nor in operational management implications, and that is what I do out there in workshops, consultation and coursework. Sometimes there are opportunities to advise government on its investments in information technology."

Diers says she is assisted by a local advisory council "to keep me from stepping into any political swamps that I don't even know are there." She will be advocating with educators, hospital administrators and government officials to increase the capacity to analyze health care data in the Australian state.

There are obvious differences between health care in the United States and Australia, which has a national health system, a more conservative approach to medical technology than the U.S., and a higher nurse/patient ratio. But Diers finds more similarities than differences with her colleagues down under. "Taking care of patients is taking care of patients," she says.

Australian nurses began exploring the use of large data sets very early on, and American and Aussie nurses have excelled in different areas of the field. So collaboration has obviously benefited both countries.

"It's the nurses who really get it," Diers says of her work. "They manage whole units, so they are used to looking beyond the individual patient to see the kinds of larger trends that emerge when you analyze data."

The applications for data that Diers has demonstrated have both improved nursing practice and set the stage for expanded work to answer both clinical and policy questions.

"Diers' co-authored paper with Cindy Czaplinski (YSN '97) 'The Effect of Staff Nursing on Length of Stay and Mortality' published in Medical Care is the best example I have seen of the use of RRS data to answer an important nursing outcomes question, such as whether patients fare better when nurses specialize," said Linda Aiken, The Claire M. Fagin Professor of Nursing and Director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania. "I expect in the future that many more nurses will follow Diers's lead in exploiting administrative data to evaluate all kinds of important issues including the impact of organization and staffing of hospitals on patient outcomes."
Yale nurses help Chinese colleagues protect themselves from blood borne pathogens

The art of the possible

The People's Republic of China has one of the highest rates of hepatitis B infection in the world, yet Chinese nurses at risk of blood exposure often do not take precautions considered standard in the United States. Of course, the same conditions that put nurses at risk of hepatitis infection also put them at risk of HIV infection. The prevalence of HIV in China is very difficult to measure, but is widely believed to be growing.

Changing practice in a country where policy is set far from the bedside is not easy. Fortunately, YSN has a history of supporting Chinese nurses who want to implement reforms in practice within the confines of a highly centralized system.

"In all our China programs, we're aiming to give nurses the tools to address their own problems," said YSN Professor Ann Williams. "We're not just giving them information. We're showing them how to use their knowledge to make real improvements in their workplace, improvements that may ultimately go beyond a single area, like AIDS care or infection control. That's very powerful."

Williams, who is also a trustee of the Yale-China Association, has led a team educating nurses in Changsha, Hunan Province about AIDS care and prevention since 1997. Yale-China has a longstanding relationship with Hunan Medical University in Changsha. Williams believed that the same model used for the AIDS care project could be used to help nurses work out strategies to reduce their workplace risks. The Becton-Dickinson Global Healthcare Fund agreed to support a "Train the Trainer Program" where nurses from hospitals throughout the province would attend special classes facilitated by the Yale School of Nursing and Yale-China Association, then go back to their own workplaces to educate their colleagues. Under the program, Chinese nurses also visited the U.S. to observe standard precautions used in American hospitals. These nurses then become a cadre of nurse educators in their own country.

Williams laid the groundwork by travelling to Changsha in the spring of 1999 with Warren Phipps, who as a Yale College student had taught English there in association with Yale-China. Phipps, now a student at Harvard School of Medicine, surveyed nurses in three area hospitals about their practices around blood. He found that less than ten percent "always" or "often" used gloves when they drew blood, gave injections or started intravenous lines. 82 percent said they'd been stuck by a blood-contaminated sharp in the past year. Many handled needles after using them—separating a needle and syringe, recapping a needle, etc. And 15 percent were neither vaccinated against nor immune to hepatitis B.

"The data are very powerful," said Williams. "We saw that we had to do something to help the nurses in Hunan Province act as change agents to make their work environments safer."

YSN Researcher Jane Burgess and faculty member Linda Pellico have since joined Yale-China colleague Chenghui Wu twice in Changsha to hold Train the

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[Chinese] Nurses also said that they did not use gloves because they believed gloves would diminish the caring and close relationship they have with their patients.

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Trainer workshops on blood-borne pathogens. Wu is an RN and a bicultural educator, that is. She tells her American colleagues what practices are likely to work in China, then translates these practices for her Chinese peers. The Hong Kong-based nurse was instrumental in the HIV program and worked with Williams, Burgess and Pellico to design the blood borne pathogen program.

Based on the surveys Phipps did, the nurses were shown what their risks were for blood borne pathogens. For example, gloves are worn far less frequently in Chinese hospitals than in Western institutions. Cost is only one of the reasons for this, but a significant one. The nurses' own reports showed that blood drawing was the activity most associated with needle sticks in their own hospitals. The team helped the nurses to identify areas of highest risk and to prioritize where changes needed to be made first.

"So if they couldn't afford to wear gloves all the time, then maybe they could wear them when they drew blood," Pellico said. "The workshops were about exploring what they could do about protecting themselves given the realities of their own situations."

Nurses also said that they did not use gloves because they believed gloves would diminish the caring and close relationship they have with their patients. So the team talked about what goes into a caring relationship and what components—listening, making eye contact, etc.—would not be affected by gloves.

Burgess stresses that she, Wu and Pellico did not send the nurses away with "to do" lists. "We went to give them the tools so that if they choose to change, they can," she said. "Once we gave them the facts, they realized they were at risk. Their policies prohibit them from changing some of the things that put them at risk, but not all of them."

At the first workshop, they asked the nurses to identify two things that they could do to protect themselves from blood borne pathogens. At the second, they reviewed how successful those efforts had been and tried to get the nurses to support each other work toward reform. They were joined by Williams in a workshop for head nurses, in an effort to win support for blood borne pathogen education at higher levels.

The work will not end with a planned third workshop, says Burgess.

"An important stage of change that is often neglected is maintenance," she says. "It's like when we say to a patient, 'You've quit smoking. Terrific. Goodbye.' That's why programs fail: we expect people to sustain change with no support. That's not how we do things. We're going to have ongoing contact with these nurses, just as we do with the nurses who were in our AIDS programs."

While Pellico concentrated on prevention of blood borne pathogens, and Wu served as an expert on both Chinese and American practice, Burgess spent more time talking about organizational change, giving examples of what's worked in the United States and inviting the Chinese nurses to discuss whether similar strategies would work for them or what other means might be more effective.

Pellico calls the sessions, "one of the most profound experiences I've ever had," because she enjoyed watching her Chinese colleagues become aware of the real power they had to affect their own practice.
Low energy. High blood pressure. Forgetfulness. Incontinence. Depression. All are serious problems, yet all are considered “to be expected” in elder adults. Courtney Lyder, director of YSN’s gerontological nurse practitioner studies, is using his role as a federal consultant to inspire clinicians to raise their expectations about the health and vitality of elders, particularly those living in nursing homes. *Continued on page 20*
Lyder's research area is pressure ulcers, or bed sores, common and very painful wounds often suffered by elderly adults with limited mobility. As a consultant for the Health Care Finance Administration, which controls Medicare and Medicaid dollars, Lyder travels around the country teaching clinicians and administrators that pressure ulcers, once considered an unavoidable side effect of long term care, are frequently preventable and highly responsive to new healing technologies. He also helps set federal standards for pressure ulcer care and is writing a “white paper” on the subject which will serve as the scientific basis for HCFA initiatives on pressure ulcers.

“You really can make a difference in pressure ulcer care,” says Lyder. Lyder's work has clearly done just that. For example, pressure ulcer care was the number-one deficiency cited by surveyors monitoring long term care in Maryland before Lyder gave a presentation there in June of 1999.

“It looks like our pressure ulcer citations have dropped approximately 35 to 45 percent since then,” said Lynne Condon RN-C, education and training supervisor at Maryland's Office of Health Quality. Condon stressed that those statistics do not cover every long-term facility in the state, but include a significant percentage. She also said that care coordinators have been telling her anecdotally that they've seen a change. Condon believes that Lyder deserves credit for helping that improvement come to pass.
"Our providers are better informed about prevention, and more aggressive interventions have been the result," she said.

"It's surprising what people think they know, but really don't know," says Lyder. Standard practice is to turn immobile patients every two hours to prevent pressure ulcers, but Lyder said that the standard has little meaning.

"I'll come into a lecture hall and say, 'I want you to sit on your hand for two hours.' Nobody wants to do it for ten minutes. It's very uncomfortable," Lyder says. "Yet we expect frail, debilitated, immobile people to sit in the same position for two hours."

Lyder asserts that some patients may need to be turned as frequently as every half hour. That leads to the obvious objection that his program calls for increased staffing in a setting where costs are already high. But Lyder insists that better pressure ulcer care doesn't require more staffing; it requires something even more difficult to secure "organizational change." It goes back to his contention that decline does not have to be accepted as a natural consequence of aging.

"You don't have to spend money for more staff," Lyder says. "You just need to use the staff you have more wisely."

Incontinence, for example, is a major risk factor for pressure ulcers. "The literature shows that 50 percent of the elders who are incontinent in nursing homes can be reversed," Lyder said. Nursing home professionals need to address and correct the risk factors for pressure ulcers, such as incontinence, poor nutrition and immobility. Lyder conducted a HCFA-funded study in five Connecticut nursing homes to see if they were properly assessing pressure ulcer risk, diagnosing early stage ulcers and treating them appropriately. None of the homes were doing all three.

"I don't think a CNA or an RN or the director of nursing goes to work in the morning and says, 'Today I want to give poor care to a patient,'" says Lyder. Believing that care providers have the resident's best interest at heart, he has tried to bridge the traditional adversarial role between nursing homes and regulators to work in concert to improve resident care.

Lyder serves as a consultant in a three state project (Pennsylvania, Rhode Island and New Jersey) that pairs HCFA officials and state health departments with 30 nursing homes to focus on moving facilities toward quality improvement in pressure ulcer care rather than on citing violations. "We have had an improvement in pressure ulcer prevention and management in all three states," says Lyder.

"The common denominator is that we want to provide good care for our residents."

In the work of raising standards of care in nursing homes, Lyder sees a prominent role for academic institutions like ysn.

"I think we have to serve as a repository for the best of the best practices in pressure ulcer care," says Lyder. "The work that we need to do for the next couple of years is to give people the tools they need to work smarter and give elders better care. That's always been a major role of nursing: looking at systems and changing them to raise the standard of patient care—and it's always been an area where Yale has taken a leadership role."

"People look at nursing homes as the end of the road," says Lyder. "Historically, nursing homes were places where people spent their very last days. But now we are prolonging life. The average time in a nursing home prior to death is seven to eight years. We have an obligation to look at the quality of those years."
Heather Reynolds would rather help a mother breathe through contractions or talk with a young woman about safer sex than make speeches. But every now and then, she does feel a speech coming on. "When I talk about families and people I care for and care about, then I get eloquent," says Reynolds. A member of the midwifery faculty, she has been active locally and nationally on issues ranging from minority representation in the health professions to infant mortality.

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Reynolds takes her clinical concerns to Washington
Reynolds just stepped down after an eight-year stint on the Secretary's Advisory Committee on Infant Mortality, part of the federal Department of Health and Human Services. Her term began just as New Haven was seeing a turnaround in infant mortality. During the 1980s, New Haven had the highest infant mortality rate in the nation for a city its size. Unfortunately, the city was not large enough to qualify for federal programs that would have provided funding to improve the situation. But concerted community efforts made a difference. From 1985–87 to 1993–95, the infant mortality rate in the city declined 28 percent for whites and 44 percent for non-whites. Reynolds has tried to bring the lessons learned in New Haven to the national level and to use her national policy platforms to benefit her patients back in New Haven.

She had served on the city's Commission on Infant and Child Health along with YSN colleague Helen Varney Burst and a variety of "payers and players" representing a broad range of constituencies. The commission worked to develop prenatal care in New Haven that would be easy to use and continuous. They formed a "Hassle Committee" to scout out everything from inconvenient hours to convoluted voice mail systems that might serve as barriers to care. Enlisting Infoline as a partner, the commission did a major public relations campaign urging pregnant women to call Infoline, where phone counselors had comprehensive information about services.

The New Haven experience and her continuing midwifery practice at Yale-New Haven Hospital's Women's Center, prepared her for the work she would do in Washington. "I was still very much in clinical practice at the front lines, so I could anticipate implications of policy decisions at the grass roots level," says Reynolds.

One of Reynolds's major concerns remains racial discrepancies in health care. People of color fare worse in a variety of health indicators than do their white peers. This is evident in infant mortality where the rate in African-Americans is two to three times that in whites. Native Americans and some subgroups of Hispanics have lower infant mortality rates than African-Americans, but still exceed the rate for whites.

"Even when we look at African-Americans and whites of similar socioeconomic status, there is still a difference in birth weight," says Reynolds. "Why? We need to spend federal money researching these disparities. What is it about the society that being black in America makes a difference? We need to find ways to measure how racism and classism affect us. The chronic stress may in fact affect us so that we're at increased risk for disease."

As the first nurse to join the Secretary's Advisory Committee, she spent a lot of time working on language: health care rather than medicine, health care provider rather than physician. "Many of my physician colleagues always thought of providing health care as something that doctors do. They didn't mean to be disrespectful to other providers. That was just not the way in which they were generally oriented," she says.

While Reynolds has spent considerable time broadening access to prenatal care, she acknowledges that it is just "a Band-Aid" to the problem of infant mortality. She believes in what she calls preconception and interconception care. To have healthy babies, women need good health care long before they conceive, she says. And for those babies to stay healthy, myriad conditions ranging from good housing to good jobs need to exist.

"Children have to be housed in their mother's womb before they come out," says Reynolds. "After they come out they have to live in families and communities. If these families and communities lack the resources to adequately nurture that child, then the quality of that child's as well as the community's life is compromised."

While infant mortality is a shocking problem that draws much attention and resources, addressing it in isolation won't work, according to Reynolds. To improve the prospects for newborns, nations and communities must ultimately address the status of women and children, she says.
The health care safety net, a loose network of providers who give care to patients regardless of their ability to pay, is woven of fragile threads and is under a disturbing amount of strain.

That is the conclusion of a recently issued Institute of Medicine report on safety net providers. On the heels of her 13-year term as dean, VSN's Judith Krauss spent a sabbatical at IOM and served as the Distinguished Scholar in Residence to provide the research for the committee who wrote the report.

"As a nurse and an educator, I have two overriding concerns," says Krauss. "First, for the patients served by this fragile safety net system, I hope we find a way to support the safety net and the providers with the special skills necessary to care for these patients; and second, for the next generation of health care professionals who must make care of the poor and uninsured a national priority both because it is the right thing to do in a nation of such wealth and because if it isn’t done right it will affect all of health care in the years to come."

The health care safety net is composed of such varied providers as community health centers, public hospitals and private physicians and nurses who give charity care. The report found many of these groups put under extreme strain by the growing numbers of uninsured Americans. Growing numbers of low-wage workers are not getting health care coverage from their employers. The need to care for immigrant populations places added stress on the safety net in some communities, particularly in California, New York and Texas. The average length of time that families go without insurance is stretching out. The safety net is also affected by a decrease in Medicaid eligibility and by Medicaid managed care. The report also said that as families are put off public assistance as a result of welfare reform, many become uninsured because they do not realize that they can maintain their Medicaid coverage.

For many safety net providers, Medicaid has traditionally been a prime source of revenue. But with the advent of Medicaid managed care, some Medicaid recipients were actively recruited for membership by managed care organizations. Thus the traditional safety net providers lost income. Ironically, many patients loose and regain their eligibility for Medicaid periodically. During periods when they are not receiving Medicaid and cannot afford private insurance, they return to their safety net providers.

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Krauss works to draw attention to threats to the health care safety net

Vulnerable patients, vulnerable providers
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The report also noted that safety net providers are more likely to provide supportive services, such as transportation, to increase access to care than are Medicaid managed care organizations. Krauss's particular interest is in one vulnerable population, people with serious mental illness, a group she has studied most of her career. She says that Medicaid managed care has helped to integrate care for minor mental illnesses, such as depression, with general health care. But systems of care for people with serious mental illness, like that for other vulnerable populations like the homeless and children with special needs, remain riddled with barriers. Mainstream providers often lack the skills to provide all the services that vulnerable populations need.

The report stressed that in addition to the moral imperative to provide health care for vulnerable populations, pragmatism dictates that Americans take an interest in the viability of the safety net. A failure of the safety net would mean more overcrowding in emergency rooms (which often function themselves as safety net providers), more homeless on the streets and a higher level of disease and illness in the population.

Krauss, who has returned to Yale to teach at the nursing school and serve as master of Silliman College, said that her Washington stint gave her an increased respect for the business of policy making as well as a sense of the imperative for nurses to publish more in the field.

"Policy studies are driven, literally driven by what's in the literature. If there's nothing in the literature that pertains to nursing, then there's very little you can say about nursing as a discipline," Krauss says. She spent much of her time as a distinguished scholar searching for relevant literature, in addition to doing site visits around the nation and commissioning original scholarship for the project. She provided the information to the IOM committee, a group of varied experience—and opinion.

"IOM seeds these bodies with every known bias," Krauss says.

Ideally, the result is rigorous debate and an eventual consensus proposal that has a fair chance of winning support. She says that the process is a good illustration of the difference between advocacy and policy.

"I can either walk around lamenting the political reality, or I can figure out how within the current political reality to implement policy changes that will benefit the people I'm more interested in," she says.

Krauss pronounces the process of consensus building, "extraordinarily healthy."
Grey shapes the agenda in a developing science

Nursing in a new century

Associate Dean for Research Affairs Margaret Grey has helped to shape nursing research through her own groundbreaking work. Now she'll have a hand in setting priorities for other scientists in the discipline. Secretary of Health and Human Services Donna E. Shalala has appointed Grey to the National Advisory Council for Nursing Research, the body that determines how federal dollars for nursing research should be spent. Her four-year term began in February, 2000.

Grey is one of only three nurses on the 12-member council that helps determine the course of nursing science. In addition to making decisions on individual grant requests, the council more broadly influences the areas in which federal dollars will be concentrated.

Historically, the National Institute of Nursing Research (NINR) has devoted a relatively high percentage of funds to research training as opposed to research projects. "That's a reflection of the developmental nature of our science," says Grey. "As more senior researchers emerge in the discipline, we'll see a shift in our funding priorities. How that shift will take place is one of the major issues that NINR will face in the next five to ten years."

Grey herself has a distinguished record of clinical research concentrating on the adaptation of children and their families to diabetes. In a health care system that often focuses on acute illness, she is a strong advocate for systemic change to better support people living with chronic conditions. "My own area of interest is patients with chronic illness," says Grey. "I strongly believe that more research is needed to chart strategies to help the large and underserved community of families coping with chronic illness."

Grey will continue to serve as the nursing school's associate dean for research affairs and Independence Professor of Nursing.

"Margaret Grey has overseen a tremendous period of growth in YSN's research effort that included the founding of our doctoral program," says Dean Catherine L. Gilliss. "The same intelligence and passion that she has brought to scholarship at Yale will now go to serve the profession of nursing as a whole. Obviously, as dean of the school I'm pleased to see faculty appointed to prestigious bodies. But on this occasion, I am pleased mainly as a nurse, because having Margaret Grey chart the course for nursing research in the next century is one of the best things that could happen to this profession that she and I love so much."
The Vietnam Effect

We know precious little about the health of Vietnam veterans as a group, but we do know enough to be scared. We know that these veterans have higher rates of cardiovascular disease than their peers who did not serve. We know that the Veterans Administration recognizes 10 diseases in veterans and spina bifida in their children as being related to Agent Orange. My vss colleague Linda Schwartz's own research shows increased rates of cancer and miscarriage in women who served during the war and high rates of birth defects in their children.

When Schwartz first approached me with her findings, I knew that I wanted to support her work. As scientists, we pursue truth for its own sake. As nurses, we have a special interest in seeing that women veterans have their health concerns addressed. In every armed conflict that the United States has ever entered, nurses have put themselves in harm's way to do their jobs. They have often gone unrecognized for this service, largely because the majority of them were women. As Linda Schwartz, herself a Vietnam veteran, said recently when she testified before Congress, "These women are dying without even having the honor of knowing that they are dying for their country."

YSN recently became the first private institution to gain access to the Air Force's Ranch Hand data. Ranch Hands were the men who sprayed Agent Orange in Vietnam. To presume that they are representative of Vietnam veterans would be absurd. But it is a large data set and worth mining for information. After having spent $140 million on the study, the Pentagon has strangely left many stones unturned. For example, they collected data on the health of 8,000 children fathered by Vietnam veterans, but analyzed that data in only 500 of those cases. Such omissions are an affront to the thousands of veterans who participated in the study and trustingely provided that information.

We should be asking about Vietnam service the same way we ask about heredity, smoking history or the presence of firearms in the home. Vietnam service is a health risk; that we know. How big a risk remains to be seen.

25 years ago, I was a psychiatric nurse working in a veteran's hospital. At night, it was a locked ward, which meant that the patients could not get out. I always found that to be a good metaphor for the mental state of many of the men I saw. They were trapped, psychologically, back in Vietnam. We did not have a name for post traumatic stress disorder back then, but that did not make it any less real. No reasonable person who saw these patients would dispute that their ongoing pain was related to their service in Vietnam. For them, the war was not over.

Recently, a veteran awoke from cancer surgery in Yale-New Haven Hospital. He also found himself back in Vietnam and began screaming for a medic. No reasonable person would dispute that his mental distress was linked to his military service. A growing body of scientific evidence makes me go one step farther to ask whether his cancer was also caused by his service in Vietnam.

It is a question that demands an answer.