Where nursing fits in the future.
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This year has been one of transition and change - both in our school of nursing and the profession of nursing. And while change can be unsettling, it also brings with it new opportunities to not just shape, but to lead the future of nursing education and nursing practice.

After serving as Acting Dean since July 2014, in March, I was named Interim Dean and will continue leading the School through June 30, 2017 while a search for a permanent dean moves forward. As a proud alumna, it is my privilege to continue in this role to further the legacy and heritage of our school. I have been overwhelmed by the positive support I have received from faculty, staff, students, alumni and friends of the School and for that I say thank you. Also, a big thank you to all of you who have donated and those who have continued to donate to the School during UCLA’s centennial campaign. Remember 2019 is our 70th birthday!

Early in my role as Acting Dean, I discovered there were several issues that needed to be addressed at the School to position us for a strong and vibrant future. In January, we announced a new administrative structure as well as new leadership within the School. Adey Nyamathi is serving as Associate Dean for International Research and Scholarly activities, Deborah Koniak-Griffin is continuing as the Associate Dean for Diversity and Equity, and
Lynn Doering will be assuming the role of Associate Dean for Academic and Student Affairs. All have been with the School for many years and are committed to addressing the challenges and creating the opportunities for leadership for students, faculty and staff.

Changes in Westwood weren’t just limited to the School, there are also major changes afoot in the Health Sciences leadership. Vice Chancellor of UCLA Health Sciences and Dean of the David Geffen School of Medicine, Gene Washington and CEO of the UCLA Hospital System, David Feinberg, have stepped down and are moving on to new opportunities. But while there was big fanfare about their departures, there is another change of leadership in the system – Heidi Crooks, the long-serving Chief Nursing Executive, will be stepping down from her role on June 30. I am pleased that the School of Nursing will be at the table to participate in the selection of the new leadership and to redefine the relationship between the health sciences and the school.

And, as if that is not enough, there are big changes and opportunities coming for the nursing profession. As we know, many of the provisions of the Affordable Care Act are aimed at advancing the roles and responsibilities of nurses in delivering healthcare. For example, we are expanding our placements for primary care nurse practitioner students with the additional funding from the Song Brown program.

We have always been pioneers in nursing education. UCLA was one of the first schools in the country to offer an interdisciplinary course – pairing advanced practice nurses and third-year medical residents together in class. Students learned about the roles each type of practitioner plays and how to collaborate and work as partners with other health professionals. Participants have been very positive in their reaction to the class.

Another new and very exciting interdisciplinary program is the new partnership UCLA Nursing and the David Geffen School of Medicine have created with three other schools of nursing and medicine (Yale, University of Michigan and University of Pennsylvania) to create the National Clinician Scholars Program with high quality mentoring and a tailored two-year postdoctoral curriculum for physicians and nurses to address regional health challenges and eliminate health disparities. Recruitment is underway with the first cohort beginning in 2016. This is an historic opportunity to advance team-based approaches in research, leadership, policy and education and I am proud of our leadership role in this arena.

As we continue to redefine our future, no doubt there will be more change, but I believe that all of this change – in the School and in the profession - positions us well to provide critical nursing leadership in healthcare.
NURSES, PHYSICIANS, PARTNER IN NEW PROGRAM TO IMPROVE COMMUNITY HEALTH

Bringing nurse and physician scientists together to improve the health of their local communities is the focus of a new initiative of four nursing schools and four medical schools. UCLA has joined with Yale University, the University of Michigan and the University of Pennsylvania to launch the National Clinician Scholars Program, which will educate nurses and physicians to serve as leaders, researchers, and change agents in healthcare, community health, and public policy.

The innovative program was formed after the Robert Wood Johnson Foundation ended its Clinical Scholars program for physicians. The novel aspect of this new initiative is that nurse scientists, as major contributors to healthcare and health research, will partner with physicians to address and transform the health of their local communities.

“Best patient outcomes require nurses to be full partners in delivering the right care in the right settings,” said Linda Sarna, co-director of the UCLA program. “Interdisciplinary relationships among healthcare providers is the hallmark of the future in patient care.”

To identify regional health challenges, the School of Nursing and the David Geffen School of Medicine have formed a consortium of community organizations – the UCLA Southern California Clinician Leaders Program - that includes the Los Angeles County Department of Health Services, Greater Los Angeles Veterans Health System, and Charles R. Drew University of Medicine and Science, among others.

This consortium will recruit postdoctoral nurses and physicians to address challenges with the goal of eliminating health disparities in Los Angeles. Research projects undertaken through the program will take place in the community so that scholars will be able to make a meaningful impact locally even as they receive their education.

The community projects make up the core of the two-year training experience. Scholars will also take part in an innovative curriculum to build a robust set of skills in organizational and social change, applied translational research methodology, community engagement, program development and evaluation, team management, communication and leadership.
Twenty-eight pioneers of the early doctoral program here at the School of Nursing, who originally received the designation Doctor of Nursing Science (DNS), have, at long last, received the degree designation they have earned – a PhD!

This is an almost unparalleled decision in the annals of the University and we are thrilled to celebrate the historic event!

First, a Little History
In the 1980s, faculty at the UCLA School of Nursing were working to introduce a doctoral program to the curriculum. At the time, some viewed nursing science as too immature to justify a PhD and believed that a DNS would be much more acceptable. Ten years later, the UCLA Graduate Council determined that the doctoral nursing program was a research-based program, and graduates were worthy of the designation of a PhD. Unfortunately, the change was not retroactive to the 28 individuals who had already received their DNS; individuals who went on to be NIH-funded scientists, endowed chairs and national leaders in nursing.

Why this Was So Important (for the 28 and for nursing)
Over the years, many of the holders of the DNS, including faculty at the School of Nursing, were troubled by holding a degree that required them to explain their training and education, something that doesn’t happen with those holding the universally recognized research degree of PhD. Those three letters caused credibility to be questioned and other scientists to ask “who really did the research.”

As nursing moves to the forefront of the future of healthcare around the globe, it was time for the academic background of these nursing leaders to be recognized. Interim Dean Linda Sarna, who benefitted by having her DNS degree from UCSF converted to a PhD, took up the cause for degree conversion at UCLA and was finally successful.

Congratulations to these 28 pioneers who now have the degree that have long deserved.

Cathy Ward ’95 and Lynn Doering ’94, turn in their DNS for a Ph.D.
In 2009, Kathy Dracup was selected as one of the 60 who made a difference for the UCLA School of Nursing. In 2014, she was named a Living legend by the American Academy of Nursing. And now – in 2015 – Dracup has been selected to receive the UCLA Award for Professional Achievement. She was honored alongside other amazing awardees, including former Congressman Henry Waxman, at Bruin Alumni Day this past May 16.

The awards tradition, which began in 1946, pays tribute to alumni who show outstanding achievement in their professional fields and whose contributions to society demonstrate a commitment to excellence. The UCLA Awards are bestowed by the UCLA Alumni Association.

Dracup is an educator and researcher with almost 50 years of experience in cardiovascular nursing and research in the care of patients with heart disease. Because of her advocacy and research, the quality of life of patients with heart disease and their families have improved dramatically. She was the first nurse researcher to look at letting patient’s families in to the ICU as a critical component of their recovery. For 10 years, she served as Dean of the School of Nursing at UCSF, which was the #1 school of nursing during her tenure. She has received numerous awards for her work on the treatment of heart failure including the Heart Failure Society of America Lifetime Achievement Award. She also is the only nurse to receive the Eugene Braunwald Award for Academic Mentorship from the American Heart Association, one of its highest honors. This award recognizes an individual whose academic career includes a long-term record of successful mentoring of promising young academicians.

For the Living Legend Award, one of her nominators and mentees said “few have done so much for so long in such a generous way and she’s not done yet. She’s on the Institute of Medicine, she contributes in the policy arena, and she is a visiting professor all over the world.” Kathy is a role model because of “her incredible listening skills, she uses optimism, patience, graciousness and generosity of spirit to mentor hundreds of cardiovascular and critical care nurses.”

Dracup joins fellow nursing alum, Sister Callista Roy, who received the Professional Achievement Award in 2014.
NEW ASSOCIATE DEAN

Professor Lynn Doering will become the Associate Dean for Academic and Student Affairs in July, 2015. As you know, for many years Lynn has held the position of Section Chair, Translational Sciences, where she has mentored faculty and students. Lynn’s background in management and faculty development, together with her knowledge of the School, make her ideally suited to assume these responsibilities. “It is a time for great opportunity and to position the School for the future, we need to have a renewed focus on teaching excellence and preparing students with the right education for entry into today’s real world of clinical practice and research,” said Doering.

“We also need to grow more partnerships with clinical sites and expand our faculty expertise.” Joining Doering will be new program directors for the degree programs: Doctoral Program: Eunice Lee; Advanced Practice: Jo-Ann Eastwood; Prelicensure: Carol Pavilish and co-director Barbara Demman.

SAYING GOODBYE

Heidi Crooks, RN, MA chief nursing officer and senior associate director of operations and patient care service for UCLA Health System has announced she will retire in June. Under her visionary leadership, she continually transformed the nursing department into a world-class center of excellence. She was known for her passion for her nurses and the opportunities she constantly provided for them. During her tenure, the hospital received designation and redesignation as a Magnet Hospital. The School of Nursing honored Crooks with its Visionary Leadership Award in 2012.
Is heart failure a disease of the brain? Before you answer “Of course not, it’s a disease of the heart,” you need to talk to UCLA School of Nursing Professor Dr. Mary Woo, whose research focuses on the correlation between brain abnormalities and cardiovascular disease.

“Heart failure patients characteristically have disturbances in sleep and breathing patterns, and they have a very high incidence of depression,” she explains. “They also have many difficulties with cognition and motor coordination, such as memory loss and balance problems.” When Woo first began to study this perplexing set of concurrent symptoms, she quickly arrived at one inescapable conclusion: “Something’s wrong with the brain in heart failure.”
Groundbreaking initial studies by Woo and her team have revealed that heart failure patients have injuries and functional abnormalities in regions of the brain that control mood, memory, decision making, blood pressure, heart rate and breathing. Now she’s digging deeper to find answers to questions like: What exactly is causing this damage? Which comes first, the brain damage or the heart failure? And how do all the different clinical pieces of the puzzle—depression, sleep-disordered breathing (SDB), memory impairment, etc.—fit together?

“Before we can treat these problems in the brain, we need to know what’s causing them,” Woo says. Her ultimate goal is to translate the answers into new heart failure treatments that can improve survival rates and quality of life for this extremely vulnerable group of patients.

Woo is currently working on several studies, funded by the National Institute of Nursing Research (NINR), that are already testing possible therapeutic interventions on a variety of fronts. For example, she is working on whether improving respiration in heart failure patients with SDB could reduce some of their risk for poor outcomes.

She has also found evidence that vitamin B1 (thiamine) deficiency is connected to memory loss in people with heart failure. “They can’t absorb nutrients properly, because of the diuretics they take,” Woo notes. “Thiamine deficiency is also associated with memory loss in alcoholics. With our heart failure patients, we’ve found that thiamine

Hearts and Minds

“Heart failure is the number one hospital discharge diagnosis for people older than age 65,” says Woo. “It costs Medicare alone more than $33 billion a year. Yet despite all the advances in treatment that have emerged in the last 10 to 15 years, the high rates of mortality and morbidity in heart failure haven’t changed. And that situation isn’t going to improve until clinical practice starts to address the compounding factors that are contributing to that morbidity and mortality—namely, the considerable amount of brain damage we’re seeing in these patients.”
levels and the amount of brain damage are directly linked. So the next thing to look at in terms of interventions is treating them with thiamine supplements.”

One of the most practical clinical implications of Woo’s work is that standard patient education methods simply won’t work with this population. “When you’ve got patients who have substantial brain damage that affects their decision making and memory, it’s not likely to be effective to talk to them about self-care instructions and expect them to remember anything,” she emphasizes. “There needs to be an immediate change in practice if we’re going to stop these patients from bouncing in and out of the hospital like ping-pong balls and help them live independent lives.”

Teens in Transition
Dr. Nancy Pike, Assistant Professor at the school, is also studying the impact of cognitive impairment on cardiac patients’ self-care skills. But Pike’s biobehavioral research centers on a younger—though equally high-risk—patient profile: adolescents who were born with congenital heart disease (CHD).

“A generation ago, most of these children died shortly after birth,” she says. “But now that they’re surviving, they face the challenge of having to take responsibility for their own health as they transition out of their parents’ care and into adulthood.” Unfortunately, too often these young chronic heart disease patients become lost to follow-up—they stop going to the doctor and neglect their symptom management regimens. And when that happens, their mortality rates skyrocket.

“We know that cognitive deficits, particularly memory loss, are common in adolescents with CHD and can significantly affect their ability to care for themselves,” Pike says. “However, it’s uncertain if their memory deficits are associated with brain structure or with brain injury resulting from their having had multiple heart surgeries at a young age.”

She is now in the second year of an NINR-funded study that’s the first of its kind to examine the relationship between a clinical symptom—in this case, memory loss—and brain structure in teenagers with CHD. Pike and her colleagues are using MRI techniques to compare parts of the brain that control memory, such as the hippocampus, in control and CHD patients.
as the hippocampus and the mammillary bodies, in groups of adolescents with and without CHD.

“Instead of just brushing this behavior off as ‘the forgetful teen,’ there may be a valid reason why this is happening,” she concludes. “If we can make that correlation between brain injury and the memory problems, we can look at interventions that could improve memory and self-care ability in this growing population of CHD survivors.”

Treating Alzheimer’s Before It Starts

Loss of synaptic function in nerve cells in the brain is one of the first signs of Alzheimer’s disease pathology, occurring long before the formation of the amyloid-beta (A-beta) plaques that advance the progression of this devastating form of dementia. Two faculty members at the school, Professor Dr. Karen Gyllys and Assistant Professor Dr. Sophie Sokolow, are trying to find out what’s behind these preliminary brain changes that cause synapses to degenerate. The results of their research could help open the door to the development of revolutionary new drugs for treating Alzheimer’s in its earliest stages, when plaque buildup and cognitive loss can still be reversed—or even prevented.

“If we scientists can understand what’s going wrong with the synapses, we could find a way to protect them,” says Gyllys. “Any drug therapy that’s going to be effective needs to work early and target the synapses. Once you get to the point where a lot of synaptic pathology has occurred, it may be too late.”

Although both researchers are exploring the same issue, they’re approaching it from different perspectives. Sokolow, a pharmacologist, is looking at whether factors like disrupted calcium regulation in neurons and A-beta buildup in synapses are possible molecular triggers for Alzheimer’s. Gyllys, a nurse who has a background in neuroscience and pharmacology, has just completed a study, funded by the National Institute on Aging, that sheds light on how cholesterol and ApoE (a lipoprotein that carries cholesterol through the bloodstream) contribute to A-beta accumulation in synaptic terminals.

The next phase of Gyllys’ research is to learn more about how the cholesterol connection could eventually lead to ApoE-related therapies for keeping the brain healthy, such as treating early-stage Alzheimer’s disease patients with cholesterol-lowering drugs.

“There’s a lot of promise and potential for drugs that affect ApoE and its pathways,” she says. “We know that some forms of the ApoE gene, particularly ApoE-e4, increase the risk for Alzheimer’s, whereas the ApoE-e2 form is protective. So that’s something we want to follow up on.”
SLEEP, GENDER, AND THE BRAIN

Obstructive sleep apnea (OSA)—a disorder in which breathing is constantly interrupted during sleep, depriving the body’s cells of oxygen—is linked to a litany of serious health threats, including heart disease, stroke, diabetes, dementia, and early death. OSA is less common in women than in men, yet its destructive cardiovascular and neuropsychological consequences are much more severe in female patients than in their male counterparts. What accounts for this troubling gender disparity?

That’s the question Dr. Paul Macey, Associate Professor in Residence at UCLA School of Nursing, wants to answer. Macey is an engineer who studies the role of brain function and dysfunction in people with OSA—specifically, how brain injury and other changes in the brain affect physical and psychological factors such as breathing, blood pressure, heart rate, anxiety, and depression in these patients.

Two recent studies led by Macey have shown that women with OSA have an even greater degree of brain damage and diminished autonomic responses than men with the same level of the disorder. This could help explain why OSA hits female patients harder and puts them at a disproportionally high risk of developing heart disease and other deadly illnesses, he says. His latest projects focus on how women’s brains respond to OSA interventions, like positive airway pressure (PAP) and stress reduction, compared with men’s.

These findings, Macey adds, point to a critical need for earlier detection and treatment of OSA in women, when’s there’s still time to prevent their brain injuries from becoming too extensive.

“Sleep apnea is more prevalent in males, so in clinical practice the male symptoms are considered the norm and the female symptoms are still considered atypical,” he says. “As a result, women with OSA are not diagnosed as often, or they are misdiagnosed.”
Unrelieved pain and suffering, an aggressive, end-of-life treatment regime, and arguing family members—all indicators of an ethical dilemma. And while nurses are positioned to identify these dilemmas, they may feel compromised in their ability to take action.

With advances in technology, complexity of healthcare financing, and proliferation and accessibility of healthcare information for patients and their families, moral pressure is more complex than ever, yet the current healthcare culture doesn’t incorporate shared ethical decision making for healthcare providers.

“The electronic medical record doesn’t provide any prompt to document ethical concerns, as it does for clinical or psychosocial issues,” said Katherine Brown-Saltzman, Co-Director of the UCLA Health System Ethics Center. “It takes a person to actually elevate the discussions, in a sense its having to go against the grain.”

Carol I. Pavlish, Associate Professor, UCLA School of Nursing, has been dedicated to pursuing cutting-edge clinical ethics research with Brown-Saltzman. They began studying what ethically difficult situations are and completed an ethnographic study to better understand what beliefs,
practices or other factors surround these scenarios, most of which pertained to treatment decisions toward the end-of-life.

“Clinical ethics is a really new field; it doesn’t have much research behind it yet,” said Pavlish “We have a lot to learn in how to effectively and proactively address ethical issues.”

Based on their findings, they developed a tool to help nurses identify ethically difficult situations and take early action to prevent or mitigate them. It was tested in oncology and intensive care units at UCLA Health System and the Mayo Clinic in Rochester, MN with results published in Advances in Nursing Science in September 2013.

“We thought the research was really valuable,” said Joan Henriksen Hellyer, Ethics Consultation Program Coordinator, Mayo Clinic, Rochester. “That project went really well having parallel projects in two different major medical centers, and we had very similar results, so that was encouraging.”

But despite use of the evidence-based tool, raising ethical concerns with physicians or bringing an ethical consult was still difficult for the nurses to do. The tool helped validate the ethical concerns they perceived, but did not provide the courage or comfort level to speak up. The nurses thought they would be ostracized by the physicians, scolded by their nurse managers or feared being the troublemaker.

“They saw those things or perceive those things as risky—say riskier than talking to a colleague or calling in a chaplain or social worker,” Henriksen Hellyer said. “So we were trying to design systems that make it easier for people to do the right thing.”
Moral Distress

Pavlish was surprised how much and for how long moral distress really affected nurses. There was prolonged regret, where healthcare providers looked back and wished they did more.

“Moral regret does accumulate in certain instances, and moves toward moral distress which obviously has negative consequences such as disengaging from the work that you are doing,” Pavlish said. “One of the dangers or morally difficult situations is not having a venue or an opportunity to process them.”

If moral concerns are addressed earlier, they can be dealt with before they become conflicts that are really difficult to resolve and before they lead to damaged work relationships or even deteriorate quality of care.

“So often an ethical conflict can be seen as I’m right, you’re wrong,” Brown-Saltzman said. “Once you enter into that realm, then people are placed into their corners.”

Conflicts can also occur among many different levels and relationships.

“We found conflicts not only between healthcare providers, which did occur, but also between providers and families, and families and patients,” Pavlish explained.

Systems Focus

Expanding the research focus to include other direct care providers, such as physicians, Pavlish found the systems were not operating well. For example, physicians are seeing more patients, are pressured for time, and didn’t always view ethical communication as a shared moral obligation for the healthcare team.

“Nurses are called patient advocates, and it’s interesting that physicians also say they are patient advocates, so what we need to do now is talk about how we can advocate together,” explained Pavlish. “We were trying to understand how these systems really could work with nurses and physicians collaborating on this.”

Ironically, “advocating” for a patient can be an aggressive, single-minded action, if not approached in the right way.

“This idea of advocacy can actually be harmful, acting simply as the lone advocate versus being a co-advocate,” Brown-Saltzman said. “In a sense, it is an essential responsibility to enter into a collaborative relationship with others where we share responsibility and enhance relationships, even as we raise difficult issues.”

Pavlish and Brown-Saltzman have developed a collaborative model called CO-ADVOCATE (as an acronym for the essential steps), which incorporates the voice of the patient, family, nurse and physician to work through moral challenges. Together with nurse ethicists from Mayo Clinic and Massachusetts General, they received a grant from the American Association of Critical-Care Nurses to test it.
Culture Shift
Improving nurses’ ethics skills is not enough; a cultural shift is needed to address all the factors surrounding ethical decisions. Ethics should be integrated to the point it is an expectation and a shared responsibility among healthcare providers—a value of the organization.

“If you have a safe environment, a safe place, people can really speak out freely about their concerns and the distress which is placed on their own personal value systems,” Henriksen Hellyer said. “Only if it’s safe, can they keep their patients interest as the highest priority.”

Pavlish, Brown-Saltzman, and Henriksen Hellyer are redesigning the ethics screening tool incorporating the results of their 2013 study. Pavlish and Brown-Saltzman are also researching how ethically difficult situations are handled by nurse managers and leaders.

“What we’ve done is create, for all healthcare professionals and administrators, a sense of comfort in cultivating an environment where ethics is integral—just a part of the fabric,” Brown-Saltzman said. “I think we are getting there.”

“In a sense, it is an essential responsibility to enter into a collaborative relationship with others where we share responsibility and enhance relationships, even as we raise difficult issues.”

— Brown-Saltzman
According to Boston-based Partners in Health (PIH), a global health organization, nurses deliver 90 percent of all healthcare services worldwide, especially in impoverished countries where resource shortages outstrip physician capabilities.

Examples of this abound. In Rwanda and Haiti nurses deliver chemotherapy and oncology education. In Lesotho, they deliver ultrasound imaging to pregnant moms, according to PIH statistics.

Fred Hagigi, director of global health initiatives, UCLA's Anderson School of Management, says “The global role of nurses ensures that patients are at the center of care. They’re collaborators with a (hands-on) understanding of patients.

“When we talk about building (healthcare delivery) capacity, we’re talking about nurse capacity. The shortest way to do this is through nurses in every country,” he adds.
SMOKING CESSION TAKES NURSE TO CHINA, EASTERN EUROPE

“Smoking is the leading cause of preventable death around the world. While smoking prevalence has decreased to 42 million in the U.S., it’s increased in other countries.”

So says Linda Sarna, interim dean and Lulu Wolf Hassenplug Endowed chair, UCLA School of Nursing, whose efforts to increase nurse delivery of evidence-based practices (EBPs) to help patients quit smoking and decrease tobacco use among nurses have taken her to many countries including China, Czech Republic and Poland.

Sarna, who became active in tobacco control early in her career as an oncology nurse, assessed the use of the first EBP guidelines, published in 1996, by nurses in Korea, Hong Kong, China and Japan. “I was especially interested in China because it has the largest population of smokers—350 million,” says Sarna who observes the adverse impact of smoking on the inability to help patients quit.

“Nurses, who are current smokers, are less likely to engage in intervention and more likely to have a negative attitude. Nurses feel guilt, shame and a reluctance to engage because they can’t address this very serious addiction. They aren’t any more or less immune to tobacco and the way it’s glamorized and associated with all the wonderful things in life,” she adds.

Of the important role nurses play in the prevention of non-communicable diseases (NCDs)—cancer, cardiovascular and respiratory diseases and diabetes—Sarna says “The common risk factor to the four diseases was tobacco.” She points to the website, www.tobaccofreenurses.org, containing a monograph about nurses and NCDs she co-authored for the World Health Organization, that show nurses “can go beyond prevention, screening, early detection and treatment” to promote health.
Indeed, PIH information reports nurses make up almost 86 percent of clinical staff. As key providers of primary healthcare, they comprise between 60 and 80 percent of the health system workforce.

Afaf I. Meleis—distinguished alumna and former dean, University of Pennsylvania School of Nursing, calls nurses “vital partners” in the global movement towards integrated, population-based care. “As frontline providers of care, they are uniquely positioned to be the driving force in mobilizing and promoting teamwork and collaboration to provide effective and equitable healthcare for all populations around the world,” she explains.

A January 2012 online article from the American Nurses Association (ANA), Silver Spring, Md., concurs, stating that nurses influence change at the local, national, regional and international level to enhance the health of populations. This is true whether the country is industrialized or a developing nation.

Nurses globally must play a role in actively shaping health policy. “All too often nursing’s role has been to implement policies and programs rather than participate and bring nursing perspective, experience, knowledge and skills to policy formulation and healthcare planning,” it notes.

Adey Nyamathi says “awareness of different cultures” optimizes bedside care at the local level. She calls the introduction of global health into nursing curricula “an important contribution” to clinical coursework, one that resonated with UCLA students.

“When we present content, it’s such an eye-opener to students. More than half the class has family from different countries,” she says.
NURSE RESEARCHER ESTABLISHES AIDS/HIV CARE MODEL IN INDIA

Several years ago, Adey Nyamathi, Associate Dean, International Research and Scholarly Activities, UCLA School of Nursing, found a way to help rural women with AIDS in India adhere to complex treatments.

With the cooperation of the Indian prime minister and a grant from the National Institutes of Mental Health, Bethesda, Md., Nyamathi developed a model of care that deployed Accredited Social Health Activists (ASHAs). Typically used to assist women with reproductive health in India, these community health workers helped with AIDS retroviral treatment, care and transportation to urban treatment facilities.

“ASHAs exist in India in the role of health counselors. They make sure women get to the hospitals to deliver their babies. And in India there are different kinds of midwives trained at different levels,” explains Nyamathi.

“Training lay-village women to become sensitive and expert in HIV was new. They help women get to the hospital to take their meds as well as with education,” she says.

The ASHA model can be modified for use in other countries, says Nyamathi who calls AIDS “a huge problem in many developing countries.” She attributes high rates among women in India to heterosexual transmission.

Nyamathi credits early work with homeless and drug-addicted patients with fostering an interest in community health on a global scale, saying “Since 1987, I’ve been working with people who were practically homeless. Coming from an Intensive Care Unit background, I knew this is what I wanted to do: make a difference at the community level,” she adds.
NURSES ARE THE KEY PROVIDERS IN PRIMARY HEALTHCARE, COMPRISING 60-80% OF THE HEALTH SYSTEM WORKFORCE, DELIVERING 90% OF HEALTHCARE SERVICES.

MORE THAN $\frac{1}{3}$ OF THE WORLD’S HEALTH WORKERS LIVE IN THE UNITED STATES AND CANADA, YET 90% OF THE GLOBAL BURDEN OF DISEASE IS CARRIED BY THE REST OF THE WORLD. (WHO 2006)
HIV/AIDS RESEARCH TAKES NURSE TO CHINA

Ann Williams, Professor, UCLA School of Nursing, credits a post-doctoral fellowship in the late ’80’s with her decision to pursue HIV and AIDS research in China. “I didn’t choose AIDS. It chose me,” she says, describing the trajectory of her research this way:

“When I first started, I tried to discover factors associated with this mysterious disease. Over the years, my research moved to clinical care of women affected by HIV. More recently, we’re working to maximize the benefits of anti-retroviral therapy.”

Now, she says, “We’re looking at depression associated with HIV in China, interventions, changing clinical outcomes and using wireless technology to help people manage and deliver depression interventions.”

“I’ve seen a robust Chinese government response, providing anti-retroviral therapy to everyone who asked for it,” explains Williams, who’s worked in Vietnam, Russia and Poland. “As far as I’m concerned a patient with HIV looks the same whether they’re in New Haven, Conn., Russia or Hanoi,” she comments.

“My research has always been driven by clinical issues and the people who bear the burden of primary care,” notes Williams who likes to share her field work with her students. “When I teach, it’s informed by who I am as a clinician and intellectual person.”

“It’s hard to disentangle my work as an educator from my history and experience. The broader geographic range of experience brings broader clinical experience,” she says.

Williams has a five-year grant from the Fogarty International Center that supports research training programs for U.S. and foreign professionals to strengthen global health research and collaboration. Two fellows from China–Lianxiang He and Yuan Ouyang–are currently studying at UCLA.
The first thing that jumps out about Ellen and Hal Meier is their enthusiasm and high energy. These “double Bruins” are very quick to explain that UCLA is at the root of their success. “Without a doubt, we feel that our professional accomplishments are tied to our UCLA education. We wouldn’t have had the same career paths without that great start,” Ellen says. Ellen holds a Bachelor’s and a Master’s in Nursing from the UCLA School of Nursing. Hal earned two Master’s degrees from UCLA, one in Engineering and the other from the Anderson School of Management.

While Hal pursued a successful career in engineering, Ellen worked hands-on in various nursing settings, with children and cancer patients. She also delved into healthcare program implementation, strategic management of resources, and leadership. Ellen even fulfilled an early interest in teaching when she came back to the School of Nursing as faculty. Currently, she is Vice President of The Advisory Board, a healthcare consultancy company.

All along, Ellen and Hal were active supporters of the university and members of the Chancellor’s Society, but in 2014, they took their philanthropic involvement one step further. They included the School of Nursing in their living trust by earmarking a percentage of their estate to create an endowment that will provide scholarships for nurse practitioner students and support the preceptorship opportunities for nurse practitioner students.

“We focused our giving on nursing,” Hal explains, “because we both agreed that the field touches so many lives, yet nursing professionals don’t necessarily earn huge incomes. Also, getting into UCLA’s School of Nursing is very competitive. Those who make it are exceptional. We felt this was where we could have the greatest leverage and impact.”

Giving.
What’s it in for you?
“If you feel your education provided you with a leg up in life, then take the opportunity to give back,” Ellen advises, “It’s a wonderful feeling. In giving, you do get back more than you give. It’s a new sense of purpose. It’ll bring new connections into your life. So, I am encouraging my fellow alumni to make a contribution. Do it. You’ll feel really good about it!”
Gift Planning: Helping You Build Your Legacy

Ellen and Hal Meier decided to support the School of Nursing through their estate plans, which allows donors the flexibility of building a lasting legacy through various arrangements. Opportunities include making a bequest through a will or living trust, establishing charitable gift annuities or charitable trusts, and/or using a variety of assets such as real estate, life insurance, or retirement accounts. Some options result in estate tax savings while others provide fixed income for life and significant income tax advantages.

Please contact Joe Ward in the Office of Planned and Major Gifts at 310-794-8823 or jward@support.ucla.edu if you would like to include the UCLA School of Nursing in your estate plans.

UCLA Legacy Society Members

The generous alumni and friends who have chosen to remember the UCLA School of Nursing in their estate plans are a special group. Turning their individual passions into action, these donors have looked ahead to the needs of future generations. They have effectively put “money in the bank” to fulfill countless opportunities that ensure excellence—from scholarships to life-changing research, fellowships to distinguished faculty recruitment.

Thank you!

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Planned gifts provide the resources that create extraordinary opportunities and preserve the future of the UCLA School of Nursing. There are a myriad of easy giving options from which you can choose—from naming us as a beneficiary in your will, to a more complex trust arrangement.

If you have already included the UCLA School of Nursing in a bequest or other planned gift, and your name is not noted above, we hope you will let us know. Your willingness to be listed as a member of the Legacy Society encourages others to follow your example.
School of Nursing Donor Honor Roll

UCLA Centennial Campaign

Gifts and Pledges for the period from July 1, 2012 through March 24, 2015. This Honor Roll recognizes our generous donors who have made cumulative gifts and pledges of $1000 or more during the UCLA Centennial Campaign, which count toward the School of Nursing’s overall campaign goal of $32 million by 2019.

The UCLA School of Nursing is grateful to all of our alumni, friends, students, faculty, staff, and foundation and corporate partners for your contributions. Whether your gift is $50 or $500,000, your generosity enables us to continue to build upon our excellent record of transforming nursing practice and advancing science by enabling students and faculty to reach new levels of success.

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It is important to us that we
acknowledge you properly. If an
error has been made in the listing
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Julia Campbell at 310-206-7813 or
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*deceased

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From the moment she entered the diploma program for nursing in New Mexico, Dr. Bonnie Faherty has had her eyes open for opportunity. Opportunity to improve health outcomes and opportunity to advance the profession of nursing.

Bonnie has obtained advanced degrees in other subjects throughout her career in addition to nursing – a Master’s in Public Health and Doctorate in Public Administration - but in her heart she is always a nurse.

Bonnie attributes her success to taking advantage of all the options nursing has to offer. “I’ve tried it all and done it all and pretty much loved it all.” That included lecturing in primary care here for seven years.

But where Faherty has really made her mark is her advocacy work for nursing and healthcare. “I think it is my role to serve as a visible reminder to others of the value and engagement of nurses in our society.” She has been very active in the American Nurses Association on both the local and national level and Gamma Tau at Large Chapter of Sigma Theta Tau International.

Faherty believes nurses make great advocates because a nurses role is educating people and, “we tend to be very articulate.” Bonnie does more than just talk about advocacy. For the past few years, she and her husband, who are proud alums of UCLA and loyal supporters to the School of Nursing, have sponsored nursing students to attend advocacy events in Washington DC. “We really believe in civic engagement and health care and affecting change through government policy. By sponsoring these trips, we want to nurture this passion and expose students to government and policy.”

All her years of volunteer and advocacy work paid off when, in 2009, she was invited to attend a news conference at the White House to show support for President Obama and the Affordable Care Act. There she sat, in the front row of the event, listening to the President spotlight the role nurses play in the healthcare system. “It was surreal. I met new nurse colleagues and enjoyed a moment in the history of our profession and our country.”

Her advocacy work was also recognized by UCLA when she and her husband were recognized as “Volunteer Advocate of the Year” as members of the Bruin Caucus in 2012.

Dr. Suzette Cardin, one of Faherty’s long time colleagues stated it best: “Bonnie is a true advocate for nursing. She is very proud to be a nurse and this has been seen in the many accomplishments she has achieved to date. It is always fun, interesting and professionally rewarding to work with Bonnie on any project, presentation or professional activity.”

Now retired, Faherty keeps active and she is still looking for any opportunity to educate people about being a nurse. “I am humbled that my peers and colleagues want to recognize me for my accomplishments.”