



# HealthWire

THE NATIONAL PUBLICATION OF AFT HEALTHCARE PROFESSIONALS



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## It's time to fix staffing—once and for all

RANDI WEINGARTEN, AFT President

PREVENTABLE HOSPITAL DEATHS due to unsafe staffing levels are inexcusable. We know that an appropriate patient load for nurses and healthcare workers saves lives, and we should expect nothing less for patients and their families.

pressure to make the case that safe staffing is an integral part of the high-quality healthcare patients deserve.

It has been estimated that more than 100,000 patients die in hospitals every year as a result of preventable medical errors. The

forego their raises in exchange for more nurses. The nurses, who are represented by the Health Professionals and Allied Employees, now have a contract that contains nurse-to-patient staffing ratios, and they are beginning to see the positive difference those ratios are making in the quality of patient care.

While some hospitals are doing the right thing and negotiating with their health professionals to improve working conditions, most will not change unless they are mandated to do so. That's why the two measures currently in Congress that address safe staffing need your support.

Both the Nurse Staffing Standards for Patient Safety and Quality Care Act (H.R. 2273), sponsored by Rep. Jan Schakowsky (D-Ill.), and the National Nursing Shortage Reform and Patient Advocacy Act (S. 1031), sponsored by Sen. Barbara Boxer (D-Calif.), require hospitals to implement staffing plans with specific nurse-to-patient ratios in certain units. Both bills also give nurses the right to refuse assignments that would violate staffing requirements or for which they are not prepared, and prohibit retaliation by hospitals for such refusal or for reporting violations.

These are powerful weapons against the burden of unsafe staffing, and frontline healthcare personnel must have a voice in these debates. The public holds nurses and other health professionals in high regard—and with good reason. The care you provide is crucial, and the reforms we seek will further improve patient care. Working with legislators and healthcare institutions, we must fix this problem, once and for all, with legislation that establishes safe staffing levels for hospitals.

Having **research** and **reason** on our side is not enough. We and our **like-minded allies** must apply political **pressure** to make the case that safe staffing is an **integral part** of the **high-quality** healthcare patients **deserve**.

A recent study reinforced the need for national safe staffing legislation. Researchers from the University of Pennsylvania found that 486 lives could have been saved in New Jersey and Pennsylvania in a one-year period if those states had required the same nurse-to-patient ratio mandated by California law. In California, hospitals must have a staffing ratio of at least one nurse for every five patients on their medical-surgical units.

With the recent passage of national healthcare reform, the focus now must be on high quality—including the need for safe staffing standards. It is well documented that quality care is linked to adequate staffing. An extensive body of research demonstrates that appropriate, consistent staffing—for nurses in particular—helps to reduce patient readmissions and expensive complications, such as pneumonia and bedsores, as well as medical errors and patient deaths. But having research and reason on our side is not enough. Because this requires choices about resources, we and our like-minded allies must apply political

real number is probably much higher because many errors go unreported. Research shows that nurses catch as many as 86 percent of medical errors. Appropriate staffing levels are not only crucial to patient safety, they are crucial to maintaining the nurse workforce. When nurses have an overload of patients, they are at greater risk of getting hurt on the job or suffering from burnout.

Yet, in spite of overwhelming evidence, hospitals continue to cut staff in order to cut costs, which often results in a lower standard of patient care. And these cuts in staffing don't stop with hospitals. The problem of short staffing exists in schools, home healthcare, long-term care and in mental health settings. But, as one of our nurse members puts it: "The fight for staffing has never been about us, it's about our patients. Health professionals want to see their patients get better and get the care that they need."

Safe staffing was so important to the nurses at Englewood Hospital and Medical Center in New Jersey, they told the hospital they would



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# Saving John Dempsey

## Grass-roots lobbying helps keep a public institution public

LIKE MANY PUBLIC INSTITUTIONS, John Dempsey Hospital has struggled to survive. As the state of Connecticut's only remaining public hospital, John Dempsey, which is part of the University of Connecticut Health Center in Farmington, has received state money to stay afloat. At the same time, there have been a number of proposals concerning the fate of the hospital, ranging from building a new facility to closing it altogether.

For the past several years, members of University Health Professionals (UHP) at the University of Connecticut Health Center have mobilized to keep John Dempsey public—and in the public eye.

"Our members are dedicated professionals who work in public service and value the public university and the health center they serve," says UHP president Jean Morningstar.

The plan to build a new hospital was defeated by other hospitals in the area that did not want the competition, says AFT Connecticut lobbyist, Jennifer Berigan.

A few months after the plan to build a new hospital fell through, it was announced that John Dempsey would merge with Hartford Hospital, which is a private institution. But after hearing details of the merger, "it was clear it was a takeover, not a partnership," says Morningstar.

UHP quickly mobilized its members and joined with other unions representing workers at the hospital to form an alliance to stop the merger. They were successful.

"It was good old-fashioned grass-roots activity and lobbying that defeated the plan," says Berigan.

### A new deal

However, the fate of John Dempsey remained up in the air. It took a few months but a new deal worked out by state lawmakers finally emerged. The legislation, which Gov. M. Jodi Rell signed in June, invests \$362 million to improve the UConn Health Center and develop a health network. John Dempsey will continue as a public hospital, in addition, the legislation calls for the construction of a new bed tower at the hospital. The new hospital addition is expected to bring in much-needed revenue.

"We never gave up," says Keith Inrig, UHP's first vice president and a radiographer at the health center. He believes the rapport

between UHP's members and state legislators really made the difference.

"We laid the groundwork over the years to create a good working relationship with our lawmakers," Inrig says. "We told them this hospital has to stay public." They listened.

After being cautiously optimistic about the proposal, Morningstar says that now "we are extremely excited."

Most of her optimism springs from the fact that the plan allows the public hospital

control of the NICU in exchange for additional medical-surgical beds at John Dempsey.

The NICU nurses will remain state employees and UHP members.

"It's no secret that Children's wants to control the NICU beds in the area. This gives them a virtual monopoly," explains Morningstar. "This is bad public policy and not good for the state,

From left, Kim Oski, Keith Inrig and Jean Morningstar lobbied with other UHP members to save Connecticut's only public hospital.



**"We laid the groundwork over the years to create a good working relationship with our lawmakers. We told them this hospital has to stay public."** — KEITH INRIG, first vice president, University Health Professionals

to remain public and that employees will continue to work for the state.

Two other parts of the plan make Morningstar cautious, however. One pertains to funding. Most of the money to fund the improvement project will come from the state, but the university has to come up with at least \$100 million. UConn plans to apply for a competitive federal grant to get that money.

"If we don't get that grant, we'll have to raise the \$100 million," says Morningstar.

The other concern has to do with a plan for the neonatal intensive care unit (NICU). Under the proposal, the Connecticut Children's Medical Center will assume operational con-

but it was necessary in order for the plan to advance."

Kim Oski, a nurse practitioner in the NICU, is concerned about the new arrangement but also understands the rationale behind it.

Her biggest fear is that the quality of care will not be the same. "Having a monopoly—what does that mean for the children in the state? In my view, the potential is there to increase the cost of care."

Oski is happy, however, that she will continue to be a state employee. "I have worked at UConn for 25 years. UHP saved our jobs and kept us under the union contract."



# culture of caring

‘Taking the time to learn about cultures other than your own is not just the right thing to do, it will also improve patient safety.’

— MARILYN JAFFE-RUIZ, professor of nursing, Pace University

AS THE POPULATION of the United States becomes increasingly more diverse, today’s health professionals must be aware of how culture can influence a patient’s communication, behavior and expectations. Cultural beliefs and language barriers can have a profound impact on the delivery of health care. Does knowing, for example, that Middle Eastern women often defer to their husbands when making decisions about their own health, or that some Asian cultures avoid direct eye contact during conversation, help health professionals provide better care?

Many people think so.

When a patient’s culture is not taken into account, barriers are created that can result in miscommunication, mistrust and non-adherence to medical advice.

“Barriers mean that not everyone gets the same quality of care,” says Marilyn Jaffe-Ruiz, professor of nursing at Pace University in New York City.

Cultural competency training is emerging as a way to help healthcare workers break down barriers they may have in dealing with patients. The goal of the training is to enable workers to provide the best patient care, regardless of cultural differences.

“Taking the time to learn about cultures other than your own is not just the right thing to do,” says Jaffe-Ruiz, “it will also improve patient safety.”

## Diversity’s challenge

Jennifer McDonald, a nurse in the medical-surgical unit at SUNY Downstate Medical Center in Brooklyn, N.Y., cares for a culturally diverse mix of patients on her unit. Having such diversity can be challenging.

She knows for example, to use the hospital’s phone interpreter system for patients who don’t speak English, instead of relying on a family member to translate, because in some cultures it may be considered inappropriate to share a bad diagnosis. She knows too, that many of her Latino patients are very religious and want to have religious items in their rooms, so she makes sure that their needs are accommodated.

McDonald says SUNY Downstate has be-

gun to offer cultural competency courses more frequently. “We used to have a class once a year, but there is only so much you can grasp in one class,” says McDonald, a member of the New York State Public Employees Federation.

The training is helpful, McDonald says. “The classes reinforce the importance of being familiar with other cultures and help me to be more nonjudgmental.”

That is the goal of cultural competency training, says Jaffe-Ruiz. “Cultural competency helps people look at themselves. It starts with knowing who you are—your background, beliefs, values, morals, and experiences and how all of it shapes you.”

Ultimately, cultural competence is rooted in respect, she explains. “If you truly respect someone, you will respect [the person’s] differences and be willing to understand what the patient needs in order to get better.”

“It is critical that we are aware of cultural customs and beliefs,” says Jeanne Sedgwick, a school nurse at Bridge View School in St. Paul, Minn. “We need to be able to work with families when it comes to medical management of our students.”

Sedgwick, who is a member of the St. Paul Federation of Teachers, says her district has been focused on cultural proficiency, in part to reduce an achievement gap among its very diverse student population.

Part of the training for school nurses included presentations by members of St. Paul’s largest ethnic communities—Hmong, Somali, Karen (from Burma and Thailand) and Latino. The presentations helped the nurses gain an understanding of the practices and beliefs that were most likely to affect students and their health.

The nurses learned about the beliefs that families from various cultures have about Western medicine, how family structures can influence who makes medical decisions, common health problems, and how to appropriately address people.

“By increasing our understanding, we not only show respect and value to our students and their families, but we also develop better strategies to reduce conflicts that may arise from ignorance,” says Sedgwick.

One of the most important messages she learned at the training was not to assume anything but to ask questions. “Cultural proficiency is not just about ethnicity. It’s about the culture of family, community, gender and much more. It all goes back to the need to be respectful, to communicate that respect and build trust. You need to work within the belief system of each culture,” Sedgwick says.

**Understanding a patient’s culture shows respect and reduces conflicts, says school nurse, Jeanne Sedgwick of Minnesota.**



ROB LEVINE





## You can't mandate attitude ...

The barriers created by differences in language, beliefs and customs may contribute to the health disparities between racial and ethnic groups. The disparities are costing our healthcare system. For example, high rates of diseases like diabetes, hypertension and stroke among Latinos and African-Americans cost the system more than \$20 billion in 2009.

Because of the need to accommodate increasingly diverse patient populations, more attention is being paid to cultural competence.

In 2001, the Office of Minority Health in the U.S. Department of Health and Human Services issued a guide to providing high-quality healthcare for diverse populations; it's called the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.

In June 2010, the Joint Commission announced a plan to develop accreditation requirements for hospitals to advance effective communication, cultural competence and patient-centered care.

States also are getting in on the act by requiring health professionals to take cultural competence courses as a part of licensure. Over the past several years, a number of states,

including California, Connecticut, Maryland, New Jersey, New York and Washington have passed legislation or regulations relating to cultural competence training.

Jaffe-Ruiz says legislation can be useful if it calls for zero tolerance for cultural disrespect. "But legislation can't mandate a change of personal attitudes," she adds.

There always will be a resistance to cultural competency, Jaffe-Ruiz points out. Much of that resistance has to do with the belief that "our way is the better way to improve a patient's situation," she says. "However, health professionals, nurses in particular, are supposed to be patient advocates. We need to be empathic in every level of an encounter with a patient.

"Some people operate on stereotypes based on race, class and socioeconomic sta-

tus, but it all comes back to communication and respect," says Jaffe-Ruiz.

Stereotypes and negative attitudes result in a breakdown of communication, she adds, and health professionals can end up paying the price—"whether in the form of an uncooperative patient or a pushy family."

## ... But you can be sensitive

"People say that they are culturally aware and while they may know that a person is different, most are not sensitive to those differences," says Jameelah Hegazy, a professor of nursing

at Long Island College Hospital School of Nursing and a per diem nurse for the Visiting Nurse Service of New York. Hegazy, who is a member of the Federation of Nurses/UFTI, has been a nurse for 26 years.

"When I meet someone and I don't know about their culture, I ask questions," says Hegazy.

"I don't look at patients based on race or religion." She knows that sometimes her patients don't feel the same about her—at least not initially.

Hegazy is a Muslim who dresses in a full hijab. "I have always been welcomed by my patients," she says. "Still, there are some who are surprised when they first see me.

But, once we interact, all the barriers come down. They see a nurse, and it doesn't matter to them what I wear."

All of our differences—whether it is race, ethnicity, age, value, gender and so on—need to be discussed in a safe environment, says Pace University's Jaffe-Ruiz. "Sometimes people are afraid to say what they really think, but cultural competence focuses on how to transcend that and work together," she says.

The bottom line is that creating cultural awareness and sensitivity is an ongoing process, says Jaffe-Ruiz. "Becoming culturally competent takes more than a couple of hours in a workshop or a classroom. It takes practice and a willingness to open yourself up," she says. "There is no recipe for culture competence, but you can recognize the facilities that value it. You see it in patients' satisfaction."

— ADRIENNE COLES



DAVID GROSSMAN

**"People say they are culturally aware [but] most are not sensitive to differences."**

— JAMEELAH HEGAZY,  
nurse, Visiting Nurse Service of New York



"The Spirit Catches You and You Fall Down," explores the clash between health professionals and a refugee family. Find it at [www.powells.com](http://www.powells.com).



EthnoMed provides medical and cultural information about immigrant and refugee groups. Visit <http://ethnomed.org>.

## Have you been trained in cultural competency (sensitivity)? Should this be a requirement for healthcare workers to receive licensure?

"I have not been trained in cultural competency. This is not yet a requirement for occupational therapists or physical therapists. In my opinion, because doctors are being required to take courses for renewal of their licensure, it validates the necessity for other health professionals to seek this kind of sensitivity within their respective fields."

LESLIE McDONNELL

United Federation of Teachers

"My license does not require the training; however, my employer, Kaiser Permanente, wants us to have the training. It is being provided during our steward council meetings. I always hesitate to endorse mandatory training as a condition of employment. I do think that the training is beneficial though."

AMANDA HILL

Oregon Federation of Nurses and Health Professionals

"Cultural awareness is part of the training for most, if not all, healthcare providers. Absolutely no need to legally add yet another layer."

JANE TORRIE

PEG Texas AFT

"Yes, all healthcare workers need to be trained in cultural competencies. I believe strongly that *all* workers be trained in cultural competencies—the sooner the better! We all work in such diverse communities. Many people are not exposed to diversity before leaving home; then in the workforce people may make terrible communication gaffes or insults, creating tense workplace environments—all because they do not know about other cultural norms."

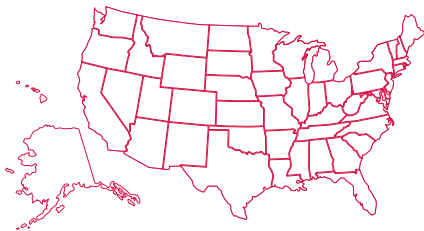
MYRA BROWN

United Faculty of Florida

## "How has the unstable economy affected your facility and the work that you do?"

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**CT** When Gov. M. Jodi Rell cut the state's LPN adult education program last December, teachers and students, including many AFT Healthcare members, reacted immediately. They turned out at rallies and public hearings statewide to call on legislators to restore the program. The result was a victory on April 14 when the Legislature passed a deficit mitigation bill, which restored the LPN program to six of the state's 10 vocational-technical high schools. Gov. Rell had eliminated the \$1.7 million in funding for the program as part of her state budget cuts, falsely claiming it would save money.

"Our analysis showed that cutting the program actually cost the state more than \$800,000," says Rick Tanasi, president of the State Vocational Federation of Teachers/AFT. "What's more, it cost the state much-needed LPNs."

**NJ** Wanting to play a larger role in patient care and to protect health services for the community, the registered nurses at Salem Memorial Hospital have filed a petition for an election to join Health Professionals and Allied Employees/AFT. About 130 registered nurses work at Salem.

"We are community nurses. We live here, we work here, we take care of neighbors and families, and we want to make sure the voices of the nurses and the community are heard at the decision-making level," says Lorie Halter, a nurse in the intensive care unit at Salem.

Recent attempts by Salem's parent corporation to close maternity services at the hospital have created controversy. "In this time of uncertainty in healthcare, the voice of the bedside nurse is critical to making sure that patients come first—before profits or any other interest," says Ann Twomey, HPAE president and an AFT vice president. "Letting nurses have an election free of delays, intimidation and endless legal challenges is crucial to giving nurses a real voice in protecting patient care and community needs."

**NY** A federal court judge in Albany has issued a preliminary injunction preventing Gov. David Paterson from unilaterally imposing furloughs on unionized state employees.

The decision stems from five union-filed lawsuits that charged, among other things, that the governor's furlough plan violated the U.S. Constitution's prohibition against passing state laws that impair contractual rights. Three of the five unions seeking the preliminary injunction are AFT affiliates: the New York State Public Employees Federation (PEF), the United University Professions and the Professional Staff Congress.

In his decision, Judge Lawrence Kahn rebuked the state for failing to explain why a particular level of savings must be obtained from state personnel. Kahn wrote: "In its submissions to the court, the state artificially limits the scope of alternatives for addressing the fiscal crisis to retrieving a certain amount of savings from unionized state employees."

This decision will allow state services to continue uninterrupted and prevent hardships to the taxpayers who depend on them, says PEF president Kenneth Brynien, who also is an AFT vice president. "We are

equally pleased the court found the state has other means to address its budget deficit, as PEF has maintained all along," Brynien notes. "We remain ready and willing to work with the governor and legislative leaders to achieve the savings the governor seeks by implementing PEF's budget solutions."

**OR** Support for the effort to create an Office of the National Nurse continues to grow with the guidance of AFT-Oregon members and Portland Community College nurse educators Teri Mills and Alisa Schneider. The National Nurse Act of 2010 (H.R. 4601) was introduced in Congress by Rep. Earl Blumenauer (D-Ore.) in February. The legislation will designate the position of the chief nurse officer of the U.S. Public Health Service to serve as the national nurse. This person would function alongside the U.S. surgeon general and focus on the priorities of health promotion, improving health literacy and decreasing health disparities. Mills and Schneider have been lobbying for more co-sponsors and recently delivered to members of Congress a letter of support for the bill signed by more than 100 organizations and prominent individuals.

## Lobbying for the profession



TIMOTHY H. RAAB

A COALITION OF NURSES from the New York State Public Employees Federation, New York State United Teachers, the Federation of Nurses/UFT and other healthcare unions traveled to Albany in May to take part in a Healthcare Professionals Lobby Day. The nurses were seeking support from lawmakers on issues such as safe staffing in hospitals and schools, safe patient handling and increased penalties for workplace violence.

## Bridging the technological gap

Nurse 'informatic' teaches colleagues how to talk the talk and walk the walk

IS IT POSSIBLE for a veteran nurse with no computer experience to give up the profession and become a computer guru? Dana Vibert has done just that. After spending 17 years as a critical care nurse at the University of Connecticut Health Center in Farmington, Vibert "went over to the dark side" four years ago and became a nurse informatic.

What exactly is a nurse informatic? Vibert brings together health information technology and real world nursing. She teaches her nurse colleagues how to use electronic health records and other computerized systems. "I do a multitude of things, but basically I am a translator," says Vibert, who is a member of the University Health Professionals. "I translate 'computer speak' into 'nurse speak,' which at times can be very different languages."

The health center began using electronic medical records five years ago, and today most of its units are paper-free. Vibert spends the better part of her day helping colleagues with their computer documentation.

It was a steep learning curve for Vibert, but she has finally found her stride.

"I didn't have any computer experience," she says. But the job posting captured her interest, and she decided to take a chance. Now, she's glad she did. Vibert says the new position offered her a much-needed transition. Her work today is very different from her days as a critical care nurse.

"The work of a floor nurse is hard on the body. Some days I miss it," Vibert admits, but "I still get to use my clinical brain."

Having a nursing background helps her get to the heart of a technical problem more quickly. "It's easier for me to understand what the nurses need," she says.

The current integration of technology into healthcare represents a real culture change, Vibert says. Her goal is to bridge the gap between the clinical and technological worlds, and it starts with getting nurses technologically up to speed. "This not the old world of



THOMAS GIROIR

nursing anymore," says Vibert. "The changes brought about by health information technology are fast-paced, but I believe we are heading in the right direction by moving forward with it rather than waiting for it to hit us."

Dana Vibert, left, a nurse informatic at the UConn Health Center has seen the evolution of health information technology from both sides. "In this job there is always something new to learn; health information technology is always evolving."

## A striking conclusion

Nurse strikes have short-term ill effects, but result in long-term improvements

SINCE 1974, HOSPITALS have been allowed to unionize. It's taken a long time, but unions have gained a foothold in the health sector, prompting two researchers to ask: Do strikes jeopardize patient health? The immediate answer is yes, but not for the reasons you might think.

"Do Strikes Kill?"—a new study from the National Bureau of Economic Research—suggests that the hospitals which continue to function during nurses' strikes are providing a lower quality of patient care.

Researchers Jonathan Gruber and Samuel Kleiner (from the Massachusetts Institute of Technology and Carnegie Mellon University, respectively) found that "in hospital" mortality increases by 19.4 percent and 30-day readmission by 6.5 percent for patients admitted during a nurses' strike. "Our results

reveal a short-run adverse consequence of hospital strikes," the researchers conclude. Strikes, however, "contribute to long-run improvements in hospital productivity and quality driven by union initiatives."

"Striking to negotiate improvements that result in safe, quality patient care is not done lightly," says Candice Owley, chair of AFT Healthcare's program and policy council, and an AFT vice president. "Nurses and others who do so put their own livelihood at risk to make the strongest possible statement about the most important issue: patient safety."

### Do replacement nurses help or hinder?

To address the question, Gruber and Kleiner looked at New York, the state with the most strikes in the past decade. Their sample covers 50 strikes at 43 facilities that took place between 1983 and 2004. Although the genesis of the strikes varied, most were over wages and nurse staffing ratios.

To reach their conclusion, the researchers were able to use information on the strikes and match it to hospital discharge records.

This is significant, because the discharge records provide data on treatment intensity and two key measures of patient outcomes: mortality and hospital readmission.

The researchers considered an "in hospital" mortality to be a death that occurred within the first 10 days of a patient's admission. Readmission was defined as rehospitalization for any reason within 30 days of discharge. "Hospital readmission," the study says, "is often an indicator of poor care or missed opportunities to improve the quality of care during a hospital admission."

Gruber and Kleiner also found evidence that patient outcomes are no better at hospitals that hire replacement workers. "Even if staffing ratios are maintained with the use of replacement workers during a strike, the quality and familiarity of these workers with hospital processes may affect the care delivered to patients," the study notes.

"It's unfortunate that hospitals think that nurses are interchangeable—that a nurse is a nurse," says Owley. "Here's another piece of evidence showing that's not the case at all."

## Making a difference

School health workers are 'not just a luxury'



School health workers from Cleveland met with lawmakers and aides in Washington, D.C., to lobby for resources to care for their students back home.

MICHAEL CAMPBELL

HAVING MORE health professionals in schools would be an effective long-term investment for students, AFT president Randi Weingarten said in her welcoming remarks to attendees of the School Health Leadership Development Conference in Washington, D.C., in May.

"The work that school health professionals do is quite remarkable," said Weingarten, recalling how school nurses took the lead during the H1N1 flu outbreak this past year. "When that virus shot through schools, it was the nurses who assessed whether or not a school should have closed," she said. "I think if it had not been for the budget crisis, there would have been an infusion of resources into school nursing."

The AFT president encouraged the school health leaders who planned to meet with their members of Congress during the conference to share their stories with lawmakers and ask for the resources they need back home. "Take the facts to the Hill. Remind [legislators] that if we ignore children's health, we ignore it at their peril."

### Data-driven decisions

"School health professionals need to ask themselves: 'How am I making a difference,'" said Martha Bergren, director of research for the National Association of School Nurses. To determine the answer to that question, school health professionals should gather data on their everyday work, she suggested. The best reason to start collecting this information is today's emphasis on data-driven decision-making, Bergren explained. "Lawmakers and their aides want numbers. Good data influences decisions, resources and legislation," she added.

"This is research with a little 'r.' You don't have to be a Ph.D. to collect information."

Martha Guttu, a school nurse consultant for the North Carolina Department of Health and Human Services, told the school health workers to take the responsibility in gathering data to prove that they make a difference. Show any doubters that "we are an essential part of education—not just a luxury."

### Attaining visibility

There are only a dozen school social workers assigned to the Cleveland school district. With nine schools and the potential of a 4,000 student-caseload, social worker and conference attendee Ben Shores says he only has time to focus on the "top-tier crisis" cases. "I would like to be more involved with the students in my buildings, but it is a juggling act," says Shores, who is a member of the Cleveland Teachers Union. "Sometimes, it's hard to feel effective."

One of the reasons why Shores attended the conference was to learn how to make his work with students more visible to teachers and parents. "It can be difficult to make sure other school staff is knowledgeable about what we do," he says.

The networking and skill-building provided at the conference will help in his job, says Shores, adding that he is also heartened by the AFT's focus on community schools. "Two of the schools I work in are converting to community schools. I want to make sure that healthcare providers are at the table during the transition," he explains. "No one can do the job of servicing our students better than a certified school health professional."

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