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COLUMBIA UNIVERSITY
School of Nursing

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Throughout our school’s 122-year history, Columbia Nursing has regularly evaluated our curriculum to assure that our students are well prepared to care for patients throughout their lives and in all care environments, and to serve as nurse leaders and as nurse scientists. With today’s fast-evolving health care system, new graduates face unprecedented challenges in the care, leadership, and research arenas. Whether it’s incorporating new technologies into patient care, national health care reform, or the American Association of Colleges of Nursing’s recommendation of doctoral degrees for advanced practice nurses, nursing education must keep pace with new developments as they occur.

As a result of our comprehensive review of our curriculum, we will be introducing a number of important changes. For example, the Affordable Care Act emphasizes the patient’s experience of care, safety, quality and cost-effective care. In response, our new curriculum will include coursework and clinical experience on safe transitions of care and care coordination across care environments. We will place a renewed emphasis on medication reconciliation, better interprofessional communication, teamwork, and cultural sensitivity. We will provide our students with an even stronger foundation in health policy and global health equity. And we will strengthen our focus on evidence-based practice and the value of research for improving the health of patients and communities.

With these additions to the curriculum, we plan to no longer offer a BS degree in nursing to college graduates. Instead, we will accept students with non-nursing baccalaureate degrees directly into a four semester MS program in nursing. Those who complete the program may choose to continue their education for a research doctorate (PhD) or clinical doctorate (DNP). The current MS/DNP track will convert from 10 semesters to eight. The new curriculum will enable students to complete the MS/DNP track in four years instead of five, resulting in substantial savings in tuition. Additionally, entry into a master’s program increases opportunities for federal student loans while nurses with DNP degree typically enjoy a higher average starting salary. We are also moving to accelerate our PhD program so students will graduate in three years.

These changes have been carefully developed to ensure that our students continue to receive the finest nursing education possible. More than ever, wherever they choose to make their contribution — health care delivery, research, leadership, or health policy — they will be well equipped to leave their mark as Columbia nurse leaders.

Bobbie Berkowitz, PhD, RN, FAAN
Dean, Columbia University School of Nursing
Mary O’Neil Mundinger Professor of Nursing
Senior Vice President, Columbia University Medical Center
Welcome to the inaugural issue of Columbia Nursing, the redesigned magazine of Columbia University School of Nursing. We hope you enjoy the updated design and stories that reflect the vibrancy and vitality of our school's community.

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ON THE COVER:
Photograph of Kyleen Swords, DNP student, by Jörg Meyer.
Midwives Rising
By Francine Russo, PhD

Midwifery is gaining popularity and acceptance as women are electing to make childbirth a life event, instead of a medical episode.

On the Front Lines of an Epidemic
By Claudia Wallis

In the fight against obesity, nurses work with individuals, families and communities to curb the epidemic.
Millions of Americans depend on home health care services to help them recover from surgeries and hospital stays as well as to manage daily living with chronic conditions. But evidence-based practices for preventing infections often aren’t followed when care is provided at home, leaving patients vulnerable to serious and potentially fatal complications. That’s what a research team led by Jingjing Shang, PhD, assistant professor at Columbia Nursing, found in a systematic literature review of studies evaluating infection prevalence and risk factors in home health.

The review, recently published in the American Journal of Infection Control, found that unsterile living conditions and untrained caregivers contribute to infections in home health settings, with patients at greater risk when they have tubes to provide nutrition or help with urination.

“This is the first review of all previous studies in this area,” Shang says. “It provides a comprehensive summary of current scientific knowledge of the rate and risk factors for the home health care setting. Also, it indicates what research direction we should take next.”

Infection rates found in the analysis varied widely, ranging from about five percent to more than 80 percent. More research is needed to assess the best methods of infection prevention and control in home health, Shang says.

The highest infection rates were among patients who received nutrients through an intravenous catheter, a process known as total parenteral nutrition, the review found. Patients may lose the ability to swallow or eat on their own due to a stroke, dementia, or advanced illness. Some patients may receive nutrition through a catheter inserted into a central vein if it isn’t possible to insert a feeding tube into the nose or mouth or directly into the small intestine. These central venous catheters often stay in place for long periods of time, and infections can easily develop when caregivers and family members who assist with care don’t keep the catheter or injection site clean, says Shang.

“The catheters cannot be replaced as often as we want. There is only a certain place you can insert an IV catheter, and the nutrition provides a rich environment for the bacteria to grow,” Shang says.

Catheter-associated urinary tract infections (CAUTI) are a big problem, too. These infections can develop when urinary catheters are left in for long periods of time, and repeated use of antibiotics to treat these infections can leave patients susceptible to antibiotic-resistant strains of bacteria.

Each year, an estimated 12 million Americans receive care from more than 33,000 home health providers in the U.S., where the annual tab for home health services exceeds $72 billion. Better infection control in home health could help achieve two of the primary goals of the Affordable Care Act: reducing costs and improving quality, Shang says.

“We are pushing patients out of the hospital as quickly as possible. As the care setting for patients with acute illness moves to the home, the infection risk will increase accordingly. If infections there can be prevented, significant improvements in patient outcomes could be achieved,” adds Shang.
Longer Nurse Tenure Improves Care

When it comes to the cost and quality of hospital care, nurse tenure and teamwork matter. Patients get the best care when they are treated in units that are staffed by nurses who have extensive experience in their current job, according to a recent study from Columbia Nursing and Columbia Business School. Results were recently published in the American Economic Journal: Applied Economics.

The review of more than 900,000 patient admissions over four years at hospitals in the Veterans Administration Healthcare System is the largest study of its kind to link nurse staffing to patient outcomes. The researchers analyzed payroll records for each nurse and medical records for each patient to see how changes in nurse staffing impacted the length of stay for patients.

Because length of stay is increased by delays in delivery of appropriate care and errors in care delivery, a shorter length of stay indicates that the hospital provided better treatment. At the same time, a shorter length of stay also makes care more cost-effective. The study found that a one-year increase in the average tenure of RNs on a hospital unit was associated with a 1.3 percent decrease in length of stay.

“The key finding is something we intuitively know: When we have teams working together the quality of care on the unit is better,” says senior study author Patricia Stone, PhD, RN, FAAN, Centennial Professor of Health Policy at Columbia Nursing. “Trust gets developed, people know how to function, know who should answer questions. Everything gets done more smoothly.”

For years hospital managers and nursing advocates have debated about the proper level of nurse staffing on patient units and the qualifications the nurses should have. As nurses’ salaries have risen and institutional finances have come under pressure, many hospitals have relied on temporary staffing agency nurses or added overtime hours rather than hire more full-time staff. That may be shortsighted, the study suggests.

For hospital managers and government policymakers, the study’s main insight is that “you really can make a difference in the lives of patients if you staff appropriately,” says the senior economist on the study team, Ann Bartel, PhD, Merrill Lynch Professor of Workforce Transformation at Columbia Business School. “By that I don’t mean numbers of nurses, or staffing levels, but the composition of nurses on the units. Patients do better when cared for by nurses who have a lot of experience on the unit.”

When one of those nurses goes on vacation, new nurses join the group, or when temporary agency nurses replace experienced personnel, productivity on the patient floor may take a measurable hit, the study suggests.

“Retention of nurses makes a big difference, and is actually more cost-effective than having a lower-paid, newer nurse,” Stone says.

Approximately one in five U.S. health facilities doesn’t make alcohol-based hand sanitizer available at every point of care, missing a critical opportunity to prevent health care-associated infections, according to recently published research from Columbia Nursing and the World Health Organization (WHO).

The study, which examined compliance with WHO hand-hygiene guidelines in the U.S., also found that only about half of the hospitals, ambulatory care, and long-term care facilities had set aside funds in their budgets for hand hygiene training. Study results were recently published in the American Journal of Infection Control.

Gaps in hand hygiene are a missed opportunity for infection prevention and control, says co-lead author Laurie Conway, RN, MS, CIC, a PhD student at Columbia Nursing.

“When hospitals don’t focus heavily on hand hygiene, that puts patients at unnecessary risk for preventable health care-associated infections,” Conway says. An organization’s approach to compliance with infection-control best practices is set by senior leadership. Yet, Conway found that “executives aren’t always doing all that they can to send a clear message that preventing infections is a priority.”

Hand hygiene is critical to preventing health care-associated infections, which kill about 100,000 people a year in the U.S. and cost about $33 billion to treat. The Centers for Disease Control and Prevention (CDC) issued guidelines for hand hygiene in 2002, and the WHO followed suit in 2009.

“U.S. hospitals are not very well prepared to promote hand hygiene at the point of care,” says Didier Pittet, MD, MS, a co-author of the study and director of the infection-control program at the University of Geneva Hospitals in Switzerland. In many instances, this is due to a lack of support for infection control and prevention at the senior leadership level, he says.

The gold standard for hand hygiene, the WHO’s “Clean Care Is Safer Care” program, calls for alcohol-based hand sanitizer to be made available at every point of care in a health care environment.

One reason this isn’t universal at U.S. facilities is the absence of dedicated hand-hygiene teams, he says. The study found that just 58 percent of U.S. facilities have a dedicated hand-hygiene team, and 37 percent have a system for designating hand-hygiene “champions.” The concept of champions has been used for process improvement in many arenas in health care, Pittet says. “This person is a leader, one people will want to follow.”
MOBILE TOOLS BOOST TOBACCO SCREENING

Smartphones and tablets may hold the key to getting more clinicians to screen patients for tobacco use and advise smokers on how to quit. Even though tobacco use is the leading cause of preventable disease and death in the U.S., clinicians often don’t ask about smoking during patient exams. Using mobile phones loaded with tobacco-screening guidelines prompted nurses to ask patients about their smoking habits in 84 percent of clinic visits and to offer cessation counseling to 99 percent of smokers who expressed a willingness to kick the habit, according to a recent study from Columbia Nursing.

“Mobile applications can play a significant role in curbing tobacco use,” says lead study author Kenrick Cato, PhD, associate research scientist at Columbia Nursing. “These findings are a win in the ongoing battle against tobacco use, and they also point to a broader benefit of mobile applications by getting more clinicians to follow evidence-based practice guidelines.”

Nurses are known to be effective advisers to patients in breaking the smoking habit. But lack of time and unfamiliarity with counseling resources have discouraged nurses from intervening on behalf of patients who smoke.

The study, published in Oncology Nursing Forum, evaluated tobacco-screening rates for more than 14,000 visits at clinics in New York City. Clinic patients were treated by 185 registered nurses enrolled in advanced-practice degree programs at Columbia Nursing.

While overall screening and counseling rates were increased by use of the mobile tools, the gains varied by race, gender, and payer source, the study found. Screening was more likely to occur when patients were female or African-American, and at clinics where the predominant payer source was Medicare, Medicaid, or the state Children’s Health Insurance Program (CHIP). Screening was also more likely for patients with private insurance than for patients who were uninsured or covered by worker compensation benefits, the study found.

“Screening for African-Americans, and men in particular, has traditionally lagged other populations, and the higher screening rates that we found for African-Americans suggest that mobile health-decision tools can help address health disparities,” Cato says. “The technology can serve to remove any unintended bias clinicians might have about which patients are most likely to benefit from intervention.”

While the study included only patients seen by nurses who had access to mobile health tools, the screening and counseling rates in the study are much higher than the baseline rates tracked by the CDC, Cato says. Using the mobile tools also helped clinicians exceed the targets for screening and counseling established by Healthy People 2020, a national road map for improving health and eliminating health disparities. Tobacco-related objectives in Healthy People 2020 include screening rates of about 69 percent during office visits, and counseling rates of about 21 percent.
While many HIV-prevention interventions have traditionally been delivered face to face, a study from Columbia Nursing suggests that digital outreach efforts delivered via text messages, interactive games, chat rooms, and social networks may be an effective way to reach at-risk younger men. The research, recently published in the *Journal of Medical Internet Research*, found that eHealth interventions are associated with reductions in risky sexual behaviors and increases in HIV testing among men who have sex with men.

A research team led by Rebecca Schnall, PhD, RN, assistant professor at Columbia Nursing, conducted a systematic literature review to determine the effectiveness of eHealth interventions for HIV prevention targeted at these men.

One interactive website, Sexpulse, designed by health professionals and computer scientists to target men who seek sexual partners online, successfully reduced high-risk sexual behaviors, the review found. Another site, Keep It Up! (KIU), used video games to help reduce rates of unprotected anal sex. A third initiative, a downloadable video game, helped mitigate shame felt by some young men who have sex with men, though the reduction in risky sexual behavior wasn’t statistically significant.

Chat rooms may also help prevent HIV, the study found. When a sexual-health expert entered a popular chat room to regularly post information about HIV testing and respond to instant messages seeking information on HIV, self-reported HIV testing among participants in the chat room significantly increased.

On social networks such as Facebook and Twitter, popular individuals can spread HIV-prevention messages to their friends and followers. The sharing of information about HIV testing via trusted sources on a social network appeared to increase requests for HIV testing kits, one study found. Another study discovered that using opinion leaders to disseminate HIV-prevention information via social networks may increase testing rates and bolster condom use during anal sex with partners found online.

“When we think about access, eHealth is an easy way for people to access information,” Schnall says. For highly sensitive diseases like HIV, “privacy is a big concern. High-risk adolescents are going to be concerned about who is going to be giving them this information. We need to have a safe space where people feel they can learn about this and protect themselves.”

The use of eHealth technologies has the potential to provide tailored messages based on the profile of the individual. An 18-year-old black bisexual, for instance, can get messages tailored specifically for him. Privacy and convenience are an advantage, Schnall says.

“In mobile technology, we can do things in real time and at the point of care,” Schnall says. “We can deliver messages when they’re hanging out at the bar or at 3 o’clock in the morning, compared to a nurse making a phone call.”

Because the study focused on research done before smartphones were commonplace, more research is needed to understand the potential of these devices. “Incorporating the lessons learned from these studies into smartphone technology has the potential to improve HIV-prevention efforts in this high-risk population,” Schnall says.
Nursing in the Community:
Learning, Giving, and Getting Something in Return

By Andrea Kott, MPH

The men’s catcalls were jarring. Their comments about her clothes and looks, crude. Several of them had histories of violent behavior. They could be aggressive, or unreachable. And when they arrived drunk or high for their medical appointments at the clinic, Ashley Knutson, MS, BSN, RN, wondered whether she had what it took to care for them, or whether they would even let her. “I’d look at these men and think, ‘What kind of authority do I have to teach you about your health?’”

Yet, it was Knutson’s desire to work among marginalized populations—so different from those she knew growing up in Fargo, North Dakota—that brought her to Washington Heights as a student at Columbia Nursing. By requiring five weeks of community health rotations, Columbia Nursing would challenge her to see beyond stereotypes. It would teach her to relate to patients as individuals whose backgrounds and hardships drove their health and health care needs. It would put a human face on every health issue that she encountered—from diabetes to HIV/AIDS to homelessness to addiction—and help her to address them not in an academic vacuum but within the context of people’s lives.

The program curriculum is designed to prepare students—particularly those moving into nursing from another career—to practice at the highest level of the profession clinically or in research. In addition to scientific rigor, the program emphasizes the role and responsibility of the nursing profession to address population health needs within a broad framework, including culture, socioeconomic status, or spiritual wishes, says Karen Desjardins, DNP, MPH, assistant dean for academic affairs and director, Entry to Practice program. In addition to rotating through clinical assignments in Columbia University Medical Center’s adult medical-surgical, psychiatric, pediatric, and obstetric-gynecology acute settings, the first-

Photographs by Jörg Meyer
Kyleen Swords, DNP student
year nursing students spend time in a community setting, such as a homeless shelter, elder care center, Head Start program, harm reduction/needle exchange center, or primary care clinic. The population health class supplements their on-site experience. Says Desjardins, “We’re all individuals but we live within a population, and everything, like our family and what restaurants or grocery stores are in our neighborhood, affects our health.”

Emphasis on community service will continue as part of the school’s new curriculum and degree programs anticipated to begin in 2016. For additional details, please see “From the Dean.”

Depunking stereotypes
For her community rotation, Knutson chose Project Renewal, an agency that provides primary care, addiction treatment, mental health services, and employment assistance for New York City’s homeless. It operates licensed, federally qualified health centers in the Fort Washington Armory men’s homeless shelter, where she worked, and in a women’s shelter on East 45th Street. It also operates a mobile medical van.

Knutson had heard about the men at the Armory. She knew they had hard lives. “I was wary,” she recalls. “I’d heard warnings about interactions I might have there.” Indeed, several of her patients had mental illness or were struggling with addiction. Some had gang affiliations. Many had chronic infections. At some point, most were in crisis. “People would leave the clinic and come back high or drunk, or would not manage their psychotropic medications,” she says.

Roslynn Glicksman, MD, MPH, medical director for primary care at Project Renewal, notes that there are many stereotypes about people with mental illness or addiction, as well as people who are poor, uneducated, or homeless. “In many situations, life just happened,” Glicksman says. Someone lost a job, suffered a trauma, or got sick. They could not work or pay their rent. “Everyone has a story. The challenge is learning to talk and listen to people with these backgrounds.”

Knutson braced herself for the challenge. She tried to ignore the catcalls. Being fluent in Spanish, however, she couldn’t help but decode the men’s comments. This helped her. Men would lob a remark at her, and she’d lob it back. They’d snicker over a joke they thought she couldn’t understand, and she’d chuckle. “Once they see you can speak the way they speak, they trust you,” says Knutson, who is studying to become a Family Nurse Practitioner and plans to pursue her DNP degree at Columbia Nursing. “If you give them sass as fast as they give it to you, it’s points in your direction. They find a bond in that.” Still, the bonding took time, especially when it came to accepting Knutson’s help. “They were very closed off,” she says.

One patient, who had hypertension, denied having the condition or needing treatment. Moreover, the clinical nursing skills that Knutson had mastered by the time she started working with the man were not what she needed to counter his resistance to treatment. She needed to follow her gut. Fortunately, she had become familiar enough with his moods to spot his distress after she took his blood pressure. “He said very little and looked down at the floor when I spoke to him,” she recalls. She sensed that speaking with him in Spanish might ease his anxiety. “I suggested we talk a bit more, but in Spanish.” After a few minutes of small talk, the man acknowledged his condition. “By the end of the visit we were communicating about high blood pressure and medication to control it. He even agreed to receive a flu shot from me, after weeks of refusing it.”

The nursing program gave Knutson an opportunity she wouldn’t have had in a controlled hospital environment: to get to know the individual behind the patient, and to tap into her own sensitivity and compassion, inner talents that had drawn her to nursing in the first place. Indeed, the more she got to know the man, the more empathy she felt for him, and the more she understood that dispatching cli-
cal knowledge was only part of what it would take to care for him; the rest would be seeing how his background and life experiences informed his health care needs.

Getting something back
Working with people who were homeless, or had drug addiction or mental illness wasn’t new to Benjamin Raudabaugh, an Adult-Gerontology Acute Care Nurse Practitioner student. Before arriving at Columbia Nursing, he worked at the The School of Medicine at the University of California, San Francisco, conducting research on people with dementia and psychiatric disorders. He also worked in a needle-exchange program for intravenous drug users. At Project Renewal, he expected to meet men with broken lives. He anticipated giving them the best care he could. What he didn’t anticipate was getting something in return.

“One certain people came in and left. They were there to get things done,” Raudabaugh says. “Then there were others who shared a little more about their lives.” Some talked about their job or housing problems; others talked about their families. One of the best parts of the rotation, he says, was when the men opened up to him about their lives and inquired about his. “They’d ask how I was doing and where I was in my education,” he says. “When that happens, the whole interaction feels a lot less like a business transaction and a lot more like a shared experience. It feels personal.”

One man, however, had a troubling story to share. He had been in prison, where he acquired an infection in his leg. The infection led to his having his leg amputated below the knee. The prosthesis he received never fit right. It chafed and created a wound. Now, the wound was infected, and the man was in pain. Furthermore, he had lost all trust in the health care system.

Raudabaugh told the man that a specialist would evaluate him for a new prosthesis. The man was grateful but leery. Raudabaugh assured him that seeing the specialist was his choice. “When you’re a clinician, it’s really important to give patients the power to make decisions, and to be in control of their health and well-being,” he says. The man accepted the new prosthesis, and returned to the clinic several times. “We cleared up his infection,” Raudabaugh says. “To have him open up and trust that we were giving him the best care possible and not cutting corners was really nice.”

Raudabaugh knew that he couldn’t solve the man’s problems. He could, however, give him the support that he hadn’t gotten in prison or elsewhere. “Caring for these guys is not just about giving them a prescription,” he says. “It is about taking a step back and trying to ignore prejudices, and realizing they are just as smart as you, and just as deserving of respect.”

Identifying disparities
People in the Manhattan and Bronx communities where Columbia Nursing students perform their community rotations are typically medically underserved. Often, English is not their first language. Some are undocumented and afraid to seek care. Ethnic or cultural biases cause others to resist or reject care that is available.

These types of scenarios sensitize students to the ways in which people’s backgrounds affect not only their health but also their access to care, and their experience of the health care system, says Jennifer Dohrn, DNP, CNM, director, Office of Global Initiatives. Dohrn teaches a required course on addressing population health needs on a global scale taught in conjunction with the community health rotations. For example, the program sheds light on why a pregnant woman from Senegal, where women help each other during childbirth, might shy away from an “interventionalized” and “medicalized” hospital delivery, and it trains students to recognize gaps in service, like the lack of linguistically appropriate nutrition information in communities where diabetes is prevalent. “We’re educating nurses who will understand health disparities in the context of how people live in the communities that nurses are serving,” explains Dohrn. “You want someone to be able to look at a community and ask, ‘What are the priorities?’”

Putting patients first
In the waiting room of a Washington Heights urgent-care clinic hangs a poster written in Arabic, Bengali, Greek, Haitian Creole,
Nursing in the Community

Hebrew, Hindi, Korean, Mandarin, Cantonese, Russian, and Spanish. It reads, “We speak your language.” It is a hot summer Saturday afternoon, and the clinic is hushed. Two patients watch widescreen televisions that are mounted on opposite walls as they wait for prescriptions. A young man emerges from a back room. His eyes scan the empty chairs. Discreetly, he calls a name. A woman stands and joins him at the front desk, where a receptionist translates their conversation from English to Spanish, and back. The woman’s case is not urgent. She is a regular patient at Columbia Student Medical Outreach (CoSMO), a free clinic that uses this space on Saturdays and occasional Thursday evenings to provide primary care largely to undocumented immigrants.

Columbia University medical, public health, and advanced nursing students run CoSMO. They see patients who come in for scheduled, routine treatment and management of conditions such as diabetes, hypertension, hyperlipidemia, joint pain, or arthritis. They also help to mentor first-year nursing students. Angela DiLaura, BSN, RN, who is studying to become a women’s health nurse practitioner is one of four nurse preceptors who teach the students basic skills: triaging patients, taking vital signs and recognizing abnormal ones, drawing blood, giving intramuscular injections, documenting medication distribution and other forms of treatment, and learning how to present patient data to senior clinicians. “By week five, they’re nurses without the license,” DiLaura says. “They don’t need help doing injections. They’re very skilled at drawing blood, triaging, and speaking with the nurses and doctors.”

Besides clinical training, working at CoSMO gives students the chance to develop relationships with patients whose chronic conditions require ongoing care. Although a language barrier prevented Kyleen Swords, RN, from fully communicating with the patients she came to know at CoSMO, she understood they appreciated her learning enough Spanish to ask, how they were feeling or what medicines

GIVING BACK TO THE COMMUNITY

AT FIRST, the teenagers were nervous. They had never spent time with elderly people before. They had no idea how to talk to them, let alone take care of them. But they thought they might like to be nurses one day, so they paid close attention to Kyleen Swords, RN, who was teaching them the basics.

During her community service rotation, Swords mentored participants of the Geriatric Career Development (GCD) program at Jewish Home Lifecare in Manhattan (she split her community service rotation between the Jewish Home and Columbia Students Medical Outreach [CoSMO]). The Jewish Home launched the GCD program in 2006 to give underrepresented high school students the chance to learn about nursing and other allied health-care fields by working with the frail elderly. Columbia Nursing students who work in the GCD program teach participants basic nursing skills or mentor them as they prepare to apply for college.

The program has a track record of helping students succeed; In 2009–2013, 98 percent of GCD participants graduated from high school, compared to 44–73 percent of non-participants. Many program alumni have become certified nursing assistants, phlebotomists, and electrocardiograph technicians. Their entry into the health care field increases its diversity, and also builds a critical pipeline for the Jewish Home, which is steadily losing geriatric health-care staff to retirement.

Swords, who is working toward her nurse practitioner (NP) and doctoral (DNP) degree in the family nurse practitioner program, loved showing the teens how to transfer patients, check patients’ identification bands, and change linens while patients were in bed. She appreciated being able to help the adolescents overcome their fears. “They were nervous about having a conversation with someone so much older,” she says. “I brought them to the patient floors. I told them to be themselves. I told them to listen, but to talk about themselves, too, because the elderly like to share. They started timidly, but they had confidence after they left. They actually enjoyed it.”

Swords, who plans to teach in the future, enjoyed it, too. In addition to reinforcing her knowledge, working with the GCD participants made her feel as if she was giving something back. “It felt good to be passing along my knowledge to budding nurses, especially those from under-served backgrounds,” she says. Indeed, learning about the teens’ personal struggles impressed her with the importance of learning about the struggles in her patients’ lives. This is a goal that Columbia Nursing and the Jewish Home share, explains Vivian Taylor, EdD, associate dean for diversity and cultural affairs. “We are working together to educate these young people to be health care providers who are culturally sensitive and culturally aware, who understand that whenever you’re working with others, you try to see where they are coming from so that you can provide the best care.”

The teens saw Swords as a role model, and she relished the opportunity to inspire them by describing her own clinical experiences as well as her lifelong dream of becoming a community nurse. “A lot of students were interested in my path, and in how I decided to become an NP. They were thinking of it as a career for themselves.”

Additionally, the GCD participants learn about the experiences of nurses, nurse researchers, and graduate nursing students when they visit the Columbia Nursing campus during the academic year. As Paige Pagan, a participant who hopes to attend Princeton University, says, “They told us about their college experiences and the requirements to get into Columbia. They said it’s very competitive, but if you have the drive, you succeed.”

— Andrea Kott, MPH
they were taking. “They were extremely grateful to me and all of the staff, and very patient with us, since we were all mostly students,” says Swords, who divided her community rotation between CoSMO and Jewish Home Lifecare in Manhattan. “What I liked best about CoSMO was that the situations were not acute; instead, the patients were seen for checkups. Working there solidified my desire to work in an outpatient setting where I can build relationships with patients.”

Over time, a sense of familiarity evolved between Swords and her patients. She didn’t focus on their being undocumented immigrants; she focused on their need to feel comfort and care. “It is my responsibility as a nurse, and as a future nurse practitioner, to accommodate patients in every way possible,” says Swords, who is pursuing a doctorate in the family nurse practitioner program. “Regardless of where someone is from, what language she speaks, or what her beliefs are, every person’s health needs to be a priority.”

Discarding assumptions
As students build relationships with patients, many find that their negative stereotypes fall away, their empathy deepens, their awareness of health disparities sharpens, and their assumptions change about what patients need most.

When Rebecca Wilkof ’14, began teaching nutrition education to the seniors at the YM & YWHA of Washington Heights and Inwood, she assumed they would know certain nutritional truths, like all sugar is bad. After all, many of the members who attended the Y’s health and wellness program had diabetes. “I assumed they knew that eating a whole watermelon was not much better than eating a piece of cake for a person with diabetes,” says Wilkof, a Northern California native who grew up eating organic foods and belonging to a gym. But her patients didn’t know why they needed to moderate their sugar intake, or why eating saturated fat was unhealthy. “It’s one thing to explain the difference between saturated and unsaturated fat to someone in their 20s or 30s, but another to someone who’s 80 and has been eating saturated fats her whole life,” she says. Moreover, most of her patients, who were Dominican or Jewish, had food traditions that revolved around meat and cheese, or cooking with schmaltz (chicken fat). “Low-fat’ wasn’t in their vocabulary.”

Wilkof’s patients faced other challenges as well, like living far from stores that sold fresh produce. “Even if they knew what to buy, it was still hard to get,” she notes. Moreover, a broken-down wheelchair or elevator, or a blizzard, could strand someone at home for days. “I didn’t understand how important mobility was to what kind of food my patients were eating,” Wilkof says. “For me, not being able to get around means not getting to the gym. It doesn’t mean having to buy a can of soup with a lot of sodium in it.”

Wilkof helped her patients make dietary changes that accommodated the challenges in their lives. In a cooking class called “Light Bites,” she made “bodega chili,” using beans instead of meat, and other healthy ingredients that local convenience stores sold. In her class on the cancer-fighting properties of antioxidants, she baked blueberry bread. She made brownies with yogurt when she taught a class on probiotics. “You have to learn what resources are available to patients,” she says. “The point of nursing is to give care to people according to their needs and not according to your prescribed version of what they need.”

Meeting patients where they are
As communities grow more diverse, and as individuals—especially the medically underserved—live longer with chronic illness, nurses are becoming the main providers of primary care. To meet the challenges of an increasingly complex health care environment, nurses need more knowledge, not about science but about their patients, whose difficult backgrounds play a pivotal role in shaping their health care needs.

Ashley Knutson never came to terms with catcalls. But by the time she finished her community health rotation, she was no longer wary of the men who made them. They were, after all, in need of care, and her job was to provide it, based in part on how well she had come to know them. “It became a process of me building confidence in my ability to relate to them, wherever they were.”
It was 2 a.m. on an August morning at Mount Sinai Roosevelt Hospital in New York City, and an exhausted Haydee Morgan, a teacher, had been struggling to push her baby out since midnight. She’d arrived at 11 p.m. the previous night, eager to deliver her second child. Her contractions were intense, but she coped by breathing and changing positions, often perched atop a giant rubber birthing ball. Although she’d been eight centimeters dilated when she was admitted, these painful hours had yielded scant progress.

Her previous delivery four years before had ended with the Caesarian birth of her beautiful daughter, Amina. But now, as an excellent candidate for a vaginal birth and with all signs positive for her and her baby, Morgan was determined to have a vaginal birth. “I grew up a midwife’s daughter,” she says. “You push your baby out.”

With her husband, her father, and her mother, Jennifer Dohrn, DNP, CNM, assistant professor, surrounding her, she agreed to the recommendations of her attending midwife, Laura Zeidenstein, DNP, CNM, the director of the Nurse Midwifery Program at Columbia Nursing. First she was given the drug Pitocin, which strengthens uterine contractions. But with little further progress, Zeidenstein suggested an epidural. The anesthesia would allow Morgan to rest and gather the strength she needed to finally push her baby out. The rest period could also permit her pelvic muscles to relax, Zeidenstein said, easing the baby’s descent into the ideal position for birth.

At 4 a.m., as a light rain was falling outside, Morgan’s bag of waters ruptured, and she felt her baby descending. She felt the urge to push and, at the same time, an anxiety about whether she could do it this time or would again need surgery. But in the hardest moments, she says, “Laura and my mom reminded me to trust my body and it would teach me how to birth. Their words were chosen and precise and just what I needed. ‘You’re doing beautifully,’” she recalls Zeidenstein saying. “‘You will soon meet your baby.’”

“I started to push,” Morgan recounts, “but I wasn’t sure how to push. I was tensing my muscles.”

“‘Breathe,’ my mom said, ‘and only with the contractions.’”

Soon everyone was cheering, “I see the baby. It’s coming!”

“I pushed with everything I had,” Morgan says. “Out came my baby, who was immediately placed on my belly.”

She lay speechless, crying grateful tears. After a few moments, someone gently suggested her husband lift the baby’s leg. It was a boy! Already her son Maceo was nursing lustily at her breast.

Although VBACs (vaginal births after Caesarians) account for a mere 10 percent of births, it is not surprising that Haydee Morgan’s baby was delivered by a nurse-midwife. As more and more women are discovering, midwifery is dedicated to the principle that each woman and each woman’s body is unique. The expectant mother should be allowed, within the limits of safety for her and her baby—and backed up or in collaboration with physicians and hospitals—to strive for the birth experience she wants rather than being treated as a member of a category subject to fixed rules and timetables. Midwifery aims to empower women who may feel powerless within the medical establishment. It seeks to give each woman a birth that feels respectful and nurturing, attuned to the nuances of her body and her labor. Moreover, as a wealth of evidence shows, a midwife-attended birth is overwhelmingly less likely to end with a Caesarian section and more likely to result in a multitude of physical and emotional benefits for mother and child.

Births by Caesarian section have increased in the United States, with nearly a third (32.8 percent in 2012 according to the Centers for Disease Control (CDC) of American mothers having such births, and a 90 percent rate following a previous Caesarian birth. These are costly surgeries fraught with far greater risks than vaginal births. Women having C-sections have significantly greater risk of infection, hemorrhage, and blood clots, and their babies face greater likelihood of respiratory distress. Future pregnancies can be more difficult because scar tissue may prevent the placenta from implanting properly.

Alarmed by these facts and the high Caesarian rate, physicians and health organizations worldwide have recently taken action. One step
Laura Zeidenstein, midwife in attendance, with Amanda Segilia '04 and her son, Gabriel.
recommended by a consortium of researchers, clinicians, and others, as reported in The Lancet, is to move midwives more into the mainstream of medicine. Not only does midwifery reduce C-sections, they say, but it also reduces maternal and newborn mortality, perineal trauma, instrumental birth, anesthesia, severe blood loss, stillbirths, preterm births, and low birth weight. It has also been shown to increase spontaneous onset of labor and increased rates of successful breastfeeding.

In the U.S., the American College of Obstetricians and Gynecologists (ACOG) this year released new guidelines for events in labor that should trigger consideration of C-sections. ACOG recognizes the evidence that normal labor progresses more slowly than physicians had previously thought. Specifically, the new guidelines recommend that a cervical dilation of six centimeters rather than four centimeters should be considered the start of active labor, and that early-phase labor should be allowed to go longer. The guidelines permit women to push for at least two hours if they have delivered before and three hours if they have not, even longer with the use of an epidural. Finally, they recommend techniques to assist with vaginal delivery, which, the authors say, “is the preferred method when possible.”

“Midwives have always thought these things,” says Zeidenstein, director of Columbia’s graduate Nurse Midwifery Program, which is the oldest graduate nurse-midwifery program in the United States and about to celebrate its 60th anniversary in 2015. In all other developed countries, where midwives do 80 percent of births, she says, the Caesarian rate is closer to 12 percent, the percentage recommended by the World Health Organization.

In the early 20th century, when obstetrics became a specialty in the U.S., says Zeidenstein, midwives, who had attended most deliveries, were essentially eliminated. In the U.S. today, she says, the majority of providers now are surgeons. “They are excellent surgeons,” she says, “but surgery is normalized for them. Moreover, the health care system loads physicians with too many patients and too little time, making it easier for them to do C-sections.”

Time pressures also push physicians into quicker use of interventions to alleviate pain and speed labor or delivery, but these interventions also increase the likelihood that the birth will end as a C-section. Pitocin, for example, can put extra stress on mother and baby. The same is true of using an epidural for pain. Breaking the bag of waters too early, which physicians are quicker to do than midwives, can lead to possible infection.

Midwives also use these interventions but very carefully. “I can’t over-emphasize,” says Zeidenstein, “the importance of going slowly and mindfully.”

One of things midwives excel at—as The Lancet’s research confirms—is helping mothers manage the often agonizing pain of labor in order to avoid the use of an epidural or delay it as long as possible. Letting the mother move freely is key. Walking, squatting, or getting on hands and knees can help her cope. Perching on a birthing ball, which Haydee Morgan found “magical,” or sitting in a rocking chair are among the other options.

In many hospital settings, however, letting the mother move is either not possible or not encouraged because the woman in labor is strapped into an electronic fetal monitor (EFM) to continuously check her baby’s heartbeat. When possible, midwives instead employ a hand-held Doppler at frequent intervals to monitor fetal heart rate. “All the studies show,” says Sylvie Blaustein ’88, CNM, owner and director of Midwifery of Manhattan, “that intermittent auscultation is just as good as continuous EFM.”

Requiring women to lie on their backs in the bed originated long before EFM, says Jessica Lynn ’97 ’00, CNM, CDE. “It originates from the traditional obstetrical delivery. The position, called the lithotomy position, is based on the deliverer sitting on a chair at the end of the bed in order to have control over the delivery.” It was also, she notes, useful for women who had anesthesia and for convenience when using forceps. EFM, which is far more recent, further restricts the woman’s mobility. “Yet lying on your back is the least comfortable position for labor pain,” says Lynn, who worked as a midwife for 11 years at Brooklyn’s Woodhull Hospital before becoming a diabetes educator for pregnant women at the Naomi Berrie Diabetes Center at Columbia University Medical Center.

At Woodhull, a large public hospital with a significant and well-respected midwifery program, continuous EFM is required. Nevertheless, midwives there encourage laboring mothers to walk and change position within the length of the electrical cord while the midwives reposition the device to pick up the heartbeat.

If, however, none of these pain-relief strategies has been sufficient over the hours, and the mother is exhausted, an epidural, timed correctly, as in Haydee Morgan’s case, can allow a period of rest so the laboring woman can then push her baby out vaginally. An anesthesiologist would administer the epidural, but the midwife would continue to care for the patient.

Women often choose midwifery for their birth because they feel that it empowers them. “They worry about being trapped in a hospital,” says Blaustein, “and having things done to them against their wishes.”

Maria Corsaro, CNM, MPH DNP, a Nurse Midwifery faculty member at Columbia Nursing who practices at Hudson River Hospital Center, tells of a recent patient who came to her practice for a second birth after what she experienced as a “traumatic” first delivery, including an episiotomy that did not heal well. “She felt she wasn’t listened to,” Corsaro relates. “She didn’t want an episiotomy or an epidural, although she did want pain relief.”

Early in her pregnancy the patient saw the rooms at Hudson River Hospital Center with their tubs of water, varieties of lighting that she could direct, television if she wanted it. She told Corsaro that she would like a water birth, and she requested that her husband cut the cord and be able to hold their baby immediately. She also
asked about options for pain medication. Screaming for help with pain does not necessarily mean patients want an epidural, Corsaro explains. They may have trouble communicating clearly exactly what they want, so she prepares them with a “safe word.” “If she says that word,” Corsaro notes, “I know she really wants an epidural.”

When this patient arrived in active labor and in intense pain, Corsaro gave her choices at each step. Did she want to enter the water, have pain medication, or an epidural? She chose the water. The patient chose to emerge because she wanted to be in bed when she was ready to push. At that point, she was nine centimeters dilated, and her midwife again gave her choices. To break her waters or not? The patient said yes. Her husband was on one side of her, giving sips of water, and her mother was on the other, wiping her brow, when Corsaro quietly encouraged her to push. “Then the head crowned,” relates Corsaro, “and then his shoulders and arms emerged. I said to her, ‘Reach down and take your baby out and onto your chest.’” She did. Her husband and mother were encouraged to gently touch this new life, with his umbilical cord still attached. The room, said the midwife, was suffused with “a quiet joy.”

The midwife’s continuous presence (or as near as possible), confers significant benefits on mothers and infants, including less likelihood of episurals, studies confirm. “The midwife’s physical and emotional presence in witnessing the woman’s pain and acknowledging it reduces her anxiety,” says Lynn. “It normalizes the pain and makes it more tolerable. I tell them it’s OK to make noise. I let them scream and don’t shut them up.”

In addition, says Zeidenstein, when the midwife is present, she can gauge the mother’s mood and sense of her progress. “It’s not a case of waiting two hours until the physician stops in to do something. We say, ‘Oh, she’s not coping well. Let’s help her calm down and ask what she’s afraid of.’” The mother’s emotional state, she explains, can affect her stress hormones, which can influence the progression of her labor.

In this and other ways, midwifery is holistic, practitioners say. It encompasses the whole woman, emotionally as well as physiologically. It also comprises the entire process of pregnancy, delivery, and the initiation of successful breastfeeding. Midwives learn who their patients are, their relationships with the important people in their lives and the people in the delivery room. “I see when they have tensions because of violence in their lives,” says Lynn, “or sadness because of the loss of a parent. I might ask, ‘Are you thinking about your mother now?’”

“Midwives tend to understand the complexities of the body-mind connection,” Lynn says. Since most women think of their own mothers during delivery, she explains, sadness would be likely for a woman who’d lost her mother. A woman who suffered violence may feel especially vulnerable and “invaded.”

Midwifery is, by its nature, collaborative, both with patients and with physicians and hospitals. The collaboration of the private practice, Midwifery of Manhattan with The Birthing Center at Mount Sinai Roosevelt, says Zeidenstein, is an example of “seamless teamwork.” This hospital, she says, is unique in having allowed attending private midwives for 50 years. “The obstetricians and perinatologists recognize our expertise,” she says, noting, “Many of the physicians come to our practice to have their babies.”

Jocelyn Finger ’05 ’06, CNM, who practices at Midwifery of Manhattan, calls it “unique” and “ideal.” The ratio of midwives to patients frees midwives to be involved with them early and deeply and to be constantly present at deliveries, even as the occasional patient is wheeled into surgery for a C-section. “As a student at Columbia,” Finger says, “we’re taught what the ideals are and to work toward them. But we’re also taught to temper our ideals with the reality of the health care system.”

The Columbia Nursing educated midwives who work at Woodhull Hospital do just that, they say. The reality is that midwives cannot always be continuously present with their patient but they try to be, at least once active labor starts. Even without constant one-on-one attendance, women benefit from what midwives do, says Lynn, “touching, talking, advising, calming.” Sometimes this occurs with the assistance of a translator for those from Africa or Asia, for example.

Women at public hospitals are assigned to midwives rather than seeking them out, explains Zeidenstein, who trained at Woodhull. “The midwives are caught in a medical model,” she says. “Yet even there midwives make an enormous difference.”

Woodhull and Mount Sinai Roosevelt, she says, are quite unusual in their support of midwifery. “The reality,” she says, “is that midwives in U.S. hospitals are completely vulnerable. We have not been fully integrated into the maternal and child health system.”

If it is a myth that only affluent or educated women give birth with midwives, it is also a myth that midwives do not attend complicated pregnancies like those of twins or when the mother has gestational diabetes. In deliveries of twins, Lynn says, midwives help with labor support, pain relief, and emotional support, and can even deliver the babies vaginally while an obstetrician assesses the babies’ well-being and is ready, if necessary, to perform a C-section.

With gestational diabetes as well as Type 1 and Type 2, says Lynn, midwives can be instrumental to women. They offer care focused on diet, blood glucose levels, and weight gain during pregnancy. Attention to these can result in healthier pregnancies, healthier babies, and less chance of macrosomia, a very large baby, common in mothers with uncontrolled diabetes, which increases the likelihood of a C-section.

Whatever the medical complications—or lack of them—says Finger, a chief role of the midwife is to make childbirth as natural, healthy, and emotionally satisfying as it can be. When she gave birth recently, for example, she and her husband told their midwives they wanted to be treated as a “pregnant couple.” They involved her husband at every step, she reports, even asking him how he was feeling when she had morning sickness.

“In our practice, we care for women all the time when things don’t go right,” Finger says. “But, above all, we know that what we are doing is facilitating the foundation of a new family.”
ON THE FRONT LINES OF AN

Working with individuals, families, communities, and policymakers, nurses play many roles in confronting the complex challenge of OBESITY

By Claudia Wallis
On a bright September morning in New York City, Rose Rodriguez ’87 ’06, MS, CPNP-PC, CCTC, is gently talking with a teenage patient about his breakfast cereal. “Do you add milk?” she asks. “What kind do you use?” Matthew, a shy 19-year-old Latino in a Yankees sweatshirt and baggy cargo pants, tells her he pours 2 percent milk on his Cheerios. “Good,” says Rodriguez. “And a good way to cut more calories would be to switch to 1 percent. Some people don’t even notice the difference.”

Next they talk about his favorite drinks. When Matthew mentions that he loves juice and fruit punch, Rodriguez is quick with a suggestion. Instead of a full glass of fruit punch, try adding a little to some seltzer water. “It’s like a whole new drink,” she says, with the upbeat enthusiasm of the cheerleader she once was. “It will be flavored with what you like,” she adds, but with a fraction of the calories. Matthew agrees to give it a shot.

At 5 feet 6 1/2 inches and 272 pounds Matthew falls well into the category of obese. This would be concerning in any patient but even more so for someone with Matthew’s medical history. When he was 14, he was diagnosed with cardiomyopathy after he presented with nausea, fatigue, and symptoms of heart failure. Nauseated and weak, he missed two months of ninth grade as his medical providers and family in Brooklyn tried to determine what was wrong. Ultimately, his life was saved by a heart transplant at the Morgan Stanley Children’s Hospital of NewYork-Presbyterian. Rodriguez, who is the chief nurse practitioner for the hospital’s Cardiomyopathy, Heart Failure and Transplantation Program, has been monitoring him ever since.

While Matthew has recovered brilliantly from transplant surgery, his weight now threatens his long-term health. Rodriguez estimates that about 30 percent of her patients are overweight, 10 to 15 percent of whom are obese. “If they are presenting with a high body-mass index,” Rodriguez says, “nutrition is a huge component of their health and well-being.” So crucial, that Rodriguez is pursuing a master’s degree in nutrition so that she can bring additional expertise quite literally to the table. She works slowly and carefully with her young patients and their families, mindful of cultural food preferences and putting an emphasis on step-by-step changes to avoid discouragement. “We make suggestions that are approachable instead of trying to radically change what they eat,” she explains. Small steps build the conviction that change is possible; they pave the road to bigger victories against obesity.

It’s virtually impossible to work in 21st-century American health care and not deal with the complex challenges of obesity.

According to data from the Centers for Disease Control and Prevention (CDC) published earlier this year, more than a third (34.9 percent) of U.S. adults are obese—meaning that they have a body mass index (BMI) of 30 or more. (For a 5-foot-9-inch adult, for example, that means weighing 203 pounds or more.) For non-Hispanic blacks, the prevalence is closer to half—47.8 percent—and
for Hispanics, 42.5 percent. These racial and ethnic disparities begin in childhood. About 17 percent of American children, ages 2 to 19, are obese, but the figure is 22.4 percent among Hispanic children and 20.2 percent among African-Americans. (For children ages 2 to 18, obesity is defined as having a BMI in the 95th percentile for their age.)

These numbers represent an alarming change from the past. While the child obesity rate appears to have stabilized in recent years, it is nonetheless triple what it was in 1980. As for adults, one recent report calculated that the average American is 24 pounds heavier today than in 1960. The medical implications of these trends are daunting. Excessive weight brings increased risks of diabetes, hypertension, heart disease, liver disease, osteoarthritis, and several types of cancer. No wonder the CDC calculates that the annual medical cost for an obese person is $1,429 higher than for a person at a healthy weight.

Experts generally agree that the causes of the obesity epidemic involve an intricate interplay of individual factors, such as an increasingly sedentary lifestyle; interpersonal factors that include changes in the way families eat and spend their time; environmental influences, such as a landscape brimming with fast food restaurants and heavily promoted processed foods; and government policies, such as federal support for corn producers that led to a food supply awash in high fructose corn syrup. Attacking the epidemic means working at every one of these levels, a concept sometimes referred to as the social-ecological model.

Nurses are, of course, ideally positioned to work at the individual level and interpersonally with families. “We are obtaining height and weight measurements; we are an integral part of that consult, having those delicate conversations about weight and obesity,” says Rodriguez. “We’re really at the crux of making change.”

Nurses are also involved in making changes that influence entire populations. “To be successful in dealing with obesity, we also need action at the interpersonal, community, and policy level,” says Elizabeth Cohn ’09, PhD, RN, adjunct assistant professor at Columbia Nursing, whose research focuses on health disparities, including the impact of policy.

HELP AN INDIVIDUAL, HELP A FAMILY
For most nurses working in clinical care, obesity is a battle fought one patient at a time. Nurses working in bariatric care, such as Dory Roedel Ferraro ‘13 DNP, ANP-BC, CBN, see its worst consequences. Patients who opt for bariatric surgery have reached the end of the line: most are morbidly obese (BMI over 40), diet and exercise have not succeeded for them in a lasting way, and they face multiple health issues. “This is a very medically—and in some cases psychologically—complex population,” say Ferraro, an assistant clinical professor of nursing, who helped pioneer bariatric nursing and currently serves as clinical director of bariatric services at Stamford Hospital in Connecticut. “They are not just obese; they are sick.” Type 2 diabetes typically tops the list, but Ferraro’s patients often have heart disease, asthma, degenerative joint problems, severe sleep apnea, hyperlipidemia, and, among women, polycystic ovarian disease. The American Medical Association recognized obesity as a disease only in June of 2013. Ferraro, among others in the bariatric field, has seen it that way for 20 years.
On the Front Lines of an Epidemic

Focusing on children less than five years old is critical, since that’s when food preferences and lifestyle habits are established—for better or for worse. 

Stamford Hospital offers four different bariatric procedures, all of which involve altering anatomy in ways that leave the patient with a very small pouch for a stomach. The benefits can be huge but this dramatic and costly intervention requires a tremendous amount of patient education, lasting changes in lifestyle, and lifelong follow-up. Ferraro finds it immensely rewarding to see a patient’s diabetes vanish, blood lipids normalize, and pounds melt away. One of the surprising benefits, she notes, is a “halo effect.” When a patient embraces lifestyle changes after surgery—such as a low-fat, low-carb, high-protein diet and regular exercise, she says, “often we see that it filters down to the rest of the family. There are more nutritious foods in the cabinets, in the refrigerator, and on the table. We see spouses and children start losing weight, along with the patient.” Research has confirmed this halo effect for the families of bariatric patients.

Studies also support a family-based approach to both the treatment and prevention of obesity in children and adolescents. Ideally, that begins at birth (if not even earlier, with prenatal nutrition and counseling), says Associate Professor Rita John, EdD, DNP, CPNP-PC, DCC, who directs the Pediatric Nurse Practitioner program at Columbia Nursing. In 2014, John, together with Christen Lefebvre, MS, CPNP, CLC, published a systematic review in the Journal of the American Association of Nurse Practitioners that looked at the relationship between breastfeeding and childhood obesity. In examining 21 studies published between 2005 and March 2012, they found substantial evidence that breastfeeding tends to protect children from becoming overweight or obese, but the relationship falls short of being definitive due to a large number of confounding variables. Basically, says, John, while the review did not show a clear relationship between breastfeeding and obesity protection, mothers should still be encouraged to breastfeed based on evidence showing it offers many advantages for child health.

In the classroom, John teaches her PNP students a technique called motivational interviewing to work with children, families, and adolescents on sensitive issues like weight. The method flips the usual paradigm of health-professional-as-expert on its head. Instead, says John, the provider recognizes that “the patient is the expert on his or her own body” and takes cues from what patients feel they can accomplish. “I want you to think about confidence and readiness for behavior change,” she recently told a class of 39 students, assuring them that this will be easier for them to master than it was for her. “I was taught that I’m the expert.”

John used the technique in a pilot study examining whether low-literacy interventions can promote weight loss for obese children, ages 5 to 10, in a low-income community. While she was encouraged by the results, John, like a majority of experts, believes the key to halting the march of American obesity lies in primary prevention. “Treatment is very difficult; getting people to change lifestyle habits is very difficult. The really important thing,” she says, “is to prevent them from getting heavy to begin with.”

Focusing on children less than five years old is critical, since that’s when food preferences and lifestyle habits are established—for better or for worse. John points to a longitudinal study published in the New England Journal of Medicine in January 2014 that found that overweight kindergartners were four times as likely as healthy-weight peers to be obese by eighth grade. Aiming prevention programs at preschoolers and their families is therefore vital, and, there’s evidence that this strategy can work. Earlier this year, the CDC revealed that the obesity rate had declined 43 percent among children ages 2 to 5—from 13.9 percent to 8.4 percent—the first broad decline in any age group and a rare bright spot in the epidemic. Researchers suspect that a variety of factors contributed to the drop: the rising popularity of breastfeeding; improvements in the federally funded Special Supplemental Nutrition Program for Women, Infants and Children (WIC), which distributes food to low-income women; First Lady Michelle Obama’s Let’s Move program, which reaches 10,000 child care centers; and other state, local, and federal policy changes.

The Role of Policy and Community Action

While it’s impossible to say precisely what may be turning the tide on obesity for the country’s youngest citizens, the important lesson is that policy and community programs can make a difference. Elizabeth Cohn ’09, PhD, RN, a Robert Wood Johnson Nurse Faculty Scholar who serves as the director of the Center for Health Innovation at Adelphi University, Cohn believes that the broad reach of public policy makes it the strongest tool for combating obesity and improving public health: “It’s the most powerful thing you can do.” She points to New York City’s decision to ban trans fats from foods sold in the city’s restaurants and the effort under former Mayor Michael Bloomberg to ban the sale of supersized soft drinks. The first eliminated a dangerous additive—one linked to
heart disease—from the city’s menus. The second effort was blocked in the courts, but the publicity around it raised awareness about the perilous level of empty calories in jumbo servings of soda. Mexico, the only nation in the world with a higher obesity rate than the U.S., last year approved a national “junk food tax” that adds eight percent to the cost of calorie-dense snacks and sugary soft drinks. Researchers and policymakers around the world are eager to examine whether this policy innovation will help to rein in that country’s runaway obesity.

Those kinds of assessments are critical, since the best-intentioned policy doesn’t always work as planned. For example, Cohn has studied the impact of posting calorie content on menu boards in fast food restaurants. Her findings, published in the *Journal of Urban Health* in 2012, suggest that the posted information demands too much math to be helpful to many consumers. She and her co-authors identify several strategies that would make the postings easier to digest.

Action at the community level is another essential ingredient in the recipe for confronting obesity. Research has long shown that obesity rates are higher in neighborhoods that lack safe parks and recreational facilities, in places where street crime keeps people indoors and where there are few full-service grocery stores selling fresh produce. Central Harlem, which has been plagued by these issues, has an adult obesity rate that exceeds 50 percent; in East Harlem, the figure is even higher.

Cohn, along with others at Columbia Nursing, works in partnership with community organizations and leaders in Harlem to raise awareness about obesity risk factors, good nutrition, and the importance of staying active. One ongoing project supports the Abyssinian Baptist Church (ABC), long a pillar of Harlem, in creating a community kitchen that will offer cooking and nutrition classes to promote healthy eating and primary prevention of obesity. In recent years, the arrival of farmers’ markets and other sources of produce have meant that fresh fruits and vegetables are more available in Harlem than ever before. A lingering challenge, says Cohn, “is what my community partner has termed the bok choy problem”—sure, there are more veggies, “but people don’t actually know what to do with them.” The ABC community kitchen takes aim at that problem.

Cohn also serves on the executive team that organizes an annual health walk in Harlem that picks up participants at places of worship throughout the area and finishes with a health fair in Riverbank State Park, where community members can receive nutritional counseling and health screenings. Columbia Nursing is among numerous local partners—including churches, grassroots groups, and nonprofits—involves in the event, which marked its 10th anniversary in September. “Working from within established organizations uses the natural pathways of information flow and incorporates the rhythm and norms of the community,” says Cohn.

Community-based approaches, she says, work best when they emanate from the concerns of the community rather than being imposed from on high by experts and authorities. It is, in a sense, parallel to the kind of patient-centered counseling that Rita John teaches her students to use in obesity treatment. “In going where people are,” Cohn says, “we can see more easily the environment they are expected to perform in, we can take into account the activities available, and understand better how we can partner for effective and lasting change.”
COLUMBIA UNIVERSITY SCHOOL OF NURSING, one of the oldest in the United States, will soon have a new home. The new building will be constructed at 168th Street and Audubon Avenue, a few blocks from its current facility, located at 617 W. 168th Street in the Washington Heights neighborhood in Upper Manhattan. Among the seven-story structure’s many features will be a sunlit atrium lobby, rooftop garden terrace, and a two-floor, state-of-the-art simulation center equipped with lifelike mannequins that imitate real-life medical conditions giving students the opportunity to learn skills in a safe, educational environment.
The future of nursing and nursing education will soon have a new address. Our new building brings renewed focus to our education and research mission at a time when advanced practice nurses are playing an ever-greater role in the health care delivery system.”

— Dean Bobbie Berkowitz, PhD, RN, FAAN
Adriana Arcia, PhD, RN, assistant professor, was the lead author of “Facebook Advertisements for Inexpensive Participant Recruitment Among Women in Early Pregnancy,” published in *Health Education and Behavior*.

Mary Byrne, PhD, Stone Foundation and Elise D. Fish Professor of Health Care for the Underprivileged, was the lead author of “Pediatric Surgeons and Anesthesiologists Expand the Dialogue on the Neurotoxicity Question, Rationale for Early and Delayed Surgeries, and Practice Changes While Awaiting Definitive Evidence,” published in the *Journal of Neurosurgical Anesthesiology*, and “Guidelines for the Implementation of Prison Mother-Child Units in Canada, Penultimate Version,” published by the Collaborating Centre for Prison Health and Education, the University of British Columbia. She was also an author of “Original Research: Using Guided Imagery to Manage Pain in Young Children with Sickle Cell Disease,” published in the *American Journal of Nursing*, and “In Their Own Words: The Experience of Professional Nurses at a Northern Vietnamese Women’s Hospital,” published in *Contemporary Nurse*.


Karen Desjardins, DNP, MPH, assistant dean for academic affairs, was the lead author of “Empowering Women: Teaching Ethiopian Girls to Make Reusable Sanitary Pads,” published in *Clinical Scholars Review*.


Kathleen Hickey, EdD, FNP, assistant professor, was the lead author of “The Effect of Cardiac Genetic Testing on Psychological Well-Being and Illness Perceptions,” published in Heart and Lung. She was also an author of “Electrocardiographic Abnormalities in the First Year After Heart Transplantation,” published in the Journal of Electrocardiology; “Initial Evaluation of the Robert Wood Johnson Foundation Nurse Faculty Scholars Program,” published in Nursing Outlook; and “Assessing Health Literacy in Urban Patients With Implantable Cardioverter Defibrillators and Pacemakers,” published in the Journal of Cardiovascular Nursing.


Kristine Kulage, MA, MPH, director, Office of Scholarship and Research Development, was the lead author of “Establishing a Program of Global Initiatives for Nursing Education,” published in the Journal of Nursing Education. Other authors on the paper include Kathleen Hickey, EdD, FNP, assistant professor; Judy Honig, DNP, EdD, associate dean, Academic and Student affairs; and Elaine Larson, PhD, RN, FAAN, associate dean for research.


Robert Lucero, PhD, RN, assistant professor, was the lead author of “Benefits and Risks in Secondary Use of Digitized Clinical Data: Views of Community Members Living in a Predominantly Ethnic Minority Urban Neighborhood,” published in AJOB Empirical Bioethics. Other authors include Joan Kearney, PhD, APRN, assistant professor; and Adriana Arcia, PhD, RN, assistant professor.

Marlene McHugh, DNP, DCC, FNP, assistant professor, was an author of “Palliative Care: Responsive to the Need for Health Care Reform in the United States,” published in the fourth edition of Palliative Care Nursing: Quality Care to the End of Life.

Lusine Poghosyan, PhD, RN, assistant professor, was the lead author of “Nurse Practitioners as Primary Care Providers: Creating Favorable Practice Environments in New York State and Massachusetts,” published in Health Care Management Review. Other authors included JingJing Shang, PhD, RN, assistant professor, and Dean Bobbie Berkowitz, PhD, RN, FAAN. She was also the lead author of “Nurse Practitioner Role, Independent Practice, and Teamwork in Primary Care,” published in The Journal for Nurse Practitioners.

Rebecca Schnall, PhD, RN, assistant professor, was the lead author of “eHealth Interventions for HIV Prevention in High-Risk Men Who Have Sex with Men: A Systematic Review,” published in the Journal of Medical Internet Research. Schnall was the lead author of “Can the HIV Home Test Promote Access to Care? Lessons Learned from the In-Home Pregnancy Test,” published in AIDS and Behavior. Elaine Larson, PhD, RN, FAAN, associate dean for research, was also an author.

JingJing Shang, PhD, RN, assistant professor, was the lead author of “The Prevalence of Infections and Patient Risk Factors in Home Health Care: A Systematic Review,” published in the American Journal of Infection Control. Other authors on the paper include Lusine Poghosyan, PhD, RN, assistant professor; Dawn Dowding, PhD, RN, VNSNY Professor; and Patricia Stone, PhD, RN, FAAN, Centennial Professor of Health Policy.
Principal Investigator: Suzanne Bakken, PhD, RN, FAAN, FACMI  
Project Title: Provost’s Postdoctoral Research Scientist & Scholar Program  
Program Funding Source: Provost  
Total Budget: $124,000  
Total Project Dates: 8/1/2013 - 7/31/2015

Principal Investigator: Suzanne Bakken, PhD, RN, FAAN, FACMI  
Project Title: 13DEAL for HIV Research  
Program Funding Source: National Institutes of Health, National Institute of Mental Health  
Total Budget: $160,000  
Total Project Dates: 5/13/2014 - 4/30/2016

Principal Investigator: Suzanne Bakken, PhD, RN, FAAN, FACMI  
Project Title: Washington Heights Initiative Community-based Comparative Effectiveness Research (WICER)  
Program Funding Source: Department of Health and Human Services (DHHS), Agency for Healthcare Research and Quality (AHRQ)  
Total Budget: $8,855,607  
Total Project Dates: 9/30/2010 - 9/29/2013

Principal Investigator: Suzanne Bakken, PhD, RN, FAAN, FACMI  
Project Title: Reducing Health Disparities Through Informatics  
Program Funding Source: National Institutes of Health, National Institute of Nursing Research  
Total Budget: $1,332,795  
Total Project Dates: 7/1/2012 - 6/30/2017

Principal Investigator: Bobbie Berkowitz, PhD, RN, FAAN  
Project Title: Hyde and Watson Foundation Grant  
Program Funding Source: The Hyde and Watson Foundation  
Total Budget: $5,000  
Total Project Dates: 5/21/2013 - 5/20/2014
**Principal Investigator:** Bobbie Berkowitz, PhD, RN, FAAN  
**Project Title:** The Louis and Rachel Rudin Foundation Postdoctoral Fellowship in Palliative and End-of-Life Care  
**Program Funding Source:** Louis and Rachel Rudin Foundation  
**Total Budget:** $40,000  
**Total Project Dates:** 7/1/2013 - 12/31/2014

**Principal Investigator:** Mary Woods Byrne, PhD, CPNP, FAAN  
**Project Title:** Center for Children and Families Award  
**Program Funding Source:** Viola W. Bernard Foundation, Inc.  
**Total Budget:** $10,000  
**Total Project Dates:** 12/12/2011 - 12/11/2013

**Principal Investigator:** Mary Woods Byrne, PhD, CPNP, FAAN  
**Project Title:** “Shared Parenting” at Bedford Hills Correctional Facility and Chittenden County Correctional Facility  
**Program Funding Source:** The Sills Family Foundation  
**Total Budget:** $25,000  
**Total Project Dates:** 10/01/2012 - 9/30/2013

**Principal Investigator:** Mary Woods Byrne, PhD, CPNP, FAAN  
**Project Title:** Shared Parenting at Lund, Inc.  
**Program Funding Source:** The Sills Family Foundation  
**Total Budget:** $25,000  
**Total Project Dates:** 10/01/2013 - 9/30/2014

**Principal Investigator:** Mary Woods Byrne, PhD, CPNP, FAAN  
**Project Title:** Maternal and Child Outcomes of a Prison Nursery Program  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $1,598,450  
**Total Project Dates:** 7/1/2011 - 12/31/2013

**Principal Investigator:** Eileen Carter, PhD  
**Project Title:** The Examination of Infection Prevention and Crowding in the Emergency Department  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $84,908  
**Total Project Dates:** 7/1/2013 - 6/30/2015
Government and Private Funding for Research and Training

Principal Investigator: Elizabeth Cohn, PhD, RN
Project Title: Examining Minority Representation in Genomic Research
Program Funding Source: Robert Wood Johnson Foundation
Total Budget: $349,934
Total Project Dates: 9/1/2012 - 8/31/2015

Principal Investigator: Laurie Conway, RN, MS, CIC
Project Title: Secondary Bacteremia in Patients with Catheter-Associated Urinary Tract Infection
Program Funding Source: National Institutes of Health, National Institute of Nursing Research
Total Budget: $84,464
Total Project Dates: 6/1/2013-12/5/2015

Principal Investigator: Eileen Evanina, DNP
Project Title: Nurse Anesthetist Traineeship Grant
Program Funding Source: Health Resources and Services Administration (HRSA)
Total Budget: $29,076
Total Project Dates: 7/1/2013 - 6/30/2014

Principal Investigator: Kathleen Hickey, EdD, FNP, ANP
Project Title: Home ECG Monitoring to Detect Allograft Rejection Following Heart Transplantation
Program Funding Source: National Institutes of Health, National Institute of Nursing Research
Total Budget: $1,123,104

Principal Investigator: Judy C. Honig, DNP, EdD, CPNP-PC
Project Title: New Careers in Nursing Scholarship Program’s Pre-Entry Immersion Program (PIP) Technical Assistance Contract
Program Funding Source: Robert Wood Johnson Foundation
Total Budget: $5,200
Total Project Dates: 9/1/2012 - 8/31/2014

Principal Investigator: Judy C. Honig, DNP, EdD, CPNP-PC
Project Title: New Careers in Nursing Scholarship Program’s Pre-Entry Immersion Program (PIP) Technical Assistance Contract
Program Funding Source: Robert Wood Johnson Foundation
Total Budget: $5,500
Total Project Dates: 9/1/2013 - 8/31/2015

Principal Investigator: Judy C. Honig, DNP, EdD, CPNP-PC
Project Title: New Careers in Nursing Scholarship Program’s Pre-Entry Immersion Program (PIP) Technical Assistance Contract
Program Funding Source: Robert Wood Johnson Foundation
Total Budget: $50,000
Total Project Dates: 9/1/2012 - 08/31/2013

Principal Investigator: Judy C. Honig, DNP, EdD, CPNP-PC
Project Title: New Careers in Nursing Scholarship Program
Program Funding Source: Robert Wood Johnson Foundation
Total Budget: $50,000
Total Project Dates: 9/1/2013 - 8/31/2014

Principal Investigator: Judy C. Honig, DNP, EdD, CPNP-PC
Project Title: Nurse Faculty Loan Program
Program Funding Source: Health Resources and Services Administration (HRSA)
Total Budget: $122,518
Total Project Dates: 7/1/2013 - 6/30/2014

Principal Investigator: Rita Marie John DNP, EdD, CPNP-PC DCC
Project Title: Buzzing to Lessen Immunization Pain (BLIP) Study
Program Funding Source: Nurse Practitioner Healthcare Foundation
Total Budget: $5,000
Total Project Dates: 4/9/2012-12/31/2014

Principal Investigator: Elaine Larson, PhD, RN, FAAN
Project Title: Health Information Technology to Reduce Healthcare-Associated Infections: HIT-HAI (Diversity Supplement)
Program Funding Source: National Institutes of Health, National Institute of Nursing Research
Total Budget: $220,640
Total Project Dates: 4/1/2014 - 12/31/2015

Principal Investigator: Elaine Larson, PhD, RN, FAAN
Project Title: Training in Interdisciplinary Research to Prevent Infections (TIRI) (Supplement)
Program Funding Source: National Institutes of Health, National Institute of Nursing Research
Total Budget: $361,556
Total Project Dates: 9/26/2013 - 6/30/2017

Principal Investigator: Elaine Larson, PhD, RN, FAAN
Project Title: Health Information Technology to Reduce Healthcare-Associated Infections (HIT-HAI)
Program Funding Source: National Institutes of Health, National Institute of Nursing Research
Total Budget: $1,094,499
Total Project Dates: 7/1/2013 - 6/30/2017

Principal Investigator: Elaine Larson, PhD, RN, FAAN
Project Title: Training in Interdisciplinary Research to Prevent Infections (TIRI)
Program Funding Source: National Institutes of Health, National Institute of Nursing Research
Total Budget: $1,093,300
Total Project Dates: 7/1/2013 - 6/30/2017
Principal Investigator: Elaine Larson, PhD, RN, FAAN  
Project Title: Keep It Clean for Kids: The KICK Project  
Program Funding Source: Department of Health and Human Services (DHHS), Agency for Healthcare Research and Quality (AHRQ)  
Total Budget: $1,656,379  
Total Project Dates: 7/1/2012 - 6/30/2016

Principal Investigator: Elaine Larson, PhD, RN, FAAN  
Project Title: Risk Factors for Spread of Staphylococcus aureus in Prisons  
Program Funding Source: National Institutes of Health, National Institute of Allergy and Infectious Diseases  
Total Budget: $3,691,537  
Total Project Dates: 8/15/2009 - 7/31/2015

Principal Investigator: Robert Lucero, PhD, RN, Assistant Professor  
Project Title: New York City Hispanic Dementia Caregiver Research Program (NHiRP)  
Program Funding Source: National Institutes of Health, National Institute of Nursing Research  
Total Budget: $2,678,507  
Total Project Dates: 6/1/2013-3/31/2018

Principal Investigator: Jacqueline Merrill, PhD, RN, MPH  
Project Title: Systems-Level Mass Fatality Preparedness  
Program Funding Source: National Science Foundation  
Total Budget: $150,461  
Total Project Dates: 10/1/2013-9/30/2014

Principal Investigator: Michelle Odlum, PhD  
Project Title: Studying the Impact of Societal Factors and the Influence of Health Information Technology on Students’ Career Choices in Health Care  
Program Funding Source: Robert Wood Johnson Foundation  
Total Budget: $99,273  
Total Project Dates: 8/15/2013-05/14/2015

Principal Investigator: Lusine Poghosyan, PhD, MPH, RN  
Project Title: Primary Care Nurse Practitioner Practice Environments and Impact on Quality of Care and NP Outcomes  
Program Funding Source: Robert Wood Johnson Foundation  
Total Budget: $349,913  
Total Project Dates: 9/1/2013 - 8/31/2016

Principal Investigator: Nancy Reame, PhD, RN, FAAN  
Project Title: Characterizing Oxytocin as a Stress Buffer in At-Risk Mothers Exposed to Interpersonal Violence (IPV): A Feasibility Study  
Program Funding Source: CUSON Center for Children & Families  
Total Budget: $9,923  
Total Project Dates: 4/1/2013-3/31/2014

Principal Investigator: Nancy Reame, PhD, RN, FAAN  
Project Title: A Placebo-Controlled, Randomized, Double-Blind, Parallel-Group, Dose-Finding Trial to Evaluate the Efficacy and Safety of TBS-2 Intranasal Testosterone Gel (TRIMEL)  
Program Funding Source: MedPace, Inc.  
Total Budget: $35,719  
Total Project Dates: 3/06/2013-3/06/2018

Principal Investigator: Tawandra Rowell-Cunsolo, PhD  
Project Title: Provost Program for Junior Faculty Who Contribute to the Diversity Goals of the University Provost Winter 2013  
Program Funding Source: Provost  
Total Budget: $24,998  
Total Project Dates: 6/1/2013-12/31/2014

Principal Investigator: Tawandra Rowell-Cunsolo, PhD  
Project Title: Contextualizing & Responding to HIV Risk Behaviors Among Black Drug Offenders  
Program Funding Source: National Institutes of Health, National Institute on Drug Abuse  
Total Budget: $703,574  
Total Project Dates: 7/1/2013-6/30/2018

Principal Investigator: Rebecca Schnall, PhD, RN  
Project Title: HEAL 6 NY  
Program Funding Source: New York State Department of Health  
Total Budget: $100,000  
Total Project Dates: 11/1/11-09/30/2013
Government and Private Funding for Research and Training

**Principal Investigator:** Rebecca Schnall, PhD, RN  
**Project Title:** Using Queuing Theory to Inform the Implementation of HIV Testing in the Emergency Department  
**Program Funding Source:** Program funding source is Clinical and Translational Science Award (NIH)  
**Total Budget:** $250,000  
**Total Project Dates:** 7/1/2012 - 6/30/2014

**Principal Investigator:** Rebecca Schnall, PhD, RN  
**Project Title:** Informing the Development of Mobile Apps for HIV Prevention, Treatment, and Care  
**Program Funding Source:** Centers for Disease Control and Prevention  
**Total Budget:** $303,778  
**Total Project Dates:** 9/01/2014 - 8/31/2014

**Principal Investigator:** Jingjing Shang, PhD, RN  
**Project Title:** Healthcare Associated Infections in Home Health Care  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $160,000  
**Total Project Dates:** 5/13/2013 - 4/30/2015

**Principal Investigator:** Arlene Smaldone, PhD, CPNP-PC, CDE  
**Project Title:** Hydroxyurea Adherence for Personal Best in Sickle Cell Treatment (HABIT)  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $413,592  
**Total Project Dates:** 5/8/2013 - 4/30/2015

**Principal Investigator:** Jan Smolowitz, DNP, EdD  
**Project Title:** Robert Wood Johnson Foundation Executive Nurse Fellows Program  
**Program Funding Source:** Center for Creative Leadership  
**Total Budget:** $35,000  
**Total Project Dates:** 11/01/2012 - 11/30/2015

**Principal Investigator:** Patricia Stone, PhD, RN, FAAN  
**Project Title:** Jonas Nurse Leaders Scholars Program  
**Program Funding Source:** Jonas Center for Nursing Excellence  
**Total Budget:** $50,000  
**Total Project Dates:** 7/1/2012-6/30/2014

**Principal Investigator:** Patricia Stone, PhD, RN, FAAN  
**Project Title:** Prevention of Nosocomial Infections and Cost Effectiveness in Nursing Homes (Diversity Supplement)  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $129,845  
**Total Project Dates:** 7/1/2012 - 4/30/2016

**Principal Investigator:** Patricia Stone, PhD, RN, FAAN  
**Project Title:** Comparative and Cost-Effectiveness Research Training for Nurse Scientists  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $743,198  
**Total Project Dates:** 7/1/2013-6/30/2018

**Principal Investigator:** Patricia Stone, PhD, RN, FAAN  
**Project Title:** Prevention of Nosocomial Infections and Cost Effectiveness Refined (P-NICER)  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $1,906,665  
**Total Project Dates:** 12/1/2006 - 5/31/2014

**Principal Investigator:** Patricia Stone, PhD, RN, FAAN  
**Project Title:** Prevention of Nosocomial Infections and Cost Effectiveness in Nursing Homes (PNICE-NH)  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $2,498,408  
**Total Project Dates:** 7/1/2012-4/30/2016

**Principal Investigator:** May Uchida, PhD, RN  
**Project Title:** Comparative and Cost-Effectiveness Analyses of HAI Reduction in Nursing Homes  
**Program Funding Source:** National Institutes of Health, National Institute of Nursing Research  
**Total Budget:** $75,491  
**Total Project Dates:** 9/1/2012 - 02/11/2014

**Principal Investigator:** Patricia Stone, PhD, RN, FAAN  
**Project Title:** Qualitative Study of the Implementation of Legal Interventions to Reduce Healthcare Associated Infections  
**Program Funding Source:** ASTHO  
**Total Budget:** $20,000  
**Total Project Dates:** 6/1/2013-12/31/2013
Congratulations to our new inductees:

JACQUELINE MERRILL
PHD, MPH, RN
Associate Professor of Nursing in Biomedical Informatics
Director, Laboratory for Informatics, Complexity and Organizational Study
Associate Clinical Director, Center for Advanced Information Management

JENNIFER E. DOHRN
DNP, CNM
Assistant Professor
Director, Office of Global Initiatives and its WHO Collaborating Center for Advanced Practice Nursing

LUKINE POGHOSYAN
PHD, RN
Assistant Professor

THEY JOIN OUR OTHER FACULTY FELLOWS:

Bobbi Berkowitz, PhD, RN, FAAN
- Dean, Columbia University School of Nursing
- Mary O’Neil Mundinger Professor
- Senior Vice President, Columbia University Medical Center

Suzanne B. Bakken, PhD, RN, FAAN, FACMI
- Alumni Professor of the School of Nursing
- Professor of Biomedical Informatics
- Director, Center for Evidence-based Practice in the Underserved

Penelope R. Buschman, MS, RN, PMHCNS-BC, FAAN
- Assistant Professor
- Director, Psychiatric Mental Health Nurse Practitioner Program

Mary Woods Byrne, PhD, CPNP, FAAN
- Stone Foundation and Elise D. Fish Professor of Health Care for the Underserved
- Director, Center for Children and Families

Kathleen Hickey EdD, FNP, ANP, FAHA, FAAN
- Assistant Professor

Elaine Larson, PhD, RN, FAAN, CIC
- Anna C. Maxwell Professor of Nursing Research
- Associate Dean for Research

Mary O’Neil Mundinger, DrPH, MA, RN, FAAN
- Dean Emerita
- Edward M. Kennedy Professor of Health Policy

Nancy Reame, PhD, RN, FAAN
- Mary Dickey Lindsay Professor of Disease Prevention and Health Promotion
- Director, Pilot Studies Core, Irving Center for Clinical & Translational Research

Patricia W. Stone, PhD, RN, FAAN
- Centennial Professor in Health Policy
- Director, Center for Health Policy

Columbia University School of Nursing

The Future of Health Care is Nursing
THE FUTURE OF NURSING IS COLUMBIA
More than 200 alumni, faculty, and guests gathered in May for Reunion. Six outstanding alumni received Distinguished Alumni Awards. The Florence Nightingale of Denmark—Charlotte Munck, Class of 1909—received a posthumous honor presented by Danish Consul General Jarl Frijs-Madsen. A jazz reception at the Georgian Building concluded the day spent connecting with friends old and new.

**Save the Date: Alumni Reunion, Friday, May 1, 2015.**
For information about next year’s event, or joining a reunion committee please contact Mairead Moore, 212.305.5999 or mm4513@columbia.edu.
1: Joan Hagan Arnold ’69; Dallas Regan ’09 ’10; Laura Ardizzone ’04 ’10; Penny Buschman, director, Psychiatric Mental Health Nurse Practitioner Program; Judy Honig, associate dean for Academic and Student Affairs; Mary Byrne, Stone Foundation and Elise D. Fish Professor of Health Care for the Underserved; Margaret Fracaro ’70; Elaine Larson, associate dean for Research; Njoki Ng’ang’a ’13
2: Mary Reid (Granddaughter) and Mary Dickey Lindsay ’45
3: Rachel Lyons ’07
4: Kathleen Barnes ’89
5: Phebe Thorne ’64 and Midge Harrison Fleming ’69
6: Kenrick Cato, PhD, associate research scientist; Elizabeth Cohn ’09; Maureen Dailey ’10; Arlene Smaldone ’03, assistant dean, Scholarship and Research; Cassandra Dobson ’06; Njoki Ng’ang’a ’13
7: Class of 1964
8: Denmark’s Counsel General Jarl Frijs-Madsen; Dean Bobbie Berkowitz; Suzanne Law Hawes ’59; Susan Rydahl-Hansen, head of Nursing Research, Bispebjerg Hospital, Denmark
9: Columbia Nursing students Samantha Gilligan, Ariel Frank, Katie Staniforth, and Anna Szarnicki
10: Kathleen McCooe Nilles ’89 and Wanda Montalvo, PhD student
11: Cassandra Dobson ’06, Rhoenna Campbell-Robinson ’01, and Jenny Delalelu ’05

Photographs by Michael DiVito
12: Njoki Ng’ang’a ‘13
13: Nina Caulo Feirman ’76 (left) and Susie Caulo Purcell ’72 (right) with their mother, Dorothy Lakeman Marshall ’49
14: Heidi Owen Ahlborn ’78 and daughter Elizabeth Ahlborn, ETP student
15: Dean Bobbie Berkowitz, PhD, RN, FAAN; Suzanne Bakken, PhD, RN, FAAN, FACMI, Alumni Professor of Nursing & Biomedical Informatics; Georgia J. Persky ’10
16: Sandra Bennett-Roach, Columbia Nursing student and Keville Frederickson ’64
17: Margaret Fracaro ’70; Elaine L. Larson, PhD, RN, FAAN, associate dean for research
18: Bottom row: Rachel Lyons ’07; Susan Doyle-Lindrud, DNP, ANP, DCC, assistant dean, academic affairs; Brenda Janotha ’08; Judy Honig, DNP, EdD, associate dean Academic and Student Affairs; top row: Darylann Ficken ’03 ’04 ’07; Laura Ardizzzone ’04 ’10; Dallas Regan ’09 ’10; Courtney Reinisch ’07; Roxana Sasse ’92 ’11
19: Sandra McLaughlin Johanson ’64; Dean Bobbie Berkowitz, PhD, RN, FAAN
20: Mary Reynolds Powell ’69, Angela Clarke Duff ’70; Regina McCarthy ’69
21: Tawandra Rowell-Cunsolo, PhD, assistant professor; Jennifer Dohrn, DNP, CNM, director, Office of Global Initiatives
22: Class of 1964 singing and marching
23: Laura Ardizzzone ’04 ’10; Marlene McHugh, DNP, FNP, assistant professor
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July 1, 2013–June 30, 2014

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Diana and P. Roy Vagelos, MD

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Estate of Edith Royce Zaager ’57

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Dorothea Kissam ’46 Scholarship
Estate of Dorothea Kissam ’46

Mary Dickey Lindsay ’45 DNP Scholarship
The Guilford Fund

Helene Fuld Health Trust Scholarship Fund
Helene Fuld Health Trust

Scholarships in Memory of Dean Helen Pettit for Undergraduate Nursing Students
Scholarships in Memory of May Rudin for Undergraduate Nursing Students
Scholarships for Oncology Students in Honor of Susan Vogel
Post-Doctoral Fellowship in Palliative and End-of-Life Care
The Louis and Rachel Rudin Foundation

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Center for Children and Families for Therapeutic Parenting Programs at the Children’s Center at Bedford Hills Correctional Facility
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Janice Jones Izlar ’06

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The Dorothy Metcalf Charitable Foundation
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Dr. Scholl Foundation Scholarship
Dr. Scholl Foundation

Rose Nadler Schefer Memorial Scholarship Fund
The Fay J. Lindner Foundation
In memory of Eli Schefer

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Ines DeBaun Berndt ’51 Nursing Scholarship Endowment Fund
Vincent C. DeBaun

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Bobbie A. Berkowitz
Robert W. Gerwig
Members of the Class of 1964

Nurse Anesthesia Alumni Scholarship Gift Fund
Donald Richard Boyd Jr. ’06
Roxana I. Sasse ’92 ’11
In honor of Mary Roxana Edwards and peri-operative nurses at RWMC

UP TO $999

Columbia University School of Nursing Building Fund
Marjorie Harrison Fleming ’69
George E. Hiller
In memory of Barbara Herrin Ertel ’55
Members of the Class of 1964
Ellen Ann Neylon ’11

Nurse Anesthesia Alumni Scholarship Gift Fund
Susan Elizabeth Adamcewicz ’07
Laura Louise Ardizzone ’04 ’10
Lauren Michelle Baker ’13
Donna Chrysilda Barreiro ’84
In memory of Eleanor Barreiro
Christine Ann Bedrock ’03
Debra Jean Brittain ’04
In memory of Edward Gloery
Monica Buff Burrell ’09 ’12
Carolyn Diane Czyz ’08
Kimberly Marie Lanfranca ’06
Monica Waziri

Psychiatric Mental Health Scholarship
Penelope Buschman ’64
Susan Patel Furlaud ’09 ’12
Mona Iris Geller ’05 ’07
In honor of Micheline Dugue
Victor Arthur McGregor ’94 and Catherine Mary Lala ’99
Glenn David Wurtzel ’00 ’02

Scholarships in Memory of Lore Mendelsohn
for Palliative Care and End-of-Life Care
Sub-Specialty Students
Paul R. Mendelsohn and Family

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Columbia Nursing gratefully acknowledges the generosity of alumni and friends whose Annual Fund gifts supported the Student Scholarship Fund, the Student Travel Fund, and Dean’s Discretionary Fund.

Your contributions enabled us to provide vital financial assistance, upgrade our simulation equipment, offer student research conference opportunities, and underwrite study overseas.

NIGHTINGALE SOCIETY

Named after Florence Nightingale (1820–1910), who laid the foundation for professional nursing, membership in the Florence Nightingale Giving Society entitles its members to award a nursing student with a named scholarship.

$10,000 AND ABOVE

Anonymous
JeanneMarie Gelin Baker ’90*
Gerald Felton ’93*
Ellen Gottesman Garber ’76*
Estate of Grace E. Laubach ’33
H. F. Lenfest, Esq.*
Mary Dickey Lindsay ’45*
Deborah Keeler Lott ’68*
Joan Seaburgh Puydak ’56*
Ruth Klawunn Randa ’52*
Megan Christian Wright ’82*
Estate of Edith Royce Zaager ’57

$5,000–$9,999

Frannie Kelly Burns ’77*
Karen Krueger Desjardins ’98 ’05^*
In honor of Ellen “Sunni” Levine ’96

$2,500–$4,999

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The Charles A. Mastronardi Foundation*
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Anna C. Maxwell (1851–1929) was the first director of the School of Nursing. She is known for pioneering professional nursing and establishing one of the first schools of nursing in the nation.

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Helen F. Pettit served as director of the School of Nursing from 1976–1981. She has been described as “dreaming dreams but always there, generous with her time, offering encouragement and opportunities for advancement.”

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Elizabeth S. Gill was the director of the School of Nursing from 1961–1968, while also serving as director of nursing service at Presbyterian Hospital. A graduate of the school and of Teachers College, Gill expressed her love for nursing in her comment: “I have received more than I have ever given.”

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Dorothy M. Rogers, director of residence at Maxwell Hall from 1928–1943, was counselor and friend to hundreds of students.

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