Clinical Issue
School of Nursing and Nursing Alumni Association at the University of California, San Francisco
Fall 2009

Science of caring

Nursing and Health Care Reform
Supporting Graduate Nursing Students
Doctoral Program in Sociology

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Health care reform is the No. 1 domestic priority of the Obama administration. As this issue of Science of Caring goes to press, proposed changes are being argued in multiple venues – the US Capitol, town halls, newspaper editorials and the blogosphere, to name but a few. Muddled misconceptions and fearmongering abound.

Despite disparate views about the issue, the majority of Americans recognize that the current health care system is not focused on health or care, and it is certainly not a system. It is focused on disease – not health – as reflected in what services are reimbursed; it is often devoid of care (just ask anyone who has battled with an insurance company following denial of service); and it is certainly not a system, given the many gaps and lack of organization among providers.

Today, Americans are asking for health insurance that is comprehensive, portable, affordable and financially sustainable. The importance of this last point was highlighted in an August 2009 study in the American Journal of Medicine, which found that 62 percent of American bankruptcies were linked to medical bills – a number that had increased by almost 50 percent since 2003. Fee-for-service payment and a fragmented system that rewards specialists over primary care providers have caused unsustainable cost inflation that cannot be endured.

What does the School of Nursing at UCSF have to offer in the current debate? In this issue of Science of Caring, you will find a discussion of the opportunities and challenges facing advanced practice nurses in this era of health reform.

The current news is filled with alarms about the projected shortage of primary care physicians in this country. According to these projections, the American Academy of Family Physicians needs to graduate approximately 4,000 family practice physicians per year, but only 1,083 graduates of US medical schools selected family medicine in 2009.

Although we need to address the primary care shortage of physicians in this country, it is important in any discussion to remember that many Americans today see an advanced practice nurse for their primary care. In fact, one out of three Americans consults a nurse practitioner annually. Researchers have shown that nurse practitioners are capable of managing 80 percent to 90 percent of the care provided by primary care physicians without resorting to physician referral or consultation. And in all 50 states, nurse practitioners prescribe medications, diagnose and treat patients, order lab tests, and refer patients to specialists.

Thus, any discussion about health care reform and primary care must acknowledge the important role that nurse practitioners and midwives now play in the health care system. Our programs in midwifery, family practice, adult care, pediatrics, geriatrics and other specialties prepare nurses to play a key role in the health care of the future. Effective reform requires innovation. Advanced practice nurses are an important innovation, and they will be a key part of any solution in which all Americans receive the health care they need.

Kathleen Dracup  
RN, FNP, DNSc, FAAN  
Professor and Dean  
UCSF School of Nursing
Another factor in many developing countries is the way the AIDS pandemic has decimated the younger generation, further reducing the number of people available to care for older adults. This has also strained older adults, who often find themselves caring for their orphaned grandchildren. Another circumstance we see is that the younger generation often moves to the city for work, leaving a larger population of older adults in rural communities without the necessary support.

How will the health care challenges that grow from an aging population differ in the developing and developed worlds?

In some parts of the developing world, there are fewer resources to draw on and the distances traveled to obtain care can be significant, especially where transportation services are limited. Shortages can get exacerbated when health care providers from other countries seek opportunities in the developed world. Also, based on what nurses and other health professionals from around the world have reported to me, much of the emphasis in the developing world has been on children and mothers or those with HIV/AIDS. This is understandable, but it means there may be fewer specialty programs focusing on the care of older adults.

In the United States, how do you expect the aging of the population will play out in the various health care settings that serve older adults?

In many settings, there is already increased demand for more responsive, highly technical care for severely ill individuals and for a greater variety of services, from those providing skilled care to those providing more supportive services. In addition, most settings are attempting to create a more homelike, less institutional environment. Laguna Honda Hospital’s new facility [a skilled nursing and rehabilitation center in San Francisco] was designed with this in mind. In hospitals, acute care for elders (ACE) units create an environment that is more conducive to healing by bringing together the expertise that will not just heal an illness,
but also keep older adults as functionally able as possible during their hospital stay.

What does all this imply for health care providers working with older adults – and for nurses in particular?

Because of time limitations and lack of knowledge, we often send older patients and caregivers home from the hospital without adequate training in how to provide care or get help when they need it. That’s why there has been so much emphasis lately on transitions and coordinating care across settings. This means all health care providers need to have a firm grounding in issues related to the care of older adults, as well as in how to assist family members with caregiving issues and direct them to the appropriate resource.

The Institute of Medicine report *Retooling for an Aging America* spoke directly to the need caregivers have for more assistance in everything from basic care (things like bathing and how best to get people in and out of wheelchairs) to what the indications are for decline and where to call when you need help, including organizations like the Family Caregiver Alliance.

What are some ways the nursing profession can and should respond to these changes? Should we educate nurses differently?

There is certainly a movement to embed content related to older adults across all levels of nursing education. Competencies for these various levels are being developed. *Retooling for an Aging America* emphasized the need for this type of education for all health care practitioners, along with a specific focus on what they termed “direct care providers.”

Again, all providers need to understand issues around aging. We can no longer attribute most problems older adults experience to getting older. We need to understand the difference between expected changes and real red flags. Can you recognize delirium and depression – and can you tell the difference between the two? Do you know who to call when you need more experience and understanding of these issues?

Increasingly, we have advanced practice nurses who are highly trained to recognize and intervene – who, like geriatricians, are highly attuned to the complex needs of older adults. Preparing this cadre of nurses is the mission of our Center of Geriatric Nursing Excellence. We prepare nurses at both the doctoral and master’s levels who are prepared to meet the needs of the growing numbers of older adults. The center is supported by the John A. Hartford Foundation, one of the few foundations focused on older adults and also one of the great supporters of building the numbers of nurses, nursing faculty and levels of expertise in this discipline so they can teach the next generation of nurses about the needs of older individuals.

The Hartford Foundation also supported the development of the Nurses Improving Care for Healthsystem Elders (NICHE) program at New York University. The NICHE program is now a national program with many participating hospitals. Select nurses at these hospitals go through an intensive program and bring that learning back to their own setting – where they educate others, creating a ripple effect throughout the system.

I also would put in a plug for interdisciplinary practice and training. Geriatric practice, especially the care of persons with multiple, complex chronic conditions, involves collaborating across disciplines, which is why it’s important that different disciplines train together, learn together and respect each other’s expertise.

One example is how the UCSF Academic Geriatric Resource Center, part of a statewide initiative to enhance geriatric education in the health professions, and UCSF’s Northern California Geriatric Education Center bring together faculty and students from all disciplines on campus to better address the needs of older patients.

To ask Margaret Wallhagen additional questions on this topic, please contact her at 415/476-4965 or at meg.wallhagen@nursing.ucsf.edu.
Fundraising appeals have become as common as television commercials. What remain unique, however, are the emotional ties between the UCSF School of Nursing and its supporters.

**Investing in Scholarship**

On May 28, 2009, during its annual induction of members, the Alpha Eta Chapter of Sigma Theta Tau International Honor Society of Nursing (STTI) celebrated two milestones. First, the Alpha Eta Chapter, with more than 800 active members, celebrated its 45th anniversary at UCSF. And second, Brenda Roberts, a founding Alpha Eta member and endowment campaign co-chair, introduced the chapter’s newest fund, which, the members hope, will ensure funding for its nursing research and leadership awards in perpetuity.

The Alpha Eta Nursing Research and Leadership Fund began with a gift from Alpha Eta itself of $100,000. But the group has bigger plans, hoping to raise another $300,000 so that it can create a full endowment. The effort already represents a major enhancement of the $19,000 that the chapter has traditionally awarded each year, with $15,000 going to research grants, $2,000 to leadership grants for members, and $2,000 to Tau Lambda-at-Large, the chapter comprising 15 schools of nursing in sub-Saharan Africa. In recent years, the research awards have enabled such projects as an exploration of Mexican and Mexican-American cultural beliefs regarding diabetes, a study on delirium in mechanically ventilated patients, and an investigation of insulin therapy reluctance in patients with type 2 diabetes.

“UCSF is Alpha Eta’s home,” says Pat Sparacino, Alpha Eta past president. “We realized that we as individuals aren’t going to be around forever, but the...
University will be. We felt that the care of members’ investments could best be entrusted to UCSF.”

Lou Mulligan, current Alpha Eta president, believes the new fund underlines the organization’s commitment to scholarship, service and leadership. Although awards are currently paid for by membership dues, the campaign aims to provide a stable source of income for these grants. “I think we’ve helped a lot of people get their research going,” Mulligan says. “We always want to be able to provide research dollars and leadership development dollars. This fund makes sure that happens.”

A Storied History

Founded in 1922, STTI is committed to supporting the learning, knowledge and professional development of nurses worldwide. The organization, with more than 130,000 active members, is open to nursing students and leaders by invitation only. The Alpha Eta Chapter of STTI, established at UCSF in 1964, ranks among STTI’s largest chapters.

Although Sparacino knows that the professionals who make up the chapter are dedicated to supporting opportunities for their peers, she says, “The commitment that we’ve made as a chapter to provide these awards cannot be supported alone by membership dues, and that’s why we felt it important to develop this fund to ensure the ongoing funding of these awards.”

Mulligan is optimistic that Alpha Eta will meet its goals. “What an incredible chapter this is,” she says. “The hope is that by our 50th year, the endowment will be well in place.”

For more information about supporting the Alpha Eta Nursing Research and Leadership Fund, please contact Development and Alumni Relations Director Judson Gregory at 415/476-6332 or jgregory@support.ucsf.edu.

– Tina Vu
The UCSF School of Nursing retains its reputation for advocacy, activism and research by virtue of its faculty and students, who never lose sight of the people behind the data.

“We all need to seek guidance related to our areas of expertise; in some areas like primary care, nurse practitioners are the experts.”

The Children’s Health Center at San Francisco General Hospital relies on effective collaboration among NPs, physicians and trainees to better serve its patients.

Where NPs Thrive, Patients Benefit
Each year, San Francisco General Hospital (SFGH) delivers care to vast numbers of the city’s most underserved patients. At its Children’s Health Center alone — a web of urgent, primary and specialty care pediatric clinics — practitioners must manage some 32,000 patient visits a year. Despite the huge numbers, the center won the Academic Pediatric Association’s Health Care Delivery Award in 2007, and has also won numerous awards from San Francisco Health Plan and the San Francisco Department of Public Health for its primary care and specialty programs.

Explaining why a particular facility effectively delivers care is always a complex calculus, but there’s no question that the Children’s Health Center relies heavily on its 10 nurse practitioners (NPs). Physician Shannon Thyne, medical director, and NPs who work with her believe the center exemplifies what can be accomplished when NPs are allowed their full scope of practice and when collaboration is more than a word.

The Vision
When Thyne arrived at the center in 2001, she quickly recognized that the NPs there possessed an impressive skill set and deep experience. “People like Nan Madden [who directs the Pediatric Asthma Clinic] and Marisa Duncan [who directs the Pediatric Neurology Clinic] have a very sophisticated understanding of our patients’ needs, which can be quite complex,” says Thyne.

The NPs’ professionalism helped Thyne formulate her vision for the center. “Shannon realized that more nurse practitioners meant increased capacity and better continuity of care,” says nurse practitioner Karen Duderstadt, who since 2005 has been a primary care provider at the Children’s Health Center.

Over the years, Thyne has not only greatly expanded the number of NPs at the center, but has also sought ways to let them practice to the full extent of their training and encouraged collaboration — not just among the NPs themselves, but with the physicians and other professionals working in the clinic as well.

“Collaborative practice is the most effective way to deliver continuity of primary care,” says Duderstadt, who founded the nurse-run Valencia Health Services in 1993 and was its director for six years.

“We all need to seek guidance related to our areas of expertise, and in

Shannon Thyne, Janis Mandac-Dy and Karen Duderstadt
some areas like primary care, nurse practitioners are the experts,” says Thyne. “Our approach is to allow people to be good at what they’re good at.”

The Clinics
As she has worked toward her vision, Thyne has turned repeatedly to the UCSF School of Nursing to hire NPs who are the best fit for a wide array of health care services. (Faculty members from all four schools at UCSF, which has formally partnered with SFGH since 1959, provide patient care, conduct research and teach at the hospital.)

The NP-driven services begin with the asthma and neurology clinics, run by UCSF graduates Madden and Duncan. Both have been associated with the center for many years and have earned enormous respect throughout the system. The Pediatric Asthma Clinic recently added a second full-time NP, Andrea Crosby; nurse practitioner Alice Chan also provides some asthma care. Both Crosby and Chan are UCSF graduates.

Duderstadt, Chan and nurse practitioner Susie Miller work with trainees in the primary care clinic, while nurse practitioner Janis Mandac-Dy, a former student of Duderstadt’s, runs the Multidisciplinary Assessment Center (MDAC), funded by First 5 San Francisco.

“The clinic provides services for children zero to 5 who would not otherwise have access to these services,” says Mandac-Dy, who graduated from the School of Nursing’s Master’s Entry Program in Nursing as a pediatric nurse practitioner in 2004. “Children are referred because someone has noticed a developmental delay.”

Once they’re at MDAC, Mandac-Dy conducts a physical assessment and medical history, while speech pathologists, occupational therapists, psychologists, a developmental pediatrician, an educational specialist and a care coordinator are available for a range of other assessments.

Nurse practitioners Jessica Axelrod and Marilyn Obedzinski, both UCSF graduates, run the foster care clinic, which conducts care management and assessment for children in the foster care system. Nurse practitioner and UCSF graduate Janet Hines directs the Child and Adolescent Support Advocacy and Resource Center, where she and Miller conduct physical and sexual abuse assessments.

The most recent addition is an NP in the newborn follow-up program, where UCSF graduate Mary Anne Israel or Duncan does a home visit within the first two weeks of an infant and mother’s returning home from the hospital, before the family has chosen a primary care provider for the child. This has cut down on unnecessary urgent care visits and, again, improved continuity of care.

“One of the patient benefits of a collaborative setting with diverse services is that providers understand what’s available and can easily refer patients or call for consultations as needed, which increases patient access to continuous, high-quality care and reduces costs,” says Duderstadt.

Training Adds to the Care
Thyne has also greatly expanded the number of trainees who rotate through the center, including NP students, medical students, residents and fellows.

“Every patient encounter is a learning opportunity and we train in a degree-blind way,” says Thyne. “I often don’t know who is an NP or a resident, and trainees come from many different specialty areas, but all of them work collaboratively with a complex patient population, making this a rich learning environment.”

Thyne notes that more trainees means patients get extra attention to every aspect of care. This is unusual in a public health setting, where patients have come to expect long waits, but rushed visits.

At the Children’s Health Center, the waits may still be long, but the visits are also long and thorough, garnering strong levels of patient satisfaction. “By the time I come into the room, the family has been totally heard without sacrificing productivity standards,” says Thyne.

Elevating Nursing
Mandac-Dy believes one reason collaboration works so well at the center is Thyne’s leadership. “Shannon respects the NP role so much,” Mandac-Dy says. “She has high expectations, which is great because it allows me to use every advanced practice nursing skill – system intervention, true primary care, and educating students and patients.”

Both Duderstadt and Thyne believe another significant factor is what the NPs bring to the table: enormous experience, commitment and expertise in working with the diverse, low-income populations at SFGH. Their professionalism is impossible to ignore, says Thyne, and it elevates the respect for nursing.

“It enables us to model NP expertise to both staff physicians and trainees,” she says. “One of the things we teach best here is how important nursing can be when you have high-quality nurses.”
Sue Currin Takes the Reins at San Francisco General Hospital
Since March 2009, she has been CEO of San Francisco General Hospital, but when Sue Currin (MSN ‘93, RN) recalls the moment that first drew her to her profession, she is again a 12-year-old girl coming to grips with her father dying.

“He had been shot during a robbery,” says Currin. “In the ICU, the doctors didn’t have time to talk to us. So it was the nurse who told us what was going on and made that connection, allowed us those moments.”

From that excruciating time, Currin seemed destined to be a nurse; the CEO part would come later. When she graduated from high school, where a school nurse had encouraged her to pursue a nursing career, Currin moved directly into a program at her local community college and then on to San Francisco State University to get her BSN degree. Her first job was as a staff nurse at UCSF-affiliated San Francisco General Hospital (SFGH).

Eventually, she became a nurse educator. It was then that she met another nurse who would touch her life in a meaningful way: Gene O’Connell.

“I loved nursing and San Francisco General, but something was missing,” says Currin. When O’Connell began a master’s program at UCSF School of Nursing, her descriptions of the program helped Currin understand how she might fill the gap. “Gene talked about how the program helped her look differently at the way we cared for patients and how we worked together.”

A Master’s-Prepared Nurse
Shortly thereafter, Currin enrolled in a School of Nursing master’s program. “The energy and passion to improve nursing practice were infectious. We were communicating in a different language, and it brought the spark back for me,” she says. “When you talk about the role of a professional nurse, something happens in a graduate school environment. It opens up possibilities and you understand the value of the work you do. I see it in staff now who return to school. We have 13 nurses here who have PhDs and over 20 in graduate programs.”

After completing her master’s degree, Currin returned to SFGH, eventually becoming director of quality for the Community Health Network, the integrated system that includes Laguna Honda Hospital, community clinics and Jail Medical Services. For a short time, Kaiser-Permanente hired her away, but in 1998, O’Connell became CEO of SFGH and asked Currin to become her chief nursing officer.

“I couldn’t turn down the best public hospital in the country,” says Currin. “I came back to a place that was home.”
Sue Currin

“We face some difficult economic challenges as a safety net hospital, but we’ve learned to be creative with limited resources.”

A CEO’s Challenges
Home, yes, but as Currin takes over the reins, she faces a number of significant challenges. The biggest one is the rebuilding of SFGH. In fall 2008, O’Connell shepherded an $887 million bond measure to victory, garnering 84 percent of the vote.

“This was an overwhelming vote of confidence, and it makes you realize that the city’s residents truly value the work this hospital does,” says Currin. Now it is her job to oversee the hospital’s rebuilding without compromising current clinical operations.

One of the things Currin has insisted on is involving staff in the new design, with an eye toward patient safety. For example, the patient care areas will have a circular layout to make gurneys and wheelchairs easier to move and patients’ rooms more visible to nurses from their stations. Handrails will help patients safely move from the bed to the bathroom, and supplies will be close to the patient, allowing nurses to spend more time at the bedside.

A second major challenge is managing the hospital’s budget. “We are not an island and we face some difficult economic challenges as a safety net hospital, but we’ve learned to be creative with limited resources,” says Currin.

She points to a number of examples, including an e-referral program for primary care providers that reduces wait times for specialist appointments and increases patients’ preparation for their first visit. Then there’s the video medical interpretation program, which gives patients and providers near-immediate access to interpreter services. This is no small thing at a hospital where more than 50 different languages are spoken and at a time when research demonstrates that care and patient-provider communication are linked.

A third challenge is to move SFGH further toward magnet status, recognition from the American Nurses Credentialing Center of hospitals that meet specific standards for the strength and quality of their nursing.

“It’s important to nursing staff,” says Currin. “They want a voice in nursing practice, more certified nurses in specialty areas and to be leaders in evidence-based practice.”

To that end, SFGH has established an evidence-based fellowship program, in which nurses apply for funding to do a project that is beneficial to patients. Currin points to one project on the swallowing disorder dysphagia. A fellow came up with a computer teaching module whereby nurses learn how to avoid patient aspirations.

“We realized that this was something bedside nurses could do and that it’s a significant patient safety issue,” says Currin.

The Influence of Nursing
Though being a nurse and a female CEO is still uncommon in the world of hospitals, Currin says, “It feels like no big deal in this setting; it feels good to work for the Department of Public Health and [San Francisco Department of Public Health Director] Mitch Katz, who believes in the role of nurses.”

Currin does, however, recognize that her nursing background has a powerful influence on how she goes about her job day to day, especially in her commitment to staying aware of patient needs and to teamwork. SFGH has a system of executive rounds, in which executives regularly solicit ideas and concerns from frontline staff. “Nurses are team-oriented, and I believe executives have to be part of the team,” she says.

“We want to collaborate and communicate effectively. It is the culture here to be that way, and it is very much my nurse’s training.”

Less formally, says Currin, “I’m often here later in the day, and when I’m tired of my desk, I’m fond of walking into the units, talking with staff and talking with patients.” Perhaps it is in those moments that Currin’s memory of what drew her to nursing in the first place is most vivid and most powerful.
Journeys

science of caring

Naomi Schapiro
By Andrew Schwartz

This past summer, with a group of nurses at his side, President Barack Obama spoke about the critical role that nurses can play in health care reform. For a profession often relegated to the shadows of the health care debate, the broad daylight of a White House event was a rare moment to showcase what nurses do.

“From birth to death, patients receive a majority of their care from nurses; one out of three Americans will see a nurse practitioner for primary care in the coming year,” says Kathleen Dracup, dean of the UCSF School of Nursing. “Yet aside from a few isolated moments, I see little in the health care debate acknowledging the integral role nurses play in primary care or in a health care system striving for lower costs and improved quality.”

Primary care is especially ripe for leveraging the skills nurses bring to the table. If, as expected, 47 million people enter the system in 2013, most experts believe there will be nowhere near enough primary care physicians to serve them; there is already a shortage.

Nurse practitioners (NPs) and midwives—the advanced practice nurses trained to deliver primary care—point out that because their training requires fewer years, they can more quickly fill the expected void. Moreover, most research confirms that primary care NPs and midwives achieve patient outcomes equal to or better than their physician counterparts, and sometimes do so at a lower cost.

Despite this, the exact role primary care nurses will play in health care reform remains unclear. Some physician groups are unwilling to cede patients and income. An arcane, inconsistent, state-by-state system often limits NP and midwife scope of practice and reimbursements. There is meager federal support for nurse training, as opposed to that of physicians. And there is the hard reality that nurses have fewer resources and less influence than other groups lobbying lawmakers in the health care debate.

Determined to overcome those barriers, many nursing leaders have been making a blunt public case about where and why they can help meet the expanding need and, in many cases, improve care and free up physicians for what they do best.

Many nursing leaders have been making a blunt public case about where and why they can help meet the expanding need.

Working with Aging Boomers

One of the first groups where nurses see an opportunity is the rapidly growing population of older adults, who often present with a complex mix of chronic conditions that demand careful clinical oversight. Gerontological NPs already play a central role among this population in settings that include long-term care, skilled nursing facilities, assisted living facilities, and hospice and palliative care.

There is also a push in some circles toward NPs making home visits to older adults who would prefer to “age in place,” but can’t get into a provider’s office because traveling is physically difficult or too expensive. Lynda Mackin, co-director of the Gerontological Advanced Practice Nursing program at the UCSF School of Nursing, believes that gerontologically trained NPs bring a particularly useful skill set to these situations.

“In primary care home visits, NPs do the type of evaluation people normally receive in a doctor’s office, only more thorough because they see things that you can’t see in an office visit,” says Mackin. “This is an area where nursing training makes a difference. It’s not that physicians can’t
do the same, but their training drives them in a different direction.”

She notes, for example, that because a home visit presents a clearer picture of the physical and social environment and available resources, the NP can create a more comprehensive and tailored geriatric care plan. “Older people tend to be more relaxed in their own home, so NPs can better evaluate things like their cognitive state and the effect of symptoms on their daily activities,” says Mackin.

Is such an approach sustainable? Home visits often take more time than office visits, and today, many such visits are paid out of pocket or supported by philanthropy because providers judge them as unsustainable under current Medicare reimbursement guidelines. Yet the approach might actually save money. The Department of Veterans Affairs runs a home visit program and has calculated that the success of its program in averting hospitalizations and nursing home placements reduces the total cost per patient per year by 24 percent.

Even if the reimbursement issues can be resolved, however, the challenge will be expanding the resource pool to meet expanding needs. Unless there is more money available to support the hiring of new faculty or help talented, midcareer nurses return to school, the ability to expand that resource pool is limited.

For the patients, staying connected to their oncology care gives them the type of reassurance that can improve their quality of life. Helping Cancer Survivors and the Worried Well

For many patients, advances in cancer treatment have made this once-acute illness more of a chronic condition. Today, there are nearly 12 million cancer survivors, many of them older adults, living full lives.

Most of those survivors receive primary care from their oncologists, their primary care physicians or both. The problem is that most oncologists don’t have the time to deliver primary care and most primary care physicians don’t have the time or training to deliver primary care with an oncology slant. According to Theresa Koetters, who co-directs the Advanced Practice Oncology Nursing program at UCSF, these patients need someone who has the time and training to deliver both.

“One reason is these patients worry all the time,” says Koetters. Those in remission often don’t know how to identify early signs of recurrence, or what to look for or report. Patients who are not in remission want to better understand how to improve their quality of life or be kept abreast of emerging treatment information.

“For these patients, it can be scary to go back out to regular primary care,” says Mary Lou Ernest, who worked for years as a clinical trial coordinator, responsible for cancer patients on experimental therapy, before returning to school at UCSF and graduating in 1993 as a gerontological NP. For the next 16 years, she provided follow-up care to cancer patients at the UCSF Helen Diller Family Comprehensive Cancer Center.

Both Ernest and Koetters note that the typical primary care provider sees his or her patients only once a year for a physical, lab work, screening and education. “An oncology-focused primary care provider would probably see a breast cancer survivor twice a year or more, looking to do a breast and axillary exam because of the higher risk for other cancers or for the original cancer to return,” says Koetters.
For patients with significant family histories or genetic indicators of cancer, oncology NPs can use their experience and training to more expertly screen for early warning signs. And because oncology NPs are typically first trained as adult, family or gerontological nurse practitioners, they can effectively screen for or manage more traditional primary care concerns such as diabetes, heart disease and arthritis—and help avert unnecessary and invasive tests. For the patients, staying connected to their oncology care gives them the type of reassurance that can improve their quality of life.

“Some of this has been going on already,” says Ernest. Although the Cancer Center’s survivorship program still refers patients back to their primary care providers, Ernest believes that, over time, there will be more reasons for oncology NPs to become these patients’ primary care providers.

“There is an acute shortage and we don’t need duplicate services,” she says. “We shouldn’t underestimate what the primary care people bring to the table, but they have to consider a broader perspective, and it may not be fair to expect them to have oncology in their bag of tricks.”

Koetters notes that in theory, oncology NPs providing primary care could produce revenue for oncology practices while freeing medical oncologists to use their expertise for the sickest of the sick. “Part of the challenge, though, is getting this service under the right umbrella in terms of reimbursement,” she says. Ernest notes that sometimes follow-up care can involve longer appointments than the 10 or 15 minutes primary care appointments are typically allotted. Current reimbursement levels hardly cover the shorter appointment, much less a longer one.

Then there is the inevitable tension over “stealing patients.” Even if traditional primary care providers are willing to cede monitoring of the cancer itself, they will still want to treat the earaches, sore throats and arthritis. Koetters understands, but believes that argument may disappear in the face of 47 million more people entering the system. “There will be more than enough work to go around,” she says.
Science of Caring

Humanizing Childbirth, Saving Money

Health care reform is yet one more reason for midwives to continue their long-running crusade to increase patient access to midwife services and to expand and standardize their scope of practice in the United States. “The single greatest diagnosis code for hospital admissions is childbirth and it can be costly,” says Amy Levi, who directs the Midwifery/Women’s Health Nurse Practitioner program at the UCSF School of Nursing.

Levi and the American College of Nurse-Midwives would argue that increased use of midwives is one sensible way to help reduce childbirth costs without sacrificing quality. “In terms of consumption of resources, midwives shy away from gratuitous use of technology,” she says. “That gets cost savings without compromising outcomes.”

Research generally confirms that midwife care is at least as safe as care from physicians, the cost is better and women tend to be satisfied with their care, according to Joanne Spetz of the Center for the Health Professions at UCSF.

Midwives approach childbirth as a normal physiological process, not a condition that in every case demands that a woman and her child be monitored by complex medical devices and, at the slightest indication, must undergo inpatient medical treatment. Though Levi knows well that there are many situations during childbirth that require skilled physicians and medical technology to resolve, she and her professional colleagues believe that medical technology is often overused and unnecessary.

Another reason Levi believes midwives fit neatly into the visions of health care reform is that many are trained to work with those patients who will be entering the system anew. In her program at UCSF, the focus of the training is on providing culturally competent care for underserved populations. Levi herself delivers babies at San Francisco General Hospital, San Francisco’s hospital of last resort and one of the best public hospitals in the country.

“Most nurse practitioners and midwives did not go to school to become high wage earners, but to provide service and care to individuals,” she says. “If reform reduces barriers to using midwives, there can be less cost and ubiquity of services.”

Today, however, some of those barriers still stand. Many states require a referral from an obstetrician-gynecologist before insurance will pay for a midwife, and midwives themselves need agreements with physicians who, when necessary, can provide the medical services that midwives cannot.

“We are always looking to increase the numbers of our physician colleagues who are supportive and collaborative,” says Levi. “Slowly, inroads are being made. But I think it’s slow because our numbers are small and we are still seen as alternative providers in the marketplace.”

“The payment differential has no analytic foundation, and many health care practices won’t be able to survive with that differential rate.”

Joanne Spetz
Suzan Stringari-Murray

Amy Levi
NP Primary Care Skills Fit the Need

“Nearly everyone agrees that [under any version of health care reform] health care service delivery needs to be more collaborative and patient-centered,” says Suzan Stringari-Murray, who directs the Adult Nurse Practitioner program at the UCSF School of Nursing. “That’s why nurse practitioners are in the best position to step into any of the models.”

There are multiple reasons why this is so. For one, NP training is patient-focused, rather than disease-focused, with an emphasis on psychosocial factors, managing illness, navigating the system and patient education. Other disciplines have begun to recognize how valuable this training is to maintaining health, but NPs are already experts in these areas. Numerous outcome studies – including a definitive one published in the *Journal of the American Medical Association* in 2000 – have established that NPs do as well as physicians in managing primary care patients, often with less utilization.

“Schools like ours have worked hard to adapt to health system and community needs and train NPs in a fundamental skill set that can move among various settings,” says Naomi Schapiro, who directs the ambulatory care Pediatric Nurse Practitioner program at UCSF.

A central part of that skill set is managing chronic illnesses like diabetes, asthma and hypertension that have come to dominate health care service delivery. This is not only an area that NPs are trained specifically to do, but, says Ellen Scarr, who directs the Family Nurse Practitioner program at UCSF, chronic disease management is the type of care that many physicians prefer not to do.

A second area ideally suited to NP training is working with young adults, the population least likely under the current system to have health insurance. “If insurance does become available to this group, the only places that will settle for what will likely be lower reimbursement are the community clinics – settings that many NPs work in because of their commitment to working with these poor and underserved populations,” says Scarr.

A third skill set where NP training is particularly apt is in managing patient education and prevention for children and adolescents. Research has shown that those types of services are among the most effective components of adolescent care. Schapiro notes, however, that expanding that role will depend on how reimbursement is structured.

“Because the changes need to be revenue-neutral, maybe rather than being reimbursed for every test that’s ordered, we can reimburse pediatricians and NPs for motivational interviewing or educating adolescents about risk-taking behaviors,” she says.

But Schapiro worries that even if those changes occur, it may be difficult to sustain these types of pediatric services. “Today, Medi-Cal and Medicaid reimbursement is often less than the cost of care,” says Schapiro. “It’s so low practices are barely hanging on or they’re folding.” People often cite these reimbursement concerns as a reason that fewer and fewer medical students opt for primary care, and it is certainly a consideration for NPs as well.

Training Enough Providers

Leaving aside the political fights, even if lawmakers agree that NPs and midwives are ideally suited to the various visions of health care reform, three key questions remain. How can you train enough providers to meet the need? What constitutes fair reimbursement? And will the system allow NPs and midwives to practice to the full extent of their training?

The first question – Can you train enough providers? – is very much on the minds of those who run graduate nursing programs.

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delivery system reforms such as transitional care and increased primary and preventive care.”

Scarr believes that if such funding materializes, some of it needs to be targeted at clinical faculty and training sites. “Practicing clinicians are the ones who can credibly teach clinical management, and schools need a management plan for clinical educators, rather than requiring clinical faculty to scramble to write training grants,” Scarr explains. Today, most hard money faculty positions are reserved for researchers and full-time professors.

“We also have to incent clinics because preceptors are very valuable,” she says. “My program has close to 70 students, who need 80 to 160 clinical hours per quarter, and it is not easy to find sites.”

Spetz points out that another important aspect of education will be creating a culture that encourages people in primary care to work where the need will be. “We will need NPs to work in underserved communities, so you need to provide that training,” she says. “Just look at the rural problem. NP programs tend to be housed at major nursing schools, which are mostly in urban areas. We do a good job here focusing on underserved urban populations, but rural is a tougher nut to crack.”

**Paying the Providers Fairly**

A second major hurdle to incorporating NPs more extensively under health care reform will be resolving a complicated maze of reimbursement concerns. “Payment rules for NPs can be so complex it might require another degree to figure them out,” says Spetz.

Consider that for Medicare, NPs are technically free to bill the Centers for Medicare and Medicaid Services, but whether they can do so directly – or under a physician’s practice – depends on which state they practice in. Some states don’t allow direct billing for NP services at all.

Moreover, the amount of reimbursement for NPs varies from state to state. In some states, the Medicare or Med-
A third hurdle will be what are called scope-of-practice rules, which again vary by state and, in many cases, add unnecessary administrative burdens for physicians and nurses.

For a nurse practitioner to provide primary care to patients, some states require physician oversight and some states require physician consultation, but in other states, no physician involvement is required. Also, different states require different licensing and education levels.

"Within those guidelines, there are differing regulations about how or even if NPs can make diagnoses or prescribe controlled substances," says Spetz. "Clearly, there are spaces where NP care is inappropriate – and good NPs know their limits – but with so much variation, it’s hard from a policy standpoint to ensure the limits."

Malpractice laws complicate this picture. Spetz says that when physicians are sued, they are sued individually. But in some states, if an NP or a midwife is working in a doctor’s office and there is a lawsuit, the nurse, the practice and the supervising physician all get sued. That drives malpractice premiums higher and reduces the number of settings where NPs and midwives can realistically work.

Catherine Dower, Spetz’s colleague at the Center for the Health Professions, conducted a thorough study of the scope-of-practice guidelines and concluded, in the executive summary of her report Overview of Nurse Practitioner Scopes of Practice in the United States (December 2007): “Preventing professionals from practicing to the full extent of their competence negatively affects health care costs, access and quality. NP practices are impeded by scope of practice laws, financing and reimbursement mechanisms, malpractice insurance policies and outdated practice models. The professions and the public are ill-served when practice authorities differ dramatically among states.”

She suggested that policymakers should consider expanding the NP scope of practice to match their competence, adopt uniform scope-of-practice laws to reduce variability among states and increase the number of NP programs to reflect growing demand for primary care.

“Primary care delivery has changed dramatically in the past 50 years, and for the better,” says Dracup. “We are living longer and more comfortably, and nurses and nurse practitioners are often the people who have provided the primary care in partnership with primary care doctors. If regulations around nurse practitioners and midwives are updated and outdated views of primary care change, that will provide one very promising pathway toward effective health care reform.”
office of student affairs

The Office of Student Affairs at UCSF School of Nursing eases the transition to student life. Office of Student Affairs staff: Charlotte Gardner, Jeff Kilmer, Terry Linton, Cathy Bain, Jill Lam, Helen Birkeland, Elizabeth Aife Murray, Leila Kern and Cynthia Ellis.

“We say to people, many of whom already have stable jobs and families, that we have ways to make your life here better and easier.”
Before Entering
The process begins with information sessions for prospective students. “Often, people don’t know what it entails to be in a graduate program, so we put together events where they can find out,” says Kilmer. In the weeks and months after these events, the OSA’s 13 staff members are available to help students understand when and how best to apply.

After enrollment – but before classes begin – students attend a mandatory, three-day orientation program. “The entire first day is focused on technology because it has become such a big part of student life and there are many things returning students are unfamiliar with,” says Kilmer. The other two days cover topics that include the School’s expectations and smaller, in-depth sessions that detail the various programs.

“The orientation takes a little of the fear away and lets people know we are the point where all this information comes together,” says Helen Birkeland, assistant director of the OSA.

Financial Assistance
Of course, priority one for many incoming students is paying for their graduate education. “Our goal, within the law, is to use every resource we can to create a package that will most benefit our students,” says Birkeland.

“We help students understand that it is worth investing in yourself,” says Elizabeth Aife Murray, who, along
with Birkeland and Cheryl Kemp, implements the financial support programs at OSA.

One of the most respected programs the group has in place is called Money for School, a one-day seminar the OSA has offered each May for the past eight years. “By May, nearly all our students have been accepted, but there’s enough time before classes start for them to think about money, rather than waiting until they’re overwhelmed with class work,” says Murray.

The first part of the day uses a light-hearted format to convey information about available money – from loans and scholarships to research and teaching assistantships, work-study, and employee educational incentives. “We try to let people know there are 64 different ways to do this,” says Murray.

The day also includes breakout sessions where incoming students have a chance to speak with others who have been through their particular program. “The former students give people the real deal about how to do this, and their message is usually ‘You can do this, and you can and should be good to yourself as you do,’” says Murray.

Money for School is just the beginning of the help OSA provides about financing an education. As the semester progresses, Murray and Kemp work closely with the campuswide financial aid office and do one-on-one advising to help students piece together the right financial packages.

Murray also has begun using new media, including podcasts and a wiki, to reach both prospective and enrolled students. “It’s a way to instantaneously get out breaking information,” she says. “Our goal is to help students follow their dream and get California its caregivers.”

**Ongoing Support**

Once students are actually in class, another OSA function is helping students navigate their new environment. “We hook every student up with a faculty adviser, who typically goes beyond advising to take on a mentor’s role,” says Kilmer.

In addition, staff members in the Dean’s Office and at OSA are available to help students, both formally and informally, with everything from writing support to connecting with mental health services when there are signs of excessive anxiety or depression. In these efforts, the OSA...
ing education are sent to the California Board of Registered Nursing.

Cynthia Ellis plays a parallel role as she helps master’s students get their nurse practitioner, clinical nurse specialist and midwife certifications. These too can be detailed, bureaucratic processes in which errors cause painful delays.

“It’s my job to make sure every ‘i’ is dotted and every ‘t’ is crossed,” says Ellis.

She says that one advance has been the use of Moodle software to create an online checklist of everything students will need when they are ready to advance their candidacy for certification.

Finally, the OSA helps students pursue their careers through a close collaboration with the Office of Career and Professional Development. There, students can find not only job listings, but also help with things like résumés, interviewing skills and negotiating skills with a potential employer.

The combination of all these services is what, for many students, makes a graduate education – the opening of new worlds – possible.

“When I came here, Kathy Dracup said to me that she wants to create grateful alumni,” says Murray. “That’s been my goal ever since.”

Balancing Dance, School and Nursing

When Brandy Logue applied to the Master’s Entry Program in Nursing (MEPN), she was working as a veterinary technician and pursuing her passion for dance through various classes. She chose nursing over medical school because “I wanted that patient connection,” she says.

But once she enrolled, Logue became concerned that the program’s time and financial demands could prove too much. Her first contact with the Office of Student Affairs assuaged those concerns. “That first informational meeting soothed a lot of us,” she says. “They made it clear that they would find a way to make this work.” And they did, by – among other things – pointing Logue toward scholarships that eased her financial stress.

Concerns kicked in again, however, when just before entering MEPN’s master’s portion, Logue accepted an offer to join a professional dance company. “It was hard [to do both], but the Office of Student Affairs and MEPN faculty encouraged us to find breaks from studying and to squeeze in other things,” she says.

They also encouraged students to support each other, a focus that began during the initial orientation. This led to a tight-knit group that, outside of their clinical and academic hours together, would get together for everything from informal Friday night dinners to holiday parties.

Logue clearly learned how to complement her love of nursing with other passions. Today, she is an RN in the transplant unit at UCSF Medical Center, teaches nursing at Samuel Merritt University in Oakland and continues with her professional dance career.
the mouse that roared: doctoral program in sociology celebrates 40 years
By Andrew Schwartz

“I like to refer to this program as The Mouse That Roared,” says Virginia Olesen, professor emerita in the Department of Social and Behavioral Sciences at the UCSF School of Nursing. “This has always been a tiny program – never more than six or seven faculty. But, my gosh, the contributions....”

Those contributions include legitimizing the concept of nursing research, establishing today’s most prominent qualitative research methodology and, oh, by the way, supplying much of the ammunition informing the most significant public discussions about health and health care over the past half century, from women’s health and health disparities to aging and the impact of science and technology.

The first sociology faculty member arrived here in 1960, a time when medical sociology was in its infancy. The doctoral program was established in 1968, and in 1972, the program found a home in the newly established Department of Social and Behavioral Sciences.

Last fall, as the doctoral program celebrated its 40th birthday, faculty and alumni gathered to reflect on the program’s history and contemplate where it will go from here.

The Beginning

In 1960, UCSF School of Nursing Dean Helen Nahm was determined that graduate programs in nursing would not just prepare nurses for leadership positions in nursing education and service, but also conduct research informed by nurses’ own unique worldview.

At the time, Anselm Strauss was already emerging as one of sociology’s leading lights, but his focus, medical sociology, was a barely recognized specialty. Strauss, however, seemed to grasp before many others did how profoundly developments in health care after World War II – among them government money flowing into both physical and mental health services, the rise of employer-based health insurance, and the emergence of what has come to be known as medicalization – would change not just

 Straus seemed to grasp before many others did how profoundly developments in health care after World War II would change not just the thrust of his discipline, but all of American society.
Two important constructs characterize that foundation: symbolic interactionism and grounded theory. The former is a sociological theory focused on how people interpret the world around them and act on the basis of those interpretations. The latter turns scientific inquiry on its head. Rather than beginning with a theory and then testing it through research, in the grounded theory method, sociologists substantively study a topic and then develop theories based on the data. Today, says Clarke, grounded theory is the qualitative methodology used most in social science and nursing research.

As the intellectual foundation took shape—and the theoretical and methodological approaches expanded—the institution found new ways to support the work. The UCSF Doctoral Program in Sociology became a permanent fixture in 1968, when an infusion of money from the state to the University of California system enabled the School of Nursing to hire more full-time faculty. Then, when the School of Nursing established departments in 1972, the program found a home in the newly formed Department of Social and Behavioral Sciences.

Understanding and Shaping Society

The program’s first mark was on classic medical sociology, including the work of Strauss and his associates on nursing roles and work by Carolyn Wiener on the technologized hospital. Then, in the early ’70s, with the emergence of the women’s movement, Olesen, Sheryl Ruzek and others began looking at the treatment of women patients, as well as at nurses as undervalued professionals. In 1975, with federal support, the department organized the first social science conference on women’s health in the United States, which Clarke attended.

“Ginny and Adele then really spearheaded the link between feminism and women’s health,” says Pinderhughes. Later, Pinderhughes’ own work helped establish violence as a health issue in medical sociology.

During the late ’70s, Carroll Estes, along with Charlene Harrington, Bob Newcomer and Patrick Fox, established a specialty in aging. Through their work and the founding in 1979 of the Institute for Health & Aging, they established UCSF as an international leader in the sociology of aging. That work led almost directly to a new specialty area: health policy. To this day, the program’s research consists of understanding and shaping society through the use of credible research, changing how everyone—from medical professionals and politicians to employers and family members—views patients and disease.

The use of credible research has often changed how everyone—from medical professionals and politicians to employers and family members—views patients and disease.
tently informs policymakers and the public on everything from nursing homes and long-term care to disability, home care, Social Security reform and the social isolation of elders.

“One of the hallmarks of this department has been the way it established a clear link between scholarship and health policy,” says Pinderhughes. “We began doing public sociology far ahead of the curve.”

Another specialty area emerged in the ’90s, when Clarke and others began to examine the impact of biomedical science and technology on not just health care, but society as a whole. Early work examined brain localization and reproductive sciences; more recent student work has looked at such topics as stem cell research, biomonitoring, Viagra and information technology. Recent faculty efforts include Janet Shim’s work on race and ethnicity in interactions between genes and the environment.

Finally, in the new millennium, faculty began to provide leadership in a newly emerging specialty area: race, health disparities and globalization. Very early student projects in the program included the Latino-Latina health paradox and the Port Chicago disaster. Recent faculty work by Shim looks at epidemiology’s use of racial categories, while Pinderhughes examines health inequalities, and Shari Dworkin examines gender relations, economic empowerment programs and HIV/AIDS prevention in Africa.

A Lasting Contribution, A Unique Home

“From the beginning, this group has really opened up the ways medical sociologists and social psychologists look at health and illness,” says Olesen. “At a time when one of the most important issues is health care reform, part of the legacy of this department is to do cutting-edge research around things like the health care system, the patient’s experience, inequalities and end of life,” says Pinderhughes.

And he notes that the impact goes beyond the policymaking arena to social movements such as those that grew up around HIV/AIDS, breast cancer and environmental health. The use of credible research to dispel stigma, affect policy or challenge how a disease is understood has often changed how everyone—from medical professionals and politicians to employers and family members—views patients and disease.

The program also has been a valued training ground for both sociologists and doctorally prepared nurses. “Most of our students find work as medical sociologists, either in government research or in higher education,” says Clarke. “Many have moved on to the best schools to teach, including London School of Economics, Brandeis and McGill.”

Doctorally prepared nurses, many of whom learned their research methods at least in part from the UCSF Department of Social and Behavioral Sciences, have gone on to positions of leadership at the finest schools of nursing in the nation.

All of these accomplishments have occurred in a unique setting: The UCSF Doctoral Program in Sociology is the only one of its kind in a school of nursing.

“It’s been a very congenial atmosphere,” says Olesen. “If you look through the dissertations, done over many years, and faculty research, they took a lot of vivacity from being here.”

“I would venture to say that it’s not happenstance that we are at the School of Nursing,” says Pinderhughes. “Nursing as a profession focuses on the provision of care versus the provision of medicine, a perspective that naturally values the type of research we conduct. There have been growing pains, but our theoretical stance and methodological grounding have been important parts of the evolution of the PhD program and of research at the School of Nursing. I think the relationship is only going to get stronger.”
Interned Nursing Students to Get Long-Delayed Degrees

Associate Dean of Administration Zina Mirsky first met Aiko “Grace” Obata Amemiya at a 2004 book signing at the UCSF School of Nursing. Thelma Robinson, author of Nisei Cadet Nurse of World War II: Patriotism in Spite of Prejudice, introduced them; Amemiya is one of the nurses Robinson profiled in her book.

“It was Grace’s story about her close connection to UC and her enjoyment about all things Cal that really intrigued me,” says Mirsky.

Amemiya recounted all the courses she had taken at UC Berkeley, and how, because she was inappropriately advised, she had to wait a year to be admitted to nursing school. It was just enough of a delay to leave Amemiya short of her degree when the executive order came down that sent her and 110,000 other Japanese Americans to internment camps in their home country.

The meeting with Amemiya kicked off a four-year quest for Mirsky that, in 2008, connected her with UCSF Vice Provost of Student Academic Affairs Joe Castro, who, in turn, connected Mirsky to Judy Sakaki, UC vice president for student affairs. The daughter and granddaughter of former internees, Sakaki took up the cause. With Daniel Simmons, a professor of law at UC Davis, she co-chaired a task force that included representatives from each of the four campuses where Japanese American students were forced to leave before completing their degrees. Donald Kishi, a clinical professor of pharmacy at UCSF, who was born in an internment camp, was a member of the group.

Eventually, with help from Bill Kidder, now assistant executive vice chancellor at UC Riverside, the task force found the right language and justification for the UC Regents to make an exception to their moratorium on honorary degrees. “They did tremendous work,” says Mirsky.

As of this writing, about 125 internees or relatives of deceased internees have come forward. All the campuses are planning awards ceremonies for late fall 2009, and Mirsky can’t wait. “I am just so proud of the University for doing the right thing,” she says.
Master's Student Chosen for Prestigious Policy Fellowship

The passion and intellect Alfredo Mireles brings to his work as a psychiatric nurse at San Francisco General Hospital (SFGH) are a natural fit for policy work. Or at least that’s what the selection committee for the Jesse M. Unruh Assembly Fellowship Program believed. This spring, they chose Mireles out of some 1,200 applicants for a fellowship with the California state government; he was one of only 64 chosen. To complete the fellowship, Mireles will take a leave of absence after completing his first year in the master's program in health policy at the UCSF School of Nursing.

The prestigious, 11-month fellowship begins with six weeks of classroom training, after which fellows are matched with a legislator for full-time work as a legislative staff member. “My hope is to work with a member of the Assembly Health Committee, but we’ll have to see the dynamics when I get there,” says Mireles.

Mireles received his undergraduate degree from UC Berkeley, and planned to work in international development. Believing one good way to work in the developing world was as a health care worker, he became a registered nurse through an accelerated program at Johns Hopkins University. But after returning to the West Coast to work at SFGH, Mireles had an epiphany. “A lot of the needs in the developing world are present in my own community as well,” he says. His work at SFGH made him acutely aware of those needs. “Inpatient psychiatry serves one of the most vulnerable populations,” he says. “These patients can’t advocate for themselves.” Mireles dove into advocacy, including working assiduously on last year’s successful campaign for Proposition A, the San Francisco bond issue that will fund the rebuilding of SFGH.

“I had great experiences with local civic groups and going door to door,” he says. “When you knock on someone’s door and preface your political advocacy with ‘I’m a nurse,’ people are more likely to listen. It’s a really effective tool.”

The Assembly Fellowship is not Mireles’ first dance in the fellowship world. Last spring, he completed a three-day Nurse in Washington Internship that equips nurses with the ability to advocate on Capitol Hill. And shortly after the school year ended, he was a Paul Ambrose Scholar in a multidisciplinary program in Washington designed to create the next generation of public health leaders.

“I think my applications have been significantly strengthened by being a UCSF student,” says Mireles. “UCSF is a universally respected institution, and it has definitely given my applications extra consideration.”
Dracup Joins US Health Secretary Sebelius to Announce Funding for Health Care Professionals

In late July, UCSF School of Nursing Dean Kathleen Dracup joined US Health and Human Services (HHS) Secretary Kathleen Sebelius to announce that $200 million had become available to support grants, loans, loan repayment and scholarships to expand the training of health care professionals. The funds are part of the $500 million that the 2009 American Recovery and Reinvestment Act allotted to address workforce shortages in the health professions.

In a conference call with Secretary Sebelius and the press, Dracup emphasized that the funding is crucial if the country hopes to address a predicted shortage in both nursing and nursing faculty. HHS predicts that the United States will need about 2.8 million nurses by 2020, 1 million more than the projected supply.

The situation at the School of Nursing illustrates why that shortage is likely to occur. Each year, about 700 people apply for the 85 slots available to prepare new nurses at UCSF. Expanding the number of acceptances necessitates hiring more faculty, even as the School is struggling with drastic cuts in state funding. In such an environment, the federal stimulus money becomes that much more important.

“It was an honor to have this opportunity to emphasize our country’s dire need to train more health care professionals, in particular nurses,” says Dracup. “Given the demands that our aging population will place on an already stressed health care system, supporting a new generation of nurses and nurse practitioners is of the utmost importance.”

Dean Receives AACN Career Award

In May, the American Association of Critical-Care Nurses (AACN) awarded UCSF School of Nursing Dean Kathleen Dracup the 2009 Marguerite Rodgers Kinney Award in recognition of her four decades of “outstanding contributions” to critical care. The award is one of the highest honors conferred by the world’s largest specialty nursing association. The AACN represents more than 500,000 acute care and critical care nurses around the world.

Dracup, who has received international recognition for her research into the care of heart disease patients and the effects of heart disease on families, has had a long history of involvement with the AACN. Among other things, she co-founded the organization’s American Journal of Critical Care, which she continued to co-edit until late 2008.

The Marguerite Rodgers Kinney Award is one of four Visionary Leadership Awards created to recognize “extraordinary and distinguished professional contributions” that further the organization’s mission of creating a health care system driven by the needs of patients and their families.
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Editor
Andrew Schwartz
Lisa Gamero
Andrew Schwartz
Tina Yu

Associate Editor
Cheri T. Anderson
Elizabeth Fial
Robert Koehler
Kai Tsutsumi

Contributors
Dean's Council
Nursing Alumni Association

School of Nursing
University of California, San Francisco
San Francisco, CA 94143-0644
415/476-1805

Website: nurseweb.ucsf.edu