Recovery & Rehabilitation: Improving Psychosocial Outcomes in Sudden Cardiac Arrest Survivors and Their Families

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I have no Disclosures
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Presentation Goal:
Overall Program Goal: To expand the health care professional’s understanding of psychosocial concerns that impact the overall outcomes in survivors and their family
Objectives:

1. To identify the normal emotional reactions and impact of sudden cardiac arrest survival on patients and their families

2. To recognize how spirituality and one’s sexuality and self-esteem are affected by a sudden cardiac arrest (SCA) experience

3. To describe the importance of cardiac rehabilitation, education, and recovery support to the positive outcomes in patients and families, after a sudden cardiac arrest experience

4. To discuss resources and community support initiatives in place for sudden cardiac arrest survivors and their families

Emotional Reactions to Heart Disease and Sudden Cardiac Arrest (SCA)
Normal Psychological Reactions to Heart Disease & Sudden Cardiac Arrest

- Denial
- Fear/Anxiety
- Depression
- Anger
- Guilt
- Denial
- Acceptance

Normal Psychological Reactions to Heart Disease & Sudden Cardiac Arrest

- Loneliness
- Helplessness
- Failure to be personalized
- Powerlessness
- Hopelessness
- Altered body image
- Transfer anxiety & home going

The Character of One’s Illness Will Greatly Influence The Ways, in Which They Cope with Hospitalization and Care
Character of an Illness

Do patients, who enter the hospital acutely, have time to “think” about being admitted?

Almost all of our cardiac patients, and certainly sudden cardiac arrest (SCA) patients come through the Emergency Dept. or arrive, emergently, from other facilities or outpatient areas.

Patients, admitted, in a crisis mode, such as in sudden cardiac arrest, do not have the time to unconsciously called their coping mechanisms into place. They are not able to cope like an individual who can plan an elective procedure or hospital admission.

Denial

♥ Denial may be positive or negative. It is denial that keeps an individual from going to the hospital, when symptoms occur.

♥ Sudden Cardiac Arrest may occur while an individual is with family, only, or alone.

♥ Ignoring symptoms & not seeking medical help, may result in a catastrophe!
Denial
♥ Denial, many times, protects an individual from the reality of a crisis situation. It is an unconscious response.
♥ Education, presented at the right time, may allay anxiety and break the wall of denial, that individuals hold on to, in crisis.
♥ Education re: The importance of seeking medical attention when experiencing symptoms—SAVES LIVES!

Anxiety and Fear

Anxiety/Fear
♥ Education, on the part of care providers (if presented at the right time) will replace fear and anxiety with confidence and stamina to endure the critical event & illness.
♥ Health professionals are key in assessing when to intervene with education, so as to NOT cause more anxiety and fear, but to allay these common emotions.
Anxiety/Fear

♥ Patients surviving sudden cardiac arrest, may fear the return of lethal rhythms or the cardiac event causing those life-threatening rhythms, such as a myocardial infarction.

♥ Many patients and their families fear that emotional situations or responses may precipitate an acute cardiac event.

(Dahabreh & Paulus, 2011)

Anxiety/Fear

♥ Patients, with implantable cardioverter defibrillators (ICD) may fear receiving a shock during physical activities, or during sexual activity.

♥ Family members may also have anxiety about receiving shocks when touching & being intimate with the individual with an ICD.

♥ Communication with, and education from, healthcare providers is essential to promote return to a healthy lifestyle, as well as physical & sexual activities.

(Vazquez, et. Al., 2010)

Anxiety/Fear

♥ Family members may be very anxious during both the acute stage of the illness and when the time comes to take the patient home.

♥ Family may be much more verbal about their anxiety and overall feelings.

♥ Nursing staff and other caregivers can make a real difference in assisting family members to cope. Therefore the family will be in a better position to support the patient, if they themselves understand and can cope with the illness.
Depression

♥Depression occurs as the reality of the situation becomes apparent to the patient.
♥Questions patients ask are:
  ♥Can I still work?
  ♥Can I still function and care for my family?
  ♥Am I still attractive and seen as a sexual person?
  ♥What will the quality of my life be like?

Sadness and feelings of depression may be situational and resolve during the initial weeks of recovery, following SCA.
♥Depression that lasts longer than a few weeks affects the patient’s quality of life, may prevent further recovery, and may need attention and possible treatment by a psychologist, behavioral health care provider, or psychiatrist.
Depression

- Depression has, for a long time, been an independent risk factor for heart disease.
- Major depressive disorders are a risk for adverse outcomes in patients with established heart disease.
- Depression is present in 1 out of 4-5 patients, with coronary disease.
- Depression is present in 1 out of 3 patients, with heart failure.

- There is significantly higher prevalence of depression in individuals with heart disease than in the general medical populations.
- Likewise, there is also a three-fold higher prevalence than the general population.
- Depression is present in up to 50% of patients recently hospitalized for CABG surgery or acute coronary syndrome.

- Healthcare professionals can impact quality of life outcomes for patients, by being aware, raising awareness for other colleagues, and by being an advocate for patients with emotional and psychosocial needs following their cardiac event.
- Knowing our best resources and when it is time to refer our patients to another health care provider, is crucial to optimal care.
Anger and Hostility

Anger/Hostility

- Anger/hostility may be observed as the gravity of the situation becomes apparent to the patient.

- Anger may also occur in the patient’s family members, however at a different point in the illness than it occurs with the patient.

- Patients and their loved ones seem to experience the emotions of illness at different times and therefore, if knowledgeable can better understand one another.

- Facilitation of expressing emotions can be key in the acute, in-hospital setting.
Guilt

♥ Family members, many times, take on the guilt of what has happened to the patient, particularly if the patient does not have full recovery!
♥ Family members need support and referral, at times, to assist them in coping with the reality of the situation.
Denial

♥ Denial may emerge, as the patient is about to return to their former lifestyle.
♥ Memory of the mentally & emotionally painful experience of SCA may be replaced with "I really just had a small rhythm problem, but everything is just fine now!"

ACCEPTANCE is a Process

Cardiac Events

♥ Myocardial Infarction and other cardiac events, certainly SCD, occurs suddenly and without warning
♥ They are unplanned, unwanted, and emotionally upsetting
♥ Cardiac events affect the family as well as the patient
Sudden Cardiac Arrest effects
One’s Meaning of Concept and Life
Related to active dying, anxiety, chronic illness, death, life changes, loneliness, pain, self-alienation, social alienation, sociocultural deprivation
(Schmid, 2009)

Relevance of spirituality to acute and chronically ill populations defined:

"As the spiritual dimension is important for the attainment of an overall sense of health, well-being and quality of life; crisis, illness, and hospitalization can precipitate spiritual distress, which must be addressed."
(Ross, 1995, p. 457)

Mind, Body & Spirit are all Parts of the Whole Individual
Mind, Body, Spirit

“Factors that affect the spiritual well-being of a person also affect psychological and physical welfare” (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1996, p. 263)

Disharmony of mind, body, and spirit may be experienced with stress, physical illness and crisis, or death. Spiritual care by health care professionals, will enhance patients’ spiritual coping strategies

(McEwin, 2005)

Human Sexuality

Involves every aspect of our total being—Including our attitudes, beliefs, and values, behaviors regarding our self-concept, and our roles as male or female. It involves every part of who we are.

We express our sexuality in many ways:

♥ By the way we present ourselves
♥ By our dress and make-up
♥ By non-verbal communication
♥ By our value system and by expressing our beliefs
♥ By our individual & sexual behavior
♥ By any part of our personality that pertains to our gender
Health professionals must develop an ability to deal with their own sexuality on three levels, before we can help our patients:

- Knowledge
- Skills
- Comfort

(Steinke, et al., 2011)

Roles of the healthcare professional in delivery of sexual health care:

- Facilitator of a milieu conducive to sexual health
- Provider of anticipatory guidance
- Validator of normalcy
- Educator (cognitive, attitudinal, and communication components of sexuality)

Roles of the healthcare professional nurse in delivery of sexual health care: (continued)

- Counselor of patients who must adapt to changes in usual forms of sexual expression
- Provider of, or referral to intensive therapy for patients with complex problems
- Consultant to other co-workers in planning care in a collaborative manner
Assessments & Interventions to Provide Optimal Psychosocial Outcomes for our Patients

Offer individual and/or small group education and counseling regarding adjustment to heart disease, stress management, and health-related lifestyle change. When possible, include family members and significant others in such sessions.

Teach and support self-help strategies.

Refer patients experiencing clinically significant psychological distress to appropriate mental health specialists for further evaluation and treatment. (Steinke, et. al., 2011)

Why Screen for Depression on Hospital Admission?

Evidence indicates that:

- Depression is an independent risk factor for cardiovascular disease
- 20-25% of medical coronary artery disease inpatients are depressed
- 30% of patients, with heart failure, are depressed
- 50% of patients, hospitalized for CABG, are depressed

(Depression and Coronary Heart Disease: Recommendations for Screening, Referral, and Treatment: A Science Advisory From the American Heart Association Prevention Committee of the Council on Cardiovascular Nursing, Council on Clinical Cardiology, Council on Epidemiology and Prevention, and Interdisciplinary Council on Quality of Care and Outcomes Research. Endorsed by the American Psychiatric Association


Depressive Symptom Assessment Project

A Quality Improvement Project was conducted, with a convenience sample of 151 (85 men & 66 women) medical and surgical cardiovascular patients, screened, at the Mayo Clinic, in 2009.

The Patient Health Questionnaire of nine questions (PHQ-9) was administered to all patients on hospital admission to assess for depressive symptoms.
Depressive Symptom Assessment Project-Using the PHQ-9

The PHQ-9 is a 9-item scale that can be a powerful tool to assist the clinician with presence & severity of symptoms, based directly on the DSM-IV (Diagnostic & Statistical Manual, 4th Ed.)

The PHQ-9 can assist in tracking a patient’s overall depression severity, as well as the specific symptoms that are improving or not.

Depressive Symptom Assessment Project-Utilizing Providers

• The convenience sample of 151 patient were screened, in a four-month period of time
• Nurse Practitioner/Physician Assistant (NP/PA), conducted the screening
• Feedback included:
  Question the “right time” to assess depression in our patients
  Time taken for assessment/screening of patients
  Not wanting to prescribe anti-depressive medications, without follow-up by self

Depressive Symptom Assessment Project

Mean age:
  69.74 yrs. For CV Medical patients
  64.13 years for CV Surgical patients
43.5% of the CV Surgical patients had from Mild-Severe Depressive Symptoms
40.6% of the CV Medical Patients had from Mild-Severe Depressive symptoms
Depressive Symptom Assessment
Quality Improvement Project

Current Bedside RN Project begun in April, 2010-August 2010:

436 patients on a CV Nursing unit, were screened, in a four-month period of time, out of approximately 700 patients admitted (62%) Depressive symptoms, mild-severe, were present in 49.08% of the patients screened

RN feedback included:
  Felt the assessment took less than 5” review and to complete documentation
  Surprised at how “open and interested” patients were in doing the screening
  Staff felt resources to address concerns were readily available to the staff

Depressive Symptom Assessment
Quality Improvement Project & Practice Change

This Quality Improvement Project has shown that:

♥ Implementing a standardized depression screening tool on admission, by the Bedside RN, is feasible & a standard of practice has been established

♥ Depressive symptoms on cardiac units, can be well-established

♥ Significant PHQ-9 subscale scores show that patients with chest pain, heart failure (HF), and ICDs, had the highest % of depression

♥ The highest self-reported indicators, by patients, were lack of: Energy 23.5%, Sleep (12.6%), Pleasure (10.0%), Appetite (9.0%)
Depressive Symptom Assessment Project

At the beginning of 2011, three new changes were implemented, as result of QI project:

♥ Nurses screen all medical CV patients, upon admission & inform Primary Cardiology Service, when appropriate

♥ Any PHQ-9 score of 2 or 3, in the “suicidal ideation” category, will be an automatic referral, from the primary CV Service to Psychiatry

Next Steps:
Depressive Symptom Assessment Quality Improvement Project

♥ The PHQ-9 is now being done at three points:
  ♥ Hospital Admission
  ♥ Entry into the Outpatient (Phase II) Mayo, Rochester, Cardiac Rehabilitation (CR) Program
  ♥ Discharge from the Phase II Mayo Clinic CR Program

Depression

Nursing works, collaboratively, with the physicians to impact quality of life outcomes for patients, by being knowledgeable, raising awareness for other colleagues, and by being an advocate for patients with emotional and psychosocial needs related to their illness.
Psychosocial Management

**Evaluation**

Using interview and/or standardized measurement tools, identify psychological distress as indicated by clinically significant levels of:

- depression
- anxiety
- anger or hostility
- social isolation
- sexual dysfunction/maladjustment;
- substance abuse (alcohol or other psychotropics).

Patient Populations at Highest Risk for Psychosocial Maladjustment & Non-Compliance

- Patients who smoke
- Patients who are obese
- Patients who have multiple chronic illnesses
- Patients with out spiritual or religious comfort
- Patients with a history of mental health difficulties
- Patients who have cultural or religious values that conflict with a philosophy of self-reliance and optimism.
- Patients who have impaired cognitive functioning.

Patient Populations at Highest Risk for Psychosocial Maladjustment & Non-Compliance

- Patients who live alone
- Patients who are not married and do not have a confidant
- Patients who are recently divorced or widowed
- Patients who are socially isolated
- Patients form multi-problem families
- Patients with low education levels
- Patients with low incomes
Patient Preferences

- **Support**—psychosocial or adjustment needs
  - Office visit or call with device nurse (23-25%)
  - Support group (15%)

- **Education**—content of diagnosis, ICD, coping strategies
  - Written materials (48%)
  
(Serber et al., PACE 2009)

Patient Preferences (Continued)

- **Education**—content of diagnosis, ICD, coping strategies
  - Office visit with cardiologist or nurse (42%, 40%)

- **Interest**—in attending supportive and educational ICD meeting (68%)

(Serber et al., PACE 2009)

Disparities in Preferences

- **African-American**—Written materials and phone contact with cardiologist

- **Women**—Support from ICD peers, device nurse, professional counselor

- **Young Age (<67 yrs.)**—Internet and e-communication for support & education

(Serber et al., PACE 2009)
Expected Outcomes
Evidence of emotional well-being indicated by the absence of clinically significant psychological distress, social isolation, or drug dependency.
Demonstration of self-responsibility for health-related behavior change; relaxation and other stress management skills, ability to obtain effective social support.

The Importance of Cardiac Education, Rehabilitation & Recovery Support for Positive Patient Outcomes

Performance Measures identifying Individuals Appropriate for Both Inpatient and Outpatient Cardiac Rehabilitation
Cardiac Rehabilitation Performance Measures

AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/Secondary Prevention Services

Endorsed by the American College of Chest Physicians, American College of Sports Medicine, American Physical Therapy Association, Canadian Association of Cardiac Rehabilitation, European Association for Cardiovascular Prevention and Rehabilitation, International Heart Foundation, National Association of Clinical Nurse Specialist, Preventive Cardiologists, Nurses Association, and the Society of Thoracic Surgeons

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Six Diagnoses for Cardiac Rehabilitation Coverage:

- Coronary Artery Disease (CAD) with Stable Angina
- Myocardial Infarction (MI)
- Percutaneous Coronary Intervention (PCI)
- Coronary Artery Bypass Grafting (CABG)
- Valve Surgery
- Cardiac Transplantation
Significance of Cardiac Rehabilitation Programs

Cardiac rehabilitation is a multifaceted program that focuses on risk factor modification, patient education, psychosocial adjustment, and to slow the progression of heart disease events, enhance quality of life, and reduce mortality.


Components of Phase I (Inpatient) and Phase II (Outpatient) Cardiac Rehabilitation

♥ Assessment/Screening
♥ Individual Treatment Plan (ITP)
♥ Intervention
♥ Outcomes

Efficacy of Cardiac Rehab Programs

“The efficacy of hospital-based cardiac rehabilitation in the domains of mortality, morbidity, quality of life, health behavior change, risk reduction, and psychosocial well-being has been well established.”

**Efficacy of Cardiac Rehab Programs**

“Patients who have coronary angioplasty /stent (PCI) and participate in cardiac rehabilitation program have a 45-47% decrease in mortality compared to those who do not participate in a cardiac rehabilitation program.”

Thomas, RJ, Squires, RW, et al; “Cardiac Rehabilitation Helps Survival Time in Heart Patients Receiving Stent Therapy”, presented 3/15/2010, at the American College of Cardiology, Atlanta, Georgia

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**Efficacy of Cardiac Rehab Programs**

“Patients need to know that once they’ve had an intervention, they may not be cured. Participation in a cardiac rehabilitation program will improve their health outcomes and quality of life.”

Dr. Randal J. Thomas, Preventive Cardiologist, Mayo Clinic, Rochester, MN, presented at ACC Meeting, March 15, 2010

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**Providing Education & Support Groups, within Phase I & Phase II Cardiac Rehab**

- Bring patients with many cardiac diagnoses together
- Ask patients to share their cardiac experience and presenting symptoms, as they introduce themselves
- Allow for open discussion between patients and families
- Encourage sharing and questions
Providing Education & Support Groups, within Phase I & Phase II Cardiac Rehab

♥ Offer a confidential, sharing environment, where patients know they can share or just listen
♥ Facilitate open, non-judgmental, and reaffirming discussion
♥ Model and discuss problem-solving
♥ Provide an environment for practice and questioning

Communication Within the Multidisciplinary Cardiac Rehab Team

Every institution has a different combination of health professionals, who may be KEY in the referral process. KNOW YOUR RESOURCES!

- The Patient and Family
- Cardiac Nurses
- Cardiovascular Clinical Nurse Specialist
- Cardiac Surgeon
- Cardiologist
- Chaplain
- Chemical Dependency
- Community Health Nurse (from nursing agency)
- Dietitian
- Exercise Specialist

Communication Within the Multidisciplinary Cardiac Rehab Team

- Local Health Care Provider
- Occupational Therapist
- Pharmacist
- Psychiatrist
- Physical Therapist
- Respiratory Therapist
- Tobacco Treatment Specialist
- Social Worker
Multidisciplinary healthcare professionals who can provide assistance with unresolved psychosocial responses, in addition to the Physicians & Nurses:

- Clinical Psychologists
- Psychiatry
- Chaplain
- Behavioral Health professionals
- Social Workers
- Clinical Nurse Specialist

Intervention & Risk Factor Modification Promoting Lifestyle Changes, in all Cardiac Patients

- Tobacco Cessation
- Control of Hypertension
- Control of Hyperlipidemia
- Control of Diabetes
- Cessation of Alcohol, if in excess
- Development of an exercise program
- Weight reduction
- Stress-reduction
- Social support
- Financial support

Measurement of Outcomes

1. Psychological well-being
2. Emotional, social, and economic well-being
3. Resolution of abnormal emotional reactions
4. Reduction of cardiac risk factors
5. Return to optimal level of functioning
6. Engaged in satisfying life activities
Measurement of Outcomes

7. Adequate social support
8. Financial Independence
9. Return to optimal level of functioning

Providing Education & Support Through Outpatient & Community-based Programs, for Cardiac Patients and Their Families

Patients and their families are educated about their Heart Disease, so that they can make the best decisions, about their own health care. Attending outpatient Cardiac Rehabilitation is strongly encouraged, by talking to patients about the individual benefits Cardiac Rehab provides.
The “Caring Hearts Visitor Program”

A Program designed for patients and families to help each other cope & recover from heart disease & CV surgery, through face to face opportunities for former patient and families to talk with and support inpatients and their families.

Community-based Patient & Family Resources

Local, State and National Cardiovascular Patient and Family Support Resources: "For Those Whose Hearts Need Healing"

Community-based Patient & Family Resources

Once You Go Home, You Are Not Alone
Example of a Coronary Club: A Community-based Organization

**Purpose:** To provide an educational experience about Heart Disease and to bring together individuals interested in prevention of Heart Disease

**Goals:**
1. To encourage heart patients to reach their full potential
2. To support patients and families through understanding and reassurance
3. To achieve heart health through active participation in risk factor reduction
4. To educate the public about heart disease prevention

Information to Share with Cardiac Patients and Their Families Re: A Community-based Organization

**Who is invited to attend:**
- Patients, spouse, families, relatives, and interested others

**Location of the program:**
- Community location of the meeting
Information to Share with Cardiac Patients and Their Families Re: A Community-based Organization

When are the Meetings held: (Example)

♥Meetings are held the second Wednesday, of the month, at 7:00 p.m. (There are no meetings held in the months of June, July & August)

♥Dues are $15.00/per year/per household. Dues & donations are tax deductible

Questions: Give participants a phone number to call, with questions

Topics covered in community-based organization cover all aspects of heart disease:

- Family history of:
  - Heart disease
  - Stroke
- Age
- Gender (male sex vs. female sex)
- Race (Ethnic background)
Topics covered in a community-based organization:
- Smoking
- Hypertension
- Increased lipids and triglycerides (Hypercholesterolemia)
- Sedentary lifestyle (Physical inactivity)
- Low HDL
- Diabetes mellitus
- Stress
- "Type A Personality"
- Obesity
- Excessive use of alcohol

Presentation Topics:
- "Nutrition and Heart Disease"
- "Hints for Holiday Eating"
- "Tobacco and Heart Disease"
- "All You Want to Know about Heart Valve Surgery"
- "The Best Goes On: Learning about Heart Rhythms"

Presentation Topics:
- "New Techniques in Heart Surgery"
- "What’s New in the Cath Lab?"
- "Diabetes and Heart Disease"
- "Sleeping with the Enemy: Sleep Apnea"
- "Exercise for Life: What this Means"
- "Update on Cardiovascular Medications"
Presentation Topics:

♥ “Living with an Implantable Cardioverter-Defibrillator (ICD)”
♥ “Differences Between Heart Disease in Women and Men”
♥ “Let’s Talk About Normal Reactions to Heart Disease”
♥ “Integrative Therapies and Heart Disease”
♥ “Affects of Alcohol and the Heart”

Improving Quality of Life is Key to To our Role as Health Care Providers.