
NP Awareness of Bi-Directional Depression-Cardiovascular Disease Risk in Older Adults

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Purpose / Objectives

The primary aim of this descriptive study was to (1) examine NPs’ ability to identify depression as a risk factor for cardiovascular disease (CVD) and to (2) examine CVD as a risk factor for depression among older adults.

A secondary aim was to explore NP risk assessment patterns related to older age.

Methodology

➢ A national sample of NPs recruited from the AANP membership completed an anonymous review of 4 patient vignettes. After review, participants developed a risk profile for each case using a standardized checklist.

➢ Two vignette versions were administered to control for identification of age-related health risks. No differences were found between responses to versions A and B (p > 0.05).

Sample (N = 111)

➢ FNP (69%); ANP (22%); AGNP (4%); GNP (3%)

➢ 93% female; 71% between age 41-60; 98% white

➢ 64% in practice as NP for 5 or more years

Background

A large body of evidence supports depression as a significant and independent risk factor for CVD as well as a comorbidity of CVD. Clinically diagnosed major depressive disorder (MDD) is the most important risk factor for developing CVD. Effective depression treatment reduces disability, improves outcomes of comorbid health conditions, and improves quality of life. Yet, older adults have but a 50% chance of being diagnosed with depression and are less likely to receive help for depressive symptoms compared to younger adults.

Results

Vignette #1

Did CVD Recognize risk:

YES n (%) NO n (%)

For CVD 2° MDD? 73 (65.8) 38 (34.2)

For breast cancer 2° family history? 24 (21.6) 87 (78.4)

For falls 2° OP and sertraline? 12 (10.8) 99 (89.2)

For shingles 2° history chickenpox? 25 (22.5) 86 (77.5)

For suicide 2° MDD? 62 (55.9) 49 (44.1)

Vignette #2

Did MDD Recognize risk:

YES n (%) NO n (%)

For CVD 2° depressive disorder? 67 (60.4) 44 (39.6)

For falls 2° nocturna? 29 (26.1) 82 (73.9)

For nutritional deficit? 30 (27.0) 81 (73.0)

For osteoporosis 2° age? 85 (76.6) 26 (23.4)

For suicide 2° depressive disorder? 43 (38.7) 68 (61.3)

Vignette #3

Did MDD Recognize risk:

YES n (%) NO n (%)

For depression 2° known CVD? 69 (62.2) 42 (37.8)

For diabetes 2° BMI and fam hap? 15 (13.5) 96 (86.5)

For falls 2° age? 26 (23.4) 85 (76.6)

For osteoporosis 2° age? 52 (46.8) 59 (53.2)

For stroke 2° CVD and obesity 39 (35.7) 78 (70.3)

Vignette #4

Did MDD Recognize risk:

YES n (%) NO n (%)

For depression 2° known CVD? 62 (55.9) 49 (44.1)

For diabetes 2° obesity? 52 (46.8) 59 (53.2)

For falls 2° etoh, arthritis, age? 77 (69.4) 34 (30.6)

For osteoporosis 2° age and etoh? 87 (78.4) 24 (21.6)

For stroke 2° CVD and obesity? 17 (15.3) 94 (84.7)

Discussion

➢ Nearly 1/3 of sample failed to recognize depression as a risk for CVD and 2 out of 5 NPs did not recognize CVD as a risk for depression.

➢ The data are concerning, particularly since a majority of respondents reported having 5 or more years of NP experience and NPs are often the de facto and sole mental health provider for many older adults.

➢ While “who is responsible” for depression care among CVD patients continues to be discussed, primary care NPs are well-suited to integrate mental & physical health as comprehensive PCPs.

Implications

➢ The data indicate there is continued need for professional development among practicing NPs and during NP graduate education surrounding CVD risk and CVD-depression relationship.

➢ Secondary findings suggest age bias in the care of older adults by practicing NPs and warrants further examination. This is particularly important given our rapidly growing, aging society and shortage of providers specializing in older adult care.

References


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