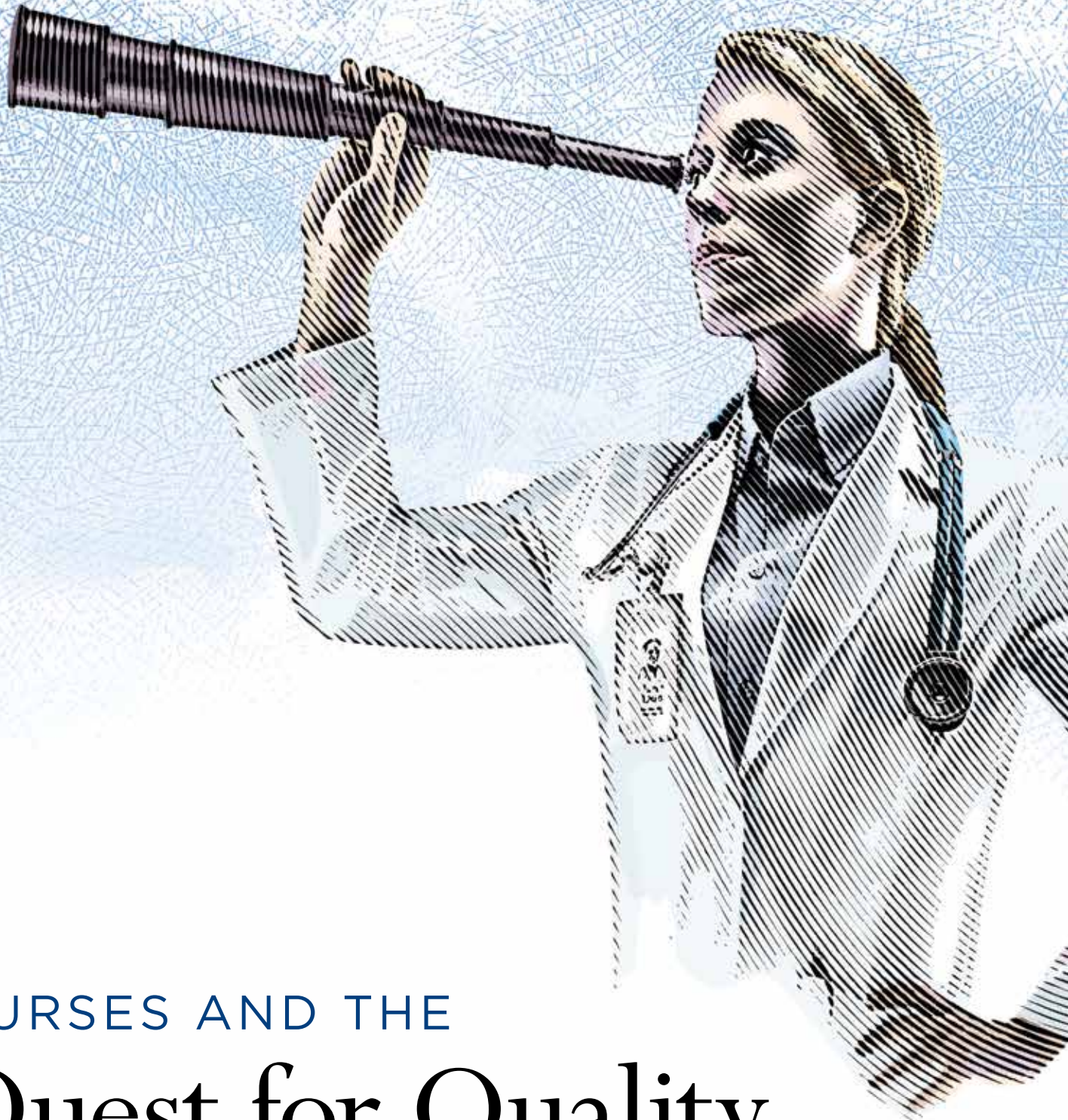


Pitt nurse

UNIVERSITY OF PITTSBURGH SCHOOL OF NURSING MAGAZINE
Winter 2016



NURSES AND THE
Quest for Quality

Nursing and Quality Improvement

It can be said that quality improvement in health care has been the backbone of nursing since the days of Florence Nightingale. It's fitting that a nurse was a pioneer in the movement to actively evaluate care procedures in order to identify their effectiveness. Today, nurses are the primary caregivers in hospital settings, and they can—and do—have a significant impact on the quality of care, the well-being of patients, and the financial status of health care systems.



“Nurses are the primary caregivers in hospital settings, and they...have a significant impact on the quality of care, the well-being of patients, and the financial status of health care systems.”

Calls for quality improvement in health care were ringing out at the end of the 1990s, after the Institute of Medicine revealed alarming statistics about hospital safety and errors. Government agencies and media outlets across the country issued challenges and mandates to improve care and protect patients. Several national initiatives and governance agencies were created at that point, including the National Quality Forum (1999), Surgical Care Improvement Project (2003), and Physician Quality Reporting System (2006). Legislative actions, from the Tax Relief and Health Care Act of 2006 to the Patient Protection and Affordable Care Act of 2010, have pushed improvement efforts and measurement at the national system level.

The national conversation around quality improvement has recently been revitalized by the Affordable Care Act and Medicare reimbursement strategies that incentivize health care systems to enhance their patient care, safety, and financial performance. Thanks to financial incentives for continuing to improve care, quality improvement programs and efforts

are here to stay. I think Nightingale would approve of the role of nurses in contemporary quality improvement measures.

The work to improve health care quality at the bedside, in clinics, in long-term care facilities, and in hospitals is far from over. There are systems in place to track progress, and hospitals and systems have instituted teams to guide and assess improvement efforts. Certainly, the federal government has been developing goals and incentives to foster an environment of quality improvement. Today, you will see new types of professionals in every kind of setting—those who are tasked with improving the quality of care and patient safety. College and university schools of nursing have built academic offerings—everything from lectures and courses to advanced degree programs—to prepare nurses to contribute to the ongoing quality improvement efforts.

In this issue of *Pitt Nurse* magazine, we explore the role of nurses in institutional efforts to improve care and patient outcomes. We called upon quality improvement experts from a major medical center and a health care plan to discuss the impetus for much of today's work to improve care and efforts to streamline operations. A former vice president/chief nursing officer who was responsible for quality programs within her 700-bed hospital system comments about some of the opportunities and challenges nurses face in quality improvement efforts. Educators discuss how collegiate nursing schools have built a learning environment that instills a quality improvement perspective in students.

On behalf of the University of Pittsburgh School of Nursing, I hope that you read this issue with great interest. After all, quality improvement policy and implementation affect all of us daily, whether we are practicing nurses, patients, or educators. Thank you for your time and your engagement with Pitt Nursing.

Jacqueline Dunbar-Jacob, PhD, FAAN
Dean and Distinguished Service Professor of Nursing
University of Pittsburgh School of Nursing

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We explore how the rising demand for quality has evoked changes in nursing education.

About the cover: Health care professionals, particularly nurses, are searching for ways to meet quality improvement and patient safety goals.

Celebrating the Class of 2015!

On April 24, the 2015 School of Nursing Graduation and Pinning Ceremony took place at the David L. Lawrence Convention Center. The attendees were welcomed by Dean Jacqueline Dunbar-Jacob and Loren H. Roth, associate senior vice chancellor for clinical policy and planning, health sciences. In addition, students from both the undergraduate and graduate programs—BSN graduate Jenna Zaldonis, Pittsburgh campus; BSN graduate Cassandra Stein, Johnstown campus; and DNP graduate Melissa Sue Connelly—offered their own congratulatory remarks to their fellow graduates.

The keynote address was given by Deborah Trautman (MSN '87), PhD, who currently serves as chief executive officer of the American Association of Colleges of Nursing, and alumni remarks were presented by Theresa Steele-Austin (BSN '85). Thanks to these Pitt Nursing alumni for being a part of the celebration!

The school's spring graduation ceremony includes two very special and long-lived traditions: pinning and the "Passing of the Light" of nursing knowledge from one year to the next. Congratulations to the 2015 Keepers of the Light, Annie Krzan (BSN '15) and Nicole Volkman (BSN '15), who were selected for this honor due to their high academic standing.

The faculty, staff, and administration of the School of Nursing salute all those who celebrated with us at the 2015 Graduation and Pinning Ceremony!



BEST GRAD SCHOOLS

& WORLD REPORT
U.S. News

NURSING
2016

Pitt Nursing Ranked Fifth!

The University of Pittsburgh School of Nursing is now ranked fifth among schools of nursing by *U.S. News & World Report* in the 2016 edition of *Best Graduate Schools*, up from a seventh-place ranking in 2011.

Many of the school's specializations in the graduate programs also are highly ranked in the report, which was released in March 2015:

#1: Nurse Anesthesia

#3: Clinical Nurse Leader

#5: Nursing Administration

Nurse Practitioner*

#5: Adult/Gerontology, Acute Care

#3: Pediatric, Primary Care

#3: Psychiatric/Mental Health

"We are very pleased that the data used by *U.S. News & World Report* affirmed the excellence of our graduate programs in nursing," says Dean Dunbar-Jacob. "We are very proud of our graduate programs, our faculty, and our classroom and clinical experiences. The increase in the rankings for the programs and the specializations validates our significant efforts to create meaningful learning experiences for our students."

**Now offered at the DNP level only*

Dean Honored by the University

On May 28, 2015, Dean Jacqueline Dunbar-Jacob was recognized for her appointment as Distinguished Service Professor of Nursing at Pitt, the highest honor that the University can bestow upon a member of the faculty. Then Chancellor Mark A. Nordenberg appointed Dunbar-Jacob for her significant body of research on patient adherence, her work as both a member of the faculty and dean of the School of Nursing, and her service to nursing and other professional organizations. She received her Distinguished Service Professor medal at a ceremony in the University's Scaife Hall. As part of the event, Dean Dunbar-Jacob presented the Provost's Inaugural Lecture on "The Academization of Nursing." Congratulations, Dean Dunbar-Jacob!

School of Nursing's Annual Career Fair

Each year, more than 25 employers participated in the school's annual career fair, seeking out future employees from among senior nursing students from the Pittsburgh and Johnstown campuses.



Cohen, Ren Win 2015 Teaching Awards



Susan Cohen



Dianxu Ren

It is with great pride that Dean Dunbar-Jacob announces the recipients of the 2015 Dean's Distinguished Teaching Awards. This year's winners are Susan Cohen, PhD, CRNP, FAAN, and Dianxu Ren, MD, PhD. These awards recognize those faculty members who best represent the

school's commitment to excellence in teaching by encouraging student development, using innovative teaching methods, and integrating their research interests and outcomes into their classroom activities. Cohen, associate professor in the Department of Health Promotion and Development, was selected for this honor particularly for her mentoring of graduate students. She devotes a great deal of her time and effort to the education and professional development of the next generation of nurse-scientists.

Her courses are identified as research driven, and she infuses her classwork and student advising with the research outcomes. Ren, associate professor in the Department of Health and Community Systems, is noted for his dedication to teaching a difficult subject (statistics) using student-centered learning and for his willingness to lend his expertise to students who are preparing manuscripts and research projects. Ren also serves as the associate director for statistical support services; as such, he is called upon to serve as a training faculty member on two of the school's T32 grants (Institutional Research Training Grants). Congratulations to these amazing educators!

New Pitt Nursing Partnership Results in Unique Student Fellowship

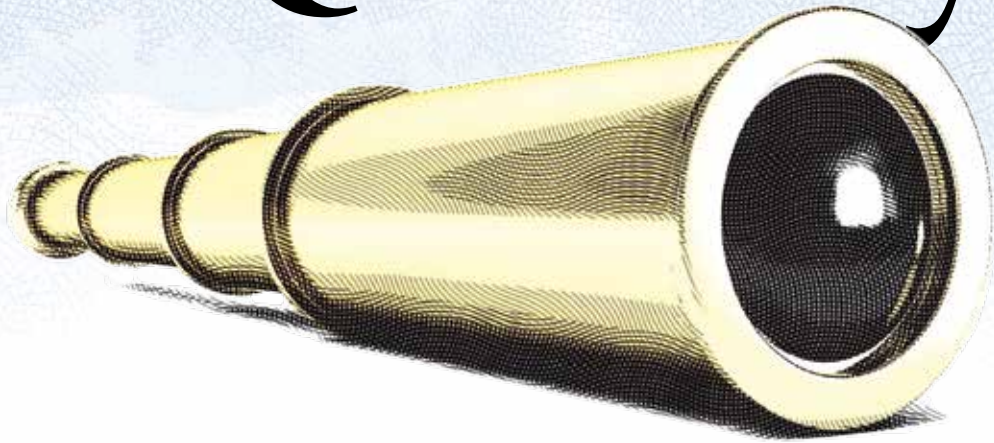
The School of Nursing is pleased to announce a new doctoral student fellowship created in conjunction with the GetWellNetwork, Inc.'s O'Neil Center. This fellowship will provide scholars with an opportunity to collaborate with O'Neil Center thought leaders, clinical experts, and researchers in the field of patient/family engagement. Up to two doctoral candidates will be selected annually to participate in this one-year fellowship, which will include mentoring

by Pitt Nursing faculty members and O'Neil Center researchers as well as the completion of a scholarly project in a real-world setting. The project will add to the body of research on the relationship between patient engagement and outcomes, the translation of patient engagement

theory into health care management, and the development and impact of patient-facing technology. The inaugural O'Neil Pitt scholars were nursing predoctoral students Taya Irizarry (BSN '10) and Teresa Hagan (BSN '10, PhD '15).



The Quest For Quality



Known as the “mother of modern nursing,” Florence Nightingale was one of the first health care professionals to design and implement a large-scale quality improvement project based on data that she gathered. Nightingale collected information to see how to improve the care of battlefield victims. Her patient-centered studies revealed a linkage between hospital sanitation and the number of wounded soldiers who died while being treated there. Nightingale literally cleaned the military hospital, designed procedures for hand washing and sterilization of surgical tools, and reduced mortality rates at the Barrack Hospital from 60 percent to 1 percent during the Crimean War in the 1850s. Thus, since the 19th century, nurses have enhanced patient health and safety through quality improvement (QI) efforts.



“MERELY MAKING INCREMENTAL IMPROVEMENTS IN CURRENT SYSTEMS OF CARE WILL NOT SUFFICE.”



*Crossing the Quality Chasm:
A New Health System for the 21st Century*



Flash forward to 1999, when the Institute of Medicine (IOM) released the report *To Err Is Human: Building a Safer Health System*. This report concluded that between 44,000 and 98,000 people died each year as a result of preventable medical errors, which represented 2–4 percent of all deaths in the United States at that point. This instigated a new push for quality improvement across all sectors of health care.



A 2001 IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, shed further light on the situation, noting that “The U.S. health care delivery system does not provide consistent, high-quality medical care to all people.” The causes for this gap between existing and potential care included the pace of advancement in medical science and technology, changes in health care needs due to longer life spans and increasing numbers of chronic conditions, and organizational deficits such as wasted resources

and a lack of care coordination. The report called for a complete overhaul of the health care system, noting that “merely making incremental improvements in current systems of care will not suffice.” In addition to improving patient safety, the report recommended strategies to address five other specific aims for improvement:

- Increase effectiveness of services provided based on evidence.
- Make health care and the system patient centered.
- Provide care in a timely fashion to reduce delays.
- Make the system more efficient to avoid waste.

- Ensure that health care is equitable, given without regard to gender, ethnicity, or socioeconomic status.

These IOM reports had profound impacts on the health care delivery system in the United States.

One outcome was the creation of the National Patient Safety Goals (NPSGs) in 2002 to help accredited organizations to address challenges regarding patient safety. These goals were created by the Patient Safety Advisory Group, whose job is to advise the Joint Commission, which accredits and certifies more than 20,500 health care institutions. For example, in 2012, NPSGs focused on catheter-associated urinary tract infections and offered a phased implementation of protocols to reduce the incidence of such infections.

Another outcome of the two IOM reports was the mandate from Congress that Medicare develop a plan for and implement a value-based purchasing program to incentivize meeting performance standards by 2009.

QI AND THE AFFORDABLE CARE ACT

The world of patient safety and quality improvement was rocked again by the Patient Protection and Affordable Care Act (ACA) of 2010, which was upheld by the U.S. Supreme Court in 2012. According to a 2011 National Institute of Health report, one goal of this comprehensive health care reform law is to “improve health care value, quality, and efficiency while reducing wasteful spending and make the health care system more accountable to a diverse patient population.” As part of the act’s efforts to improve quality of care, all qualified health plans must participate in an enrollee survey, which feeds into the overall Quality Rating System and the public reporting of clinical quality and enrollee experience ratings—and reimbursements based on those ratings.

ACA aims to build a health care system that fosters quality of care while driving down costs

to both consumers and the nation. It aims to do so by creating accountable care organizations that will facilitate the improvement of coordinated care to patients through incentives. In addition, it ties Medicare Advantage bonuses to quality of care coverage offered by these private plans. ACA's Hospital Readmissions Reduction Program impacts Medicare payments to hospitals with higher rates of preventable readmissions, a key indicator of patient safety and care quality.

In 2012, IOM issued another report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, which called for "achieving a learning health care system—one in which science and informatics, patient-clinician partnerships, incentives, and culture are aligned to promote and enable continuous and real-time improvement in both the effectiveness and efficiency of care." While the IOM panel that authored this report indicated dissatisfaction with the lack of progress since the publication of IOM's seminal calls to action in 1999 and 2001, it also highlighted four tools (which had emerged in the subsequent decade) to support future actions to improve quality: computing power, connectivity, organizational sophistication, and advances in teamwork; as well as the concept of the patient as a member of the health care team.

In the same year, Medicare began a program of bonuses and penalties to hospitals based on the institutions' rankings in quality standards. Prior to this, Medicare paid hospitals and doctors based on the type of services provided. The Hospital Value-Based Purchasing program was applied to nearly all acute care hospitals, unlike earlier efforts, which were voluntary on the part of providers. Seventy percent of the funding is based on scores hospitals earn for rudimentary standards of care, and 30 percent is distributed or taken away based on patient ratings of stays.

"At first, most quality improvement efforts looked at how to measure ... and what exactly to measure. Now that we've established standards and metrics, we can look at the outcomes. How many fewer falls? Has there been a decrease in infiltrations? Have we lowered the number of patients having to be readmitted? We can see the real benefits of each and every quality improvement effort—patients are getting better care, recovering more quickly, and doing well long term.

"Also, the payment and reimbursement system has changed so much in recent years. With things like value-based purchasing, payment is now linked to performance. It started with Medicare enacting financial incentives to encourage hospitals to bring up the level of their care to the national average across many measures. Because so many of our patients are Medicare enrollees (69 percent), even a 1.5 percent payment adjustment can be huge. The Hospital Readmissions Reduction Program exacted a 1 percent reduction in 2013 and will levy a 3 percent reduction in 2015 for those who were readmitted to the hospital within 30 days. Efforts such as the Hospital Readmissions Reduction Program are making us think about what happens to the patient after he or she leaves the hospital and what we can do to keep him or her healthy when he or she is not in our care."

Judith F. Zedreck Gonzalez (BSN '79, DNP '13), professor and former chief executive officer, vice president, and chief nursing officer, Allegheny Health Network



AN INTERVIEW WITH

Tamra E. Minnier

(BS '81, MSN '85), Chief quality officer, UPMC, and executive director, the Beckwith Institute

MEASURING QUALITY

Much of the discussion in the literature on health care improvement deals with data collection—what to collect from whom and how to organize it. As there are financial implications for performance, the data against which to benchmark are quite important. But, information gathering aside, the *National Healthcare Quality and Disparities Report* (produced annually by the Agency for Healthcare Research and Quality) notes several optimistic statistics:

- Across all measures of quality that are tracked, 60 percent showed improvement by 2010–11.
- Almost 60 percent of quality measures in home health, hospices, and nursing homes improved.
- The quality of hospital care improved more rapidly than that of ambulatory care.
- Four adolescent vaccination measures are on the list of measures improving at the fastest rate.

But the report also has some less-than-stellar observations:

- In 2010, 26.4 percent of Americans reported encountering barriers to accessing care, up from 24 percent in 2002.
- Poor people received worse care than high-income people for 60 percent of measures in 2010–11.
- Of the eight quality measures declining at the fastest rate, two are related to diabetes and two are related to maternal and child health.
- No state performed in the highest quality quartile in *all four* settings of care.

So what began in the 1850s with one nurse trying to determine how to save more battlefield victims has grown into a multiyear, multibillion dollar effort to improve the quality of care provided to patients across the United States. This effort is far from complete. And, once again, nurses will be on the forefront of revamping health care, which is only fitting.



Q: When did hospitals begin to address quality improvement (QI)?

A: Process science and quality management truly became legitimate sciences, rather than business fads, in the 1980s. At that point, clinicians were interested in how to apply quality management principles to the health care field, but we didn't really see a concerted effort until there was a con-

fluence of events: the publication of the Institute of Medicine report *To Err Is Human* and the federal government's introduction of prospective payment rules. You then had people studying the work of W. Edwards Deming (who was the true pioneer of quality control and market survey techniques) and applying it to health care. People like Brent James (chief quality officer at Intermountain Healthcare) and Donald M. Berwick (president and CEO of the Institute for Healthcare Improvement for nearly 20 years) began to call for the medical profession to apply the scientific perspective of quality management to health care.

Today, we define quality improvement as both patient safety and process improvement. We use process improvement techniques to enhance the quality of care and patient safety. It's ironic—Florence Nightingale studied how to make medical care better in the 1850s, and the industry is coming back to that effort again in the 2000s. Nurses have always been at the center of quality improvement efforts, but now they can take on serious leadership positions.

Q: Can you provide real-world examples of QI in action?

A: Well, one effort to improve patient safety that I have experienced involved the standard protocol of giving blood to patients after surgery. This was automatic, and we thought it was a good thing to do. Then the industry had to consider the risks of using donated blood, particularly in light of HIV. Plus, even giving the patient's own blood back to him or her

can increase clinical risks such as blood clots and infections. So, we undertook a QI project, which found that doctors and nurses didn't know that this automatic giving of blood could be a problem. We ran education efforts to make our physicians and staff members aware of the potential risks and lowered the hemoglobin threshold for postsurgery transfusions from 10 down to seven g/dl. This proved to be a successful patient safety initiative—it was better for patients, and it saved money in terms of the costs of blood and blood products.

Another example specifically targeted nurses. It's been estimated that staff members on the medical/surgical unit walk the equivalent of the circumference of the earth in six months. To get to drug carts or to get to equipment closets was such a waste of the nurse's time and resulted in patients waiting for treatment. So, we went to the unit and watched how nurses traveled. We noted where they spent the majority of their time and marked when they had to go out of their way to retrieve something. Then, we put equipment and supplies in the places where nurses needed them. The cost of new storage units was far less than the amount of time nurses wasted walking around the entire floor to get something. Research says that health care suffers from 30 percent waste, which has traditionally meant human resources. We can cut that rate of waste simply by looking at the processes that we do every day and figuring out if we can do it better. Plus, the nursing staff can then spend more time with patients.

Q: What do you see as a barrier to the success of QI?

A: Fear. I think that fear is probably the biggest barrier to any quality improvement process, not just in health care. As an industry, we're still not comfortable admitting that something's messed up, that we have been doing something wrong or in a way that's less than perfect. Health care as a whole has been less than transparent, and we're still not ready as an industry to be completely honest about our performance. But the fear also exists on the individual level. If I point out that my unit, my supervisor, or a doctor has been doing something wrong, what will the reprisals be? How

IT'S BEEN ESTIMATED THAT STAFF ON THE MEDICAL/SURGICAL UNIT WALK THE EQUIVALENT OF THE CIRCUMFERENCE OF THE EARTH IN SIX MONTHS. TO GET TO DRUG CARTS OR TO GET TO EQUIPMENT CLOSETS WAS SUCH A WASTE OF THE NURSE'S TIME AND RESULTED IN PATIENTS WAITING FOR TREATMENT.



far can I go to push for an improvement before there will be consequences? Personally, I'd say the most important attribute in a quality officer has to be courage. We must have the courage to present the truth, revealing that something is wrong and here is how we could fix it.

Q: What do you see for the future of QI in our field?

A: I think that the next few years will be quite tumultuous for health care. Quality improvement is going to grow even more important, and the money at risk will continue to increase. We have to advocate for more research support and for standardized metrics that will allow patients and families to understand where they can get the best care. We also need more people to specialize in QI, because it sometimes takes an outsider's perspective (someone not working on the unit) to see the problems within a system and how to fix them.

Q: Why should nurses care about QI?

A: As I said before, nurses have always been involved in [and led] such efforts. Rejiggering is hard, but it's so necessary. After all, hospital errors have been noted as the third leading cause of death, and we have to take action to stop them. Nurses, because of their unique roles in health care, can make sure that people across the institution—as well up and down the corporate ladder—take QI seriously. In fact, nurses are perfectly poised to do so. We just need to give them the framework, the knowledge, and the courage to do so.

What is Quality Improvement?



Quality improvement (QI) is a formal approach to performance evaluation and the systematic efforts to improve that performance. It is traditionally thought to be just one aspect of quality management, in addition to quality control and quality assurance. The groundwork for contemporary efforts in quality control and improvement has its roots in the creation of statistical methods to improve the manufacture of weapons and other strategic items during World War II.

Massive industrial quality initiatives began in the 1980s, initially at Ford Motor Company to make the car producer more competitive with Japanese manufacturers. The concepts expanded to other industries, including engineering and construction, but also into service sectors

such as marketing and customer service. In fact, by 1987, there was the ISO 9000 family of quality management systems, which has become the international standard for quality management certifications.

In the health care field, which was not an early adopter of quality management, national efforts at fostering QI date mostly to the late 1990s. These efforts were spurred on by the publication of reports by the Institute of Medicine (IOM) as well as the formation of the National Quality Forum, a nonprofit created in 1999 to define national goals and priorities for the improvement of health care and to endorse the standardization of performance metrics. Since then, the industry and the government have initiated numerous studies and reports, pieces of legislation, and oversight organizations to push the quality improvement agenda in U.S. health care.

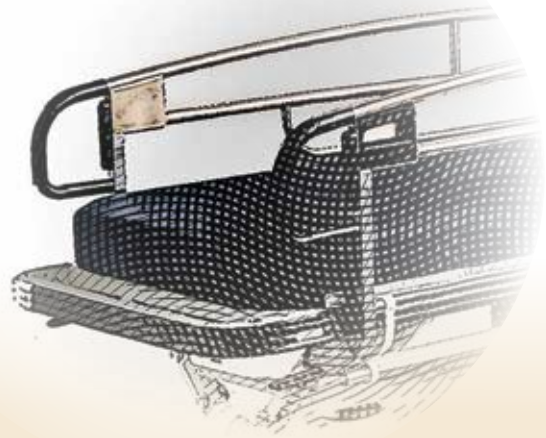
IOM defines quality care as “safe, effective, patient centered, timely, efficient, and equitable.”

The National Quality Strategy, developed under the aegis of the U.S. Department of Health and Human Services (HHS), has three broad goals:

- Improve the overall quality of health care by making care more patient centered, reliable, accessible, and safe.
- Improve health by supporting proven interventions to address behavioral, social, and environmental aspects of health.
- Make health care affordable to individuals and institutions.

The goals have been distilled into six priorities that address patient safety, patient engagement, communication, and coordination of care; promoting effective practices and treatments for the leading causes of death; enabling healthy living; and making care affordable through new health care models. There is an alphabet soup of agencies and organizations contributing to these efforts, including the Joint Commission, Quality Improvement Organizations, and the Agency for Healthcare Research and Quality. One example would be accountable care organizations, which are groups of providers and insurers working together to improve patient outcomes and streamline costs.

How institutions approach QI is just as diverse. There are a myriad of tools and methodologies



According to National Public Radio, the World Health Organization estimates that hundreds of millions of patients are “affected” by hospital- and health care-acquired infections, and hospital bed safety railings are the source of a significant number of them. Researchers in Chile proved that copper bed railings can make a huge difference because the element copper is a “contact killer” for microbes. A study of copper-alloy surfaces in U.S. hospitals’ ICUs published in *Infection Control & Hospital Epidemiology* found that they decreased the number of health care-acquired infections from 8.1 to 3.4 percent.

to frame QI implementation; the FADE (Focus, Analyze, Develop, and Execute) model, Plan-Do-Study-Act, and Six Sigma (designed by Motorola) are just a few. They all contain several common actions: analyzing where the institution is now, planning to improve quality, and evaluating progress to identified quality goals.

To date, a great many national efforts have focused on the gathering and dissemination of data against which to measure the progress toward enhanced quality. HHS has established a national strategy as noted above; it also has identified gaps, as well as measures to fill these gaps, in care, efficiency, and accessibility. The agency has developed a process for collecting and aggregating public performance information, the Healthcare Effectiveness Data and Information Set (HEDIS), which reports on 81 measures across five domains of care. The Center for Quality Improvement and Patient Safety (at the Agency for Healthcare Research and Quality) undertakes and supports the research to define best practices for QI.


“When I was with a regional hospital (about 10 years ago), we undertook a project to bring down our rates of central line-associated bloodstream (CLAB) infections, which were a problem across the country. We had five ICUs and more than 100 specialty beds. We had noted that there were a significant number of problems with the central line’s insertion within the first 48 hours after it was installed. To impact infection reduction within 48 hours, we studied how the line was installed, the access, the cleaning, and even the location of the port. We designed protocols for insertion and for ongoing maintenance and then educated our staff members about those protocols. When we followed those protocols, we saw a significant drop in the number of infections.

“We went even further. We wanted to show our staff that this was very important—not just for our reporting statistics but also as caregivers. So, if we had a month in which the number of CLAB infections dropped, we celebrated. If a patient acquired such an infection despite our efforts, we put information about the patient and his or her family up on a bulletin board in our office. We wanted to personalize it, put a face to the statistic. Over time, and with much effort, we got to zero CLAB infections on a regular basis. That was such an achievement for each one of us.”

Judith F. Zedreck Gonzalez (BSN '79, DNP '13), professor and former chief executive officer, vice president, and chief nursing officer, Allegheny Health Network

Some national programs and initiatives have been introduced, including the Hospital Readmissions Reduction Program, which imposes financial penalties for excess readmissions; the Health Information Technology for Economic and Clinical Health (HITECH) Act, designed to improve health care safety and quality through information technology; and the Hospital Value-Based Purchasing program, which rewards improved care and reduces payments to poorly performing hospitals.

While progress has been made, there is still much to be done. The legislation guiding much of the current work on health care quality improvement remains the subject of debate and appeals. The research that will add to the evidence base for both better clinical practice and administrative efficiencies needs to be



“WE ARE BURYING A POPULATION THE SIZE OF MIAMI EVERY YEAR FROM MEDICAL ERRORS THAT CAN BE PREVENTED...DURING THIS TIME OF RAPID HEALTH CARE TRANSFORMATION, IT’S VITAL THAT WE WORK TOGETHER TO ARM PATIENTS WITH THE INFORMATION THEY NEED AND TELL DOCTORS AND HOSPITALS THAT THE TIME FOR CHANGE IS NOW.”

Leah Binder, president and CEO of the Leapfrog Group, Hospital Safety Score fall 2013 update

expanded, with more evident ways in which to translate research and data analysis into action. For example, hand hygiene is acknowledged by the Joint Commission, World Health Organization, and Centers for Disease Control and Prevention as the primary way to reduce health care-acquired infections. Sadly, hand hygiene compliance among health care workers has historically been very low, averaging 39 percent. Now there are many programs to remind staff members to wash their hands and to reward institutions for higher compliance rates.

Much like quality improvement itself, the effort to improve care is a continual process. There is no ending, no completion of the task. As more people participate in the health care system and as technology and research fuel expansion of our knowledge and capabilities, there will be more to learn and to do to ensure that everyone has access to the right care at the right time.

AN INTERVIEW WITH

Sandra E. McAnallen

Senior vice president, clinical affairs and quality performance, UPMC Insurance Services Division



Q: What do you see as the role of insurance plans in health care quality improvement (QI)?

A: Insurance plans are paid for by both the government, through Medicare and Medicaid, and employers who

purchase insurance plans for their employees. It is our responsibility to judiciously manage costs for these payers. So we act to make sure that resources are being put to the best use for patients and for our customers.

We also act as an information source for clinicians and consumers. Insurance companies are accredited (by the National Committee for Quality Assurance, in our case), and we have to meet a rigorous set of more than 80 standards and must report on our performance every three years. This means that we're constantly gathering and maintaining evidence of how we are performing and, therefore, how providers are performing to maintain our accreditation. We report on clinical effectiveness, prevention services (such as immunizations), member satisfaction, and quality of service offered by physicians and practices. This wealth of data can be used to improve clinical practice, customer service, and quality of life for our enrollees.

Another role for the insurance plan is to help with coordinating care for patients. Our nurses work

with primary care physicians and offices to ensure that patients get the correct follow-up appointments and treatments. We have a unique perspective on the patient: We see the whole patient through his or her insurance record, not just his or her current ailment or condition. We see that he or she was supposed to set up a specialist appointment, and we contact the patient to help him or her do so. This can be particularly important for those enrollees who are "super users"—people with multiple conditions and many providers. The coordination of the super users' care is very important, and we can close any gaps in that care.

"WE PLAY A HUGE PART IN DOCUMENTING AND IMPROVING CUSTOMER SERVICE. WE MAKE SURE THAT PATIENTS FEEL THAT THEY'VE GOTTEN THE VALUE THAT THEY PAID FOR THROUGH A NUMBER OF EFFORTS."



Q: Do insurance plans contribute to QI in other ways?

A: Yes, we do. We play a huge part in documenting and improving customer service. We make sure that patients feel that they've gotten the value that they paid for through a number of efforts. We contact enrollees after they have an office visit or a procedure and assess their experience with the provider, the facility, and the staff. This information can show providers how they deliver service from the perspective of the user,

which is often quite different from the viewpoint of the provider.

In addition, we make available data that cover our entire enrollee base. That allows us, as well as governing and health care agencies, to see trends and to design care or interventions for the group or community as a whole. This can be incredibly useful in anticipating and dealing with flu outbreaks, measles or other infectious diseases, or environmental issues.

Q: Do insurance plans practice QI internally?

A: We do; in fact, it is a continuous process for us. One of the biggest internal issues we faced had to do with dealing with enrollees calling us about coverage, their plan, or their bills. As we all know, being put on hold or transferred endlessly is incredibly frustrating, particularly for those who might be ill or worried about a loved one. So, we began a project to implement "first call resolution," with the goal to eliminate transfers or callbacks. We wanted calling us to be a warm, reassuring process, one in which you spoke with an actual person. Part of this involved training those who answered the calls and part involved having the right data on hand. So, we studied what information enrollees wanted, what type of training was needed for our staff, and how best to present information to those who were answering calls.

We also work with members of their employers' plans, and that is often a different type of enrollee. So we researched their specific needs and began a "health care concierge" program, in which we have particular staff assigned to a specific employer. When those employees have a question, they are directed to one of our concierges, who are extremely knowledgeable about the employer's plan.

The Role of Nurses in Quality Improvement



“**R**esearch is now beginning to document what physicians, patients, other health care providers, and nurses themselves have long known: how well we are cared for by nurses affects our health, and sometimes can be a matter of life or death.”

Institute of Medicine, Keeping Patients Safe: Transforming the Work Environment of Nurses, 2003

It is indisputable that nurses are at the vanguard of patient care. They are responsible for monitoring and assessing patients, coordinating care, and educating patients and families. In light of the new push to enhance health care quality, it will be nurses who implement a great many of the efforts. Their work can be directly linked to most of the top priorities in the National Quality Strategy, which was developed by the U.S. Department of Health and Human Services in 2011.

Patient safety: Nurses ensure that proper infection control procedures are followed.

Patient engagement: Nurses provide patients and their families with critical hospital stay information, guide and support their

care decision-making processes, and ensure that patients are equal participants in the care program.

Communication and coordination of care: Nurses are responsible for designing, implementing, and participating in care coordination for patients in the hospital and after discharge.

Enabling healthy living: Nurses perform the research and implement interventions (e.g., smoking cessation, healthier eating, getting more exercise) on both individual and community levels.

Nurses also can contribute significantly to other national quality improvement (QI) goals. They have firsthand knowledge of their institutions, both strengths and weaknesses, which can benefit

“While it is a lot of work to design and implement Quality Improvement projects, it is the perfect opportunity to showcase nursing’s role in providing the right care at the right time.”

Judith F. Zedreck Gonzalez (BSN '79, DNP '13), professor and former chief executive officer, vice president, and chief nursing officer, Allegheny Health Network

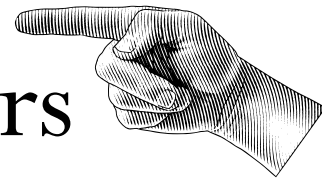
both micro- and macro-level efforts to decrease costs and improve resource use. They can marshal the services and expertise needed to speed up discharge processes, which improves the patient experience and smooths out transitions to other care facilities or home. They are part of the daily work that happens on each unit and can offer expert opinions on improving hospital design to make the layout or scheduling of staff more efficient. “To benefit from the insight and input of these staff members, hospitals will need to value their potential contributions, shifting their vision of nursing from being a cost center to being a critical service line,” state the authors of an article in *Quality & Efficiency*.

There are several challenges to better using nurses in the QI effort, ones that can severely hinder progress. Such obstacles include a scarcity of nurses, the need to engage all types of nurses, growing demand that nurses participate in multiple assessment activities and the associated administrative burden, and traditional nursing education that does not best prepare nurses for QI participation. Hospitals and other care facilities need to have their best nurses at the bedside or doing their “normal” jobs; often QI is seen as an additional task or responsibility. Hospital leadership, as well as the nurses themselves, must realize that QI efforts should permeate through every aspect and level of care and that such efforts will have a significant impact on patient satisfaction and outcomes. QI managers should recognize the expertise that nurses from RNs to nurse managers to chief nursing officers can bring to the process, dramatically impacting both the process and the outcomes. And nursing schools and the profession have already begun to develop new academic, certification, and continuing education programs to give nurses the foundation to research, create, and implement QI endeavors.

“While quality improvement is not solely the domain of nurses, they are integral to these activities because of the day-to-day patient care responsibilities,” stated the Center for Studying Health System Change in 2008. With nurses representing the largest single group of health care professionals, “nurses have key roles to play as hospitals continue their quest for higher quality and better patient safety.”

BY THE

Numbers



98,000



Up to 98,000 people die per year due to medical error. The Centers for Disease Control and Prevention puts that estimate at 99,000.



\$750

\$750 billion of health care spending was wasted in 2009—30 percent of health care spending that year.

1/3 2009

One-third of all hospital admissions suffer an adverse event.

The year that the Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law, incentivizing the use of an electronic health records system

75,000

75,000 deaths could have been prevented in 2005 if every state had delivered care on par with the best-performing state.

\$850,000

The amount of hospitals' reimbursements (1 percent) held back as part of the Value-Based Purchasing program in its first year

2.6

Each year, 2.6 million (nearly one in five) Medicare enrollees are readmitted to the hospital within 30 days of discharge.

\$575

\$575 billion in savings over 10 years to the Medicare Hospital Insurance Trust Fund is estimated due to the passage of ACA in 2012.

Quality Improvement *and* Nursing Education



At the turn of the 21st century, it was apparent that nursing education had to evolve in order to fill the gaps between training and quality improvement (QI) in health care. Several factors were driving this enhancement of graduate nursing education: rapid expansion of knowledge underlying practice, increased complexity of patient care, national concerns about the quality of care and patient safety, and increasing educational expectations for the preparation of other members of the health care team.

To design and implement QI programs, nurses and other health care professionals needed to be prepared to use data to monitor patient outcomes and process methods to improve the quality and safety of systems.

The American Association of Colleges of Nursing (AACN) led the development of two new educational opportunities to better prepare nurses to contribute to QI. First, a new type of nurse role, the clinical nurse leader (CNL),

debuted in 2003, followed shortly thereafter by the Doctor of Nursing Practice (DNP) degree program.

The University of Pittsburgh School of Nursing initiated its CNL major within the MSN degree program. The CNL is a leader in the clinical setting who assumes accountability for patient care outcomes through the assimilation and application of evidence-based information to design, implement, and evaluate patient care

**“TO MAKE QUALITY IMPROVEMENT WORK,
NURSES HAVE TO APPLY CRITICAL THINKING
AND CLINICAL REASONING...WE AS EDUCATORS
MUST STRIVE TO PREPARE THEM TO TAKE ON
LEADERSHIP ROLES IN THE QI EFFORT.”**

**Irene Kane, PhD, associate professor, University of Pittsburgh
School of Nursing**



processes and models of care delivery. This course of study prepares nurses to evaluate and improve point-of-care outcomes, synthesizing data, and other evidence to produce optimal outcomes at both the individual and aggregate levels.

In 2006, the school began offering its DNP program. AACN called for DNP curricula to “build on current master’s programs by providing education in evidence-based practice, quality improvement, ... informatics, and systems thinking.” Pitt’s DNP program includes a culminating project, many of which are QI projects: Students solve a clinical or administrative problem through an in-depth investigation of current research using an evidence-based practice model. Recent projects have explored the impact of a unit-based safety officer on adherence to fall interventions, using early warning systems to reduce cardiopulmonary arrest calls in telemetry/medical/surgical settings, and the evaluation of parental perceptions of eating habits on prevention of dyslipidemia.

In addition to new degree programs and majors, there also was a shift in nursing education pedagogy and theory. The Robert Wood Johnson Foundation introduced the Quality and Safety Education for Nurses (QSEN) initiative in 2005 to prepare nursing students with the knowledge, skills, and attitudes needed to participate in QI efforts in the workforce. The program identified quality and safety competencies to be developed in prelicensure programs, after which a pilot study with 15 schools was undertaken.

Pitt Associate Professor Irene Kane, PhD, is an avid advocate for the use of the QSEN framework in her classes. “QSEN offers a wide-angle perspective on daily practice with patients. It allows you to determine if you’re being patient centered, for example,” notes Kane.

“Nursing has evolved from being a task-based job to being a position that requires critical thinking, so we have to change what we teach and how we teach it. If you look at Bloom’s taxonomy, most education moves students from the knowledge and comprehension levels to the application level. We need to guide our students to the analysis and synthesis levels; frameworks such as QSEN help us to do that,” explains Kane.

Kane has changed the way she teaches in order to better model the QSEN approach so that her students will infuse their thinking and practice with a constant awareness of QI. For example, she assigns her students an evidence-based clinical project, encouraging them to address an issue they have seen in practice and wanted to resolve. Students are required to apply QSEN principles and are mentored through preparing and delivering oral and written presentations on their project, including a manuscript.

“To make quality improvement work, nurses have to apply critical thinking and clinical reasoning; QSEN encourages both. RNs and nursing managers will be held accountable for QI outcomes across the care spectrum. We as educators must continually strive to prepare them to take on leadership roles in the QI effort,” says Kane.



Finding the Link

BETWEEN NEIGHBORHOODS AND AGING

Mijung Park, PhD, assistant professor, recently completed a study that was published in *PLOS ONE* and has garnered a great deal of national and international media attention. The study looked at living in unsafe neighborhoods and found a significant impact on telomere length, a marker of aging cells. Park and her colleagues noted that those who live in bad neighborhoods are biologically older—by about 12 years—than those who live in more favorable neighborhoods. This study has received a great deal of attention from media outlets around the globe, including *The New York Times*, the *Daily Mail*, and *The Telegraph*.

Q: Describe your research on the link between neighborhood quality and cellular aging.

A: We found that, when comparing two individuals of the same age, gender, and other sociodemographic and clinical characteristics, those who live in neighborhoods with high crime, noise, and vandalism are biologically older than those who live in better locations. And the differences in telomere length between the two groups were comparable to 12 years in chronological age.

In this study, we examined the length of telomeres of about 2,900 Dutch individuals. Telomeres are stretches of DNA at the ends of chromosomes that are often compared to caps on shoelaces because they protect the DNA strands from damage. Telomeres get trimmed each time the cell divides because they are not fully

copied by enzyme mechanisms, and it is thought that aging occurs when the telomeres become too short for DNA replication and cell division to proceed normally. Telomere shortening can be accelerated with exposure to biological or psychological stresses. We hypothesized that living in disadvantaged neighborhoods would increase levels of stress and, in turn, accelerate telomere shortening.

Q: What is the effect of the shortening of the telomeres?

A: Telomeres are considered to be an indicator of biological stress that one has experienced over the course of a lifetime. Such biological stresses include physical illnesses, such as cancer, but also can include psychological stresses (e.g., anxiety and depression) and unhealthy lifestyle choices (e.g., obesity, smoking, and drinking). Studies have shown that

In nursing, we witness and experience firsthand the interaction between the social and the biological in our practice. Therefore, nurses can be strong advocates for the disenfranchised and marginalized segments of the population.

a shortened telomere length is associated with greater morbidity and mortality.

Q: Were you surprised to find such a significant difference in the telomere length?

A: We were. We had a hypothesis that living in disadvantaged neighborhoods would be associated with accelerated cellular aging. However, 12 years of difference is quite significant.

Q: Did it make a difference if the poor quality of the neighborhood was perceived or documented?

A: Perceived neighborhood quality and documented neighborhood quality represent different aspects of a neighborhood. A single measure, such as crime statistics, may not fully capture the neighborhood's quality. Also, the perception of higher neighborhood crime may be more anxiety provoking than the actual crime statistics. Nevertheless, individuals living in areas where the crime rate is high tend to report high *perceived* crime in the neighborhood. So the perception of neighborhood quality is highly correlated with documented neighborhood quality.

Q: Was there one negative neighborhood factor that seemed to have the most impact?

A: We examined three aspects of perceived neighborhood quality: crime, vandalism, and noise. Among the three, perceived crime showed the strongest association with cellular aging.

Q: Your work has received a great deal of media attention. Why do you think that is?

A: There may be several reasons. First, everyone is interested in issues of aging because growing old is a universal experience. Generally, people want to achieve healthy aging. I think it also is very intriguing that we can measure biological age, which is different from chronological age. We want to know what ages us and how to slow the aging process. Secondly, there are growing concerns about disparities in society. The gaps in living conditions between the “haves” and the “have-nots” have been growing over the past several decades. Now the gap may have become too large to ignore. Our paper addresses one aspect of such gaps and the potential consequences.

Q: What does this connection between disadvantaged neighborhoods and cellular aging mean for society and the government? For nursing?

A: Our paper is one of the very early works examining social conditions in the context of biological aging. Thus, I would like to caution about applying our findings directly to social change. However, I hope that our paper will pique interest among government officials and citizens to seriously examine ways to improve living conditions of the poorer segments of the population. In nursing, we witness and experience firsthand the interaction between the social and the biological in our practice. Therefore, nurses can be strong advocates for the disenfranchised and marginalized segments of the population.

Charron-Prochownik Secures Prestigious NINR Funding



Congratulations to Professor **Denise Charron-Prochownik** for successfully pursuing R01 funding from the National Institute of Nursing Research (NINR). Charron-Prochownik was awarded \$3,182,365 for her project, Supporting American Indian and Alaska Native Mothers and Daughters in Reducing Gestational Diabetes Risk. The five-year grant will allow Charron-Prochownik to extend her much-lauded preconception counseling intervention, the READY-Girls program, to American Indian/Alaska Native adolescent females at risk for gestational diabetes mellitus. The project aims to enhance healthy lifestyle behaviors and family planning vigilance prior to a first pregnancy. Charron-Prochownik is a pediatric nurse practitioner and currently serves on the national advisory boards for the Alliance to Reduce Disparities in Diabetes and for the Centers for Disease Control and Prevention/National Institutes of Health National Diabetes Education Program.

Mobile Health Technology Shows Potential to Improve Health Behaviors

Professor **Lora Burke**, PhD, is the lead author of a scientific statement published in the American Heart Association's journal, *Circulation*. It examines the state of the literature about the effectiveness of mobile health (mHealth) technologies for managing weight; increasing physical activity; quitting smoking; and controlling high blood pressure, high cholesterol, and diabetes. According to this work, mHealth tools for managing weight led to greater success in the short term, but there is a lack of published data on success beyond 12 months. Mobile phone apps using text messaging can double the chances of quitting smoking, but about 90 percent of people using the apps fail to quit after six months. Burke and her colleagues noted a lack of research on diabetes, blood pressure, or cholesterol management and also that most mHealth studies were short term and limited in size.

The statement calls upon researchers to produce the needed evidence on the effectiveness of new technologies, which are currently used by one in five adults in the United States.



Maria Petrisko (BSN '15)

In April 2015, Maria Petrisko graduated from Pitt Nursing's undergraduate program, where she was enrolled in the accelerated second degree BSN track. She had previously earned a bachelor's degree in biology at Duquesne University. She was selected as a 2014–15 recipient of a B.K. Simon Family Charitable Foundation Scholarship.

Q: Are you working or pursuing another degree at this point? Where?

A: I am working at Children's Hospital of Pittsburgh of UPMC. I plan to pursue an advanced degree, but I feel that I need to gain clinical experience first in order to choose the correct path. When I began the accelerated second degree BSN program, I had hoped to apply to the PhD program immediately afterward. My science background sparked an interest in research, but I did not find a niche until I discovered nursing research. It is very interdisciplinary and focused on patient care and patient outcomes, which is the type of research that I would like to do. However, after doing a work-study job with a professor at Pitt for two terms during the accelerated program, I realized that I need to spend time "in the field" to discover my passion. I hope to soon continue learning and moving in the direction of an advanced degree.

Q: Was the B.K. Simon Family Charitable Foundation Scholarship of significant help to you?

A: This scholarship was an amazing, unexpected gift that helped to lighten the financial burden of this second degree. Education is an investment, and although I was ready to commit to pursuing this new career, I recognized that it would not be financially easy. I was unable to maintain a job (other than a part-time work-study position) throughout the program because of the extremely demanding nature of the curriculum. With the exception of government loans and my own savings, I had no other assistance. Therefore, I had to cover

tuition as well as my living expenses for 12 months without an income. With the assistance of this scholarship, I was able to complete this program without accruing unmanageable debt. This also put me one step closer to being able to afford graduate school. So yes, the scholarship was a great help to me—it made it possible for me to pursue a new career about which I am very passionate.

Q: Was there an emotional aspect to receiving this scholarship?

A: There was definitely an emotional impact. I was ecstatic and felt incredibly grateful that someone—a complete stranger—was kind and generous enough to contribute to my education. Receiving this scholarship also helped to boost my confidence in myself and my decision to enter this new field. Knowing that someone had read my story in the applicant essay and felt that I deserved this award made me feel as though I had the ability to achieve everything that I wanted.

Q: Is there anything that you'd like to say to the family members involved in the B.K. Simon Charitable Foundation?

A: I would express my admiration of and appreciation for their generosity, and I would thank them for their financial support of my pursuit of this new career. I also would thank them for the intangible gift of self-confidence that they also gave to me, because knowing that someone else believed in me and my ability to be a nurse helped me to believe in myself.

One Family Makes a Difference for Many Students

It's amazing how many lives can be touched by one family's generosity. The B.K. Simon Family Charitable Foundation established a nursing scholarship fund in 2009. Since then, the School of Nursing has been able to award scholarships to more than 30 students each year.

The fund was created in memory of the late B. Kenneth Simon, a Braddock Heights, Pa., native who became an extremely successful entrepreneur. He built a local container distribution company into All-Pak, a national distributor, designer, and contract manufacturer of packaging containers. Simon strongly believed that supporting local educational institutions would strengthen the Pittsburgh community. Although



Some of the 2014 Scholarship recipients at the school's recent scholarship luncheon.

he earned his degree at Cornell University, he and his charitable foundation were extremely supportive of institutions of higher education in the greater Pittsburgh area. As a tribute to their father, Simon's sons made a number of gifts through the B.K. Simon Family Charitable Foundation to the School of Nursing.

The fund is to be used to support nursing students from Southwestern Pennsylvania with demonstrated financial need. Since 2009, the school has offered 184 scholarships from this fund. That's a significant number of students who received the help they needed to complete their degree programs and embark upon careers as

nurses or to continue on to graduate study. Thanks to the generosity of Simon's family, these alumni have the skills and knowledge to make a difference in the lives of their patients.

If you would like to help support students, please consider making a donation to one of the school's scholarship funds. Michael S. LaFrankie, senior executive director, Health Sciences Development and Alumni Relations, would be happy to help you determine how to maximize the impact of your gift. He can be reached at 412-647-9071 or lmichael@pmhsf.org. Thank you in advance for supporting nursing students at the University of Pittsburgh.

An Outing to Remember!

The school would like to express its gratitude to the sponsors of and all who participated in the 2015 Nancy Glunt Hoffman Memorial Golf Outing. The weather held out for those attempting the challenging course at Shannopin Country Club. Fun was had by all! The day wrapped up with an elegant dinner and silent auction—all to benefit the School of Nursing's Nancy Glunt Hoffman Endowed Chair in Oncology Nursing.



Our thanks to the following:

Presenting sponsor: UPMC

Meal sponsor: Edgar Snyder & Associates

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Closest to the pin sponsor: FHLBank Pittsburgh

Hole in one sponsor: Kenny Ross Chevrolet

Hole sponsors: Lawrence Chaban; Linda and G. Reynolds Clark; Cuccaro Plumbing, Inc.; Fazio Mechanical Services, Inc.; Debbi and Jay Gillotti; Glunt Contracting Services; Ted Mahoney; MM Marra Construction, Inc.; and Oncology Nursing Society

Congratulations to the 2015 winners:

Men's (upper right): Marcus Bowman, Adam Gunn, Mike Plunkett, and Jason Richards, representing the Pitt Department of Athletics

Mixed (lower right): Lee Thompson, John Albrecht, Jill Weimer, and John Albrecht Jr.



Degree Programs

AT THE SCHOOL OF NURSING

For complete descriptions of the academic offerings at the School of Nursing, please visit nursing.pitt.edu/degree-programs.

UNDERGRADUATE

BSN

Traditional Four-year BSN Program
Accelerated Second Degree BSN
RN Options

GRADUATE*

MSN

Neonatal Nurse Practitioner
Nurse Anesthesia
Nurse Specialty Role:
Nursing Administration
Clinical Nurse Leader
Nurse Informatics

DNP

BSN to DNP

Clinical Nurse Specialist
Adult-Gerontology
Nurse Administration
Nurse Practitioner
Adult-Gerontology Acute Care
Adult-Gerontology Primary Care
Family (Individual Across the Life span)
Neonatal
Pediatric Primary Care
Psychiatric Mental Health Nurse Practitioner

Post-master's DNP

Clinical Nurse Specialist
Adult-Gerontology
Psychiatric Mental Health
Nursing Administration
Nurse Anesthesia
Nurse Practitioner
Adult-Gerontology Acute Care
Adult-Gerontology Primary Care
Family (Individual Across the Life span)
Neonatal
Pediatric Primary Care
Psychiatric Primary Care Nurse Practitioner

PhD

*Numerous graduate areas of concentration are available online as well as on site.

Notable Alumni

We invite you to meet University of Pittsburgh School of Nursing alumni who have become extraordinary leaders in their respective fields:

Nursing Deans

Margaret Grey, DrPH, FAAN
Yale University (former dean)

Terri Weaver, PhD, FAAN
University of Illinois at Chicago

Bernadette Melnyk, PhD, FAAN
Ohio State University

Susan Bakewell-Sachs, PhD, FAAN
Oregon Health & Science University

Mary Kerr, PhD, FAAN
Case Western Reserve University

Barbara Broome, PhD, FAAN
Kent State University

Valerie Howard, EdD
Robert Morris University

Mary Pat Lewis, PhD
SUNY Delhi

Marlaine Smith, PhD, FAAN
Florida Atlantic University

Kathy Mayle, MNEd
Community College of Allegheny County

Hospital/Health Administration

Lynn George, PhD, RN, CNE
Dean, College of Health and Wellness,
Carlow University

Michael Harlovic, MSN
President and CEO, Allegheny General
Hospital

Amy Pollard, MPS
President and CEO, Nicholas H. Noyes
Memorial Hospital

Rita Doll, MA
Founder, Angeles Home Health Care

Anne Hast, DNP
CEO, Advanced Surgical Hospital

Nancy Rothman, EdD
Independence Foundation, Professor
of Urban Community Nursing, Director
of Community-based Practices,
Temple University

Health System Administration

Tamra Minnier, MSN, FACHE
Chief Quality Officer, UPMC; Executive
Director, the Beckwith Institute

Helen Burns, PhD, FAAN
Senior Vice President and Chief Nursing
Officer, Excela Health

Andrea Mazzoccoli, PhD, FAAN
Vice President and Chief Nursing Officer,
Bon Secours Health System

Melanie Shatzer, DNP
Director, Learning and Innovation,
Health First

Federal Government

Wendy Henderson, PhD
Principle Investigator, Biobehavioral Branch,
Division of Intramural Research, National
Institute of Nursing Research, National
Institutes of Health

Holly Williams, PhD
Program Analyst, Office of Evaluations
and Inspections, Centers for Disease
Control and Prevention

Military

Patricia Horoho, MSN, FAAN
U.S. Army Surgeon General and
Commander, U.S. Army Medical Command

Industry

Darinda Sutton, MSN
Chief Nurse, Cerner Corporation

Cynthia Brown, MSN
Senior Clinical Research Associate,
Merck & Co., Inc.

Diane Scott, BSN
U.S. Operations Owner, iOpener Institute
for People and Performance

Professional/Academic

Deborah Trautman, PhD
CEO, American Association of Colleges of
Nursing (AACN)

Rosemary Hoffmann, PhD
Board Chair, Commission on Nurse
Certification, AACN

Cynthia Roth, MPM
President and CEO, West Virginia University
Foundation

International

Yu-Mei Yu Chao, PhD
Adjunct Research Fellow, National Health
Research Institutes, Taiwan

Prakin Suchaxaya, PhD
Coordinator; Gender, Equity and Human
Rights; World Health Organization

Phensiri Dumrongpakapakorn, PhD
Dean, Boromarajonani College
of Nursing, Thailand

Nurses are at the center of patient care—and leading quality improvement efforts.

The American Association of Colleges of Nursing calls for graduates of master's degree programs to

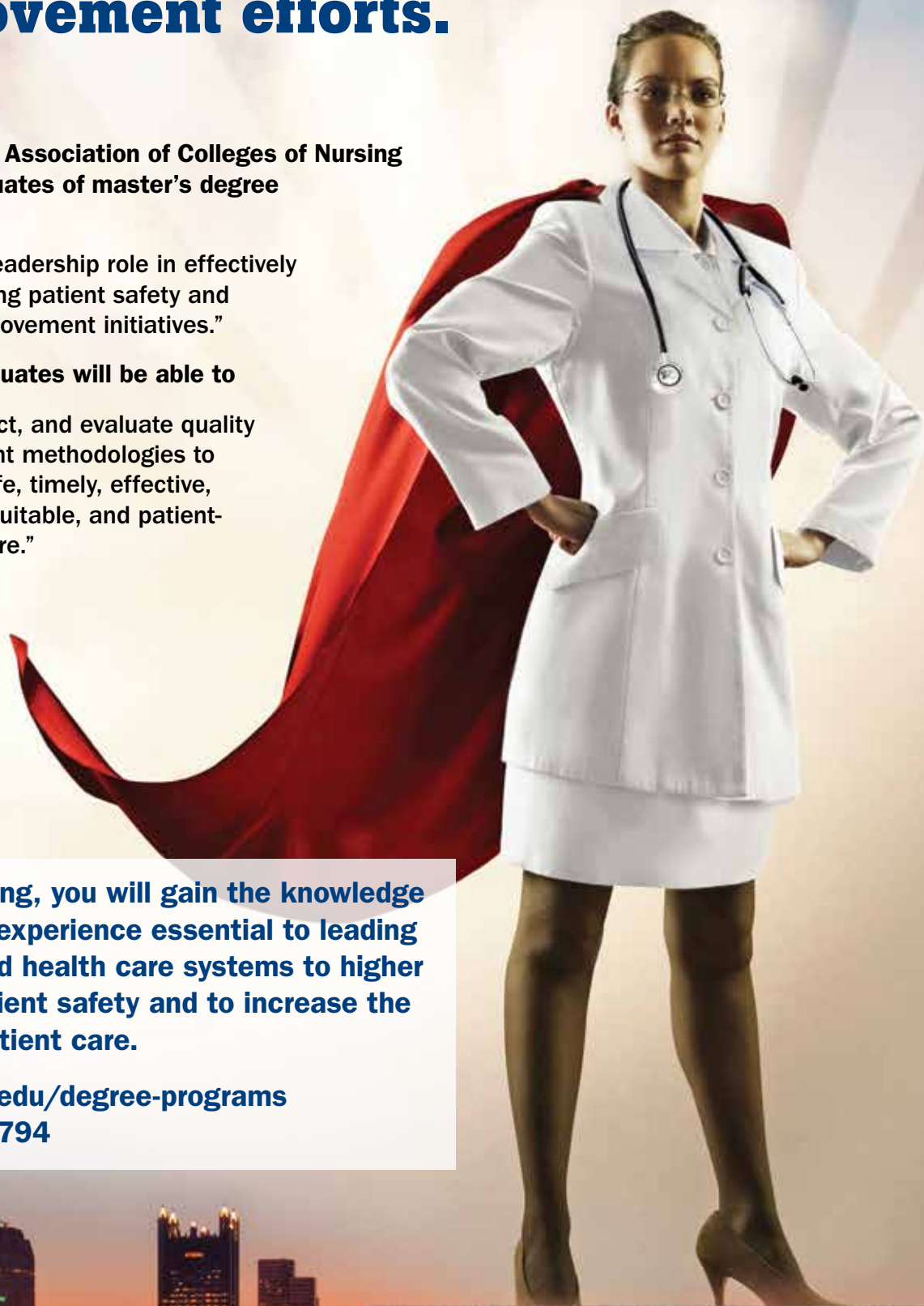
“assume a leadership role in effectively implementing patient safety and quality improvement initiatives.”

And DNP graduates will be able to

“design, direct, and evaluate quality improvement methodologies to promote safe, timely, effective, efficient, equitable, and patient-centered care.”

At Pitt Nursing, you will gain the knowledge and clinical experience essential to leading hospitals and health care systems to higher levels of patient safety and to increase the quality of patient care.

**nursing.pitt.edu/degree-programs
1-888-747-0794**



CLASS NOTES

1960s

Lois Gerber (BSN '62) published *Runaway Girl: A Nurse's Story*, set in Pittsburgh in the 1920s. Gerber has self-published three previous books of short stories and has more than 40 years of experience in community health.

1970s

Joyce Kettren (BSN '73) previously worked as a CRNA in Los Angeles, Calif., at the Westwood VA Medical Center and for Kaiser Permanente. Kettren then attended law school at Loyola Marymount University and now serves as the director of contracts and risk management at Pathways Home Health and Hospice in California.

Marilyn H. Oermann (MNEd '75) and Judith Hays coauthored the third edition of *Writing for Publication in Nursing*. Oermann is editor in chief of *Nurse Educator* and the *Journal of Nursing Care Quality*. She is the Thelma M. Ingles Professor of Nursing and director of evaluation and educational research at the Duke University School of Nursing in Durham, N.C.

Rita (Bolek) Trofino (BSN '76, MNEd '81), associate dean of the School of Health Sciences and nursing department chair at Saint Francis University, has been elected vice president of the Pennsylvania Higher Education Nursing Schools Association and appointed to the Membership Committee of the American Association of Colleges of Nursing.

1980s

Victoria Soltis-Jarrett (MSN '88) was recently awarded the Carol Morde Ross Distinguished Professorship in Psychiatric-Mental Health Nursing at the University of North Carolina at Chapel Hill School of Nursing.

1990s

Lynn George (MSN '90) was named the inaugural dean of the College of Health and Wellness at Carlow University. Before her appointment at Carlow, George served as the associate dean of the School of Nursing and Health Sciences at Robert Morris University and as head of the nursing program at the Community College of Allegheny County's Boyce Campus.

Mildred A. Jones (MSN '90, PhD '00) was named professor emerita by Carlow University in May 2015. Jones is currently president of the Pennsylvania State Nurses Association, District 6.

2000s

Tammy M. Haley (MSN '02, PhD '12) has been named director of nursing and radiological sciences at the University of Pittsburgh at Bradford. Before starting at Pitt-Bradford, Haley practiced as a certified family nurse practitioner.

Robin Lane (BSN '05), a senior manager of value analysis for UPMC, currently serves as the Northeast regional director and board member for the Association of Healthcare Value Analysis Professionals.



Pittsburgh's Favorite TV Chef Wows at Cooking Demonstration for Alumni

Alumni Day 2015 was a huge hit! Graduates from 1958 to 2014 were in attendance. They were so happy to join in the fun when Pittsburgh TV chef extraordinaire Chris Fennimore led the group, step by step, through the making of an outstanding pasta dish. Everyone learned something new, whether they were cooking novices or

experts! After a delightful lunch, Dean Jacqueline Dunbar-Jacob recognized each of the classes celebrating a special reunion year (those class years ending in 5 or 0). Each member of those classes was repinned and received a bouquet of spring flowers.

Thanks to Fennimore and all who joined the School of Nursing for Alumni Day 2015!



New Graduates Introduced to Alumni Family

In April, the School of Nursing hosted its first kickoff to graduation event for all students graduating that month—what a great way to welcome the newest members of the Pitt Nursing alumni family!



The School of Nursing was honored with a Gold Banner Award for its achievements in the Pitt Alumni Association Banner Program in 2014. The award carries a monetary award to the school's scholarship fund. The Banner Program honors those constituent groups whose activities support the mission of the Pitt Alumni Association.

PITT NURSING

in Memoriam

Naomi R. Cherup
(BSNEd '52)

Beth Ann Moore Klar
(BSNEd '51)

Kathryn C. Conway
(BSN '49)

Gina A. Levy
(BSN '97)

Pearl J. Davis
(BSN '44)

Clara M. Long
(BSN '61)

Alice Robinson Evans
(BSN '46)

Barbara Lusnak
(MSN '85)

Patricia M. Frey
(BSN '83)

Jennifer M. Newell
(BSN '05)

Mary Bernardine Golonka
(MN '72)

Dolores Nejak Perri
(BSN '59)

Marie Gresko
(BSN '52)

Joan M. Pryor-McCann
(BSN '76, MN '78)

Marilyn C. Harris
(BSNEd '58)

Ruth E. Smith
(BSN '50)

Mildred Volz Kegel
(BSNEd '53)

Virginia L. Williams
(MLit '59)

Linda E. King
(BSN '63)



Pitt Nurse Chosen for First “Year of Humanities” Event

To kick-off its “Year of the Humanities” series, Pitt hosted a book launch event for *The Shift: One Nurse, 12 Hours, Four Patients’ Lives* by Theresa Brown (BSN '07). Throughout the 2015-16 academic year, the University will present campus-wide programs to showcase the importance of the humanities across of spectrum of academic disciplines, from

the sciences to business and medicine. It was very exciting to have a School of Nursing alumna chosen for the inaugural event.

A 2007 graduate of Pitt Nursing’s accelerated second degree BSN, Brown is perhaps best known for her work as an op-ed columnist for *The New York Times*.

In *The Shift*, published in September 2015, Brown lets readers experience the dynamics of one day on a busy oncology ward. She chronicles 12 hours and introduces four very different patients, thereby revealing the skills, sensitivity, and humor that enable a nurse to be a patient’s “most ardent advocate in a medical system marked by heartbreaking dysfunction as well as miraculous successes.”



On June 20, 2015, **Adena Johnson Davis** (BSN '47) was recognized as a Living Legend by the Pittsburgh Black Nurses in Action organization. She was recognized for her role in diversifying the face of the profession and her long and pioneering career at Magee-Womens Hospital of UPMC and the U.S. Department of Veterans Affairs. She is shown here with Dawndra Jones (DNP '14) and Assistant Professor Claudia Kregg-Byers (BSN '04, PhD '14).

Photo courtesy of the *New Pittsburgh Courier* online



Susan Albrecht



Brenda Cassidy



Denise Charron-Prochownik



JiYeon Choi



Rose Constantino



Annette DeVito Dabbs

FACULTY DISTINCTIONS

Susan Albrecht, PhD, CRNP, FAAN, associate professor and associate dean for external relations, recently was awarded the Association of Women's Health, Obstetric and Neonatal Nurses Distinguished Professional Service Award for her contributions to the field of women's health and newborn care.

Brenda Cassidy, DNP, assistant professor, received the *Journal of Pediatric Health Care's* 2014 Ellen Rudy Clore Excellence in Scholarly Writing Award for coauthoring the article, "A Quality Improvement Initiative to Increase HPV Vaccine Rates Using an Educational and Reminder Strategy with Parents of Preteen Girls" along with fellow faculty members **Betty Baxter**, **Denise Charron-Prochownik**, and **Elizabeth Schlenk**. She received the award on behalf of all of them.

Ji Yeon Choi, PhD, assistant professor, received the 2015 Assembly on Nursing Early Career Achievement Award at the American Thoracic Society International Conference in May 2015.

Yvette Conley, PhD, professor and vice chair for research in the Department of Health Promotion and Development, received the 2015 Distinguished Alumni Award for Teaching and Dissemination from Pitt's Graduate School of Public Health. The award was in recognition of her leadership in incorporating genomics into nursing education across all degree levels, both at the University and across the nation.

Rose Constantino, PhD, FAAN, FACFE, associate professor, was elected to the fellow selection committee of the American Academy of Nursing as well as to the American Nurses Association Advisory Group on Workplace Violence and Incivility.

Heidi Donovan, PhD, has been promoted to the rank of full professor. Congratulations!

Linda Dudjak, PhD, retired in May 2015. Dudjak most recently served as lead faculty member for the school's concentration in nursing administration.

Andrea F.R. Fischl, PhD, CRNP, research assistant professor, was named to the Alliance to Improve Community-clinical Partnerships, a new statewide multidisciplinary partnership of community-based organizations, health care systems, government agencies, and managed care organizations charged with improving the health of Pennsylvania residents who have or are at risk of developing diabetes.

Rosemary Hoffmann, PhD, associate professor, was appointed director of MSN programs at the School of Nursing.

Marilyn Hravnak, PhD, FAAN, professor, has been named cochair of the University Senate's Equity, Inclusion, and Antidiscrimination Advocacy committee.

Jennifer Hagerty Lingler, PhD, has been promoted to associate professor.

Donna Nativio, PhD, FAAN, FAANP, associate professor and vice chair for administration in the Department of Health Promotion and Development, received a lifetime membership in the American Association of Nurse Practitioners in recognition of her years of effort and commitment to the nurse practitioner movement nationwide.

Michael Neft, DNP, has been promoted to associate professor.

Gail Wolf, PhD, FAAN, professor, retired in May 2015 after more than 30 years of teaching at the School of Nursing, during which time she also held significant leadership roles with UPMC. Wolf joined the faculty full time in 1995 to develop a graduate program in nursing leadership.

FACULTY GRANTS

(since March 2015)

Judith A. Callan, PhD
University Research Council/Central Research Development Fund
Reducing Mental Health Care Barriers and Stigma for Veterans of the OEF/OIF Engagements Using Smartphone Technology

Denise Charron-Prochownik, PhD
National Institute of Nursing Research
RO1: Supporting AI/AN Mothers and Daughters in Reducing Gestational Diabetes Risk

Ji Yeon Choi, PhD
International Society for Heart & Lung Transplantation
Telerehabilitation for Lung Transplant Candidates and Recipients

Annette DeVito Dabbs, PhD, FAAN
Aging Institute of UPMC Senior Services and the University of Pittsburgh
Understanding Barriers to Access and Effective Use of Patient Portals to Promote Engagement of Older Adults in Their Health Care

Heidi Donovan, PhD
Graduate School of Public Health/Center for Health Equity
Student-led Health Connection Centers in Community Food Pantries

John O'Donnell, DPH
Human Resources and Services Administration
Nurse Anesthetist Traineeships

Mijung Park, PhD, assistant professor, has been awarded a prestigious K01 grant from the National Institute of Nursing Research. The grant for \$280,000, a Mentored Research Scientist Development Award, will support Park's work on FACE-PC: Family-centered Care of Older Adults with Multiple Chronic Conditions. The overall goal of the National Institutes of Health's



Heidi Donovan



Linda Dudjak



Andrea F.R. Fischl



Donna Nativio



Michael Neft



John O'Donnell

research career development program is to foster a diverse pool of highly trained scientists in appropriate scientific disciplines to address the nation's biomedical, behavioral, and clinical research needs. This grant will support Park for a sustained period of research career development and training under the guidance of a mentor. Park will then be prepared to launch an independent research career, one with greater potential to be competitive for significant research project grants in her area of interest, which involves improving the quality of care for older adults with multiple medical and psychosocial comorbidities.

NEW FACULTY POSITIONS

Grace Campbell, assistant professor, Department of Acute/Tertiary Care

Laura Fennimore, professor, Department of Acute/Tertiary Care

Young Ji Lee, assistant professor, Department of Health and Community Systems

Britney Kepler, assistant professor, Department of Health and Community Systems

Mandy Schmella, assistant professor, Department of Health Promotion and Development

STUDENT DISTINCTIONS

Lynn Baniak accepted an appointment as a postdoctoral scholar in the Department of Health and Community Systems.

Kelley Baumgartel (BSN '06, PhD '15) accepted an appointment as a postdoctoral scholar in the Department of Health Promotion and Development after successfully defending her PhD dissertation, "The Impact of Promoter Polymorphisms on Cytokine Concentration in Preterm Breast Milk and Subsequent Infant Outcomes."

Grace Campbell (BSN '94, PhD '13), when a postdoctoral researcher, was selected as a member of the Subject Matter Expert Consortium on Cancer Rehabilitation, which is sponsored by the National Institutes of Health Clinical Center, the National Cancer Institute, and the National Center for Medical Rehabilitation Research.

Yun Jiang successfully defended her PhD dissertation, "Factors Associated with Acceptance and Use of Mobile Technology for Health Self-monitoring and Decision Support in Lung Transplant Recipients."

Cameron Kramer (BSN '00, MSN '10) successfully defended his PhD dissertation, "Self-management and Adherence in Chronic Disease."

Nicole Osier, a PhD candidate, was selected as the overall winner of the American Association of Colleges of Nursing Graduate Nursing Student Academy video contest. The contest, My 2020 Vision for Nursing, asked participants to describe what they foresee for the nursing profession in 2020. Osier's video explained her vision for nurse scientists working in tandem with bedside nurses to improve health care.

Jennifer Thurheimer successfully defended her PhD dissertation, "Examining Short- and Long-Term Effects of Preconception Counseling Delivered during Adolescence on Risk-taking Behaviors, Condom Use, and STIs among Females with T1D."

Yaguang Zheng successfully defended her PhD dissertation, "Electronically Recorded Self-weighing in Weight Loss Treatment."

STUDENT GRANTS

Lu Hu, PhD student

Sigma Theta Tau International, Eta Chapter
Trajectory Analysis of Adherence to Self-monitoring in Lung Transplant Recipients

Jenna Snyder, BSN student

Greater Pittsburgh Chapter of the Oncology Nursing Society
Emerging Oncology Nurse Scholarship Award

Ann Mitchell Inducted into IAAN

Congratulations to Professor Ann Mitchell for being selected as a fellow of the International Academy of Addictions Nursing (IAAN). IAAN aims to foster excellence in addictions nursing and to recognize those who have contributed to addictions nursing in sustained and significant ways through practice, administration, research, and education. Mitchell is the project director or principal investigator on two Health Resources and Services Administration (HRSA)-funded grants, two Centers for Disease Control and Prevention-funded grants, and a grant through the Substance Abuse and Mental Health Services Administration. Her current work looks at addiction training for nurses using a Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. With more than 50 peer-reviewed publications to her credit, Mitchell also is a fellow in the American Academy of Nursing.

Are You a Prescriber?

Need to have the latest research and pharmacology updates at your fingertips? Want information that will impact your practice immediately?

Sign up for the University of Pittsburgh School of Nursing Continuing Education Pharmacology and Clinical Practice Update Series. This year marks the sixth year for this popular series that focuses on pharmacology updates with corresponding clinical practice implications. Monthly programs cover today's topics such as treatment of hyperlipidemia and medication issues for geriatric patients and are available on campus and via Web conference.

Save the Date for The Practice of Mindfulness.

Learn to develop mindfulness strategies and techniques to aid with the care of patients and family members as well as help improve your quality of life.

The Practice of Mindfulness, facilitated by Kathryn Hammond Holtz, will be held on Friday, April 15, 2016, from 8:30 a.m. to 4 p.m. at the Boiler Room, 1070 Banksville Road, Pittsburgh, Pa. The program costs \$175 and participants will earn 6.5 contact hours.



Need Continuing Education but Have No Time to Attend Classes?

Between working shifts, teaching students, and trying to have a home life, it's hard to find the time to earn the required continuing education contact hours. Through Pitt's nursing continuing education enduring/online activities, you can explore topics in addiction, ethics, technology, arthritis, chronic diseases such as diabetes, and best practices—all from the comfort of your home and whenever you have the time.

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News

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NSNA Convention

Pitt Nursing was well represented at the National Student Nurses' Association (NSNA) 63rd Annual Convention, which was held in April in Phoenix, Ariz. The BSN students learned much while attending the general sessions, seminars, workshops, and poster presentations. The students were accompanied by Susan Albrecht, advisor for the Nursing Student Association at Pitt.



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- ranked **first** in nurse anesthesia in the *U.S. News* rankings.
- ranked **sixth** in NIH funding among schools of nursing.
- designated a research-intensive environment by the NINR

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Pitt is:

- one of the nation's best institutions for undergraduate education, according to the Princeton Review.
- the top value among all public colleges and universities in Pennsylvania, according to *Kiplinger's Personal Finance*.
- the eighth best U.S. school at which to study health professions, according to a ranking by College Factual.