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Yale School of Nursing

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COMMENCEMENT AND ALUMNAE/I WEEKEND

SEPTEMBER 1986
From the Editor - Judith Tierney '79

This is our annual gala issue of Yale Nurse, with articles and pictures of YSN's two Spring celebrations, graduation day and Alumnae/i Weekend. As new Editor of the Yale Nurse, I'd like to make each issue chock full of news --- news about YSN and news about you, the alums. Graduation and Alumnae/i Weekend come only once a year and many of you across the country are doing interesting things that the rest of us would like to know about - or you have gleaned insights from practice and teachings -- or you work with special populations.

I know writing, even a short summary for the Yale Nurse, takes time -- so I'll do it for you. Drop a brief note to the Alumnae/i Office about yourself or another alum, and I'll arrange a telephone interview, and write it up for one of our issues.

If you have comments or thoughts about the School, do write a letter to the Editor. We'll print as room permits!

Judy Tierney '79

THE 1987 ALUMNAE/I WEEKEND WILL BE HELD
ON JUNE 4-5-6
START PLANNING NOW!
The Yale University's 285th Commencement on May 26th was topped with clear, cool sunny weather, and the excitement of the day was evident in the faces and actions of the 3,000 students and over 12,000 guests. The academic procession marched amid bright balloons, banners and flags to the Old Campus where the traditional and colorful ceremonies took place, with awards and honorary degrees being presented.

The afternoon ceremony at the School of Nursing under the tent beside the building was the more personal and informal event when 67 graduates received MSN degrees and 25 students received Certificates in Nursing. Dean Judith B. Krauss greeted families and friends with remarks to open the program.

"I love Yale Commencements. There is just the right cacophony of color, song, majesty and commentary, understated but elegant, that makes one feel elite, which seems to me to be so very Yale and so very right for all of us gathered here on this particular day for this particular occassion.

I've been especially pensive about this Commencement. In fact, my melancholy has persistently prevailed upon my efforts to put cogent thoughts to paper. Some of you here might have empathy for my temporary case of writer's block, having all too recently experienced it yourselves. Others of you might take a certain pleasure in the fact that I, like you, had a final deadline to meet and we all met it! Nonetheless, my pensiveness persisted. Why? I did one of these last year. Granted, I was then the Dean designate -- time yet to escape the dubious deanery with dignity still intact; and, granted, the man who appointed me has resigned the Presidency -- enough to give one pause about the ultimate wisdom of one's career decision. None of these things, while they may be contributory, explains my sense of the potency of this day, this Commencement.

I finally realized that you explain it -- the Class of '86. The significance of my relationship with this particular class is that I have known many of you in my previous roles as an active member of the teaching faculty and Associate Dean. You are likely to be the last class that I know both personally and individually as well as collectively. It is this change in the way of knowing you that will make this Commencement as indelible in my mind as I suspect it will be in yours.

Just what do I know about you? Judging from the color of the Bixler Lounge (hot pink), I know that many of you are heavily influenced by Miami Vice. I know that one of you was willing to risk the loss of her thesis to flames in order to save our building from burning in the dead of night. I know that about a third of you will be leaving here heavy with both the acquired insights and the acquired pounds that sometimes goes with the graduate professional school experience. Another third of you will leave uplifted by new knowledge and a significant loss of pounds that sometimes goes with the graduate professional school experience. The remainder of you will neither gain nor lose weight and I can only hope that your learning curve has no correlation whatsoever with that variable.

How do I know all this? I know that some people eat under stress, while others stop eating, and still others deny the stress so vigorously that they fail to experience the associated anxiety. And, I certainly know that this has been a stressful experience for most of you -- for most of us.

I also know that it is uncontroversible fact that the members of the graduating Class of '86 who sit before me capped and gowned have been placed on a certain reference librarian's desk no fewer than 3 bound copies of their masters thesis, in the proper shade of blue, with all pages accounted for, APA format, and no detectible dot matrix print.

I have been privileged to know many of your more serious struggles to achieve this degree -- the sacrifice of your families; the pain and then the elation of self-discovery; the achievement of clinical wisdom; the toll that can be taken by time alone; and, finally, the mastery. All of this has taken place in the context of a unique university environment.

President Giamatti has had much to say about the value of a university education. In a recent interview, he had this to say about being the President of Yale:

"...you don't think of yourself as running a company because it's clearly not. Its a university. It's a
university whose purpose is to foster an environment where people of all ages and interests and talents teach and learn and disseminate ideas... (Universities) are fragile, tough artifacts which the human mind makes up so that the human mind can then have a place devoted constantly to continuing to make with the mind. They are products of our human part and make us explore the nature and purpose of our humanity and its worlds. They are endlessly worth cherishing.

(YAM, May, 1986, p 17)

Who among us could doubt that nursing has a rightful and purposeful place in such a setting? Nursing care is heady, human, stuff. Clinical judgments are made with the mind. They are not preordained and do not leap lightly from predigested facts. For nurses, clinical judgments are nurtured in the medium of human relationships and have as much to do with values and ethics as they do with taxonomy and technology.

While you have been here you have learned to care by attending to human vulnerability and assisting people to cope through knowledge of their illnesses, awareness of risk factors, self-care, comfort, and counseling. You have also learned to assess, diagnose, and use certain technological skills sometimes referred to as the practice of medicine.

But, you've really refined the practice of nursing through the roles of the clinical specialist, nurse-midwife, or nurse practitioner. You've used those technologies in a different context and with a different goal. They were vehicles to the total care of people -- people who hurt, or were frightened, incapacitated, or changed by illness and people who were well and wanted to know how to stay that way. In using the technology in a nursing context you provided relief as well as understanding and knowledge, ever mindful of the larger meaning of health, illness, and the quality of life.

You've made a large investment in your Yale education and, here, I speak directly of your tuition and loan indebtedness. We've made a large investment in your Yale education, and here I speak directly of our resources, financial and human. I already know that the investment has been a wise one -- I have the advantage of traveling the nation to meet and speak with our Alumnae/i. I know that they have been prepared to shape a dynamic health care system. I know that your two or three years here have provided a kind of depth and immersion in nursing practice that is not offered elsewhere, a depth that is enriched by research and the science of caring.

The process of becoming a clinical scholar and advanced practitioner of nursing is not without other costs. Your metamorphosis has undoubtedly altered your personal and professional relationships in significant and enduring ways. So enduring that I feel compelled to use the occasion of this address to warn your families, friends, and colleagues that we are not returning you in exactly the form we received you; and that, for the most part, it is you, not we, who are responsible for those changes -- changes that will make it possible for you to capitalize on your investment by transforming and enriching an eroding health care system. I encourage all of you to take some time to come to know one another again.

I seem to have returned to the original theme of knowing you. How do I know you? I know you very well, my friends, because you are the Yale School of Nursing and you are what I mean when I speak of nursing and of caring. In that sense we cannot become strangers. Indeed we are intimate partners in a mission of reform and leadership. I am sure the faculty and the Alumnae/i welcome you as YSN Alumnae and Alumni!

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**VECKERELLI PRIZE**

Through the generosity of June Veckerelli, Class of 1955, a prize to be given to a graduating student was established. Called the Andrew A. Veckerelli Prize, it is given annually at Commencement to the graduating student who: ...has demonstrated outstanding performance in scholarship and clinical practice and through these efforts has inspired others with an admiration for professional work.

This year's Veckerelli Prize recipient has been a source of constant academic and clinical inspiration to students and faculty alike. Her standards of clinical and academic excellence have been paradigmatic for those who have been fortunate to know her.

As a clinical scholar, her ability to take the minutiae of the field, see relationships, and pull together ideas tailored to nursing care...
that meets the individual patient's needs is beyond the seasoning of her time in nursing. She has captured the idea of a conceptual framework for clinical practice and uses a basic needs and illness trajectory approach to identify common problems for nursing intervention beyond ordinary expectations.

As a practitioner, she is exemplary. She attends to detail and makes excellent use of self with patients. Her ability to translate theory into practice is exceptional. Indeed, she has done pioneering work in the application of theoretical models to practice. Her scholarly papers are uniformly of publishable quality and her master's thesis has been characterized as doctoral level research.

Although many with her competence, knowledge, technical skills and interpersonal savvy would be resisted, she moves freely among her peers and those beyond her experience as an equal. She efficiently and gently commands respect. She is a clinical scholar equal to few in nursing today or any day. In this year of Haley's Comet let us count her as a new star in the YSN constellation -- Rhea Carolyn Sanford.

This year the recipient was Ruth Nelson Knollmueller, R.N., MPH, lecturer in Community Health Program.

Ruth Nelson Knollmueller congratulated by Sarah Abrams '87

"The clinical specialist in Community Health Nursing is both continuation and improvisation on a theme with deep historical resonance, that of public health nursing. Our honoree has been both bridge to the present and compass for our future efforts. She has shown us how to live and work on the cutting edge of health and nursing care. She has also prepared us to act as cushion for those all to often injured by that sharp edge. She is a nationally recognized nursing leader, and an eloquent, vigorous, farsighted, independent-thinking and caring model, both for those of us who come here as nurses, as well as for those, like myself who have been directly shaped by and modelled at YSN. For me, she has been both a secure foundation and a vision of new creation."

Don Edwards

"I am delighted to have the opportunity to present an award to someone dear to me and dear to many of us who are graduating today. The award is the Annie Goodrich Award given for excellence in teaching. This year's recipient was my first impression of the Yale School of Nursing. She was ready and willing to share with this unannounced visitor from the West her time, her enthusiasm for the Yale Community, her energy, and her commitment to Community Health Nursing. During the past two years I have discovered that her energy and enthusiasm are surpassed only by her ability to give of herself in many ways. Her humor and her faith and her experiences have fostered independence, creativity, and professional responsibility in her students which will keep them in good stead as they move onward with their lives and careers."

Kathryn Barrett

GOODRICH AWARD

Annie W. Goodrich, founder and first dean of YSN is remembered as a leader and innovative contributor to nursing education. Since 1978 an award for excellence in nursing education has been presented in her honor to a faculty member. A student committee chooses this person based on nominations submitted by classmates. The winner receives a certificate and his or her name engraved on a plaque in the YSN library.
ALUMNAE/I WEEKEND - 1986

A record number of Alumnae/i returned for some parts of the weekend on June 5-6-7. They came to YSN for reunions and continuing education from Washington, California, Texas, Florida and many points in between. Those arriving on Thursday enjoyed a picnic in the courtyard at Saybrook College hosted by Ann Ameling '67 who is now the Master of that College. After supper, Beatrice Burns lead a discussion on the Impaired Nurse.

The Alumnae/i College Program on Friday, "The Deinstitutionalization of Nursing: Back Home with New Challenges" was expanded, illustrated and made alive by the presentations of outstanding speakers. We are anxious to share these stimulating and thought provoking papers with all Alumnae/i.

Keynote address by Margaret J. Cushman YSN '76, Executive Vice President, Visiting Nurse and Home Care Inc., Hartford/Waterbury.

A REDISCOVERED OLD CONCEPT:
HOME CARE

I am delighted and honored to be with you today. When I first entered the corridors of YSN it was with the hope armed with my Yale education, I would be in a position to be considered for a leadership position in home care within 10 years of graduation. I mean, directorship of a small to medium sized home care agency.

Yale, I apologize for underestimating your education! You (and special thanks to former Dear Diers and Ruth Knoellmuller) armed me with an education and experience which has challenged me far beyond my wildest dreams, in the brief decade since I left your halls. In my biased opinion, this esteemed school, through its Public Health Program and more recently in the clinical specialist track of the Community Health Program, has provided the finest grounding of home care and community health practice... and even more important, management ... for nurses, of any school in the nation. Thank you.

You are also to be congratulated for your forward thinking. You have picked a trendy topic - avant guard even glitzy. Literally glitzy. Last fall, the annual convention of the National Association for Home Care was held in Las Vegas. Amid flashing lights, neon signs and video displays, we were greeted by Kirk Douglas and Helen Hayes. That is significant, because what is happening in home care today is so popular that they have dedicated themselves to furthering the development and public recognition of home care.

The keynote address at that conference was delivered by futurist Paul Starr, and the closing keynote by futurist Marvin Cetron. I'm delighted to share with you they both concluded that home care is a vital, essential and growing part of health care. Health care, as you all know, is the fastest growing segment of the gross national product and home care is the fastest growing part of health care. Home care has been reinvented after nearly 100 years.

To be in home care in the 1980's and 1990's is a glorious opportunity for nursing. Just like it was in the 1880's and 1890's. And it's a good obligation, because we've nearly lost it.

Before talking to you about the future or present of home care and nursing, I want to talk a bit about our mutual origins in the United States. Early home care founders and providers were aligned with revolutionaries. They were visionaries, driven to create change ... to take care of people ... to promote the health of communities.

Who were these leaders? These visionaries? They were nurses: the same visionaries and leaders who did so much to shape professional nursing in this country. They include Lillian Wald, Annie Goodrich, Mary Adelaide Nutting, Lavinia Dock and Mary Beard, to name a few.

I recently found out that Lavinia Dock founded the Norwich agency, the oldest in Connecticut. Mary Beard, an early leader of the American Organization of Public Health Nursing was the second director of the Waterbury Visiting Nurse Association. These women were not complacent homemaidens. They were suffragettes. They were underhanded when necessary to achieve their goals. They were risk takers who believed in their mission. That's how we started.

In the 1940's, when physicians moved their practices into offices and hospitals, there was a concomitant growth in visiting nurse services. Nursing was home care in the United States for the first half of this century. Most agencies offered only nursing services. In contrast, home care in Europe was founded principally on home help, or ancillary workers. Separate homemaker - home health aide agencies grew up in the United States in the 1950's to provide ancillary services.

Then came Medicare in the 1960's. Medi-care had a dramatic impact on reshaping most of home care into an extension of acute care. The Medicare home care benefit was created and cast as a medical model. Medicare quickly became the largest payment source for home care services, which has fueled it's influence on what services are available. Covered services include intermittent nursing, physical therapy, occupational therapy, speech therapy, medical social work and home health aide visits. Coverage of services is dependent on a written plan of treatment ordered by a physician.

Today, the need for home care is growing with the increase in the elderly population and...
early hospital discharges under prospective payment. By the year 2020, almost one-third of the U.S. population will be age fifty-five or older. We already serve the old, and the old - old. Seventy-five percent of our agency's clients are over 65 years of age: of that 33% are ages 75 to 84, and 13% are over 85 years old. Until a few years ago, most agencies kept statistics by 10 year age groups up to age 64, and then 65 and over. A couple of years ago, our agency added breakdowns for 65 to 74, 75 to 84, and 85 and over. Last year we added categories for 85 to 94, 95 to 104, and 105 and older.

With the growth in the aging population, we are taking care of elderly who are assisting with the care of their more elder parents. We also are witnessing the problems of the "sandwich generation" who are trying to put children through college and cope with the long term care of aging parents. I believe there is a great misconception that the growth of home care is due to overutilization by people who could be cared for by their families. We find most families want to help and do everything they can within their limited resources, both time and money.

These trends highlight the growing need for long term care services modeled after the European systems. We need to integrate increasing amounts of non-professional services, and case management into our care, even though funding for such services is fragmented and inadequate.

Meanwhile, with the explosion of home care needs and the lack of adequate funding, preventive services have all but disappeared from home care. Child and adult health guidance are key to reducing the growing need for long term care services in the future.

The 1980's are a time of new program thrusts in home care. New services include hospice care, respite care, Alzheimer's specialties, geriatric counseling, pediatric home care, and provision of high tech procedures in the home. We are also seeing a return to private duty nursing and service availability 7 days a week, 24 hours a day, as patients are being discharged "sicker and quicker", often directly from intensive care units.

The change in need and the nature of care explains part of the growth in home care. The growing elderly population is further fueling the growth. However, all is not smooth sailing.

The Congressional Budget Office now estimates that the Medicare trust fund will go broke in 1994 ... instead of 1989. The current Medicare outlay is increasing 11% a year. Recent presentations by the American Enterprise Institute note that health and retirement are enormous problems to the federal budget. They note that if all government expense except health programs, retirement, defense and interest were eliminated, we still couldn't balance the budget.

As you know, Congress must balance the budget, and there are strong feelings among some that health and retirement must be cut in the process. These forces have led to a federal schizophrenia about home care: a sort of love-hate relationship.

Prior to Medicare, there were around 1500 home care agencies in the United States. Virtually all were voluntary (visiting nurse associations) or official (public health nursing agencies). In 1982, there were 3,765 agencies: 516 voluntary, 1,207 official, 518 hospital based, 725 proprietary, and 626 private non-profit agencies. By last year, there were over 5,000 agencies with major increases in hospital based, followed by proprietary agencies. As of June, 1986, there are over 6,000 agencies.

This kind of growth in providers is scaring federal policy makers. On the one hand, we have a need for more services due to the early discharges and larger elderly population ... on the other hand we face budget problems, concern about unnecessary utilization, and fear of fraud and abuse. Hence, the schizophrenia, leading to an unprecedented series of attacks on home care from 1983 to 1985.

Those of you who are providers may feel that I am understating what is happening in terms of the administrative attempts to dismantle the Medicare home care benefit. The Health Care Financing Administration has made no less than 35 initiative to curtail home care in the past two years. Unfortunately, we will see these efforts continue for the rest of this administration.

We will see continued denial of benefits under Medicare if an individual needs more home care than the Medicare definition will cover, and the individual chooses to purchase the additional care they need. There are issues related to the change in fiscal intermediaries to 10 regional F.I.S. There are new documentation forms and guidelines which have significantly increased the length of nursing visits due to additional paperwork. There have been attempts to repeal waiver of liability, invalid statistical sampling denials applied to the universe of claims, restrictive interpretations of the terms intermittent, skilled, and homebound, and too many more issues for me to enumerate.

To focus attention on the critical series of initiatives against home care, the National Association for Home Care (NAHC) issued The Attempted Dismantling of the Medicare Home Health Benefit: A Report to Congress, released in March of this year. Findings documented in that report are based partly on a survey of home care agencies in the United States. In that survey, 97% of all agencies reported a significant increase in the paperwork burden under Medicare; 92% reported sharp increases in the number of sicker patients; and 75% consider a significant number of persons are going without the home care services they need in their own communities.

I would like to quote Val Halamandaris, President of NAHC: "...At a time when the air-
lines, the trucking industry, hospitals and nursing homes are being deregulated, the Department of Health and Human Services has promulgated an oppressive series of requirements applicable to home health agencies. Val describes the Medicare home care benefit as a box. The top of the box is the requirement for physician orders indicating that care is reasonable and necessary, the bottom of the box is the homebound requirement, the left is the term skilled, and the right is intermittent. All of these requirements are being redefined and interpreted more narrowly by fiscal intermediaries to deny home care coverage. Just like Alfred Hitchcock's elevator, the sides of the box are being squeezed together.

All of this is occurring at a time when the implementation of the hospital prospective payment system has had a dramatic impact on the home care industry, both in terms of the acuity level and the number of patients needing home care after a hospital discharge. In addition to the volume of anecdotal evidence from home care providers relating that patients are being released from hospitals "quicker and sicker" since the implementation of DRG's, there have now been several studies documenting this occurrence. In response to a request by Senator John Heinz, Chairman of the Senate Special Committee on Aging, the General Accounting Office prepared a report which concluded that under the DRG system, patients were in fact being released from hospitals to home care sooner and with greater severity of illness.

The increase in early discharges and growth of home care has led to a rash of Congressional hearings on the quality of Medicare and the adequacy of the home care benefit. The Medicare Quality Assurance Act has been recently introduced in the House of Representatives by Congressman Pete Stark, and in the Senate by Senator John Heinz. These bills contain several measures which would alleviate some of the problems outlined above. Incidentally, virtually everyone who testified at the hearings on these bills mentioned home care as a solution to caring for earlier discharged patients, including the American Hospital Association, and physicians.

Now, at the beginning of my talk, I spoke of a golden opportunity for nurses, and said we had nearly lost it. What did I mean? Home care is growing, with or without nursing in leadership roles, and with or without us in caring roles. After outlining the directions of home care, we can see that we traveled a full circle in the past 100 years. The basic needs of the majority of clients call for nursing care, case coordination and preventive health counseling. There is still a need for safeguarding the client and the community.

However, home care reimbursement is very complex. Cost finding is very complex. The management and understanding of resource flow in a home care agency is complex. Perhaps even more awesome, is the fact that direct care nurses actually control 80 to 90% of the flow of all costs within a home care agency, whether they are aware of the process and results or not.

Although VNA's were started by nurses and, even though we moved later to a Medicare imposed medical model, what we're now seeing is the danger that as we move more and more into home care, it is looking more like an acute hospital with the walls taken away.

The profit involved with home care is attracting a lot of people and attracting a lot of competition ... a lot of competition and a lot of players. Hospitals are now interested in providing home care due to changes in reimbursement. All kinds of folks are providing home care.

Equally significant, all kinds of folks are interested in running home care agencies. It is a very attractive place for hospital administrators and business leaders to move into and manage. Many agencies now seek MBA's to run the agencies. There is a whole cast of characters -- everyone is scrambling: it's a wonderful place to be!

Businesses are very interested in home care and there is a lot of activity by employers to understand what it's all about. There is also significant business interest in owning or investing in home care agencies.

Physicians are extremely interested in home care right now. A recent article in the New England Journal of Medicine discussed the physicians' role in home care and advocated that physicians really ought to recreate their home care role and act as a safeguard against delivery of inappropriate care (Koren, 1986).

It's even getting to be fun when an agency asks for a bid for an adult or other work. Auditors and management consultants are beginning to apologize to home care agencies because their literature is all hospital related. They are working very hard to change that as home care is assuming a greater role in the health care arena. It's a different atmosphere.

What I don't want to see happen with the shift of the acute care into the home care setting is the client's home turned into a hospital. We now allow the patient and family to set the parameters of care in the home. In "Ten Trends" (1986), an article that appeared in the January issue of Nursing and Health Care, ten trends affecting nursing in the future are cited. One trend deals with home care and states: "The home threatens to become a high-tech health care setting of the future, dominated by the medical model and run by the hospital and medical supply industries."

I read what's happening in health care across the nation in Modern Health Care in order to get a feeling for what the latest changes are, and the predictions for where health delivery is going. By the way, outsiders, when referring to the health care system or health care industry, are calling it the health care arena: like the gladiators arena. Some of the articles I've read give you the feeling for why. A huge number of those articles are devoted to the impact of prospective payment.
as it relates to new tactics to survive and "win" in health care today.

I'm caught between getting amused versus appalled at the number of articles which read like self-survival handbooks for providers. Some of the titles include "Prospective Payment and Budgeting", (that's fairly innocuous); "Prospective Payment Implications for Survival"; "Prospective Payment and Planing"... that sounds fairly innocuous until we get into guiding, controlling, and case mix management; and then there is "Prospective Payment and Boosting Nursing Productivity. I am amused because those are the kinds of things that health care providers could have done without prospective payment to the extent they are cost effective. I am appalled because we did not pay attention to those items which are cost effective without prospective payment and because they sound more self-serving than patient serving. How could a payment system so completely skew our values? Can we prevent providers from becoming nothing more than self-serving greedy folks?

Arnold Relman asks us to put the public interest first -- even if it's ahead of our own survival (Clark, 1986), and I agree with him. The public is very concerned about how we're behaving in the scramble for the health care buck.

I don't know if you are aware of it, but Aetna has created a "Fraud Squad" (Washington News Briefs, 1986). There's a gentlemen whose sole purpose, in private insurance, is to stem financial fraud by health care providers in the home, in the hospital, in all kinds of practices. According to Mr. Garcia, who heads the fraud squad: "Healthcare fraud has increased because providers have been forced to devise alternative ways to protect their incomes and their practices. A lot of practitioners feel they must commit fraud to stay competitive. These behaviors are a far cry from home care's roots and our founders' nursing commitment to patients. Who can better lead us back to that commitment -- care first, not survival first -- than nursing? And where is nursing in all this?

I referred to the federal schizophrenia a moment ago. Nursing is displaying apparently even greater divided behavior over home care than the federal government. I don't want to call it schizophrenia -- there is a fun term that's come to my attention from my boss who had received a transcript of a meeting that she had chaired. The person transcribing and didn't know medical terminology and recorded a new term "skit - so - frantic."

As was noted in the article "Ten Trends": "the locus of health care is shifting from the hospital to the community and home, where other providers' and values are treading once traditionally nursing turf." Nursing magazines are beginning to display concern about everybody else moving into our territory, but it's our own fault. This trend results from our failure as a profession, to acknowledge that at the same time that clinical practice could and should be developed for nurse practitioner roles, nurses also needed to be educated in management.

At a time when the development of business skills were essential to nurses to maintain management of home care agencies, nursing actively discouraged nurses from entering management. Our profession and schools actually scourgized a lot of folks who wanted to learn such skills and aspire to management positions. As a result, many of the people in the leadership positions in home care, determining the future of the care and services to be rendered: deciding whether or not it will become a scramble as opposed to a compassionate setting, are not nurses.

In an article written by Bartkowski and Swandy (1986) this past Spring, they comment that if nursing doesn't capitalize on its unique relationship to the trends that are now going on, other professionals will. To quote: "The future holds remarkable opportunities for health care professionals to change traditional delivery system." The authors challenge us -- nursing -- to be the ones to do that. Nursing is slowly awakening.

The American Nursing Association (ANA) has drafted a resolution for this year that would have community health nurses maintain leadership positions within the field of nursing and community health. ANA's rationale is that nursing should maintain their historical control of home care (Thomas, 1986). The National League for Nursing is suddenly realizing its accreditation program addressing home care so that nursing can maintain some control over quality standards. Incidentally, the new competitor in home care accreditation is the Joint Commission on Accreditation for Hospitals (JCAH).

It was fun at the University of Michigan's second annual symposium on home care this year, because unlike previous home care gatherings, the associate editors of major nursing magazines were there and virtually everybody who was giving any type of presentation, was deluged with requests to provide information about home care. They are seeking information on the new high-tech, on casefinding; anything on home care. RN Magazine is planning to open a whole section within their journal dedicated to nothing but nursing care in the home. Those are some good signs. I was also pleased to see that Dean Krause, in a recent edition of The Yale Nurse noted that with the aging of the population and all those types of things, that we need to expand our understanding of the nurse practitioner's role to meet the care of patients at home (Krause, 1986).

This is where I'll risk saying something controversial before an audience of strong practitioner advocates. What we don't need is super specialists in nursing moving in and making the home a super specialist setting in a turf war with physicians. What we need very much are nurse practitioners and physicians to join hands and collaborate with excellent well-
rounded and prepared community health nursing experts who are generalists. In the home one person may have to address a variety of issues. In the absence of the generalist population, it would be extremely difficult to care for folks in the home. That is a tremendous opportunity for nursing because generalists, the nursing leaders, and the practitioners can all join hands to change, not just home care, but, remember, its the fastest growing segment of an industry - Health Care. That means we can also shape the values and the practices of the home health care arena. We can be a mover and a shaker in that!

There are some things that keep us from moving in that direction. I'm about to retell a story that I heard from Dennis Waitley in one of his tape series where he talks about Tim. Tim is this fellow who was watching his wife one day fixing dinner. She took the ham and she cut off both ends and put it in the oven. Tim asked who do you always cut the ends off the ham? She replied, my mother always did. Next time he was over to her mother's for dinner he asked her the same question, why do you cut off both ends of the ham? I don't know why, but my mother always did, she answered. At the next opportunity when at grandmother's house for dinner, she was not cooking ham by the way, he asked why she cut the ham at both ends. She looked at him and said, I don't know why you're asking, but, it's because my pan was too small. That tale is about change.

Rosebeth Moss Cantor dresses it up a little bit differently when she says in her book, The Change Master that it's very hard to drive forward when you're looking at the rear view mirror. If we are to move back into the leadership position in home care and exerting our rightful place in something that bore our name from the beginning, we have to be prepared to shake off some of those "ends of the ham" behaviors that might cloud our vision of where home care could go.

There's another phrase that I'd like to share from the article by Bartkowski and Swandby (1986) which relates to the Taoist tradition of leadership which suggests "he who wants to lead, find a parade and get in front". This is what this talk is about today and, I urge Nursing to get in front!

It's not business as usual. If you support change, there is no question. And, change is inevitable. Will we make the change or be afraid of it? According to Roger Von Oeh, (1986), "the only thing that likes change is a wet baby." The only three things to fear according to Waitley are: fear of rejection, fear of change itself, or fear of success. We as a profession are not afraid of rejection, that's been done to us from time to time. We very well know how to change, we must. And, I hope we don't hesitate because we are afraid of success and won't be sure we'll get it.

It's our proper job to take the caring, the compassion and the quality into the home and keep it there! Not to become glorified brokers of an outdated mode of delivery. It is an opportunity in so many ways. There are roles for nurse practitioners, there are roles for generalists, there are roles for leaders and, there are roles for researchers ... critically necessary. We must rekindle our rightful position.

I said earlier that we nearly lost it. I'd like to applaud some of the folks who are making sure nursing doesn't lose it. It might not be too late.

There are schools now purposely going into new programs and going for grants to provide (it's not community health care anymore), home care administration and home care clinical specialty. Boston University has opened a program with a grant. The University of Michigan was the first one to open such a program with a grant. One of my classmates is working on such a program at the University of South Carolina in home care administration.

In concluding, I'd like to challenge us, Yale, to resume our rightful leadership in all of these areas. We should claim to be the first. I have not had the ability to publicly dispute, but I have privately disputed our rightful place as the preeminent leader in nursing in the home, as leaders and as providers. I stand confident in asking you to resume our leadership because I know that all of my predecessors who are involved in this field and, all of my successors will join with me in helping the school to do so.

Nursing, Yale, please come home!

REFERENCES

Tom Cook, MSN, Family Nurse Clinician, V.A. Medical Center, Murfreesboro, TN, moderated a lively panel which addressed the impact of early discharge on specialty nursing care required in the home.

Sandra Talley, Chairperson of Psychiatric-Mental Health Nursing at VSN began the panel with her thoughts on psychiatric nursing and home care opportunities. She reviewed the evolution of psychiatric care from its beginnings in asylums to the disappointments of deinstitutionalization. She noted that asylums were created to protect society from "individuals deemed unlikely to recover from their lunacy which had rendered them dangerous to others and themselves."

The therapeutic milieu evolved as nurses were educated to work in psychiatric institutions and methods of treatment were more humane. This highly predictable 24 hour call environment was supposed to be replaced by programs for the deinstitutionalized patient consisting of a weekly 50 minute psychotherapy appointment or mediation group. Families and group homes were prepared to deal with the concomitant behavioral problems and patients were not accustomed to demands and expectations of society. Funding policies at the federal level have reduced resources for more creative and potentially expensive programs. The result is more than half of the psychiatric patient population is receiving care in primary care centers rather than mental health facilities. With both private and public psychiatric treatment systems preparing for DRGs by adopting shorter lengths of stay, the burden has shifted to the family, group home or nursing home where many of these patients are placed. Sandy surmises:

"We have learned that highly structured economically compromised systems are not effective settings for home care bases: chronically ill, fragile patients are unable to sustain contact with agencies that do not meet them half-way in negotiating health care interventions. Family members and non-psychiatric health care providers have limited expertise, tolerance and energy when the majority of home care becomes their exclusive burden."

The integration of primary care concepts into psychiatric nursing would foster creativity in practice, management of the symptomatology of the psychiatric problem and education/support for family or extended family members who are available. In this model, the emphasis shifts back to the nurse-patient relationship from which the nurse's role is that of care provider, advocate, acquisitioner of services for the patient, family therapist and environmental engineer; says Talley. She acknowledges that new role expectations require the development of skills in new areas such as physical assessment and the formation of linkages with rehabilitation or employment services.

In conclusion, Sandy stated that this new era of psychiatric home care must not be encumbered by organizational constraints, providing only episodic care. She calls for the integration of principles of psychiatric care into the environments in which the patients exist; to "take charge of the patient's total care and effect changes in the environment which will reduce the frequent need for the hospital to intervene." She challenges psychiatric nurses to "establish nursing models for home care or risk fragmenting this service once more into a modality of care rather than a framework for delivery of numerous necessary services required by our clients". This theme was echoed throughout the day's presentations.

Eric Hardt, M.D., Director of Long Term Care at Boston City Hospital, described the rapidly emerging crisis in geriatrics. The crisis, he says, is created by the simultaneous implementation of DRGs and the rigid interpretation of Medicare regulations for home care, resulting in many patients being disallowed. Patients are being discharged from the hospital quicker and referrals are on sicker patients. Absurd technicalities: homebound status, or patients deemed to be "too sick" adds to the increased cycling of patients through Medicare cycles. As soon as a person recovers from an acute episode or is considered "too sick", they are discharged from home care. If the patient is poor, he can apply for Medicaid which will marginally reimburse agencies for home care services. If the patient is not poor enough, the agency might provide free care, but often is forced to refer these patients to clinics. Entry into yet another system is often overwhelming, so many are lost to follow-up. When they become ill again, they are re-admitted and require new paperwork. To avoid this, agency physicians like Dr. Hardt, might make reimbursable home visits when patients are not considered acute, until patients become sick again, and nurses' visits are again reimbursable; often in opposition to what is clinically indicated. Ironically, 6 months prior to DRG implementation, as continuity of care is increasingly difficult to provide, Massachusetts nurse practitioners were given prescriptive authority for "chronic patients in long term care or home care that would otherwise require re-hospitalization".

Dr. Hardt went on to declare that the current influx of the sickest elderly into the public sector and who are the greatest liability to inpatient hospitals are becoming our most recently disenfranchised group.

Historically, the sick elderly were desirable patients in the private sector. Now that they are discharged faster from hospitals, and need more services at home, (which are not being adequately reimbursed) they are being dumped into the public sector for care. To illustrate, there has been a 50% increase in
the number of hospital-based home health agencies in 1985 alone. Hospitals save money by shunting patients from inpatient to outpatient services without losing their referral base. There was also an increase in the number of proprietary home care agencies by 30%, but these agencies reportedly selectively admit patients who will remain active or who have alternative means to finance their care. Not surprisingly, there has been no increase in the number of VNA's. They provide much free care in order to preserve continuity, are eventually forced to their limits and must discharge patients.

On the positive side, Dr. Hardt cited recommendations from the recently released Harvard Medicare project. In addition to suggesting simplification of the process, and decreasing deductibles and co-payments, the study advocates extending coverage to include long-term care. They believe that all costs of providing home care to the sick elderly, whether medically or mentally ill, acute or chronic could be achieved at reasonable levels of funding, beginning in 1990. They also advocate paying for annual preventative home visits for all elderly and a semi-annual visit by an RN to all elderly who have not seen a physician in two or more years.

Panelists: Eric Hardt, M.D., Deanna Xistris, Patricia Harris '74, Sandra Talley and Peg Cushman '76, field questions from audience.

Deanna Xistris, Clinical Specialist with Hematology - Oncology Associates, described oncology nursing as a specialty that has demonstrated an incredible rate of growth and change over the last 10 years. Though a relatively new area of specialization, oncology nursing has emerged as a strong and effective specialization which continued to attract practitioners to advanced practice. Concomitantly, the growth of medical oncology, increases efficacy of treatments and complexity of the treatment modalities have provided varied settings in which the oncology clinical specialist can effectively base a practice: traditional hospital role, nurse-run clinics, joint or collaborative nurse-physician practices, and only now, the emergence of advanced practice nurses in home health agencies and free standing hospice programs. Wherever the practice exists, urgency exists to demonstrate the cost-effectiveness of the work and quality provided. This must be accomplished if these positions are to be spared in the budget cuts.

Deanna outlined the following areas as stressful to the oncology patient and their families with the move to shorter hospital stays and increased home care needs.

1. knowledge - understanding of illness and treatment.
   It's worth is well documented and cannot be labeled a luxury. But creative approaches must be found such as out-patient classes, perhaps taught by in-house staff so that staff satisfaction might also be nourished.

2. self-care who is to teach it? The reachable moment in which learning is best accomplished is now made evasive.

3. staff - at risk!
   a. advanced practitioners are often considered "icing" to a nursing budget.
   b. staff nurses would then fill the loss of the support and roll modeling of advanced practitioners.
   c. short hospital stays increase the risk of burn out.
   d. staff needs to feel the satisfaction of meeting patient needs.

4. abandonment - the risk that we will fall back to the milieu of the late 60's, in which Jean Quint Benadit and others described the medical and nursing abandonment to patients when they no longer responded to treatment.

Deanna notes that the current health care climate presents a great challenge to caregivers and patients and families. As the models for delivery of care change and as the deinstitutionalization of patients and care givers increase, patients and families are exposed to more agencies, more numbers of staff and more questions - more and different at a time when they must need calm and security. "Our challenge is to change our care delivery models as we must AND to provide for continuity; to render our care in an atmosphere where the patient feels known," concluded Xistris.

Patricia Harris presented a case to illustrate the challenges of pediatric home care and of her role as clinical consultant to a durable medical goods company. She described the home care needs of a six-month-old child with spina bifida, complicated by Arnold Chiari syndrome. This infant, her 11-year-old brother and their parents live on a farm, a considerable distance from the closest health care institution. Clinically, the infant had deficits in virtually every body system. Her meningomyelocele had been repaired, leaving her with gross motor deficits of the lower
extremities. She had a shunt to relieve her hydrocephalus. She had seizures secondary to electrolyte disturbance of unknown etiology. Of primary importance was that she was ventilator dependent during sleep (slowly increasing her ability to breath on her own for periods while awake) and had difficulty swallowing as her gag reflex was suppressed.

Pat saw her role as setting up the family for a successful experience. To do this, the family was assessed for their commitment and coping resources as well as ability to perform needed procedures, such as trach care, suctioning and tube feedings. The need to match the child and family with appropriate and safe equipment for home care was well illustrated by this case. Elise had both an in-home, non-portable ventilator and a portable one for trips outside the home, a suction machine, apnea monitor, air compressor and back-up generator, to name a few! Her family had little extended family support and respite care was not available because of the lack of reimbursement mechanisms for such services. The family needed help to try to balance the needs of the family members and nursing needed to allow the family to care for their ill child independent of nursing as much as possible.

The challenges to nurses in pediatric home care are to stay abreast of hospital techniques and specialty advances and manage their own stress. Cases such as Elise's are emotionally and physically draining yet Pat concluded that "it can be very rewarding to see children do well in their own homes despite many physical problems."

A special address was presented by Edward Halloran, RN, MPH, PH.D., Senior Vice President, University Hospitals of Cleveland, who discussed the "DEINSTITUTIONALIZATION OF PATIENTS: HOSPITAL'S SHRINKING NURSING EXPENSE."

Since the onset of Medicare and Medicaid in 1966 American hospitals have had an identity crisis. Prior to then there was a dimension of charity that pervaded these noble institutions. Since then all have become frankly less charitable and some have become money machines, sharing increased benefits to all (doctors, nurses, administrators, employees) but the patient. There is a healthy skepticism forming among well informed consumers and a confusion in the unknowing. The latter are often patients and families exposed for the first time to the hospital non-system. On the one hand, one reads billboards and advertisements for hospital care (ironically positioned next to cigarette ads) and on the other, patients are asked to seek alternatives for care because a length of stay average for their DRG has been reached.

This paper will outline the premise that a substantial part of what happens in a hospital is related to the professional relationship between nurses and patients, b) that nursing and medicine are different yet should be provided synergistically, and c) dynamic tension must exist between nurses, physicians and administrators to ensure patients are well treated. Finally, an argument will be made that nurses are in a unique position in the American health care system to influence for the better the publics' health and illness care. The success of professional nursing will depend on how well we do for our patients. It is they alone who will determine how much and what kind of nursing there will be in the future.

Since 1972 the hospital expense for nursing has been shrinking as a proportion of total hospital expense (Figure 1). In one Midwestern teaching hospital 30% of expenses were in nursing in 1972; 23% in 1984. During the same 12 year period the number of intensive care unit beds grew from 25 to over 100, the proportion of registered nurses grew from 61% to over 90% and nurses wages rose considerably faster than inflation. The same period saw two major periods of nurse shortage, in 1979 and 1983.

While the number of patients treated (discharged) from American hospitals is at all time high, the growth rate has plateaued and may now be showing a slight decline. Since 1965 the length of stay was reduced by a day (7.8 to 6.9) and the days of care and the beds used are decreasing.
Nursing Complexity, the DRGs and Length of Stay

Exclusive use of medical diagnostic terminology to determine case mix management and hospital reimbursement is based on the premise that all clinical activity directly or indirectly evolves from the medical diagnosis and is therefore prescribed by physicians. While the prescriptions for hospital admission and discharge are written by physicians, there is little agreement by nurses that the care they give their patients is predicated upon there being an established and accurate medical diagnosis. In fact, classic works in nursing do not mention medical diagnosis and treatment at all (Abdallah, Beland, Martin, & Matheney, 1960; Henderson and Nite, 1978; Nightingale, 1969).

The total time nurses spend with patients has been shown to be highly correlated with the length of hospital stay (Caterinichio & Davies, 1983; Halloran, 1980). If nursing care is prescribed by the medical diagnosis and, therefore, by physicians, then we would expect to find a strong association between medical diagnosis and the length (in days) of time that patients spend in the hospital. On the other hand, if nurses practice independently of physicians as suggested in nursing literature, then we can expect nursing time, as measured by length of stay in hospital, to have a stronger association with nursing diagnosis.

It seems vitally important to accurately attribute nursing diagnosis and treatment behavior since nursing accounts for 20 to 30 percent of total hospital expenditure (American Hospital Association, 1983; McKibbin, 1983). If nursing diagnosis and treatment decisions made by skilled nurses are shown to be redundant with medical diagnosis and treatment then it might be possible to substitute physician protocols for nurses' judgment. If so, non-nurses could simply carry out physician protocols to achieve the same outcomes achieved by nurses using nursing judgment. If, however, nursing care and length of stay are predicted by nursing diagnosis patterns, then it would seem appropriate to shift greater responsibility for hospital length of stay management and for patient discharge prescriptions to nurses.

Hypotheses

The two hypotheses tested in this study were:

H1: The nursing complexity index predicts length of stay
H2: The DRG relative cost weight predicts length of stay

Definitions

1. Nursing Diagnosis - human responses to actual or potential health problems that are identified by nurses and that those nurses by virtue of their education and experience are capable and licensed to treat (Field, L. & Winslow, E. (1984).

Operational definition - measured by the patient health conditions identified by nurses on the Nurse/Patient Summary.


Operational definition - measured by the nursing complexity index that is computed by adding the number of different nursing diagnoses present during the hospitalization.

3. Medical Complexity - severity of illness, likely outcome, difficulty of treatment, need for timely intervention, and amount and composition of resources used to treat the patient (Luke, 1979).

Operational definition - measured by the DRG relative cost weight, an index of relative resource consumption assigned to each DRG.

Sample

This study used data collected at an urban health science center in the Midwestern United States from March through July, 1983. The sample consisted of all patients (n=1294) on four conveniently chosen adult medical and surgical wards. The single criterion for inclusion in the study was that the entire length of stay was within the data collection period.

The sample was heterogeneous in character. The age of the sample ranged from 16 to 97 years with a mean of 54 years and standard deviation of 19.9 years. There were 611 men and 683 women included. Of these, 605 were treated with some surgical intervention and 623 were treated without surgery. DRGs representing 281 of the 470 DRG categories and 21 of the 23 major diagnostic categories were included. Each nursing diagnosis was identified at least once.

Instruments

The data collected included: a) the nursing diagnoses identified for each of the 1294 patients by the nurses providing direct nursing care to those patients, b) the DRG assigned to the case by the GROUPER software program at discharge (Yale University School of Organization and Management, 1981), c) the length of stay generated from the hospital admission and discharge dates using the SAS statistical package, and d) demographic descriptors of the hospital episode extracted from the inpatient record at the time of discharge. All of the data including the nursing diagnoses were retrieved from computer files.

The tool used to collect nursing diagnosis data (Nurse/Patient Summary) was developed by Halloran and Kiley to describe patients' need for nursing care. The instrument includes the nursing diagnoses approved for clinical testing.
by the North American Nursing Diagnosis Association (NANDA) in 1982, elaboration of some of the NANDA nursing diagnoses, and terms from the nursing literature hypothesized to describe needs for nursing care. Gordon’s (1982) functional health patterns provided the organizing framework for the tool.

Nursing Complexity Index

The nursing complexity index was determined for each of the 1294 subjects. The index is the number of different nursing diagnoses present at any time during the hospital stay. The nursing diagnoses approved by NANDA in 1982 and seven nursing diagnoses derived by combining several subcategories of a diagnosis on the instrument were used for the study. The derived variables were: a) bleeding (internal bleeding plus external bleeding plus oozing from wound plus hemorrhage); b) infection (contagion plus susceptible to infection); c) prolonged disease or disability (prolonged disease plus prolonged disability); d) socioculturaleconomic considerations (socioeconomic considerations plus cultural considerations); e) five types of impaired skin integrity combined into a single nursing diagnosis, impaired skin integrity; f) bathing, feeding, grooming, and toileting deficits combined into self-care deficit; and g) seven stages of immobility combined into impaired mobility. For computation of the index each nursing diagnosis was equally weighted.

Table 1

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<th>Patient’s Nursing Conditions by Day</th>
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<th>1</th>
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<td>36</td>
<td>36</td>
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<td>DRG weight .8096</td>
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| Nursing Complexity Index 7

Table 2

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<th>Patient’s Nursing Conditions by Day</th>
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<td>DRG weight .8097</td>
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| Nursing Complexity Index 19

The nursing diagnoses identified each day during the hospitalization and the nursing complexity index are illustrated for a patient assigned DRG 278 carrying a relative cost weight of 8096 in Table 1. A second patient with a different DRG, yet the same relative cost weight, and a different constellation of nursing diagnoses comprising more than twice the nursing complexity of the patient in Table 1 is illustrated in Table 2. The nursing complexity index for the patient in Table 1 is computed by summing the four different nursing diagnoses present on Day 1 (16, 34, 36, and 45), the new nursing diagnosis that appears on Day 3 (37), and the additional nursing diagnoses noted on Day 5 (60) and Day 6 (17). The complexity index for the patient in Table 1 is, therefore, seven. Using the same computational method, the nursing complexity index for the patient in Table 2 is 19.

DRG Relative Cost Weight

This numerical factor is intended to reflect the relative resource cost of treating all cases in the DRG across all hospitals. Multiple diagnoses were taken into account in the data base used at the Health Care Financing Administration to construct mutually exclusive and exhaustive weights and average standardized cost amounts for each DRG. Higher DRG relative cost weights are assigned to DRGs believed to contain sicker patients who are, therefore, expected to consume greater amounts of resources. The actual Federal payment rate for each DRG is determined by multiplying the DRG relative cost weight by the standardized costs. The relative cost weights were published in the Federal Register and are in the public domain (DHHS, 1983).

Results

Values for both complexity indexes were broadly dispersed. The possible values for the nursing complexity index were 0 to 61 and the actual values ranged from 0 to 52. The mean nursing complexity index was 14.5 and the standard deviation was 10.54. The actual values for the medical complexity index covered the entire range of possible values, 0 to 6.63. The mean relative DRG cost weight was 1.09 and the standard deviation was 0.69.

The distribution of the nursing complexity index was skewed to the right, a log-normal distribution (Averill & McMahon, 1977). The skewness and kurtosis were 0.94 and 0.36, respectively. The relative cost weight distribution was also non-normal with positive skewness. The skewness of the relative cost weight distribution was 2.16 and the kurtosis was 8.29. In order to meet the mathematical assumptions of normality for statistical analysis all variables were transformed to their logarithms based on the integer 10.

Nursing Complexity Index

The relationship between nursing complexity and length of stay was explored using the linear regression model

\[ Y_i = \beta_0 + \beta_1 x_i + e_i \]

where \( i = 1, \ldots, 1294 \).
For this sample 45 percent of the variation in length of stay was explained by the nurse's complexity index (R² = .451, F(1,1261) = 1037.22, p < .0001).

DRG Relative Cost Weight

Using the same linear model, a regression of Log 10 length of stay on the DRG relative cost weight was done. This regression resulted in a coefficient of determination of .2088 (F[1, 1270] = 355.1, p = <.001). Thus, the DRG relative cost weight explained 21 percent of the variation in length of stay. The nursing complexity index was more than twice as predictive of length of stay as the DRG relative cost weight.

Nursing Complexity Index and the DRG Relative Cost Weight

A third regression was done to test the combined explanatory power of nursing complexity and the DRG weight for LOS. The linear model was

\[ Y_i = B_0 + B_1 x_{1i} + B_2 x_{2i} + e_i \]

where \( x_1 \) = nursing complexity index
\( x_2 \) = DRG relative cost weight

\( i = 1, \ldots, 1294 \)

Nursing complexity entered the regression equation first and explained 45.4 percent of the variation in LOS while the DRG weight explained 53.7 percent additional variation (R² = .507, F[2,1245] = 640.62, p < .0001). The superior explanatory power of nursing complexity over the DRG relative cost weight was again supported.

Discussion

Results of this study suggest that use of a patient's physician and DRG rate is less effective for management and control of hospital length of stay than use of nurse and nursing diagnostic data. The nurse manages such patient circumstances as immobility, pain, and anxiety. These circumstances cut across medical diagnostic categories. Patients need services from nurses that will empower them to be independent of the nurse's help, or will lead to a peaceful death (Henderson & Nite, 1978). These services are substantially different from those obtained from a physician and impact directly on how long the patient stays in the hospital.

A Separate Existence

The data have provided evidence that the length of a patient's stay in the hospital can be explained by the presence of conditions that nurses treat. Length of stay was not prescribed by physicians. If it were, a higher degree of association between hospital stay and medical condition would have been found.

A characteristic of the concept of the nursing condition was the uncertainty surrounding the onset and resolution of given nursing diagnoses. Nursing was operationally described in this study as the continual surveillance of patients for, and assistance with, the management of nursing diagnoses. The occurrence of nursing diagnoses changed from day to day. The nurse often reacted to these changes in the patient's condition. Nursing then, was concluded to be a dynamic patient centered endeavor, separate from other professions and activities, and entirely worth differentiation as a domain for practicing, teaching and studying.

Medical condition descriptors, such as stroke and urinary calculus, etc., were less predictive of the hospital stay than were nursing condition descriptors such as immobility, anxiety, constipation, etc. In other words, nursing diagnoses provided better explanation of what caused more care to be given than did medical diagnoses.

In examining a list of nursing diagnoses, one is hard pressed to find anything about the patient's medical condition or procedures although some may seem implicit. When constipation is present, it could be related to any one of 25 medical conditions. The business of nursing is constituted by helping patients with what they can't do for themselves, helping them understand it, helping them have the will to do it; and that is extraordinarily different from the business of medicine. It just happens that the two frequently take place with the same patients at the same time.

Pellegrino (1964) agreed that a barrier to efficient, effective, comprehensive and personalized health care is our lack of a design for the synergistic interrelationship of all who can contribute to the patients' well-being. This investigation raised the issue of whether there is a single body of knowledge on health and disease, or whether it can be divided into separate entities such as nursing knowledge and medical knowledge, among others (Henderson & Nite, 1978). The position taken here is that both nurses and physicians apply basic sciences to different dimensions of patient need. Physicians, in the main, treat pathological processes. In the hospital setting, this consists of identifying or diagnosing pathological processes followed by chemical or surgical treatment. Nurses, on the other hand diagnose the effect of actual or potential debilitating processes and give personal care during the time
until the person (or family) again cares for himself or dies. It seems then, entirely useful for nurses and physicians to develop separately while recognizing the synergistic effect of their work for the person they both treat and care for. This study of nursing diagnoses, medical diagnoses and length of stay attempted to distinguish the separateness of nursing in the synergistic relationship between nurse, patient and physician.

A Separate Cost

Stevens (1975) argued that the failure to account for differing nursing costs for patients has led to professional and financial disadvantages for nurses within the health care system. The major professional disadvantage was the formulation of nursing care routines for the typical patient and then having nurse substitutes carry out the routines under the supervision of nurses. The provision of routine nursing care is inconsistent with the professional practice model for care. As concluded in this study, the function of nurses was to use knowledge and judgment to allocate nursing resources in varying amounts to patients for specific purposes. A mechanism for supporting nursing functions and accounting for allocations of nursing resources is to cost patient care separately for nursing based on the amount of care each patient receives.

Another disadvantage of not regularly identifying differing consumption of nursing resources among patients relates to hospital and health industry financial practices (Stevens, 1975). The common denominator in resource consumption is money. Nursing services, the largest single expense item in every hospital, are not accounted for except in daily room charges. Failure to account for this varying usage of a major hospital resource seems especially incongruous when a measurable portion of nurses' time is used to charge patients separately for minor supply items; the cost of which often exceeds the cost of the items. The key to control of expenditures is knowledge and understanding of how and why they occur. Regular accounting of expenses and revenues for nursing resources on a case specific basis would contribute to a proper understanding of the implications of financial decisions on patient care.

Study results indicate the reimbursement system formulated on DRGs is inappropriate for the nursing care component of hospital costs. DRGs were not highly associated with the variation in hospital stays. A reimbursement model based on a combination of nursing diagnoses and DRGs would provide a better explanation of total hospital costs than either nursing diagnoses or DRGs taken alone.

The data regarding the relative explanatory power of nursing diagnoses over DRG in predicting the length of stay suggests the condition which nurses treat are what keep patients in the hospital. Another way of putting this is that physicians probably should continue to admit patients but nurses should discharge them.

Nurses should make discharge decisions because patients typically do not go home incontinent, immobile, anxious, etc. If these nursing conditions are present patients shouldn't go home unless they can manage their circumstances. They should be in the hospital until provisions are made for continuing (including self or family) care. They should not be admitted or continue in the hospital unless they need the round the clock services of nurses.

These arguments legitimize the notion that nurses contribute immeasurably to patient well-being and length of hospital stay. If a nurse recontinents an incontinent patient, that is apt to change the length of stay. It is incumbent that nurses view their work in ways that impact positively on their patients.

Nurse Staffing Implications

An extension of the argument that nursing requires knowledge and judgment as well as physical presence, is that nursing must be done for patients by nurses. If either nurses or patients were not present, nursing cannot exist. The substitution of persons without preparation in nursing to perform certain time consuming patient care tasks is common hospital practice (Halloran, 1975; HAS Administration Profiles, 1983). Task performance, out of the context of the judgment and decision regarding task needs for a specific expected result, seems to raise a false sense that nursing has been accomplished.

The questions raised about nurse staffing from this study concern the mix of staff rather than their number. Assumed here to be required from the nurse was both physical proximity to patients and a knowledge base for constant evaluation of dynamic patient states.

Conclusion

Nursing care, which represents a significant portion of hospital costs has been mis-measured historically. It is nurses' responsibility to accurately identify what nursing is and to measure and manage that activity and its cost.

The patient hospital length of stay would ideally be clinically managed by nurses and physicians working together with the patient. Each must have a better understanding of their unique role. Patients need physicians, patients need nurses, and patients need to know what to expect from each. There should be little overlap in the activities and responsibilities of nurse and physician, lest confusion, waste, and untoward care results arise. The ideal information base, reflective of a patient's use of health care services, would include nursing diagnosis and treatment information, as well as medical diagnosis and treatment information.
REFERENCES


Nursing, EPH and Medical School Alumnae/i attended the final address of the day presented by Dr. Samuel Thier, President, Institute of Medicine, National Academy of Sciences, Washington, D.C., who addressed the challenges to medical education in the world of technology and tremendous advances in medical science.

Continued from page 10


The Banquet on Friday evening in the Dining Hall of the School of Organization and Management was a festive highlight of the weekend. Each of the ten members present of the 50 year reunion class, 1936, was introduced and presented with a yellow rose corsage. (Every one present earnestly wished to be as lively and inspired when their own 50 year reunion comes around!)


It was announced that Mollie Curtis, Class of 1931, is the sole member of her class to be attending this weekend -- graduated 55 years ago! Brief reports were made by a representative of each of the reunion classes.

Class of 1981 attending Banquet were: Dana Higgins, Louise Dodd and Cheryl Fida. Other 1981's also registered for other parts of the program were: Claudia Buzzi, Susan Wood, Cheryl Marsh, Pam Driscoll, George Daner, Bonnie Miller Piascyk, and Susan deBarba Megas.

Kit Nuckolls spoke for the eight people here from 1941. By far the largest reunion classes were 1946 with 21 and 1946W with 16 members present. Their reporters were Barbara Mathews and Betty Sullivan. Justine Glassman reported for her class of 1951 (15 came for some parts of the weekend). Priscilla Kissick and Barbara Pratt represented 1956, Sandy Bialos and Catherine Forrest represented 1971, and Linda Goodhart cheered for the eight '76ers who were here for some parts of the weekend. The diversity of activity among all Alumnae/i and the continuing generosity, loyalty and interest in YSN is heartwarming!

The presentation of awards was the climax of the evening:

"Even in her student days her leadership and creative involvement in professional action were apparent. At YSN her interest in politics and change led her to become President of the Student Government Association. In that role, she achieved the inclusion of students on numerous faculty committees and spearheaded the successful campaign to organize a chapter of Sigma Theta Tau at the School.

Since her graduation her concern for social policy has been apparent in many arenas. As a scholar, she has written widely on aging, health policy, and women's issues, and is now completing a doctorate in Social Economy and Policy. As President of the Massachusetts Nurses Association, she led the successful
Connecticut has found her calling in the public health arena. She has used her position at Yale School of Nursing and its Alumnae/i Association to take great pride in presenting the Outstanding Alumna Award to Judith Shindul Rothschild Class of 1978."

"The greater part of her professional experience has been in nursing education at the University of Connecticut and more recently as one of the founding faculty members of the Nursing School of Southern Connecticut State University. She is a dedicated nurse - an excellent role model for young students of nursing. Her clinical practice in medical nursing at Yale-New Haven Hospital enriches the lives of her patients and her students as she shares her scientific knowledge and her concern for compassionate patient care. She is a scholar - endowed with the gift of excellence in the art of teaching - inspiring respect and confidence in her students. Year after year grateful students sing her praises!

Her Chinese heritage bears out the words of Confucius "To remember quietly what I have studied, to learn untiringly and to teach others without being wearied." This philosophy truly reflects Helen Chuan, Class of 1952 and it is with pride and pleasure that the Yale School of Nursing and the Alumnae/i Association present to her this Distinguished Alumna Award."

"Nationally renowned as a leader and visionary in promotion of home health care, she has helped prepare landmark reports on the quality of nursing home care. Since then she has continued her legislative involvement in Connecticut and the nation. A founding member of the National Association for Home Care, she has carried her concerns to the Congress testifying on the needs of the elderly and terminally ill and monitoring the funding of home care.

As a teacher she inspires students with her skill at translating the techniques of commerce and technology into the humane care of patients and the fullest development of each staff member.

Through her vision two large home health care agencies have merged to become one of the largest and most progressive nursing agencies in New England. She has proven that nurses can develop and manage multi-million dollar health care businesses without losing sight of their basic mission; that nurses can affect legislation that protects the rights of and responds to the needs of the disadvantaged, and can deliver high quality health care with minimal medical input and intervention.

Her youth, intellect, energy and record of achievement guarantee that she will be in the forefront of home care and concern for the aging in this country for decades to come. The Yale School of Nursing and her Alumnae/i Association are proud to present the Distinguished Alumna Award to Margaret Jane Cushman, Class of 1976."
"Early in her career as a visiting nurse she was moved by the needs of the terminally ill. What she saw in the home provoked her to search for a better way, a journey that took her to St. Christopher's Hospice in London. As a visiting fellow she studied and worked under the tutelage of Dame Cecily Saunders, conducting a study of hospice programs throughout the United Kingdom. Her report, 'Humane versus Technological Death,' provided a strategy for the development of what ultimately became the Wissahickon Hospice in Philadelphia, one of the first Medicare certified hospices in the country and the first to receive prospective reimbursement through Blue Cross.

As founding Executive Director of that organization she displays a spirit of inquiry, initiative, and leadership through her support of clinical practice, volunteer services, and research. She has accomplished all of this while pursuing doctoral studies in health policy and planning. Her career exemplifies a commitment and achievement of which Yale can be justly proud.

Evidence of her loyalty to her friends and to YSN is seen as she serves as class agent and an Association of Yale Alumni Representative for the Yale School of Nursing. For all of these accomplishments the Yale School of Nursing and her Alumnae/i Association take great pride in presenting a Distinguished Alumna Award to Priscilla D. Kissick of the Class of 1956."

Alumnae/i of the Medical, EPH and Nursing Schools continued celebrating on Friday evening at a dance at the Yale Commons - a new addition to the weekend!

Once again, Nursing Alumnae/i were invited to attend the Medical School Seminars on Saturday morning. This is always an interesting part of our Alumnae/i Weekend program. One chose to attend discussions on Child Development, Medical Education, Geriatrics or Mental Disorders. A buffet luncheon at noon was followed by the YUSNAA Annual Meeting presided over by Sheila Conneen, President. Her President's report follows:

"Welcome to Alumnae/i Weekend. Traditionally the Board begins planning for the next Alumnae/i Weekend Program in mid-June, while the previous one is still fresh in our minds. Last year it was especially fitting that the happenings of the old and the planning of the new be almost simultaneous because this year's program has so clearly grown from your responses to last year's program. Many of you suggested that we respond to our speaker's challenges to address the needs of those patients most affected by technology and changes in reimburse-
ment. As a result, André deLisser, chairperson, and the Board have structured a program that looks at the economical, ethical, and technological aspects of early discharge and home care.

Because of the large number of responses to last year's letter soliciting nominations, we had a pool of qualified nominees for the Distinguished Alumna Awards, and more nominations have come in through the year. For several years the Board has talked about how we might honor recent graduates with outstanding achievements; therefore, this year we are offering the first "Outstanding Alumna/us Award" to a graduate who has been out fewer than ten years.

On evaluating the efforts put into the Connecticut Regional Meetings and the small number of participants, the Board decided to defer those meetings for this year. Instead, we have supported the Dean's efforts to meet with and encourage other regional groups. This year the Dean has met with alums in Boston, New York, Washington, Baltimore, Denver, Chicago, and will be in Southern California later in June. The Board has supported recruitment efforts and is anxious to have more Alumnae/i support and participation in the Recruitment Committee plans around the country in the future.

Through the income of the Reva Rubin Fund, and a $1500 Initiative Prize from the Yale Alumni Club of Greenwich, Connecticut, and MUCH volunteer labor, the students have redecorated the Bixler Room, the Student Lounge.

We appreciate the response of many Alumnae/i to our questionnaire regarding the Directory. An up-date on the plans will be included in the next Yale Nurse in the Fall.

Thank you for giving me the opportunity to be President of this Alumnae/i Association. I have enjoyed every aspect of it, and the best part has been getting to know so many of you."

Sheila Conneen '79, President, YUSNAA

Nominating Committee Report was given by Karen Suchanek '79 in absence of chairperson, Nina Adams '77. The new Board members who were present were introduced. The entire slate for 1986-1987 was read:

President-elect: Beatrice Burns '79
Vice President: Ruth Gee '74
Secretary: André deLisser '79
Treasurer: Jane Milberg-Rubenstein '78

Board Members: Patricia Albertoli '81
Victoria Wirth '76
Nina Adams '77
Mary Ann Beres Starkes '84
Judith Tierney '79

Nominating Committee: Karen Suchanek '79 Chm.
Mary Bast '85
Lorraine Rose-Lerman '85
Karen explained that this is really a working Board and it needs to have members who live close enough to New Haven to come to monthly meetings. An attempt is made each year to find members from a variety of classes to have good representation. She urged members to think about giving some time to YSN in this way. The Board invites interested alums to attend the Board meeting on October 20, 1986 to get an idea of an agenda and concerns of the Board. All meetings this year will be held in Room 4 at YSN at 5:30 p.m. on the 3rd Monday of each month.

**Distinguished Alumnae/i Awards:** the tradition of honoring distinguished and outstanding alumnae/i is a very important, special and difficult job of the Alumnae/i Board. So many alums are truly deserving! The committee of Board members eagerly awaits nominations from Alumnae/i around the country of possible recipients. Please consider seriously the criteria described on the nomination form (found on page 31) and bring to the attention of the Committee names of folks to be considered.

**Alumnae/i Fund Report:** Mary Jane Kennedy, Alumnae/i Fund Chairperson, happily announced that the Fund this year has passed it's goal of $100,000 and there is still this month to go! YSN has the highest percentage of participation of any of the G & P Schools at Yale (over 50%). She extended thanks to the Dean, to Claire Lauterback at the Fund Office, to the Advisory Committee, to all class agents, and to every one of our Alumnae/i who have been so generous this year with time, effort, and funds. She also reminded us that we cannot "rest on our laurels", another year is coming and we must continue to keep YSN high on our priority list!

Mary Ellis, Chairman of the Bequest and Endowment Committee cited examples of ways gifts to Endowment have been given this year; memorial gifts, gifts honoring colleagues or classmates, including YSN in a will, giving stock to the School, life income and deferred gifts. All are ways of ensuring income for the School each year, forever.

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**THE 1987 ALUMNAE/I WEEKEND WILL BE HELD**

**ON JUNE 4-5-6**

**START PLANNING NOW!**

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Class of 1951 present at noon on Saturday. Peg Meagher Lundebjerg, Pam Perkins Tisza, Ann Barnard Wilson, Shirley Howard, Betty Dyer Wortham, Justine Rizinsky Glassman, Vera Venable Yordon. Others attending over the weekend: Jean Hopkins, Irene O'Reilly Burns, Carolyn Byrne Wheeler, Mary Vesta Marston Scott, and Gertrude Vogel Graham.

Mary Colwell reminded everyone to fill out and turn in the green evaluation forms— as these are most helpful in planning for next year's Alumnae/i Weekend.

A big note of thanks was expressed to Andrée deLisser for her leadership in planning and working on this most successful weekend. And also a warm expression (an ovation and many hugs) of thanks to Sheila Conneen for the time and considerable effort given to YUSNAA during her term as president. Sheila is resigning June 30th, and will be married to David Johnson '80 and they will be living in Oakland, CA. She has been a very willing and productive president and will be sorely missed.

**Dean's remarks at Annual Meeting, June 7, 1986**

Dean Judy Krauss opened her remarks to the Alumnae/i by expressing special thanks to Sheila Conneen, who will be ending her term as Alumnae/i President to move to California; Andrée deLisser, who chaired this year's Alumnae/i College Program Committee; and, to Beatrice Burns, who gave the opening night program on impaired nurses. Additionally, she expressed her gratitude for the invaluable assistance provided her by Mary Jane Kennedy in the Alumnae/i Fund drive; Mary Ellis in Bequests and Endowments; and, Claire Lauterback through the Alumnae/i Fund Office. Finally, she acknowledged the contributions of Mary Colwell to the continued positive development of the YSN Alumnae/i community.

Judy then reported on the several developments at the School since September, 1985, including:
1. Continued planning for the initiation of a DScN program with a projected target date of September, 1989.
2. Two major searches -- one for an Associate Dean and one for a Chairperson of Community Health Nursing.
3. The formation of an Ad Hoc Gerontology Committee, comprised of faculty from Community Health, Medical Surgical Nursing, and Psychiatric Mental Health Nursing to explore the development of a cross-specialty gerontologic concentration that would emphasize interdisciplinary approaches to the care of the elderly.
5. The establishment of a Small Grant Support Program for the faculty.
6. Plans for a review of the core curriculum needs of the School.
7. The review of the School by:
   a) The University Committee on Medical Affairs
   b) The Connecticut State Board of Nurse Examiners (review of the Certificate component of the Three Year Program)
8. A discussion of the current economic, applicant pool, and policy influences on the School's operating budget.
9. A review of the longrange planning activities of the Executive Committee which will result in the publication of a Five-Year Plan for Programatic and Fiscal Development. The plan will be ready in the Fall of 1986 and will be distributed to faculty, students, staff, and Alumnae/i.

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Students Awarded Scholarships

Ann McCrum, Nancy Tamarisk, and Martha Curley, are recipients of a Louise Mellen Graduate Fellowship in Critical Care Nursing for 1986-1987. Ann and Nancy are enrolled in the Medical-Surgical Nursing Program. Martha is in Pediatrics, and all are of the class that will graduate in May, 1987.

Sandra Flood '87, who is jointly enrolled in master's degree programs at YSN, the School of Organization and Management was presented the Stewart/ANNA Career Mobility Scholarship by the American Nephrology Nurses' Association at its national meeting in New Orleans in April. The award is granted to one outstanding nurse each year for continued education.

Nursing Grand Rounds

The Medical-Surgical Nursing Program and the Nursing Grand Rounds Committee at Yale-New Haven Hospital collaborated to present a Nursing Grand Rounds on March 4, 1986, in Fitkin Ampitheatre.

Marjorie Funk, MSN, CCRN Instructor in the Medical-Surgical Nursing Program and Clinical Nurse Specialist Cardiac Surgery at

Elouise Duncan '46, first Black student at YSN, met Don Edwards '86, first Black male student at YSN.
Y-NHH coordinated the presentation of the case study. The title of the rounds was, "Terminal Cardiac Disease: Does Transplant Improve the Quality of Life?"

The patient, Mr. B., had cardiomyopathy and was the recipient of a heart transplant in November, 1985.

Also contributing to the presentation of the case were Mary O'Gorman, BNS, CCRN, Head Nurse of the CT-ICU, and Gail Eddy, BSN, Staff Nurse in the CT-ICU.

Kathleen Dracup, DNSc, CCRN, was invited to serve as clinical expert and to comment on the case. Dr. Dracup is a Clinical Nurse Specialist and Associate Professor at the University of California - Los Angeles and is the Editor of Heart and Lung.

The Grand Rounds are funded by an Advanced Training Grant that was awarded to the Medical-Surgical Nursing Program. Dorothy Sexton is the Project Director.

Gretta also received an honorary doctorate degree from Valparaiso University at the Commencement in May.

Jessie Scott Award

Donna Diers '64 received the Jessie Scott Award at the ANA Convention in June. In accepting the award Donna spoke of those who have influenced her career. "Jessie Scott set and implemented the priorities that have kept nursing practice, nursing education and nursing research on the federal agenda. We have all benefitted from her foresight, conscience and sophisticated leadership. She guarded nursing's place with courage and honor. I learned from various professional dealings with Jessie of her steadfast determination as well as her support for nontraditional programs and people.

We share another link: Jessie's role in the Division of Nursing followed upon the late Margaret Arnstein's. I succeeded Miss Arnstein to the deanship at Yale. Margaret -- Peg -- succeeded Florence Wald, a nurse of such extraordinary vision we are just now catching up to her.

Whatever in my work is thought to deserve this award derives from uncounted influences. My parents, Ilene and Don Diers, gave me life and confidence. Florence Wald and Margaret Arnstein gave me purpose and vision."

Donna's address to the Convention entitled: "Beyond Chicken Litte: Nursing Practice, Research and Policy" reviewed current and past nursing concerns, from nursing shortages to lack of malpractice coverage to allegations of divisiveness among us, and asserted that nursing's future is more optimistic than these issues have indicated.

She emphasized four trends favorable for nursing's future: the power of clinical wisdom, a growing responsibility, authority and accountability, the ability to analyze and document nursing care, and the fact that nursing now claims credit for our realm of care.

Donna predicted that within the next two years, nursing costs will be separated from room and board costs, and nursing will become an "income center" for hospitals, with nurse managers controlling the budget. She also predicted, to a standing ovation, that "the world of nursing, of health and illness care, is about to return to us."

In Memoriam

Esther Budd '31 died May 16, 1986
Audria G. Cady '34 died March 10, 1986
Francine Becheraz Coffen ex'39 died April 8, 1986
Marcia Files Ashley '46W died March, 1986
Priscilla Crim Leidholt ex'49 died Dec. 1985
The gift that keeps on giving

Graduates annually provide support to the Yale School of Nursing through the annual giving program of the Alumni Fund. Now, through the Yale School of Nursing Alumnae/i Fund Endowment, our graduates can make the School of Nursing the beneficiary of lifetime gifts and deferred gifts intended to function as permanent endowment. With the income they generate going to the School each year, these are truly gifts that keep on giving.

Gifts can be made to the Alumni Fund Endowment in a number of different ways. In many cases, it is possible to make a substantial gift at relatively little cost, and in some cases a gift arrangement can actually increase the donor's income.

Among these gift options are:

- **Outright Gifts** of virtually any property which has value.

- **Bequests** through your Will.

- **Life-Income Gifts** which will guarantee to you or to whomever you designate a lifetime income.

However you choose to make your gift, you will be establishing a permanent fund in your name which will produce income for the Nursing School in your name forever.

If we all do our parts, the cumulative effect will be a guarantee of the future health and vitality of Nursing at Yale.

Please use the reply form to request additional information.

Yale University School of Nursing Alumnae/i Fund Endowment
P.O. Box 1890 New Haven, CT 06508

Please send me information about making an Alumni Fund Endowment gift by bequest ( ) outright gift ( ) or life-income arrangement ( ).

Name ___________________________________________ Phone __________________________

Address ___________________________________
CLASS NOTES

Helen Wersebe '31 was honored as the Community Citizen of the Year by the Grange (Washington, CT) in March. In listing her accomplishments her citation included her being a nurse educator, an active nurse in WWII, a Red Cross director and Girl Scout leader, active in church activities and civic organizations and "is known for her willingness to volunteer her services!"

Kit McClure '46 has reported to Mary Ellis how deeply involved she and her sister have been with sponsoring two Korean orphans, helping a black girl in Knoxville College, and with helping two grandnieces with their college plans and expenses. What full and rewarding experiences they are having!

Wanda Hilliker Smith '46W missed her reunion but reported that her husband is retired from surgical practice in Torrington, Connecticut; their eight children are doing fine in their chosen professions. (Four of five daughters are nurses!)

Mary Castenholz Stack-Dunne ex '54, received her MPH degree in February 1986 and has a new job near Washington, D.C.

"Dede" Elmer Robertson '55 was recently named Christian Woman of the Year. This award is given by the Christian Woman of the Year organization for "outstanding Christian character, leadership, and for faithfulness to the call of God on their lives."

Madelon O'Rawe Amenta '57 and Nancy L. Bohnet have produced a book, with five others who wrote sections, entitled "Nursing Care of the Terminally Ill", Little Brown & Co., 1986.

Penny Camp '58 and Pierce Wiggin were married in Florida in March.

Linda Norton '80 had a second son, Christopher at home in May, 1986. The Nortons have moved to California.

Toya Gabeler '84 and Lauretia Henderson '84 are both working at Martin Luther King, Jr., Hospital (Normal Birth Center) in Los Angeles.

Darlene Fortune '85 is a Psychiatric Clinical Specialist, self-employed in private practice in Coral Gables, where she conducts individual and group psychotherapy. She also has taught a class at Miami-Dade Community College and has presented several seminars for continuing education in local psychiatric hospitals. She and Denise Canchola '81 are working together to develop a stronger networking system in the Miami area.

Andrea Rosetti Giletti '85 is living and working in London. She writes patient information materials for persons with cancer at Royal Marsden Hospital. Her article on "Nursing Care of the Patient with Intrapleural Tetracycline Infusion" was published in the International Journal of Cancer Nursing (March 1985).

Nancy Lim '85 was working earlier this year at Asian Women's Health Center in San Francisco and living in Oakland.

Deborah Meredith '85 is working in a Maternal and Infant Care Program with 5 other midwives. "The setting is fairly high risk and a tremendous learning experience".

Joanna Ward '85 is a pediatric head nurse at King Faisal Specialist Hospital and Research Centre, Saudi Arabia. This is a two-year contract - she is pleased to have the Red Sea nearby so she can go scuba diving for relaxation.

Virginia Henderson, Honorary Alumna, received an honorary degree in May from St. Joseph's College in Hartford.

1985 Addresses (As Promised)

Suzanne Abbott, 26 Lexington Road, Lexington, MA 02173
Betty Ang, 107 Bishop St., New Haven, CT 06511
Mary Barst, 120 Pheasant Run Road, Wilton, CT 06897
Deborah Benton, 616 Elmwood St., Apt. 3, Evanston, IL 60201
Concetta Bove, 61 Bullard St., Fairfield, CT 06430
John Cosenza, 430 Green Hill Road, Madison, CT 06443
Kathleen Diamond, 3028 Guilford Ave., Baltimore, MD 21218
Grace Erickson, 5911C Willow Oaks Dr., Richmond, VA 23225
Jeanne Finn, 73 Coldwell St., Manchester, NH 03103
Mary Jane Fitzpatrick, 162 Cheney Lane, Newington, CT 06111
Darlene Fortune, 9225 S.W. 45th St., Miami, FL 33165
Karen Forzani, 61 Richard Road, Torrington, CT 06790
Jane Frey, 128 Cabot St., Holyoke, MA 01040
Laurie Friedman, 140 Brooks St., Brighton, MA 02135
Sheila Gillespie, 255 Bradley St., New Haven, CT 06511
Jane Golay, 312 N. Geneva St., Apt. 4, Ithaca, NY 14859
Ellen Graves, 542 Chapel St., New Haven, CT 06511
Olympia Gregory, Way Road, Salem, CT 06415
Margaret Haggerty, 703 Elm St., New Haven, CT 06511
Kristin Hale, 754 Orange St., New Haven, CT 06511
Allegro Hamman, 1924 N. Fremont, Chicago, IL 60614
Lauren Hinson, 58 Avon St., New Haven, CT 06511
Tony Howard, P.O. Box 46, Danville, VT 05828
Shelley Jerige, 256 Edwards St., Apt. 6, New Haven, CT 06511
Francine Kaplan, Malvern Hall Condos, 6655 McCallum St., Apt. 413 E., Philadelphia, PA 19119
Marie Kelly, 32 West Glen St., Holyoke, MA 01040

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Diane L. Kessler, 912 Bellas Artes, El Paso, TX 79940
Sharon Lee, 610 N. 12th St., Moorhead, MN 56560
Deborah LePore, RFD 1, Box 251-C, Cooper Road, Chepachet, RI 02814
Nancy Lim, 123 Bay Place, Apt. 305, Oakland, CA 94610
Barbara MacDonald, 1817 Belt St., Baltimore, MD 21230
Deborah Mayer, 87 Armory St., Apt. 1, Cambridge, MA 02111
Norma McNair, 2255 Braeswood Park Dr., Apt. 257, Houston, TX 77030
Deborah Meredith, 141 Neese Dr., Apt. P350, Nashville, TN 37211
Jill Muhrer, 37 Linden Ave., Landsdowne, PA 19050
Michele Murphy, 7 Jeffrey St., Lake Waubeeka, Danbury, CT 06810
Patricia Ann Murphy, 144 Point Circle N., Coram, NY 11727
Terri Murtland, 7272 Park Lake Dr., Dexter, MI 48130
Linda Olney, 6912 Hidden Lane, Clarkson, MI 48106
Janet Parkosewich, 116 Gorham Ave., Hamden, CT 06517
Karen Poushter, 117 Morningside Road, Verona, NJ 07044
Lorraine Rose-Lerman, 1232 Forest Road, New Haven, CT 06515
Andrea Rossetti Giletti, 69 Dovehouse St., London SW3, England
Jacqueline Rugg, 131 Russet Drive, Guilford, CT 06437
Christine Santoni, 179 Norton St., New Haven, CT 06511
Elon Shlosberg, 412 Whitney Ave., Apt. 1, New Haven, CT 06511
Beth Sipple, 78 Stanley St., New Haven, CT 06511
Sandra Slater, 36 Lillibridge Court, Hamden, CT 06517
Anna Smillie, 112 Lauris St., Pittsboro, NC 27312
Frances Smith, 256 Shiperd Circle, Oberlin, OH 44074
Kay Sophar, 7325 Baltimore Ave., Takoma Park, MD 20912
Joan Spencer, 1370 Middle Road, East Greenwich, RI 02818
David Steffen, Dona Ana Field Health Office, 530 N. Church St., Las Cruces, NM 88001
Lois Strecker, 154 Allen Place, Hartford, CT 06106
Libet Streiff, 200 Lanyon Drive, Cheshire, CT 06410
Mary Beth Swerz, 25 Barrack Hill Road, Ridgefield, CT 06877
Anne Teitelman, 17 Grafton St., New Haven, CT 06513
Mary Ann Thompson, 31 Prospect St., Bloomfield, CT 06002
Joanna Townsend, 241 Main St., Dansville, NY 14437
Carol A. Van Steenberg, 15 Cooper Hill Dr., Guilford, CT 06437
Saraswathi Vedam, c/o Jeff Miller, 108 Bristol Place, Syracuse, NY 13210
Robin Landes Wallin, 1821 Newton St., N.W., Washington, DC 20010
Joanna Ward, King Faisal Specialist Hospital, Dept. of Nursing, Box 3354, Riyadh 11211, Saudi Arabia
Shirley Way, 3203 Stoneham Dr., West Chester, PA 19382
Jana Weiss, 1193 Great Hill Road, North Guilford, CT 06437
Wendy Wheeler/Joseph Landolfi, 19 Vincent Ave., Belmont, MA 02178
David Whitehorn, 7401 Flower Ave., Takoma Park, MD 20912
Christine Zaleski, 235 Camp St., Forestville, CT 06010
Shoshana Zax, 21 Woodland St., Apt. W, New Haven, CT 06511

Ex '85
Janice Jones, 115 Pendleton St., Apt. E22, New Haven, CT 06511
Mildred Sartucci, 13 Governor Andrew Road, Hingham, MA 02043

All Other Classes
Doris Pinkney Allison '26, P.O. Box 462, Essex, CT 06426
Marian Axtell Cowperthwait '31, c/o John C. Roth, 4017 Keeley Dr., Antioch, TN 37103
Carolyn Walsh ex '31, c/o Smith, 525 Brookside Dr., Eugene, OR 97405
Marian Godehn '33, 1209 21st Ave., Apt. D102, Rock Island, IL 61201
Clara Gross Lawrence '33, 1200 Mira Mar Ave., Apt. 826, Medford, OR 97504
Aileen W. Harms '40, 377C Chatham Court, Leisure Village, lakewood, NJ 08701
Margaret Hultberg '40, 38 Cedar Circle, Green Ridge Village, Newville, PA 17241
Mary Wheeler Ohle '40, 272 Seven Mile Ridge, Burnsville, NC 28714
Dorothy Hubbard Pedersen ex '40, Box 196, West Main Branch, Dudley, MA 01570
Martha Dudley Gilbert '41, 812 Bentley Dr., Naples, FL 33963
Carol Bowman Coven ex '42, 1033 Sutton Circle, Apt. 183, Daytona Beach, FL 32014
Bess Morrow Piggott '43, 4400 Poplar, Apt. 26, Memphis, TN 38117
Ann Perkins Bradley '44, 10020 San Pablo, Fort Myers, FL 33907
Mary Jean Sealey Janssen '44, 970 Madrid Dr., Palm Harbor, FL 33783
Jane Payson Stevens ex '44, 5935 N. 16th St., Arlington, VA 22205
A. Elizabeth Cole '45, 1825 Clifton Road, Apt. 409, Atlanta, GA 30329
Dorothy Hart Lang '45, 603 Parker Road, Salisbury, MD 21801
Ruth King Mance '45W, 24 Eagle Drive, Liberty, NY 12754
Mary Quinlan '46, 140 Nahant St., Lynn, MA 01902
M. Geraldine M. Robinson '46, 23 Cedarwood Lane, Old Saybrook, CT 06475
Betty D. Sullivan '46W, 9 Ennismore Gardens, Flat #7, London SW7, England
Carolyn Pullar Haeger ex'47, 1701 Asylum Ave., West Hartford, CT 06117
Gladys Day Thompson ex'47, 32 Laurel Drive, Mount Dora, FL 32757
Patricia Pearson Fruhe '48, P.O. Box 115, Falls Village, CT 06031
Esther Luttrull Hoffman '49, P.O. Box WGM, Marion, IN 46952-0948
Mary H. Otis '49, 181 Meadow Neck Road, Waquoit, MA 02536
Margery Martsolf Krieger '50, 84D Nome Parkway, Aurora, CO 80012
Virginia Wilke Nelson '51, 1414 North Hudson St., Arlington, VA 22201
Mary Pryor '51, 1302 6th Ave., S., Moorehead, MN 56560-2949
Doris Moses Preus ex'51, 3430 List Place, Apt. 1201, Minneapolis, MN 55416
Lucinda Pratt Ferrill '52, 3229 Jupiter Road, Las Cruces, NM 88005
Dee Jorgensen Clothier ex’52, 219 North 19th St., Colorado Springs, CO 80904
Joan Deming Garratt ex'52, 41 Jericho Drive, Old Lyme, CT 06371
Bernice Hughston Clayton ex'53, 4101 Gladstonbury Road, Winston Salem, NC 27104
Dorothy Durkin Kenney '54, P.O. Box 21, Campbell, CA 95008
Mary Castenholz Stack-Dunn ex'54, 2516 Oakhampton Place, Herndon, VA 22071
Joanne Heckman Blyler '55, 335 Jefferson St., Bloomsburg, PA 17815
Vesta K. Rich '56, 12-33 Beverly Mai, 31 Tomlinson Road, Singapore 1024, Republic of Singapore
Dorothy Platte Bittner '57, 9 West Craig St., Basking Ridge, NJ 07920
R. Pendleton Camp '58, 7761 Las Palmas Way, Jacksonville, FL 32216
Jean Goss '65, Tainan Center, 26 Lane 18, Ta-Hsueh Road, Tainan 700, Taiwan
Margaret Megill ex'67, 234 Justice Court, Washington, DC 20002
Karen Westbrook '68, 4818 Trinity Drive, Little Rock, AK 72209
Betty L. Armacost '69, 6203 S.E. 17th St., Portland, OR 97202
Sherry Shamansky '69, 53 Round Hill Road, Dobbs Ferry, NY 10522
Donna M. LeBlanc '70, 1808 Eagles Cove, Springfield, TX 77546
Robert Rankin Matheis '70, 317 Cave Ave., N.E., Bainbridge, WA 98110
Sister Mary Agatha Cebula '71, 510 Ridge Road, Lyndhurst, NJ 07071
Paula Waxse Goering '71, 101 Lyndhurst Ave., Toronto, Ontario, Canada M5R 2Z8
Cheryl Tatano Beck '72, 140 Gideon Lawton Lane, Portsmouth, RI 02871
Janet Cellar '73, 87 Thistle Court, Cheshire, CT 06410
M. Col. Judith Walstra Flanagan '73, 377 Woolmarket Road, Biloxi, MS 39532
Sister Marilyn Perkins '73, Good Samaritan, East Norwegen & Tremont Sts., Pottsville, PA 17901
Linda Carson Richardson '73, 5239 Arholes Dr., Apt. M, Houston, TX 77035
Susan Wilensky '73, 7737 Rocton Court, Chevy Chase, MD 20515
Mary Erlandson-Malone '74, 56 Whitelaw Ave., Milton, MA 02186
Kathleen Puffenbarger '74, 1922 View, Myrtle Point, OR 97458
Elizabeth Braun '75, 285 Harvard St., Apt. 309, Cambridge, MA 02139
Carolyn E. Cole '75, KGSM Apts., Apt. 416, 1725 Orrington Ave., Evanston, IL 60201
Raymond Stefan '75, 2476 Hilgard Ave., Berkeley, CA 94709
Susan Behrenfeld Zekauskas '75, 2777 East 28th St., Tulsa, OK 74114
Lily-Scott P. Formato '76, 614 Petronia St., Rear, Key West, FL 33040
Inger Henriksen '76, P.O. Box 157, Readsboro, VT 05350
Nancy S. Leake '77, 293 Thimble Island, Stony Creek, CT 06405
Nancy McLean Holdren '77, 4237 N.W. Douglas, Corvallis, OR 97330
Carol Bowen '78, 30 Cottage Lane, Milton, MA 02187

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Vickie Greene Healey '78, 6 Sweetbriar Lane, Chapel Hill, NC 27514
Susan Kalma '78, School of Nursing, Memorial Univ., St. John's, Newfoundland A1C 5S7, Canada
Karen Lee-Benner '78, 3295 Carse Dr., Los Angeles, CA 90068
Judith Shindul-Rothschild '78, 11 Morse Road, Sherborn, MA 01770
Beverly Dixon Spencer '78, PSC Number 3, Box 16372, APO San Francisco 96432
Janet Taft '78, 70 Remsen St., Apt. 11B, Brooklyn, NY 11201
Mary W. Bassis '79, Times Farm Road, RR 1, Box 247, Andover, CT 06232
Scott Quincy Garfield '79, 100 Sunset Ave., Lakewood, NJ 14750
Sasha E. Slayton '79, P.O. Box 5675, Kennenwick, WA 99336
James Spall '79, 7580 Stirling, Apt. 221, Hollywood, FL 33024
Terry Fox Stoller '79, 1 Howard Ave., Branford, CT 06405
Marilyn Germano '80, 29 John St., Newport, RI 02840
Dorothy Kent '80, 141 North Lake St., Grayslake, IL 60030
Linda Norton '80, 12131 Country Squire Way, Saratoga, CA 95070
Kathleen Ryerson '80, 3801 North 9th Place, Phoenix, AZ 85014
Carol Ausuble '80, 43 West 16th St., Apt. 8F, New York, NY 10011
Karen Longo-Baldwin '80, 16 Lewis St., New Haven, CT 06513
Holly Blanchard '81, 18 Head O'Meadow Road, Newtown, CT 06470
Denise Canchola-deTournillon '81, 1101 98th St., Apt. 5, Miami Beach, FL 33150
Sandra Zordan Friedman '81, 7 Ayer Road, Wellesley, MA 02181
Cheryl Izen '81, 7 Bockdale Ave., Lynn, MA 01904
Kathleen Mitcheom '81, 69 Seaview Ave., Branford, CT 06405
Margaret L. Plunkett-Shedd '81, RR 2, Box 240C, West Lebanon, NH 03784
Patricia Ryan '81, 10 Cleveland St., Pittsfield, MA 01201
Nancy K. Charles-Parker '81, American Embassy-Brussels, APO New York 09667
Margaret Beal '82, 101 Cottage St., New Haven, CT 06511
Annabil Ching '82, 45 Havenwood, Irvine, CA 92714
Rachel Frazin '82, 3035 17th Ave., Minneapolis, MN 55407
JoAnn Graziano '82, c/o Alan Weber, 77 Park Terrace East, New York, NY 10034
Eleanor Griffin '82, 38 Hancock St., Arlington, MA 02174
Karen Fahey Herold '82, Promenade 20, CH-5200, Brugg, Switzerland
Kristen Kreamer '82, 128 Gertrude Ave., Portland, ME 04103
Barbara Misiewicz '82, 502 South Ave., Apt. 2, Pittsburgh, PA 15221
Mary Quindlin '82, 222 Summit Ave., Providence, RI 02906
Rebecca Stockdale-Woolley '82, 403 Cypress Road, Newington, CT 06111
Susan Andrews '83, 101 Cottage St., New Haven, CT 06511
Catherine A. Buck '83, 14071 Highland Road, Clarksville, MD 21029
Margaret Colby '83, 11925 Avon Way, Apt. 7, Los Angeles, CA 90166
Donna Haggarty '83, 135 West Allentown Road, New York, NY 10852
Nancy B. Hall '83, 6329 Brandywine Way, Las Vegas, NV 89107
Joyce M. '83, 96 Palm Road, Prospect, CT 06752
Susanna Peyton '83, 39 Moore St., Princeton, NJ 08540
Deirdre O'Connor Rea '83, 20875 Ramita Trail, Boca Raton, FL 33433
Susan Turner-Savage '83, 2536 Webster St., Philadelphia, PA 19146
Elizabeth Baldwin '84, 92 Avon St., New Haven, CT 06511
Katherine Biers '84, 4730 West Moorehead Circle, Boulder, CO 80303
Robin Lawrence Cowper '84, 7410 Whittier St., Rahway, NJ 07065
Deborah H. Garfield '84, 131 Cottage St., Apt. 2, New Haven, CT 06511
Brenda Gypson '84, 514 Elm St., New Haven, CT 06511
Lauretia Henderson '84, 1838 West 43rd Place, Los Angeles, CA 90062
Mary Innis '84, 53 South Main St., Branford, CT 06405
Mary Ross '84, 199 Bronson Road, Southport, CT 06490
Brenda Wong '84, 1731 Pacific Coast Hwy., Apt. 13, Hermosa Beach, CA 90254
Anne Hutchinson '84, 2 Lake Ave., Great Barrington, MA 02303
Late arrival
Deborah Jansen '81, 29 Whittier St., Amesbury, MA 01913
Anybody know addresses of?
Lois Brown Stokes '42
Elizabeth Johnson Finck '47W
Kathleen Hedge '65
Carolyn Jaramillo '81
Deborah Pentland '83
Jorcelyn Bessette-Gorlin '84
Elizabeth Blish Genly '85
The tradition of honoring outstanding Alumnae/i was started at the time of the 50th Anniversary celebration in 1973. It is a very special opportunity to honor colleagues and classmates who have distinguished themselves with special talents and achievements. We again solicit your nominations of YSN alums who, you feel, should be recognized in this way. Those Alumnae/i who were suggested last year will be considered along with new ones submitted before March 1st. These awards will be presented during the Alumnae/i Weekend in June. The deadline for receipt of your nominations is March 1st. Please send them to the Alumnae/i Office at the above address:

Review the criteria below and provide as much specific information as possible to indicate the ways in which your nominee meets these criteria. You may wish to solicit help from your friends or colleagues. A Curriculum Vita would be helpful, if one is available.

Criteria for eligibility for nomination:

Achievement and outstanding contributions to any of the following categories:
- Teaching and scholarship
- Clinical practice
- Leadership
- Research in clinical nursing
- Community/Society
- YSN growth and development

Explanation:
1. How is the achievement or contribution beyond the normal expectation of the activity or position?
2. How is the achievement or contribution unique and innovative having more than local impact?
3. Describe how the service to YSN/Community/Profession is continuous and sustaining?
4. How do the activities contribute to the development of new dimensions and directions in nursing?

Your NOMINEE _____________________________ CLASS ________

Your name __________________________ Class ______
Address _______________________________
_____________________________________
Home phone ( ) _________________________
Work phone ( ) _________________________