

Yale Nursing Matters



In this issue:
**Clinical Excellence:
The Science of Care**

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#6 Ranked Graduate Nursing School,
U.S. News & World Report



Yale Nursing Matters

Dean: Ann Kurth

Editor: Virginia Leahy

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Cover Photo: YSN's Erin McMahon with patient at Vidone Birthing Center

Photo by: Bob Handelman

Contributing Writers:

Katherine Kraines

Virginia Leahy

Jeanna Lucci-Canapari

Susan Verrilli

Photography:

Mags DePetris

Elisabeth Fall

Bob Handelman

Mara Lavitt

Design:

Gregg Chase and Karin Krochmal

Copy Editor: Nancy Simonds

Yale University School of Nursing

Post Office Box 27399

West Haven, CT 06516-0972

203-785-2389

nursing.yale.edu

This issue of *Yale Nursing Matters* covers events that took place from fall 2016 through spring 2017.

Yale SCHOOL OF NURSING

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mat•ter n. Something that occupies space and can be perceived by one or more senses; a physical body, a physical substance, or the universe as a whole. A subject of concern, feeling, or action. Something printed or otherwise set down in writing. v. To be of importance or value. Signify.

Left:

March 2017: Students and faculty at work inside Yale School of Nursing's existing assessment lab. A community-led architectural space study is currently underway to design and construct additional simulation and assessment learning spaces at the School. Photo by Mags DePetris.

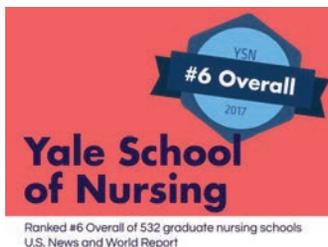


DEAR FRIENDS,

“Caring” is a theme that seems paramount today, as a value and a practice that is foundational to us as nurses. Caring for individuals and communities—clinically, ethically, and emotionally—necessitates valuing all people and supporting them to the highest possible standard of wellness. This issue of Yale Nursing Matters highlights the ways in which our faculty, students, staff, alumnae/i, and supporters provide outstanding care—clinical care, prevention guidance, policy leadership, and health system change. You will read here about this core philosophy outlined in YSN Associate Professor Mark Lazenby’s new book, “Caring Matters Most”—a succinct declaration of what it means to be a nurse, working in partnership with the people we serve. Since its very founding, Yale School of Nursing has exemplified this theme, providing evidence-based care, and teaching, in a framework of excellence. In recent weeks as we discussed our values at a faculty staff community meeting, we returned to our school motto—providing *Better Health for All*—a phrase that is a modern package for a historic mission. It’s a principle that has been part of our School for nearly a century.

Founding Dean Annie Goodrich integrated “responsibility to the community” into the YSN curriculum from day one. The Yale School of Nursing, at the time, was an experiment—an innovative experiment coming out of the Goldmark Report. Here nursing was recognized as an autonomous profession that could and *should* integrate the concepts of education, science, and clinical practice. When Dean Florence Wald created modern hospice in America, or when Helen Varney Burst wrote the textbook on midwifery, YSN students were encouraged to look at the patient holistically, to involve families and to consider context and circumstances in the patient’s care. Yet another “radical” idea. In today’s era of political uncertainty around health care access—and support for science itself—the care delivered, and the work done, by YSN and Advanced Practice Registered Nurses nationwide is more important than ever.

It is just another reason why we are particularly proud to share the news that *U.S. News & World Report* has ranked YSN as the number six graduate school of nursing in the nation (the School’s highest ever ranking). And, after graduating only two cohorts, our Doctor of Nursing Practice program is ranked eighth nationwide.



We have a remarkable community of faculty clinicians, scientists, and educators here and we attribute our rapid ascension in the rankings to their robust funded research and the sustained excellence of our entering classes.

Individual health, community health, health of the planetary ecosystems that sustain life itself—these are goals we continue to strive toward at YSN. They are goals that cannot be achieved without the commitment and passion of our students and graduates toward care. It is a foundational concept with incalculable import and impact.

We are educating America’s future health care practitioners, leaders, and scientists here at YSN at a complex time for our profession and the health care sector. But, as our history has shown, where the road is wide-open or the path unpredictable, we have the map: innovation in evidence-based clinical practice, led by caring as a foundational value, and always with the mission of *Better Health for All*.

Respectfully,

Ann Kurth '90, PhD, CNM, MPH, FAAN
Dean and Linda Koch Lorimer Professor of Nursing

YSN SPOTLIGHT NEWS

High-Touch, Innovative Leader Tapped for Key Finance Role

Marcia Thomas, EdD, MPH, MS, began her full-time role as Yale School of Nursing's associate dean for Finance on April 1. Before coming to YSN, Thomas handled assessment, accreditation, compliance, and risk management as senior associate dean for Planning Finance and Administration at New York University's College of Global Public Health.

As the inaugural associate dean of the College, she assembled a superb team and developed and implemented new administrative policies and procedures. "I've personally witnessed Marcia's expertise at NYU: it was inspiring to see her craft the administrative structure of a new, truly interdisciplinary master's program across multiple distinct schools and departments, that led to an entire new school of public health," says Dean Kurth in a letter announcing Dr. Thomas's appointment. "She collaborates with people and across campus units with aplomb and is an innovative, energetic, and high-touch leader."

Dr. Thomas served as the College's principal administrative and fiscal officer, responsible for budget modeling and organizational, procedural and finance matters, as well as human resource, facilities, and planning concerns. Her leadership was instrumental in the College's success in enrollment management, growth in student numbers, and admission and recruitment efforts. Thomas's previous NYU roles included executive director of Public Health Initiatives and administrative director of the Master's Program in Public Health.

Upon completing her doctoral study in Higher Education Management at the University of Pennsylvania, Dr. Thomas was awarded the "Dissertation of Distinction" for her work on the topic of faculty joint appointment models. She received her MPH from the Harvard School of Public Health as well as a master's in nutrition from Pennsylvania State University. At both NYU and Harvard, she directed academic programs, developed courses, and taught in public health and nutrition.



InterGEN Researcher and PRIDE-CGE Award Recipient Appointed Assistant Professor

Veronica Barcelona de Mendoza, PhD, MSN, APHN-BC, RN, has accepted an appointment to Yale School of Nursing as an assistant professor effective July 1, 2017. Since the fall of 2015, she has served at YSN as a post-doctoral associate with the Intergenerational Blood Pressure study with co-Principal Investigator, Associate Professor of Nursing and Associate Dean of Diversity and Inclusion Jacquelyn Taylor, PhD, PNP-BC, RN, FAHA, FAAN.

Dr. Barcelona de Mendoza earned her PhD in epidemiology from Tulane University's School of Public Health and Tropical Medicine in 2015. She also holds a joint MSN/MPH from Johns Hopkins University, and is ANCC certified as an advanced public health nurse with experience working in a variety of maternal and child health settings. A skilled clinical, public health, and research nurse, she has classroom and faculty experience in adjunct and instructor roles at Louisiana State University. She publishes frequently in nursing and health-related journals and has publications related to her current work in process.

Her research interests and work include genomics, cardiovascular health, maternal-child health, care of Hispanic populations and health disparities, and intimate partner violence. She has consistent leadership in and publications about diverse issues related to culturally appropriate care of Latina and Hispanic women, and is active in increasing advocacy, education, and legislative efforts for people with limited English proficiency.

Recently, Dr. Barcelona de Mendoza was admitted to the Summer Institute in Cardiovascular Genetics and Epidemiology, which is part of the Programs to Increase Diversity Among Individuals Engaged in Health-Related Research at Washington University School of Medicine in St. Louis. The program is funded by the NIH/National Heart, Lung, and Blood Institute with the goal of providing training and mentoring in genetic epidemiology and risk factors to junior-level faculty and who are underrepresented and/or who have a disability, so they can effectively develop independent research programs on cutting edge heart, lung, and sleep disorders.

New Director and Deputy Director Offer Broad, In-Depth Experience to Doctor of Nursing Practice Program

Yale School of Nursing has appointed Judith Kunisch, MBA, BSN, RN, as the director of the Doctor of Nursing Practice (DNP) Program. She was previously co-director of the Program and is an expert in the business and economics of health care, nurse executive leadership, and innovative health care service operations.

Kunisch is former vice president Medical Strategies for a Fortune 100 insurer, executive director of a managed care for-profit network, and managing director of the not-for-profit Hartford Action Plan on Infant Health.

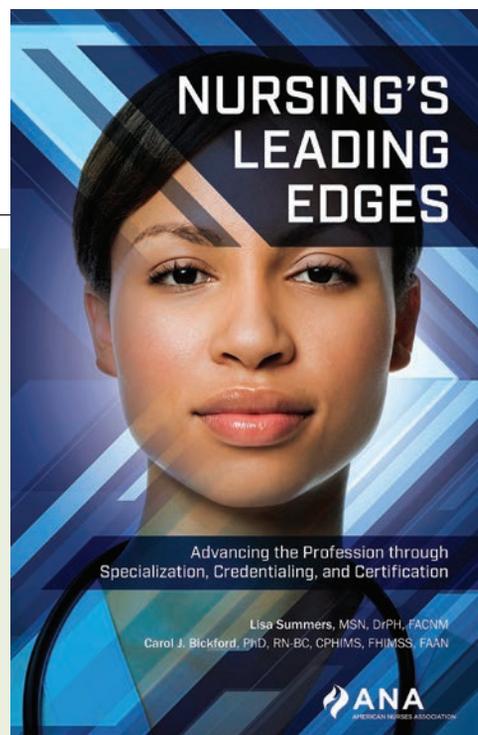
A governing board member for public and private organizations, Kunisch brings a wealth of experience to nurses in masters and doctoral education. She worked with national leaders to disseminate health care service innovations as an expert panel member of AHRQ Innovations Exchange.

Kunisch has co-authored peer reviewed articles on infant mortality risk factors, marketing of electronic fetal monitors, and health care business education for nurses and other providers. She has also presented at national conferences.

She is a recipient of the Robert U. Massey, MD Award for Distinguished Service and the T. Stewart Hamilton, MD Fellowship in Healthcare Management. Kunisch was elected to the Sigma Theta Tau Honor Society for her innovative nursing model to reduce low birth weight infants. She is a trained Six Sigma champion and her versatility and commitment are widely recognized by her peers.

Lisa Summers, CNM, DrPH, will assume the role of deputy director of the DNP Program. She is a YSN graduate ('83) and has exceptional clinical midwifery and health policy experience.

Summers served on the faculty at Baylor University and Columbia University and has held medical school faculty positions at Baylor, University of Texas Health Science Center at Houston, and Johns Hopkins University. She has served the DNP Program since the beginning, and will take on this additional leadership both while on campus and at her current home base in Haiti.



Nursing's Leading Edges

Nursing specialization and credentialing isn't a sexy topic, but it is an important one and so the deputy director of YSN's Doctor of Nursing Practice program, Lisa Summers, co-wrote a book about it. While there may never be a movie adaptation of "Nursing's Leading Edges," Summers certainly hopes that this essential information reaches a broad audience of employers, policy makers, payers, and of course, nurses themselves. Below is a brief excerpt reprinted with the permission of the American Nurses Association.

ANA is in the unique and important role of advocating for all nurses—registered nurses and advanced practice registered nurses—across all roles and specialties. As the profession of nursing has evolved and the industry in which we work has undergone seismic changes, ANA has fielded inquiries from a wide variety of stakeholders. Nurses long credentialed in a role or specialty wonder how the changes affect them, while nurses seeking to advance their career wonder how to choose between a growing number of new programs. Employers wonder how to retain experienced nurses with "old" credentials and how to attract the most qualified new nurses. Policy makers seek to make sense of competing requests for changes in the legislative and regulatory framework. And payers (both private sector and in the government) are wielding influence as they move toward limiting reimbursement to providers with particular credentials.

This book sets out to meet the difficult challenge of providing concise background and information for this broad audience. In some instances, decisions and the path forward are clear. In others, there are important questions that remain to be answered. ANA has and will continue to work closely with colleagues in the nursing community toward a unified message.

YSN SPOTLIGHT NEWS

Sleep Science Expert Receives Prestigious Hall of Fame Award

Professor Nancy Redeker, PhD, RN, FAHA, FAAN, has won the prestigious Sigma Theta Tau International (STTI) International Nurse Researcher Hall of Fame Award. Dr. Redeker is a frequent presenter on sleep-related topics to public, scientific, and clinical audiences locally, nationally, and internationally. Her book, "Sleep Disorders and Sleep Promotion in Nursing Practice" was the first text focused on the incorporation of scientific evidence on sleep into nursing practice settings and is a winner of the AJN Book of the Year Award. She will be inducted at the STTI meeting in Dublin, Ireland this summer.

The award recognizes nurse researchers who "have achieved significant and sustained national and/or international recognition for their work and whose research has impacted the profession and the people it serves."

Dr. Redeker's leadership and scientific innovation in the area of sleep science and self-management is globally recognized and we congratulate her on this well-deserved honor.



YSN's Jacquelyn Taylor Receives Presidential Early Career Award for Scientists and Engineers

Yale School of Nursing's Jacquelyn Taylor, PhD, PNP-BC, RN, FAHA, FAAN, is only the third nurse scientist to receive the Presidential Early Career Awards for Scientists and Engineers (PECASE), the highest honor of its kind bestowed on behalf of the U.S. government. President Barack Obama announced the winners before leaving office in January stating that "These innovators are working to help keep the United States on the cutting edge, showing that federal investments in science lead to advancements that expand our knowledge of the world around us and contribute to our economy."

Recipients are chosen "for their pursuit of innovative research at the frontiers of science and technology and their commitment to community service as demonstrated through scientific leadership, public education, or community outreach."

Dr. Taylor is principal investigator on a five-year research study funded by the National Institutes of Health/National Institute of Nursing Research entitled, "Intergenerational Impact of Genetic and Psychological Factors on Blood Pressure." In addition to this role, Dr. Taylor is being recognized for her complete body of work on gene-environment interactions on blood pressure among minority populations, the community service she has provided to underserved communities, and her work's alignment with national goals and priorities for science.

"Clinical translational research is what nursing science is all about. We always think about how it helps the patient, not just in molecular terms, but in terms of how this can be helpful to patient care and how this work can improve health care outcomes. If you've ever been a patient, you can appreciate the work that nurses and nurse scientists do," says Dr. Taylor, who is associate professor of nursing and associate dean of diversity and inclusion at YSN. "It is truly humbling to be nominated by NINR and selected by President Obama for this most prestigious award."

The PECASE is a family affair. Dr. Taylor's husband, Andre Taylor, associate professor of chemical and environmental engineering, was a 2010 recipient. The Taylors are the only husband-and-wife team to have been granted this prestigious award.



YSN Professor Receives Funding for Diabetes and mHealth Study in Mexico City

Professor Robin Whittemore, PhD, APRN, FAAN, has received funding from the National Institutes of Health/ National Institute of Nursing Research (NIH/NINR) to develop and evaluate "Diabetes Self-Management Education + mHealth Program in Mexico City." She will serve as principal investigator and will be collaborating with Dr. Rafael Perez-Escamilla in the School of Public Health and faculty at Iberoamericana University.

With Dr. Whittemore's research focus on lifestyle change to prevent and treat type 2 diabetes, the NIH/NINR project dovetails with her recent research evaluating the translation of the diabetes prevention program, delivered by homecare nurses, for residents of subsidized housing, and the use of technology to improve health behaviors and psychosocial outcomes in youth at risk for obesity and youth with type 1 diabetes.



Season of Speakers

This year, YSN has had the privilege to welcome a number of amazing speakers to our campus, all of whom have brought depth of knowledge and innovative perspectives that have helped enrich our learning environment.

New NLM Director Sees the Future in Data

Libraries, once a static archive of global knowledge, long ago evolved beyond dusty stacks into the digital age. But the newly appointed director of the National Library of Medicine sees a more engaged and maybe even, to borrow a buzzword, disruptive future for libraries as epicenters for scientific discovery driven by data.

Patricia Flatley Brennan, RN, PhD, the inaugural guest of the Dean's Speaker Series at Yale School of Nursing, opened her remarks with a very simple idea, that the NLM is "not your mother's library anymore."

During her presentation at Yale's West Campus, Brennan emphasized that clinicians should think about medicine broadly as "the care and the creation of health across populations and across the world." The library then, she says, represents "the dynamic interplay between the information needed to do that and the act of doing that."

She focused her remarks on the evolution of the National Library of Medicine, the function of data science in health care, and

strategies for nurses and other clinicians to leverage both.

To that end, the NLM is embracing the concept of "open science" and will be making data discoverable in future initiatives.

But amidst all the data-sets, Brennan did not leave out the most essential part of the health care equation: the patient. "The patient is a partner in the data science of the future, because they contribute some of the data but also because they have to benefit from it. As clinicians we have to figure out how this person intersects with all of that data."



Visiting Scholars at YSN

Through the combined efforts of the Office of Diversity and Inclusion and the Dean's Office, YSN faculty and students were able to benefit from the perspectives and knowledge of a number of renowned visiting scholars this year.

Jemima Dennis-Antwi, PhD, MSc, BScN, founding president of the Ghana College of Nurses & Midwives, spoke about the important contribution midwifery has made, and must continue to make, to vulnerable populations across the globe. She also recognized that policy-makers and governments, particularly governments in the 73 developing countries where 92 percent of the world's maternal and newborn deaths occur, must put in place strategies and support systems that allow midwives to provide for women across the continuum of care.

James Kiarie MBChB, MMed, MPH, PhD (c), coordinator for the human reproduction team in the Department of Reproductive Health and Research at the World Health Organization, also recognized the challenges in aligning goals with resources when it comes to global health. In particular, he identified interprofessional training and education along with technology as opportunities to increase capacity to train, deploy, and retain sexual reproductive health workers across poor and developing countries where such training would have the greatest impact on both health and economic outcomes.

Bernice Coleman PhD, ACNP-BC, FAHA, FAAN, '83, is an assistant professor in the Department of Translational Biomedical Science, Cedars-Sinai Medical Center and associate professor, Nursing, Medical College of South Carolina. Dr. Coleman's research addresses the outcome disparity between African American heart transplant patients and other racial/ethnic groups. Her lecture focused on the rapidly growing field of genomics and the utility of these methods in reducing health disparities and noted a key question for nurse scientists: "Heart transplantation is complex—what role will omics have in helping us understand contributors to poor outcomes in this population?"



From left to right: Bernice Coleman, James Kiarie, Jemima Dennis-Antwi with Dean Ann Kurth.

Bellos Honoree Speaks about America's Health Care Future

Established in 1964, the Bellos lecture honors 1927 YSN graduate Sybil Palmer Bellos, who led an exemplary nursing career, working with immigrant families in New York and holding several leadership positions in New York and Connecticut. Each year, the Bellos lecture features a remarkable individual who epitomizes Bellos' dedication to expanding the frontiers of healthcare.



This year, **Elizabeth H. Bradley, PhD, MBA**, the Brady-Johnson Professor of Grand Strategy and faculty director of the Yale Global Health Leadership Institute, is YSN's Bellos honoree.

Dr. Bradley is renowned internationally for her work on health system design and large-scale implementation of efforts to improve

management capacity in health care delivery within the United States and abroad. Dr. Bradley has several health system strengthening projects in international settings, including China, Ethiopia, India, Liberia, Rwanda, South Africa, and the United Kingdom.

She was the recipient of Bill & Melinda Gates Foundation grant that developed a novel framework of diffusion, dissemination, and widespread take up of health innovations, and she leads the Yale African Women's Forum for Strategic Impact.

Professor Bradley has published more than 300 peer-reviewed papers and has co-authored three books, including "The American Healthcare Paradox: Why Spending More Is Getting Us Less."

The Bellos lecture will be followed by the annual Wisser Tea reception on Tuesday, May 2.

For more information: nursing.yale.edu/bellos-lecture

YSN SPOTLIGHT NEWS

New Executive Deputy Dean Attracted by YSN's Faculty, Students, and Mission

Carmen J. Portillo, RN, PhD, FAAN, will begin her position as Yale School of Nursing's new executive deputy dean on July 1. Dr. Portillo comes to Yale from The University of California San Francisco (UCSF) School of Nursing where she was a professor and chairperson of the Community Health Systems Department.

With expertise in HIV/AIDS and nearly 25 years of outstanding leadership managing UCSF's HIV/AIDS minor in nursing, Dr. Portillo also led the International Center for HIV/AIDS Research and Clinical Training in Nursing. She was the principal investigator of a multiyear HRSA-funded training of advanced practice nurses for HIV clinical management.

Dr. Portillo says three key elements attracted her to her new role at YSN. "I met a lot of the school's faculty and was excited. I thought, 'I would like working with this group of faculty.' YSN faculty are making it happen in education, research, and practice by providing exceptional education and experience for advanced practice students, conducting basic and applied research both domestically and globally, and looking at ways to improve student and faculty diversity," she says. "After meeting with students and other stakeholders from campus and the community, I was thrilled. Students had great questions, and faculty from main campus were willing to partner and collaborate with YSN whether it was about faculty development in educational pedagogy, educational development for students, or research collaborations. My third attraction was YSN's mission and vision and values statement coupled with working with Dean Kurth."

In addition to her research interest in HIV/AIDS-related medical and social issues, her other areas of interest encompass women's health, symptom management, quality of life, health systems, health disparities in vulnerable and high-risk populations, and international capacity development.

As an advocate for Hispanic health issues and a leader in expanding opportunities for Hispanic nurses, Portillo helped found the National Association of Ethnic Minority Nurse Associations, Inc., which represents five ethnic minority nurse associations. She has been instrumental in expanding opportunities nationally for Hispanic nurses in four-year degree and graduate programs. And other schools of nursing frequently tap her expertise in developing recruitment and retention strategies for minority nurses.



Widely known in the nursing sciences as the recipient of many national and international awards and honors, Dr. Portillo received the Dr. Martin Luther King Award from UCSF, was named a Fulbright Senior Specialist, and was recently honored by Sigma Theta Tau for excellence in nursing leadership. A highly published author, she has also served as a reviewer, advisor, and editor for many prominent journals.



Pioneering Researcher and Expert in Urban Health Joins YSN as Associate Dean of Research

"I have great respect for the Yale School of Nursing, which has a reputation for groundbreaking innovation and an impressive record of leadership. Dean Kurth's vision is inspiring and the faculty's dedication to excellence in research, education, and service is impressive. I also see the ease with which schools across campus collaborate. I resonate with the School's commitment to embrace the expansion and benefits of diversity and to continuously strive to achieve health equity."

On July 1, 2017, David Vlahov, RN, PhD, FAAN, will begin his new role as the associate dean of Research for Yale School of Nursing. He comes to YSN from the University of California San Francisco (UCSF) School of Nursing, where he was a professor of epidemiology and biostatistics and served as dean for five years. Under his leadership total grant revenue to researchers from the National Institutes of Health (NIH) increased by nearly 68 percent, funding studies in symptom management, alarm fatigue, drug intervention, and other research areas.

Vlahov began his career in service to others after attending Dr. Martin Luther King Jr.'s "I Have a Dream" speech. As a nurse educator, innovative scientist, and internationally recognized expert on urban health among vulnerable populations, he has served on the nursing faculty at Johns Hopkins and Columbia Universities, and was adjunct professor in the Medical Schools at Cornell, Mount Sinai, and New York Universities and the College of Nursing at New York University.

His research interests include infectious diseases, substance abuse, and mental health. And his study of urban health has been groundbreaking. Vlahov received the NIH MERIT Award for his work on the longest-running epidemiological investigation of its kind, looking at HIV infection in Baltimore among people who inject drugs.

His research at the New York Academy of Medicine included a mental-health assessment and follow-up on 3,000 New York City residents after the events of Sept. 11, 2001. He also headed epidemiologic studies in Harlem and the Bronx, which led to intervention studies to address racial and ethnic health disparities.

Vlahov was an expert adviser to the World Health Organization (WHO) and served on the National Academy of Medicine's Global Health Board and the American Association of Colleges of Nursing board of directors. He has developed programs for and consulted with the Medical School in Belo Horizonte, Brazil, and the WHO's Urban Health Center in Kobe, Japan. With colleagues, he initiated the International Society for Urban Health, serving as its first president. Currently, he co-directs the Robert Wood Johnson Foundation's national Evidence for Action program.

A fellow of the National Academy of Medicine and of the American Academy of Nursing, Vlahov has published more than 660 journal articles, edited three books, and is the editor-in-chief of the Journal of Urban Health.



Clinical Excellence: The Science of Care

by Jeanna Lucci-Canapari

“I was curious,” says Associate Professor of Nursing Jessica Coviello, DNP, APRN, ANP-BC. While caring for women with cardiovascular disease, she began to notice how many of them were coming in with heart failure several years after undergoing chemotherapy for breast cancer. She wondered if there was a connection.

An Advanced Practice Registered Nurse, or APRN, like Coviello, is well-poised to delve into this question. As registered nurses with advanced degrees—a master’s or a doctorate—in nursing, “APRNs are not only clinicians,” she says, “but they really should be scholars as well.” Nursing research focuses on the science behind clinical practice, as well as prevention, and managing the symptoms related to a variety of illnesses. Clinically, APRNs can act as Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists, or Clinical Nurse Specialists. The Yale School of Nursing’s APRN programs for NPs and CNMs are top-ranked in the nation.

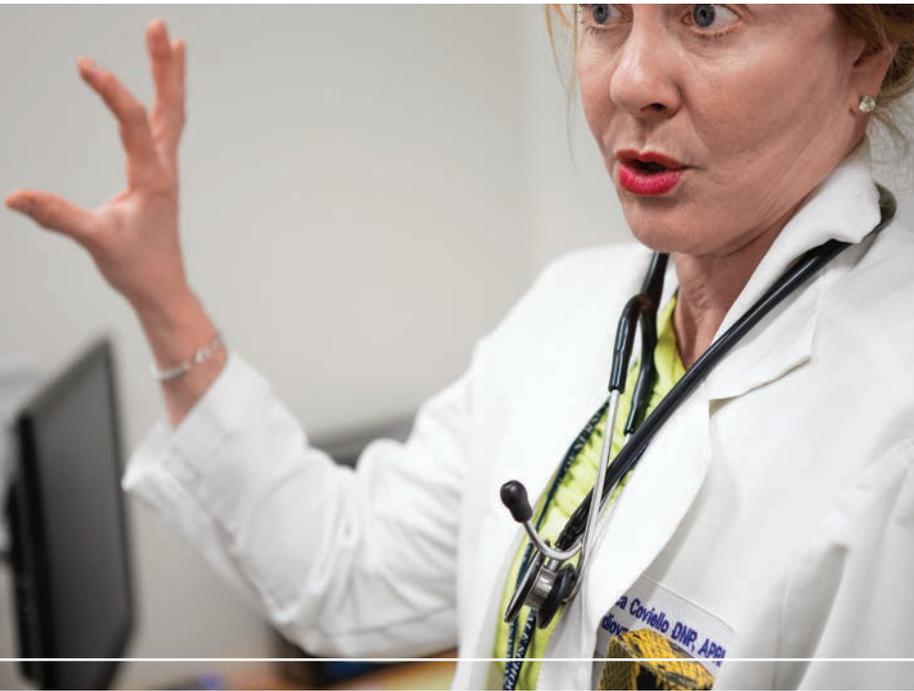
Spurred on by what she saw in her daily practice, Coviello began to investigate the cardiac consequences for breast cancer chemotherapy treatments, and what protocols were in place to

prevent them. “I came to realize,” she says, “there was actually no guideline for patients to have a cardiovascular assessment before they received treatment.”

She was surprised at the omission. “It was pretty astounding to me that no one looked at cardiovascular risk before people received drugs that put them at risk.” Along with a colleague, Coviello set to work designing a study to examine cardiovascular risk in women with breast cancer. Their research uncovered that many women entered chemotherapy with several risk factors for heart disease, including hypertension and high body mass index. “They were set up for metabolic syndrome,” she says. “Then during treatment, they received a steroid, which made that metabolic syndrome worse.”

Coviello’s experience is a powerful example of the clinical excellence achieved by APRNs: by looking at the whole health of her patients, rather than at just the particular ailments that brought them to the clinic, she was able to find this gap in care. This holistic approach to patient care is a hallmark of the APRN.

While the practice of medicine has traditionally been founded upon curing disease, “nursing is a preventive model,” says Coviello.



“I came to realize there was actually no guideline for patients to have a cardiovascular assessment before they received treatment. It was pretty astounding to me that no one looked at cardiovascular risk before people received drugs that put them at risk.”

— Jessica Coviello, DNP, APRN, ANP-BC

“Even looking back to Florence Nightingale’s work, she was looking at how you could create a healthy environment for individuals,” rather than just treating disease. In Coviello’s practice, “the gaps that we found were the gaps that were related to risk. If you don’t look at risk prevention, or if you don’t act on risk, then you end up with an ailment.”

Nursing draws from clinical, basic, social, and translational science to inform practice, and APRNs work squarely in the model of evidence-based care. The role of the APRN began in the 1960s as a response to the increased need for primary care, as Medicaid and Medicare coverage expanded. Similar urgency has been felt in recent years with the expansion of coverage seen with the Affordable Care Act (which recently withstood a Republican challenge for repeal). As the need for primary care has grown in the United States, so has the contribution of APRNs to diagnosing, treating, managing, and preventing illness. Recently, the Veterans Health Administration ruled to grant APRNs nationwide full practice authority, including prescribing medications and interpreting test results. While many APRNs practice in ambulatory settings, acute care NPs practice in hospitals to improve health outcomes for patients who receive sometimes overwhelming amounts of information from many providers.

“We are taught from day one to take care of the whole person, not just their medical condition,” says Elizabeth Doyle, DNP, APRN, PNP-BC, BC-ADM, CDE. Doyle is a Lecturer in the Pediatric Nurse Practitioner specialty and conducts clinical research on diabetes.

“Diabetes care really lends itself to the care of an APRN,” Doyle says. “My colleagues and I have a saying about diabetes care: it’s 15 percent medical care, and 85 percent worrying about the rest of the patient’s life, and the psychosocial influence on their care.” In her practice, Doyle is investigating how to best transition adolescent diabetes patients from pediatric to adult care. Older adolescents, she observes, make for a challenging cohort of patients. “They don’t quite belong in pediatrics, because they are becoming more independent,” she says, “yet they still really need additional support, because they are not quite ready for the level of independence that is expected in an adult practice.”

As she worked with young adult patients she began to notice a high incidence of a dangerous practice, disordered eating— interestingly in both girls and boys. “Patients with diabetes learn if they skip insulin, they’ll lose a lot of calories in their urine, and they’ll use it as a form of weight loss. It becomes a type of purging. That’s pretty unique to diabetes.” The practice causes a threefold increase in mortality among diabetes patients, but, as Doyle discovered, “there are no guidelines on how to treat this.”

To address this gap, Doyle is collaborating with a psychologist and colleagues at the Yale Diabetes Center to help patients address their disordered eating habits with mindful eating. She is also working with Dr. Robin Whittemore, director of YSN’s PhD program, to develop a pilot study to examine the effectiveness of this type of treatment. “There isn’t really any research, other than anecdotal, on how to treat this.”

Both Doyle and Coviello are doctors of nursing practice (DNP). As DNPs, “our job is to take the research and operationalize it,” says Coviello. Often, “research sits there, and it takes too long for things

Jessica Coviello examining a patient.

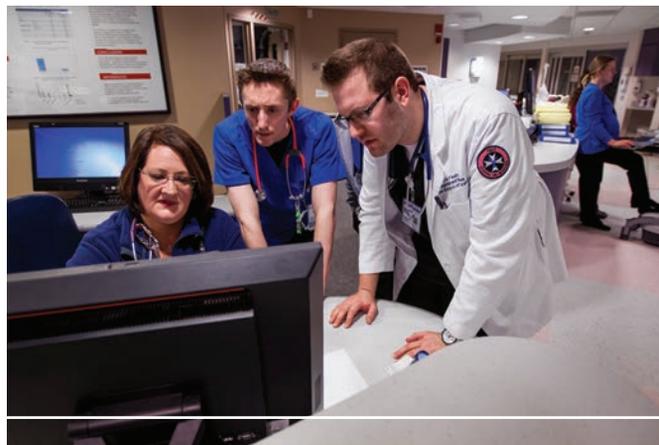


to change. The process of bench to bedside can take almost 20 years. That's why the DNP was developed, to help fill in that gap. We are leaders in taking evidence and turning it into practice."

"All of the research I have been involved in has stemmed from practice," says Dr. Doyle. "We are taught to utilize evidence, and go out to create the evidence if it doesn't exist. We identify a problem, and if we don't know how to care for patients with that problem, our goal becomes to find out how to care for them."

The evidence-based care provided by APRNs is founded on outcomes proven by research. Evidence-based care refutes and replaces traditional types of care that relied merely on what had always just been done. "There are so many things that are traditional, what we call 'sacred cows,'" says Associate Professor of Nursing Laura Andrews, PhD, APRN, ACNP-BC. "There are things that are written in stone and nobody knows why. They came down from the mount eons ago, but we still do them."

Andrews specializes in acute and critical care. "One of the standard norms in acute care is the temporary feeding tube, used in feeding liquid nutrition. The custom is that you aspirate back on it, and see if there is a residual, and that's how you can tell if a patient is tolerating the tube feeds or not," she says. However, she has found, through evidence that comes from practice and research, that this practice actually harms the patients. "Critically ill patients need



Laura Andrews reviews a case with her team.

nutrition, and if we keep checking residuals and stopping feeding, patients never meet their nutrition goals."

A major challenge that APRNs face in operationalizing these evidence-based findings, Andrews says, is a culture of habit, which is slow and difficult to change. "Some of these traditions are hard to get through," she says, "despite having all this evidence that it's actually harmful, it's so engrained in people's practice."

Laura Andrews and YSN student Eric Festa with a critical care patient.





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—Laura Andrews, PhD, APRN, ACNP-BC

Because of extensive experience working as part of a team and expertly coordinating between physicians, residents, nurses, and other staff, APRNs are able to lead this charge for change. At the Hospital of Central Connecticut’s New Britain Campus, where Dr. Andrews cares for patients, she is working to implement a policy to change the feeding tube practice, but it is still commonly done. To reduce the practice, she is training medical residents, nurses, and physician assistants on its dangers and educating them on how to change it.

When change does happen, it is powerful. Dr. Coviello was able to operationalize the results of her research, and collaborated with two cardiologists to begin a cardio-oncology clinic at Smilow Cancer Hospital. The clinic assesses patients who are about to begin chemotherapy for cardiovascular risk, and now sees up to 50 patients per week, though Coviello would like to see every patient prior to chemotherapy to assess them for risk. “Our primary job at Smilow is to keep people safe through their treatments,” she says. This goes beyond reducing cardiovascular risk. “If patients need dietary care, I refer them. It’s always with this holistic idea, trying to create an interdisciplinary team for patients.”

The APRN’s holistic approach to care not only identifies protocols and clinical needs that might fall through the cracks, but can provide a safety net for vulnerable groups of patients, who might fall through the cracks themselves. Erin McMahon, CNM, EdD, is a nurse midwife at the Vidone Birth Center at Yale New Haven Hospital’s Saint Raphael Campus and the midwifery faculty practice director at YSN. “Vulnerable women can really benefit from a midwife who is not only talking to her about her pregnancy, but will also say, what else is happening at home?” says McMahon. “We are trained to look at what else is going on in a patient’s life that we know will impact a person’s pregnancy, such as adequate food, or safety.”

One recent patient returned to the hospital shortly after giving birth, along with her children. “She told us she didn’t feel safe at home,” Dr. McMahon recalls. “She knew, because she had been with us before, the birth center was a safe place, and if I go there, they will

help me.” Once patients confide in them, APRNs must then know to whom to reach out to in the community to get patients the help they need. “We couldn’t provide housing, we didn’t have a safe place for her to go, but we had a social worker on our team who could connect her to the necessary resources. We provided lunch for her and her children while the team worked on a safe plan. And she then went from our clinic to a private, secure shelter that day.”

Patricia Ryan-Krause, MS, MSN, RN, CPNP, cares for refugees at Yale’s outpatient Pediatric Primary Care Center, where New Haven’s local agency for helping immigrants and refugees, IRIS, brings people who have recently arrived in the city for their initial comprehensive health care visits. Refugee patients “have had a total disruption in their life and their family,” says Ryan-Krause. Because there is so much ground to cover in these visits with refugee patients, it is “essential to go beyond the checklist of a routine visit,” says Ryan-Krause. “For clinical excellence, it’s important to engage the family. It’s based on responding to the family’s needs, and doing so in a culturally sensitive way.”

Erin McMahon and new mom, Ayse Maras with her new baby girl.





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Part of this sensitivity means not having any assumptions about what new arrivals might expect from their health care providers. Children, in particular, are at risk for mental health, behavioral, and developmental issues upon arriving in the United States. The challenge for their caregivers, says Ryan-Krause, is that many of their home cultures do not recognize these issues. “We expect people to know what well care is,” or to understand the importance of evaluating development in children, she relates. “In Syria, if a child is sick, they try home remedies, and if they don’t work, they go to the pharmacy where they can buy anything, from controlled substances to cough drops, and then they might go to the doctor. But there are no wellness visits to talk about nutrition, safety, or development. We need to talk about what these visits mean.”

The APRN delivering care to refugee families must recognize their courage and resilience, and that “every person from the same country does not have the same culture or experience things in the same way,” she says. “All that being said, we still need to address issues of health promotion and health safety when we are taking care of these families.” For example, she sees many patients who, as part of an ancient tradition, use kohl, a black eyeliner, on small children to protect their eyes. Kohl is full of lead. “We always suggest that there are other products,” she says, “but you have to be sensitive to their culture, and listen to the concerns of the family.”

“To me, clinical excellence is caring for the patient and caring for the whole family,” says Nancy Banasiak, MSN, PPCNP-BC, APRN. Banasiak works with patients with asthma, and a large part of her role, she says, is making sure that her patients, often from underserved, low-income communities, have the medications they need to manage their asthma, and keep them from going to the emergency room with acute asthma exacerbations. “There are ways to find medications, but maybe parents don’t have time, or knowledge, or access to the Internet,” she says, and it is up to the APRN to help them navigate the challenges of the health care system. “I think that is one piece missing in health care today, the notion of advocating for patients.”

In acting as advocates for patients, “one of the things that midwives and nurses do is offer respect,” McMahan says. “Some women are not getting that in their life, especially if they are trying to use a federal system to access safety net services, housing, or food stamps. Sometimes, we don’t always treat people very well. The idea that somebody would sit down and say, ‘So tell me how you would like this birth to go? How can we get you enrolled in school? How can we get you child care so you can attend classes?’—that adds value.”

McMahan underscores that holistic care means treating patients as individuals. The Vidone is a midwifery-led unit, in which the focus is on natural physiologic birth, guided by the conviction that most of the time, labor and birth progress normally. The midwife monitors labor, and decides when intervention is necessary, including transfer to obstetrician and surgical delivery, if needed. “The best care for women is when we work together and we negotiate,” she says. “Looking at each individual woman, and saying, what does the evidence say we should do to assist her with her pregnancy or her labor?”

Pat Ryan-Krause leading a lesson on teeth brushing with Syrian refugee children at their home.



As an academic clinical center, the Vidone exposes health care providers to a wide array of complications. “When you have seen really sick moms and babies, you can start to see disaster looming around every corner, but our role is to help everyone remember that not all women are those women,” she says. “Midwifery care is about the judicious use of interventions, to make sure we are not just applying them to everybody, but that we are applying them in an evidence-based way.”

Sometimes, examination into long-held practices reveals surprising insights. Since the 1970s, electronic fetal monitoring, which essentially allows a labor team a window into the womb, with constant information on contractions and fetal heart rate, has been a delivery room staple. “You would think if we listen in all the time, that the outcomes are going to be better,” McMahon says.

The evidence, however, proved otherwise. Research revealed that “constant monitoring did not change rates of cerebral palsy or complications related to birth,” she says. “What it did do was increase Caesarean section rates, without necessarily improving outcomes for the moms and babies.” Increasing Caesarean rates, which have been on the rise for the past several years, is responsible for many complications for the mother after birth, including placental problems and hysterectomies after multiple Caesarean deliveries.

“What the evidence has shown us is that for a normal, low-risk labor, intermittent monitoring is just as protective, and our outcomes are just as good.” That is now the practice at the Vidone for low risk women.

APRNs are constantly making connections: between physician and nurse; researcher and clinician; patient and community. At heart, APRNs are clinicians, collaborators, investigators, and teachers, and could not fulfill one of those roles without full commitment to the others. “The best teachers were those who stayed in clinical practice,” says Jessica Coviello, “because each of those worlds informs the others.”

“I think we are in a good position,” says Laura Andrews, “because we provide quality care to patients, and we are training the next generation.” This education is based on a deep experience of caring for patients. “Because I work clinically, I am a better educator, and because I work in academics, I am a better clinician,” she says. In health care, “everything changes so quickly. If I am not firmly rooted in clinical care, what am I teaching my students?”

All of it, for the APRN, is driven by one thing: caring for people. Being in the clinic with patients “feeds my soul, and it makes me a better teacher,” says Coviello. “Those of us who do it, we do it because we love it.”

Jessica Coviello and patient Elizabeth Martich exchange a warm embrace at the end of an appointment.



Why “Caring Matters Most”



When Yale School of Nursing faculty member and philosopher **Mark Lazenby, PhD, APRN, FAAN**, was asked to give a series of lectures on nursing and the good of society in the spring of 2013, his research into that intimidatingly broad subject led him to the very foundation of nursing itself...through the writing and work of YSN’s founding dean, **Annie Goodrich**.

Goodrich believed that ethics were at the very heart of the vocation of nursing, and that they serve as a compass guiding those who choose to work toward making the world a better place.

In his new book, **“Caring Matters Most: The Ethical Significance of Nursing,”** the first in a planned trilogy, Lazenby takes that bedrock principle and builds upon it. He emphasizes that **“Nursing is a profoundly radical profession that calls society to equality and justice, to trustworthiness, and to openness. The profession is, also, radically political: it imagines a world in which the conditions necessary for health are enjoyed by all people.”**

There may be no better time than now to expand on and give voice to the **“radical”** idea of better health for all.



Annie Goodrich surrounded by faculty and students at the 25th Anniversary of YSN (1949).

Below is an excerpt from the book:

Chapter 4 ~ Beauty

I will leave this earth with the memory of this event. It was horrible, so horrible, in fact, its repulsiveness is forever etched in my mind—indelibly etched, etched with the acid of injustice. Even now, I can conjure up the moment it happened, and even now, I feel its injury. I say the moment it happened, because it was one of those moments in which the event isolated itself, set itself off from everything else. It was the only event in my consciousness at the time. Everything else going on disappeared, even my awareness of being in my body. Darkness took over everything. It was so horrible.

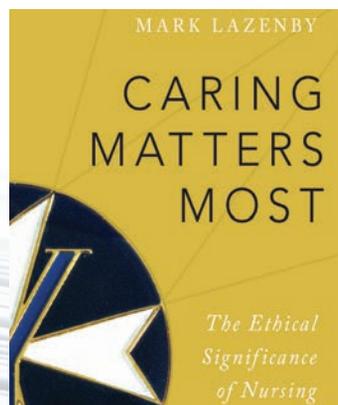
I was abroad. Three graduate students were with me as research assistants. They were in their mid-twenties, all quite mature and dedicated to advanced practice nursing. We were standing in the middle of a hospital ward. We had been in this ward daily for almost a month collecting data on symptoms from patients. We knew that one of the patients on the ward was near death. We had seen her before. We knew her clinical situation. She was in quite a lot of pain; this she had told us, but her body told as much, too. She writhed in bed. We tried to get the physicians on the ward to give her pain medication. Fear of using opiates and lack of opiate supply

conspired; her pain remained unmanaged for the month we had been on the ward.

As we stood there that morning, a crisp, bright morning, the sun’s rays entered the ward’s windows and danced on the bare cement floor. We had arrived early so we could start collecting data just after the physicians finished rounding. The ward buzzed; it was crowded with patients in beds and with patients who were not hospitalized but who were waiting to see the physicians after they finished rounding. That morning the ward buzzed, and it rocked with this patient’s moans. We stood there, the four of us, in the middle of the ward,

waiting to collect data from patients. We remarked to each other that this woman’s moans were different this morning, this bright morning, this morning full of the buzzing business of the ward.

As her moans grew into shrieks, I looked in her direction. A family member stood by her side. Two nurses attended her. They were washing her limbs and brow with cool cloths, the pain management techniques they had available to them. Her shrieks turned to screams, screams the sort of which I had never known before. We know the death rattle; its sound is familiar to us.



It is the sound of secretions piling up in the throat and upper chest, which dying patients cannot clear. I knew the death rattle. But I had not known the death scream, not until I heard it that morning. My students heard it, too. We heard this woman scream the death scream, and in the very middle of that scream, she died. She announced her death with that scream, and then she died. The scream, loud and desperate, shook everything—our bones, our minds, our hearts.

It was sad, gut-wrenching, depressing, unfathomable. It was all that. But more than all that, it was violent, repulsive, unjust. Its injustice disturbed me, disturbed me as far down as I could be disturbed. It was one of the most horrible events I have ever experienced—a woman dying screaming into her death.

“Beauty,” Augustine said, is “a plank amid the waves of the sea.” The sea waves that morning on the ward—dark and cold and rogue—overtook this woman; and in the moment, they overtook us. As soon as we came to our senses, my students and I stepped outside into the hospital’s garden. The sun was warm and strong. We stood by a tree; it had the most beautiful red blossoms on it. Bougainvillea with purple flowers climbed up trellises on the hospital’s walls; they, too, were beautiful. We saw the beauty of these flowers, of their colors and shapes, and we felt the sun hitting our backs, taking the edge off the coldness that had settled into our bones. Beauty was the saving plank amid the waves of the stormy sea that morning.

Daily we nurses sail on stormy seas, and daily we need the saving plank of beauty. The hospital’s gardens were beautiful, exotically beautiful—nature’s beauty. “Beauty,” the essayist Elaine Scarry says, “is lifesaving.” But the beauty that preserved me amid that dark and choppy sea that morning was not the beauty of the gardens or the warm sun. What saved me that morning was the beauty of nursing. The nurses themselves, and their nursing acts aimed at alleviating the dying woman’s pain, were beauty, beauty amid the injuries of pain.

Injury, not ugliness, is the opposite of beauty. In fact, the base of the word “injury,” Scarry points out, is *jur*, which means right, right in the sense of justice. An injury is an event that is not right. An injury is an injustice. To die a death that is not peaceful is an injustice; it is not right. The nurses who attended the dying woman, in their healing acts of addressing her pain with the only tools they had, addressed the pain that injured the dying woman’s humanity.

It is in this sense that injury is wrong—morally wrong: injury threatens life. There are public health injuries that threaten life—lead-laced water the public have been told is safe to drink, the Earth that is warming up to degrees unsustainable for life, inadequate resources to address diseases and pain and suffering equally around the world. And there are personal injuries that threaten life. Nursing practice, in its unique function, addresses these injuries. Nursing practice, by addressing these injuries, seeks to beget beauty, and beauty is lifesaving.

Beauty is lifesaving to patients through the work of nurses. Nurses, Annie Goodrich says, should have a “love of beauty,” for beauty motivates nurses to restore and promote health and to lead patients to serene deaths. But for this to be the case, nurses need to develop the habit of seeing their patients as beautiful. It is not so much that our patients are beautiful in the sense of a supermodel or someone whose physical presence matches that of Michelangelo’s David. We often see patients in their injured state. Even if they look like a Gisele or an Adonis, they come to us injured

or potentially injured. Our choice as nurses is to imagine the beauty of their lives.

Let me illustrate with an example from my own practice. I assumed the care of a patient in an oncology clinic because the nurse practitioner who had been caring for him went out on leave. The patient had prostate cancer, but it was not clear if the cancer had spread or if the cancer was contained in the prostate. The patient, a man about a decade older than me, struggled with anxiety. It

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debilitated him at times, leaving him alone in his home shut off from daily life. Even to come to the hospital to see me, he would have to take anti-anxiety medication. Unemployed, he always came to appointments with his partner, a woman of about his age who worked but whose job did not bring in much money. She was loving and attentive: she took notes on everything I said during the appointments and repeated them back to me to make sure she understood my instructions. They both wanted his prostate cancer treated. But there was an obstacle that was getting in the way.

The oncologist wanted my patient to have a colonoscopy to screen for colon cancer before he would make a decision about how to treat the tumor in the patient’s prostate. This is common. We need as much information as possible when making treatment decisions about cancer care. But going under the sedation necessary for a colonoscopy frightened my patient. He had been refusing this colonoscopy for several months before I become involved in his care. Although no one called him “a problem patient,” some clinicians who had worked with him hinted that he was. And I admit, a few times I found myself impatient with him, he was so full of anxiety. One day, he and his partner came to the clinic to see me. It was a winter day and the heat was on a bit too high in the clinic room. One of them had been smoking cigarettes, though my patient said he did not smoke, but the room reeked when I entered it. The overpowering smell, the heat, and my frustration at my patient’s refusal to have a colonoscopy—yet again—got the best of me. I started to feel physically ill. In the middle of that visit, I thought I had come to my end. I did not think I could care for my patient anymore.

The choice I had in that moment was how I viewed my patient. I knew it would be two weeks before I saw him again, so I had two weeks to start imagining a future for him. I started telling myself a story about him in my head. I knew a bit about his life; I had, after all, taken his social history. I knew where he was born and raised, how much education he had had, and what he used to do for work. I knew that anxiety debilitated him, and I knew that his mother, who had died of cancer, was also “an anxious sort.” His father had

passed away, too; this I knew. I knew enough to start imagining my patient as other than a “prostate cancer patient” in my clinic room. I started imagining him as having lived a life before my life with him. I also started imagining him as having a life with a future, a future of getting a colonoscopy and of getting the right treatment for the prostate tumor. And I imagined a future for him in which he did not come again to the cancer clinic, a future in which he did not need to come because the cancer had been controlled. I hoped for a future for him free from disease.

This is our choice as nurses—the choice to view our patients as having lives outside the context in which we see them. It is an ethical choice. It is the choice to view our patients as if disease and disorder do not rule their lives, even though they may be afflicted with disease and beset by disorder. It is the choice of viewing our patients as having beautiful lives. Life, after all, is beautiful.

Stories—our patients’ stories, how we interact with our patients’ stories, and the stories we tell ourselves about patients, as I did with my anxious oncology patient—have the power to transform how we view our patients.

I recently went to the Neue Gallery in New York City with my wife. She wanted to see Gustav Klimt’s portrait of Adele Bloch-Bauer. I didn’t care to see it. I am not a big fan of Klimt’s work; it doesn’t resonate with me. But my wife wanted to see it. About a month before, she had seen the movie “Woman in Gold,” about Klimt’s portrait of Bloch-Bauer. Since then, she was on a mission to see the actual portrait. It was a very cold and windy late December morning that I found myself waiting in line with my wife to get into the gallery to see the “Woman in Gold” portrait. We waited for an hour. The movie had made it one of the most popular paintings to see in New York City. We finally got into the gallery, walked upstairs, and saw the portrait. After a few minutes of looking at it, I was done. My opinion of Klimt’s work had not changed. But my wife kept looking at the painting. She circled around the room and looked at it from seemingly all the possible angles. She walked into a different room and looked at different pieces of art and then went back into the room in which the “Woman in Gold” hangs. She looked at it again and again. I was stupefied about what captured her attention. After we left

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the gallery, she said it was so beautiful, so breathtakingly beautiful. I asked her what was beautiful about it; I just didn’t see what captured her so much. She said, “Oh, you don’t know the story. You need to watch the movie.”

A few days later, I watched the movie, “Woman in Gold,” which tells the story of Maria Altmann trying to reclaim Klimt’s portrait

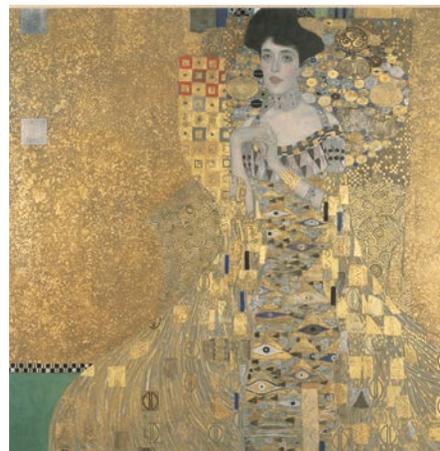
of Adele Bloch-Bauer, who was Altmann’s aunt. When Altmann was young, in the years before World War II, she lived in Vienna in the same house as her aunt. They had a very close relationship.

Altmann, who was Jewish and from a wealthy family, fled Vienna just as the Nazis were about to detain her. Her escape was daring, as the movie portrayed, so daring that as I watched the movie, I grew anxious that Altmann would get caught and be sent to the concentration camps. But she escaped. Eventually, she made her way to the U.S., where she lived the remainder of her life. During her life in the U.S., she often remembered the portrait Klimt painted of her aunt, the portrait that graced her childhood Viennese home. But the Nazis stole the portrait, and after the war, the Austrian government claimed the portrait belonged to the country, not to Altmann, Bloch-Bauer’s sole surviving heir. Altmann, who in her later life in the U.S. was a woman of modest means, spent years trying to recover the Klimt portrait of her aunt. This was Altmann’s story: a story of her being a refugee, a story of the Nazis killing her family, a story of her family’s history ripped off the walls of their house and then re-appropriated by the Nazis and the Austrian government, and a story of struggle to regain that which was rightfully hers. After years of struggle, the Austrian government returned the Klimt portrait of Adele Bloch-Bauer to Maria Altmann, and now, it hangs in the Neue Gallery in New York City, where Altmann, now deceased, wanted it to hang.

After I watched the movie, my wife said to me, “See why the portrait is so beautiful?” The story—the awful but amazing story—transformed what I had seen with my eyes into something more. It was more than a mere portrait painted by Klimt. It was the whole story, a story of unspeakable injustice that ended with the triumph of justice. And so it is with our patients. They may come to us anxious. They may be what other clinicians have labeled them—“uncompliant” or “patient does not adhere to treatment plan of getting a screening colonoscopy.” They may come to us with all kinds of diseases and disorders, injustices beyond their control. But their human story transforms our opinions of these unbeautiful aspects of their lives into something beautiful.

I now think of my time in the presence of that Klimt portrait as a time in which I was in the presence of something transcendent, something that inspires awe. I now can think of that portrait as awe-inspiring. Its story transformed my view of it. I now choose to see the portrait as beautiful, and with that choice, the portrait bestows upon me a sense of awe.

Awe, the philosopher Immanuel Kant suggested, is associated with morality. There was something good (in the sense of moral) about the story of how Klimt’s “Woman in Gold” now hangs in the



Gustav Klimt's portrait of Adele Bloch-Bauer at the Neue Gallery in New York City.

gallery Maria Altmann chose for it. There is something good about restitution, about Altmann's relentless struggle for restitution—for justice. This struggle inspired in me a feeling of awe. I haven't gone back to see the portrait again, but even now, the memory I have of standing in its presence is transformed by knowing its story. I feel awe at its beauty, the beauty the story bestowed upon it. Our patients' stories bestow beauty upon them, and we can choose to stand in their presence with a sense of awe.

When we view our patients as beautiful, their beauty, not the disease and disorder that injures them, fills our minds. Our minds, then, full of beauty, search for something beyond our patients in order to fit them into a larger scene, the *mise en scene* of all the beautiful things of their lives—even the beauty of life itself. It is a moment of life untrammelled by the injuries of disease and disorder. When we choose to see our patients as beautiful, we see them in the fullness of their lives, their lives as if they were not beset with injustices. We stand in their presence with a sense of awe—awe that they are here, awe that they are alive. When we do this, we engage in an imaginative exercise that creates life for them. Through our decision to look upon our patients as beautiful, we create the beauty of our patients' present lives—beauty amid pain and suffering and disease and disorder.

And so it was with my patient who was too anxious to get a colonoscopy. The next time I saw him, I had a new attitude toward him, an attitude in which I thought of his life as beautiful. And I stood in awe of him, at his being alive, at his wanting to do what he needed to do to stay alive. He may have been too anxious to undergo the sedation necessary to get a colonoscopy, but he wanted to be alive. He kept all his appointments with me, after all; he was doing the best he could. I told him so. Well, I didn't tell him that he was beautiful, but I did say that I cared for him and wanted to do whatever he needed me to do so he could get the colonoscopy. He said he would get the colonoscopy if I went with him. I did; it was a struggle to schedule so that I could go, but I did. We booked the appointment for the procedure. When the day came I met him and his partner at the procedure clinic. I had told the nurse anesthetist ahead of time about my patient's anxiety, and she and I came up with a plan about what anti-anxiety medication he could take before coming. Even with this medication in his system, he was still anxious. The anesthetist came out to the waiting room and walked with my patient into the procedure room and properly sedated him. He did it. He underwent the sedation necessary and got the colonoscopy. In the end, he didn't have any polyps. After the procedure, he began treatment for his prostate cancer. His regular nurse practitioner came back from leave, and I have never seen this man again. But I do remember him not so much as an anxious man but as a man who was doing what he could to stay alive.

The intentional choice of viewing our patients as beautiful is a choice of leaning toward justice. When we look upon our patients as beautiful we choose to believe that all patients have the same right to have their injustices redressed. We feel within ourselves the demand to redress their injustices with our everyday, trustworthy acts of nursing care. In fact, it is our nursing care that aims to right our patients' injustices. Acts of nursing care seek to right the injustices that threaten our patients' beauty. When we look upon our patients as beautiful, when we see all who need nursing care as beautiful,

we transform our thinking in such a way that we see our patients as having the right to have their injustices addressed—whether by restoring or promoting their health or providing them a serene death. Beauty addresses injustice. As Goodrich says, we nurses have a love of beauty (p. 26), and because of this, we address our patients' injustices.

We can choose to see our patients, in the fullness of their human stories, as beautiful. When we do, we create a moment in our patients' lives when they are free from injury: we see them as fully alive. In so doing, we bring life to them; we give them the fullness of their lives. When we decide to view our patients as beautiful, we stand before

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the fullness of their lives with a sense of awe. We vow to do for them what they would do, if they had the will, knowledge, or power, to bring themselves back to the fullness of their lives, even as cancer threatens it or even as they lay dying in pain. Our seemingly most mundane acts of nursing care become sublime—giving a bed bath, changing the bed, holding a spoonful of ice chips up to parched lips, sitting silently by the bed and holding the hand of the dying. Through our decision to look upon our patients as beautiful, these acts become more than merely lifesaving: they become life-giving. Our seemingly mundane acts of nurse care bestow upon our patients that which is justly theirs—life, even as they are dying.

It is as if when we come to our patients to perform our everyday, trustworthy acts of nursing care, we knock at the doors of their lives and present to them a gift, the gift of our care, the gift of looking upon them as beautiful human beings worthy of our care. It is only when we do this that our patients welcome us into their lives. “Welcome” means that we come into our patients' lives—that we become part of their life stories—with their consent. Our patients, when they welcome us into their lives, consent to our request to be part of their lives. And that is just what looking upon our patients as beautiful is: a request to be part of the healing of their lives, the restoration or the promotion of their lives to health, or to aid them in achieving a peaceful death. It is only when we choose to see the beauty of our patients that they can say to us, “I know that you're here for my good. I can see this by how you look upon me. And so, I welcome you. I present to you my consent for you to work on my body and mind. I present to you my well-wishes for you to care for me.” This welcome is our patients' response to our choice of thinking about them as beautiful.

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Prevention in United States Primary Care: The USPSTF



“I have been deeply honored to serve on the Task Force. The opportunity to contribute as an APRN on a panel dedicated to raising the bar with regard to the methods with which evidence-based prevention is delivered—and to reducing disease in the United States—is an absolute privilege.”

—Dean Ann Kurth

Primary care is the foundation of a dynamic health system. From newborns to the elderly, it serves as a patient’s first point of entry into the health care system, as well as the touchstone for prevention and early identification of disease, access to health care services and teams. Approaching these tasks from a person-oriented rather than disease-focused perspective is what advanced practice registered nurses (APRNs) do every day. As one of the largest groups responsible for primary care, the nation’s 225,000 nurse-practitioners and nurse-midwives bring the education, practice, and leadership skills to coordinate care integration and management, while at the same time providing patients with the information, counseling, and advocacy integral to disease prevention itself.

Supporting that enormous responsibility is the United States Preventive Services Task Force (USPSTF). USPSTF is a 16-member independent body of national health care experts charged with generating primary care screening and prevention recommendations to improve the health of the United States population at-large. After a strict vetting process, members serve 4-year terms and represent a range of expertise from the fields of prevention and evidence-based medicine. YSN’s Dean Ann Kurth is a current member of the USPSTF.

“I have been deeply honored to serve on the Task Force,” Dean Kurth states. “The opportunity to contribute as an APRN on a panel dedicated to raising the bar with regard to the methods with which evidence-based prevention is delivered—and to reducing disease in the United States—is an absolute privilege.”

Created by Congress in 1984, the USPSTF has become the gold standard for evidence-based recommendations around clinical preventive services that include screenings, counseling, and preventive medications. When the Affordable Care Act (ACA) went into effect, it designated that all USPSTF recommendations that were considered a grade “A” or “B” recommendation were to be covered by insurers. (This is considered to be a floor rather than a ceiling and the USPSTF does not consider costs in its development of recommendation statements.)

Dr. Kurth pays particular attention to the Task Force’s “I” or insufficient evidence ratings. Each time a service is assigned an “I,” it is accompanied by “Suggestions for Practice” to guide clinicians in further discussion with their patients. In addition, an “evidence gap” is published, outlining what data are lacking for the recommendation to be adequately assessed, including communication of the gaps to the National Institutes of Health. This acts as a call out to highlight further research needed. “The Task Force prepares reports to Congress each year. This year we chose to focus our report on the ‘I’ ratings and the subsequent evidence gaps they represent,” she states.

How are these clinical recommendations developed? Once assigned their current topic, Task Force members pore over evidence reports generated by evidence-based Practice Centers. These centers synthesize anywhere from a handful to thousands of studies on the given topic. “It’s like going to evidence-based heaven,” Kurth states. “We have the privilege of digesting the data and deriving practical guidance for primary care settings. Nurses and midwives are true believers, not only in evidence-based research, but in preventive practice. We thrive on this so you can imagine how appealing this is.” Kurth has the distinction of being the first nurse-midwife to serve on the USPSTF and currently sits as the sole nurse on the panel. She has also chaired the USPSTF Dissemination and Implementation Workgroup, which strives to enhance the reach and utility of these carefully developed guidelines.

The Task Force finds itself amidst an evolving landscape with regard to the nation’s health care, with calls by the current Republican leadership to repeal the ACA and uncertainty about what will replace it. While more patients and health care providers are exploring the power of prevention in health care, not all approaches give proportionate support to preventive services over curative ones. Regardless, a culture of prevention is growing in the United States. Additionally, the concept of *more* care not always or necessarily meaning *better* care, might very well be coming of age.

“It is the USPSTF’s mission to provide evidence-based recommendations as to which services can best improve outcomes for asymptomatic patients. More screening does sometimes lead to more false positives, which can in turn lead to more biopsies, or unnecessary surgeries,” Kurth continues. “Not to mention side effects from medicines you may have otherwise avoided. There is a growing awareness of that now. What we *don’t* do in health sometimes can be just as important as what we do—and it’s the nursing and primary care communities at the helm of getting this information to the patient properly.”

The USPSTF’s goal is to inform the primary care community. Given the rigor and transparency with which they work to produce these guidelines, they have become the go-to resource for both primary care teams as well as the individuals they serve. The Task Force publicly posts drafts of their research plan, evidence reviews, and recommendation statements on their website prior to finalization. As these reports undergo a period of public and peer review, they are also subject to input from related professional societies and federal agencies. This draft period invites public comments as well. Once finalized, the Journal of the American Medical Association publishes each of the USPSTF recommendations along with editorials, provider, and sometimes patient, materials.

As primary care providers, APRNs are fundamental in the successful implementation of clinical guidelines. According to the American Association of Nurse Practitioners, there are a quarter of a million APRNs in the United States, 83 percent of whom (207,500) have certification in an area of primary care and, per Agency for Healthcare Review and Quality, roughly 209,000 physicians (about 1 in 3 medical doctors in the United States) practice in primary care. The Association of American Medical Colleges recently reported that it projects the overall physician-to-APRN ratio will fall from what they say is 3.6:1 in 2015 to 1.9:1 in 2030; in this regard “it is apparent that the market itself has decided that APRNs form an essential core of our health care system” says Dean Kurth. “The recent approval on the part of the Veterans Health Administration supporting full practice authority for APRNs is a clear nod to this fact. Access to primary care and avoidable disease and hospitalizations are problems that will continue to demand answers in the United States, and APRNs are part of the solution.”



Just as it is the USPSTF’s mission to “improve the health of all Americans” and YSN’s to achieve “better health for all,” Kurth feels a profound commitment to meet this challenge and has been grateful for the opportunity to work with the USPSTF towards that goal.

Table 1. Interpreting USPSTF Recommendations

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

An “A” USPSTF recommendation reflects that the benefit of the service is significant, and a “B” grade that the net benefit is deemed moderate-to-substantial. “C” means that the service might be of potential, smaller benefit dependent upon a patient’s circumstance, while a “D” grade indicates that the service should not be done. An “I” grade stands for insufficient evidence, assigned when benefits and harms are not yet determinable, given lack of data.



DONOR PROFILE

Bequest from Clytie C. Webber, '46 Establishes YSN GEPN Innovation Fund

In 2016, Yale School of Nursing received a generous bequest from YSN alumna Clytie C. Webber, '46, in support of YSN's Graduate Entry in Prespecialty Nursing (GEPN). Ms. Webber, a MN grad, passed away on February 6, 2015 in Washington, DC.

While her bequest was thoughtfully written as open ended and unrestricted, Yale School of Nursing brought the entire School, including the students, to the decision-making process about deploying these funds.

"The GEPN experience has been innovative since the program was conceived," writes Dean Kurth in conversation about this bequest. "So this was an important opportunity to build on that spirit of innovation and engage the whole community in that process."

In late 2016, YSN announced the "Webber GEPN Innovation Fund," a competitive grant process within the School for students, faculty, and staff to discover and implement the innovations that directly impact the quality of our GEPN students' experience. Applications were evaluated on the basis of *measurable results*, *innovation*, and *advancing the mission of YSN*. The interest and response from the community was remarkable.

In February 2017, the School announced the grantees:

- to provide practice model equipment/simulation upgrades in order to enhance clinical skills and prepare GEPN students for clinical practice.
- to support the purchase of "Victoria S2200," the most advanced female birthing simulator available. "Victoria" also has applications beyond maternity, midwifery, and pediatrics, which will benefit multiple specialties and disciplines.
- to upgrade the lactation room for breastfeeding parents within the YSN community.
- to conduct an Interdisciplinary Longitudinal Clinical Experience workshop, offering tools and training for students who will eventually encounter behavioral challenges and disruptions working in interprofessional environments.
- to purchase the CardioSim VII and PneumoSim, which will allow instructors to create custom heart and lung sounds in addition to simultaneously projecting animations of the heart and ECG rhythm.
- to secure the purchase of teaching stethoscopes, which will allow for more immediate instructor involvement/guidance by allowing the instructor to simultaneously hear what the student is hearing.
- to transform the back rows of the main GEPN and first specialty classrooms into "active learning zones" where students can stand (at standing desks) and take notes comfortably during class.

- in partnership with the Yale West Campus Urban Farm, to support a series of farm-based experiential nutrition workshops and programming integrated into GEPN clinical courses, with mobile capacity to bring student-led healthy eating lessons to local communities.
- to upgrade the YSN Wellness area, allowing students to practice self-care and meditation, and conduct group sessions to enhance self-care practices.
- to purchase a digital projection microscope for classroom use, and histology slide sets to enhance GEPN training.
- to provide equipment upgrades including classroom robots and Fly Wire devices to help support GEPN student learning and situational exposure as they transition into Advanced Practice specialties.
- to conduct career services workshops and assess models of ongoing longitudinal career services delivery for YSN students.

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10 QUESTIONS...

with YSN Alumna Anne McDermott about the Women's March on Washington

Using the power of social media, Anne McDermott, CNM, MSN (YSN '08), organized a collective of like-minded YSN alumni and students to lend their voices to the millions of women (as well as men and children!) who participated in January's historic march. Women's March organizers estimate that nearly 5 million people assembled in cities across the globe. YSN alumni were among them. Below Anne answers 10 questions* about the event and the impact she hopes it made on the future of health care.

1. What made you decide to form YSN at the Women's March on Washington?

It became clear through conversations I was having with colleagues that there were lots of us who had either graduated from YSN or who were current students or faculty who planned to march. There was a sense among us that we wanted to try to connect and represent as a group.

2. How many participants did you have in DC?

This is hard to tell due to the way that we structured our group; at this point, based on responses, I'd say we had well over 120 marchers in marches in the United States and internationally.

3. Apart from DC, what other cities were YSN alumni marching in?

We had YSN alumni marching in New York City, Providence, RI, San Jose, CA, Santa Ana, CA, San Francisco, Salt Lake City, Boston, Spokane, WA, Vancouver, Los Angeles, Northampton, MA, Hartford, Old Saybrook, CT, New Haven, Oakland, CA, Madison, WI, Santa Barbara, CA, Seattle, Portland, OR, Portland, ME, and Oxford, England. Those are just the responses I have gotten. I am sure there are more.

4. What was the atmosphere in DC like when you arrived, as you marched?

Absolutely amazing. Charged. But so respectful and polite. I was heading into the



city via Metro and when the first train pulled in to my station, it was already packed to capacity. When the train pulled in, a huge cheer came up from the crowds both on the platform and from within the train. There were so many marchers on the platform waiting to get onto the train, but the feeling was one of solidarity. The crowds were intense and energized, but so polite. The experience in DC was the same.

5. What was the best thing you took away from the experience?

The best thing I took away from the experience was that those of us as nurses who dedicate our lives to helping others who need help will still be out there and that there are so many who support us and are ready to help us do what we do. I met other nurses and midwives from other programs and practices from all over the country who were there to advocate for the same things we were there to work for. It gave such a sense of hope!

6. Most interesting thing you saw?

How do I pick the most interesting thing that I saw in a day full of amazement? I can only narrow it down. I think the most powerful thing I saw was the very youngest and oldest

(continued)



YSN Student Cecilia Duran Midwifery '18 with her sister Lorena Van Buskirk (at left).

members of our country marching. It was a long and sometimes uncomfortable day. But I never saw a child have a meltdown and I saw elderly people with canes, walkers, and wheelchairs cheerfully participating so that they could make their voices heard.

7. What do you think was the most essential message of the march?

The most important message is that as YSN nurses, we all still care for the same things we always cared about. We all came into nursing for a reason. We care about the health of our patients and we want to make sure that none of our patients, friends, or family ever feel the sting of discrimination or the inability to access appropriate care. We feel strongly that health care is a private issue between patients and their care provider. And we believe very, very strongly that health care is a right and not a privilege.



Julia Dickinson '08 at the Women's March in DC.

8. Women's health specifically and health care generally was certainly one of the many themes of the march. In what ways do you think nurses are so vital to the ongoing health care conversation?

Our roles as nurses have been to be at the front lines of health care policy and practice and at the bedsides of our patients in a way that is unique to our profession. At this moment in American history, nurses stand at the crossroads of what our patients need and what our patients might be denied. Our ability to see things from multiple perspectives is invaluable at this time.

9. What was the most important thing you hope people take away from the march?

There was a tremendous amount of energy at the marches around the country and the world. Any of us who were there were both energized and humbled by the experience. But the most important thing, especially for those of us from YSN who have so much passion and so many resources, is to take that energy and carry it forward to advocate for our patients and the communities we serve.

10. For people who want to get more involved in health care advocacy going forward, what is your advice?

People who come to YSN to become nurse practitioners, DNs, or to receive a PhD all have passion. You don't come to this school without a passion. So whether you're a new student, an alumni, or a faculty member, you know what you care about and you are probably already thinking about other health care issues that you are interested in. Many of us are already very active in working for change. But if you are looking to go further, it's not hard. You don't need to think big. It's easy to focus on the bigger issues right now as we're all worried about what might happen



Sara Thurman '08 with her daughter Eliza at the Women's March in Santa Barbara.

under the current administration, but sometimes you can make change more easily on a local level. Local government committees are always hoping for those who are educated, energized, and ready to help. Some town committees lack members with health care experience. If you want to go big and do more to help shape policy but don't know much about it, contact an organization you believe in and tell them what you are doing and explain that you would like to learn more about affecting policy and see if you can shadow. There's also the option of an additional degree that will give you the expertise you need to work in these areas. We are YSN. We are smart, motivated, and ready to serve. If we want to advocate, we will!

(*light editing for clarification)

IN MEMORIAM AS OF MARCH 22, 2017

Margaret H. Carson '40
October 21, 2016

Jeanette F. Dillabough '40
January 3, 2017

Helen Southon Taffel '41
July 1, 2016

Marjorie M. Kenney '42
September 12, 2016

The Rev. F. Robert Steiger '42
July 6, 2016

Grace K. Fellows '45
October 30, 2016

Dewitt Weed '45
June 28, 2016

Helene L. Byrns '46
February 14, 2017

Marion R. Fleck '46
August 28, 2016

Mary Butler Giesler '46
December 2, 2016

Grace C. Lett '46
December 22, 2016

Elizabeth J. Finch '47
January 4, 2017

Evelyn H. Shopp '47
September 30, 2016

Nancy W. Cook '49
October 5, 2016

Harriett H. Mitchell '49
December 4, 2016

Robert W. Johnson '51
September 11, 2016

Marie C. Pepe '53
February 19, 2017

Mavis K. Chittick '57
October 21, 2016

Jeanne S. Neideck '61
October 29, 2016

Charlotte Houde Quimby '72
January 7, 2017

Diane M. Libby-Ramage '80
December 26, 2016

Deborah A. Cibelli '81
February 7, 2017

Beverly R. Wright '83
December 15, 2016

Elizabeth M. Fordiani '89
October 12, 2016

Mary Ann Polacek '91
February 18, 2017

Katherine Roeltgen '08

Katherine Roeltgen '08, MSN, passed away suddenly on March 6, 2017. All of us who graduated with Katherine from Yale School of Nursing are deeply saddened to hear



of her passing. Those of us who learned the art of midwifery with her especially know how much she gave of herself to others through her work and know how much of a loss this is. Katherine was generous with her time and her heart and always up for an adventure. She will be sorely missed.

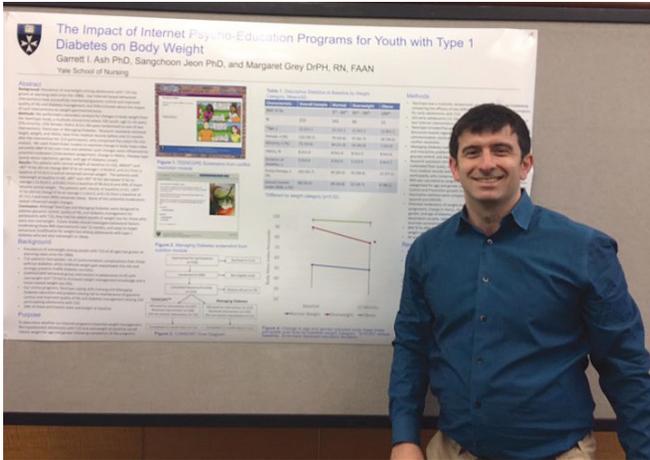
Written by Julia Dickinson '08



POST-DOC

SPOTLIGHT

Garrett Ash: From Runner to Researcher



Ash at 2016 Diabetes Research Center Symposium, November 2016

Sometimes the road to a career is straightforward. At other times it evolves as personal interests shape life experiences. Garrett Ash, PhD, CSCS, loved to run and started participating in marathons after completing his bachelor's degree in chemistry. "I became very interested in how the body responds to exercise and I decided I wanted to do a project involving the elite Olympic runners from east Africa," Dr. Ash says.

He was also interested in using sports to help third world countries, mainly Ethiopia and Kenya, where long distance running could help bolster the economy. These interests led him to Oxford University and to research in Ethiopia for his master's degree in exercise physiology. While in Africa, Dr. Ash started "Running Across Borders," a charity with the mission of expanding economic opportunity to east African youth through long distance running.

Although his master's project, examining associations between angiotensin-converting enzyme genetic polymorphisms and elite Olympic performance among Ethiopian distance runners, didn't find any such associations, he says, "It was a great project that got me really excited about sports

science." His next step was a PhD in exercise physiology at the University of Connecticut, where he worked on studies related to hypertension and exercise.

In January 2016, Dr. Ash began at YSN as a post-doctorate fellow focusing on type 1 diabetes. He is the principal investigator for the "Bright 1 Bodies Exercise and Discussions Program for Teens with Type 1 Diabetes," which

utilizes the Yale Bright Bodies curriculum. "Bright Bodies has been open to teens who have obesity, pre-diabetes, or type 2 diabetes," says Dr. Ash. "But we've never run a program like this for teens with type 1 diabetes."

The 12-week program combines behavioral curricula, developed by YSN's Margaret Grey, DrPH, RN, FAAN, and

Robin Whittemore, PhD, APRN, FAAN, for type 1 diabetes with the exercise, healthy diet, and lifestyles program from Bright Bodies. The study has enrolled 18 teens from the Yale Children's Diabetes program who participate in weekly exercise classes along with diabetes education and coping skills discussions. The study measures each participant's clinical profile, diabetes management, metabolic health, and blood work to look at some of the epigenetic factors.

Dr. Ash is also coordinating the "Teens Connect" study for co-Principal Investigators Dr. Grey and Jacquelyn Taylor, PhD, PNP-BC, RN, FAHA, FAAN. In this online program, participants receive coping skills training and diabetes education with their DNA and biomarkers of stress tested at baseline and post-intervention. "We sample cortisol and some other stress related molecules at home over the course of a morning to check the circadian rhythm of cortisol," he explains. "The overall goal is to look at these physiological indicators of stress along with self-reported stress to see if the interventions will improve the physiological markers that indicate stress reduction, and if this relates to better blood sugar control."

Because much of his earlier work was done with community populations, Dr. Ash says that working with Drs. Grey, Whittemore, and Taylor has taught him a lot about the clinical world. He hopes to continue to do type 1 diabetes research. "It's not an easy population to study because you need access to a patient population and health care providers and faculty members who know about it. It is a rare and unique opportunity that Yale has set up for post-docs to train in. I feel really fortunate that I've had the chance to get involved."



Garrett Ash training with Running Across Borders in 2009



DNP

SPOTLIGHT



Nate Christopherson at Baghdad Airport, Iraq (2003).

Nate Christopherson: Leadership, Commitment, Service



Christopherson working as a paramedic at Falls Park in Sioux Falls (2005).

When Nate Christopherson was a boy growing up in Sioux Falls, South Dakota, he spent more than a few Saturdays at his father's EMT Basic certification class. *As the assessment mannequin.*

His dad, Reid, then working with a crash investigation team for the U.S. Air Force, was taking EMT classes as part of a larger portfolio of disaster preparedness training and Christopherson was an eager and willing participant. "I remember thinking that his classmates were just so cool," he says. "I don't know why, I just thought they were the coolest people ever." His father's



Company B, 109th Area Support Medical Battalion doing a medivac on the six-lane road north of Safwan. From left to right are Trent Kielty, Shane Toupal, Nathan Christopherson, and Chris Storms (July 2003).

class would practice everything from the mundane, like splinting "broken" bones, to the more urgent, like responding to mass casualty events where young Nate would play a victim.

Those early Saturday mornings left an impression. By the age of 18, Christopherson had become an EMT Basic himself and followed that accomplishment with a year of basic training with the South Dakota Air National Guard.

"I really honestly didn't know what I wanted to do with my life at that point. My parents forced me to go to college, so I went to school," Christopherson says.

On orientation day, he followed a friend into the pre-nursing group and it stuck. While taking nursing courses during the day, he was also getting his paramedic certification at night and, now a member of the South Dakota Army National Guard, he was also fulfilling another call to service: Operation Iraqi Freedom.

For months, Christopherson missed nursing classes in order to help prepare activated units for deployment to Iraq. Then, the medical unit that fell under his battalion received word that not only had it been called up to deploy but it was also short on medics. So, when Christopherson arrived to help with the unit's deployment activation, "They handed me all my equipment and they said, 'Oh, by the way, you're going with them.'"

Nate Christopherson, a paramedic on his way to becoming a nurse, was now also a combat medic on his way to Baghdad.

Once on the ground, when he wasn't working in a medical capacity, he worked as a gunner doing convoy security and helping out in the motor pool. Christopherson sees his commitment to service, both military and civilian, as just part of who he is. "Doing trauma care, even with the intense chaos all

around, it was easy for me to be able to focus on what needed to be done at that moment to save someone's life."

It makes some sense, then, that after his return from Iraq and after finishing his nursing degree, he ended up in an emergency room—the first new graduate nurse ever hired by Sanford USD Medical Center.

From there, he rose up the ranks and, perhaps no coincidence, it was his military training that influenced his direction and determination.

"I didn't leave bedside care because I didn't enjoy it. I left bedside care because of the frustrations that I had with the administration. So instead of being the person who just sits there and complains about it, I adopted the attitude, and a lot of this comes from my time in the military, don't just gripe about it. Do something about it. So I did."

He became one of the youngest charge nurses in the emergency department and followed that with a combined MBA/MSN degree, as well as multiple certifications, before becoming the medical center's Pediatric Trauma Program manager.

He is now the assistant vice president of Northwell Health Trauma Institute, overseeing eight trauma centers in the New York City region. Most people would stop there.

But influenced in part by the "high caliber" (as he describes it) of medical professionals he encountered in New York, he decided to pursue his Doctor of Nursing Practice (DNP) at Yale School of Nursing.

While Christopherson is already incorporating evidence-based practice in his centers and in the surrounding community, he says the DNP curriculum enhances what he does day to day, making him better and building upon his foundation of commitment, leadership, and service.

The credit for the bulk of his success both now and in the future, however, he gives to his parents, Reid and Ruth, and to his time serving his country, "The military really shaped who I am and what I've done in my life and who I've become."

YSN FACULTY PUBLICATIONS *As of March 2017*

Title	Authors	Publication
Taking Another Look at Screen Time for Young Children.	Swartz MK.	J Pediatr Health Care. 2017
Correlates of overweight and obesity in 5529 adolescents with type 1 diabetes: The T1D Exchange Clinic Registry.	Minges KE, Whittemore R, Weinzimer SA, Irwin ML, Redeker NS, Grey M.	Diabetes Res Clin Pract. 2017
Factors associated with school-aged children's body mass index in Korean American families.	Jang M, Grey M, Sadler L, Jeon S, Nam S, Song HJ, Whittemore R.	J Adv Nurs. 2017
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Cognitive behavioral therapy for insomnia in stable heart failure: Protocol for a randomized controlled trial.	Redeker NS, Knies AK, Hollenbeak C, Klar Yaggi H, Cline J, Andrews L, Jacoby D, Sullivan A, O'Connell M, Iennaco J, Fioia L, Jeon S.	Contemp Clin Trials. 2017
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Screening for Obstructive Sleep Apnea in Adults: US Preventive Services Task Force Recommendation Statement.	US Preventive Services Task Force., Bibbins-Domingo K, Grossman DC, Curry SJ, Davidson KW, Epling JW Jr, Garc�a FA, Herzstein J, Kemper AR, Krist AH, Kurth AE, Landefeld CS, Mangione CM, Phillips WR, Phipps MG, Pignone MP, Silverstein M, Tseng CW.	JAMA. 2017
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Time and participation in workplace health promotion: Australian qualitative study.	Sargent GM, Banwell C, Strazdins L, Dixon J.	Health Promot Int. 2016
Executive Function in Adolescents With Type 1 Diabetes: Relationship to Adherence, Glycemic Control, and Psychosocial Outcomes.	Perez KM, Patel NJ, Lord JH, Savin KL, Monzon AD, Whittemore R, Jaser SS.	J Pediatr Psychol. 2016
Serologic Screening for Genital Herpes Infection: US Preventive Services Task Force Recommendation Statement.	US Preventive Services Task Force., Bibbins-Domingo K, Grossman DC, Curry SJ, Davidson KW, Epling JW Jr, Garc�a FA, Kemper AR, Krist AH, Kurth AE, Landefeld CS, Mangione CM, Phillips WR, Phipps MG, Pignone MP, Silverstein M, Tseng CW.	JAMA. 2016
Palliative care is treatment for Muslims who wish to be faithful.	Lazenby M.	Palliat Support Care. 2016
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Sleep Disturbance Among HIV-Infected and Uninfected Veterans.	Womack JA, Murphy TE, Bathulapalli H, Akg�n KM, Gibert C, Kunisaki KM, Rimland D, Rodriguez-Barradas M, Yaggi HK, Justice AC, Redeker NS.	J Acquir Immune Defic Syndr. 2017

Title	Authors	Publication
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Diffuse bronchiectasis as the primary manifestation of endobronchial sarcoidosis.	Hiles PD, Kemp KR, Coviello JM.	Respir Med Case Rep. 2016
Avoiding Hospitalizations From Nursing Homes for Potentially Burdensome Care: Results of a Qualitative Study.	Cohen AB, Knobf MT, Fried TR.	JAMA Intern Med. 2017
Missing Domains of Lung Transplant Patient Selection.	Blumenthal NP, Petty MG, McCorkle R.	Prog Transplant. 2016
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DEAR YSN ALUMS,

I am writing to you with two purposes: to update you on some alum activities and to seek your input on what you would like from your alum organization.

YSNAA is heavily focused on service activities for the students. Our programs range from pairing Alum-Student Mentoring Dyads to a resume review service in the spring to career panels. Our aim is to support students during their education as well as to help them make a successful transition to professional practice. All these activities are well received by the students and we do them annually with a spirit of continuous improvement and we use student feedback to make modifications every year.

I encourage you to be in touch with me (mgeary@earthlink.net) if you have an interest in participating in this fun and valuable work with the students. Most of my career was in Florida and California and I was not involved with YSNAA because I believed that I was too far away to be of assistance. But five years ago, I moved back to the east coast, became involved, and found out how wrong I was about my belief that involvement necessitated living in or near Connecticut.

Your YSNAA Board members live from Hawaii to Boston and many points in between. Our involvement with both the Board and these student service projects is done with phone work—we only meet once a year in New Haven. Many projects like the Mentor Dyads or the spring Resume Review Service are entirely phone- and email-based and happen at the mutual convenience of the alum and his/her assigned

student. If you have any interest in being involved with YSN, we can make it easy. Please be in touch and we can find a way for you to be involved that works for you.

On another note, I want to seek your input. The Board has been talking about the fact that we have been heavily student focused and we are looking to be more involved with alums in ways that would be supportive to you. What would you like from YSNAA?

We have talked about doing some regional meetings but want input on what you would like. Is there a greater need for socializing, networking, or professional development? What are your ideas about venues or times of day that would work?

We have been talking about developing some discussion format programming on the topic of career transitions, which seems like a topic of near-universal interest. Does that topic resonate, or do you have other ideas? We want to hear from you and make plans that are appealing to you.

As YSN grads, we have had the experience of a life-transforming education and the power of a YSN education continues through our lives. Please let us know how you might like to join us in being of service to the students and how you would like YSNAA to be of service to you.

Mary C. Geary, RN, MSN'74
YSNAA Board Chair



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