

Call for Abstracts

Submission Deadline: November 1, 2011

PCNA is now accepting abstracts for the 18th Annual Symposium, *Cardiovascular Risk Reduction: Leading the Way in Prevention*, to be held April 12-14, 2012 at Gaylord National Resort in the Washington, DC Metro Area.

- 2012 Highlights:**
- **Mentoring is now available** (pre-submission) for abstract authors.
Contact Kristie at kkasbohm@pcna.net if you are interested in being connected with a mentor.
 - Two outstanding written abstracts will be selected for oral presentations
 - All accepted abstracts will be published in the *Journal of Cardiovascular Nursing*

INVITATION: We invite healthcare professionals involved in original data-based research or innovative projects related to cardiovascular risk reduction & disease management to submit an abstract. Only original abstracts will be considered (not previously published or presented prior to submitting to PCNA). Submission of an abstract constitutes a commitment by the author to present a poster if accepted. Poster Presentations will take place on Thursday, April 12 during a special reception at Gaylord National Resort. All posters will be randomly numbered and displayed together in the foyer outside of the exhibit hall.

PURPOSE: The purpose of the poster session is to present original research findings and share new and innovative ideas for successful approaches to cardiovascular risk reduction and disease management. PCNA is proud to provide a forum for members and colleagues to share their ideas and best practices.

AWARDS & PUBLICATION: Two outstanding written abstracts will be selected for oral presentations. Winners will have the option to deliver a 10-minute oral presentation to over 500 participants during general sessions.

A \$250 award will be given to the most innovative and significant abstract/poster presentation in two categories:

1. Data-Based or Original Research
2. Innovation in Patient Care

During the Symposium, a first, second, or third place ribbon will be placed on winning posters. All presenters and winners will be recognized during PCNA General Sessions on Friday, April 13. All accepted abstracts will be published in the conference syllabus, on the PCNA website, and in the *Journal of Cardiovascular Nursing*.

SELECTION PROCESS: Each presenting author must submit two forms of their abstract: the first must list all authors and the second must be "blinded," excluding author information. The PCNA Abstract Review Committee will make selections using a blind review process. In order to be accepted for review, abstracts must adhere to the guidelines set forth in this Call for Abstracts and must be received via the PCNA online submission form no later than November 1, 2011. Authors will be notified by December 15, 2011 of acceptance.

Grading Criteria for Each Category	
<p>Data-Based or Original Research</p> <p>Including research that reports data from existing data sets or original basic, clinical, or population-level research.</p> <ol style="list-style-type: none"> 1. The investigation should be based on original concepts and provide important new data. 2. The topic should be relevant to the theme of the meeting and/or mission of PCNA. 3. The study design and methodology of the research project should be appropriate. 4. The abstract should include complete data (mentioning that the results will be presented at the meeting is unsatisfactory). 5. The findings should be factual, unique, useful, and appropriate to the PCNA audience. 6. The conclusions should be valid. 7. The abstract should be well written (i.e., clear and easy to understand). 	<p>Innovation in Patient Care</p> <p>Including, but not limited to, quality and process improvement projects, patient education/counseling programs, and creative approaches to patient and system-focused programs</p> <ol style="list-style-type: none"> 1. The innovative project/program should be based on original concepts and provide new insights into efficient, effective patient care strategies. 2. The topic should be relevant to the theme of the meeting and/or mission of PCNA. 3. The description/design and implementation of the project/program/innovation should be clearly presented. 4. The abstract should include complete information or outcomes (mentioning that the results will be presented at the meeting is unsatisfactory). 5. The outcomes should be innovative, feasible, clearly described, and appropriate to the PCNA audience. 6. The evaluation and implications should be valid. 7. The abstract should be well written (i.e., clear and easy to understand).

PCNA Abstract Submission Guidelines for Each Category

Data-Based or Original Research

Including research that reports data from existing data sets or original basic, clinical, or population-level research.

Innovation in Patient Care

Including, but not limited to, quality and process improvement projects, patient education/counseling programs, and creative approaches to patient and system-focused programs

The following components are required in each abstract:

- Background summary
- Statement of specific objectives
- Description of design & methods, including measurements
- Summary of the results obtained
- Statement of the conclusions

The following components are required in each abstract:

- Background summary
- Purpose/problem being addressed
- Description of the design/implementation of the project/program/innovation
- Evaluation and outcomes
- Implications for practice

General Submission Guidelines:

- Only original abstracts will be considered (not previously published or presented prior to submitting to PCNA).
- Submission of a poster abstract constitutes a commitment by the author to present a poster at the PCNA Annual Symposium if accepted.
- The abstract itself may not exceed a word count of 300, including tables. The 300 word limit does not include title or author(s) information.
- Preferred style: Examples of winning abstracts are included on the following pages. Abstracts must include the following section headers:
 - Data-Based or Original Research headings: Background, Objectives, Methods, Results, Conclusions
 - Innovation in Patient Care headings: Background, Purpose, Design/Implementation, Evaluation/Outcomes, Implications for Practice
- Arial font, 10 point minimum is required.
- Do not indent the title, and be certain that it is completely CAPITALIZED, but do not use capitals or underline for emphasis within the body of your abstract (this will be lost in the electronic transfer).
- In the full abstract (non-blinded version), please list full name followed by degrees/credentials, employer, and city/state for each author.
- Be sure that street address, zip code, and grant support are NOT listed in abstracts.
- Any author may not be first author on more than two submissions.
- Any investigator may not present more than two posters.
- Industry representatives (i.e. from device/pharmaceutical/food companies) cannot be first author on any submitted abstracts to avoid a potential conflict of interest.
- When using abbreviations, spell out in full the first mention, followed by the abbreviation in parentheses.
- Do not squeeze letters or lines.
- Left-hand border must be perfectly straight.
- Check accuracy of spelling, grammar, and punctuation: Your poster abstract will appear in print exactly as you submit it; thus any errors, misspellings, incorrect hyphenations, or deviations from good grammatical usage will appear in the published abstract.
- Deadline for submission is 11:59 pm on November 1, 2011. Submissions received after this date will not be accepted for review.
- If you do not receive an e-mail confirmation within 24 hours after submitting your abstract online, it is your responsibility to contact the PCNA National Office to make sure we have received your submission.

Submit your abstract online at www.pcna.net

Questions?

Please contact Kristie Kasbohm
Preventive Cardiovascular Nurses Association
Tel: 608-250-2440 x 1, E-mail: kkasbohm@pcna.net

2011 Winning Abstracts – Oral Presentations at the PCNA 17th Annual Symposium

1st Place Abstract Winner: Data-Based Research

EXERCISE DECREASES FLUCTUATIONS IN 24-HOUR WEIGHT VARIABILITY IN PATIENTS WITH ADVANCED HEART FAILURE

Andrea M. Boyd, PhD, RN, MA/MSN, Veteran's Health Administration; Georgia Health Sciences University, Augusta, GA

Background: Heart Failure (HF) is a significant healthcare concern in the US costing an estimated \$37.2 billion/year. Fluid volume overload is considered the major cause of hospitalization for decompensated HF. Exercise training (ET) has been linked to various physiological benefits and decreases in HF hospitalization rates yet translational research has not been conducted yet linking ET to fluid instability.

Objectives: The purpose of the study was to determine if a prescribed, progressive home-based aerobic exercise program would alter the physiological processes that maintain fluid balance stability in the advanced HF patient after medical optimization (titration of oral medical therapy with or without the infusion of an intravenous inotrope).

Methods/Designs: A retrospective design utilizing an innovative application of visual analysis with data from 56 men/women 21 and older who had been diagnosed with HF for over 6 months, and had been hospitalized for a decompensation in which they had been classified as NYHA III or higher, were recruited from a southeastern, large tertiary trauma I teaching hospital, which had a HF and transplant program. Fluid status (daily body weight) and measures of actual exercise (exercise intensity, duration, frequency) were the primary variables measured during the 24 weeks of the study. The ET intervention was a home based ET protocol prescribed and progressed over 24 weeks.

Results: A hierarchical multiple regression model significantly predicted daily weight fluctuations within an advanced HF population after medical optimization (R^2 linear= 0.713, $F=3.224$, $p=0.015$). The model determined that exercise intensity (BORG), exercise frequency (days exercised/week), and exercise duration (minutes of exercise/session) directly predicted daily weight fluctuations (standard deviations of daily weights during a week time frame) when controlling for baseline weight fluctuations and event causing exit from the study.

Conclusions: The study demonstrated that ET is a successful adjunctive therapy to managing the fluid status instability of advanced HF patients that is a debilitating aspect of HF.

1st Place Abstract Winner: Innovation in Patient Care

PREVENTING WINTER HOLIDAY WEIGHT GAIN THROUGH WEEKLY WEIGH-INS AND HEALTHY TIPS AT THE WORKSITE

Heather McCormick, MS, RD, LD, CDE, Susan Nemer, RN, MS, Linda Fester, RD, LD, Jennifer Fralic, RD, LD, LifeCare Alliance, Columbus, OH

Purpose: The average winter holiday weight gain is only one pound; however, this pound is not typically lost by the next holiday season. These pounds can accumulate over the years, contributing to increased body weight in adults. Excess weight increases the risk for coronary heart disease, high blood pressure, stroke, type 2 diabetes and other diseases. We designed a weigh-in program at the worksite to help employees prevent winter holiday weight gain.

Design/implementation: Employees are invited to participate in a 12-week program starting the last week of October and concluding the second week of January. The registered nurse or registered dietitian visits employees at the worksite to obtain weekly weights and provides weekly tip cards that include health and nutrition information. The focus of the program is for employees to prevent gaining weight during the 12 weeks. Employees who maintain or lose weight and participate in 75% of weigh-ins receive a wellness-related prize. We titled the program: *Don't Let the Holidays Get You Stuffed!*

Evaluation and outcomes: The table represents 445 employees from four worksites who participated in the holiday program from 2005 – 2010. Sixty-nine percent of the employees maintained or lost weight during the 12 weeks. Average weight loss was 1.05 lbs.

Worksite	2005 (n=30)		2006 (n=42)		2007 (n=61)		2008 (n=77)		2009 (n=121)		2010 (n=114)		Total (n=445)	
	%	lbs	%	lbs	%	lbs	%	lbs	%	lbs	%	lbs	%	lbs
1	56%	3	75%	1.31	87%	2.83	69%	1.8	74%	2.00	64%	1.30	71%	2.04
2	N/A		78%	1.69	63%	0.20	81%	1.9	88%	2.00	100%	2.04	82%	1.57
3	60%	0.22	88%	1.56	50%	0.29	78%	1.2	58%	0.22	73%	1.55	68%	0.84
4	N/A								84%	1.12	54%	0.4	69%	0.76
5	N/A										58%	0.02	58%	0.02
													69%	1.05

Implications for practice: This program can be adapted to multiple settings. It requires a short time commitment, provides weekly contact with a health professional, and offers an avenue for health and nutrition education. Clients gain a sense of accountability for their weight management because of the weekly weigh-ins and the 75% participation goal to attain a prize. LifeCare Alliance continues expanding the program to other worksites.

1st Place Poster Winner: Data-Based Research

INTEGRATIVE CARDIAC HEALTH PROJECT RISK SCORE IMPROVES CARDIOVASCULAR RISK ASSESSMENT IN WOMEN WITH SUBCLINICAL ATHEROSCLEROSIS

Elaine Walizer, MSN, Mariam Kashani, CRNP, Arn Eliasson, MD, Marina Vernalis, DO, Henry M. Jackson Foundation, Rockville, MD

Background: The Framingham Risk Score (FRS) substantially underestimates lifetime risk of cardiovascular disease (CVD), especially in women, when only a 10-year risk model is used. The Integrative Cardiac Health Project (ICHP) Risk Score, which incorporates family history and novel risk factors such as BMI, waist circumference, diastolic BP, LDL-cholesterol, triglycerides, and hsCRP, has been previously validated with carotid intima-medial thickness (CIMT), a surrogate marker for atherosclerosis, in middle-aged men where an increase in ICHP Risk Score was associated with increasing CIMT 0.3%.

Objective: To hypothesize that the ICHP Risk Score may improve CVD risk identification in women, we compared risk prediction using FRS and ICHP Risk Score in women with abnormal CIMT.

Methods: 113 non-diabetic female military healthcare beneficiaries underwent clinical and serologic risk factor screening in a study clinic. All had at least 2 CVD risk factors and subclinical atherosclerosis by CIMT (>75th percentile by age/gender). FRS and ICHP Risk Score were calculated and compared.

Results: Of these middle-aged (mean age=54, range 26 to 81), predominately black (50%) women, 4% smoked, 47% were hypertensive, and 81% were dyslipidemic including 27% with low HDL; 33% with LDL>130 mg/dL and 18% with triglycerides \geq 150 mg/dL. Family history of CVD was positive in 65% and 50% had hsCRP \geq 0.3 mg/dL. Subjects were obese (mean BMI=32; mean waist circumference=100 cm). All subjects were identified as low risk by FRS. When the ICHP Risk Score was applied, 60% shifted from low to medium risk classification for CVD ($p<0.0001$).

Conclusions: The ICHP Risk Score dramatically improves CVD risk classification in this cohort of women with diagnosed subclinical atherosclerosis.

Implications: These findings emphasize the need for improved CVD risk identification in women. Family history and other novel risk factors add predictive value to current risk models and identify potential therapeutic targets.

1st Place Poster Winner: Innovation in Patient Care

A NEW REGISTERED NURSE (RN)/COMMUNITY HEALTH WORKER (CHW) HEALTH CARE DELIVERY MODEL PROVES TO BE COST EFFECTIVE IN SELF-MANAGEMENT OF CHRONIC DISEASE

Linda Heine, BSN, RN, Raymond Neff, ScD, Robin Parks, BSN, RN, Spectrum Health, Healthier Communities and Meijer Heart Center, Grand Rapids, MI

Purpose: To develop a cost-effective methodology for client management of chronic disease.

Design: Elements of our integrated home-based delivery strategy were based on best practices and innovative thinking: (1) care implementation as assured by the RN, (2) medication reconciliation by RN and adherence followed by RN/CHW team, (3) symptom recognition and early reporting through education and mentoring, (4) connecting the client to community and health resources by the CHW, (5) identification of barriers by the RN/CHW team, and (6) mentored goal setting by the client.

Evaluation and Outcomes: Two populations of low-income and minorities within a structured program of chronic disease management were used to test the model: a mixed group of Type I and Type II diabetics and all classification types (New York) of heart failure. Individual clients were enrolled into the program and baseline data were collected. The program interventions consisted of monthly home visits with more frequent contact during the initial months. Heart failure clients were seen within 24-72 hours of hospital discharge. Diabetic clients were referred by multiple community resources/agencies. Cost effectiveness was measured by the change in both Emergency Department (ED) and inpatient usage patterns. Two follow-up analyses showed a decrease in ED and inpatient utilization. ED utilization rate for diabetic cohort went from 17.0% to 14.2% and resulted in 25.7 (18.6%) fewer ED visits: the inpatient utilization rate for this cohort went from 5.6% to 3.0% and resulted in 23.7 (67.8%) fewer inpatient visits. For the heart failure cohort, the ED utilization rate decreased from 33.3% to 15.3% and resulted in 42.0 fewer ED visits (a drop of 113.6%); inpatient utilization for this cohort went from 25.8% to 8.6%, a reduction of 210.9%.

Implication for Practice: This experience demonstrates the cost effectiveness of the innovative RN/CHW model.