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Collaboration Is Key—Strategies for a Multidisciplinary Approach to Anticoagulation Management for Patients with Atrial Fibrillation

Announcer Open:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Patel:

Hi, thanks for joining us again. My name is Manesh Patel, and I'm joined by a friend and a colleague, John Alexander, here today. This is a program entitled multidisciplinary approach to treating your patients with atrial fibrillation with oral anticoagulation to try to prevent stroke. This is brought to you by Duke Heart On The Go, and we're really excited to have a conversation with John about this because, you know, thinking about leaders in this space, he's thought about this for a while, and we have really good passionate conversations about what we can do for our patients with atrial fibrillation. So, thanks for joining me, John.

Dr. Alexander:

Yeah, glad to be here.

Dr. Patel:

Well, John, maybe you start by outlining for us, you know, we thought going into a multidisciplinary approach conversation, we could talk about our institution or another institution, but unfortunately, there are no perfect institutions, we're always striving for what that system is. So, maybe you could maybe give us a sense of what your sort of conceptual framework would be for the things that we're going to need to talk about if we're trying to build a perfect system for anticoagulating our patients with a multidisciplinary approach.

Dr. Alexander:

Yeah, so I mean, Manesh, the first thing I think that it's important to recognize is that patients with AFib are taken care of by all kinds of different providers. So, they're not all seeing tertiary care center or cardiologists, like you and me. They're seeing general cardiologists, they're seeing primary care doctors, they're seeing nurse practitioners, and physician's assistants, and then they're seeing all the other specialists too, who take care of these patients. And so, I do really think a system - I think about a system approach and all the people who play a role in it is important.

You know, the first - it really starts when you identify the patient who has atrial fibrillation, and, you know, they're newly popping up all over the time, often symptomatic, sometimes not symptomatic, device-detected atrial fibrillation. And so, you know, once you have this patient, you need to think about anticoagulation. And that's what we're here to talk about today.

Dr. Patel:

Yes, so it's great. So, a lot of people seeing these patients, we're going to come back to how do they - all those individuals interact to try to make sure these patients get the best care. And it starts with the patient. And so, tell me a little bit about how you think about patients' risk for stroke or bleeding and how you think about that, to get us to where we make the decision these days pretty quickly, about how to - about anticoagulating them.

Dr. Alexander:

Yeah, so, I mean, the reason we use anticoagulants is because they're really effective at preventing stroke. And stroke's a terrible, disabling side effect of atrial fibrillation. And so, you know, we usually use some score, CHADS-VASc is widely used to calculate people's stroke risk. And if you have CHADS-VASc of 2 or more, you know, maybe 3, maybe depending on whether you're male or female, your risk of stroke is high enough that you really need to start thinking about taking an oral anticoagulant. So, I start with having that conversation with people, that telling them like, what is their risk, got a couple percent a year or 5% a year? What does that turn out to be over a lifetime? And most patients are pretty receptive to reducing their risk of stroke. But I always start there, because that's, you know, they need to understand why they're doing this, why they're taking this medicine.

Dr. Patel:

Yeah. And in the perfect system, I would even say, let's say that this is a patient with known AFib, and this isn't the first visit, it'd be wonderful to have targeted materials for education, you know, we're thinking about that. So, as that patient comes, whether it's in the waiting room, whether it's in their MyChart, they're not only getting you to tell them that but that the system is providing them with, I'll call it, simple, understandable language and information about what a stroke is, and how the stroke might affect them, what that would look like; what bleeding events are, what that might look like. And we've done some work, as you know, thinking about this and understanding patient's preferences, because we are going to get to a point where after you've exchanged information with them, and they've sort of shared their preferences, then we're going to get towards treatment.

But let's assume our patient has a significant CHADS-VASc score, is at risk for stroke, and willing and wanting to be treated. Many of our patients these days are over 75 with a lot of different comorbidities, so they have a risk. How do you make the choice? I guess that's the next question. Tell me about the choice.

Dr. Alexander:

Yeah, well, the choice I mean, we now have options. We didn't used to have options a decade ago. Now we've got all these great options. So, there's vitamin K antagonists, warfarin, and then there are the DOACs, the direct oral anticoagulants, one factor II inhibitor, dabigatran, which I don't personally use very much. The 150-mg twice a day dose is approved in the U.S., but it has renal clearance issues that are big issues in our patients. And then the factor X inhibitors, there's apixaban or Eliquis, rivaroxaban or Xarelto, and edoxaban. And we don't use a whole lot of edoxaban in the U.S. either, or I don't in my practice. So, it's usually an apixaban, rivaroxaban kind of decision. I've done a lot of work with apixaban and know it well and so I tend to lean toward that if there's – there are some advantages of rivaroxaban, which we'll come back to.

But, I really do think that getting familiar with one of the DOACs in your practice makes a lot of sense to get really good and facile in using it. And having sort of niche reasons to use the other DOACs, it makes a lot of sense.

Dr. Patel:

I think so too. And I would at least say that, at least knowing two of the Xa's, probably more than the direct thrombin just because of renal dysfunction, makes sense. Understanding some patient risk factors and how they might compare, I think that makes a lot of sense. So, we get a nurse clinician or a pharmacist to help us, we might have some preauthorization mechanisms inside of our EHR.

I would say for me, the other big thing is to make sure we know the renal function, we're dosing them correctly. This is a big thing, because we want systems in place, not just with you ordering it, maybe sometimes at the pharmacy, I'm sure the pharmacy team is going to help us, and sometimes with our own APPs and others. So, I think that's the start: the conversation, the treatment, and getting the dose right. Let's say you've prescribed them, they're gone home, they're starting to take it, what do you do then? What does the system need to do then so that – because it's not just starting it, of course.

Dr. Alexander:

Yeah. So just one more thing, Manesh, that's really important about starting it, particularly in some of our complicated patients, is drug interactions, right? So, you know, an ideal system has a pharmacist who's either in that loop, looking at their other drugs that they're taking and making sure there are no major drug interactions, or at least is available to talk to about potential drug interactions, particularly in complicated patients.

Dr. Patel:

Yeah, so another key member of the team, a pharmacist who can help us with at least thinking about interactions and dosing.

And I'll sort of wrap it up a little bit by saying, you know, for us after that, at that moment with the pharmacist or our team, there's a lot of conversation about bleeding. And I do think it's an opportunity to think about other strategies to reduce bleeding, stopping aspirin in a patient who's chronically got coronary disease, ibuprofen, a variety of other things, making sure that they're prophylaxed for GI issues, if they've got GI issues. Those are the things I can think of. Any, from there to sort of our last 30 seconds submitted here, what about

population? How do we manage the population of patients with atrial fibrillation?

Dr. Alexander:

Yeah. Well, I mean, I think that's, Manesh, really a matter of figuring out finding all those patients, making sure they're all having the appropriate conversations, making sure we're just not missing people falling through the cracks, is really the population question for anticoagulation in atrial fibrillation.

Dr. Patel:

Yeah, if we're lucky enough to have a population office, or at least a group practice where you systematically do it.

Well, John, let me just say thank you for joining us on this multidisciplinary approach. It starts with the patient, but you've got to make sure you know their risks, you dose them right, you have systems in place to look at interactions, and you try to take your whole practice and get them treated, and you maximize using your APPs, your endocrinologists, primary care doctors, others that are going to help you, but certainly pharmacists to help you do this. Thanks for joining me.

Dr. Alexander:

Yep. Great to be here.

Announcer Close:

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