

JOHNS HOPKINS NURSING

Been There, Done That

PhD Learning Lab passes wisdom and experiences from one doctoral cohort to the next

Welcome Words

Spanish class helps nurses clear barriers to care at the bedside

Top 5 Once Again

School of Nursing (No. 2) remains among top graduate programs in *U.S. News* rankings for 2016

BIG DATA'S BIG PICTURE

Pumping red blood into cold statistics at healthcare's bottom line



JOHNS HOPKINS NURSING

A publication of the Johns Hopkins School of Nursing, the Johns Hopkins Nurses' Alumni Association, and the nursing departments of the Johns Hopkins-affiliated hospitals



Data at their fingertips: From left, Ashley Cannizzaro, Michael Philip Gilliam, Eriqum Gumbs, and Nicole Grafilo compare notes during clinicals at Franklin Square Hospital Center. The Johns Hopkins School of Nursing was ranked No. 2 in the latest *U.S. News & World Report* survey for 2016. In separate surveys, the Bloomberg School of Public Health kept its No. 1 ranking and the School of Medicine was No. 3. (Article on Page 7) PHOTO BY WILL KIRK

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BIG DATA AT WORK
BY STEVE ST. ANGELO

The term “big data” is thrown around so loosely these days—a catchphrase for all the statistics, crunched numbers, charts, schematics, and other brain propellants behind great advances in patient safety and quality of medical care (and engineering, and economics, and ... apparently everything)—that perhaps we don’t understand its true meaning or importance where red blood and big data meet.



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Cover artist **Mitch Blunt** is a conceptual Illustrator from Hastings, England. His clients include AARP, Adweek, Bloomberg Businessweek, Esquire, House & Garden magazine, the New York Observer, Reader's Digest, Runner's World UK, the Atlantic, the Boston Globe, the Guardian, the New York Times, the Wall Street Journal, and Wired. For inside this issue, he boils the complexities of big data down to their essence ("Big Data's Bottom Line," P. 16).



Freelance health and technical writer **Wendy J. Meyeroff** makes her Johns Hopkins Nursing debut with a look at a program at Howard County General Hospital that better instructs discharged patients on how to properly take meds ("1-2-3, Go," P. 35). She has been nationally published for over 20 years in both clinical and consumer information for clients including NurseWeek and Graduating Nurse, the National Institutes of Health, American Heart Association, and the Epilepsy Foundation.



Jon Christofersen shoots images for the Pathology Photography & Computer Graphic Department, or Path Photo, at The Johns Hopkins Hospital. For this issue, he found a perfect angle at which to capture Ann Marie Albright, RN, a School of Nursing grad who rode a "win-win" clinical pilot program to a job at a Hopkins intensive care unit ("Transformative Transitions," P. 30).



Illustrator **Leonard Peng** ("Financial Vision," P. 28) is a 2014 graduate of the Maryland Institute College of Art in Baltimore. In addition to his work for such clients as the Johns Hopkins Film Society, the San Francisco Chronicle, Nautilus Magazine, and the Loadstone Journal, Peng has had a number of gallery shows of his artwork in Baltimore and Minneapolis, MN. He is a native of San Jose, CA.



Jennifer Walker, a regular contributor to Johns Hopkins Nursing, is a freelance writer based in Baltimore, where she writes about health and medicine, food, business, and education. Her work has appeared in Saveur, Baltimore Style, Johns Hopkins Magazine, and ENT Today, among other publications. For this issue, she offers a look at Spanish courses that help nurses develop "a capacity for connection" ("Welcome Words," P. 22) as well as a story of love and giving back ("Forever Hopkins," P. 45).

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Johns Hopkins Nursing is a publication of the Johns Hopkins School of Nursing, the Johns Hopkins Nurses' Alumni Association, and the nursing departments of the Johns Hopkins-affiliated hospitals. The magazine tracks Johns Hopkins nurses and tells the story of their endeavors in the areas of education, practice, scholarship, research, and national leadership.

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LETTER FROM THE EDITOR:

Plainly and Simply



A self-important writer at another publication once accused me of “dumbing down” a feature story by substituting a simpler word for one usually reserved for a Rhodes Scholar’s spelling bee. I argued that the vast majority of readers might not know his chosen word’s meaning. He snorted: “They can look it up in the dictionary.” I offered that the dictionary was certainly far more interesting and better written than his article and thus those sent to “look it up” might never return. Ahem.

I can’t claim never to have been guilty of that sin myself, but I try to remember the look on his face ... and find a less-expensive synonym for 50-cent words. With all of the acronyms we throw around in nursing (URI, CVSICU, HCV, etc.), it’s difficult enough to keep the narrative flowing. (And just so you don’t have to look them up, that’s upper respiratory infection, cardiovascular surgical intensive care unit, hepatitis C virus, etc.) Nursing is its own colorful language.

So what do we do about newbies to the profession who don’t yet know their

ACLS’s (advanced cardiac life support) from their elbows? Or patients we serve, especially those who not only don’t speak nurse but do not speak English? When we can, we should provide translation.

And that’s really what this issue of *Johns Hopkins Nursing* is all about. We’ve got a report on what the fairly vague expression “big data” looks like in practice (“Big Data’s Bottom Line,” Page 16), a Spanish class for nurses (“There’s a Word for What They Do,” Page 22), PhD grads showing new students the ropes (“Been There, Done That,” Page 26), and even a profile of a returned Peace Corps volunteer—RPCV to us—eager to practice her Spanish in Guatemala who landed, instead, in the only predominantly “English”-speaking country in South America (“Key Word Is Flexibility,” Page 14).

All of it translates to what we think is an informative, readable package (oops: see letter below). Thanks for giving it a look.

Steve St. Angelo

Think of Your Readers, Please

I have been a reader of this magazine, in several formats, since my graduation in 1960. I have always looked forward to receiving it with its informative articles and updates from alumnae of all years.

This issue [Winter 2014] has prodded me to write you for the first time. Nurses tend to be picky individuals, with an eye to waste and idiotic decisions, so I am asking for some explanations for decisions made that are glaringly evident in this issue.

First, waste. You could have published another entire article, maybe two, with all the “artistic” white space in the layouts. It may win you prizes, but I doubt its value in this magazine designed to update nurses of all ages and interests.

Secondly, your choice of font and font color may again be “artistic,” but pale blue against white leaves many of us unable to read the names of the authors of the articles. And the primary color choice for most of the articles appears to be gray rather than an easier-to-read black. The font size is difficult to read in many parts of the magazine, and since you have all that vacant white space anyway, it is obvious that you could have selected a larger font size.

So take your choice, please. Think of the age and eyesight of many of your readers, and take pity on us. I’d prefer to think that you are designing for your readers rather than for “glory.”

Nancy Edgar Liskey,
Diploma JHH, 1960; BSN JHU, 1965

Editor’s note: *Johns Hopkins Nursing* is and ever shall be an evolving publication, and so we’ve tried to subtly tweak things like point size and background colors as we hear concerns. Yes, we love the newer

look of the magazine. But we’re not trying to win contests, just loyal readers like Ms. Liskey. Alumni, working nurses, retired nurses, students, prospective students, parents, faculty, instructors, researchers, and friends of nursing—and my dad, who is 85—are all incredibly important to the magazine and to me as its editor. So we’ll see what we can do. Please stick around and stay picky.

Steve St. Angelo

Letters to Johns Hopkins Nursing

We welcome all letters regarding the magazine or issues relating to Hopkins Nurses. Email 200 words or fewer to son-editor@jhu.edu or send to:

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Letters will be edited for length and clarity.

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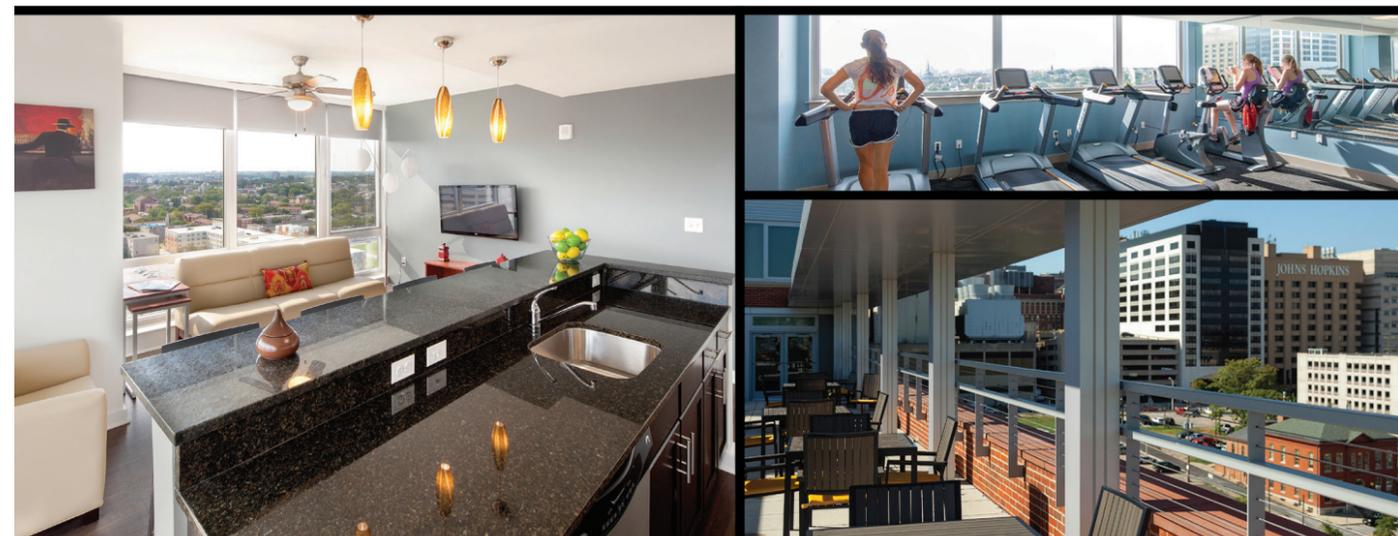
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NOTES FROM THE DEAN:

From Point A to Point A



“The truth is, the vision—our vision—never changes. It’s the same as it was when the doors of this institution first opened: Be the best nursing school in the world and create critical thinkers and leaders in the field.”

It’s common for people to approach me as dean to ask about my vision for the future. The truth is, the vision—our vision—never changes. It’s the same as it was when the doors of this institution first opened: Be the best nursing school in the world and create critical thinkers and leaders in the field. What changes is the strategy used to achieve those ends.

This issue features several such strategies in action, beginning with the cover story on big data and how our doctor of nursing practice (DNP) students are using hard evidence and whip-smart ideas to tackle complicated healthcare problems across the United States. Then there is the PhD Learning Lab, doctoral graduates mentoring those following in their footsteps. And as always, there are stories of nurses being heard, setting the tone at a time when that matters so much.

The Institute of Medicine report on The Future of Nursing sends a stark message about the critical shortage of nurses today, when:

- The Affordable Care Act adds 32 million newly insured patients to those already seeking care.
- One-third of current MDs are expected to retire over the next 10 years, causing the physician deficit to grow from 7,000 to as high as 100,000 across all specialties.

While daunting, these factors represent a tremendous opportunity for nurses to step up more and more in primary care, locally and globally, despite our own challenges:

- The median age of a nurse is 46, and some 900,000 nurses over age 50 (of 3 million total nurses) will need to be replaced by 2020.
- The Health Resources and Services Administration (HRSA) estimates a nursing shortfall of 1 million by 2020. More conservative estimates put the number at “only” 260,000 by 2025. For comparison, the last great nursing shortage peaked in 2001 at 126,000. So we face a situation doubly as bad (conservatively) as anything we’ve ever experienced.

The need for advanced nursing will expand whether we’re prepared or not. We need a larger, better educated national nursing workforce to meet the complex healthcare needs of the coming decades. Nurses should be ready and able to practice at the top of their licenses, and nurse practitioners should continue to establish their vital role. We must be culturally competent and sensitive, and so you will meet instructor Sarah Dutton, whose Spanish classes here at the school have for more than a decade helped Hopkins nurses comfort non-English speakers and clear barriers to care at the bedside. We need to make better use of resources and find ways to provide the same quality care at a time when there is tremendous pressure to keep costs down.

It will take smarts, a desire to remain the best nursing school in the world, and a continued thirst to be leaders in all things nursing. It will take strength, not to mention nerve.

Fortunately, we have more than a little of all that stuff around here. Please enjoy the Spring 2015 issue.

Patricia M. Davidson
PhD, MEd, RN
Dean, Johns Hopkins School of Nursing



ON THE PULSE

News from **Around the School**

Inside this section:

P. 08

STUDENT Q&A: ASHLEY SAYLES, RN

Master’s student and brand-new Johns Hopkins Hospital pediatric nurse on her path to the school and resilience when times weren’t nearly so good.

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THE BEST AND THE BRIGHTEST AT LIGHTING OF THE LAMP

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NP SURVEY FINDS THEM HAPPY AND ENGAGED IN DIRECT CARE

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DECEMBER GRADS URGED TO EARN STRIPES BY STICKING TOGETHER

P. 10

DIANA CHIA AND HER NEIGHBORS KNIT TO HELP THE HOMELESS

School Remains in Top 5

U.S. News & World Report has named the Johns Hopkins School of Nursing one of the top accredited nursing school graduate programs in the nation for 2016, placing it at No. 2. Across the East Baltimore campus, the Johns Hopkins Bloomberg School of Public Health ranked No. 1 and the Johns Hopkins School of Medicine No. 3, making the university the only institution to rank among the top 5 in all three divisions.

“Even as a top-ranked institution, our work is never finished,” says Dean Patricia M. Davidson, PhD, MEd, RN. “Our faculty, students, and alumni continue to have tremendous impact both locally and globally in the areas of HIV/AIDS, intimate partner violence, nursing ethics, and aging to name only a few.”

Traditionally measured by peer assessment, this year’s rankings also took into account quantitative factors such as enrollment, financial aid, tuition cost, student expenses and demographics, programs offered, grade point averages, and research funding received from the National Institutes of Health and other educational and practice initiative grants. Other changes to the



PHOTO BY WILL KIRK

2016 methodology include specialty rankings in new categories and the omission of specialties like adult/medical-surgical, nurse practitioner adult, and community-public health, in which Hopkins Nursing has ranked No. 1. The frequency of the rankings has also changed from once every four years to yearly.

Hopkins Nursing’s online graduate nursing programs ranked No. 3 in a *U.S. News* survey released in January. ■



Find additional news and notes about students, faculty, and staff in the new digital *On the Pulse* newsletter. Watch for it in your “in” basket every other month. If you’re not on the school’s internal system and would like to receive a copy by email, or if we’ve somehow overlooked you, send a note to son-editor@jhu.edu. A link also appears on the school’s homepage: nursing.jhu.edu. ■



PHOTO BY CHRIS HARTLOVE

Student Q&A

Ashley Sayles, MSN candidate

It would be tough for things to be going any better right now for Ashley Sayles, RN. The Jamaica, Queens native, December grad, and current member of the master's program recently passed the NCLEX, starts her dream job in pediatrics at The Johns Hopkins Hospital this spring, and has begun planning her wedding. Sayles talked about how she got to such a good place from November 27, 2013, the day her father died suddenly, less than two weeks before finals in her first semester.

HOW DID YOU KEEP YOUR FOCUS?

I went home for Thanksgiving, and came back one day after. My mom was, like, "Go!" And I can just imagine my dad saying, "If she loses four months of work, when she's only two weeks away, just so she can sit home and cry? I'm going to be pissed." Of course I thought about it, but at the same time, my family worked hard for this, put in a lot of sacrifice for me to be here. I pushed through.

WHY PEDIATRICS?

It's like I've come full circle. I grew up as a sick kid. I still today have chronic asthma. I was diagnosed when I was 2, and was in and out of the hospital. But I remember the hospital being fun. There were all these games. And my mom, I wouldn't say she was so strict, but it was the one time, you know, I could eat whatever I wanted. I didn't have to study. I could just ... be a kid.

DID YOU EVER FAKE AN ATTACK TO GET TO GO TO THE HOSPITAL?

I tried, but my mom knew. She's a nurse.

HOW DID YOU END UP AT HOPKINS?

I never gave much thought to going to Hopkins, what it would be like, because I didn't think I would get in. So I heard from the University of Miami first, and I said, "OK, this is it!"

WHAT CHANGED THAT?

I missed my flight. I was taking the metro, with my roommate and my best friend, to the airport in DC and the metro just ... stops. It was a direct flight. Now we had to go through Atlanta. The next flight to Miami only had two seats. The rental car was in my roommate's name and the hotel was in my best friend's name. I told them, "You guys go." So I'm at the Atlanta airport, all alone. And I call my mom all upset. "Oh my gosh, I'm going to be here forever!" I'm just going off, and I get a call on the other line, some weird Baltimore number. So I listened to the voicemail: "Hi, I just wanted to let you know you've been accepted by Johns Hopkins." I was, like, "oh my god, oh my god, oh my god." ... I came to Accepted Students Day, fell in love with the school, bought a sweatshirt, took a picture and posted it on Instagram: "I picked Hopkins!"

DID YOU MAKE THE RIGHT CHOICE?

Hopkins is amazing. Just ... the support you get, the experience. I was over at Hopkins Hospital in the infant and toddler unit. It's like, 1 kid in every 10 million is born with this, and you have three of them on this unit. You never see that anywhere else! ■

© FULL INTERVIEW AND VIDEO ARE AT MAGAZINE.NURSING.JHU.EDU/ASHLEY



Warm glow: The January 12 Lighting of the Lamp Ceremony, which marks a transition for students, celebrates the history of nursing, and provides a bonding opportunity for each class.

PHOTO BY KELLEY CARPENTER

Survey Finds NPs Happy, Providing Direct Care

Even 25 years ago, an analysis by the Office of Technology Assessment indicated that nurse practitioners could safely and effectively provide more than 90 percent of pediatric primary care and 75 percent of general primary care services.

Results of the first National Sample Survey of Nurse Practitioners show that NPs are fast becoming just such a linchpin of the U.S. healthcare system. They play a critical role in extending access to primary care, especially in rural areas, and are poised to play an even greater one.

"Practice Patterns and Characteristics of Nurse Practitioners in the United States: Results From the 2012 National Sample Survey of Nurse Practitioners" appeared in the February issue of the *Journal for Nurse Practitioners*. In the survey commissioned by the Health Resources and Services Administration (HRSA), the vast majority of nurse practitioners reported being in clinical practice, providing direct patient care at a median salary of \$82,000.

Associate Professor Kathleen White, PhD, RN, helped lead the survey as an advisor to HRSA's Center for Health Workforce Analysis, the Division of Nursing, and the Office of Performance Management in the Bureau of Health Professions.

Among other key findings:

- There were an estimated 154,000 licensed nurse practitioners (NPs) in the United States in 2012.

- Within the NP workforce, about 127,000 NPs were providing patient care, and nearly half of NPs in patient care (60,407) were working in primary care practices or facilities.
- The average age within the NP workforce was 48.
- Approximately 94 percent of the NP workforce held a graduate degree. Of the 6 percent without a graduate degree, most were trained before 1992.
- Seventy-six percent of the NP workforce maintained certification in what is generally considered a primary care specialty (family, adult, pediatric, or gerontology). The most widely held certification is family NP.
- Overall, NPs in the workforce reported high levels of job satisfaction based on level of autonomy, time spent in patient care, sense of value for what they do, and respect from colleagues. ■



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JOHNS HOPKINS
SCHOOL of NURSING

Grads Earn Their Stripes

Lean on each other, AACN chief urges December class

Remember the zebras, Deborah Trautman, PhD, RN, urged graduates at December's Degree Completion Ceremony at Shriver Hall on the Johns Hopkins University Homewood campus.

Trautman, PhD, RN, executive director of the Center for Health Policy and Healthcare Transformation at The Johns Hopkins Hospital and CEO of the American Association of Colleges of Nursing, explained that zebras in the wild cannot lie down to rest for fear of predators. Rather, they place their weary heads on the back of a comrade. As brand-new Hopkins nurses, Trautman said, classmates should likewise seek

each other out for mutual support and mentoring, citing a favorite African proverb: "If you want to go fast, go alone. If you want to go far, go together."

Graduate Kelly Lynn Hann spoke of her father's mantra, offered each time she headed off for volleyball practice, for nursing school, or for an address to a room filled with her peers: "Run fast, jump high." The 17-month program, she said, has been "like a crazy, mad, 100-year dash."

"We finished this race and we've made record time," Hahn said, adding: "Run fast, jump high ... and go save some lives!" ■

Her Hobby Is Helping



Graduate student Diana Chia wanted to help the homeless of Baltimore through the cold winter nights, a desire reinforced when she volunteered for the city's annual homeless Point-In-Time Count during two Code Blue nights—evenings declared too cold to spend outdoors by the Health Department. An idea (hats) came to her through knitting, a hobby originally taught to Chia by her grandmother and reintroduced in the past year by some crafty friends.

Through her project Knitting Neighbors Together, Chia formed a community of like-minded folks from various Baltimore neighborhoods. She solicited donations through Kickstarter and gathered up to 30 people of "all types, men and women, all levels of ability" for her knitting events. Chia, on the family nurse practitioner track, even caught the attention of Baltimore's ABC2 News, which in early February did an "In Focus" segment on her and the project.

The first eight hats, the product of Chia's initial knitting session, were distributed during the annual count. By February 14, she had exceeded her goal of 50 hats, and the group kept right on going, adding scarves and mittens distributed directly to individuals in need on additional Code Blue nights. "They pretty much go out of my hand as soon as I get them."

She sees the impact of her efforts on the streets when she recognizes a hat. "There's something personal in knowing where each hat came from," she told ABC2 News. ■

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CELLS TO SOCIETY

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The Promise of CAPABLE

By Steve St. Angelo

Preliminary findings: 80 percent of elder participants see daily life, health improved

An 80 percent success rate at anything is great. Helping 80 percent of elder residents stay safely, independently in their own homes longer, with a potentially tremendous cost savings to the healthcare systems of the United States, is an astonishing accomplishment.

According to preliminary findings, that's just what Community Aging in Place, Advancing Better Living for Elders is capable of. "We find that working with older adults on their own goals while making small changes to the home environment is powerful medicine," says Sarah L. Szanton, PhD, ANP, who launched the program (called CAPABLE) in Baltimore, MD and has since seen it piloted in Michigan among lower-income older adults on Medicaid and Medicare.

Older adults who have difficulty with such daily activities as bathing, cooking, or just getting to the bathroom often end up in hospitals or nursing homes, spending a disproportionately huge number of healthcare dollars, according to a report conducted for the U.S. Department of Health & Human Services. The CAPABLE intervention involves home visits with an occupational therapist, a registered nurse, and a handyman to work together with older adults to identify mobility and self-care issues (a missing handrail, no system for remembering to take medicines, etc.) and fix

or modify them. Szanton's study is called "Preliminary Data from Community Aging in Place, Advancing Better Living for Elders, a Patient-Directed, Team-Based Intervention to Improve Physical Function and Decrease Nursing Home Utilization: The First 100 Individuals to Complete a Centers for Medicare and Medicaid Services Innovation Project." In it, the team made 10 visits of 60 to 90 minutes to each home over a five-month period.

Of 100 low-income older adults who participated:

- 79 percent improved their self-care over the course of five months.
- The average participant improved by cutting disability in half (i.e., the number of self-care tasks that are difficult for the participant were halved).
- Participants experienced a decrease in depressive symptoms similar to that of taking an anti-depressant medicine. ■

Publication: *Journal of the American Geriatrics Society*



Protection for Homecare Workers

Hired to care for those aging at home, many suffer abuse, poor health

Research by Nancy Glass, PhD, MPH, RN, and colleagues reveals that homecare workers—frequently employed by older adults who want to live independently—experience substantial levels of workplace violence carried out by the consumer or others in the home. Negative health outcomes like fear, burnout, stress, depression, and sleep problems are a common result.

"Overall, 61.3 percent of female homecare workers in the consumer-driven model experienced at least one type of workplace violence in the past year," write the researchers in "Workplace Violence Against Homecare Workers and its Relationship with Workers' Health Outcomes: A Cross-Sectional Study." Abuse included "verbal aggression, workplace aggression, workplace violence, sexual harassment, [and] sexual aggression."

By 2025, it is projected that the adult social care workforce could increase to as many as 2.86 million workers. This growth is driven by the aging of baby boomers, increase in life expectancy, and a growing value placed on consumer-centered care, and the desire to lower healthcare costs for recovery and long-term care. The researchers say preventive safety policies and procedures should be put in place, and homecare workers should receive training to boost their confidence in creating and maintaining safe environments and work boundaries. The consumer-employers (patients, families, and guardians) should receive similar training, they suggest. ■

Publication: *BMC Public Health*



Sobering Look at India's Dowry Deaths

Judged harshly for meager marriage payments, wives often perish in fire

In India, "dowry death" refers to the often grisly killing of a woman by a husband and/or in-laws who judge her wedding dowry (a marriage payment of property or money) inadequate or too slow to come. Of domestic violence homicides in India, 54.1 percent were dowry deaths, according to "Motives and Characteristics of Domestic Violence Homicides and Suicides Among Women in India," a study by Bushra Sabri, Maria V. Sanchez, and Jacquelyn C. Campbell of the Johns Hopkins School of Nursing. The researchers also found 34 suicides among the domestic violence-related deaths, suggesting a number of those likely were killings misreported by families as suicides.

"Motives and Characteristics" paints a grim picture of domestic violence in India. The most common scenario in dowry death, for instance, was husbands or both husbands and in-laws killing women, often burning them to death since kerosene is the cheapest

and handiest weapon available in India ("much like a gun or a baseball bat in U.S. homes"). Strangulation was the second most common method. The study looked at domestic violence-related homicides and suicides in India from 2011 to 2012.

"The findings highlight the need for stronger prevention/intervention programs in India to identify and intervene with women at high risk for being killed or committing suicide," the authors write. "The knowledge may be useful for understanding the presence of homicide and suicide-related risk factors among families in India, and for developing risk assessments for safety." ■

Publication: *Health Care for Women International*

Key Word Is Flexibility

The phone rang in the middle of a going-away party for Krista Brooks. It was the Peace Corps. She wasn't going to Guatemala after all. The Chevy Chase, MD native, eager to practice her Spanish, was instead being sent to the one predominantly English-speaking nation in South America: Guyana. Oh, well. What was one more about-face on a path that initially had Brooks headed toward veterinary school? "I had this moment: Children don't get healthcare, and I was just around a person getting a \$7,000 MRI for a ferret."

She of course ended up loving what she kiddingly calls Peace Corps Lite: running water (sometimes), electricity (on and off), and a Creolese local dialect that at first meant "no idea what people were saying to me." The need was no joke. Her assignment was to teach nursing students basic health promotion in a country where even talk of cancer can be taboo and nurses and instructors are in short supply. Brooks also helped organize and run Camp GLOW, a nationwide empowerment program for girls.

A member of the Accelerated 2015 class, Brooks hopes to become a nurse practitioner and serve families like those she sees—and speaks Spanish with—through organizations serving Latino populations of East Baltimore. Her Class of 1965 Scholarship means she can spend more hours volunteering. "It reminds us, 'This is why we are doing this.'"

Also a Coverdell Peace Corps Fellow, Brooks figures to be at Johns Hopkins (no one's idea of Nursing School Lite) until 2017 as she earns that NP. From a childhood fascination with healthcare-based reality TV to caring for her dad in the hospital to pre-vet to Guyana to East Baltimore, she's already come a long way. ■

Class of 1965 Scholarship

Established in 1989 by members of the Class of 1965 for their 25th reunion.

Learn more at nursing.jhu.edu/financialaid

PHOTO BY CHRIS HARTLOVE



IF IT DOESN'T CHALLENGE YOU, IT DOESN'T CHANGE YOU

By Stephanie Olmanni

To say that nursing school has been extraordinarily time-consuming would be a gross understatement. But then I look back on the past seven months or so and can't even wrap my mind around how much we've learned. As we breeze through physical assessments in clinicals, or rattle off the complex pathophysiology of disease, or calculate IV drip rates in seconds, I'm astonished at the dizzying learning curve of this program. But, whew.



Here's a self-diagnosis: Stress R/T sleep deprivation, imbalanced nutrition, lack of social interaction, and "disturbed energy field" (yes, it's a thing) secondary to nursing school as evidenced by uncontrolled crying, extreme exhaustion, hysteria, and patient's statement: "Sim

Man is the only one who gets me anymore."



OK, it's not that bad. I'm doing fine. Really. I mean, there was that one time I melted down over Safeway Delivery being out of my favorite ice cream bar and I don't have a car so

maybe I Uber'd all the way to Whole Foods in Harbor East just to purchase its entire stock ...

And it's not like I haven't worked long hours before. When I turned 17, I attended the Berklee College of Music in Boston, MA. I completed a dual major in Film Scoring/Electronic Production & Design and a minor in Pulling All-Nighters. After Berklee, I lived in Los Angeles, putting in 90-hour weeks at a studio writing, orchestrating, and producing background music for prime-time TV shows and movies. I worked on five seasons of *Grey's Anatomy* (which I promise is NOT what brought me to nursing, although it's rather ironic) and four seasons of *Raising Hope*, scored documentaries, and even sang Japanese vocals for reality TV.

While grateful for the opportunity to make a living with music, however, the work left me exhausted and unfulfilled. I did some soul-searching and began volunteering at Comfort Zone Camp for children who have lost a parent or sibling (I lost my own mom, a nurse, right after freshman year in college). There, I found a fulfillment I never thought possible. Apparently the passion for nursing was in my blood.

So here we are. I'm surviving. We're surviving.

I'm not going to sugarcoat it for those who might be considering the Johns Hopkins School of Nursing. This program is rigorous. It challenges you intellectually, physically, and emotionally to the core. But it's supposed to be that way. Because we're taking on the enormous responsibility of having people's lives in our hands. And no matter what my sleep-deprived alter ego may say otherwise, it's an absolute honor to be challenged for that. ■

READ MORE ABOUT JHSON LIFE AT BLOGS.NURSING.JHU.EDU



STORY STEVE ST. ANGELO | ILLUSTRATION MITCH BLUNT

BIG DATA'S BOTTOM LINE

Nurses are key figures in turning great numbers into best practices

The term “big data” is thrown around so loosely these days. It’s a catchphrase for all the statistics, crunched numbers, charts, schematics, and other brain propellants behind great advances in patient safety and quality of medical care (and engineering, and economics, and ... apparently everything). But perhaps we don’t understand its true meaning or importance here on the ground, where red blood and big data meet.

Here are some large numbers we all can understand: Up to 75 percent of antibiotics prescriptions in the U.S. are for upper respiratory infections (antibiotics work in only a fraction of these cases), with such misuse creating drug-resistant “superbugs.” At least 3.2 million Americans have hepatitis C and up to 85 percent don’t know they have a deadly but curable virus. More than 8 million healthcare workers are employed in settings where they are exposed to hazardous drugs by leaks, vapors, or residue. These can cause cancers, infertility, and other serious health problems.

Data are at the root of possible solutions sought by students in the Doctor of Nursing Practice program at the Johns Hopkins School of Nursing to these and other real-world problems. They are poring over the numbers, naturally, but also studying the people, the systems, the cultures, the hows, whys (and why-on-earth nots?) behind life-and-death issues. From their big data, clearer answers emerge.



THE ANTIBIOTICS EQUATION

In the middle of cough-and-cold season, Melissa Jones-Holley, MSN, APRN, FNP-c, was standing her ground against superbugs, and getting plenty of support. An intervention at Carroll Hospital Center My Care Now that she'd developed and helped to initiate had drastically cut antibiotic prescriptions for upper respiratory infections (URIs) at the Maryland clinics. And people were getting better anyway.

The simple explanation, Jones-Holley explains, is that in some 80 percent to 90 percent of cases, URIs are viral in nature. Antibiotics help to cure bacterial infections, not viral ones. So, many antibiotics are being prescribed unnecessarily. Patients get well either way, so the message received is too often: get URI, get antibiotics (feel better, stop taking

“We have taken steps to improve the health of our community. We're not going back to a time when people died of simple infections.”

— Melissa Jones-Holley, MSN, APRN, FNP-c

the antibiotics, help create drug-resistant bacteria), repeat. It's a cycle Jones-Holley is determined to break.

“We have taken steps to improve the health of our community,” Jones-Holley says of medical advances that brought so many killer microbes under control in the first place. “We're not going back to a time when people died of simple infections.”

So, armed with her data, Jones-Holley embarked on an intervention to decrease antibiotic prescriptions by putting providers on a common course. “The intervention we chose was to pull the full-time providers together and say, ‘Here's the problem. Here are the guidelines.’ We got consensus to adopt the guidelines.” Next, Jones-Holley used peer feedback and an audit to show providers where they fell on a graph of prescribers, offering a gentle nudge in the preferred direction.

Then came educating patients. “We want them to be on board,” she says, so patients discharged without antibiotics receive materials that explain why, including a Centers for Disease Control pamphlet called *Get Smart: Know When Antibiotics Work*. Its simple message:

“Bacteria cause strep throat, some pneumonia, and sinus infections. Antibiotics can work.”

“Viruses cause the common cold, most coughs, and the flu. Antibiotics don't work.”

Jones-Holley and her team set a data point, aiming for 80 percent provider compliance (they got 87 percent). This is even allowing for part-time providers and parents who won't take “no antibiotics” for an answer. “There is always going to be an insistent parent—‘This has worked for my child before’—and the key is to really have a conversation.”

Jones-Holley's team also developed a protocol to quickly identify bacterial cases and properly treat them with antibiotics. “We can do tests here,” she says of My Care Now. “And all patients are advised to follow up with us or their healthcare provider if their symptoms worsen or persist.”

Before the intervention, antibiotics were handed to suspected URI patients 74.4 percent of the time. Now it's 56.8 percent, “which is awesome,” Jones-Holley says.

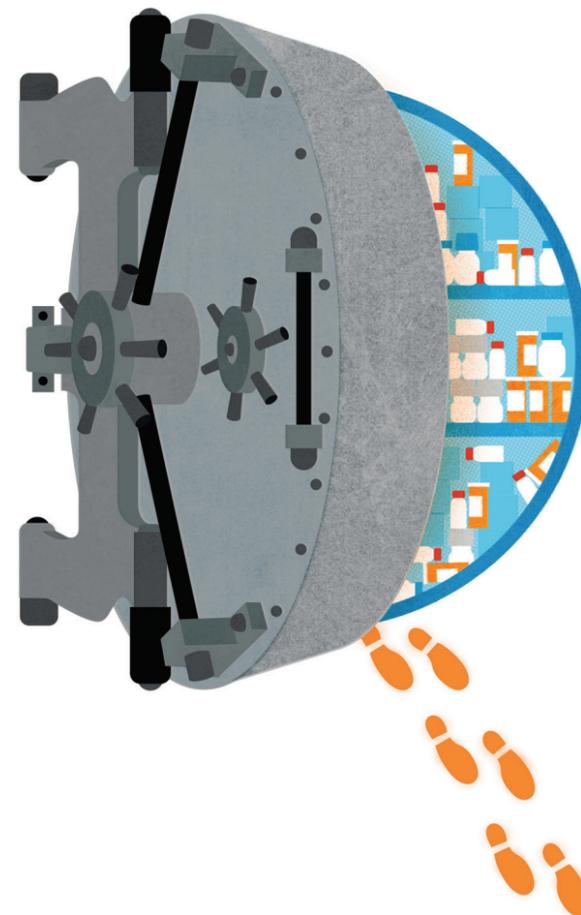
CLOSING THE LOOP

On the day Washington passed a law on the safe handling of hazardous drugs in medical settings, the first state to do so, Rachael Crickman, MN, RN, remembers being struck “that there was not already a mandatory requirement.”

According to the Bureau of Labor Statistics and the Centers for Disease Control, in 2010, more than 8 million healthcare workers were employed in settings where they were potentially exposed to hazardous drugs, with chemotherapy drugs among the most toxic. And many did not wear proper personal protective equipment, or PPE, for various reasons: among them the bother or inaccessibility of PPE or simply a lack of knowledge or encouragement.

In 2008, the chemo unit at Virginia Mason Medical Center in Seattle, Crickman's first stop as a clinical nurse specialist, was not unlike most others nationwide. There was a system to alert for patient safety events, but not a comprehensive system to capture events or exposures involving staff. There were policies in place for reporting exposures from spills or other events, yet no reports had been filed. This, Crickman learned, was despite a number of hazardous drug spills. “Safety measures that I had benefitted from were not in place here,” she says. An oncology nurse herself for 15 years, Crickman suspected symptoms she'd noticed among nurses on the chemotherapy unit at a previous hospital—infertility, for instance—might be due to exposure over time to drugs that can vaporize, spill, or otherwise get free to contaminate shelves, floors, medical supplies, other hospital units and even the outside environment.

Changes could happen only over time. Working through each link of the chemo drug chain—vendor to pharmacy to healthcare worker to



patient—Crickman developed an intervention to begin to “close” the drug-handling system literally and figuratively, implementing it in 2010. Use of so-called closed-system drug transfer devices, or CSTDs “really minimizes contamination.” She also worked to change the culture, from pharmacists to physicians to nurses to support staff. That meant education. “We made it mandatory for all RNs to go through it, and we established a training day for all nurse technicians.” It also meant subtlety. “There is a fine line between increasing awareness and spreading fear,” Crickman explains, adding that she made sure workers knew why surveillance over everything they touched and did had suddenly increased. For instance, “When we took the time to talk to the techs, trust developed ... they weren’t being watched, they were being helped.” The team repeatedly swipe-tested multiple surfaces in the unit for contamination, did cleanup, then swipe-tested again for improvement. PPEs were standardized and placed at the point of use.

Crickman also was fortunate, working with a similarly new director who she says was 100 percent open to changes. And now, she gets to start over again in a brand-new building at Virginia Mason. “This is the time,” she says of the pending relocation from a 1930s building. “I want to test the environment of the old unit, then the unit in the new building” to make sure safety improvements don’t get lost in the move, that “the interventions we have in place are controlling contamination. If not, maybe we need to do something different.”

“When we took the time to talk to the techs, trust developed ... they weren’t being watched, they were being helped.”

— Rachael Crickman, MN, RN

DANGEROUS SURPRISE

On a stormy day in Connecticut, Mary L. Blankson, APRN, points to an even more dark and ominous cloud approaching. A look at the big data suggests that at least 3.2 million Americans are infected with hepatitis C, which attacks the liver, and up to 85 percent don’t know it yet. At Community Health Center Inc., Blankson and her team are working to identify the unaware and then make sure care is there for them. The challenges are significant.

In 2012, the Centers for Disease Control made screening for the hepatitis C virus (HCV) a priority after research found that those born from 1945 to 1965 were more impacted than any other age group, Blankson explains. “So being born in those years was added as a risk factor.”

Why this age group? “You know, sex, drugs, and rock-and-roll,” Blankson says of a generation perhaps more open to the types of risky behaviors that can lead to infection. Plus, she adds, “Back then we hadn’t even identified hepatitis C in the nation’s blood supply, so if you got a transfusion or maybe if you had a transplant ...”

HCV is a killer, a leading cause of chronic liver disease and liver cancer in the U.S. It is also treatable, but many don’t act on it because they don’t know about it. “There’s a challenge for many in receiving their diagnosis: ‘How come I never knew? How come my provider never figured it out?’ They don’t feel sick, and it’s, ‘Surprise! You have this illness.’ ”

The challenges: ID all of those who need treatment. Get them into care. Get primary care providers ready to treat them.

The good news is newer, more effective meds.

“There’s a challenge for many in receiving their diagnosis: ‘How come I never knew? How come my provider never figured it out?’ They don’t feel sick, and it’s, ‘Surprise! You have this illness.’ ”

— Mary L. Blankson, APRN

“It’s so much easier to treat people. The medicines don’t have as many side effects. Patients are more likely to take the medications when they don’t feel sick [afterward]. If they take it and adhere to the treatment, it’s just about certain that they will be cured.”

The bad news? Those new drugs are more expensive. At \$80,000 and up per regimen, health systems don’t want to treat those

unready or unwilling to adhere to it or to abstain from dangerous or unhealthy behaviors. And this is where Blankson sees nurses having a great impact.

“How can I make these patients the best candidates possible, to set them up for success in their treatment? How do we as a team go about making sure there is adherence?” ■



WELCOME WORDS

SPANISH-LANGUAGE COURSES CAN HELP NURSES EASE PATIENTS' JOURNEYS

PALABRAS DE BIENVENIDA

CURSOS DEL LENGUAJE ESPAÑOL PUEDEN AYUDAR A LOS ENFERMEROS FACILITAR EL CAMINO DE LOS PACIENTES

STORY JENNIFER WALKER | PHOTOGRAPHY CHRIS HARTLOVE

In 1996, faculty lecturer Sarah Dutton, studying abroad in Mexico, went to a local hospital to get treatment for a second-degree sunburn. Although she spoke some Spanish, she still felt vulnerable about seeking care in another country. “When we come for medical care, we’re in pain, we’re on medication, we’re confused, we’re angry, we’re altered from our normal selves,” she says. “Add a language barrier to that, and it’s very difficult. There was such a divide between me and my doctor. If someone had said, ‘Hi, how are you?’ ... just spoken in my own language, I would have felt better.”

Research has shown that language barriers between patients and providers increase the risk of medical errors and decrease patient satisfaction. Working with a certified interpreter—to facilitate patient-provider conversations—is the best way to improve outcomes for limited English proficiency (LEP) patients. But healthcare providers can also improve the patient experience for their LEP patients, particularly Hispanics and Latinos, who make up 17 percent of the U.S. population, by learning about language and culture themselves.



Through her Spanish-language classes, instructor Sarah Dutton helps caregivers “develop that capacity for connection.”

Since 2002, Dutton has been preparing nurses (as well as physicians and public health professionals) to break down these language barriers. At the School of Nursing, her beginner, intermediate, and advanced Spanish classes cover medical terminology and cultural competence. This year, she will also unveil “Beginning Spanish for Medical Personnel,” a noncredit class taught through a combination of online and in-person lessons for registered nurses and healthcare providers who are already working with patients.

“There is such a need—and it’s only increasing—for providers who can bridge language gaps and create more positive patient experiences,” she says.

At The Johns Hopkins Hospital, the number of LEP patients has skyrocketed in the past four years. In 2013, there were nearly 50,000 requests for interpretation services, more than double the number of requests in 2009. Fifty-seven percent of them were for Spanish-speaking patients.

The Civil Rights Act of 1964, which prohibits discrimination based on national origin, requires interpreters for hospitals that receive federal funding. Johns Hopkins Medicine International’s

thriving Language Access Services department (LAS) has 18 full-time interpreters and 45 floaters—many of whom have passed a rigorous two-year testing period to become certified—who interpret in-person and by phone and video in 111 languages 24 hours a day.

So where do nurses come in?

Knowing some Spanish words and phrases helps “nurses connect with their [Hispanic and Latino] patients,” says Susana Velarde, administrator for LAS. This improves the care experience for both patients and providers, she adds.

A small 2008 study published in the *Journal of Emergency Nursing* came to the same conclusion: Of five emergency room nurses who

“There is such a need—and it’s only increasing—for providers who can bridge language gaps and create more positive patient experiences.”

— Sarah Dutton, Instructor

“You can have all the medical information that patients need to be well, but if you cannot communicate it effectively, it doesn't matter.”

— Sarah Dutton, Instructor

treated Mexican American patients, the only one to report developing a relationship with those patients spoke some Spanish. Building this rapport with patients can lead to better outcomes, too: In a 2014 *Journal of Cancer Education* study of Latina and Caucasian women, patients who had good experiences with their healthcare providers were more likely to be positive about future screenings and treatments.

To “teach [healthcare providers] to develop that capacity for connection,” Dutton says, the classes cover enough Spanish vocabulary for nurses to react to conversations in a medical setting. To do this, they learn to use the theory of circumlocution, or speaking around a word. For example, if they don't know the word *otorrinolaringólogo* (otolaryngologist), they

can say “*un medico para enfermedades de los oídos, la nariz y la garganta*” (a doctor for illnesses of the ears, nose, and throat).

Although most will still work with interpreters, nurses who take the classes will also be able to ask a variety of questions, collect basic biographical information, and tell patients how long they have to wait in Spanish. “Even those basic questions [and statements] are a huge

bridge in terms of that moment of vulnerability for patients,” Dutton says.

Schruti Thomas, RN, an operating room nurse at The Johns Hopkins Hospital who recently completed the first beginner Spanish class (there are two beginner levels), agrees that knowing only a few phrases can help put Spanish-speaking patients at ease. “They're scared going to sleep in the OR,” she says. From the class, she has learned “what you say to calm [patients] down when they go to sleep or when they are waking up from anesthesia.”

To deliver the classes, the School of Nursing works with interpreters from LAS, a partnership that gives nursing students an opportunity to practice their speaking skills before working with patients. During a final exam, all students take health histories for an interpreter, who plays the role of a patient. Intermediate students also shadow interpreters to get a behind-the-scenes look at their jobs.

Although she has worked with interpreters as a nurse, public health nursing and nursing midwifery master's student, Stephanie Estes, RN, who recently completed the intermediate Spanish class, says that shadowing one made her realize that their jobs go beyond interpreting. The interpreter accompanied one patient during several appointments with different providers, even reminding the patient when she had to make new appointments at the desk. “She was like a cultural broker,” Estes says. “She was able to navigate the system for this patient who may have gotten lost in it otherwise.”

Along with working with interpreters, some former students still use their language and cultural competence skills on a daily basis. As a nurse practitioner with Weill Cornell Internal Medicine Associates at New York Presbyterian Hospital, Anthony Pho, BSN '08, MSN/MPH '11, RN, works with a patient population that is 30 to 40 percent Spanish-speaking. Growing up in a more formal Asian culture, he might not have

automatically known that these patients prefer a more open communication style. He says it's not uncommon for them to hug and kiss him, like they would a family member. Knowing this, Pho aims to build trust with these patients, often asking them about their families.

Because he makes this connection with them, “[my patients] are more willing to be honest about what is happening in their lives,” Pho says. “They also trust me more with their medical care.”

Cultural competence and sensitivity are a major part of the curriculum for each Spanish class. Wanting her students to feel comfortable working with patients from many cultures, Dutton teaches Kleinman's Questions. Developed by Harvard physician Arthur Kleinman, these eight, open-ended questions—such as “What do you fear most about your sickness?” and “What do you think caused the problem?”—are designed to help providers learn their patients' cultural beliefs, thus giving them a better idea of whether they will be comfortable with treatments.

Dutton also covers specific Hispanic and Latino cultural beliefs, such as the concept of the *mal de ojo*, or “the evil eye.” Say a mother visits a clinic with her sick child. Trying to develop a rapport, a nurse compliments the child, calling him “strong” and “beautiful.” But the mother suddenly looks uncomfortable. That's because some in the Latino culture believe that children who receive compliments are more susceptible to illnesses from the *mal de ojo*. Nurses familiar with this belief system will know to touch the baby's shoulder or his blanket—a gesture thought to offer protection from the evil eye—while offering compliments.

Then there is the Spanish naming system, which can feature compound first and last names and (as with some other non-English naming constructions) be misunderstood by the unfamiliar. Thus, patients can get logged into the hospital's system under different names and numbers, a mistake that



can have huge implications for billing, insurance, and patient outcomes.

Nurses also learn about the economic and social challenges that Spanish-speaking patients could be facing. They may fear deportation; may be struggling financially; may be separated from families who stayed in their home countries.

Many also have very little, if any, experience with medicine. “Coming [to Hopkins] is like landing on the moon,” says Robert Stucky, a Spanish language interpreter and a frequent volunteer during Dutton's final exams. “Being sensitive to that is huge.”

Arming her students with language skills and cultural knowledge so they can improve patient care is Dutton's goal. “You can have all the medical information that patients need to be well, but if you cannot communicate it effectively, it doesn't matter,” she says. Through these classes, “we're getting this wealth of information to [providers] so they can effect better outcomes and improve the quality of life for their patients.” ■

Dutton seeks to provide students not only with language skills but with cultural knowledge.



FOR MORE INFORMATION, VISIT [NURSING.JHU.EDU/SPANISH](https://nursing.jhu.edu/spanish)



SHARING EXPERIENCE AND PASSING ON WISDOM— ONE PHD COHORT TO THE NEXT

STORY DANIELLE KRESS | PHOTOGRAPHY CHRIS HARTLOVE

For PhD students at the Johns Hopkins School of Nursing, the first semester is a constant swirl of information, classes, deadlines, research-intensive work, and small but hopeful glimpses into what the future might hold. It's a crunch recent grads Yvonne Commodore-Mensah and Grace Ho and almost-grad Kyounghae Kim know all too well. As mentors in the new PhD Learning Lab, the trio can now offer their hard-earned knowledge and insight to the slightly dazed newcomers in pursuit of their degrees.

Sponsored by the school's Office for Teaching Excellence, the Learning Lab is a way to provide extra assistance to those who might be struggling with coursework, writing, budgeting time, or just facing daily life as a PhD nursing student. Commodore-Mensah says it's an opportunity "to pass on wisdom or things we wish we would have known" and a great idea for the school's largest PhD class yet.



From left, Grace Ho, Kyounghae Kim, and Yvonne Commodore-Mensah guide students through many of the same adjustments they faced as PhD candidates.

So far the mentors have held a couple of group workshops and offered office time for individual questions. But Commodore-Mensah says that in the midst of classes, studying, and work, the students don't always have time to think about what questions to ask. "We recently held a session about how to use library resources," she explains. "It was a chance for them to learn about the tools and resources in advance of needing them, before they were down to the wire and didn't know where to turn. Once we started getting into it, the students were extremely interested and had lots of questions."

That's what the program is about—being prepared and getting knowledge from a student who has already been through the struggles of coursework and balance. Ho says, "We stumbled so many

“It was a chance for them to learn about the tools and resources in advance of needing them.”

— Yvonne Commodore-Mensah, PhD

times and had to learn how to do some things the hard way." As a former international student herself, she can relate to the many in the newest cohort who have come from outside of the U.S. "Through the Lab, I can tell them that they're not alone, that the challenges they're experiencing aren't unique to them. Everyone struggles, but there are strategies they can use to prepare themselves and provide a little ease."

With only a couple of courses to complete before graduation, Kim, a native of South Korea, shares

the sentiment. "Even though I had worked as a nurse practitioner in the U.S., I was finding it difficult to adjust myself to the rigorous research involved with the program. I thought it was because I was the only international student in my group, but it turned out most of my peers were experiencing the same difficulties."

Kim also believes an important part of her success in the program has been finding harmony in juggling the responsibilities of school and life. "Even though we are PhD students, we are still daughters and sons, mothers and fathers, and wives and husbands with commitments outside of our work here at the school. I've learned how to be a multi-player, and I'd love to be able to pass along some of my tips for how to do that."

While it's only in the beginning phases, all three mentors say they have high hopes for the Learning Lab in the next semesters. "We'd like to offer more workshops about reference management software, how to meet with your advisor, completing your dissertation, and other areas where the students express a need," says Commodore-Mensah. She believes that timing of the sessions will also be key to helping the students with their already busy schedules. Ho adds, "We want this to be something they can use and will find time for. It has great potential and can really bring benefit to the students. More opportunities for them to express their needs will help us design discussions and meetings that will support them the most in the future." ■

HOPKINS NURSE

News from **The Johns Hopkins Hospital & Affiliates**

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TRANSFORMATIVE TRANSITIONS

Transitions Pilot at The Johns Hopkins Hospital helps nursing students like Ann Marie Albright get a foot in the door of an intensive care unit and then stay there. The program promises to turn a Catch-22 into a win-win.

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TEACH 3 OFFERS COMFORT ON MEDICATIONS

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IN NEPAL, RELIEF AFTER BIRTHING INJURY

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STAFF DOESN'T MISS A BEAT ON SEPSIS

Financial Vision

By Steve St. Angelo

Wilmer surgical committee opens eyes with inclusive approach to sensible cost cutting

Asked to help cut operating room costs, Corazon Sarmiento, RN, and her team at Wilmer Ophthalmology took a surgical approach.

"We asked our finance guy, 'What is the budget?' 'What does this number mean?' We had him spell

it all out so we were educated," explains Sarmiento, operating room manager. "So much of this effort is about education." Next, they used their eyes.

Each year, major U.S. hospitals collectively throw away at least \$15 million worth of unused surgical supplies, according to a recent report by a Johns Hopkins research team. Part of the problem at Wilmer was the process. Standard operating procedure was for nurses and techs to open all surgical items so they'd be ready for doctors who might each have their own preferences. Once opened, used or not, sterile supplies needed to be disposed of to avoid spreading infections.

Also, too many instruments present meant that every so often one would go missing—"some of these instruments are very tiny," Sarmiento explains—perhaps accidentally rolled up in a surgical disposable drape and tossed. Discarded items

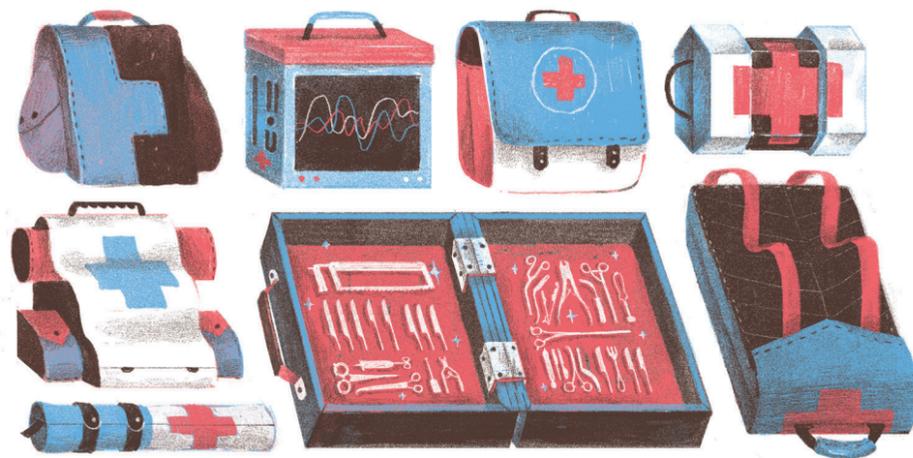


ILLUSTRATION BY LEONARD PENG

cost anywhere from \$37 to \$5,000, adding to a patient's bill and nurses' frustration. "We wanted to be fiscally responsible," she says.

So, about two years ago, Sarmiento helped form a committee of "everyone from junior nurses to senior nurses to NCHIs to techs to finance to insurance people." This finance committee charted items, priced them out, and made its recommendation: customized operating room packs.

Sarmiento says that rather than persuasion, all the finance committee needed to win over surgeons was presentation. "We put all the items on a spreadsheet. We had everything priced out and discussed this at our staff meetings, then we would post the costs. We're not telling them not to use a particular piece of equipment. The doctors see this and say, 'Oh, maybe I don't really need to use this anymore.'"

The group is now working to bring the number of customized packs to two from four. "The key is



It empowers nurses to say of an item that might be needed, 'It will be available for you, but I won't open it until you need it.'

— Corazon Sarmiento, RN

including the nurses in the initiative. It empowers nurses to say of an item that might be needed, 'It will be available for you, but I won't open it until you need it.' It's about education: Now, the doctor might say, 'I need this, but don't open it yet.'

Next for the committee: Look at the bigger equipment for the center. Sarmiento is a member of the supply chain group of the American Association of Eye & Ear Centers of Excellence, which can buy in bulk and get the best price. "We know what's out there," she says. ■

This Way Forward: Carolyn Conant Van Blarcom (1875-1961)

Carolyn Conant Van Blarcom (with infant) entered The Johns Hopkins Hospital Training School for Nurses in 1898 as a "pupil nurse"—funny today, considering her pioneering work in preventing childhood blindness through better hygiene and infant and maternal care.

A belief in greater nurse and midwife training drove her career: head nurse in Hopkins' obstetrics wards, superintendent of nurses at St. Luke's Hospital in St. Louis and the Maryland State Sanatorium for Tuberculosis, executive secretary of the New York Association for the Prevention of Blindness (she was the first trained nurse registered as a midwife with New York City's Department of Public Health), and, by 1917, director of the Atlantic Division of the American Red Cross, outfitting and supplying nurses going

overseas in World War I. She helped organize the curriculum for the first midwives school in the United States.

In 1922, Van Blarcom published the widely used textbook *Obstetrical Nursing*, later completing the advice books *Getting Ready to Be a Mother* and *Building the Baby*. In 1926, she helped secure from her friend the E. Bayard Halsted Fund for research in bacteriology at Johns Hopkins University.

"The nurses whose skill is warmed by a sincere desire to give of their best will, by virtue of this very desire, learn something from each patient," Van Blarcom once said, "and will be steadily enriched and broadened by their experiences." ■

Sources: Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions

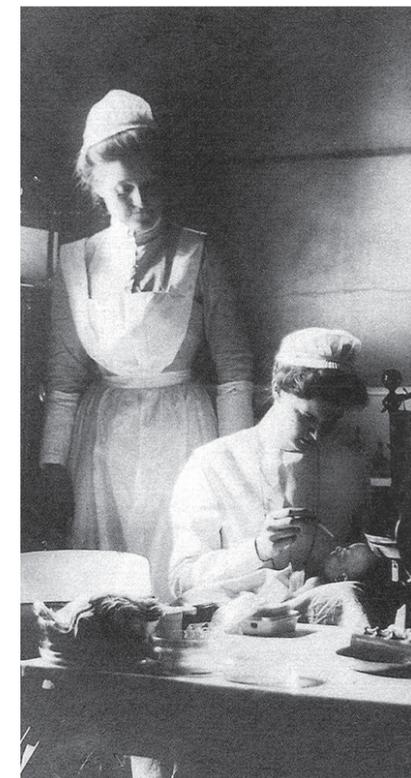




PHOTO BY JON CHRISTOFERSEN

Transformative Transitions

By Kim Polyniak

Pilot clinical program helps students put one foot, then all of themselves, into an ICU

New nurses generally don't walk out of the NCLEX testing site and into a job at an intensive care unit at The Johns Hopkins Hospital. So when Ann Marie Albright learned about a pilot program that would allow select students from the Hopkins School of Nursing to gain priceless experience in an ICU across the street and even get a job at graduation, she jumped. "It was tailor-made," she says.

Albright was one of six in the Student Transitions Pilot: a Johns Hopkins Hospital and School of Nursing partnership developed to help end nurse shortages in surgical critical care and post-anesthesia units at the hospital. It does so, in large part, by addressing a Catch-22 situation.

"The seed of the problem is new graduate nurses can't get jobs in ICUs because ICUs require a practicum," explains Deb Baker, DNP, RN, ACNP, director of Nursing for Surgery, Ophthalmology and Rehabilitation at Hopkins Hospital. "And they can't get a practicum because when it comes to going to ICUs for [a traditional] Transitions class, ICUs don't have enough preceptors for them."

In this case, instead of students being matched one-to-one with a preceptor, they would be immersed in the cardiovascular surgical intensive care unit (CVSICU), cardiovascular progressive care unit (a step-down unit called the CVPCU), or post-anesthesia care unit (PACU). Students would also spend clinical time in a simulations lab, at a seminar course, and in conferencing for a total of 168 hours from October to December. Successful participants would later



The seed of the problem is new graduate nurses can't get jobs in ICUs because ICUs require a practicum. And they can't get a practicum because when it comes to going to ICUs for [a traditional] Transitions class, ICUs don't have enough preceptors for them."

— Deb Baker, DNP, RN, ACNP

be offered jobs in the area of their focus (CVSICU, CVPCU, or PACU) or elsewhere in the hospital.

"I really thought that this was a win-win situation, where students would be excited about the opportunity both to have a job at the hospital and a Transitions placement at the hospital, and it would work really well for the hospital to get some really qualified nurses," says Hayley D. Mark, PhD, MPH, RN, director of the baccalaureate program at the School of Nursing.

During the pilot, students moved between units to gain perspective on the entire process of care. For instance, Albright followed a cardiac patient as he transitioned to other units. "It made me see the entire flow of things, the big picture of patient care at Hopkins," she says.

As students rotated spots, JHH nurse faculty remained with them. "Each one of these students is assigned to a nurse on the unit, but we had extra

faculty who helped do that critical thinking with them," Baker says.

Based on evaluations, all six students considered the pilot a success for them personally. And why not? "In the process of doing this, we were saying, 'We're going to hire you in these areas, or we're going to find you a spot somewhere that is right for you,'" says Martha Kennedy, PhD, RN, CRNP-AC, nurse practitioner, Weinberg Intensive Care Unit and education lead, department of Surgery at Hopkins Hospital.

Hired students are asked to make a three-year commitment to the hospital so that all benefit from the investment. Plans and logistics for next phases of the program are being ironed out.

Albright, now a registered nurse, recently started her job in the CVSICU. "I'm over the moon, because my career goals and aspirations were to: one, get a job at Hopkins Hospital; two, do it in cardiology; three, do it in critical care," she says. ■

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Other Lives: Firmly Planted

By Joan Davila

Psych nurse/foodie savors the stories and benefits of a deliciously varied life

Pat Sullivan, MS, RN, finds inspiration in her patients and their life stories. Understanding illness and the science behind treating people is fascinating to this psychiatric nurse manager who joined The Johns Hopkins Hospital Meyer 3 unit in 1984.

But mention urban farms, ethnic food traditions, her family cookbooks, her love for vegetables (as well as painting, sculpture, writing, you name it), and Sullivan may step outside of her beloved role as nurse long enough to share her own eclectic life story.



PHOTO BY CHRIS HARTLOVE

“Being a nurse is important work, and I’ve loved patient stories since I began my medical career as an ER nurse in my late 20s,” she explains. “But my life is a collage.”

As Sullivan’s nursing career flourished, so did her love for the arts. “I was always pulled back to my creative side,” she says. “I enjoyed drawing, clay making, creative writing, and photography—just to name a few.”

Sullivan was once a docent at the Baltimore Museum of Art, sharing her knowledge and enthusiasm with crowds of visitors. And when she needed solace, she often sought it within the quiet walls of her darkroom, bringing moments captured in the click of a camera shutter to full life. “The photos were so telling. I loved that, through photography, I was able to reveal emotions and tell the stories of others with powerful pictures.”

The latest chapter of Sullivan’s life centers on food: a taste for real, local vegetables, a passion for



Being a nurse is important work, and I’ve loved patient stories since I began my medical career as an ER nurse in my late 20s. But my life is a collage.”

— Pat Sullivan, MS, RN

growing, harvesting, and cooking them, and a knack for bringing people together through food rituals that keeps her fresh.

“What can I say? I love peppers,” explains Sullivan. “Their vibrant colors, their different flavors, their brilliant capability to compliment a multitude of diverse meals. And tomatoes! I have ‘tomato buddies.’ We grow tomatoes, we pick them, then we create culinary masterpieces together.”

Sullivan, whose culinary works have been featured in Baltimore’s *Style Magazine*, sees food as so much more than simple sustenance. “Food inspires memories of family and friends for so many people, stories of mealtime traditions.”

As co-president of Slow Food Baltimore, which “supports a locally sourced, environmentally and socially responsible food system,” Sullivan promotes the concept of creating memories—and telling stories—through food.

And as a nurse, she sees the role living things play in ... living.

“The patio garden outside of Meyer 3 represents life, vitality, and wellness, which helps patients recall fond food memories, she explains. “It’s therapeutic.”

“Food reminds us to be well, to continue to grow as people, to enjoy life,” Sullivan says. “It’s nice to see things grow.” ■

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“It got them thinking in a way that they never had before.”



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“It makes you get inside the decision-making before you see the consequences. You live it,” says Cohen, whose students have gone on to leadership positions in government, business, and the military. “This experience is the one that students really remember and cherish because it got them thinking in a way that they never had before.”



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THE CAMPAIGN FOR JOHNS HOPKINS

HOWARD COUNTY GENERAL HOSPITAL

1-2-3, Go

By Wendy J. Meyeroff

At Howard County General, a nurse-patient education plan ensures that the takeaway is a proper understanding of meds

When patients are headed out the door with anywhere from one to more than a dozen new medications, it's crucial that they understand proper usage and precautions to prevent bad reactions or even readmittance. At Howard County General Hospital (HCGH), nurses are making that take-home message count through a program called Teach 3.

For Debbie Fleischmann, MPH, RN, director of education and professional development at HCGH, a suspicion that medication communications were not being delivered as clearly as they could be was confirmed by the results of a December 2013 inpatient Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Among discharged patients, only 43 percent said they had discussed their medications' potential side effects with members of the medical team and another 23 percent reported they'd never had such a conversation at all.

“Lots of our nurses do talk to patients about their medications,” Fleischmann says, adding that there can be numerous obstacles to true comprehension. “Patients can be sick, tired, in pain, anxious, fearful, upset.” There are also language barriers and challenges associated with an aging population.

So Fleischmann and her team created Teach 3, an education and communication program to improve nurse instructions, increase patient understanding, and lower readmissions. It started at HCGH in spring 2014 in the medical/surgical unit, whose patients tend to leave with the most medications.

In Teach 3, nurses learn three key points to make. “The first is the name of medication, second is what it's for, and third are [potential] side effects,” says Fleischmann.

Patients are asked to relay the information back to determine how quickly and clearly they comprehend.

“I think the consistent teaching that we do and then the patients' talking back to us about what we taught them really helps us know that they understand the medications they're going home on,” says Caroline Bean, RN.



PHOTO BY CHRIS HARTLOVE

In particular, Charles Dammers, RN, who works with Bean in orthopedics (both are pictured above), notes, “Sometimes we have to give patients DVT prophylactics [which prevent blood clots but can have serious side effects]. We do a fair amount of teaching.”

Fleischmann's team also created cheat sheets, laminated cards that aid nurses' memory of key points in about 10 drug categories. “There are so many medications out there, plus medications changing all the time,” she says.

In a fairly short time the program has seen improvement in medication education scores. As for costs? The price of laminating the quick cards. “We spent a little money,” Fleischmann explains, “but that's not very much for the gain: helping nurses help their patients and a good response from patients that they better understand their medications.” ■

ALL CHILDREN'S HOSPITAL

Best Prepared for the Worst

By Joan Davila



Lessons of Ebola training help ACH nurses feel ready for whatever's next

Ebola never crossed the threshold at All Children's Hospital, an outcome the healthcare staffs are extremely thankful for. Here's another: The lessons learned, about themselves and hospital preparedness, have left ACH and its nurses feeling

competent, equipped, and confident in one another's ability to react quickly to any such health scares in the future.

And the teamwork forged during Ebola prep is now pretty much standard operating procedure.

"As a nurse leader, it's my job to oversee the impact nursing has on evidence-based practice and the delivery of quality patient care, no matter the reason," says Susan Byrd, RN, executive director of nursing and nursing support services at ACH. "Our efforts to improve Ebola preparedness have helped us grow and understand that we are capable of more than we imagined."

Ebola preparations began in St. Petersburg, FL in August 2014 with a small team that quickly grew into a multidisciplinary Ebola Preparedness Task Force led by Chief Operating Officer Roberta Alessi,

“Our efforts to improve Ebola preparedness have helped us grow and understand that we are capable of more than we imagined.”

— Susan Byrd, RN

MHSA, and Chief Patient Safety Officer Brigitta Mueller, MD.

"The task force included nurse leaders and nurses on the front lines in the emergency center, pediatric intensive care unit [PICU], and clinical education," says Byrd.

Working with preparedness plans and drills specific to ACH, the Ebola care team—about 30 volunteers, mostly nurses—prepared and practiced to effectively care for both potential and confirmed Ebola cases. (Since its outbreak in late 2013 in West Africa, the virus has killed more than 10,000 people worldwide, sickening tens of thousands more overall. Ebola patients have been treated at U.S. hospitals in Texas, Georgia, Nebraska, New York, and Maryland.)

Disaster Coordinator Jesse Rauch; Emergency Center Nurse Manager Radek Hoffmann, RN, Emergency Center Director Michelle Moran, RN, and PICU Director Melissa Macogay, RN, shared expertise, experience, and time in creating Ebola preparedness drills, expectations, and accountability, all while ensuring that volunteers were comfortable with their roles.

Clinical Education's Lisa Matamoros, RN, created practical drills allowing team members to put their knowledge and skills to use in simulation labs while in full isolation equipment, the personal protective equipment that prevents skin contact with the deadly Ebola virus or other potentially hazardous agents.

"The lessons learned from those drills have transcended beyond the lab doors," Byrd explains. "I feel strongly that this worldwide crisis was a benefit for the U.S. healthcare system and for us, personally, because it challenged us to test our processes, to work far beyond our comfort zones, and to showcase the operational aspects that nursing does extremely well."

And at ACH, the anti-Ebola efforts "demonstrated how cohesive teamwork produces life-saving results," Byrd says. ■

JHPIEGO

A Delicate Matter

By Sandhya Limbu

Nurses in Nepal become active partners in repairing obstetric fistula and the social fabric

Binita Rai and Reeta Limbu are among the first nurses to receive specialized training in Nepal to help repair obstetric fistula, a devastating complication of birth that has left up to 400 women incontinent and often scorned by their families.

They joined a pair of physicians—Tarun Pradhan and Ajay Agrawal—for the inaugural class of a Jhpiego-supported initiative to give healthcare providers competency-based, on-the-job training in surgical skills to repair the condition. During labor, pressure from the baby's head can cause a tear or "fistula" between a woman's vagina and bladder, resulting in a leakage of urine and other embarrassing health consequences. One woman at a Nepal hospital, awaiting a fourth attempt to repair her fistula, said she rarely left her house. "Even though I bathed twice a day, I couldn't completely remove the odor," she said.

In Nepal, few health facilities had the surgical capacity to repair a fistula. But through Fistula Free Nepal, the B.P. Koirala Institute of Health Sciences will serve as the first national training site for obstetric fistula repair. In the past, healthcare providers had to rely on apprenticeships to learn how to address the condition, and nurses were often on the sidelines. Through this new training, in partnership with the government of Nepal, "treatment and management of obstetric fistula cases is a team effort of nurses and doctors," says Chandra Rai, Jhpiego's country director in Nepal.

Nurses Rai and Limbu graduated last fall. Each had participated in both classroom and operating room learning. "While this initiative is focused on surgical repair of fistula, an exciting outcome of the training has been the attention to and strengthening of post-operative care for women who suffer from this debilitating condition," says Deirdre Russo, a Jhpiego staffer who attended the graduation in Nepal.

The Jhpiego-developed training package includes a Reference Manual, Facilitator's Guide, Learner's Handbook, and a logbook for participants to record their clinical exposure. It also includes videotapes

“While this initiative is focused on surgical repair of fistula, an exciting outcome of the training has been the attention to and strengthening of post-operative care for women who suffer from this debilitating condition.”

— Deirdre Russo, Jhpiego



of fistula repair so trainees can observe different surgical techniques.

For their part, Pradhan and Agrawal spoke about the pressure as doctors of feeling solely responsible for fistula patients. After training with nurses, they realized they were part of a team.

The graduates pledged to provide quality care and services in obstetric fistula treatment and surgery so that Nepalese women in need can return to their lives. ■

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

Bayview's Journey of Improvement

By Rebecca Proch

Nurses drive reduction in preventable complications through MHACs initiative



PHOTO BY CHRIS HARTLOVE

It starts with patterns. Lisa Grubb, MSN, RN, director of quality management at Johns Hopkins Bayview Medical Center, conducts chart reviews with an eye for the ones that emerge around potentially preventable complications (PPCs) such as urinary tract infections from catheter use. “These don’t happen in a vacuum,” she points out. “There are always many factors surrounding them, from admissions to maintenance to patient education.”

Once she spots these trends, she begins assembling teams to study ways to reduce those complications. It’s a highly collaborative, interdisciplinary

approach that has led to Johns Hopkins Bayview being named by the Maryland Health Services Cost Review Commission (HSCRC) to “the reward zone” for reducing PPCs as part of the Maryland Hospital Acquired Conditions (MHACs) initiative.

The MHACs program is a state-driven initiative first introduced in 2009 by the HSCRC and revised in 2014 that seeks to reduce hospital PPC rates by 30 percent over a five-year period. It provides financial incentives for hospitals to identify and implement measures that reduce complications.

““

I think that our nurses view the management teams as partners. We really try to understand their world, and we want them to be the ones suggesting the interventions that are then piloted in a careful, systematic way.

— Lisa Grubb, MSN, RN

The hospital’s Quality Management Team took up the challenge soon after MHACs launched. Grubb and Janet McIntyre, MSN, RN, senior director of quality and patient safety, attended a national conference session about mechanisms of communication and problem solving for PPC reduction. They formed a multidisciplinary committee of coders, pharmacists, credentialing office attendants, and other staff as well as nurses and physicians. It meets monthly to review MHACs data to target areas of improvement. Subcommittees including a physician documentation group and action teams dig into the daily experiences of clinical staff to find the root causes of trouble spots and develop measurable solutions.

“The quality improvement team serve as investigators trying to uncover the root causes of complications in care,” says Marcy Post, MSN, RN, clinical quality project coordinator, who leads these clinical task forces. “Often, we start out fixing one thing but it leads us to discover completely different issues.” She cites an example from the group working to address venous thrombus embolisms, where solving the problem of incomplete documentation turned up a need to expand and more carefully track equipment inventory.

Bedside nurses are crucial to successful practice changes like these because their observations serve as trail markers. Post therefore goes to great lengths to ensure that they’re heard. She expanded the size of teams from what she considers an optimal

number of eight to 10 people to include as many as 18, knowing that only six to eight nurses will be able to leave their units to attend any given meeting. She seeks them out on the unit as well for updates and informal conversations that can yield valuable insights. “We have such committed nurses,” she says. “That’s huge. We just want to get their feedback however possible.”

“I think that our nurses view the management teams as partners,” says Grubb. “We really try to understand their world, and we want them to be the ones suggesting the interventions that are then piloted in a careful, systematic way.”

That spirit of collaboration and exchange extends beyond MHACs team meetings, as the participants welcome opportunities to share their success strategies with many different audiences. The physician documentation committee has produced physician champions who now serve on a state task force to help establish a standard statewide definition for four areas of difficulty. Grubb routinely presents to a variety of groups including faculty and trustees, and she and Post validate outcomes through discussions at professional practice council meetings. “We want to see what makes a significant difference for the MHACs program, but also for the staff and patients,” emphasizes Grubb. “We’re taking a holistic approach to improve practice and make an easier path for everyone. No matter what, we’re going to impact the patient when each of us succeeds.” ■

SUBURBAN HOSPITAL

Not Missing a Beat

By Elizabeth Heubeck

Suburban anti-sepsis video entertains and empowers nurses to act quickly



SUBURBAN HOSPITAL YOUTUBE ACCOUNT

It's catchy the first time you hear it. Listen a time or two more and the beat and, more importantly, the message get stuck in your head.

It is an educational video on sepsis, which sounds routine enough. But *Sepsis Is Serious* is delivered via an infectious hip-hop rhythm.

RN Alicia Folk's quirky knack for rhyming lyrics sparked the idea for the witty and effective video. Folk's raps provided the cornerstone of a serious, comprehensive campaign at Suburban to raise awareness among staff members of a fast-acting and potentially fatal infection too-commonly seen in hospitals.

"We here at Suburban encourage nurses' development. We want them to help with the communication of ideas," says Patricia Gabriel, RN, clinical nurse educator for the Emergency, Trauma, Pediatrics, and Clinical Decisions units at Suburban Hospital. "So here was a staff nurse

who said, 'I think I have a really cool idea to get this message across.' Hospital leadership and administration supported it. It's a great example of our collaborative nursing practice model."

While a nationwide sepsis awareness campaign has been ongoing for years, Suburban's Andrew Markowski, MD, spearheaded an initiative to personalize it at this Bethesda hospital. Unique to Suburban's campaign? It introduces a comprehensive and systematic protocol for responding to sepsis immediately: "The protocol would give nurses autonomy to initiate certain steps if a patient met the given criteria," Gabriel explains.

Because early signs of sepsis can be tricky to ID, Markowski first presented the latest data that assured nurses what steps should be taken in any suspected case. "He really helped us understand the science of it," Gabriel says.

Then, Folk and other Emergency Department staffers figured out a fun way to convey it to colleagues. Dani Crane, RN, a 24-year-old clinical nurse at Suburban, was one of the first to volunteer. "Alicia was the star performer, and she developed the rap. Then I thought, 'I'm game for making a fool of myself,'" says Crane, who last performed in high school plays.

In the video, Crane, Folk (who recently left Suburban), and others dance around a bedridden patient as they rap. It was a hit not just in Suburban's ED but throughout the Johns Hopkins medical system, earning first prize at its fifth annual Patient Safety Summit.

Gabriel says that since the campaign rollout, she's observed strong anecdotal evidence that nurses are more proactive in testing for sepsis. "We have a huge increase in the number of patients getting their serum lactate drawn [to look for unusual levels of lactic acid in blood], which means staff members are thinking about it," she says. ■

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 So let me break it down from the Hopkins crew
about a protocol that we all should do...

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VIGILANDO

News from **the Johns Hopkins Nurses' Alumni Association**

Inside this section:

P. 45

FOREVER HOPKINS

David and Susan Epstein, '64, fell in love at—and with—Johns Hopkins. In her husband's memory, she is giving back to the schools of Nursing and Medicine, offering future students the chance to experience what the Epsteins did.

P. 43 CLASS NEWS

Updates from the alumni of 1954 through 1999

P. 43 'A BOOK OF HEALTH AND PRAYER'

Notes on a frequently requested tome

P. 47 CHURCH NOTES

Freda Creutzburg scholar graduates; Reunion Weekend plans; donations to the Archives

Alumni Update

Susan Kulik, BSN '86, MSN/MBA '06, DNP '12



Greetings from Baltimore!

I hope this finds you having survived the winter weather and getting ready to enjoy the coming spring! As you can tell, winter did not slow down the activities of our JHNAA.

First, I am very happy to introduce Erika Juengst, our new alumni director. Erika comes to us from the Development and Alumni Relations department at the Peabody Institute, where she worked with alumni, donors, and volunteers. Erika, a trained opera

singer and alumnae of Peabody, is full of energy and looking forward to further building connections and activity within our community. Her experience in development, alumni relations, and non-profit arts management will certainly benefit our association. We welcome Erika and look forward to working closely with her.

Dean Davidson continues to focus on the launch of the school's new Master's Entry into Nursing program, which will enroll its first class this fall. The program emphasizes leadership, global impact, quality and safety, and evidence-based interprofessional education. She continues to champion the role of nursing.

The dissolution of the separate JHNAA 501(c)3 went smoothly this winter and our funds are now invested in a designated endowment within the JHU portfolio. The earnings from this fund are designed to provide sufficient interest income to support annual activities such as professional archival care for our collections, Alumni Weekend festivities, and the cost of our Vigilando section in this magazine.

The JHNAA will celebrate the continuing legacy and wonderful spirit of its alumni and family during the weekend of September 24-26, 2015. If you are interested in participating in the planning activities, please contact me: skulik@jhmi.edu.

We continue to be visible to our students through mentorships, panel discussions, and project support. Our vision this year is to have our alumni engage even more frequently with the students, who truly want to know more about our lives as nurses. The Alumni-Student Committee calls for volunteers to join!

Finally, I want to remind you to support your alumni association. For those who have not done so, please consider making your gift. Being a part of our Alumni Association is all about staying connected, and there are so many ways to do so. Whether as an active volunteer on one of the numerous board committees, as a Class Ambassador, or simply as a member of the LinkedIn and Google+ groups, you can make an impact. As someone who has been involved in the life of Johns Hopkins Nursing since 1986, not a day passes that I don't see the value of being a part of this community. I encourage all of you to do the same and reap the benefits of being an active JHNAA alumnae! ■

CLASS NEWS



1954

Arianne Regester called Alumni Weekend an experience she truly

hopes to repeat. Somehow, some way she plans to attend in 2019. Seeing classmates was a real pleasure, but even more she enjoyed hearing about how well the school is responding to needs of the future—of both the students and those they will serve.

1994

ACCELERATED Shelley Garfield is a nursing consultant who also

sells fused glass jewelry. She is married and has one son. **Julie Zuydnoek Nicholas** has become certified in occupational health and currently works in employee health in Seattle, WA. She is married with two sons, and has just run her sixth half-marathon. Julie also serves on the Nursing Practice Advisory committee for Washington state, and as the co-vice president for the Association for Occupational Health Professionals (AOHP). **Mary Florenzo** is

working at Children's National Medical Center and here at JHUSON as a clinical instructor. Mary has four children.

1999

Theresa Young received

her master's degree from the University of Maryland with a desire to become a nurse anesthetist. She currently works at R. Adams Cowley Shock Trauma Center in Maryland. **Frank Cardoza** earned his MSN with a career path that will include anesthesiology. He is currently working at Kaiser Permanente. He was the recipient of the Agatha Hodgins Award for achievement and excellence.

1999

ACCELERATED Angela Griffiths earned her MS

in Nurse anesthesiology from the University of Michigan at Flint. She is currently employed at Hurley Medical Center there. **Lauren Ann McKae Sperry**

Photo above: Josephine Nappi, director of Nursing Professional Development at Memorial Sloan Kettering Cancer Center; Piera M. Cote Robson, Accel. '95, clinical nurse specialist at Memorial Sloan Kettering Cancer Center; Julia Taylor, '12, registered nurse at Memorial Sloan Kettering Cancer Center; Meredith Close, '11, registered nurse at New York-Presbyterian Weill Cornell; Susan Appling, '73, assistant professor at Johns Hopkins University School of Nursing; Eizabeth Nelkin McCormick, senior vice president and chief nursing officer at Memorial Sloan Kettering Cancer Center

Book on the Christ Statue

Many alums from the 1960s and early 1970s asked about the name of a book regarding the Christ statue at The Johns Hopkins Hospital for which the Rev. Clyde Shallenberger wrote a message. The book is available for purchase online.

The information is as follows:

HERE IS MY HOPE: A BOOK OF HEALING AND PRAYER

Written by

Randi Henderson and Richard Marek

Published in 2001 by

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 Kay Barclay Feild '60
 Judith A. Hallagan '64
 Nancy Moose '72
 Virginia P. Kormann '79

earned her MSN from the University of California, San Francisco. She has been the coordinator for the deep brain stimulation program at UC-Davis in Sacramento since 2012. She volunteers for the Junior League of Sacramento and is married with two sons. **Jennifer Lynn Pummell Hamner** has been the school nurse at Herbert Hoover Elementary School in Bettendorf, IA since 2012. She is a married self-described soccer mom and dance mom of two children. **Rebecca Mines Paschall** is now a certified legal nurse consultant and a certified medical examiner for the Federal Department of Transportation. She is working in outpatient surgery and urgent care, and her career path will include family practice, urgent care, and legal nurse counseling. Rebecca is married with two children. **Bridget Roughneen** is working at the Alaska Medical Center in Anchorage, AK. She enjoys Alaska tremendously and is planning to work in emergency room care. **Hilkka Korvola Bold** works at the Providence Alaska Medical Center and plans to become a labor and

delivery nurse in the future. She is married with two children, and they enjoy outdoor activities. **Astrid Lizotte** has done some graduate work at Colorado University Health Sciences Division in Denver, CO. She is employed by Aspen Valley Pediatrics and has two children. Astrid enjoys art, travel, and raising her children. **Kashiko Nagayama Fujii** is a licensed registered nurse in Japan. She worked at a university hospital in Japan for nine years since her JHSON days. She also has a care manager license. Kashiko plans to pursue her PhD in the next few years and focus her interest in international research regarding bedridden patients. She is married and currently works as a home care nurse. **Leslie Rectenwald Mason** earned her MSN degree from the University of North Carolina at Chapel Hill and is now working on her PhD there. She is the associate director of Duke Quality Network as part of the Duke University Health System. Leslie is married with two sons. **Tarah Somers** earned her MSN and MPH at Hopkins. She is on active duty with the U.S. Public Health Service working at the Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry in Boston. She holds the rank of commander and wrote a chapter for a textbook on Environmental Health Nursing. Tarah is married with three children, one of whom is a newborn. **Mary Ruth Pugh** works at the Intermountain Healthcare Level One Trauma Center in Murray, UT and is interested in trauma and critical care nursing. She is married with twins. **Amy E. Wechter** is a nurse at Ellis Hospital in Schenectady, NY serving as a nurse navigator (care manager). She is married with four children, and plans to continue her work in community health nursing. ■

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All-Star Sponsors

The following sponsors helped make the 2014 Evening With the Stars gala a great success. While looking forward to the 2015 edition (6 p.m. Saturday, September 26), it seems a good time to look back and say thank you.

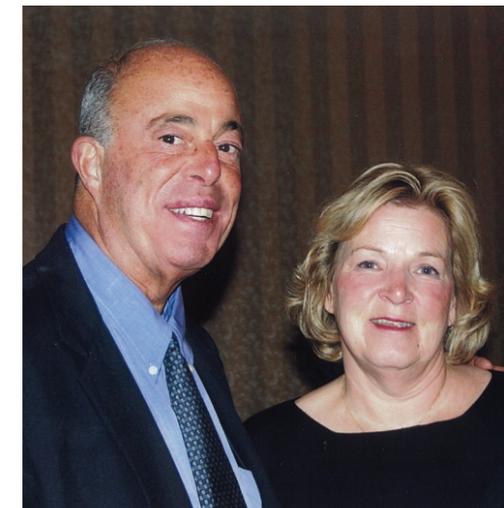


Forever Hopkins

By Jennifer Walker

The Epsteins fell for each other and the university, pledging to one day give back

The Epsteins' love story has a comedic beginning: During a snowball fight in the winter of 1964 in front of The Johns Hopkins Hospital, Susan hit David in the eye and knocked out his contact lens. "I was apologizing to him, but I was also admiring this very handsome, tall, young medical student," says Susan Epstein, who was a student at the neighboring School of Nursing at the time. They got engaged on the day Dr. David Epstein graduated from the School of Medicine, and they were married the following November.



David and
Susan Epstein

For this reason, of course, Susan feels a deep connection to Hopkins. The Epsteins were even talking about supporting the university through an estate plan. But when David, who was chair of the Department of Ophthalmology at Duke University School of Medicine for 22 years, passed away suddenly in 2014, Susan decided to make their gifts early.

She donated \$250,000 to the School of Nursing to support a student interested in patient advocacy and healthcare policy and \$250,000 to the School of Medicine to support a student who intends to pursue a career in academic medicine and research.

"David was a scholarship student through all of his undergraduate and medical school education," Susan says. "He felt a very keen responsibility to return that favor and pay it back, so that other young people could have the same opportunity that he had at Hopkins. After his death, I knew that this is the one thing that he would want to accomplish."

But Susan's time as a nursing student also had a profound impact on her: She calls those years "the most formative of my life." Even though Susan

did not stay in the nursing field—she became a lawyer instead—the drive she found at the School of Nursing to give her best effort to every pursuit stayed with her.

"Good enough was not good enough," Susan says of nursing school. "It didn't matter if you were exhausted or you had worked three hours beyond your shift. There was no excuse for not providing absolutely top-notch nursing care. That demand for excellence pervaded everything I did afterward."

After Hopkins, Susan worked as a psychiatric nurse in Boston and San Antonio before getting an undergraduate degree in history, then her law degree from Boston College. She had spent years working with people with mental health challenges, trying to get follow-up services for them after they left big state facilities and rejoined the community, so she wanted to use her law degree to advocate for this population.

She went on to work for what is now known as Legal Aid, representing children who could not access healthcare, often because of mental health issues, and working with other attorneys to change government policies for them.

In March, Susan was in Phoenix, visiting with three friends she made at the School of Nursing. One night, they reminisced about their graduation day when, dressed in their white uniforms, they listened to Mary Price, director at the time, quote poet Rupert Brooke's "The Soldier" in her commencement address: "If I should die, think only this of me:/That there's some corner of a foreign field/that is for ever England."

For Susan, Hopkins is her England. "There is always going to be this Hopkins experience that will be a part of you," she says. She has met other former Hopkins students at cocktail parties and events around the country, and "there is this instant connection, an understanding that exists kind of like it would in a family," she adds. "That is what David and I have felt all of our lives." ■

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Church Notes

By Deb Corteggiano Kennedy, '73

Freda Creutzburg Scholar Graduates

Congratulations to the latest recipient of the scholarship, **Madeleine Barab**. I had the pleasure of meeting her just before her December 2014 graduation. Madeleine is currently pursuing her nursing career in critical care nursing.



Madeleine Barab, '14, Freda Creutzburg scholar, left, with Deb Corteggiano Kennedy, '73

Reunion Weekend Coming

It's exciting to hear that the classes who will be celebrating 40th- and 50th-year milestones have started planning! If you were in the class of 1965 and will celebrate 50 Golden Years of nursing, contact **Pat Kniffin Roberts**. Pat is in the planning stages of making this a very special reunion for her class.

Members of the Class of '75 should look for a special Facebook page set up by **Teri Lura Fink Bennett** to connect for your 40th reunion. Teri reported that 10 classmates have already signed on to plan and make the celebration of their milestone also very special.

Donations to the Archives

Thank you to **Kay Kaufman**, '63, for her recent donation of many historic medical and nursing books to the Alan Mason Chesney Medical Archives. I was in awe as I looked them over before I turned them in. Among the items was Miss Nash's personal copy of Florence

Nightingale's *Notes on Nursing*! When you have time, this is an excellent place to spend a day to really soak up some nursing history and see the care our precious archives receive.

Help the Scholarship Grow

Maybe you will be getting a big tax refund? Hope so, but even if you are not, always remember the scholarship when you are making charitable contributions. We have grown from \$23,000 to over \$245,000 in the 10 years we have given to support nursing education. Let's continue to make a difference! ■

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IN MEMORIAM

Cynthia Shobe Quinn '73

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2015 ALUMNI WEEKEND

The weekend will start with a Thursday night cocktail party, then tours, class dinners, a little bit of learning and a lot of fun and reminiscing that wraps up with the Evening With the Stars gala on Saturday night.

@ FOR MORE INFORMATION ON EVENTS AND ACCOMMODATIONS, VISIT NURSING.JHU.EDU/ALUMNIWEEKEND



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Chalk one up: Sarah Allison at the blackboard, teaching the self-care deficit nursing theory to students around 1970. A foundation was established in 2000 in Allison's honor to promote the development and formalization of the practical science of nursing based on Dorothea Orem's theories, including self-care deficit nursing, considered the basis for the advancement of both nursing knowledge and nursing as a profession. PHOTO FROM THE ALAN MASON CHESNEY MEDICAL ARCHIVES



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