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Published in:
EP - Europace

DOI:
10.1093/europace/euae078

Publication date:
2024

Document version:
Accepted manuscript

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Citation for published version (APA):

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Download date: 05. Apr. 2024
A call for action to include psychosocial management into holistic, integrated care to patients with atrial fibrillation

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Keywords: atrial fibrillation, integrated care, psychosocial management
Atrial fibrillation (AF) is the most prevalent arrhythmia worldwide. Over the next three decades, the number of cases in Europe will almost double. Although increasing age is a prominent risk factor for AF, several modifiable risk factors and underlying conditions such as hypertension, also significantly contribute to the development and progression of AF (1, 2). AF is independently associated with increased risk of mortality, heart failure, and stroke, which is the most devastating consequence of AF: cardioembolic stroke is usually severe, often recurrent and fatal, or at least
permanently disabling (1, 3). Also, up to one third of AF patients have left ventricular dysfunction with varying degree (1). Moreover, AF is associated with an increased risk of cognitive impairment and dementia, even without a history of stroke (1). Even if AF can be asymptomatic, more than 60% of the patients have symptoms, reduced functional capacity, and impaired quality of life (QoL) (1). The impairment of health-related QoL is even more pronounced in patients with a distressed personality type (Type D) (4). It is important to note that AF patients more often develop anxiety disorders and have a higher burden of depressive symptoms (1, 5, 6). Moreover, poorer mental health functioning has been recognised as a contributing factor to non-adherence to warfarin treatment (7), which may result in an increased risk of stroke. Due to increasing case numbers, AF, its consequences, symptoms, and underlying comorbidities, do not only add a significant disease burden on the individual patient, but also a significant economic burden on society at large due to repeat contacts with the healthcare system and associated and increased treatment costs (8).

**Current treatment and what is needed to handle the crisis – unmet needs and lack of integrated care**

The past two decades have seen marked changes in the management of patients with AF towards more structured care, which has led to important improvements of clinical outcomes (9). At the same time, management of AF has become more complex and requires a systemic, comprehensive, and multidisciplinary approach. International clinical practice guidelines recommend that AF treatment should include the following three aspects: 1) appropriate anticoagulant therapy to prevent...
thromboembolic complications; 2) rate- and/or rhythm control therapy to preserve LV function and control symptoms; and 3) treatment of underlying cardiovascular conditions as well as risk factor management and lifestyle modification to reduce risk factor burden, which consequently would reduce the burden of AF. Integrated models of care delivery have been introduced largely to focus on the delivery of care with specific attention to secondary prevention (10) and improving outcomes. Although these models mention that carers should be aware of the psychological morbidity of AF patients,(11) there is still a lack of detailed guidance, how to identify and appropriately treat AF patients with psychological health issues. Care for AF patients should also include patient involvement – their preferences and needs –, psychosocial and psychological management (e.g., prevention and treatment of anxiety and depression), a multidisciplinary and collaborative team approach where multiple specialists work closely with the patient and their carers (12), and the use of technology to support the integrated character of this approach (1). Current international guidelines recommend such approach in providing care and treatment for patients with AF (1). Although such approaches are promising (13, 14), establishing them in clinical practice can be tedious, and in reality, AF care is often fragmented, resulting in suboptimal clinical and patient outcomes.

**Psychosocial assessment and support in comprehensive AF management**

Currently, AF management is largely medically driven, and aspects such as psychosocial wellbeing, mental health, and anxiety and depression are often overlooked. Even though international guidelines state that an integrated care approach should include psychosocial management, including
cognitive behavioural therapy, stress management and other psychological assessment and/or treatment (1), there is no further guidance on how to implement this in clinical practice, including how and when to include dedicated psychologists in the integrated AF care team providing tailored psychological management according to patients’ needs and preferences. This may have several reasons. The lack of focus on psychosocial management of AF patients is at least partly a consequence of the fragmentation of AF care and the lack of education of healthcare professionals in psychological aspects, as it prevents healthcare professionals from having a holistic view of patients. Unless such guidance is provided and a consensus is reached within the field, patients’ unmet needs and lack of integrated care are likely to continue to the detriment of patients and costs to society. If we are not able to establish and implement a comprehensive and integrated care approach for patients with AF, this would be particularly challenging given that we are looking into a global public health crisis, as the prevalence of AF has increased threefold during the last 50 years and will continue to do so over the coming decades (15). Already, the healthcare system is burdened with ongoing workforce issues potentially leading to capacity issues in the near future. Hence, there is an urgent need to redesign practice, so that healthcare professionals have sufficient time to engage with patients and together determine a tailored care and treatment approach in which patients also have a responsibility and play active roles. The use of digital technology could guide this process. Previously, an integrated mHealth approach calling upon the active involvement of patients demonstrated significant adherence and motivation in patients with AF (16). AF as the most common sustained cardiac arrhythmia with a prevalence of 3% in adults often goes hand-in-hand with psychological reactions, including excessive worrying, continuous focus on the body's signals, which may lead to withdrawal from the things that...
give AF patients quality of life and ultimately depression. The prevalence of anxiety and depression in AF ranges from 28%-38% with women being more likely to becoming depressed than men (17).

As depression can be both a consequence of being diagnosed with AF and a trigger of the onset of AF, and they influence each other, also with regard to treatment, they are vicious twins. Hence, psychology matters, and it is paramount that an integrated care approach not only largely focuses on stroke prevention, improving arrhythmia symptoms, and treating the underlying cardiovascular disease and risk factors for AF as proposed with the ABC care pathway. Although attention to psychological morbidity of AF patients is mentioned in the original publication of the pathway,(11) it is crucial not only to identify, but also to treat patients' underlying mental health issues, such as depression, appropriately extending the care pathway to ABCD, where psychologists are an integrated part of the AF care team. This is particularly important, as depression is listed as a key AF-related outcome in the current ESC guidelines for the management of AF and may even be associated with suicidal ideation (1).

However, implementation and provision of holistic, integrated AF care in the 21st century is still associated with multiple barriers and challenges. To overcome these barriers, we need to educate and prepare healthcare professionals to work together and establish multidisciplinary teams, as we are facing a diminished workforce, an increasing treatment burden, little time to spend with patients and inadequate reimbursement for integrated care, which all are detrimental to our patients and call each of us into action to find ways out of this crisis.
Funding

This work has not received any funding.

Conflicts of interest

AB has received research grants from Theravance, the Zealand Region, the Canadian Institutes of Health Research, the European Union Interreg 5A Programme, the Danish Heart Foundation, the Independent Research Fund Denmark, and a lecture honorarium from Bristol-Myers Squibb outside the submitted work. SSP and JH have nothing to declare.

References