

Position Statement

HFSA and AAHFN Joint Position Statement: Advocating for a Full Scope of Nursing Practice and Leadership in Heart Failure

CHRISTOPHER S. LEE, RN, PhD,¹ BARRY H. GREENBERG, MD,¹ ANN S. LARAMEE, APRN, MS,¹
 SUSAN E. AMMON, RN, MS, FNP,¹ MARILYN PRASUN, PhD, CCNS-BC,²
 MARIE GALVAO, MSN, ANP-BC, CHFNP,² LYNN V. DOERING, DNSC,¹ M. EUGENE SHERMAN, MD,¹
 LYNNE WARNER STEVENSON, MD,¹ DOUGLAS D. GREGORY, PhD,¹ PAUL A. HEIDENREICH, MD, MS,¹
 NAVIN K. KAPUR, MD,¹ JOHN B. O'CONNELL, MD,¹ ANNE L. TAYLOR, MD,¹ JOSEPH A. HILL, MD, PhD,¹
 LINDA BAAS, RN, PhD, ACNP, CHFNP,² ASHLEY GIBBS, RN, MSN, ANP/GNP-BC, CHFNP,²
 KISMET RASMUSSEN, FNP-BC, CHFNP,² CONNIE LEWIS, MSN, ACNP-BC, NP-C, CCRN, CHFNP,²
 PEGGY KIRKWOOD, RN, MSN, ACNPC, AACC, CHFNP,² JUANITA REIGLE, RN, MSN, ACNP-BC, CHFNP,²
 LISA RATHMAN, MSN, CRNP, CHFNP,² AND CYNTHIA BITHER, RN, MSN, APN-C, ACNP-C²

Saint Paul, Minnesota and Mount Laurel, New Jersey

The Heart Failure Society of America (HFSA) and the American Association of Heart Failure Nurses (AAHFN) share a common core mission to improve outcomes of patients with heart failure. A recent report underscored the importance of increasing advocacy efforts to enable nurses to practice to the full extent of their education and training and engage in full partnership with physicians and other health professionals in redesigning health care.¹ Heart failure is the fastest growing cardiovascular disorder in the U.S. and the most common reason for hospitalization among older adults.²⁻⁵ Effective management of heart failure requires that experts from many disciplines practice to the full extent of their education and training.⁶ Moreover, leaders from multiple disciplines must act accountably in full partnership to transform health care delivery in the U.S. so that it meets the needs of heart failure patients, their families, and others involved in the health care system. For

these reasons, advocating for the removal of barriers to scope of practice and for increasing engagement in health care leadership for nurses is central to the missions and values of the HFSA and AAHFN.

The Role of Nursing in the Care of Persons With Heart Failure

With more than 3 million members, the nursing profession is the largest segment of the health care workforce in general⁷ and of heart failure programs in particular.⁸ Nurses provide effective care to patients and families living with heart failure across all health care settings. Nursing care for heart failure patients extends over a wide range of settings with the scope of activities expanding well beyond traditional roles to include such diverse functions as participation in multidisciplinary disease management teams and, for advanced practice nurses with appropriate training, independent management of patients.

Nurses have demonstrated excellence in collaborating with other disciplines to optimize and coordinate the delivery of evidence-based heart failure care. Moreover, disease management programs that are coordinated or led by nurses with specialized training improve care by optimizing medications, improving adherence, enhancing self-care behaviors, improving quality-of-life, and reducing morbidity and mortality of heart failure patients.⁹⁻¹⁶ Working with heart failure patients across all socioeconomic classes, categories of age, and phases of the heart failure trajectory, nurses are in a key position to prevent complications, recognize early signs and symptoms of worsening heart failure,

From the ¹Advocacy Committee of the Heart Failure Society of America, Court International, Suite 240 S., 2550 University Avenue West, Saint Paul, MN 55114 and ²American Association of Heart Failure Nurses Board of Directors, 15000 Commerce Parkway, Suite C, Mount Laurel, NJ 08054.

Manuscript received August 30, 2012; revised manuscript accepted September 4, 2012.

Reprint requests: Christopher S. Lee, RN, PhD, Oregon Health and Science University School of Nursing, mail code: SN-2N, 3455 SW US Veterans Hospital Road, Portland, OR 97239-2941. Tel: +1 503 494 4410; Fax: +1 503 494 4456. E-mail: csleern@gmail.com

This paper is being simultaneously copublished in *Heart & Lung - The Journal of Acute and Critical Care*, Volume 41, Issue 6.

See page 812 for disclosure information.

1071-9164/\$ - see front matter

© 2012 Elsevier Inc. All rights reserved.

<http://dx.doi.org/10.1016/j.cardfail.2012.09.001>

and tailor educational and treatment strategies to ensure high quality care. There are a number of historical, cultural, regulatory, and policy barriers, however, that limit nurses' ability to fully contribute to the health of Americans in need; this is particularly true for advanced practice nurses.^{1,17} For example, several state scope-of-practice regulations do not conform to the National Council of State Boards of Nursing Model Nursing Practice Act.¹ Nursing practice in some states is limited by restrictive collaboration requirements, including on-site supervision, nurse practitioner–physician ratio caps, and mandated chart review,¹⁸ as well as variation in abilities and limitations to prescriptive authority regarding medications, durable medical equipment, and home health services. Further, many managed care organizations limit reimbursement below the level appropriate for care provided by advanced practice nurses.¹⁹ Thus, what has emerged is heterogeneous policy in which nurses are not uniformly allowed to practice at the full level of their training in many parts of the U.S. This compromises nurse contributions to innovation and partnership in health care, government, and business.

Position

To optimize health outcomes among persons living with heart failure, the HFSA and AAHFN strongly advocate for the removal of scope-of-practice barriers for nurses to allow advanced practice nurses to practice to the full extent of their educational training. Furthermore, and as a call to action, the HFSA and AAHFN endorse recent recommendations to make nurses full partners in the redesign of health care through leadership roles in foundation and governmental organizations where health policy decisions are made.¹

Disclosures

None.

References

1. Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. 1st ed. Washington, DC: The National Academies Press; 2011.
2. Heidenreich PA, Trogon JG, Khavjou OA, Butler J, Dracup K, Ezekowitz MD, et al. Forecasting the future of cardiovascular disease in the United States: a policy statement from the American Heart Association. *Circulation* 2011;123:933–44.
3. Lloyd-Jones D, Adams RJ, Brown TM, Carnethon M, Dai S, de Simone G, et al. Heart disease and stroke statistics—2010 update: a report from the American Heart Association. *Circulation* 2010;121:e46–215.
4. Ross JS, Chen J, Lin Z, Bueno H, Curtis JP, Keenan PS, et al. Recent national trends in readmission rates after heart failure hospitalization. *Circ Heart Fail* 2010;3:97–103.
5. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med* 2009;360:1418.
6. McAlister FA, Stewart S, Ferrua S, McMurray JJ. Multidisciplinary strategies for the management of heart failure patients at high risk for admission: a systematic review of randomized trials. *J Am Coll Cardiol* 2004;44:810–9.
7. US Department of Labor Bureau of Labor Statistics. *Occupational Outlook Handbook 2010–2011*. Available at <http://www.bls.gov/oooh/>. Accessed January 1, 2011.
8. Jessup M, Albert NM, Lanfear DE, Lindenfeld J, Massie BM, Walsh MN, et al. ACCF/AHA/HFSA 2011 survey results: current staffing profile of heart failure programs, including programs that perform heart transplant and mechanical circulatory support device implantation. *J Card Fail* 2011;17:349–58.
9. Ansari M, Shlipak MG, Heidenreich PA, van Ostaeyen D, Pohl EC, Browner WS, et al. Improving guideline adherence: a randomized trial evaluating strategies to increase beta-blocker use in heart failure. *Circulation* 2003;107:2799–804.
10. Stone PW. Nurse-led heart failure management improved quality of life and was cost-effective. *Evid Based Nurs* 2009;12:59.
11. Hebert PL, Sisk JE, Wang JJ, Tuzzio L, Casabianca JM, Chassin MR, et al. Cost-effectiveness of nurse-led disease management for heart failure in an ethnically diverse urban community. *Ann Intern Med* 2008;149:540–8.
12. Stromberg A, Martensson J, Fridlund B, Levin LA, Karlsson JE, Dahlstrom U. Nurse-led heart failure clinics improve survival and self-care behaviour in patients with heart failure: results from a prospective, randomised trial. *Eur Heart J* 2003;24:1014–23.
13. Naylor MD, Broton D, Campbell R, Jacobsen BS, Mezey MD, Pauly MV, et al. Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. *JAMA* 1999;281:613–20.
14. Naylor MD, Broton DA, Campbell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *J Am Geriatr Soc* 2004;52:675–84.
15. Lowery J, Hopp F, Subramanian U, Wiitala W, Welsh DE, Larkin A, et al. Evaluation of a nurse practitioner disease management model for chronic heart failure: a multi-site implementation study. *Congest Heart Fail* 2012;18:64–71.
16. Rich MW, Beckham V, Wittenberg C, Leven CL, Freedland KE, Carney RM. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. *N Engl J Med* 1995;333:1190–5.
17. Fairman JA, Rowe JW, Hassmiller S, Shalala DE. Broadening the scope of nursing practice. *N Engl J Med* 2011;364:193–6.
18. Safriet BJ. Federal options for maximizing the value of advanced practice nurses in providing quality, cost-effective health care. Paper commissioned by the Committee on the RWJF Initiative on the Future of Nursing. In: *The Future of Nursing: Leading Change, Advancing Health*. 1st ed. Washington, DC: The National Academies Press; 2011:443–75.
19. Hansen-Turton T, Ritter A, Begun H, Berkowitz SL, Rothman N, Valdez B. Insurers' contracting policies on nurse practitioners as primary care providers: the current landscape and what needs to change. *Policy Polit Nurs Pract* 2006;7:216–26.