Special Issue
CV Health

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aacn Viewpoint
The Voice of Ambulatory Care Nursing

Cardiovascular Disease in Women

Closing the Treatment GAP

Nancy Albert (right), clinical nurse specialist, and Linda Kelly, nurse practitioner, work with patient Brenda Roberts at the Kaufman Center for Heart Failure in Cleveland, OH. The clinic is led by nurse practitioners who make patient education and women's cardiovascular health a focus of care.

Nancy M. Albert

Women are more likely to die from some form of cardiovascular disease (CVD) than any other condition. Statistics show that if all forms of major cardiovascular disease were eliminated, life expectancy would rise by almost 7 years. The probability at birth of eventually dying from a major CVD is 47%. In comparison, if all forms of cancer were eliminated, Americans would gain 3 years, as the chance of dying from cancer is less than half that of CVD (22%) (AHA, 2001).

Issue Highlights

When a person is diagnosed with cancer, aggressive treatment strategies and lifestyle changes are likely to be discussed and taken seriously by the patient, his/her family, and the health care team. Yet, when a person is told to exercise; eat more grains, vegetables, and fruits; stop smoking; and maintain a healthy weight as cardioprotective measures, the impact of the message and subsequent adherence to the preventative plan can be less than optimal.

Gender Disparity

A treatment gap exists in the primary prevention of cardiovascular disease in women. In addition, recommendations for risk management after diagnosis of cardiovascular disease are not optimized even though guidelines that rely on evidence-based medicine are widely available through the American Heart Association (AHA), American College of Cardiology (ACC), and other groups. As "baby boomers" age and the population of elderly Americans grows, the prevalence of cardiovascular disease – specifically, coronary heart disease (CHD) and heart failure (HF) – is expected

continued on page 17

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The American Academy of Ambulatory Care Nursing
East Holly Avenue Box 56
Pitman, NJ 08071-0056
(856) 256-2350 • (800) AMB-NURS
Fax (856) 589-7463
aaacn@ajj.com
www.aaacn.org

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Publication Management by
Anthony J. Jannetti, Inc.

President's Message

Candia Baker Laughlin

Dear Colleagues:

I hope this holiday season finds you and your loved ones in good health.

The focus of this issue of *Viewpoint* is cardiovascular health in women, a public and personal health issue that is underestimated and often undertreated. Although I practiced in a cardiovascular risk factor clinic early in my career, there is new science in this area, and I found that I learned a great deal reading these *Viewpoint* articles.

Stephen Covey tells us to "Begin with the end in mind" (Covey, 1989). I find this motto works well in any problem-solving or planning situation, but also in patient care. When we consider the patient outcomes we hope to achieve, we should also attend to the preventive care needs and the long-term outcomes that may be optimized.

The articles in this issue have value for every nurse in ambulatory care, whether one is helping children to build physical activity and good eating habits into their lifestyle, guiding students in their learning about community health, assuring that employees have a work-life balance, or assessing a woman's flu-like symptoms on the telephone. Enjoy the expertise offered here by your peers.

Operations Update

The following is the status of some current activities regarding AAACN's five strategic goals.

Goal 1. Be the Voice of Ambulatory Care Nursing

- AAACN has added its voice to the Americans for Nursing Shortage Relief Alliance (ANSR Alliance). This is a group of nursing and health related organizations committed to relieving our nation's nursing shortage. We have signed letters of support to draft legislation for the appropriations of the Nursing Reinvestment Act funding.
- President-elect Catherine Futch, Executive Director Cynthia Nowicki, and I attended the Inaugural Annual Meeting of the Nursing Organizations Alliance (The Alliance) on November 14-17, 2002. Nursing organizations, formerly the National Federation for Specialty Nursing Organizations (NFSNO) and the Nursing Organizations Liaison Forum (NOLF), came together to network, listen to top national speakers, and discuss mutual issues.
- Sheila Haas, PhD, RN, FAAN, former AAACN president, has agreed to represent AAACN on the Editorial Board of *Nursing Economic$*. We are fortunate to have a leader and scholar who is also an esteemed expert on ambulatory care nursing representing us. Thank you, Sheila.
- Our Web site, **www.aaacn.org**, is under major reconstruction to incorporate e-commerce and enhance member services. The precise timing of implementation is difficult to project but will occur sometime in early 2003. Please see the Board Report on page 9 for more details.

Goal 2: Promote Professional Practice

- A team of AAACN members led by Cynthia Pacek is being called upon to update the ***Ambulatory Care Nursing Administration and Practice Standards*** and the ***Telehealth Nursing Practice Administration and Practice Standards***. Where did the past 3 years go?

continued on page 10

Hyperlipidemia

Equal Risk Calls for Equal Treatment

Valerie Spotts, BSN, RN

Despite the efforts of the American Heart Association and others, the public still perceives CVD as a "man's disease." In fact, numerous polls have demonstrated that women feel their greatest risk of death is breast cancer, with little concern about the health of their hearts.

Health CV

Cardiovascular disease (CVD) is the leading cause of death for men and women in the United States and the industrialized world. In every year since 1984, more women than men have died from CVD (American Heart Association [AHA], 2002).

Nurses can play an important role in educating the public and their patients about preventing and treating cardiovascular disease.

This article focuses on hyperlipidemia (excess lipids in the blood), one of the major risk factors for coronary heart disease (CHD). The issues and concerns in primary and secondary prevention of CHD in women are also explored.

Silent Killer

Atherosclerosis and CHD develop silently for many years, often killing victims before they have any symptoms. Data from 2001 show that 50% of men and 63% of women died suddenly with no previous symptoms (AHA, 2002). For those individuals, secondary prevention measures are too late.

Atherosclerotic lesions begin to develop in childhood. Risk factors (hypertension, hyperlipidemia, smoking, diabetes, age) injure the endothelial lining of the arteries. This injury allows low-density lipoprotein cholesterol (LDL-C) to enter the wall of the vessel and start the formation of atherosclerotic plaques.

For decades of plaque growth, the lumen of the vessel is preserved. This occurs because the external elastic membrane expands and allows the plaque to grow in artery walls, leaving the lumen obstructed. Not until late in the disease process does the plaque begin to obstruct the lumen causing a decrease in blood flow.

This contradicts how we have traditionally viewed plaque growth. Probably because of the influence of angiography we assumed that plaque growth initially progressed toward the lumen, leading us to believe that we were seeing the disease process in the early stages on angiography. However, a wealth of data from intravascular ultrasound (IVUS) studies has proven this wrong. Moreover, a meta-analysis has demonstrated that 68% of myocardial infarctions (MI) occur in vessels with less than 50% stenosis (Falk, Shah, & Fuster, 1995).

These non-obstructive plaques are more numerous than the severely obstructive plaques that are obvious on angiography and are more likely to rupture leading to a coronary event. Characteristics of these vulnerable plaques include: a thin cap, large lipid core, few smooth muscle cells for support, and numerous macrophages with enhanced inflammatory activity. Because the plaque does not obstruct the lumen, it does not limit blood flow and therefore does not cause symptoms unless it ruptures, causing a platelet-initiated thrombus.

Hyperlipidemia plays an integral role in initiating and developing plaque growth. Moreover, oxidized LDL-C causes migration of monocytes into the intima (increases inflammation leading to plaque rupture); increased levels of plasminogen activator inhibitor-1 (PAI-1), which promotes clot formation; and increased platelet aggregation.

National Cholesterol Education Program (NCEP) Guidelines

The most recent guidelines, Adult Treatment Panel III (ATP III) were released in 2001 (NCEP Expert Panel, 2001). Although the guidelines state that an LDL-C <100 mg/dl is optimal for everyone, goals of treatment vary by the presence of CHD and the number of risk factors (see Table 1). Lowering LDL-C is achieved through diet, exercise, weight loss, and medications (primarily statins).

High-density lipoprotein cholesterol (HDL-C) levels should be >40 mg/dl. Although these guidelines do not differentiate goals for men and women, it is known that a low HDL-C has a stronger association with CHD for women than for men. Raising HDL-C levels is much

Table 1.
Adult Treatment Panel III Guidelines for Lipid Goals 3

Risk Category	LDL-C Goal mg/dl	LDL-C Level for TLC mg/dl	LDL-C Level for Drug Treatment mg/dl
CHD or CHD equivalent	<100	≥100	≥130
2+ risk factors	<130	≥130	10 year risk 10-20% ≥130 10 year risk < 10% ≥160
0-1 risk factor	<160	≥160	≥190 (160-189; LDL lowering drug optional)

Adapted from NCEP Guidelines, ATP III

more difficult than lowering LDL-C and is generally achieved through medications and smoking cessation.

Diabetes is now considered a CHD equivalent, which means the risk of a coronary event is equal to the risk of someone without diabetes but with known CHD (NCEP Expert Panel, 2001). This is particularly concerning for women as the risk of CHD is much higher for a woman with diabetes than a man with the disease. This is also true for the insulin-resistant state that often precedes the development of type II diabetes by many years. The typical cholesterol profile of type II diabetes or insulin resistance is as follows:

- Elevated triglycerides
- Low HDL-C
- Normal or slightly elevated LDL-C, but the type of LDL-C is a small, dense, very atherogenic particle

Role of HRT

Completed studies, as well as the National Institutes of Health's recently reported Women's Health Initiative, have failed to demonstrate that hormone replacement therapy (HRT) has any benefit in preventing cardiovascular disease (Grady et al., 2002). This is true for primary and secondary prevention, despite improvement in the lipid profile. In fact, treatment with HRT has been shown to increase cardiovascular events. These studies treated women with a combination of estrogen and progesterone.

Studies are continuing in women without a uterus who are receiving only estrogen to determine if there is any cardiovascular benefit without the progesterone. Thus, HRT is not recommended for any cardiovascular benefit.

Treatment of Hyperlipidemia

Therapeutic Lifestyle Changes (TLC). Therapeutic lifestyle changes (TLC) are included in the treatment plan for primary and secondary prevention. Dietary recommendations include reducing cholesterol (<200 mg/day) and saturated fat (<7% of total calories) intake. Other dietary options included in ATP III are the use of plant stanol/sterol products (such as Benecol® margarine) and increasing viscous fiber to 10-25 grams/day (NCEP Expert Panel, 2001). Other components of TLC are weight loss and increased physical activity.

Medications. Many double-blind randomized controlled trials have demonstrated the benefits of statin therapy in preventing and treating cardiovascular disease. These benefits include a reduction in major coronary events, CHD mortality, the need for coronary procedures, stroke, and total mortality. Guidelines for beginning drug therapy recommend treatment when LDL-C is 30 mg/dl over goal after a trial of TLC. The decision to use medications for primary prevention is more difficult and the number and severity of risk factors will help determine those at highest risk warranting medications.

Statins. Statins are the primary drugs used to treat hyperlipidemia due to their effectiveness, favorable safety profile, and patient acceptability. The range of LDL-C reduction varies among agents, averaging 18%-55%. They have a modest effect on raising HDL-C in the range of 5%-15%. Triglycerides are lowered 7%-30% with statins (NCEP Expert Panel, 2001).

Contraindications to statins. The presence of active liver disease is a contraindication to treatment with statins. Contraindications particular to women are pregnancy and breast-feeding. Because statins interfere with cholesterol synthesis, there is a possibility of fetal harm or death. We have to consider these contraindications as many premenopausal women (the majority of those with type 2 diabetes) are candidates for drug therapy.

Therapeutic and adverse effects. Monitoring for therapeutic and adverse effects is an important nursing role. With most statins, maximal LDL-C lowering will be obtained after 6 weeks of treatment. It is necessary

to reassess the LDL-C at that time and determine if dosage adjustment is needed to reach LDL-C goal.

Incidence of side effects of statins is low, however they do exist and the nurse must be vigilant. Minor side effects include such gastrointestinal disturbances as dyspepsia, nausea, and flatulence. Major side effects include liver dysfunction and myopathies (mylagia, myositis, and rhabdomyolosis).

Liver function tests (LFTs) should be assessed prior to starting therapy, 6-12 weeks after treatment, and every 6-12 months thereafter. When increasing the dose of a statin, it is prudent to recheck the LFTs 6-12 weeks after the dosage change.

Mylagia and myositis both involve muscle pain or weakness, but creatine kinase (CK) levels are elevated in myositis. Rhabdomyolysis involves extensive skeletal muscle breakdown and exhibits extremely elevated CK levels, greater than 10 times the upper limit of normal (ULN) which can lead to acute renal failure and death. Excessive cases of fatal rhabdomyolysis was the reason behind the withdrawal of cerivastatin (Baycol®) in August 2001. This side effect has been reported with all statins, however the range of reported events of rhabdomyolysis for other statins has been 0.6-3.6 per 1 million prescriptions dispensed, as compared to cerivastatin that had 88.7 cases per 1 million prescriptions (FDA Database).

Concomitant use of certain medications with statins (niacin, cyclosporine, fibric acid derivatives, azole antifungals, and macrolide antibiotics) increases the risk of myositis and rhabdomyolysis. When patients express musculoskeletal complaints, practitioners should stop the statin and draw CK levels. There appears to be no benefit in routinely monitoring CK levels, as the patient always has symptoms with myositis or rhabdomyolysis (Pasternak et al., 2002). Some experts recommend a baseline CK level only to identify the rare patient who has elevated CK levels at baseline (Pasternak et al., 2002).

Assessing and interpreting the CHD profile. Cholesterol screening should begin at age 20. Current recommendations call for a complete fasting CHD profile. When interpreting the results, remember it needs to be a fasting sample.

Errors can occur when a patient forgets or is not informed of the need to fast. Mistakes can also occur in the hospital if blood is drawn at an inappropriate time. Another scenario that can lead to misinterpretation of the results is not obtaining the CHD profile within 24 hours of a coronary event. The problem this causes is that the results will be falsely low, leading the practitioner to underprescribe treatment. After an acute coronary event, the liver triggers an acute phase response that causes a decrease in the lipoproteins, especially LDL-C which can be reduced by up to 30% from the baseline value. These levels can remain falsely low for 4-6 weeks (Rosenson, 1993).

Benefits of initiating lipid-lowering therapy in the hospital. Recent revisions to the guidelines for non-ST elevated myocardial infarction (NSTEMI) have included recommendations to begin lipid lowering therapy in the hospital (Braunwald et al., 2002). There are many benefits to this approach. Treatment at the time of the event has been shown to improve long-term compliance, decrease risk of death and MI, and prevent patients from "falling through the cracks" in the transition from inpatient to outpatient care.

One trial that provided support to the guideline revisions was the MIRACL (Myocardial Ischemia Reduction with Aggressive Cholesterol Lowering) trial. Patients were randomized to either atorvastatin 80 mg plus diet therapy or diet therapy alone during the hospitalization, regardless of baseline LDL-C levels. This was only a 16-week trial looking for short-term benefit. Results were as follow:

- 16% reduction in time to ischemic event
- 25% reduction in worsening angina requiring hospitalization
- 50% reduction in fatal stroke

(Schwartz et al., 2001)

Case Studies

Below are several types of cases that illustrate what practitioners encounter in treating women for hyperlipidemia.

Case 1

A 42-year-old woman comes to your clinic for health screening. She has results of a recent CHD profile: total cholesterol 208 mg/dl, LDL-C 140 mg/dl, HDL-C 22 mg/dl, triglycerides 308 mg/dl. A close friend of the same age recently had an MI and the woman is concerned about her own risk. She thinks she is starting menopause and would like to start HRT. She is overweight, hypertensive, and has a sedentary lifestyle.

What further areas do you need to assess? What interventions are needed?

Discussion

- This patient has two known risk factors for CHD: hypertension and low HDL-C. You need to assess for other risk factors. Ask about smoking history and family history of premature heart disease. She needs immediate evaluation for insulin resistance or type II diabetes. This lipid profile is typical of the insulin-resistant state. If she does not have diabetes, her LDL-C goal would be <130 mg/dl, and <100 mg/dl if she has diabetes.
- Hypertension is another component of the metabolic syndrome. This needs aggressive control with antihypertensive medications. If diabetes is present, an ACE inhibitor would be the preferred agent.
- An elevated body mass index (BMI) is associated with CHD, however the waist circumference is a better indicator because abdominal fat is more metabolically active, contributing to an elevated triglyceride level and a low HDL-C level. The woman's waist circumference should be measured.

A waist measurement over 35 inches for women is associated with the metabolic syndrome. The woman needs dietary counseling for a low cholesterol and low saturated fat diet. Also, she needs instruction about weight loss and possibly a diet recommended for patients with diabetes.

- A sedentary lifestyle is a risk factor for CHD and type II diabetes. The woman would derive multiple benefits from increasing her activity level including BP control, improvement in lipid levels, weight loss, and decreased risk of type II diabetes. Patients often feel that they have no time to exercise, so the challenge is to help them integrate exercise into their daily routine. Some suggestions may include a walk during lunch time, parking farther away from buildings, and taking the stairs instead of elevators.
- The patient asks about the use of HRT. First, assess her symptoms of menopause. Explain that HRT does not offer protection against cardiovascular disease and actually may increase risk. Indications for starting HRT include severe vasomotor symptoms and prevention of osteoporosis.

Case 2

A 40-year old woman with type II diabetes comes to see you for recommendations as she wishes to get pregnant. She is on a statin for hyperlipidemia.

Discussion

- Statins are contraindicated during pregnancy, so she should stop the statin while trying to get pregnant. In addition, she cannot take the drug if she breast-feeds. Options in this situation include using only dietary management or a non-systemic agent like Welchol® (pregnancy rating B), which is a bile acid sequestrant.

Case 3

A 72-year-old woman comes to the clinic with symptoms of stable angina. She has a history of hypertension and type II diabetes. Her LDL-C is 145 mg/dl. Current medications are metoprolol and aspirin.

Discussion

- Stable angina symptoms should be evaluated with a stress test.
- Hyperlipidemia should have been addressed in this elderly woman with diabetes. LDL-C goal is <100 mg/dl. Starting a statin would be appropriate. Check baseline LFTs. The elderly, and especially elderly women, are often not prescribed lipid-lowering therapy despite the fact that they benefit as much as men do from the treatment. One significant effect of statin therapy is stroke reduction, which is extremely important in this patient who is at high risk for a stroke.
- Diabetes and hypertension – This high-risk patient should be on an ACE inhibitor, unless contraindicated, which will contribute to a decreased risk of CHD and stroke.

Conclusion

Women are less likely to survive their first coronary event. Furthermore they have a worse prognosis than men after a myocardial infarction or revascularization procedure. These facts highlight the need for equal and aggressive treatment of hyperlipidemia.

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Valerie Spotts, BSN, RN
Educational Nurse Coordinator
University of Michigan
Ann Arbor, MI
(734) 936-4724 • vspotts@umich.edu

Please see page 16

NIH Web Resources for Women's Cardiovascular Health

The following National Institutes of Health Web sites contain information on cardiovascular health topics and education programs for women.

http://www.nhlbi.nih.gov/whi/index.html

Description: The Home Page of the National Institutes of Health (NIH), National Heart, Lung, and Blood Institute (NHLBI), Women's Health Initiative (WHI).

WHI started 15 years ago and is one of the largest preventive studies of its kind in the United States. The study will focus on the major causes of death, disability, and frailty in postmenopausal women. The overall goal of WHI is to reduce coronary heart disease, breast and colorectal cancer, and osteoporotic-fractures among postmenopausal women via prevention/intervention strategies and risk factor identification.

http://hin.nhlbi.nih.gov/womencvd/cmpgn/

Description: Updates on the Development of the NHLBI Women's Heart Health Awareness Campaign.

This is a national public awareness and regional/local outreach campaign. The primary objective is to convey the message that heart disease is the #1 killer of American women, and that it can be successfully prevented and treated. It also seeks to "put a face on heart health," motivating women to take heart health seriously and engage in personal action to reduce their risk of heart disease. A secondary objective is to motivate health professionals to provide their female patients with clear messages about heart disease prevention and a high standard of care for the treatment and control of heart disease and its risk factors.

http://www.nhlbi.nih.gov/health/women/index.htm

Description: NHLBI Postmenopausal Hormone Therapy page. Contains links to the latest information on postmenopausal hormone therapy:

This site also offers information on the Women's Health Initiative Estrogen Plus Progestin Study and new findings/guidance about hormone use.

The AAACN Grand Scan Plan

Nancy Kowal, MS, RN, C, ANP

The AAACN Board of Directors recently contacted a random sample of members for feedback about AAACN. The reason for the interviews, which were conducted by telephone, was to help the Board identify the issues members feel are most critical. These issues will then be incorporated by the Board into the Association's strategic plan.

Participants were asked the following five questions:

1. What are the three key issues you are dealing with in your ambulatory care work environment?
2. What are your expectations of AAACN as a professional organization? How can AAACN best meet your expectations?
3. What value are you getting for your AAACN membership/dues?
4. How can we make AAACN relevant to your concerns and interests?
5. How would you describe effective participation in a professional organization?

Recent issues of *Viewpoint* have addressed questions 1-4. Below, the responses for question #5 are described.

Question #5

How would you describe effective participation in a professional organization?

The responses to this question are categorized into six areas:

- Proactive membership with national and international linkage
- Participatory leadership roles
- Knowledge expansion role
- Authorship
- Proactive legislative participation to support, define, and elevate the practice of ambulatory care nursing
- Professional input on the broader "real world" knowledge to the organization

Results

Members recognize the diversity of professional opportunities as a primary benefit of AAACN membership. The "volunteerism" reward is valued and professionally satisfying. Some of the areas in which our volunteer leaders participate are:

- Member of the *Nursing Economic$* Editorial Board
- Member of the JCAHO board
- Ambulatory experts in the corporate setting
- Valued representation at multiple national professional conferences
- Partners with the AAACN SIGs on specialty projects
- Diverse ambulatory care clinical experts
- Legislative representatives nationally and statewide on ambulatory nursing practice, research and provider status
- End-of-life care and pain management expertise
- National educators, researchers, and clinicians in the field of ambulatory care

Networking and the leadership pre-conference were valued as great initial exposures to AAACN. Special interest groups further heightened the value within the organization.

We Value Your Feedback

The Board would like to know what you think. Please feel free to contact any Board member and tell us if these responses reflect your own opinions (see back cover for contact information). This is an ongoing environmental scan and we are hoping to hear from every AAACN member. Your feedback is a valued part of our strategic planning.

Nancy Kowal MS, RN, C, ANP
Director, AAACN Board
kowaln@ummhc.org

AAACN Board Report

A visionary business plan, and an upgraded Web site get exciting finishing touches.

The AAACN Board of Directors at the University of Michigan campus in Ann Arbor. Shown (from left) are Cynthia Nowicki, executive director; Regina Phillips, director; Cheryl McGee, executive secretary; Deborah Brigadier, director; E. Mary Johnson, immediate past president; Candia Baker Laughlin, president; Beth Ann Swan, director; Catherine Futch, president -elect; Nancy Kowal, director; and Kathy Krone, treasurer.

The AAACN Board of Directors held its annual fall Board meeting in Ann Arbor, MI, home of the University of Michigan Wolverines!

During the meeting, which was held September 27-29, Board members toured numerous departments of the University of Michigan Health System. They were also showered with souvenirs and delicious food by their Ann Arbor hosts Candia Baker Laughlin, AAACN president, and Kathleen Krone, treasurer.

As always, the board meeting was a mix of hard work and a few good laughs and was thoroughly enjoyed by Board members and Anthony J. Jannetti, Inc., staff.

Accomplishments

The Strategic and Business Plan for 2002-2004 was finalized to emphasize the ambulatory care nursing "Mega Issues" that were defined at the summer 2002 meeting in Philadelphia.

The Board also reviewed and approved the layout for AAACN's new Web site. Some of the site upgrades include:

- A complete redesign: easy to navigate, many new features
- The latest e-commerce tools (a "Shopping Cart" to order AAACN products and publications)
- A function that allows members to create their own username and password to access the site
- An on-line and searchable membership directory
- "Members Only" discussion areas and a "Chat Room"
- Improved, easy-to-use membership application and conference registration
- A "Press Room" for news releases and media use

The new site is expected to be launched in early 2003. The address will remain **www.aaacn.org**.

The theme for the 2004 AAACN Annual Conference in Phoenix, AZ, "***Forging New Partnerships and Challenging Change"*** was enthusiastically approved by the Board. The 2004 conference is scheduled for March 18-21, 2004 at the Hyatt Regency.

The Board also discussed a successful collaboration with Contemporary Forums (CF) this fall. AAACN's **Telehealth Nursing Practice Core Course (TNPCC)** was offered as a pre- conference at CF's fall 2002 telehealth conferences in New Orleans and Las Vegas. The course will also be presented during the AAACN National Conference in Tampa, FL, April 10-13, 2003 and is available on-line and on CD-ROM (go to **www.aaacn.org** to order; also see the ad on page 7).

Cheryl McGee
AAACN Executive Secretary
mcgeec@ajj.com

Today is the Day to Recognize an Outstanding Colleague

There are many RNs working today in ambulatory care settings who are leaders and role models. AAACN wants to recognize these dedicated individuals, and we need your help.

Please take a moment to read the Excellence Award form on page 11 and nominate a colleague today!!!

President's Message

continued from page 2

- The Board has reviewed and endorsed the Practice Evaluation and Research Committee's proposal for the study of staffing models in ambulatory care settings. "How do you determine staffing?" seems to be the question that we most frequently ask each other and that others ask us. We will be sure to present updates on this topic in future issues of *Viewpoint*.

Goal 3: Stimulate Innovative Thinking

- We continue to work on directions and priorities for AAACN and translate these into a strategic business plan. The "Mega Issues" published in the September/October 2002 issue of *Viewpoint* and e-mailed to about 100 emerging leaders in AAACN have stimulated some excellent discussion and feedback. The Board revisited these issues as we continued our strategic discussions, prioritizing and planning at our board meeting September 27-29 (see page 9). We have identified the AAACN business priorities for the next 6-12 months and are in the process of assigning people who will be responsible for each of the strategies. We will publish the written plan on the AAACN Web site as soon as it is finalized.

Goal 4: Strengthen AAACN Resource Base

- An independent audit of AAACN's financial records was conducted for the year ending June 30, 2002. The good news is that all income and expenses are being accurately reflected in our accounting methods. The unfortunate news is that the loss on operations for the past year is real. The budget adjustments that the Board has undertaken are necessary, and hopefully sufficient. Please see the treasurer's report on page 13 for more information.
- ***Nursing Spectrum*** and **Purdue Pharma L.P.** have joined AAACN as corporate members. We welcome and thank them on page 24.
- The Membership Council is updating the AAACN membership brochure and the application for membership to better capture the rich and changing variety of roles and practice settings of our members.

Goal 5: Develop AAACN Leadership Ability and Capacity

- The **Telehealth Nursing Practice Core Course (TNPCC)** was presented as a pre-conference for the two Contemporary Forums conferences this fall. The course, which was very well received, was presented by Maureen Espensen, Penny Meeker, Aurelia Marek, and Denine Gronseth. We thank them and look forward to their offering the course as a post-conference April 14, 2003 at the 28th Annual AAACN Conference in Tampa, FL.
- At the invitation of the Academy of Medical-Surgical Nurses (AMSN), AAACN Board Member Deborah Brigadier represented the Association at the opening ceremonies of AMSN's Annual Convention in Washington, DC, October 17-20, 2002. We are in discussion with AMSN about partnering on some mutual interests.

Reflection

"Joy, temperance, and repose,
slam the door on the doctor's nose."
Henry Wadsworth Longfellow

Good health!

Candia Baker Laughlin, MS, RN, C
AAACN President
candial@umich.edu

Reference

Covey, S. (1989). *Seven habits of highly effective people*. New York: Fireside.

Real Nurses, Real Issues, Real Solutions

Every day, across the country, nurses make a difference in care delivery, leadership, administration, academia, and research in ambulatory care. These nurses are your colleagues, mentors, and managers.

You have an opportunity to nominate a special colleague for a AAACN Excellence Award to recognize how this individual has made a difference. Simply fill out the form below and help AAACN celebrate ambulatory care nurses' many accomplishments!

Excellence in Administrative Ambulatory Nursing
Excellence in Clinical Ambulatory Nursing Practice

CRITERIA – The candidate must be:

1. A registered nurse currently providing administrative leadership or clinical nursing practice in an ambulatory setting.
2. Recognized as a positive role model in ambulatory nursing as characterized but not limited to:
   A. Mentoring peers and colleagues and willingness to share expertise.
   B. Promoting interdisciplinary collegial working relationships.
   C. Demonstrating effective management of rapidly changing situations, and/or clinical nursing practice.
   D. Demonstrating improvement of patient care outcomes with effective implementation into practice.
   E. Being recognized as a nursing expert by nursing colleagues.

ELIGIBILITY – The candidate must:

1. Be a member of AAACN in good standing.
2. Not be a current member of the Nominating Committee or the Board of Directors.
3. Have at least 3 years experience in ambulatory nursing and currently practice in an ambulatory setting.

AWARDS – Each recipient will be awarded $500 which will be presented at the annual conference. The awards are sponsored by the Anthony J. Jannetti, Inc. Nursing Economic$ Foundation.

Nominating Procedure

1. The candidate may be nominated by a colleague or supervisor.
2. Self-applications are encouraged.
3. Nomination submission must include:
   A. Two letters of recommendation from nursing colleagues addressing the identified criteria (preferably one AAACN colleague).
   B. Candidate's resume/curriculum vitae, if available. If not, describe the candidate's experience.
   C. Completed nomination form (see below).
4. Nominations must be received in the National Office by **February 1, 2003.**
5. Nominations will be reviewed. An objective point system will be used in the selection process. Selection will be submitted to the Board of Directors for approval. Applicants will be notified prior to the annual conference.

NOMINATION FORM

1. Name of nominee _____
2. Nominee is an active member of AAACN. ☐ Yes ☐ No
3. Nominee is not currently serving on the Nominating Committee or Board of Directors. ☐ Yes ☐ No
4. Nominee has the experience required as specified under eligibility requirements.
5. Please attach: Nominee's curriculum vitae or brief description of nursing experience and two letters of recommendation. These letters must document how the candidate meets the nominating criteria.
6. Return this form and requested materials to:

AAACN
East Holly Avenue Box 56
Pitman, NJ 08071-0056
(800) AMB-NURS; Fax (856) 589-7463
E-mail: aaacn@ajj.com

SIG News

Telehealth Nursing Practice Special Interest Group: Informatics Workgroup Update

Interest in nursing informatics within AAACN has waxed and waned over the past several years. At one time, there was enough interest to support the development of the Informatics Special Interest Group (SIG). Several individuals devoted significant time and interest in getting this fledgling group started. Despite their best efforts and dedication, there were not enough individuals interested in nursing informatics to keep it going as a separate SIG. As a result, 2 years ago the group was formerly transitioned from a SIG to a workgroup within the Telehealth Nursing Practice (TNP) SIG, as it was believed that among all the SIGs, this would be the specialty with the most interest in informatics.

Within the TNP SIG, there have been various efforts to gauge the level of interest and the direction AAACN members would like to see the Informatics Workgroup go. A survey was distributed at the 2002 AAACN Annual Conference this spring, with 60 completed surveys returned. These surveys represented individuals from a variety of practice settings and clinical foci.

Survey results revealed that the majority of respondents:

- Had a clear understanding of the definition of informatics
- Were interested in learning more about nursing informatics
- Were neutral on the lack of consistency in terminology regarding nursing informatics and the effect this had on their ability to apply informatics to their daily practice
- Felt that use of informatics would improve practice efficiencies, allow for performance measures, and enhance standardization of practice

From the group surveyed, 20 nurses indicated that they would be interested in being part of the Informatics Workgroup. A secondary survey was then e-mailed to this group of individuals in June. This survey asked if they were still interested in participating in the workgroup and if so, at what level. Ten responded. however, only five (25%) people wanted to take an active role, and no one indicated that they would be willing to provide leadership for the group.

As to what focus the group should pursue, the responses included:

- Focus on nursing informatics supporting TNP
- Develop interventions and outcomes to measure practice in ambulatory care
- Support staff education and development
- Encourage nurses to use the computer/Internet to support practice and research

A common theme or interest in informatics did not develop, but rather the concept that informatics is pervasive in all aspects of nursing.

The TNP SIG leadership had several discussions regarding the survey responses. After weighing the commitments and interests of current AAACN members, TNP SIG leaders determined that AAACN and the SIGs would be better served if we help nurses understand that informatics is in every element of their workplace, and not an isolated activity. In support of this concept, it was proposed to the AAACN Board of Directors that the Informatics Workgroup be disbanded and that the three remaining TNP workgroups and other SIGs begin highlighting how informatics affects their particular focus.

Each of the respondents to the second survey specified particular areas on which they would like to focus their informatics expertise. We would like to encourage them and anyone else who might be interested in promoting informatics in nursing to join the most appropriate workgroup or SIG in their primary area of interest.

Thank you to all who took time to respond to the surveys, as you provided a great deal of insight on how we can most effectively use AAACN's resources.

Penny S. Meeker, BS, RN, C
Co-chair, TNP SIG
(217) 383-4276 (w)
penny.meeker@carle.com

AAACN 2002 Financial Profile

An independent auditor's report conducted by Gold, Meltzer, Plasky, & Wise was presented to the AAACN Board of Directors in August 2002. This report concluded that the financial statements "present fairly, in all material respects, the assets, liabilities and fund balance of the American Academy of Ambulatory Care Nursing as of June 30, 2002 and 2001 and the results of its revenues, expenses and its cash flows for the years then ended."

As of June 30, 2002 AAACN's expenses exceeded revenues by $39,270, leaving a fund balance of $280,071. Of this, $24,350 can be accounted for by a loss of sale of investments and the decrease in interest and dividends from investments, which is consistent with the market as a whole over the past year.

In spite of this, AAACN's 7-year average rate of return on investments is still quite positive at 6.8%.

As per last year's financial report, the Board of Directors did not see much opportunity to reduce expenses further and focused instead on increasing revenues. However revenues did not meet projections, as is consistent with current national trends for volunteer organizations. Other than the $10,850 loss of interest and dividend income, most of the remaining deficit was related to insufficient income from membership dues and our products/programs.

Since membership dues and conference fees are AAACN's primary source of income, two actions will be taken. Membership dues have remained constant for 10 years and the Board reluctantly decided that it was time for a modest increase. Dues will be raised by $10, effective July 2003. Conference registration fees were also last increased in 1999. The FY 2003 budget includes a $25 (9%) increase in conference registration fees. In addition, significant effort is being made to realize income from our state-of-the-art Telehealth Nursing Practice Core Course (TNPCC). AAACN telehealth nursing practice experts will present three pre- and post-conferences over the next year.

The Board also developed a more conservative income budget for 2003, with increases only projected in the areas of Grants'/Contributions/Scholarships and *Viewpoint* advertising. The increase in Grants/Contributions/Scholarships has already been achieved through donations by the president and president-elect of their honoraria. *Viewpoint* continues to be attractive to both members and advertisers, and significant effort is being made to solicit more ads.

Expenses were well controlled in FY 2002, coming in $28,685 under budget. Since it was learned that there were further opportunities to reduce expenses, the Board scrutinized the budget very closely. We decided to decrease expenses for Board of Director meetings and the membership directory. The membership directory will be available on the AAACN Web site and paper copies will be printed for leadership volunteers. As per the association's usual practice, increases in expenses focused on providing better member service. This year's budget includes a $4,000 (33%) increase in Internet services, primarily to develop and maintain an e-commerce site.

Industry standards maintain that an organization should have at least 50% of their operating budget as a fund balance, and AAACN's balance exceeds this standard. However, the Board of Directors decided that, in the interest of fulfilling their fiduciary responsibility, it was time to take some prudent action. The FY 2003 budget reflects the changes necessary to maintain a viable organization in an unstable financial environment.

Kathleen P. Krone, MS, RN
AAACN Treasurer
kkrone@umich.edu

Statements of Assets, Liabilities and Fund Balances
Modified Cash Basis

June 30,	2002
Assets	
Current assets	
Cash	$ 98,024
Accounts receivable	2,032
Accrued interest receivable	1,018
Prepaid expenses	1,485
Total current assets	102,559
Other assets	
Investments	323,201
	$ 425,760
Liabilities and fund balance	
Liabilities	
Accounts payable	$ 38,728
Deferred revenues	106,961
Total liabilities	145,689
Fund balance	280,071
	$ 425,760

Statements of Revenues and Expenses
Modified Cash Basis

June 30,	2002
Revenues	
Membership dues	$ 168,810
Annual conference registration	199,382
Annual conference exhibit and grant income	32,000
Certification review course	15,514
Standards publication sales	7,952
Telephone standards	6,682
Telephone nursing practice resource directory	335
Interest and dividend income	10,152
Grants/contributions	3,002
VP advertising and subscriptions	6,293
Miscellaneous income	3,361
Certification products	7,164
Royalties	6,472
Gain on sale of investments	-
ANA/AAACN monograph	358
TNPC course	22,618
Total revenues	490,095
Expenses	
Administration expenses	181,568
Membership expenses	127,851
Committee expenses	5,681
Educational programming	198,725
Educational materials	2,026
Loss on sale of investments	13, 514
Total expenses	529,365
(Expenses) in excess of revenues	(39,270)
Fund balance, July 1	319,341
Fund balance, June 30	280,071

Editor Becky Pyle Goes on a Quest for...

The Best Way to Celebrate Nurses Day

Becky Pyle

I recently sent an e-mail to a group on my distribution list I call "The Usual Suspects." Some of you reading this may be on that list. I often use it when I am looking for authors to write for *Viewpoint* or *Nursing Economic$*.

The list is made up of nurses from all over the United States whom I have met through the years in my work with AAACN. It is a very handy way to communicate with nurses from different organizations and in different settings.

This time, however, I wasn't looking for authors. I needed some help as I took on a new position in the organization where I have worked for the past 17 years. I was now responsible for developing and implementing nursing guidelines for the Colorado Region of Kaiser Permanente. I would also have a role to play in nurse recognition.

My questions to the Suspects were "What do you do in your organization for Nurses Day?" (As I am sure most of you already know, Nurses Day is celebrated each year on May 12th to mark Florence Nightingale's birthday.) I also asked "What nursing guidelines do you have and how are they used?" One of the Suspects sent me a response and in an interesting role reversal, suggested that I write an article for *Viewpoint* to let other AAACN members know what I found out.

While my study was not scientific, I'll share with you here some of what I learned. Below are the responses to my Nurses Day question and I will follow-up with the feedback to my guidelines question in the January/February issue of *Viewpoint*.

How Does Your Organization Celebrate Nurses Day?

Responses varied and featured the following:

- "Nurses Day is celebrated in a haphazard sort of way at our clinic."
- "It's quite a week here."
- "At Kaiser Permanente in Southern California, the celebration is handled differently at each medical center, and there is quite a bit of sensitivity around who gets recognized. It is this sensitivity that has caused most recognition to be very low key in the outpatient setting."
- "It used to be just the RNs, which made LPNs and MAs upset. Now everyone gets recognized on Nurses Day and the RNs are unhappy."

Regarding the sensitivity response, there was a similar reaction from my contact at Kaiser Permanente in San Diego.

"There has been a reaction to doing anything for nurses that would cause others to feel as if they were singled out as a preferred profession," she said.

Another contact told me one organization she had worked for pulled out of the Nurses Day commemoration altogether. She said this facility now celebrates National Healthcare Week during the same week as Nurses Day and recognizes all employees. I also got several responses from managers who said they give their RNs a token of appreciation.

It is important to note that one of the barriers identified by organizations with multiple sites was nurses' ability to get away and participate in a celebration.

My contact at Everett Clinic in Washington said her facility allocates money each year for Nurses Day. Some of the money is used to buy presents and provide a brunch or lunch in the offices for RNs. The same thing is done at this clinic for MAs during their recognition week in October.

Some of the replies outlined a very full week of activities surrounding the actual May 12 Nurses Day. In one example, nurses describe notable aspects of their jobs at a research conference. The event included a vendor fair with raffled prizes such as plane tickets, product baskets, etc.; an address by the Director of Nursing or other guest speakers; award presentations; gifts (duffle bags with the company logo, fanny packs, backpacks, calculators, etc.), and festive outdoor events with food and music.

Different sources of funding are used in the organizations and include contributions from the medical staff and management team ("The managers pay for it themselves as we have no budget," one person said), as well as donations from drug company representatives.

At one organization, there is a slide show of nursing personnel. The show, which was very well received, featured nurses from different departments and was set to music.

The Navy Nurses at Naval Hospital Camp Lejeune have an official "Nurse Appreciation Day," which falls in the same week in May as the birthday of the Navy Nurse Corps. The event includes an awards ceremony, certificates of appreciation, and flowers for the winners.

Linda Brixey at the Kelsey-Seybold Clinic in Texas said "We have limited funds in the budget for this celebration so creativity is a must. Committees of nursing supervisors meet to plan the event. Each one develops a game (Jeopardy, drop the pea in the urinal), some very silly but fun. Prizes were purchased and it was set up like a carnival. Staff could choose to participate in all or some of the events or just have snacks or visit the ice cream Sunday bar. It was well received by the staff and was fairly inexpensive."

continued on page 23

Ambulatory Care Nursing Resources

Telehealth Nursing Practice Core Course (TNPCC) Manual (2001)

The TNPCC focuses on the essential competencies associated with delivering nursing care to patients via telecommunications technologies. This 260-page manual was developed by telehealth experts. Use this manual to understand practice issues related to telehealth nursing; orient new nurses to the role of telehealth practice; brush up on the skills needed to practice telehealth successfully and to study for the NCC's Telephone Nursing Practice Certification Exam.

2000 Edition Ambulatory Care Nursing Administration and Practice Standards

This 20-page, fifth edition of the ambulatory care nursing standards includes sections on Structure and Organization, Staffing, Competency, Ambulatory Nursing Practice, Continuity of Care, Ethics and Patient Rights, Environment, Research, and Quality Management.

Ambulatory Care Nursing Certification Review Course Syllabus

Straight from the live Ambulatory Care Nursing Certification Review Course to you is this comprehensive course syllabus.

Highlights:

- **CONTENT** is based on the Test Content Outline for ANCC's Ambulatory Care Nursing Certification Exam
- **CONTENT** outlines can be used to design your individualized study plan for the exam

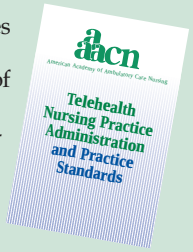
Ambulatory Care Nursing Self-Assessment

This valuable resource provides over 200 multiple choice test items covering various components of ambulatory care practice. You will be able to test your knowledge of your specialty and practice answering multiple choice questions written in the same format as the certification exam.

This Self-Assessment will provide you with an excellent assessment and validation tool.

The multiple choice items are grouped into 5 topic areas which are Clinical Practice, Systems, Communication, Patient/Client Education, and Issues and Trends.

Telehealth Nursing Practice Administration and Practice Standards (2001)



This document identifies the practice standards that define the responsibilities of both clinical practitioners and administrators responsible for providing telephone care across a multitude of practice settings.

Examination Preparation Guide for Ambulatory Care Nursing Certification

A 48-page guide designed to help you learn specifics about the exam, develop your own study plan, and review test taking strategies.

Telehealth Nursing Practice Resource Directory (2002)

This 35-page manual contains a detailed listing of resources helpful for any telehealth practice including references, web sites, conferences, consultants and much more.

Publication Order Form

PN

Name _____ Job Title _____

Employer _____

Mailing Address _____ City _____ State _____ Zip _____

Daytime Phone _____ E-mail address _____

Publications	Member	Nonmember	Quantity	Total
❑ Telehealth Nursing Practice Core Course Manual	$69	$79	_____	_____
❑ Ambulatory Care Nursing Administration and Practice Standards	$15	$25	_____	_____
❑ Telehealth Nursing Practice Administration and Practice Standards	$12	$17	_____	_____
❑ Ambulatory Care Nursing Certification Review Course Syllabus	$35	$40	_____	_____
❑ Ambulatory Care Nursing Self-Assessment	$25	$30	_____	_____
❑ Examination Preparation Guide for Ambulatory Care Nursing Certification Exam	$15	$20	_____	_____
❑ Telehealth Nursing Practice Resource Directory	$5	$7	_____	_____
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Exp. Date _____ Total $ _____

Signature _____

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Order online at: *www.aaacn.org*

☐ Check here if you would like information on AAACN membership

AAACN 28th Annual Conference

Networking in Ambulatory Care: Advancing Innovative and Professional Practice

April 10-13, 2003 · Tampa, Florida

Connie Curran to Deliver Keynote Address

Connie Curran, EdD, RN, FAAN, keynote speaker for the AAACN 28th Annual Conference in Tampa, FL, will address the "Three Things that Keep Patient Care Leaders Awake Nights." Dr. Curran will speak on the opening day of the conference, which is scheduled for April 10-13, 2003.

Dr. Curran is a nationally-known speaker and nurse consultant. She is also the editor of *Nursing Economic$, The Journal for Health Care Leaders.*

Although there are many issues confronting health care leaders today, three key areas of concern for most organizations are: the bottom line, winning the talent war, and regaining public trust.

In addition to the data underlying each of these issues, Dr. Curran will focus on the specific implications for ambulatory care nursing professionals. She will also discuss the application of the Balanced Scorecard as a way of tracking results.

As a consultant, Dr. Curran has worked with nurses in a wide range of practice areas. She understands the issues confronting nurses from her own experience as a frontline health care provider and from an administrative point of view. Dr. Curran blends her knowledge and expertise with a dynamic and thought-provoking style. This keynote session will be an excellent beginning to a comprehensive, innovate conference.

Dr. Curran's keynote speech will be supported by an education grant from Purdue Pharma L.P.

Sally Russell, MN, RN, BC
AAACN Education Director
russells@ajj.com

We've Got You Covered

Mentor Program Nurtures New Members, First-Time Attendees

Are you a new AAACN member? Are you planning to attend your first AAACN conference at the upcoming 2003 meeting in Tampa, FL?

If you fit either of these descriptions, the AAACN Membership Council would like to help you get the most out of the conference and the association's networking opportunities.

First-time conference attendees will have the opportunity to be matched up with a current AAACN member from the same region or state. This individual will serve as your "Conference Mentor." The mentor will assist you with conference activities, serve as your own personal resource for the meeting and the association, and assist you in networking.

The Membership Council encourages you to use this new program because we care about our members and conference participants. We also want you to be able to tap into all the benefits available to you as part of a wonderful conference experience.

To request a Conference Mentor please send your name, telephone number, state of residence, and e-mail address to Susan Paschke at **paschks@ccf.org**; or Christine M. Ruygrok at **christine.m.ruygrok@kp.org**. You will also be able to sign up for a Conference Mentor at the registration table in Tampa.

We look forward to hearing from you.

Christine M. Ruygrok, RN, MBA
Co-chair, Membership Council
christine.m.ruygrok@kp.org

Women's Cardiovascular Health

continued from page 1

to double, further expanding these conditions as public heath problems.

One of AHA's stated goals is to help affect a 25% reduction in CHD, stroke, and coronary artery risk by 2010. This call to action has led to an effort to better educate women about CVD since they are often underrepresented in research trials and do not think of themselves as being at high risk for cardiovascular morbidity and mortality, even though their risks are higher than those faced by men.

In addition, women are often the gatekeepers of medical care and lifestyle modifications for their families, so it is important that they understand their risks and the synergistic benefits of recommended therapies.

One example of an education initiative facilitated by nurses was a recent Invitational Conference on Cardiovascular Health for Women. The conference was convened on December 7-9, 2001 in Scottsdale, AZ. The goal of the meeting was to increase nurses' knowledge about cardiovascular issues and provide guidance and resources to develop professional education and community outreach programs.

> One study found that women with suspected coronary artery disease received fewer additional diagnostic tests (38% in women versus 62% in men) even though their initial diagnostic test results were similar to those of the males studied.

Recent findings from research studies have challenged previous observational data. The studies have made it clear that many women would benefit from enhanced communication about cardiovascular health during a routine ambulatory care visit with their health care provider.

This article provides a brief overview of the clinical spectrum of cardiovascular health in women, with an emphasis on CAD (coronary artery disease) and HF. A detailed reference list has been provided at the end for readers seeking more information on specific topics. When nurses understand the scope of the problem and can communicate heart-healthy messages with confidence, patient communication and care planning is facilitated and there is hope that the national call to action might achieve results.

Incidence

The prevalence of CVD in Americans is high (62 million) and women account for more than half of the cases (AHA, 2001). Hypertension is the leading cardiovascular condition, afflicting 50 million Americans, CAD ranks second (12.6 million), and HF ranks third with nearly 5 million cases.

Cardiovascular disease claims the most lives each year (nearly 1 million or 1 in 2.5 deaths) and is the leading cause of death in women, accounting for 53.5% of all deaths.

In comparison, death from cancer (all types) was approximately half that of CVD (549,000). Breast cancer accounted for 1 death in 30 women in 1999, while CVD claimed 1 death in 2.4 women. To bring even more perspective to the mortality risk of CVD, the third most frequently cited cause of death in adults was in 1999 was accidents, which claimed less than 100,000 lives or one-tenth that of CVD (AHA, 2001).

Coronary Heart Disease

Coronary heart disease includes myocardial infarction, angina pectoris, and CAD. In women, the incidence of CHD increases two to three-fold after menopause. It is the single largest killer and its risk factors (hypertension, high total cholesterol, low high-density lipoprotein (HDL) cholesterol, diabetes, obesity, and cigarettes) are well documented (AHA, 2001).

At any age, men are more likely than women to have a myocardial infarction. However, the age-adjusted prevalence of angina pectoris is higher in women than in men, leading to a higher rate of hospitalizations for angina in women (47,000 for women versus 35,000 for men per year, respectively) (AHA, 2001).

Prevention through risk reduction. Recently, AHA published a consensus panel statement on preventive cardiology for women (Mosca, et al., 1999) and the Association of Women's Health, Obstetric and Neonatal Nurses (2001) published a primary practice guideline. In both, emphasis was placed on three areas:

1. Lifestyle factors (smoking, physical activity, nutrition, weight management, and stress reduction)
2. Risk factors (blood pressure, lipids/lipoproteins, and diabetes)
3. Pharmacologic interventions (hormone replacement therapy, oral contraceptives, antiplatelet/anticoagulant agents, beta-blockers, and angiotensin converting enzyme (ACE) inhibitors).

The guidelines for risk reduction provide recommendations on each topic in the three areas cited above. Much of the information is still current today (see Table 1), however recent research has provided some new thoughts about how we can enhance primary and secondary prevention that will be discussed in more detail below.

Hormone replacement therapy (HRT). For years, it was thought that HRT (either estrogen alone or a combination estrogen/progestin replacement) might reduce the risk for developing CVD in postmenopausal women.

In an earlier report by the Heart and Estrogen/progestin Replacement Study (HERS) investigators, Hulley et al. (1998) found a pattern of early increase (first year) and later decrease (years 3-5) in CHD events in the HRT

Table 1.
Guidelines for Risk Reduction

Lifestyle Factors			
Factor	**Goals**	**Nurse Screening**	**Recommendations**
Cigarette smoking	Cessation; avoid passive smoke	Assess status, smoking level, total exposure (pack-years); evaluate readiness to quit	At each visit, encourage smoking cessation; reinforce nonsmoking status; provide counseling and nicotine replacement or other measures (behavior therapy) to facilitate goals.
Activity	30 or more minutes of moderate-intensity activity 5-7 days/week	Assess level of activity (including household work, occupational and leisure time activities; if sedentary or if symptoms suggest CVD, consider "stress" test to determine an exercise prescription	Encourage 30 minutes of dynamic exercise/day (brisk walking); can be achieved in smaller segments throughout the day. Encourage exercise by changing routines using stairs or walking briskly from car to office, etc. If already physically active, reinforce and encourage more vigorous activities, muscle strengthening and stretching exercises as part of routine.
Nutrition	Heart-healthy diet; optimal total caloric intake/day = current weight x 15 if moderately active or current weight x 13 if inactive	Assess habits and consider a formal assessment if history of HTN, obesity, hyperlipidemia, or DM	Limit sodium to 2,000 mg/day (the equivalent of 1 teaspoon of table salt); choose fats with ≤ 2 grams saturated fat/serving; consume ≥ 5 servings of vegetables and fruits/day and ≥ 6 servings of grains/day; limit alcohol to 1 drink/day; limit foods with trans-fat, saturated fat, and cholesterol; choose low-fat dairy products.
Weight management	Achieve/maintain desirable weight; target BMI between 18.5-24.9 kg/m2 and waist circumference < 35 inches	Measure weight and height, calculate BMI; measure waist circumference periodically	Encourage gradual weight reduction (5-10% of initial weight); formal nutritional counseling; during pregnancy, recommend weight gain of 25-35 lb if pre-pregnancy weight is normal; adjust for multiple gestation and pre-pregnancy if overweight (i.e., gain 15-25 lb, obese gain < 15 lb).
Psychosocial/ psychological	Positive adaptation to stress; improved quality of life; maintained social connections	Assess for anger, depression, social isolation/support, stress, and quality of life	Encourage positive coping mechanisms for stress; encourage adequate rest and relief for caretakers; treat depression or anxiety as needed; encourage participation in social activities (volunteer work, church, city hall, hospital, or health services).
Risk Factors			
BP	< 140/90; optimal < 120/80	Measure and follow-up as needed: If < 130/85, recheck in 2 yrs; if 130-139/85-89, recheck in 1 yr; if 140-159/90-99, confirm in 2 mo, if 160-179/100-109, evaluate in 1 mo; if ≥ 180/110, recheck in 1 wk.	Use correct size cuff; patient should avoid caffeine and smoking for 30 minutes prior and be sitting for 5 minutes with back support before taking BP. Average 2 readings, taken 2 minutes apart if needed for accuracy or diagnosis. Promote lifestyle behaviors as discussed above.
Lipids, lipoproteins	Without CVD - Total cholesterol: 200; HDL: ≥ 45; LDL: < 160; triglycerides: < 150 mg/dL. With CVD - LDL < 100 mg/dL	Fasting lipoprotein analysis; follow-up is based on initial assessment and CVD risk factors	Promote lifestyle (as above); statin, resin, fibrate or niacin may be suggested based on individual lipoprotein levels.
DM	Maintain hemoglobin $A1_c$ level < 7%, LDL < 100 mg/dL, triglyceride level < 150 mg/dL, and control blood pressure	Assess for symptoms plus plasma glucose level ≥ 200 mg/dL or fasting level ≥ 126 mg/dL, or 2-hour plasma glucose level ≥ 200 mg/dL during a glucose tolerance test	Encourage American Diabetes Association diet (< 30% fat, < 10% saturated fat, 6-8% polyunsaturated fat, cholesterol < 300 mg/dL); encourage weight loss and physical activity if needed; pharmacotherapy with oral agents or insulin.

continued on next page

Table 1. (continued)
Guidelines for Risk Reduction

Pharmacological Interventions			
Factor	**Goals**	**Nurse Screening**	**Recommendations**
Antiplatelet agents	Prevention of thrombotic events when CVD is established	Determine if contraindications exist; evaluate ongoing adherence to drug therapy, side effects, risk during routine evaluation	If atherosclerotic CVD, use aspirin at low dose (75-80 mg/day). In this group, clopidogrel (75 mg/day) decreases the risk of future CVD events better than aspirin. After percutaneous intervention for ACS, clopidogrel (300 mg x 1 then 75 mg/day) or combination aspirin (low dose) and clopidogrel (75 mg/day) may provide better secondary prevention than aspirin alone in the first 8 months post-intervention.
Beta-blockers	To reduce re-infarction, promote reverse remodeling and decrease the risk of sudden cardiac death after MI or diagnosis of HF	Assess contraindications (reactive airway disease, symptomatic bradycardia or sick sinus syndrome without pacemaker); evaluate ongoing adherence to drug therapy, side effects, risk during routine evaluation	After acute MI diagnosis, begin therapy (within hours); continue indefinitely. Use cardioselective agent (atenolol, metoprolol) or 3rd generation agent (carvedilol). After diagnosis of HF, begin therapy and up-titrate to target doses used in large, randomized trials. Use only drugs that have been studied in HF: carvedilol, metoprolol, or bisoprolol.
ACE-I	To reduce morbidity and mortality after MI or in any woman with history of CVD or HF	Assess contraindications (symptomatic hypotension, history of angioedema, high serum creatinine or potassium); evaluate ongoing adherence to drug therapy, side effects, risk during routine evaluation	Start early during hospitalization after MI when possible; continue indefinitely. If histories of DM, HTN, HF, or other cardiovascular disease, begin therapy for secondary prevention. Up-titrate dosage to "target" doses used in large randomized trials. Discontinue therapy if a woman becomes pregnant.

Adapted from Mosca et al., 1999

Legend: ACE-I, angiotensin converting enzyme inhibitor; ACS, acute coronary syndromes; BP, blood pressure; BMI, body mass index; CVD, cardiovascular disease; DM, diabetes mellitus; HDL, high-density lipoproteins; HF, heart failure; HTN, hypertension; lb, pounds; LDL, low-density lipoproteins; MI, myocardial infarction; mo, month; wk, week; yr, year.

group compared to a placebo group. Other investigators found that women who were taking HRT when hospitalized for myocardial infarction had a reduction in mortality. In this report, significant association was found even after adjusting for medical history, clinical characteristics, and in-hospital therapies and the benefit was noted in all age strata (Shlipak et al., 2001).

However, it was also known that HRT could cause such health risks as breast cancer, thromboembolic disease, gallbladder disease, and osteoporosis. Thus, the recommendation until this past July had been to initiate therapy (beyond short-term therapy for menopausal symptoms) only when the potential benefits exceeded the potential risks (Mosca et al., 1999). In fact, the HERS investigators recommended not to start HRT for the purpose of CHD benefits but to continue therapy if already started (Hulley, 1998).

This past summer, two newly published reports, one by Grady and colleagues (2002) and the other by Hulley et al. (2002) led to a change in HRT recommendations. The HERS II investigators sought to determine if long-term (6.8 years) HRT led to CHD risk reduction. The main outcome was non-fatal myocardial infarction and CHD death. Secondary cardiovascular events were coronary revascularization, hospitalization for unstable angina or heart failure, nonfatal ventricular arrhythmias, sudden death, stroke or transient ischemic attack, and peripheral arterial disease.

The researchers found no significant decrease in CHD events or secondary cardiovascular events in those assigned to the HRT group compared to the placebo group. In fact, the late benefit found in HERS was lost in the longer follow-up period. Using the same data analysis, Hulley et al. found that the HRT group continued to have an increased incidence of non-CVD outcomes, specifically, venous thromboembolism, biliary tract surgery, cancer (any type), and fracture over the 6.8-year period.

Due to the non-favorable trends in non-cardiovascular conditions and the lack of CHD event reduction in women taking HRT, Grady and colleagues recommended that postmenopausal HRT should not be used to reduce the risk of CHD events.

The fish story: Eating omega-3 fatty acids. The Lyon or Mediterranean diet has been found to have a protective effect in preventing CVD death and complications (unstable angina, HF, stroke, pulmonary or

peripheral embolism, or minor cardiac events requiring hospitalization) in patients with CAD (de Lorgeril, 1996) and after myocardial infarction. The diet includes a large intake of fiber; antioxidants; minerals; vegetable protein; marine and plant omega-3 fatty acids; and B vitamins.

It is important to note that the protective effects, which were not due to lowered cholesterol levels, were maintained up to 4 years after a first myocardial infraction (de Lorgeril et al., 1999). In both of the de Lorgeril studies, the risk reduction for primary and secondary endpoints was dramatic, at 65%-76%. These results were better than many solo and combination pharmacologic therapy results, and led to a search for the mechanism(s) of benefit.

Table 2.
Sources of Fatty Acids

Fish and shellfish (primary source)	
~ 1.5 grams/serving	Salmon Bluefish Mackerel Artic char Swordfish
~ 0.42 grams/serving	Canned tuna fish
~ 0.48 grams/serving	Other fish
~ 0.32 grams/serving	Shrimp Lobster Scallops
Alpha-linolenic acid (secondary source):	Vegetable oils: canola, soybean Nuts (walnuts) Seeds (flaxseed)

Researchers believed the protective effects were likely due to certain nutrients; specifically, omega-3 fatty acids, oleic acid, and antioxidant vitamins (GISSI-Prevenzione Investigators, 1999; Gokce et al., 1999; & Freedman et al., 2001).

In an effort to determine if protection from sudden cardiac death was due to higher blood levels of omega-3 fatty acids, healthy men from the Physicians' Health Study were followed for 17 years. The serum level of omega-3 fatty acids found in fish was strongly associated with reduced risk of sudden cardiac death in men without evidence of prior CVD, leading researchers to believe that omega-3 fatty acids might prevent ventricular arrhythmias (Albert, 2002) and be one mode of benefit. While these findings were important, the studies were conducted in a solely to predominantly male population (60%-100%).

To learn if the protective CHD benefits extend to women, researchers analyzed data from 84,688 female nurses enrolled in the Nurses' Health Study. Women who rarely ate fish (1-3 times per month or less) were compared over time to women who had a higher intake of fish (once or more per week). During 16 years of follow-up, results showed that a higher intake of fish significantly lowered CHD events including CHD death, even after adjustment for age, smoking, and other cardiovascular risk factors (Hu, 2002). This diet-heart relation gives credence to the AHA's recommendation to eat at least two servings of fish per week – especially fatty fish – and to ingest other fatty acids to total 1 gram per day (see Table 2).

Gender differences: What's the real story? Is there really a gender bias when it comes to evaluating and treating women with CHD? In 1994, Shaw and colleagues published a report that found women with suspected CAD received fewer additional diagnostic tests (38% in women versus 62% in men; P = 0.002) even though their initial diagnostic test results were similar to those of males studied. In other landmark studies, researchers found that race (black) and gender (women) influenced the likelihood to receive cardiac catheterization to manage chest pain (Schulman, et al., 1999) and that the difference in use of cardiac procedures (noninvasive and invasive) within 90 days of a cardiac event also affected outcomes (Roger et al., 2000).

As shown in Table 3, these studies spurred articles on how to do better and highlighted the differences between women and men in relation to signs and symptoms (Penque et al., 1998). They also led to studies of outcomes between the sexes based on specific intervention treatments for acute myocardial infarction (Mehilli et al., 2002). Of note, women tend to be older when they present with CHD symptoms and are more likely to have diabetes or hypertension (Mehilli et al., 2002), both of which may affect symptom severity and patient interpretation of symptoms.

Nurses must be astute observers, ask the right questions, and be sure to perform a thorough assessment when patients complain of vague or flu-like symptoms because these symptoms may reflect early signs or be the only clue of a cardiac event. Nurses must be careful not to assume symptoms are just related to age or other morbidities. Nurses must be proactive in communicating with other health care providers and facilitating optimal testing to determine if coronary interventions (percutaneous or coronary artery bypass surgery) are warranted, especially in young women or those without a history of CHD.

In two prospective studies that compared the outcomes of men and women after percutaneous coronary intervention, women who received very early aggressive revascularization (coronary stenting) for non-ST-elevation acute coronary syndromes or acute myocardial infarction had better long-term survival than men (Mehelli, 2002; Mueller et al., 2002).

Heart Failure

Heart failure is a pathophysiologic state that occurs when the heart does not pump enough oxygenated blood to meet the needs of the body's tissues. It is the only form of CVD that is increasing in prevalence and

the incidence is higher in women than in men (AHA, 2001). This phenomenon is due, in part, to better management of myocardial infarction. People who would have perished in past years are now alive and at a higher risk for developing HF over time.

Also, HF is a condition of the elderly, and the American population is aging. Hypertension, diabetes, valve disease, obesity, and CAD are all risk factors for developing HF and many of these conditions are more common in the elderly, especially in women.

There are many forms of HF and there are sex-specific differences in the clinical spectrum. Terms used in HF are as follow:

- Systolic dysfunction (decreased contractility)
- Diastolic dysfunction (decreased relaxation or stiffness during diastole or ventricular filling with normal contraction)
- Acute HF (cardiogenic shock after myocardial infarction or myocarditis that improves after recovery from the initial event)
- Chronic HF (progressive condition that may lead to death)
- Right, left, or bi-ventricular failure

There are also many etiologies that can cause HF, however, the most prominent today are CAD and hypertension. Women are more likely to develop diastolic left ventricular dysfunction from hypertension while men are more likely to have systolic left ventricular dysfunction due to a history of myocardial infarction and CAD. Of note, women are at two times greater risk of developing symptomatic HF after a myocardial infarction, compared to men (Wenger, 2002).

While etiologies of HF may be different between the sexes, the signs and symptoms are often identical, necessitating the need for careful diagnostic testing. In addition, treatment strategies may appear very similar in systolic and diastolic dysfunction, however, the rationale for use of specific drugs and dosing often differs based on HF etiology.

No matter the etiology, once diagnosed, HF is generally a chronic, progressive condition that often worsens "silently." It is considered to be more malignant than cancer! Only lung cancer was associated with fewer survivors in a study of both men and women who were admitted to a Scottish hospital in 1991 for HF, myocardial infarction, and the five most common sites of cancer (Stewart, MacIntyre, Hole, Capewell, & McMurray, 2001).

MacIntyre et al. (2000) studied case fatality trends for 10 years in 66,547 consecutive patients hospitalized for HF in Scotland in 1986. In this group, the majority of patients were women (53%) and the women's median age was 78 years. Overall, median survival for this group of females was 1.39 years. For women who survived the first 30 days after the index hospitalization, median survival improved to 2.36 years.

These very sobering statistics are slightly worse for women than men and reinforce the need for health care providers to evaluate and treat the condition more aggressively and to promote primary prevention.

Table 3. Signs and Symptoms

Common Signs and Symptoms of Myocardial Infarction in Women

- Chest pain or pressure (in middle of chest).
  - Declines with age in women (likelihood is 80% if < 60 years and 48% if > 70 years).
  - Peak pain intensity of 8.4 on a scale of 1 (no pain) to 10 (worst pain)
- Shortness of breath*
- Fatigue*
- Sweating*
- Weakness*
- Nausea, indigestion, loss of appetite
- Back pain

Common Signs and Symptoms of Unstable Angina in Women

- Chest pain or pressure
  - Declines with age
  - Peak pain intensity of 7.7 on a scale of 1 to 10.
- Shortness of breath*
- Fatigue*
- Sweating*
- Weakness*
- Lightheadedness
- Numbness of the hands
- Neck discomfort

** Identical in men and women*

Aggressive Management

In an effort to promote aggressive evaluation and management by health care providers, the American College of Cardiology (ACC) and AHA recently published revised guidelines for chronic HF (ACC/AHA, 2001). Stages of HF were developed. Similar to staging in cancer, once labeled at a specific stage patients should receive care based on consensus guidelines for that stage, which offer the best hope of improved morbidity and mortality (see Table 4).

Patients must understand that they do not go "in" and "out" of HF and that even when they are stable, the heart may be enlarging and HF might be progressing. Patients also need to understand that many of the pharmacotherapies (ACE inhibitors, beta-blockers, and spironolactone) are not given for acute symptom relief but are used to prevent progression of HF or to cause regression in the condition by reversing the underlying silent pathophysiologic mechanisms. Ultimately, the patient's symptoms and quality of life will improve.

Clinicians should use the staging guidelines to aid in decision making and care planning. In addition, the stages of HF can be used to facilitate discussion and understanding of the condition; to endorse and support self-management initiatives; and to promote adherence to the plan of care.

Ambulatory care nurses should assess risk factors, functional class, and HF staging at every visit to determine if new diagnostic testing or therapies are needed.

Table 4.
Stages of Heart Failure

Stage	NYHA Functional Class	Description (overview)	Therapies (overview)
A	Not Applicable	Patients at high risk for developing HF; examples: HTN, CAD, DM, Hx of cardiotoxic drug therapy, personal Hx of rheumatic fever and family Hx of cardiomyopathy	• Treat HTN • Encourage smoking cessation • Treat lipid disorders • Encourage regular exercise • Discourage alcohol and illicit drug use • ACE-I and beta-blockers in appropriate patients • Weight modification
B	I	Structural heart disease that is associated with the development of HF, but who have never had symptoms. Examples: previous MI; asymptomatic valve disease; left ventricular hypertrophy or fibrosis	• All measures above • ACE-I and beta-blockers in appropriate patients • Assess for cardiac surgery (myocardial hibernation requiring CABG; valve repair, etc.) or percutaneous revascularization
C	I-II-III	Patients with current or prior symptoms of HF associated with underlying structural heart disease	• All measures under "A" • Routine drugs: ACE-I, beta-blockers, diuretics, digoxin • Dietary sodium restriction to 2,000 mg/day • Fluid restriction to 2 liters/day • Implantable cardioverter-defibrillator if Hx MI and EF ≤ 30% or with symptomatic VT/VF • Fluid monitoring (daily weights, daily intake, signs/symptoms of volume overload)
D	IV	Patients with advanced structural heart disease and marked symptoms of HF at rest despite maximal medical therapy; those who require specialized interventions	• All measures under "A," "B," and "C" • Mechanical assist devices • Bi-ventricular pacing (cardiac resynchronization therapy) • End-of-life care • Heart transplantation • Continuous IV inotropic infusion (for palliation)

Source: Adapted from American College of Cardiology/American Heart Association

Legend: ACE-I, angiotensin converting enzyme inhibitor; CABG, coronary artery bypass grafting; CAD, coronary artery disease; DM, diabetes mellitus; EF, ejection fraction; Hx, history of; HF, heart failure; HTN, hypertension; IV, intravenous; MI, myocardial infarction; NYHA, New York Heart Association; VT/VF, ventricular tachycardia/ventricular fibrillation.

Most importantly, patient education is crucial to promoting adherence to the plan of care. Patients must understand not only the self-management expectations, but also *why* it is important to make lifestyle changes (in relation to improving morbidity and mortality). Patients should receive this important information in clear terms with sufficient detail.

Summary

Ambulatory care nurses have the power to affect changes that will help improve quality and length of life for women with CVD. Their advocacy and education efforts should include themselves, their peers, and their patients.

Many interventions require lifestyle changes that are often hard to initiate or continue, especially when under stress. Nurses can increase patients' confidence in their ability to initiate and sustain optimal behaviors, but it takes time, patience, and much repetition in educational messages.

As educators and patient advocates, nurses must carve out time in their busy practices to ensure patients have the tools to affect change. As risk factors (and symptoms) change with age and co-morbidities, nurses must be astute to patients' verbalizations and objective assessment findings and ensure that diagnostic tests are ordered and results communicated to primary health care providers.

Then, nurses must actively promote changes in the plan of care to assure that national consensus recommendations are implemented. Women's cardiac health needs are an important subject that requires serious attention to details and actions.

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Nancy M. Albert, MSN, RN, CCNS, CCRN, CNA
Manager, Clinical Investigations,
Thoracic and Cardiovascular Surgery
Manager, Heart Failure Disease Management Program
Kaufman Center for Heart Failure
The Cleveland Clinic Foundation, Cleveland, OH
(216) 444-7028 • albertn@ccf.org

Nurses Day

continued from page 14

The University of Massachusetts Medical Center gives patients the opportunity to vote for their "Nurse Who Made a Difference." A nursing essay contest is held on "What Is Special about Being a Nurse." The entries are posted all week with the award for the top three essays given at a celebration breakfast. The top three essay winners are given a free parking space for one month. In addition, vice-presidents distribute flowers and pins for each nurse (RN, LPN, and MA) and personal thank-you's.

Cleveland Clinic in Ohio includes RNs, LPNs, MAs, and technicians in their observation of Nurses Day. Carle Clinic in Urbana, IL, does not include MAs and NAs in their celebration but they do hold an Employee Appreciation Week during the summer which includes a one-day picnic and a week-long distribution of treats to all the units. The organizers at Carle also learned that it was more convenient for their nurses to hold an event right after work rather than later in the evening.

Each of Florida Health Care Plans 10 facilities has their own internal celebration, and what they do, my contact said, "is up to them." Activities include all of the clinical staff – RNs, LPNs, CMAs, receptionists, phlebotomists, and EKG techs.

As you can see, Nurses Day celebrations vary across the country. While I haven't decided yet how we will celebrate Nurse's Day at my own organization, I do have some very creative ideas worth considering. The most important thing is to ensure that nurses and related health care providers are recognized and appreciated for all they do.

Rebecca Linn Pyle, MS, RN
Editor, Viewpoint
RLPyle@AOL.com

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East Holly Avenue, Box 56
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(800) AMB-NURS
(856) 589-7463 FAX
aaacn@ajj.com
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