

The CONNECTION

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The Official Newsletter of the American Association of Heart Failure Nurses

The Importance of Healthy Communication for Caregivers and Heart Failure Patients

Fostering Self-Care Adherence

Chronic Sorrow in Heart Failure



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The Connection is published quarterly by the AAHFN and is distributed to approximately 1,500 AAHFN members. These members come from the full spectrum of nurses and other health professionals interested in heart failure. AAHFN serves as the interface for sharing ideas, translating research findings into practice and setting priorities for the future. AAHFN welcomes and values all professionals involved in heart failure care. AAHFN focuses on patients across all environments of care from the hospital, to the clinic, to home.

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AAHFN Mission:

Leading nurses in heart failure care

AAHFN Vision:

To be the foremost nursing association across the heart failure continuum



“The volunteers play a significant role in achieving the AAHFN mission statement of leading nurses in heart failure care.”

Volunteers: A Salute to Past, Present, and Future

*Connie M. Lewis, MSN, ACNP-BC, NP-C, CCRN, CHFNP
Director, AAHFN*

AAHFN volunteers provide strength to the organization and allow it to grow and be attuned to the needs of the members. They commit their time, talents and creativity to ensure AAHFN continues to move forward and fulfill its strategic goals. Volunteers spend many unpaid hours contributing to their committees and working on assigned tasks. They bring their specific professional knowledge and skills to enhance each work group. Many volunteer for short-term projects, and some do committee work for years, serving as a member, chair-elect or chair of a committee. The volunteers play a significant role in achieving the AAHFN mission statement of “leading nurses in heart failure care.” They are contributing to community and national heart failure awareness by Leading, Educating, Advocating and Driving quality care—LEAD. We salute you for the many contributions to AAHFN! You are invaluable!

You may say to yourself, “Why would anyone want to give up their free time?

I’m too busy.” There is a personal satisfaction in knowing you make a difference and that your opinions are valued. As a volunteer, you build relationships with nurses across the country. Networking enables you to develop new friendships and contacts with your colleagues. At the same time, you are gaining organizational knowledge. Ultimately you may desire to take on a larger role in the leadership of the organization.

We are all aware that sometimes “right now” is not always the right time. There are life circumstances and events that prohibit us from making a volunteer commitment; however, perhaps the right time will come for you in the future. Keep AAHFN on your radar.

For all of you who have served AAHFN in some volunteer capacity, you have our heartfelt thanks. Stand up and be recognized! You have been instrumental in the growth and recognition of AAHFN as the premier heart failure nursing organization. 📌



“While we believe our patients can’t manage their illness without us, the fact is that most could not manage their daily routine without their families and friends.”

Caregiving, Depression and Family Support in Heart Failure

Carolyn Miller Reilly, RN, PhD, CHFNP

This edition of *The Connection* is devoted to psychosocial care of the heart failure (HF) patient and caregiver/family member. While much of healthcare is focused on the physical aspects of care, so much of nursing is centered on the humanistic aspects of listening, encouraging, educating and demonstrating. For our patients and their families, every smile, touch and knowing glance translates our understanding and empathy. But too often, we resort to parental chiding when our patients ‘fess up that they ate Chinese food and pizza all weekend or decided to skip their lasix because they needed to run errands.

While we believe our patients can’t manage their illness without us, the fact is that most could not manage their daily routine without their families and friends. In *Promoting Self-Care in Persons with Heart Failure: A Scientific Statement from the American Heart Association*, the evidence regarding the benefits from social support is discussed. Highlighted are the facts that unmarried or un-partnered HF patients report greater depression, poorer self-care and more hospitalizations, while those reporting higher social support have better medication, dietary and exercise adherence.¹

In this edition, we focus on promoting effective communication between HF

patients and their families with tips for fostering autonomy supportive communication by Erin Ferranti, a PhD student at Emory University. Effective communication can also be enhanced by improving congruence in the assessment of symptoms between patient and family as highlighted in the Research Corner. This innovative intervention by Dr. Christina Quinn demonstrates improved congruence in symptom assessment between family caregivers and HF patients, and it could foster timely recognition of worsening symptoms and activation of self-care strategies to mitigate effects.

Our guest editor, Rhonda Moore, brings into focus caregivers’ need for nurses who are sensitive to their experiences and able to support their efforts. She provides several strategies for helping family members and caregivers recognize and manage their chronic sorrow, while also supporting the important bond that the family members and the healthcare provider share. Donna Petrucci, Donna Doe and Melisa Kubic stress the importance of recognizing and treating depression in persons with HF and suggest employment of a simple screening tool available free for use at www.cqaimh.org/pdf/tool_phq2.pdf. Finally, Julie Gee rounds out this edition with a Clinical Pearl. Helpful tips from Dr. Eric A. Coleman are presented, such as delivering more personal care

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Chronic Sorrow in Heart Failure

Rhonda Weller Moore, APN-BC, PhD, CHFNP

Chronic illness presents demands for both the patient and caregiver(s). Chronic heart failure is no exception; in fact, the demands of dealing with heart failure are often seen as more stressful than those for other illnesses.¹ Loss and grief are common experiences of the heart failure illness trajectory; however, insight into the lived experience of caregivers is often only a snapshot at best. The bulk of illness care in heart failure is shouldered by caregivers who rise to these challenges and deal effectively with these complex and difficult demands, without succumbing to depression and helplessness. Nevertheless, caregivers need professional navigators who are sensitive to their experiences and able to support their constructive efforts to juggle recognition of the potentially fatal illness of a loved one with the chaotic uncertainty of the roller coaster ride of “the patient with nine lives.”

Chronic sorrow is defined as feelings of sadness related to loss that is perceived as ongoing in nature, can be periodic, episodic, initiated by specific triggers, and is both cyclical and progressive in nature.² It differs from grief in that the loss(es) are not resolved because the person to whom the losses pertain, continues to be present. This is analogous to the situation of the patient with Alzheimer’s disease who remains present, despite being significantly

changed from the person he/she once was. Chronic sorrow is different from depression also in that it does not interfere with a person’s ability to function. Although there are patients and spouses who become depressed for valid reasons, the vast majority of patients and their caregivers seem to rise to the challenges of illness and do so without becoming clinically depressed.

Managing Chronic Sorrow

Several means of trying to cope with losses in chronic illness have been identified. Just as individuals vary in their perceptions, so, too, will their choice of coping strategies. Action-oriented strategies³ are things one chooses to do in an attempt to feel more in control of one’s destiny. Doing things such as continuing personal interests and activities, taking advantages of opportunities for respite and finding out as much information as possible are common action-oriented strategies.

Cognitive re-framing strategies may also be useful to make feelings more manageable. “Taking one day at a time” means taking things as they come and stressing the positive aspects are useful to avoiding being overwhelmed.

Interpersonal strategies include talking with a friend or other trusted

individual. Protective buffering³ is the opposite and consists of not talking in order to avoid increasing emotional discomfort. This pattern of interaction has been observed between couples dealing with chronic illness.

Denial is a common coping response. Patients and caregivers are not the only ones to deny sources of sadness. Denial on the part of healthcare providers is common also. Without saying it aloud, patients and families are encouraged to “get a grip,” “deal with it” and get on with their lives. Thus, caregivers are sometimes tacitly encouraged to repress their feelings. Grief that is not recognized or sanctioned often goes unexpressed and may cause it to intensify.

Emotion-focused strategies are used by some individuals to help regain their emotional equilibrium. Having a good cry may be cathartic and regain a sense of control. Relying more heavily on one’s spirituality or other personal rituals may be soul-soothing and increase comfort.

What can heart failure nurses do?

The most important thing for nurses to do is to accept their limited knowledge of the illness experience and to recognize that there are many sources of loss and grief as well as many means of coping with it. Nurses need to recognize that loss and grief are a large

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Fostering Self-Care Adherence: When Heart Failure and Depression Intersect

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Dedicated to the care of patients with heart failure (HF), nurses constantly strive to identify and overcome barriers to improve patients' quality of life and well being. While these barriers vary from patient to patient, there is an increasing amount of data suggesting psycho-social barriers are prevalent and make treatment adherence extremely challenging for patients with chronic, complex illness. In parallel, poor adherence to the plan of care leads to symptom exacerbation, re-hospitalization and subsequent patient and caregiver distress. Early identification of HF and coexisting psychological co-morbidities and an understanding of the ways these factors are intertwined can facilitate early intervention and limit devastating effects on patient outcomes. Because patients are often reluctant to discuss sensitive emotional topics such as depression with their health care providers, the use of established screening tools in the inpatient and outpatient care settings can lead to early identification and evidence-based treatment.

As patients age, they face an increasing risk for both HF and depression. Rozzini, et al., found hospitalized patients more than 70 years of age who suffer from a combination of HF and depression experience re-admission rates of 67% versus 44% among this same age group with HF but without depression.¹ Patients with HF were twice as likely to die if they had depression compared with those who did not have depression.^{1,2} More recently, Sherwood, et al., found worsening depression contributed to adverse clinical outcomes in HF, independent of HF disease severity.³

A meta-analysis in 2006, performed by Rutledge, et al., demonstrated a direct relationship between HF functional class and severity of depression.⁴ Specifically, patients with NYHA functional class I (mild) HF suffered an 11% occurrence of depression; this increased steadily to 20% in class II, 38% in class III and 42% in class IV (severe) HF.⁴ Although the incidence of depression increases with HF symptom severity, it is unclear if it is an independent primary diagnosis or if the depressive symptoms are

secondary to the patients' chronic, complex illness. Both diagnoses share common pathophysiologic pathways and benefit from disease-specific specialty care early in their diagnosis.²

Screening for endogenous or prolonged reactive depression in patients with HF is recommended by the 2010 HFSA guidelines following diagnosis and at periodic intervals as clinically indicated.⁵ Similarly, the AHA notes that while the effect of depression interventions on survival and hospitalizations is unknown in persons with HF, evidence suggests that screening and treatment for depressive symptoms may help improve self-care behaviors and increase physical functioning.⁶

Screening for depression early in patients with coronary heart disease has been shown to improve patient adherence and outcomes when positive screening leads to the implementation of a combination of individualized patient interventions.⁷ This includes the prescription of antidepressant drugs, cognitive behavioral therapy and an activity/exercise program, as



well as the provision of disease specific education to equip our patients with the tools necessary to help keep them safe.⁷ For pharmacologic treatment specific of HF, selective serotonin reuptake inhibitors are recommended over tricyclic antidepressants, because the latter have the potential to cause ventricular arrhythmias, but the potential for drug interactions should also be considered.⁵

While there are several screening tools available to screen our patients for depression, selection should be guided by the tool's design. Not all tools are designed to assess and diagnose depression in a medically ill population.⁹ The Patient Health Questionnaire (PHQ-2) is a valid screening tool for identifying major depression or any depressive disorder demonstrating a sensitivity of 79-100% and a specificity of 42-86%.¹⁰⁻¹² This two-item questionnaire inquires about the frequency of depressed mood and anhedonia and is intended for use in combination with PHQ-9 when the results are positive (Score>2).¹¹⁻¹² At the very least, patients with HF should be screened with the PHQ-2 as part

of their assessment. This will help to identify those patients at increased risk for poor self care adherence and outcomes. Once identified, patients can be assisted to overcome barriers to their quality of life and self care adherence by providing additional clinic/home visits, initiating specialty/subspecialty psychiatric consultation, and by enlisting the support and encouragement of family and friends. Research is on-going to determine the best medical management of these high risk patients to optimize their adherence, well-being and outcomes. 📌

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The Importance of Healthy Communication for Caregivers and Heart Failure Patients

Erin Poe Ferranti, RN, MSN, MPH

Effective communication skills are essential for any healthy, well-functioning interpersonal relationship, but become a critical matter in the relationship between caregivers and heart failure patients. The strain and major life changes that accompany a disease such as heart failure can

alter the roles of both the patient and the caregiver, requiring new methods of communication. Frequently, the caregiver is the spouse or adult child who must assume the role of caregiver and establish a new relationship with someone who either was once their equal partner or their own caregiver in childhood.

These role strains and communication patterns are rarely addressed adequately in clinical practice, contributing to psychosocial suffering that could be prevented or modified. Many patients and caregivers report a decline in their interpersonal interactions, often contributing to depressive symptoms in both.¹ Depressive symptoms then

Situation/Issue	Non-therapeutic	Therapeutic
Heart Failure patient choosing high salt lunch menu item at a restaurant.	CG: "Why are you always choosing foods that you are not supposed to be eating?" PT: "Why are you always nagging me about my diet?"	CG: "Let's talk about ways we can modify our diet the rest of today to accommodate this high sodium choice." PT: "I appreciate your concern and help with adhering to my diet restrictions, but I would like to indulge a little. Let's compensate for this high sodium choice throughout the rest of the day and at dinner."
HF Patient no longer can help around the house and CG feels really burdened with additional responsibilities.	CG: "I spend all day cooking, cleaning and taking care of you. I am not your personal nurse. I wish someone would take care of me." PT: "I didn't ask for this and I don't want you taking care of me. I don't even like your cooking anyway - it has no taste."	CG: "I understand that you sometimes are too tired or don't feel well enough to do much. However, I am feeling really overwhelmed with all the house chores. Can we talk about ways that we can work together so that I don't feel so overwhelmed?" PT: "I very much appreciate and recognize the additional responsibilities you have taken on since I have been diagnosed. I don't want you to feel overwhelmed - let's talk about things I can do to help out or where else we can reach out for help and support."
HF patient choosing to watch TV instead of going for the daily walk with CG.	CG: "Are you just going to sit on that couch all day? This is why you keep getting sick. You are never going to make any improvements if you don't try a little harder." PT: "Leave me alone, I don't want to be bothered and I hate walking."	CG: "It sounds like you are feeling too tired to do the walk today. Would you like to try after this TV show is finished? Maybe then if you are still feeling tired, we can come back early." PT: "Thank you for walking with me. Would it be OK with you if we go after this TV show is over? I am feeling really tired, but I think I will feel better if I just try to get out there. If I am still too tired, we can just come back."

lead to further declines in self-care management and heighten caregiver burden. In a recent review of the consequences of heart disease on the partner relationship, five common themes were identified:

- Overprotection.
- Communication deficiency.
- Sexual concerns.
- Changes in domestic roles.
- Adjustment to illness.²

The research literature also consistently highlights the need for a supportive family/social environment that prioritizes autonomy for the patient.³ And although 75% of patients in a recent study reported having supportive family involvement, 78% also reported family members nagged or criticized them.⁴ With caregivers so involved in the day-to-day implementation of a very complex self-management program, often bearing significant burden in the preparation of specific foods or accompanying patients during clinic visits and hospital stays,

the tendency to micromanage, nag or criticize in response to non-adherent behavior is well understood and seemingly justified. However, because of the detrimental effect that this communication pattern has on both patients and caregivers, it is our role as clinicians to assess and treat it as if it were any other sign or symptom.

But how? Perhaps one way is through the teaching of the listening-focused, non-judgmental, person-centered, therapeutic communication style that we as providers have been trained to do. Arguably, this communication style is easier to implement between a provider and patient with no previous relationship or established roles with each other, however, it can be taught and implemented among patients and caregivers as well. It has been demonstrated successfully in a dyad study between caregivers and patients and resulted in significant improvements in dietary sodium adherence.⁵ Table 1 highlights

both therapeutic and nontherapeutic communication strategies for common issues between heart failure patients and their caregivers. Clinicians can assess with patients and their caregivers what communication challenges they are experiencing by sharing some of these more common situations. 📌

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Improving Heart Failure Symptom Congruence through the use of a Perspective-Taking Intervention

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Inadequate symptom management in heart failure (HF) patients is a major factor in repeated re-hospitalizations.¹⁻⁴ Family members play an important role in symptom management and can influence symptom assessment and outcomes. Luttik interviewed partners regarding their experiences with HF and found mutual communication to be a concern.⁵ Conflicts occurred when there was discordance, for example, in balancing activities such as walking together in relation to the disease process and symptoms that occur.

This pilot longitudinal study tested the feasibility of using a perspective-taking intervention designed to improve congruence in symptom assessment between family caregivers (FCG) and HF patients. Studies such as this may ultimately lead to more appropriate health care use and quality of life.

Perspective taking, described by Davis,⁶ is similar to stimulating the empathetic process. Long has described perspective-taking as focusing on the cognitive dimension of empathy.⁷ In addition, perspective-taking has been described as the ability to stand in another person's shoes in order to understand the thoughts and feelings of that person. In Lobchuk's discussion of perspective taking, this approach requires the caregiver to make a judgment regarding the patient's experience that may not be based only on visible signs.⁸ By asking the caregiver to imagine the patient's viewpoint (imagine-patient perspective-taking), the caregiver is able to differentiate between his/her own viewpoint and may prevent his/her own viewpoint from influencing the judgment of what the patient is experiencing.

In this study, a group of home health HF patients and their designated FCG were enrolled (11 dyads). For a baseline measure of symptoms, the Heart Failure Symptom Survey (HFSS) was completed by the patient and FCG prior to the intervention. The imagine-patient perspective-taking intervention was then explained to the FCG in private. The FCG was asked to notice their loved ones' symptoms over the next two weeks and try to imagine how the symptom was felt by the HF patient. The FCG was asked to put themselves "in the patient's shoes" when evaluating any symptoms. Following the FCG interpretation, they were asked to validate their assessment with the HF patient. Two weeks after the intervention, the HF patient and FCG were asked to complete the HFSS again. The FCG was then asked if they noticed anything differently in how they perceived symptoms with this new

For this edition, we are highlighting the research completed recently by Dr. Christina Quinn on patient and family congruence. This research was supported by a Sigma Theta Tau International Small Grant Award.

perspective-taking technique. Some of the main findings included:

- At baseline: there was high symptom assessment congruence on only one symptom (chest pressure)
- Post intervention: symptom assessment congruence increased in 6/14 symptoms (SOB lying down, SOB waking up at night, chest pressure, irregular heart beat, difficulty sleeping and difficulty concentrating)
- This intervention stimulated the FCG to use a patient-oriented empathetic process to understand HF symptoms from the patient's point of view
- CG response to question: Did you notice anything different in yourself or the HF patient in the last two weeks since learning this perspective taking intervention?
- "I was much more aware of changes in my brother and how drastic a change in his condition can be."
- "It changed the way I look at her. I noticed when she could not sleep and other changes like the ankle swelling today. I watched her more closely in the last two weeks."
- "Because of what you taught me, I noticed my sister's leg was hurting. I had never noticed that before, so after I saw that, I asked her about it."
- "This was different from the past. I used to wait until she told me and then it was usually really bad by then. This time with the teaching you gave me, I was more alert to her problems."
- "This teaching you gave me changed the way I look at my aunt's symptoms. Her facial expressions of her mood were the cues I noticed before she even said anything was wrong."

- "This teaching will help me in the future to make sure I ask more questions when I notice a change even before she says anything."
- "I don't think I had noticed her facial expressions when she was short of breath before, so that was something new for me."

In summary, though a limited sample size, perspective-taking as an intervention improved symptom assessment congruence in HF patients and their FCG. Future research on perspective-taking warrants further development and testing on a larger sample for its ability to improve HF dyad symptom assessment congruence, and ultimately health care use and health related quality of life. 🏥

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Making Transitions Meaningful: Suggestions from Dr. Eric Coleman


Julie Gee, *CNP, CHFN*

Eric A. Coleman, MD, MPH, is Associate Professor of Medicine at the University of Colorado, trained in both geriatrics and health services research. Dr. Coleman has emerged as one of the world's leading authorities on issues surrounding transitions of care, particularly between acute and post-acute settings. His care model, the Care Transitions Intervention, has been associated with a significant decrease in re-hospitalization rates and is being adopted by leading health care organizations around the country. His provocative talks at healthcare conferences are energizing providers to reassess their traditional methods of care and teaching of patients.

Dr. Coleman suggests that health care providers (HCP) must "...retire the term 'non-compliant.'" When non-compliance or non-adherence is documented, what is really being said is that the HCP did not have the time to play detective and get to the real reasons why the patient missed their medications or ate a high sodium diet. Instead, HCPs need to investigate why patients are having problems and customize their care by having patients express their preferences and honoring these preferences for the type, intensity and settings of services they desire.

Dr. Coleman emphasized the importance of "...doing more and assessing less." Patients are asked the same questions over and over again, and HCPs do very little because they run out of time. The questions asked should be pertinent to direct patient care and could be carried across settings. A care tool could be used and updated during times of transition and passed on with the patient to the next care setting. The tool could include information on their mental and physical status at the time of discharge, their caregiver(s) and the roles of these caregivers, why they were in the hospital or ECF and what is expected or needed at their follow-up visit.

Do not confuse information with communication. Many times HCPs think they are teaching patients, but what are they learning? It's important to gain understanding of the patient's role and the caregiver's role. What are the patient's beliefs, cognitive function, health literacy and locus of control? Are they activated? Patients need to control their own outcomes and make mistakes. This is part of the learning process. When we fix their problems for them, we create expectations that it will be done for them again. We need to help them develop skills by using tools to define activation and by using the teach-back model.

An understanding of patient home workflow could be best ascertained by having them demonstrate how they manage certain situations. How do they take their medications, what do they do when they need a refill, how do they track their follow-up appointments, what circumstances would warrant a call to their nurse/provider, what do they do when their medications are changed or how do they interpret and act on their daily weights? Gaining understanding of their methods is essential to understanding how and why they are getting into trouble. If their system works then you should not try to fix it. But if they do not have a working system, maybe instead of verbal or written information HCPs should consider teaching them by creating "demonstration stations" in the hospital or clinic and showing them ways to do things differently. Having the patient demonstrate the activity prior to going home or at a follow-up visit might go further than old traditional ways of teaching patients. Teach them how to fish rather than fishing and preparing it for them would likely impact long-term outcomes and readmission rates. More information and helpful tips from Dr. Coleman can be found at www.caretransitions.org. 

Heart Failure CEs

Dana Harris, RN, CHFNP • AAHFN Certification Board Member

Are you preparing to meet continuing education requirements in heart failure education before completing the application to take the Heart Failure Certification exam next year? Do you need to complete your CE requirement? Are you wondering what are considered acceptable Heart Failure CEs? We are here to help you!

Heart failure continuing education refers to education related specifically to the care of patients with heart failure. It can involve:

- Pathophysiology, assessment, drugs, devices (including ventricular assist devices), self-care and other treatments, monitoring and evaluation strategies.
- Heart failure with reduced ejection fraction or preserved ejection fraction.
- Left- or right-sided heart failure.
- Wellness and prevention of heart failure, heart failure decompensation and ambulatory care throughout the continuum to end-of-life.
- Comorbidities/confounders with heart failure (e.g.: diabetes, hypertension, cancer, COPD), but the focus must include heart failure

You can find Heart Failure-related CEs at/in:

- Local conferences.
- National conferences.
- Journal clubs that offer CEs.
- Online journals that offer CE credit.

- Webinars.
- CE articles published in journals.

Remember, heart failure should be the focus of the education and will most likely be in the title of your education source.

Heart Failure related topics are accepted as well.

- Cardiac transplantation.
- Diagnostic devices used in patients with heart failure.
- Primary or secondary pulmonary hypertension.
- Quality initiatives and performance measures to improve care outcomes of patients with heart failure.
- Transition care to reduce heart failure re-hospitalization.

CEs that do not meet the heart failure CE requirements are:

- ACLS or PALS class.
- BLS class.
- 12 lead ECG interpretation or Basic ECG arrhythmia interpretation class.
- Or courses not focused on heart failure.

Remember, you can use these CEs toward the non-heart failure related education hours. 📌

Membership Committee

Connie Lewis, MSN, ACNP-BC, NP-C, CCRN, CHFNP •

Interim Chair, Director

Gail Haas, Director of Membership Services

Spring is here and the Membership Committee is getting ready to “Soar to New Heights” in Chicago this June! The AAHFN Annual Conference is a great time to network, meet new colleagues and benefit from all of the educational offerings. Make your plans to attend today!

Thanks to everyone that participated in the 2012 Needs Assessment Survey. Your feedback has provided us with a lot of valuable information that will help us meet and set the goals in our strategic plan.

AAHFN continues to grow membership at a steady rate. We are still working hard at reaching our target of 2000 members. Your active support in building a stronger organization is vital to the growth of heart failure care. Take the membership challenge and commit to recruit one new member this year. No one knows the value of AAHFN membership better than you, our members.

The membership committee would also like to recognize and thank Beth Davidson DNP, ACNP, CHFNP for her tremendous leadership as the membership committee chair the past two years!

The membership committee is here to listen and support your ideas. We can be reached via the AAHFN National Office at information@aahfn.org

See you in Chicago! 📌

Research Committee

Marilyn A. Prasad, PhD,
CCNS-BC, FAHA • Chair

The committee has been very busy in recent weeks preparing for the upcoming annual meeting. This year we received a large number of abstract submissions in both the research and clinical innovation categories. The increased abstract submissions have translated into a very busy committee that has been carefully reviewing abstracts to ensure high quality research and clinical innovation poster and podium presentations at the annual meeting.

The Research Committee continues to move forward with the mentor program this year. This program is available to all AAHFN members and was designed to facilitate support for abstract development and submission. The research committee hopes to further heighten awareness and expand the program to allow for earlier access prior to the call for abstracts. In addition, the committee is currently working on opportunities to further increase networking of members with a research interest.

Finally, the Research Committee anticipates enlightening podium and poster presentations at the annual conference in Chicago. As the Research Committee continues to work on their initiatives we welcome any suggestions or recommendations you may have that furthers the research efforts within AAHFN. 📧

Annual Meeting Committee

Robin Trupp, PhD, RN, APRN, CHFNP • Chair

The Annual Meeting Committee remains hard at work to bring you the “best meeting yet.” The keynote speakers have been confirmed: Donna Hartley (an inspirational and motivational speaker who has survived plane crash, cancer, and open heart surgery); Michael Bleich (Professor, Oregon Health and Science University School of Nursing; Member, Institute of Medicine Future of Nursing Report); and Clyde Yancy MD (Chief, Division of Medicine-Cardiology, Northwestern University; Past President of AHA). Invitations to faculty and to AAHFN members who submitted proposals have been sent.

Back by popular demand are the Heart Failure Disease Management Program and Mechanical Circulatory Systems workshops Wednesday, June 27.

As a reminder, the second offering of the Certified Heart Failure Nurse (CHFNP) examination will be held on Sunday,

July 1 from 8-11am. The CHFNP review course will be held on June 29 from 6:30-9:30 pm. In addition, the program for the meeting will denote lectures and topics that contain content relevant to the examination.

New this Year

- Pharmacology workshop
Wednesday, June 27 (Seven CEUs of cardiovascular pharmacology)
- Expanded three full days of content—June 28-30
- Two “Great HF Debates”—
Thursday, June 28 and Saturday, June 30
- “Power Hours”—Featuring 2.25 hours of concentrated content of atrial fibrillation (June 28) and innovative care delivery models in HF (June 29)

We also have a number of other exciting surprises in store, so make your plans now to “Soar to New Heights” with us in Chicago. Hope to see you there! 📧

Editor’s Note (Continued from page 6)

to overcome barriers to self-care instead of simply labeling them and verifying acquisition of patient knowledge through teach-back or demonstration sessions.

We hope you find this edition compelling and useful to your practice, whether in the hospital, clinic or patient home. We are grateful to these authors who have generously shared with us relevant, evidence-based strategies and communication techniques that transcend the usual patient-nurse relationship and bring into the fold the family and caregiver. 📧

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Education Committee

Rebecca Castro, MSN, CNS, FNP-BC, CHFN • Chair

This past spring, the Education Committee focused on preparing for its American Nurses Credentialing Center (ANCC) accreditation. In the past, AAHFN offered continuing education through Washington State Nurses Association (WSNA). However, new regulations were implemented requiring all organizations who market more than 50% of their CE to nurses extending beyond Washington's region of 10 states must go directly to ANCC. As a result, the AAHFN board elected to pursue becoming accredited providers of continuing nursing education through ANCC.


This past spring was very busy for the Education Committee as its members familiarized themselves with the ANCC planning process, submitted the application and prepared for a site visit. Some new terms members will be hearing in the future include the provider unit, which is the new name for the education committee, the Lead Nurse Planner (LNP), who is the Chair of the Education Committee, and nurse planners, who are the members of the education committee. As one of the main goals of AAHFN is to provide quality education for its members, becoming an ANCC provider will only enhance this process.

Once the site visit was completed, three continuing education activities were posted. These activities were co-provided by Edupro (an ANCC provider) and AAHFN. The webinar presented by Nancy Albert in September on the IMPROVE-HF study was posted. Therefore, if you missed her live presentation you will be able to view it for CE. The second activity posted is an enduring activity (previously named an independent study) on Sleep-Disordered Breathing (SDB), which contains great content on the association between SDB and HF. The third activity posted was authored by the Supportive and Palliative Care Community of Practice and describes the 10 principles of hospice and palliative care in caring for patients with HF. This will be the basis for future activities presented by the Supportive and Palliative Care Community of Practice.

The decision regarding our ANCC provider status is anticipated by July with several activities ready to be posted on our website once AAHFN is an official ANCC provider. Another activity is a presentation on diversity. This is an excellent presentation on the different types of diversity encountered when caring for HF patients. The Supportive and Palliative Care Community of Practice is also developing a

presentation on communicating with patients about palliative care and end of life. The Mechanical Support Community of Practice also has several ideas for activities.

Last but certainly not least, the Education Committee has been busy preparing for the annual meeting and the review course for the certification exam. The annual meeting will have contact hours co-provided by Edupro and AAHFN. The Heart Failure Nursing Certification Exam review course is scheduled for Thursday, June 28 from 6:30 to 9:30 pm at the Annual Conference with three dynamic speakers: Mickie Gilbert, Susan Halter, and Kimberly Johnson. Everyone who plans to take the Heart Failure Nursing Certification Exam this year should register for the review course, and all are encouraged to purchase the *Heart Failure Nursing Certification: Core Curriculum Review, 1st Edition, The Official Study Guide of the American Association of Heart Failure Nurses* developed by the Publication Committee.

As always, we are looking for educational ideas from our members. If there is a topic you would like to learn more about, please contact Becky Castro at jbcastro@embarqmail.com. 

Reference

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Brief Statement

Medtronic ICDs and CRT-ICDs

Indications

Medtronic Implantable Cardioverter Defibrillators (ICDs) are indicated for ventricular antitachycardia pacing and ventricular defibrillation for automated treatment of life-threatening ventricular arrhythmias.

Medtronic Cardiac Resynchronization Therapy (CRT) ICDs are indicated for ventricular antitachycardia pacing and ventricular defibrillation for automated treatment of life-threatening ventricular arrhythmias and for the reduction of the symptoms of moderate to severe heart failure (NYHA Functional Class III or IV) in those patients who remain symptomatic despite stable, optimal medical therapy and have a left ventricular ejection fraction less than or equal to 35% and a prolonged QRS duration.

Contraindications

Medtronic ICDs and CRT-ICDs are contraindicated in patients whose ventricular tachyarrhythmias may have transient or reversible causes, patients with incessant VT or VF, patients who have a unipolar pacemaker.

Warnings and Precautions

Changes in a patient's disease and/or medications may alter the efficacy of the device's programmed parameters. Patients should avoid sources of magnetic and electromagnetic radiation to avoid possible underdetection, inappropriate sensing and/or therapy delivery, tissue damage, induction of an arrhythmia, device electrical reset, or device damage. Do not place transthoracic defibrillation paddles directly over the device. Additionally, for CRT-ICDs, certain programming and device operations may not provide cardiac resynchronization.

Potential Complications

Potential complications include, but are not limited to, rejection phenomena, erosion through the skin, muscle or nerve stimulation, oversensing, failure to detect and/or terminate tachyarrhythmia episodes, acceleration of ventricular tachycardia, and surgical complications such as hematoma, infection, inflammation, and thrombosis.

See the device manual for detailed information regarding the implant procedure, indications, contraindications, warnings, precautions, and potential complications/adverse events. For further information, please call Medtronic at 1 (800) 328-2518 and/or consult Medtronic's website at www.medtronic.com.

Caution: Federal law (USA) restricts these devices to sale by or on the order of a physician.

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(24-hour technical support for
physicians and medical professionals)



**For additional information
see back cover.**

Guest Editor Message (Continued from page 7)

part of the care-giving experience in heart failure. Nurses should seek to align themselves in a way that encourages disclosure of the patient and caregiver experience. Positive reinforcement of constructive management strategies should be encouraged. A kind and empathetic presence that is conducive to disclosure is likely to be more beneficial in identifying ways in which the nurse can help. Recognizing the caregiver as an essential component of the patient's care plan is imperative.

One area that is consistently identified as one where caregivers need assistance is in navigating the system. Heart failure patients need an "in" to the system that allows them rapid access and evaluation. When caregivers speak, it is essential that professionals recognize they live with the patient and know him/her much better than anyone. Taking time for active listening is validating to the caregiver and may actually lessen the amount of time required for problem-solving. Failure to include the caregiver can lead to anger and frustration. This can exacerbate negative exchanges that sap the already depleted resources of the caregiver.

Recognition of the role that chronic sorrow plays in the day-to-day experience lends to empathetic exchanges that are respectful of the individual and caregivers, honor their survival and set the stage for reassurance. Exhaustion of resources, fears about finances and sleep deprivation may impede the most efficient plan and act as barriers to effective outcomes. Constant teaching during informal conversation in words that are easily understood may most easily be incorporated into daily life.

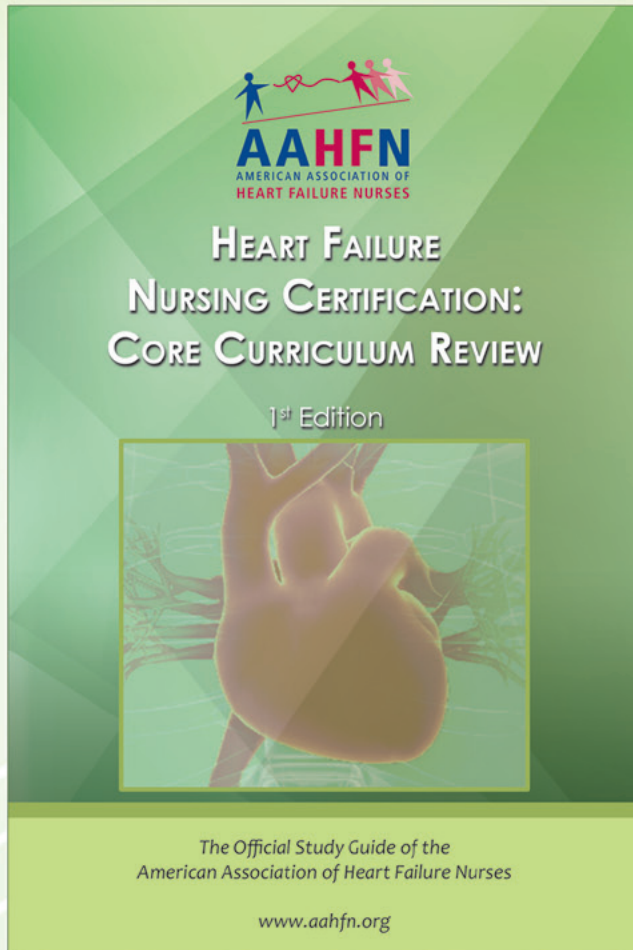
In heart failure, one has not far to look before identifying loss and grief. The patient, the object of grief, is present in the circumstances caregivers confront from day to day. Recognizing and addressing chronic sorrow goes a long way in assisting caregivers to cope. 📱

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The American Association of Heart Failure Nurses

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IMPROVE HF Showed CRT and Beta Blockers Each Provided > 50% Survival Benefit

Reduction in Risk of Death with Use of Guideline-Recommended Therapies in Patients with Heart Failure¹

IMPROVE HF Nested Case-Control Analysis Shows:

- Beta blockers and cardiac resynchronization therapy (CRT) were associated with the greatest 24-month survival benefit (Table 1)
- Incremental benefits were seen with each successive therapy, with 90% reduction in odds of death with combination of ACEI/ARB, Beta Blockers, and CRT-D (Figure 1)

See the full article in *Circulation* to learn more about enhancing the quality of care for Heart Failure Patients

Table 1

HF Quality Measure	% Death Risk Reduction Odds Ratio (Adjusted)
ACEI/ARB	44%
Beta Blockers	58%
Anticoagulant for AF	27%
Aldosterone Antagonists	None
ICD/CRT-D	38%
CRT-P/CRT-D	56%
Heart Failure Education	28%

Figure 1

