NEW HEIGHTS:
DNPs SHARE THEIR STORIES

BEHIND THE NUMBERS:
REDUCING RATES OF HOSPITAL INFECTION

TRANSGENDER HEALTH
The American public has placed significant trust in our profession. I believe we, as nurses, have a compact with society to keep its members safe when they are in our care; and society expects us to do so. But what exactly does that mean, to keep one safe? It is one of our most important roles along with promoting health, managing symptoms of illness and distress, and advocating for a more just, progressive, and prosperous society.

I consider earning and maintaining the public’s trust through our roles as educators, scientists, and clinicians as our most important mission as a school of nursing. I think about how to gain the trust of our current students, future students, and our alumni in our ability to assure that the future of health care is aligned with the hallmarks of excellence in all that we do, particularly in relation to our role as clinicians.

Therefore, this issue of The Academic Nurse features three themes which constitute the essence of our work as a trusted profession: advanced practice education that is changing the face of the health care system; research which points the way toward eliminating costly, deadly, and persistent health care problems; and new insights and perspectives on meeting the needs of an underserved population.

A decade has passed since we established the Doctor of Nursing Practice program at Columbia Nursing. With its challenging, comprehensive curriculum, the DNP degree represents the pinnacle of advanced education for professional nurses. Those who’ve earned it acquire extensive clinical knowledge and skills anchored in evidence. And they gain insights for use every day in their practices. As health care reform brings nurses to the forefront of increasingly complex care delivery and management of chronic illness, DNP-prepared nurses are leading the transformation of the American health care system. We’re doing so by working to ensure that health care is cost-effective, of high quality, and promotes the well-being of entire populations.

We honor the DNP decade at Columbia Nursing by introducing you to three extraordinary graduates of our program. You’ll hear from a chief nurse anesthetist at a world-class cancer hospital, a distinguished nurse educator and champion of nurse education on a global scale, and a dedicated family nurse practitioner who delivers outstanding care to patients in a Denver suburb. All three describe how their DNP degree empowers them to make real and sustained differences in the lives of the people they serve, while opening doors to opportunities for fulfilling professional and personal goals. You’ll also be introduced to the perspective and experiences of a current Columbia Nursing DNP student.

Our DNP program prepares nurses to apply the latest research advances to their practice, whether at the bedside or in a community setting. For example, Patricia Stone, PhD, RN, FAAN, director of our Center for Health Policy and Centennial Professor of Health Policy in Nursing, has investigated health care-acquired infection (HAI) rates at almost 1,000 hospitals. HAIs are one of the most widespread and intractable problems in our field, which the Centers for Disease Control and Prevention estimate affect one of every 20 hospitalized patients every day, causing or contributing to 99,000 deaths each year. Stone and her colleagues found that many hospitals are slow to adapt demonstrated best practices for curbing HAIs as well as fail to comply with their own HAI-reduction policies already in place. “To Stop Hospital Infections, Start at the Top,” looks behind the numbers to show how we can do a better job of reducing these often preventable and life-threatening scourges.

Nursing has a long and honorable tradition of delivering care to underserved and vulnerable populations irrespective of economic, ethnic, social, or cultural determinants. Many obstacles to providing such care still confront our profession and we remain as dedicated in our resolve to address them as ever. For example, nursing today is a leading advocate for the health of the lesbian, gay, bisexual, and transgender (LGBT) communities, particularly where stigma and discrimination have reduced access to high quality and affordable care. In 2010, I served on an Institute of Medicine consensus committee that examined the health of LGBT populations. Our report assessed the state of science of LGBT health, identified research gaps and opportunities, and outlined an agenda for the National Institutes of Health with recommendations on research priorities for improving LGBT health. Through my work on the committee I had the pleasure of meeting Walter Bockting, PhD, a global expert on LGBT health. Our committee completed its work in 2011, but Walter and I kept in touch. To my delight, he joined our faculty and that of the College of Physicians and Surgeons in a joint appointment. As co-director of our LGBT Health Initiative, he is continuing his groundbreaking work on transgender health by helping develop evidence for effective care for this often underserved population. “Walter Bockting: Exploring Transgender Health on Its Own Terms,” will introduce you to a health care pioneer and perhaps a new way of thinking about the transgender population.

The three areas explored in this issue have been at the heart of our mission for decades. Through the work of extraordinary members of the Columbia Nursing family, they are being revitalized for the 21st century. Let them serve as an inspiration to us all!

Bobbie Berkowitz, PhD, RN, FAAN
Dean, Columbia University School of Nursing
Mary O’Neill Mundinger Professor of Nursing
Senior Vice President, Columbia University Medical Center
More than a dozen states have passed legislation expanding the role of nurse practitioners (NPs) to help fill the shortage of primary care providers in the U.S. But despite such legislation, NPs still face hurdles in organizational culture that undermine these policy changes. That’s what a research team led by Lusine Poghosyan, PhD, MPH, RN, assistant professor at Columbia Nursing, found when it investigated how workplace environment affects NPs’ ability to practice autonomously and deliver quality care. Results of the study were recently published in the Journal of Professional Nursing.

Because Massachusetts was the first state to recognize NPs as primary care providers, it was an ideal place to study their workplace experiences. The results suggest that legislative reform did not immediately translate into practice. Poghosyan looked at the levels of support and resources available to NPs, who reported in interviews that they often felt excluded from decision-making. They also felt invisible to administrative staff, who poorly understood their roles and contributions to patient care. Further, they felt stymied by insufficient access to personnel support and operational resources such as adequate exam-room space. The study also cited instances where NPs were not allowed to see new patients or even conduct physical assessments. NPs often did not achieve greater autonomy to see new patients, prescribe medications, conduct physical assessments, or order diagnostic tests.

These findings have repercussions beyond Massachusetts. With a surge of newly insured patients under the Affordable Care Act, demand for primary care services will increase nationally. At the same time, an aging population—living longer with more diseases—is also heavily relying on primary care providers.

Says Poghosyan, “Organizational policies often trump government policies by precluding NPs’ making a full contribution to effective patient care. This kind of climate will not help our nation’s primary care-provider shortage, nor will it enhance patient care.” While legislation to create a legal framework for NPs to practice independently is a good first step, health care organizations need to establish internal policies conducive to effective NP practice. For example, administrators should clearly define ways for NPs to be included on the decision-making committees that govern the daily operations of the health care workplace.”
A New Way to Look at Health Information

The use of imagery can help reduce knowledge gaps and help educators better deliver health information to communities with lower levels of health literacy. But there are no uniform visual models in use that are tailored to the needs of individuals with varying degrees of comprehension.

In the first phase of a study led by Suzanne Bakken, PhD, RN, FAAN, FACMI, the Alumni Professor of Nursing and professor of biomedical informatics, researchers explored methods for designing and evaluating the effectiveness of innovative visual images—“infographics”—to convey health status and health behaviors. These methods will ultimately be tested among residents of New York City’s Washington Heights and Inwood neighborhoods who participated in a community survey that generated these data, as part of a large interdisciplinary research project called WICER: Washington Heights/Inwood Informatics Infrastructure for Community-Centered Comparative Effectiveness Research. (WICER, whose goal is to understand the health of the community in order to improve its health, was funded by the Agency for Healthcare Research and Quality.)

Bakken and colleagues, as well as trainees from Columbia Nursing and Columbia’s Department of Biomedical Informatics, developed a number of design models, including block charts, icon bar charts, reference range number lines, and analogy-based graphics. For example, an effective analogy graphic is a stoplight using the red, yellow, and green lights to convey reference ranges for blood pressure. Another image, of batteries, offers individuals a visual way to assess their energy levels.

Multiple versions of the designs were created, varying in color, direction (horizontal vs. vertical), and icon images. One innovative design featured a four-leaf clover to depict a person’s overall health status, with each leaf representing a different aspect of health such as nutrition, physical activity, sleep/energy, and mental health. The varying sizes of the leaves can help show the need for, say, more sleep or better nutrition.

The researchers used images to outline and measure several goals, such as body mass index and blood pressure. Other images track a person’s health behaviors, such as the number of vegetable servings eaten and frequency of exercise, as well as changes in physical and emotional health. The graphics also show how an individual’s health behaviors and status compare with others of similar age and gender.

Adriana Arcia, PhD, RN, postdoctoral trainee on the Reducing Health Disparities Through Informatics training grant, was first author of a paper describing the methods that the WICER team used to develop the infographics. “Method for the Development of Data Visualizations for Community Members with Varying Levels of Health Literacy” was presented at the annual symposium of the American Medical Informatics Association (AMIA). It won the AMIA’s prestigious Harriet H. Werley Award, which recognizes the paper making the greatest contribution to advance the field of nursing informatics.

The challenge for health educators has long been to establish better methods of reaching individuals who, for a variety of reasons—whether because of education or language barriers—have difficulty understanding information about disease prevention, management, and treatment. This limited knowledge affects their ability to make informed health decisions.

“Understanding health information is critical to improving the health of individuals,” says Arcia. “In most cases, those with lower health literacy tend to have poorer outcomes for chronic yet mostly manageable conditions such as diabetes and hypertension. And people with limited comprehension are less likely to benefit from public health education initiatives.

At the same time, they are among the highest-risk populations for illnesses that would most benefit from an understanding of preventative health measures. That’s been a major public health challenge to health educators and one we hope this study helps to mitigate,” says Arcia.

These individuals also disproportionately live in poorer neighborhoods, contributing to the nation’s growing health inequity. According to a study by the John D. and Catherine T. MacArthur Foundation, adults with lower socioeconomic status are more likely to experience high blood pressure, obesity, heart disease, infectious diseases, and premature death.

Low or marginal health literacy affects approximately 46 percent of Americans, who are more likely to have trouble taking medication as prescribed and managing their health through good nutrition and exercise. People with low health literacy also use more health care resources, including emergency room visits and hospital admissions.

Subsequent phases of the Columbia team’s work on infographics will measure the efficacy of various visual designs at supporting comprehension, compared with text alone, and will determine whether specific illustrations influence and encourage changes in health behaviors and ultimately health outcomes. This work is funded by the follow-on grant to WICER entitled WICER 4 U, which is also funded by the Agency for Healthcare Research and Quality, and is aimed at facilitating use of the WICER data by a variety of stakeholders, including community residents, community-based organizations, researchers, and health care providers.
Improving Care in the Crowded ED: What Nurses Can Do

Nurses have long believed that patients treated in crowded emergency departments (EDs) are more likely to experience setbacks than patients treated during slower, calmer periods. Eileen Carter, RN, who left work as a full-time ED nurse to pursue a PhD at Columbia Nursing, was determined to better understand the relationship between crowded EDs and patient care and what nurses can do to improve the situation for patients.

Carter and her research team conducted a literature review—recently published in the *Journal of Nursing Scholarship*—that examined the effects of ED crowding on patient mortality and serious complications. She found several studies linking ED crowding to higher death rates, both in the hospital and after discharge. ED crowding was also associated with increased rates of patients leaving the ED without being seen, again confirming nurses’ experience.

“In the ED, there is a culture of immediacy rather than an emphasis on thinking about how care provided will affect patients down the road,” says Carter. “The nature of ED work is to prioritize the sickest patients, which of course has to happen, but we need to think more about how best to care for those people who have been stabilized but still need medical attention.”

One way is to systematically address areas that aren’t immediately life-threatening but can help improve long-term patient outcomes, such as infection control and discharge planning. Some hospitals prevent infections by assigning one person per shift to ensure that hand sanitizers and face masks are always available for clinicians and visitors. Similarly, some assign nurses solely to patients who are done with their emergency care and waiting to be sent home or admitted to the hospital.

Even in such cases, problems remain. “We don’t have a uniform, nationwide standard to measure ED crowding,” Carter says. “There’s a patchwork of different measures that are used, which limits our ability to understand the full scope of the problem.”

Each year, millions of Americans seek medical care at emergency departments—and the number grows annually. Also growing is the typical wait time; in many cases, patients go hours before being treated. “Clearly this is a serious public health issue,” says Elaine Larson, PhD, RN, FAAN, associate dean for research at Columbia Nursing and senior author of the study. “So many people seek care in our nation’s EDs, and these numbers are rising every year. We cannot provide and sustain the high level of care that patients deserve without enacting additional policies to ensure their safety.”

Carter agrees. “We hope,” she says, “that as a result of our study more attention will be paid to this issue, and nurses will play a pivotal role in effecting system-wide changes.”

For decades, nurses in China enjoyed guaranteed employment for life. But those days are over. The country has recently undergone sweeping economic and health system reforms that have rolled back the number of these traditional nursing jobs, known as Bianzhi—or “iron rice bowl”—positions. Today, more than half of hospital-based nursing posts are filled by contract (Bianwai) nurses who do the same work for lower pay, fewer benefits, and less job security.

A research team led by Jingjing Shang, PhD, RN, assistant professor at Columbia Nursing, examined the effects of the two-tiered nursing pay system on job dissatisfaction, staff turnover, and patient outcomes at 181 hospitals throughout China between 2008 and 2010.

Shang found that contract nurses were more dissatisfied with their pay and benefits and more likely to leave than nurses with lifetime job security. The study, “Nurse Employment Contracts in Chinese Hospitals: Impact of Inequitable Benefit Structures on Nurse and Patient Satisfaction,” was recently published in the *Journal of Human Resources for Health*.

“China’s rapidly changing labor practices combined with a brewing nursing shortage emphasize the importance of equal pay for equal work,” says Shang. “Otherwise, patient care is likely to suffer.”

The use of contract nurses is expected to increase as China continues its evolution to a free-market economy and demand for health care increases as a result of an aging population.

Shang and her colleagues also found that contract nurses were more likely to be male, and significantly younger, less likely to be married and have children, had less nursing experience, and were less likely to have an advanced nursing degree. Contract nurses were also significantly more likely to express the intention to leave their current job within a year. With more than 1.3 billion people, China has the largest population in the world. Current nursing employment practices and limited opportunities for growth are causing many nurses to change occupations or migrate to other countries which, facing their own nursing shortage emphasize the importance of equal pay for equal work,” Shang says.

China urgently needs to address the inequalities in nursing compensation to stabilize the nurse workforce and improve the quality of care in hospitals,” Shang says.

With Increasing Reliance on Lower-Paid Nurses, China Risks a Revolving Door of Care

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Menstrual Problems a Key Predictor of Emotional Health in Women with PCOS

Polycystic ovary syndrome (PCOS) is one of the most common endocrine disorders in the United States, affecting 6-17 million women during their childbearing years.

Symptoms include infertility, hirsutism (excess body hair), irregular menstrual cycles, and obesity. The condition has also been linked to a range of mental health problems including anxiety, depression, and eating disorders. Nancy E. Reame, PhD, RN, FAAN, Mary Dickey Lindsay Professor of Disease Prevention and Health Promotion at Columbia Nursing, supervised a research project that set out to find the links between PCOS symptoms and specific mental health complications.

The study, published in a recent issue of the Journal of Behavioral Health Services & Research, found that of all PCOS symptoms, menstrual problems was the strongest predictor for psychological distress. The study also found that body hair and menstrual problems most strongly predicted anxiety, while obesity was most strongly associated with hostility.

“It isn’t a surprise to clinicians that physical symptoms such as infertility, excessive hair growth, and weight gain would be emotionally upsetting to patients,” says Professor Reame. “Our goal was to expand on these findings from previous studies by looking at the level of psychological distress caused by individual physical symptoms of PCOS. We believe this will provide clinicians with more precise information for identifying psychologically at-risk patients.”

“When we compared PCOS patients with a sample of women in the general population, we found significantly higher correlations between all of the physical symptoms we evaluated and several psychological distress measures, particularly anxiety, depression, somatization, and interpersonal sensitivity,” says Judy G. McCook, PhD, RN, associate professor of nursing at East Tennessee State University and co-investigator. “But we found that distress caused by menstrual irregularities was by far the most significant, across-the-board predictor of emotional distress. But because menstrual problems are so common, their psychological impact may be overlooked or not fully addressed during clinical examinations.”

Something all clinicians should keep in mind when treating PCOS patients.
This year marks the tenth anniversary of the Doctor of Nursing Practice, or DNP, program at Columbia University School of Nursing. Columbia Nursing’s program was among the first in the nation, and in the years since it was established, DNP programs have proliferated at nursing schools across the nation. Columbia Nursing’s DNP focus is unique among these programs in its distinctive emphasis on comprehensive clinical care.

“The DNP program at Columbia University School of Nursing is a terminal degree that prepares the advanced practice nurse with the knowledge and skills necessary for comprehensive care of patients across sites and over time,” says Susan Doyle-Lindrud, DNP, ANP, DCC, (’94 ’08), director of the DNP program. “The advanced practice nurse with a DNP degree is well positioned not only to manage the individual patient, but is also prepared to improve patient outcomes through translation of research into practice.”

Not only has Columbia Nursing’s DNP program graduated a cadre of exceptional nurse leaders, it is changing the face of nursing for the 21st century by helping to revolutionize the way health care is delivered in this country and around the world.

In honor of the DNP decade, The Academic Nurse asked three DNP graduates and a current DNP student to tell us what the DNP degree means to them and how it affects their ability to care for patients, families, and communities.

Revolution,
Evolution,
Solution:

A DECADE OF DNP AT COLUMBIA NURSING

BY ROBERT BROWN
Jennifer Dohrn ’85 ’05

Jennifer Dohrn graduated with Columbia Nursing’s first DNP class, while she was on the faculty of Mailman School of Public Health, and an assistant professor of nursing at Columbia University Nursing.

“P”

ior to Columbia Nursing’s DNP, there was no established pathway for nurse clinicians to expand their expertise to the doctoral level. It made little sense to acquire a PhD—we are clinicians, not researchers. That’s the brilliance of the DNP. It provides a fantastic opportunity for nurse clinicians.

“My current day-to-day responsibilities are very different from what I thought they would be when I enrolled in the program. At that time, I was primarily focused on midwifery, which remains at the heart of all I do. However, today, among other things, I build nursing capacity models for developing programs in other countries, specifically Sub-Saharan Africa. I know the DNP would help me provide better care for patients, but I didn’t realize how important it would be for my global work. It establishes a higher level of credibility for me within traditionally hierarchical systems. Here everyone knows me as Jennifer, but in Africa I am known as Dr. Dohrn among ministers of health, physicians, and educators—and that opens doors. It takes a lot of time, work, support, coordination, hope. But people need you, so you do these things with a full heart. If you can be

Deanna Tolman ’11

“Nurse practitioners have lobbied for years for the freedom to practice independently,” says Deanna Tolman, an independent family nurse practitioner who founded Head2Toe HealthCare in Aurora, CO. “In fact, given the inadequacies of our health care system, we have an ethical responsibility to pursue this freedom.” Tolman attended Columbia Nursing because “the program was directed toward clinical expertise and independence, both of which are important to me.”

I earned my bachelor’s at age 37, worked in critical care for a while, then got my master’s at age 47. But I soon realized that the master’s degree was insufficient. I did not feel ready to take care of patients the way I wanted to. Then I heard about the DNP program. I emailed Columbia Nursing, asking if I would have to relocate and if I could get tuition assistance. In the end, I had to spend only 10 months in New York, and I worked as a teaching assistant to help defray costs. “When I finished the DNP, I was 56 years old. I knew I wanted to open my own practice, and the DNP gave me the credentials to make that happen. In fact, while I was at Columbia Nursing I wrote a 50-page business plan, which I implemented when I returned home to Colorado. That led to my founding the Head2Toe Clinic in Aurora, an open-access clinic. We have a four-person staff working in an inexpensive 800-square-foot office. We serve about 1,400 patients: 20 percent uninsured, 40 percent receiving Medicaid, and the rest privately insured.

“Traditionally, nurse practitioners have deferred to physicians for direction regarding patient care. And many expect to always work as employees of physicians, because that is how nurse practitioners are often accredited. It’s a matter of living up to the ethics to each other. I am serving my brothers and sisters—and you shouldn’t be determined by whether I can afford to spend appropriate time with patients or whether they have health insurance; that is immoral. Everyone should have health care and everyone should receive the best health care I can give them. The question is how to set up such a practice and keep it profitable. But we are proving it can be done. It’s not a matter of seeing more patients so as to make more money. It’s a matter of living up to the ethics of our profession and creating the best outcomes, the best service, built upon the privileges we’ve received.”

DNP, Columbia University School of Nursing, 2005

MS, Nurse Midwifery, Columbia University School of Nursing, 1985

BSN, Nursing, City University of New York/Hunter-Bellevue School of Nursing, 1983

BA, History, University of Chicago, 1967

COURTESY OF DEANNA TOLMAN

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What drew you to nursing as a career? “I knew I wanted to be a nurse going into my freshman year in college. What attracted me to nursing was its focus on compassionate care and the close relationships I could have with patients as a nurse. It was a perfect fit for my personality, my communication style, and my personal goals.”

Why did you choose Columbia University School of Nursing for your DNP? “Columbia Nursing was my ‘that’ll never happen’ application for graduate school. I had been east of Chicago only once! I had already been accepted to another school in the Midwest. But when I got the email accepting me to the program, I reevaluated everything to come to Columbia Nursing because of, among other things, the strength of its DNP program. I also liked the idea that higher education for nurses is embraced by the New York nurse clinician community.”

What challenges do you see for your career path? “One challenge is that there is no national license for nurse practitioners, to level the playing field for what we can and cannot do. There are still states where I can’t prescribe meds. In New York, as a nurse practitioner, I must have a collaborating agreement with a physician who reviews my work, whereas in other states I can be entirely independent in my practice.”

Laura Ardizzone ‘04 ‘10

Laura Ardizzone is chief nurse anesthetist at Memorial Sloan-Kettering Cancer Center, where she manages a team of about 60 nurse anesthetists working in more than 40 locations. She is also an elected member of the Board of Directors of the New York State Association of Nurse Anesthetists. Ardizzone was an assistant professor of clinical nursing at Columbia University School of Nursing from 2008 to 2012.

“My exposure to health care was fairly traditional. In high school, I volunteered as a candy stripe. I knew I wanted to work in the medical field, but as what? A nurse? Physical Therapist? Physician? In the end, I chose nursing because I saw it as the epitome of science and caring. It was a career I could grow with.”

“I had seen a lot of nurse anesthetists in action in college and afterwards as an RN. I remember a night early in my career when I was in charge, and we called a code on a patient. A nurse anesthetist showed up and he took care of things immediately. To me, he represented that place where nursing meets science meets autonomy.”

A Q&A: Philip Gyura ‘14

Philip Gyura recently completed his master’s degree in the Family Nurse Practitioner Program at Columbia Nursing and is now a first-year student in the DNP program. Gyura’s focus is on addiction medicine and adolescent sexual health. He anticipates earning his degree in summer 2015.

With this as a backdrop, the leadership of the American Academy of Nurse Practitioners turned to level the playing field for what we can and cannot do. There are still states where we can’t prescribe meds. In New York, as a nurse practitioner, I must have a collaborating agreement with a physician who reviews my work, whereas in other states I can be entirely independent in my practice.”

What’s your long-term plan after you earn the DNP? “I will probably return to the midwest to live near family. However, the state I settle in will be partly determined by laws governing our practice. Regardless of where I end up, the DNP will prepare me to serve a population of patients that is often ignored. If we can correct the habits people acquire in their teens and 20s, we can affect their health in their 50s. This is the legacy the DNP will help me create.”

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What drew you to nursing as a career? “I knew I wanted to be a nurse going into my freshman year in college. What attracted me to nursing was its focus on compassionate care and the close relationships I could have with patients as a nurse. It was a perfect fit for my personality, my communication style, and my personal goals.”

Why did you decide to pursue a DNP degree? “I am originally from Minnesota and worked at the Mayo Clinic for two years as an RN. I also worked a year in a detox center, where I was drawn to the needs of young adults. And I realized that I could better serve these people with a DNP degree.”

Why did you choose Columbia University School of Nursing for your DNP? “Columbia Nursing was my ‘that’ll never happen’ application for graduate school. I had been east of Chicago only once! I had already been accepted to another school in the Midwest. But when I got the email accepting me to the program, I reevaluated everything to come to Columbia Nursing because of, among other things, the strength of its DNP program. I also liked the idea that higher education for nurses is embraced by the New York nurse clinician community.”

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A Brief History of the Doctor of Nursing Practice Degree

In a sense, the origin of the DNP degree goes back to the beginnings of nursing itself since it’s a logical extension of nursing education’s focus on safe, effective patient-centered care. Its modern day roots, however, can be traced to a series of three milestone reports issued by the Institute of Medicine, culminating in 2003 with an examination of the education received by health care professionals. That report, “Health Professions Education: A Bridge to Quality,” recommended that to refocus the nation’s health care system on safe, effective patient-centered care, nurses increase their knowledge and skill to deliver enhanced clinical care across services and sites. With this as a backdrop, the leadership of the American Academy of Colleges of Nurses (AACN) convened a task force to explore a clinical practice doctorate in nursing. In 2004, the AACN called for an educational framework that would provide nurses with a doctorate-level of clinical care preparedness. In 2006, the AACN member institutions endorsed the Essentials of Doctoral Education for Advanced Practice Nursing Practice, which defined the curricular elements and competencies required in a practice doctorate in nursing. While momentum was building on a national level, Columbia University School of Nursing was ahead of the curve, under the leadership of Dean Mary Mundinger, DNP, FAAN, who had been working to develop a clinical doctorate. In June 2004, the Columbia University Trustees approved the new degree, DrNP, which raised nursing education to an unprecedented level by preparing advanced practice nurses with the knowledge, skills and attributes necessary for a fully accountable, independent comprehensive practice. Today, the DNP degree awarded by Columbia Nursing stands alone in providing graduates with the ability to deliver complex care, across practice sites and over the lifespan of the patient.
Walter Bockting, PhD, is one of the world's leading experts on transgender health

Walter Bockting, Explores Transgender Health on Its Own Terms  By Andrea Kott

In the early 1990s, near the beginning of his career as a clinical psychologist specializing in LGBT health and sexual identity development, Walter Bockting, PhD, spotted a trend that would ignite the research that has made him one of the world’s leading experts on transgender health.

It was ten years into the AIDS epidemic. Although the disease had initially affected men who had sex with men, Bockting was seeing increasing incidences among the transgender people in his clinical practice at the University of Minnesota. What he wasn’t seeing, however, was any recognition of this trend. The Minnesota health department was tracking transgender people with HIV, but the Centers for Disease Control and Prevention (CDC) was not; it was simply lumping them in with men who had sex with men, or with heterosexual women. And CDC surveillance data was driving prevention efforts. Bockting, who had worked with transgender individuals extensively as coordinator of the university’s transgender health services, sought HIV–prevention protocols tailored to their experiences and needs, but none existed. In fact, there was little public health research about transgender people at all.

Bockting dedicated the next 20 years to conducting this research, which he continues as professor of medical psychology at the Columbia University School of Nursing and the College of Physicians and Surgeons. He is also co–director of the LGBT Health Initiative, a collaboration involving the School of Nursing, the Division of Gender, Sexuality and Health at the New York State Psychiatric Institute, and the Columbia University Department of Psychiatry. The Initiative focuses on research, clinical care, education and policy regarding the health of LGBT people.

“By 1995, it was clear that to understand HIV in the transgender community, we had to look at transgender health more broadly,” he said.

What began as his inquiry into HIV–prevention needs and corresponding interventions for the transgender community has evolved into a vast body of scholarship. Bockting is internationally known for his expertise in the assessment and treatment of gender dysphoria—the incongruence a person may feel between their sex assigned at birth and their gender identity—and in the general mental health and psychosocial adjustment of transsexual, transgender, and gender-nonconforming individuals and their families. He received his doctoral degree in psychology from the Vrije Universiteit, Amsterdam, the Netherlands, and was a postdoctoral fellow, and went on to become a tenured professor at the University of Minnesota Medical School’s Program in Human Sexuality, in the Department of Family Medicine and Community Health.

In 2010–2011, he served on the Institute of Medicine (IOM) Committee of the National Academies, whose work culminated in the IOM report, The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. In his many scientific articles, textbook chapters, and books, Bockting has identified a constellation of issues—stigmatization, in particular—that once obscured transgender health, as well as the needs of gender-nonconforming women and men. “Stigma is the overriding theme affecting the health of transgender people,” he said. He learned early in his research that HIV was not among transgender people’s main health concerns. Rather, he said, “Transgender persons’ main concerns are affirming their gender identity and attaining the health care necessary to make the changes needed to transition to living comfortably in a gender role that is congruent with their gender birth.”

According to Bockting, transition is first and foremost a psychosocial process. Thus, helping transgender individuals make the physical and social changes needed to affirm their identity is elemental to improving their health and wellbeing, and ultimately, to also prevent HIV infection and transmission, he said. Achieving these goals requires confronting and dismantling social stigma: the negative feelings in society toward transgender individuals and once internalized, the negative feelings transgender individuals feel toward themselves.

This stigma and its accompanying stress are the main ingredients in vulnerability to illness—mental and physical—including HIV. “The stress associated with stigma, prejudice, and discrimination will increase rates of psychological distress in the transgender population,” Bockting wrote in a study that appeared last year in the American Journal of Public Health.
In that study, an online survey of 1,093 male-to-female and female-to-male transgender people, 44.1 percent ranked high on depression, 33.2 percent on anxiety, and 27.5 percent on somatization (physical symptoms that have a psychological cause). Family support, peer support, and identity pride were identified as protective factors that were “negatively associated with psychological distress.” In particular, support from other transgender people was shown to buffer the negative impact of stigma on mental health.

Of course, stigma is not unique to transgender individuals. All minorities—especially sexual and gender minorities—experience stigma. Indeed, among the LGBT community’s many goals is to eliminate all forms of sexuality and gender-based stigma and discrimination by conducting research, providing clinical care, and enhancing health care providers’ knowledge of, and sensitivity toward, the diverse needs of sexual and gender minorities, said the director, Anke A. Ehrhardt, PhD. “Progress in knowing about and giving care to these populations has been haphazard over the past 20 to 30 years,” said Ehrhardt, who is vice chair for faculty affairs and a professor of medical psychology in the Department of Psychiatry. “Our focus is not just on HIV but on improving the overall health care for transgender people, which has been largely missing from medical schools.”

Although the transgender community is currently allied with the larger LGBT community in the fight for human rights, historically it has been its most marginalized member, Bockting said. This marginalization explains, in part at least, why transgender people fell through the cracks during the early years of the AIDS epidemic. It also explains why so little is known about transgender health.

“Transgender people were late in the game when it came to HIV,” Bockting said. “Moreover, there’s a lot we don’t know about the health and wellbeing of the LGBT population more generally because so much of the focus has been on HIV for many years.”

The diversity of the transgender population makes the field of transgender health especially rich and complex, Bockting said. Transgender people experience a gender identity that differs from the one assigned at birth. How they express their identity on a job application or during a job interview, or socially in terms of appearance, personality, behaviors, or relationships varies widely. “There is a broad spectrum of gender and sexual diversity,” he said.

For example, some people may be assigned male at birth, discover their identity is more female, and begin to live as women. They may take hormones, with or without undergoing surgery. Others may be assigned female at birth, discover a male gender identity, and live as men. Transgender individuals may be attracted to men, women, or both; they may be attracted to other transgender people. Many identify as straight. “Gender identity goes deeper than being a boy or a girl, a man or a woman,” Bockting said. “Some transgender people can’t be described as being male or female. They would describe themselves as being a little bit of both or belonging to a third gender altogether.”

What is known about the health of transgender individuals is its association with pervasive social stigma, which commonly traps transgender people in what Bockting calls a “cycle of marginalization.” This cycle may begin with social or professional discrimination and spark an accumulation of unemployment, poverty, homelessness, violence, and depression or substance abuse, which undermine health.

“Think of a young transgender man who has just come out to his family,” Bockting said. “His family is struggling to accept his being transgender. At the same time, he’s being bullied in school. All of this makes him vulnerable to dropping out of school, leaving home, and being at risk for homelessness.” The young man may turn to alcohol or drugs. To affirm his identity as a gay trans man, he may have unprotected sex with multiple partners or engage in other high-risk behaviors. “When you have a difficult relationship with your family, or you don’t know how to address your identity on a job application or during a job interview, you can find yourself without much support,” Bockting said. “And if you are homeless, you may have to do things you ordinarily wouldn’t to afford food, water, or shelter.”

Compared with lesbians, gay men, and bisexual and heterosexual men and women, transgender people have higher rates of depression, anxiety, and suicidal ideation, Bockting has found. Among the transgender women and men he surveyed, 71 percent had experienced verbal harassment, 38 percent had had difficulty finding a job, 23 percent had spent a night with them. Few problems obtaining health services, 24 percent had experienced physical abuse, and 12 percent had been denied housing. “It is the social determinants of health that make them most vulnerable,” he said.

Across 29 studies focusing on transgender people’s vulnerability to HIV, risk behaviors included unprotected receptive anal sex (44 percent), sex while drunk or high (29 percent), and needle sharing during hormone or silicone use (6 percent). Mental health issues (54 percent suicidal ideation, 31 percent suicide attempts), illicit hormone use (34 percent), and homelessness (13 percent) increased their vulnerability to HIV. Other studies have found that transgender women of color who had dropped out of school, were unemployed, or had been sexually assaulted were also more likely to be HIV positive. In additional but unrelated research, HIV–positive transgender women were less likely than other groups to be engaged in HIV care.

According to Bockting, transgender women experience more job discrimination than non-transgender women and are therefore more likely to turn to prostitution. As a result, they may engage in substance use, impairing their ability to make sound judgments, let alone negotiate condom use. In addition, feminizing hormones can cause mood swings or sexual functioning difficulties when improperly used, impeding judgment. “Mood swings can make you more vulnerable to high-risk behaviors,” Bockting said.

As pernicious as external stigma is the internal stigma that plagues many transgender people. Bockting describes this as felt stigma, the perception or anticipation of rejection on the part of another person. “Felt stigma,” he said, is the “negative consequences of stigma, but it can result in a preoccupation with hiding, which itself can become a significant source of stress,” he wrote in the American Journal of Public Health.

Felt stigma also may prevent transgender people from seeking health care, Bockting said. The fear of being identified—or simply regarded—as a gay or transgender person can lead to HIV. “Think of a young transgender man who has just come out to his family,” Bockting said. “His family is struggling to accept his being transgender. At the same time, he’s being bullied in school. All of this makes him vulnerable to dropping out of school, leaving home, and being at risk for homelessness.” The young man may turn to alcohol or drugs. To affirm his identity as a gay trans man, he may have unprotected sex with multiple partners or engage in other high-risk behaviors. “When you have a difficult relationship with your family, or you don’t know how to address your identity on a job application or during a job interview, you can find yourself without much support,” Bockting said. “And if you are homeless, you may have to do things you ordinarily wouldn’t to afford food, water, or shelter.”

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Reducing stigma, therefore, especially in health care settings, is paramount to improving transgender health and is an important focus of the LGBT Health Initiative that Bockting co-directs. This requires clinical as well as cultural competence. Clinical competence includes helping people work through feelings of gender dysphoria, (discomfort with sex characteristics and/or gender role), supporting them as they make a social and/or medical transition, and helping them to access hormone therapy or surgery, and adjust to living life as a transgender person. It also entails recognizing, as Bockting said, that “hormone therapy and surgery are just two interventions within a much broader process of coming out,” underscoring the importance of facilitating family and peer support.

Cultural competence, he said, “is about how we interact with patients. Affirming transgender people’s gender identity and validating and supporting their social transitions are essential. Providers should call transgender patients by their preferred name or the appropriate corresponding pronoun, rather than by the name given to them at birth, Bockting said. “People’s identities must be accommodated in their electronic health record.” When providers ask about gender, they should pose two questions: What is your current gender identity? (male, female, transgender, genderqueer, other), and what sex were you assigned at birth (male or female)? “Both questions are important,” Bockting said. Asking transgender patients who they are attracted to should also be included in a regular assessment, he added. Moreover, providers should be fully informed of a patient’s history of hormone therapy and its health implications. These are among the key lessons included in the course materials that Bockting has developed as part of his work with the LGBT Health Initiative. While asking patients about their gender identity or sexuality, providers need to keep in mind that this information will help them improve the care they give, said Ragnhildur Ingibjargardottir Bjarnadottir, BSN, MPH, a PhD student at Columbia Nursing who is working with Bockting on a study about the barriers and opportunities nurses encounter in assessing LGBT and transgender patients within the Visiting Nurse Service of New York. “In the context of a home health assessment, we may not be able to get the whole picture of what this population looks like, but we can try to identify the challenges that many share, so we can improve our services,” Bjarnadottir said.

Said Bockting, “When people have better access to health care and are better accommodated in terms of their gender and sexual orientation, when their identity is affirmed, they’re going to have better self-esteem and take better care of themselves.” And when people take better care of themselves, they are in a better position to benefit from early interventions to prevent a cycle of cumulative disadvantage and marginalization.

At the same time, providers must be aware of the sex assigned to a person at birth. First, Bockting said, “transgender women keep their prostate even after genital surgery, so if it’s a primary care clinic, providers must not forget to do a prostate exam.” Second, “most transgender men still have a uterus and ovaries and may need gynecological care.” Third, people’s genetic blueprint informs the trajectory of their health. Even though a transgender woman may identify as female, her body and brain are still chromosomally male. “She is not like most other woman; she is a transgender woman. A transgender woman has a history of being male,” Bockting said, and in addition she has a unique experience that differs from the experience of nontransgender women and men. It’s about improving our understanding of transgender people’s unique experiences and transgender the idea that there are more than two genders into practice.”

Of course, there is a conundrum: How do providers assess the health status and make prognoses without knowing what is typical for a transgender person? Do they compare transgender patients with male or female norms? “We need to advance our knowledge in this area,” Bockting said. “We may need to compare transgender women with other transgender women, and transgender men with other transgender men. ‘We need to learn more about what is normative for them and take this into account so we can serve them better.’” Likewise, the creation of public policy in this and many other issues, needs to be addressed by expanding the evidence base, a significant goal of the LGBT Health Initiative.

Bockting said more research is needed on the health of transgender people and on the psychosocial factors that make them vulnerable to certain risk behaviors, health behaviors, and health concerns, including but not limited to HIV.

The LGBT Health Initiative is about to launch such research: a longitudinal study of transgender women and men age 16 and older who are at various stages of coming out and transitioning and who are at risk for HIV and other health concerns. The study will aim to provide a better understanding of identity development among transgender people, while examining their vulnerability and to resilience across their lifespan. Bockting said, “When you look at vulnerability in a developmental context, you can actually understand how the health inequities and challenges people face come about. They just all don’t happen at the same time. They are related to what people are going through as they seek to affirm their gender identity and live their lives as women, men, and persons of transgender experience.”

Ultimately, Bockting and his co-investigators hope to determine what resources and policies are associated with transgender people’s resilience, so as to develop interventions to help them overcome the challenges they face during coming out and throughout their lives. “The goal is to place these challenges on a developmental timeline and identify where we can intervene early and what kind of strengths help people make it through challenging times,” he said.

The study will provide important insights into transgender people’s experiences and needs, their ability to cope with stigma, and ways that providers can serve them better. “To make progress with HIV in the transgender population, we need to understand other health issues that often are of higher priority for transgender people themselves,” Bockting said. “It will not only be another step toward ending the AIDS epidemic; it will be good for promoting transgender people’s overall health.”
To Stop Hospital Infections, Start at the Top

By J. Duncan Moore, Jr.

Patricia Stone, PhD, RN, FAAN, could get an idea of a hospital’s infection rate just by seeing who took the time to meet with her at the dozens of hospitals she visited as part of her research on the effectiveness of U.S. infection control. While she spoke with prevention specialists, physicians, and bedside nurses—“most everybody involved” in a hospital’s effort to reduce infection rates—it was the hospital executives who provided the first, and often most telling, sign.

“Although our interview with the top administrator wasn’t available and the physician we were interviewing—the ICU physician—arrived late and sorted through his emails as we spoke. Ten minutes later, he was gone.”

“We knew their infection rates in advance,” she concludes slyly. “Which one do you think had the lower rate?”

If U.S. hospitals are truly to move the needle on infection control, top leadership has to recognize the problem, show commitment and perseverance, and devote all the resources necessary to implement and enforce evidence-based prevention strategies, Stone says. And all of the clinicians on the front lines have to work together as a team that puts patient safety first.

The impetus for sustained, effective infection control “has to come from the top,” says Stone, who is the director of the Center for Health Policy at Columbia University Medical Center; Andrew Dick, an economist at RAND Corporation; and Lindsey M. Weiner, a statistician with the Centers for Disease Control and Prevention.

The report provides a national snapshot of infection prevention and control programs in intensive care units (ICUs), as well as a review of how well clinicians are complying with the implementation of evidence-based processes to prevent health care-associated infections (HAIs). The project, known as the Prevention of Nosocomial Infections and Cost Effectiveness Refined (P-NICER) study, was funded by the National Institute of Nursing Research, the National Institutes of Health, and supported by the Centers for Disease Control and Prevention.

Stone’s team reviewed compliance policies at 1,653 ICUs at 975 hospitals nationwide. It focused on three of the most common preventable infections: central-line associated bloodstream infection (CLABSI), catheter-associated urinary tract infection (CAUTI), and ventilator-associated pneumonia (VAP). The study found that, despite decades of research establishing best practices for prevention of these infections, approximately one in 10 hospitals lack checklists to prevent CLABSI, and one in four lack checklists to prevent VAP. Even worse, the checklists are followed only about half of the time, the study found.

“Establishing infection-control policies in the hospital is insufficient,” Stone says. “There needs to be a focus on the clinicians at the bedside, to make sure they are doing the right thing every time.”

Most hospitals take what’s known as a bundle approach to infection control, a strategy that deploys checklists of evidence-based practices to follow at the bedside along with protocols for monitoring compliance.

Catheters, for example, can transmit deadly infections to the bloodstream or urinary tract if clinicians don’t follow proper insertion, utilization, and maintenance policies. ICU patients can be protected against CLABSI through simple infection-prevention measures such as hand washing before handling the catheter and immediately changing the dressing around the central line if it gets wet or dirty.

Guidelines to prevent CAUTI are more recent, and there are no universally accepted checklists to follow at the bedside. About one third of hospitals had no prevention policies in place to prevent these infections. Even at hospitals that had established guidelines, they were followed less than 30 percent of the time, the study found.

To avoid VAP, precautions on bedside checklists typically include raising the head of the bed 30 to 45 degrees, providing a daily sedation vacation to assess the patient’s readiness for unassisted breathing, and providing medication to prevent stomach ulcers and mouth sores.

Even though most hospitals have adopted at least some checklists, “it’s very difficult for everyone to do the right thing the right way every single time,” said co-author Furuya, an epidemiologist at NewYork-Presbyterian Hospital.

“Patients in the ICU are very sick and very complex. There are so many competing priorities. You’re trying to prevent bloodstream infection; you’re trying to prevent them from falling out of bed or getting a pressure ulcer; and you’re trying to prevent a catheter urinary tract infection—all at the same time.”

Nurse staffing levels can pose another hurdle to infection control. If one nurse is assigned to care for several ICU patients at once, “then it becomes almost impossible to pay attention to everything,” says Furuya. Given the complexity of ICU care, in many cases hospitals try to assign just one patient to each nurse. This has become a more common ICU staffing goal, as patients arrive at the hospital older, sicker, and often with multifaceted medical issues involving the control of infection, such as organ transplantation.
Reducing HAIs has been elevated to one of the CDC's 10 “winnable battles,” along with improving food safety, preventing teen pregnancy, and eradicating HIV. These are “public health priorities with large-scale impact on health, and with known, effective strategies to address them,” the CDC says on its website. At any given time, about 1 in every 20 inpatients has an infection related to hospital care. HAIs kill an estimated 100,000 Americans a year and create approximately $33 billion in excess medical costs, according to the CDC.

For NewYork-Presbyterian Hospital, preventing HAIs involves everyone who comes in contact with a patient, including nurses, physicians, and visitors, says Wilhelmina Manzano, MA, RN, senior vice president and chief nursing officer at NewYork-Presbyterian and assistant dean for clinical affairs at Columbia Nursing. “It begins with the question, ‘do we have the right training for all the individuals?’ Manzano says. “And not just for our health care professionals, but anybody who interacts with patients. It’s a massive undertaking to make sure everybody who needs to have the right information has it.”

Patient education and empowerment are also essential, she says. “If I am a patient in the hospital bed, I should be comfortable asking, ‘Did you wash your hands?’ The most basic thing we can do to prevent infection is hand washing. With everything we do to provide the best care possible at the bedside, it’s imperative that we remember to do the simple things, like washing hands.”

To ensure that every clinician on the health care team remains vigilant, the hospital has various interdisciplinary initiatives led by senior executives, focused on improving communication and patient safety. Additionally, staff are educated during orientation and on annual updates, and everyone is held accountable for their practice and patient outcomes. These interventions have pushed hospital-wide adherence to hand washing to 98 percent, Manzano says. The hospital’s standardized infection ratio for CLABSI in the ICU is 0.58—“the lowest we’ve ever seen, and we exceeded our goal.” Daily bathing of patients with antibacterial soap and a focus on proper maintenance of central lines proved effective in pushing those infection rates down, she says.

For many years, hospitals had little incentive to reduce their infection rates. If a patient got an HAI, the hospital could bill Medicare or the private insurers. “Hospitals weren’t held accountable for their practice and patient outcomes,” Gould says. “They had incentives to make sure patients get better, but incentive to safeguard a hospital’s reputation. This, combined with the impending financial penalty from CMS for poor showing, forces executives to become more aware of all that is at stake, Stone says, improving the likelihood that “they can really lead and give people the resources they need.” The importance of HAIs needs to be visible all the way to the board level, she adds.

The hospital board level is where the corrective action really needs to take root, said James L. Reineitsen, MD, a consultant and former senior fellow at the Institute for Healthcare Improvement. Board members are responsible for everything in the organization—especially what goes wrong clinically,” he said in an interview in the Joint Commission Journal on Quality and Patient Safety. “They are responsible for everything in the organization—especially what goes wrong clinically,” he said in an interview in the Joint Commission Journal on Quality and Patient Safety.

Stone’s study is the most significant follow-up to the CDC’s seminal Study on the Effectiveness of Nosocomial Infection Control (SENIC), undertaken in the 1970s, which established that hospitals with well-organized infection control programs had lower HAI rates. That, and subsequent research, set basic expectations and requirements for effective infection-control measures in hospitals. The goal of the present study was to assess the current state of affairs.

One of the study’s most surprising findings is that hospitals are employing a higher ratio of infection-prevention specialists per patient bed than those in the recommendations established just a decade ago. “It’s risen to the top,” says Stone. “We need to continue to invest in that.”

Infection-control departments can range from one person at a small hospital to a large group at a major medical center. At NewYork-Presbyterian Hospital, there are seven physicians, including Furuya, plus 13 infection preventionists, most of whom are nurses, as well as a group of managers and data analysts.

“We do everything we can to make sure patients and health care workers and anyone else in the hospital minimize their risk of developing an infection,” Furuya says.

While those focused on infection control certainly help lower HAIs, these individuals often spend too much of their time on surveillance and documentation for quality reporting, instead of working with front-line staff at the patient bedside, where they could add more value.

Furuya thinks part of the solution is more resources for data management. “If you have somebody whose job it is to collect data or put reports together, that is time the infection preventionist can spend out on the floor.” It also helps if hospitals invest in information systems for infection control. Such systems offer “a way of extracting data, getting rid of the statistical noise, separating out what you need to look at,” thus saving manual labor.

The most important thing to keep in mind, Stone says, is that infection prevention obligates everyone in the hospital to work as an interdisciplinary team. “They have to work together, have the right policies in place, and ensure that everybody is adhering to them.” It’s a culture of collaboration that we need.”

Collecting and sharing data is critical to the enterprise of infection prevention. Medical literature demonstrates time and again that it’s not sufficient to lecture people on doing the right thing. You have to show them their data. “When you tell surgeons what their surgical infection rate is, they get better,” Furuya said. “It’s a powerful motivator for change.”

This public display of a hospital’s HAI rates also works as an effective incentive to safeguard a hospital’s reputation. This, combined with the impending financial penalty from CMS for poor showing, forces executives to become more aware of all that is at stake, Stone says, improving the likelihood that “they can really lead and give people the resources they need.” The importance of HAIs needs to be visible all the way to the board level, she adds.

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Selected Faculty Publications 2013 - 2014

Mary Byrne, PhD, Stone Foundation and Elise D. Fish professor of Health Care for the Underserved in Nursing, was an author of "Using Guided Imagery to Manage Pain in Young Children with Sickle Cell Disease," published in the American Journal of Nursing (in press).

Karen Desjardins, DNP, MPH, assistant dean of academic affairs, was the lead author of "Empowering Women: Teaching Ethiopian Girls to Make Reusable Sanitary Pads," in the Clinical Scholars Review. Mary Moran, FNP, MPH, RN, clinical instructor, was also an author.

Jennifer Dohrn, DNP, CNM, director, Office of Global Initiatives, authored "Building Nurse and Midwifery Capacity in Malawi: A Partnership between the Government of Malawi and the PEPFAR/Nursing Education Partnership Initiative (NEPI)," a chapter in Transforming the Global Health Workforce.


Laurie Conway, MPhil, CIC, PhD candidate, was the lead author of "Tensions Inherent in the Evolving Role of the Infection Preventionist," published in the American Journal of Infection Control (AJIC). Other authors on the article included Monika Pogorzelska-Maziarz PhD, MPH, associate research scientist; May Uchida RN, MPhil, PhD candidate; Patricia Stone, PhD, RN, FAAN, Centennial Professor in Health Policy; and Elaine Larson, PhD, RN, FAAN, CIC, associate dean for research.

William Enlow, DNP, ANCP, CRNA, assistant professor, was the lead author of "Strategic Planning for Curricular Excellence, Anesthesia and Comprehensive Care," published in AANA Journal. Other authors of the paper include Judy Honig, DNP, EdD, CPNP, associate dean for student affairs, and Sarah Sheets Cook, DNP, RN, professor emerita.

Judy Honig, DNP, EdD, CPNP, associate dean for student affairs, was the lead author of "Building Framework for Nursing Scholarship: Guidelines for Appointment and Promotion," published in The Journal of Professional Nursing.


in Nursing. In addition, she was an author of "The Use of Non-Physician Providers in Adult Intensive Care Units," published in *The American Journal of Respiratory and Critical Care Medicine*, and a chapter "Nurse Practitioners in Trauma Care," in *The Encyclopedia of Trauma Care*. 

Joan Kearney, PhD, CS, APRN, assistant professor, was a lead author of "Understanding Parental Behavior in Pediatric Palliative Care: Attachment Theory as a Paradigm," in *Palliative and Supportive Care*. Mary Byrne, PhD, Stone Foundation and Elise D. Fish professor of Health Care for the Underserved in Nursing, was an author.

Kristine Kulage, MA, MPH, director, Office of Scholarship and Research Development, was the lead author of "How Will DSM-5 Affect Autism Diagnosis? A Systematic Literature Review and Meta-analysis," published in *The Journal of Autism and Developmental Disorders*. Co-authors of the paper include Arlene Smaldone, PhD, RN, associate professor and Elizabeth Cohn, PhD, RN, assistant professor.

Jeffrey Kwong, DNP, MPH, ANP-BC, program director, Adult-Gerontology Nurse Practitioner Program, was the lead author of "Leadership Skillset for the Advanced Practitioner Organizational Climate in Primary Care Settings: Implications for Professional Practice," published in *The Journal of Professional Nursing* (other authors included Patricia Stone, PhD, RN, FAAN, Centennial Professor of Health Policy in Nursing and Arlene Smaldone, PhD, assistant dean, Scholarship and Research); and "Revisiting Scope of Practice Facilitators and Barriers for Primary Care Nurse Practitioners," published in *Policy, Politics and Nursing Practice*.


Nancy Reame, PhD, RN, FAAN, Mary Dickey Lindsay Professor of Disease Prevention and Health Promotion in the Faculty of Nursing, was an author of "Differential Contributions of Polycystic Ovary Syndrome (PCOS) Manifestations to Psychological Symptoms," published in *Journal of Behavioral Health Services & Research*. 

Rebecca Schnall, PhD, assistant professor, was the lead author of "Feasibility Testing of a Web-based Symptom Self-Management System for Persons Living With HIV," published in *The Journal of the Association of Nurses in AIDS Care*. Other authors on this paper include Monika Pogorzelska-Mazairz, PhD, MPH, associate research scientist; Carolyn Herzig, MS, project director; and Elaine Larson, PhD, RN, FAAN, associate dean for research. She was also an author of "Night and Day in the VA: Associations Between Night Shift Staffing, Nurse Workforce Characteristics, and Length of Stay," published in *Research in Nursing & Health*. 

Arlene Smaldone, PhD, assistant dean, Scholarship and Research, was an author of "The Use of Vitamin K Supplementation to Achieve INR Stability: A Systematic Review and Meta-Analysis," published in *The Journal of the American Academy of Nurse Practitioners* and Using Information Technology and Social Networking Strategies for Difficult to Recruit Pediatric Research Populations," published in *Journal of Medical Internet Research*. Nancy Reame, PhD, RN, FAAN, Mary Dickey Lindsay Professor of Disease Prevention and Health Promotion in the Faculty of Nursing was also an author.

Caroline Sullivan, DNP, assistant professor, and Janice Smolowitz, DNP, EdD, senior associate dean, authored "Patient Notification of Test Results in a Primary Care Setting," published in *Clinical Scholars Review*.


Mary Byrne, PhD, Stone Foundation and Elise D. Fish professor of Health Care for the Underserved in Nursing, was an author of "Understanding Parental Behavior in Pediatric Palliative Care: Attachment Theory as a Paradigm," in *Palliative and Supportive Care*. Mary Byrne, PhD, Stone Foundation and Elise D. Fish professor of Health Care for the Underserved in Nursing, was an author.

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Jeffrey Kwong, DNP, MPH, ANP-BC, program director, Adult-Gerontology Nurse Practitioner Program, was the lead author of "Leadership Skillset for the Advanced Practitioner Organizational Climate in Primary Care Settings: Implications for Professional Practice," published in *The Journal of Professional Nursing* (other authors included Patricia Stone, PhD, RN, FAAN, Centennial Professor of Health Policy in Nursing and Arlene Smaldone, PhD, assistant dean, Scholarship and Research); and "Revisiting Scope of Practice Facilitators and Barriers for Primary Care Nurse Practitioners," published in *Policy, Politics and Nursing Practice*.


Nancy Reame, PhD, RN, FAAN, Mary Dickey Lindsay Professor of Disease Prevention and Health Promotion in the Faculty of Nursing, was an author of "Differential Contributions of Polycystic Ovary Syndrome (PCOS) Manifestations to Psychological Symptoms," published in *Journal of Behavioral Health Services & Research*. 

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Arlene Smaldone, PhD, assistant dean, Scholarship and Research, was an author of "The Use of Vitamin K Supplementation to Achieve INR Stability: A Systematic Review and Meta-Analysis," published in *The Journal of the American Academy of Nurse Practitioners* and Using Information Technology and Social Networking Strategies for Difficult to Recruit Pediatric Research Populations," published in *Journal of Medical Internet Research*. Nancy Reame, PhD, RN, FAAN, Mary Dickey Lindsay Professor of Disease Prevention and Health Promotion in the Faculty of Nursing was also an author.

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“Change in Health Department Organizational Networks After an Evidence-Based Performance Improvement Intervention,” Parks C., Byon H., Keeling J., Betsch L., Merrill J.


Laura Arzidzone, DNP ’10 ANES ’04 was appointed as a member of the National Quality Forum’s Patient Safety Steering Committee.

Penelope R. Buschman, MS, RN, PMHCNS-BC, FAAN, director, Psychiatric Nurse Practitioner Program, presented “Predictors of Retention for Behavioral Health Nurses” at the American Academy of Nursing. In addition, she received the Dorothy H. and Thomas L. O’Neill Distinguished Faculty Award.

Mary Byrne, PhD, Stone Foundation and Else D. Fish professor of Health Care for the Underserved in Nursing was invited as an international expert on co-residence programs for criminal justice involved mothers and their babies at the University of British Columbia, Vancouver. She also presented an administrator/staff workshop at the National Offender Management Services, in London, UK.

Rozelle Corden, FNP, assistant professor, presented “Evidence Based Management Strategies to Reduce Surgical Site Infections in Neonates Undergoing Cardiac Surgery,” at the Congenital Heart Disease-Clinical Care and Translational Research meeting in Shanghai, China.

Karen Desjardins, DNP, MPH, assistant dean of academic affairs, presented “Incivility in Nursing Education,” a Columbia Nursing Anna C. Maxwell teaching seminar and “Interprofessional Education for the Practice-Focused Doctorate” at the American Association of Colleges of Nursing (AACN) Doctoral Education Conference, in Naples, FL.

Will Enlow, DNP, ACNP, director, Continuing Nursing Education, assistant director Nurse Anesthesia Program, presented a workshop on careers in nursing to high school and college students at the Borough of Manhattan Community College. He also presented “Evaluating Clinical Performance,” at the American Association of Nurse Anesthetists Assembly of School Faculty in San Diego, CA.

Rita Marie John, DNP, EdD, director, Pediatric Primary Care Nurse Practitioner Program, presented the: “What’s New in Pediatrics” plenary and “ENT Assessment for School Nurses,” breakout session at the 30th Anniversary North Carolina School Nurse Conference. In addition, she presented “Pediatric Mental Health Specialist Certification Review,” and “Pedials for the New PNP,” at The National Association of Pediatric Nurse Practitioners (NAPNP) annual conference in Boston, MA.


Judy Honig, DNP, EdD, FNP, associate dean of student affairs, was installed as the Dorothy M. Rogers Chair.

Marlene McGugh, DNP, OCC, FNP-BC, ACHPN, presented “ER and Outpatient Management of Patients with Chronic and Advanced Illness in an Underserved Community, NP/MD Model of Care,” at Innovative Models of Transitional Care: Bridging the Gap from Theory to Practice, a joint conference sponsored by Columbia Nursing and Visiting Nurse Service of New York; and “Preparation and Care for the Time of Death,” at NewYork-Presbyterian Hospital for Palliative Care Physicians Fellows.

Nancy Reame, PhD, RN, FAAN, Mary Dickey Lindsay Professor of Disease Prevention and Health Promotion in the Faculty of Nursing presented “Musculoskeletal Pain in Premenopause: A Qualitative Study,” at the 25th Annual Meeting of the North American Menopause Society.

Jeanne Rubsam Kane, APRN, PN-P-C, assistant professor, was elected as Vice President of the New York State American Trauma Society for the 2014-2016 term.

Rebecca Schnall, PhD, assistant professor, was selected as an Alliance for Nursing Informatics (ANI) Emerging Leader and presented a Webinar, “Adolescents’ Use and Perceived Usefulness of Mobile Technology for Meeting their Health Information Needs and Improving Adherence to Improved Health Behaviors,” for the Office of Behavioral and Social Sciences Research at the National Institutes of Health (NIH).

Jan Smolowitz, DNP, EdD, senior associate dean, clinical practice, presented “ABCC Certification: What It Is and What It Isn’t” at the American Association of Nurse Anesthetists Assembly of School Faculty in San Diego, CA.

Mary Tresgallo, DNP, MPH, presented “The Ethical Considerations of Left Ventricular Assist Device (LVAD) as Destination Therapy in a Child Diagnosed with Dilated Cardiomyopathy (DCM) and Duchenne’s Muscular Dystrophy (DMD)” at the Society of Pediatric Anesthesiology Meeting in Las Vegas, NV. She also participated as one of 11 faculty members in a Biosciences mediation training sponsored by Morgan Stanley Children’s Hospital.
Alumni Association 2013-2014

Alumni Association members are all Columbia University and Presbyterian Hospital School of Nursing graduates. The Alumni Association works with the Office of Development and Alumni Relations to develop programs designed to connect alumni with the School and with each other. Within the Alumni Association, alumni participate by class and program.

All Alumni Association initiatives are designed to promote the strengthening and renewal of alumni friendships and partnerships that enhance the School, including encouraging support of the Annual Fund.

President
Martha Cohn Romney ’81
President (2012-2015)

Vice President, Annual Fund
Beth Zedeck ’04 ’06 (2011-2014)

Nominating Chair
Sarah C. James ’97 (2013-2016)

Secretary
Maria Magliacano ’06 (2011-2014)

Directors
Ellen Soley Adkins ’81 (2013-2016)
Laura Pearson Armstrong ’85 (2011-2014)
Monica Buff Burrell ’09 ’12 (2013-2016)
Sharron Close ’01 ’03 ’11 (2011-2014)
Patricia C. Dykes ’04 (2012-2015)
Ellen Gottesman Garber ’76 (2012-2015)
Michelle Kolb ’05 ’09 (2012-2015)
Marguerite “Peggy” Lorey Peoples ’57 (2012-2015)
Rosalie Perez ’04 ’07 (2011-2014)
Julie Schnur ’03 ’05 (2010-2013)
Catherine Tanksley ’98 (2011-2014)
Glenn Wurtzel ’00 ’02 (2011-2014)

Dean
Bobbie Berkowitz, PhD, RN, FAAN

Associate Dean for Development & Alumni Relations
Reva Feinstein

From the President

Martha “Marty” Cohn Romney ’81
RN, MS, JD, MPH
Alumni Association President

It is a pleasure to write this letter on the eve of my second year as president of the Columbia University School of Nursing Alumni Association.

I am honored to continue serving in this role and eagerly anticipate welcoming alumni back to campus in early May at Alumni Reunion. I also look forward to the opportunity to speak to the Columbia Nursing Class of 2014 later in the month and congratulate hundreds of graduates on their new alumni status.

The Alumni Association was involved with a wide range of events during the past year: The sixth annual Welcome Breakfast hosted by the Alumni Association for new students at the Faculty Club was well attended. A new “Real Talk” series launched which featured recent graduates speaking to current students candidly about life after Columbia Nursing. The Alumni Admissions Ambassador program also began this spring. Newly admitted Entry to Practice students received a message from me inviting them to connect with an alumnus/volunteer to answer questions during the critical window when applicants decide which nursing school to attend. And Suhanna De Leon-Sanchez ’06 ’09, a recent grad, extended a welcome message on Visiting Day for accepted students on behalf of all Columbia Nursing alumni.

The Alumni Association also sponsored three receptions during the 2013-2014 school year: A joint reception with the United Nations Population Fund; a celebration for Judy Honig, DNP, associate dean for student affairs, in honor of her installation in the Dorothy M. Rogers Chair; and a health care panel discussion and reception organized with the school’s Center for Health Policy.

Our partnership with the Columbia Alumni Association (CAA) continues to grow. Columbia Nursing alumni participation and input were solicited and incorporated into the CAA’s five year strategic plan. The plan’s objectives include increasing and enhancing communication and opportunities for Columbia schools; collaboration between regional clubs, global centers, affinity groups and alumni; and more engagement between Columbia University schools and the global alumni community. This partnership helps afford us opportunities to engage with Columbia Nursing alumni as well as interact in meaningful ways with graduates of other schools.

For example, Columbia Nursing had a fruitful collaboration last fall with all the other CUMC schools on Giving Day when the school organized a lively panel discussion on the Affordable Care Act in tandem with the CAA. Columbia Nursing continues to partner with the CAA on other University-wide events. Michelle Kolb ’06 ’09 received the Richard E. Witten Award for Volunteer Leadership at The Trustees’ Luncheon at last fall’s Alumni Leaders Weekend. Later that night, Roxana Sasse ’92 ’11 was one of nine University honorees at the CAA’s Alumni Medalist Gala.

I look forward to reconnecting and meeting with alumni across the generations at Reunion this spring, and at future events in the year ahead.

Warm regards,

Martha Romney
2013-2014
CLASS AND PROGRAM NOTES

1940s

Jean Lagakis Benner ’42 sends her regards from Port Royal, South Carolina.

Elizabeth Schoonmaker Booth ’42 has hung up her riding boots, but is still traveling. As a former Navy nurse, she was given the opportunity this year to take an Honor Flight to Washington, D.C.

Annette Fitch Donovan ’42 is active in several groups including a poetry club. She enjoys knitting and is proud of her four great grandchildren.

Barbara Tanis Fetzer ’42 is doing well and living in Stamford, Connecticut with her husband.

Martha Pearson Freeman ’42 is enthusiastic as ever and still driving her car.

Doris Sawyer Jimison ’42 is very active and still driving. She spends her time playing bridge and enjoying her family.

Irene Holtan Schmidgall ’42 is well and keeps busy by participating in her community and visiting her family.

Marion Howald Swarthout ’42 has been keeping busy spending time with family and enjoys staying in touch with fellow classmates.

Frances Smith Caulo ’44 has been happily living at a retirement community in Hingham, MA since 2005. Her two daughters, Susan Caulo Purcell ’72 and Nina Caulo Feirman ’76, are also graduates of Columbia Nursing.

Virginia Stanforth Stuart ’44 is residing happily in a retirement community at age 92 and enjoys spending time with her three children.

June Travers Werner ’45 worked with Dean Grace of Illinois College of Nursing to fold the diploma program.

Anita Siegel Epstein ’46 retired from the American Cancer Society in 1991 and volunteers at several community organizations while living comfortably in a senior retirement community.

Elizabeth Raimet Bechtel ’49 worked in public health nursing and taught in nursing schools for a number of years after graduation. In 1961, she moved to Valdosta, Georgia and taught in the Biology Department at Valdosta State College, which is now Valdosta State University. In 1972, Elizabeth was the first woman elected to Valdosta City Council and served 10 years, two as mayor pro-tem. Elizabeth is now retired and is a very active volunteer in her community.

June Abercrombie Hutchison ’49 worked as head nurse in the operating room at Presbyterian Hospital, supervising head, neck and maxillo-facial surgery. She married Tom Hutchison in 1954. She taught emergency preparedness classes for Suffolk County, New York Civil Defense, the practical nurse program in the Loudon County and Virginia public school system. She was active in Girl Scouts for over six decades and sings in the Loudun Chorale.

1950s

Eva Wohlauer Rolnik ’50 writes from Hilton Head, South Carolina where she is enjoying retirement with her husband Morton.

Rachel Content Fields ’51 celebrated her 60th wedding anniversary with her husband and family in February.

Marilyn Johnsen Hamel ’51 is doing well and enjoys keeping in touch with her fellow alumni.

Alice Daly Thomas ’51 is well and celebrated her 60th anniversary with her husband last year.

Barbara De Vecchi Klauber ’53 fondly recalls working in the OR from her graduation in 1953 until 1960. She is well and lives in Naples, Florida.

Marilyn Miller Stiefvater ’54 received the Realtor Emeritus award from the National Association of Realtors in recognition of her 40 plus years of service and still works as a realtor. Marilyn and her son were selected by the Rotary Club of the Pelhams as honorary chairs and sponsors of the “Tastings for Gift of Life,” a life-saving, pediatric cardiology surgery program.

Barbara Scrivens Amatruda ’57 lost her husband in 2010. She is doing well and is becoming more mobile with the help of her Old English sheepdog.

Marilyn Miller Stiefvater ’54 received Realtor Emeritus award
last three years, she has worked as a clinical nurse for Arbor Pharmaceuticals, LLC.

Leah C. Morris ’79, nurse practitioner with Yolo Hospice in Davis, California, attended a lecture given by Dean Berkowitz at the Moore School of Nursing at UC Davis in February.

1970s

Ellyce (EJ) Engle Charles ’74 continues to work as the lead school nurse in a public school district which is 95% Native American and located on a reservation.

Barbara Desch Lenihan ’74 was promoted to Regional Clinical Liaison at Benchmark Senior Assisted Living in Wellesley, Massachusetts.

Jeri Bigbee ’75, adjunct professor at the Betty Irene Moore School of Nursing, attended a lecture given by Dean Berkowitz at UC Davis in February.

Jill Nadolny Kilanowski ’77 ’82 was selected as an inductee of the Fellows of the American Academy of Nursing.

Roxanne Guiness ’78 left hospital nursing more than 20 years ago and moved to industry, mainly selling medical devices for the operating room. For the

1980s

Ellen Soley Atkins ’81 received a DNP last year from the University of South Carolina. Ellen and her husband, Stan, have three children, and proudly celebrated their son Nick’s graduation from Princeton University last year.

Christina Alvarado Shanahan ’81 joined Blue Cross/Blue Shield of North Carolina in 1994 as director of Public Policy & Regulatory Affairs. She served as staff director of the U.S. House Subcommittee on Hospitals and Health Care and as professional staff member of the U.S. House Committee on Veteran Affairs from 1989 to 1994. She was selected for promotion to Rear Admiral, US Navy. She serves as deputy commander Navy Medicine East, Nurse Corps.

Pennie Sessler Branden ’85 earned a PhD from Villanova College of Nursing.

Carol F. Roye ’86 wrote A Woman’s Right to Know, a book about how women’s health devolved from a medical issue to a political one.

1960s

Constance “Connie” Crisci Corwin ’64 recently retired. She attended a lunch with other area alumni in Deerfield Beach, Florida with Dean Bobbie Berkowitz in January.

Mary Masterson Germain ’64 was awarded an honorary Doctor of Science degree at SUNY Downstate last year.

Mary Turner Henderson ’64 hosted a gathering for Dean Berkowitz and Bay Area alumni in her home last November. Margaret Mabrey Craig ’64 also attended.

Betsy Kerr Hay ’67 and Molly Marsden Schneider ’67 reunited after discovering they both lived in Nashville, Tennessee. Both are retired from nursing and are members of the Herb Society of Nashville. They are celebrating their renewed friendship.

Midge Harrison Fleming ’69 is pleased to announce the engagement of her son Alex.

Brenda Barrowclough Brodie ’65 has a new granddaughter — Dahlia Constance Brodie — who was born in January in New York City.

1970s


1960s

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Children of Ellen Soley Atkins ’81 celebrate her son Nick’s graduation from Princeton University in 2013

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Patricia M. Ruiz ’86 received a post-Master’s certificate from University of Pennsylvania School of Nursing in 2000. In 2012, she worked at Rutgers University School of Nursing where she planned, implemented, and evaluated an evidence-based depression screening program. She is the director of Clinical Affiliations and Career Development at Seton Hall University College of Nursing.
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PROGRAM NOTES

Adult-Gerontology Acute Care Nurse Practitioner Program (formerly Acute Care Nurse Practitioner)

Marianne Baernholdt ‘94 oversees the Rural and Global Health Care Center at the University of Virginia School of Nursing where she also teaches. She was selected as an inductee of the Fellows of the American Academy of Nursing last year.

Joan Ostrander Valas ‘90 ‘91 ‘95 wrote a chapter on ethical considerations in the care of vulnerable adult populations in Ethical and Legal Issues for Doctoral Nursing Students: A Textbook for Students and Reference for Nurse Leaders.

Adult-Gerontology Primary Care Nurse Practitioner Program (formerly Adult Nurse Practitioner)

Janica Barnett ‘10 ‘13, Debbie Dubeansky ‘10 ‘13, Josh Raufman ‘10 ‘12, Kathy Wu ‘10 ‘12, Martha Yepes ‘11 ‘13, and Annie Yu ‘08 ‘13 spoke about their career paths since graduation in a panel discussion organized by program director Jeffrey Kwong.

Paige Mackey Bellinger ‘10 ‘12 spoke at Columbia Nursing’s “Real Talk,” a candid discussion with students about life after Columbia Nursing.

Kristine Takamiya ‘01 ‘07 moved to Seattle with her family last year, and is now a clinical associate professor at the University of Washington School of Nursing. Kris reports she is enjoying her new work, but misses New York City.

Virginia Ranitovic Rudd ‘95 ‘98 ‘07 had her poem Invisible War published by Oncology Times.

Doctor of Nursing Practice

Norma Hannigan ‘07 is now a clinical professor of nursing at Hunter College-Bellevue School of Nursing. She celebrated her 10th year writing a health column for 10-4 Magazine, a publication read by truck drivers. She sings with Jasper Glee at Manhattan College, and studies Irish Gaelic at the Irish Arts Center in Manhattan.

Julie Lindenberg ‘07, associate professor of Clinical Nursing at The University of Texas Health Science Center School of Nursing, was named Clinical Quality Manager, a newly created position, at RediClinic. Julie serves on the Texas Health Services Authority Statewide Collaborative Planning Process: Electronic Health Record Adoption and Consumer Engagement work group, the American College of Nurse Practitioners Practice Committee, The Convenient Care Association Clinical Advisory Board, and the American Board of Comprehensive Care Board of Directors.

Rachel Cintolo Lyons ‘07, assistant clinical professor, is the Pediatric Nurse Practitioner specialty director at Rutgers University School of Nursing. She maintains a clinical practice at Newark Beth Israel ED and Hasbro’s Children’s Hospital in Rhode Island. She presented a poster at the Annual National NAPNAP conference outlining her program for active video gaming and nutrition education for fifth graders at the Greater Newark Charter School.

Clare Cardo McKegney ‘08 recently moved from the Boston area to Summit, New Jersey, and works at a large private practice. Clare launched a new business, thesavvyparent.com, offering classes on newborn care, nutrition, safety, vaccines, and breastfeeding.

Courtney Reinsch ‘07 wrote a chapter in Ethical and Legal Issues for Doctoral Nursing Students: A Textbook for Nurse Leaders.

Julie Lindenberg ‘07, associate professor of Clinical Nursing at The University of Texas Health Science Center School of Nursing, was named Clinical Quality Manager, a newly created position, at RediClinic. Julie serves on the Texas Health Services Authority Statewide Collaborative Planning Process: Electronic Health Record Adoption and Consumer Engagement work group, the American College of Nurse Practitioners Practice Committee, The Convenient Care Association Clinical Advisory Board, and the American Board of Comprehensive Care Board of Directors.

Entry to Practice Program

John Menzies Godfrey ‘94 has been publishing poetry collections since 1971. He worked as head nurse in a clinic at Kings County Hospital Center from 2003 until his retirement in 2011.

Family Nurse Practitioner Program

Samantha Ashley Armstrong ‘08 ‘11 married Grant Andrew Blosser in Clinton, NY last year.

Sara Buros ‘09 ‘11 and Rebecca Mizrachi ‘10 ‘12 spoke at Columbia Nursing’s “Real Talk,” a candid discussion with students about life after Columbia Nursing.

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Nurse Anesthesia Program

Laura Ardizzone ’04 ’10 was appointed to the National Quality Forum’s Patient Safety Steering Committee.

Donald R. Boyd ’06, a current PhD candidate, was selected as a 2013 Jonas Nurse Leader Scholar. He was also featured in a poster for National Nurse Anesthetists Week.

Roxana Sasse ’92 ’11 was one of 10 Columbia University graduates who received the 2013 Alumni Medals at last October’s Medals Gala organized by the Columbia Alumni Association. Roxana recently facilitated the establishment of a Columbia University Columbia Club of Rhode Island. She volunteers as a Columbia Nursing admissions interviewer, and works as a CRNA at Roger Williams Medical Center in Providence, Rhode Island. She is an associate editor for Columbia Nursing’s Clinical Scholars Review: The Journal of Doctoral Nursing Practice.

Nurse Midwifery Program

Karla Silverman ’98 ’01 attended the 2013 Welcome Breakfast for new students hosted by the Alumni Association last June. She lives in New York City with her husband and two daughters and is senior program manager at the Primary Care Development Corporation.

PhD Program

Michelle Gellman Appelbaum ’07 was named Nurse Practitioner of the Year by the Nurse Practitioner Association (NPA) of New York State. Michelle has served as the president of the Greater Newburgh Chapter of the NPA since 2011 and has written and published articles in various nursing research journals.

Janice Jones Izlar ’06 completed her term as president of the American Association of Nurse Anesthetists (AANA) last year. She focused on scope of practice and other important issues for CRNAs.

Sarah A. Collins ’09 was recognized as a 2012 Emerging Nurse Leader by the Alliance for Nursing Informatics.

Nicole Faerman Geller ’11 ’13 and Mary Ann Witt ’95 ’07 will present findings from their Alpha Zeta chapter Sigma Theta Tau-funded research projects at NewYork-Presbyterian affiliated hospitals during National Nurses Appreciation Week this spring.

Sharron Close ’01 ’03 ’09 ’11 and Pamela Blythe de Cordova ’09 ’11 were named 2013 Emerging Scholars by the Bloomberg faculty of Nursing at the University of Toronto.

Sarah A. Collins ’09

Ann-Margaret Dunn Navarra ’92 ’10 ’11 and Barbara Sheehan ’10 spoke at Columbia Nursing’s “Real Talk: PhD,” a candid discussion about career opportunities for PhD nursing grads.

Lorie Goshin ’10, Ann-Margaret Navarra ’92 ’10 ’11 and Barbara Sheehan ’10 spoke at “Real Talk: PhD.”

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Njoki Ng’ang’a ’13 was a speaker at a reception sponsored by Columbia Nursing’s Alumni Association and co-sponsored by Friends of the United Nations Population Fund in 2013.

Victoria Tiase ’06 was named an Emerging Nurse Leader by the Alliance for Nursing Informatics (ANI).

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In celebration of the DNsC-PhD conversion, newly conferred alumni of the PhD program raised more than $10,000 for the 2013-2014 Annual Fund to support scholarships for two Columbia Nursing PhD students.

**Pediatric Primary Care Nurse Practitioner Program**

Tara Helene Geist '05 completed her post-Master’s certificate in nursing education at Villanova University College of Nursing.

Michelle Kolb '05 '09 received the Richard E. Witten Award for Volunteer Leadership at the Columbia Alumni Association’s Leadership Weekend in 2013.

Martha Cohn Romney ’81 and her husband Benjamin celebrated the wedding of their daughter, Ari, last summer.

**Psychiatric Mental Health Nurse Practitioner Program**

Jeanne Marie Gelin Baker ’90 received the 2013 Norman Vincent Peale Award for Positive Thinking Award.

Suhanna de Leon-Sanchez ’06 ’09 addressed newly admitted students at Visiting Day this year and encouraged them to enroll at Columbia Nursing. She works at Memorial Sloan Kettering Cancer Center and also has a private practice in Brooklyn.

Susan Patel Furlaud ‘09 ’12 hosted the Annual Psychiatric Mental Health Nurse Practitioner Alumni Reception on November 4, 2013.

In celebration of the DNSc-PhD conversion, newly conferred alumni of the PhD program raised more than $10,000 for the 2013-2014 Annual Fund to support scholarships for two Columbia Nursing PhD students.

**Save the Date: November 7-16:**

Dean Berkowitz will lead a nursing delegation to Vietnam, open to alumni and friends of Columbia Nursing.

Giving Day

Columbia Nursing raised $46,000 (including a University Trustee bonus) for scholarships, an increase of 50 percent from the 2012 Giving Day total. Thank you to all volunteers and donors for making the day a success!

Save the date: Columbia Giving Day 2014 - October 29. To join the 2014 Columbia Nursing Giving Day committee, please contact Janine Handfus at jh2526@columbia.edu.
Losses in our Community

Ayanna N. Ade ‘89
Kate Wilbur Amssden ’41
 Milton A. Auzan ’86
Karen Gwin Barger ’63

Helen Brandt Battiste ’60 was a registered nurse working in behavioral health for 50 years, and was an early pioneer in hospice nursing. She retired from her position as nurse case manager from Carondelet Hospice in 2007. Helen passed away at age 76 this year.

Carol Cooke Beal ’44 worked as a dedicated registered nurse at Lewis Co. Extended Care Facility in Lowville, NY from 1980 until she retired in 1993. In 1991, she was selected by the New York State Legislature to receive the Nurse of Distinction Award. She served as a Sunday school church teacher and volunteered for many organizations including the Blood Mobile and Daughters of the American Revolution. She loved traveling, playing golf, camping, and entertaining friends and family. Barbara passed away at age 81 in Florida this year.

Lydia Winslow Carroll ’63
Lucille Prior Clark ’45
Maryanne Costa ’06 ’09
Gwendolyn Hines Costello ’48 ’68
Janet S. Cowern ’54
Sarah Louise Crawford ’34
Jane Bauer Crusthers ’39
Harriet Tilton Daams ’48

Gladys Swayze Gies ’28
Gertrude Whiteford Godfrey ‘44
Virginia Anderson Gorosh ’59
Virginia M. Green ’40
Jean Falist Gremse ’39
Mary Ogden Hall ’40
Shirley Clarke Hall ’61
Marjorie Brook Harding ’46
Marilyn A. Hanscom ’70
Price Elizabeth Hinson ’36
Anna Deyo Howerton ’54
Patricia A. Hummel ’46
Elizabeth Jennings Lyons ’39
Elaine Fox Jones ’63
Margaret Gunn Kane ’41
Jane Rielse Kuefer ’62
Patricia George Kempton ’54 was an active humanitarian, involved in the founding of the Danville Health Center in Vermont, holding all roles in the Peakam Women’s Fellowship, and serving as a Justice of the Peace for several years in Peakam, Vermont. She was also involved with her local HeadStart, and served as a mentor for students in her hometown area. Patricia passed away peacefully last year at age 81.

Jeannette Helms Koehnken ’43
Mary Ruth Foley Kohlmann ’38
Sheila Sax Lacey ’60
Natalie B. Lass ’32
Grace E. Laubach ’53
Dorothy Reichling Loranger ’36
Harriet Tilton Daams ’48

Gloria Beach Tenney ’51 considered her time at Columbia Nursing the happiest and most treasured part of her life and was proud to be associated with such a wonderful group of accomplished women. She passed away last year.

Jean Acomb Van Landingham ’43
Victoria S. Wald ’78
Joan Miranda Walther ’51
Jennivieve Tootell Weston ’42
Mary Soranno Witt ’40 was instrumental in creating Shelters for Battered Women and Children in exurban Livingston County. She worked as a nurse at various hospitals throughout her life and when she received a BA degree from Empire University in 1987 she was honored for being the school’s oldest diplomat. Mary passed away peacefully in Pennsylvania at age of 96 last year.

Nancy Dunn Wolcott ’44
Marion Clark Wood ’46

Edith Royce Zaager ’57 entered the U.S. Air Force as a nurse in 1959, became an instructor, and eventually retired as a captain. She spent much of her later life as an avid golfer and collector. Captain Zaager passed away this year and was given a funeral ceremony with full military honors.

Please notify the Office of Development and Alumni Relations at (800) 859-6728 if you learn of the death of a fellow alumna.
Plan Your Legacy

Support the next generation of Columbia Nursing students

Edith Royce Zaager ’57 understood the importance of a great education and the opportunities that it can bring. Columbia Nursing gave her the independence to follow her dream of helping people. After graduating, Zaager entered the United States Air Force as a nurse. She worked as an instructor and served her country as far as Japan, retiring as a Captain. Edith was the ultimate teacher, even in her final days, when she mentored the nurses caring for her.

Edith and her family wanted to give back to the school that was a stepping stone for her career. Edith wanted to not only educate the next generation of nurses but to empower them. The donation will support students scholarships, the student travel fund and the school’s new building. Edith was a true trailblazer in every sense of the word. She forged her own path throughout her life. Her generosity will enable future nurses to pave their own way.

Will you consider making Columbia Nursing part of your legacy? For more information about planned giving, please contact Janice Rafferty at jar2272@columbia.edu or 212.305.1088.

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Then & Now:

Myrna Lee Bergman '68, right, looks over a patient chart with a nurse. Image courtesy Archives & Special Collections, Columbia University Health Sciences Library

Columbia Nursing students reviewing patient charts during their clinical rotations.