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Comprehensive Anticoagulation Management for Atrial Fibrillation

Announcer Open:
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Dr. Patel:
Hi, my name is Manesh Patel. And thanks for joining us again on this MedEd On The Go. You know, we're going to be talking about putting it all together for our AF patients. I'm a Cardiologist at Duke, and I'm going to have my friend and colleague, Steve, introduce himself, and then we're going to get into sort of the things we can do. So, Steve, thanks for joining me.

Dr. Deitelzweig:
Oh, Manesh, always my pleasure. And as you alluded to, I'm Steve Deitelzweig. I serve as the Service Line Physician Leader for Hospital Medicine, as well as I'm a Vascular Medicine Expert at the Ochsner System in New Orleans, Louisiana.

Dr. Patel:
Well Steve, always great to work with you. And talk about a great place to work, I'm sure, with a lot of diverse patients and a lot of patients that you probably see across Ochsner Health, which I know is a large place. So, you know, I guess I'll start by saying when we put it all together for our patients with atrial fibrillation, and there seems like a growing number of patients with atrial fibrillation as people age, what do you see is the one or two biggest opportunities that you see in your practice, or at least across your system, for how we care for our patients with AFib?

Dr. Deitelzweig:
Yeah, thanks for the question, Manesh. And, really, you hit the nail on the head with 30 plus million globally, some datasets saying that's going to increase by 60% by 2025. And what I'm confronting on a regular basis is just so many AFib folks that come in, that they'd had no idea they had AFib, they were asymptomatic, about a third of them find themselves in that circumstance. And then even once we diagnose them, we appreciate later on that only a third or so get the treatment that we believe would be – is strongly evidence based. And we can certainly chat about what that evidence is. And we should, you know, whether it's the VKA's or the NOACs or DOACs, if you choose.

Dr. Patel:
Yeah.

Dr. Deitelzweig:
I think those are probably the two cornerstones of concerns.

Dr. Patel:
Yeah. No. Talk about two big areas, the first being a lot of people both asymptomatic, and now with whether it's a watch, a patch, and a device that's implanted that can tell you if you have AFib or not, there's a lot of people that are actually getting newly identified atrial

fibrillation.

And then the second biggest opportunity, which I think you're right, you know, when we look at, in PCORI, or in national datasets, we see in large systems, somewhere up to 35-40% of people with atrial fibrillation and significant risk, not on, I'll call it, sick not on treatment. And treatment being an anticoagulant at the right dose, whether it's a VKA or a DOAC. So, still a large number of untreated patients or undertreated patients, and a larger and growing number of patients that are getting it diagnosed or identified.

So, let me take the first one on, Steve. How do you tackle the – and who should be involved in a multidisciplinary approach to figuring out for that patient that gets admitted, let's say, to the hospital with not knowing before that that atrial fibrillation, they come in a little short of breath or something, now they have AFib, they got some other problems. They're there for, let's say, a leg issue, and now they have AFib, right, and they didn't know they had AFib. How do you, I'll call it, risk identify and decide what to do for that patient regarding anticoagulation treatment?

Dr. Deitelzweig:
At least what's easy enough there, so without even confronting the asymptomatic, right, now they're symptomatic and we don't have to rely on an FDA approved single detection device to make the diagnosis, right, for us?

Dr. Patel:
Yeah.

Dr. Deitelzweig:
We have the EKG confirmation. But certainly, I'd look at this as we have to think about what's the clinical aspect and what we're doing there, we have to think about the value aspect, the quality of a course, of cost. And this has to be, you said it correctly, in multidisciplinary. So, HM, hospital med, certainly many of these folks will fall into our midst, 90% of the patients are managed by hospital medicine nationally these days. But then certainly, there's going to be nuances of the patients. Whether it's, you know, octogenarian plus, you're obese, there's chronic kidney disease, chronic liver disease, you name it, obesity, and that's where not all hospitals might not be that confident. And then we involve experts like a cardiologists. And these days, we also have our pharmacy, cardiovascular experts that could help and especially with the course components. So, it becomes quite a coordinated effort, and that's just on the inpatient side. But obviously, they're not going to be there for, these days, an average stay, if you pass poor, you're not - you're going to probably not be in your role too long. So, then you have to involve, you know, the appropriate handover not handoffs anymore, handover to the post-acute care space, so, whether it's a PCP or a cardiologist, or whomever, so to really orchestrate their care.

Dr. Patel:
No, that's a fantastic overview. And, you know, in fact, I would say the biggest pearls for us is that we've, and you guys have likely done this too, is that we've tried to automate it at least as much of the in inpatient work or Epic-related work, I won't even call it inpatient, as much of what I'll call is your EHR-related work as you can. For me, I think the biggest opportunity in that regard is involving everyone but making sure we involve the patient and their family to understand their risk, because a lot of people are worried about bleeding. It may be part of the second part of undertreatment, why they don't get therapy. But the conversation of understanding their risk, their stroke risk, and getting their stroke risk and their patients values on what they value - stroke, and bleeding, and some of these things that they may want to avoid. But let's say you've had that conversation, you've got the team there, you're making a decision about anticoagulating, how do you help with, I guess I'll call it, the second biggest opportunity, which is implementation? You know, we often in medicine know the right thing to do, we just have a big problem trying to get it done.

So, what are some pearls on how we get people anticoagulated that are at risk, remembering that the guidelines say CHADS-VASc of 2 or more, most people should be getting anticoagulation. All of the DOACs were shown to reduce bleeding and stroke and significantly fatal bleeding. Now, apixaban reduced all bleeding, some of the others reduced some of the ICH and fatal bleeding, but those are important conversations individually for patients. There's renal function, other things you'll look at. But we know that the DOACs are better than warfarin. So, one is, you've got to get them treated. How do you then get them treated, whether it's with the DOAC? Or make sure they're getting the right dose of that DOAC?

Dr. Deitelzweig:
Yeah, the patient and family engagement is key. And one of the models that we've endorsed, at least at Ochsner, has been something called SIBR, that's structured interdisciplinary bedside rounding. So, this, in concept, is a simple one, you have the clinician, physician, the nurse, the case manager, all round in a time-based manner with the patients to outline all that you just expressed. And so, this is the – and the case manager may run off and make sure that this patient gets – be able to get, say, if it's apixaban and they have that available to them, have meds to beds at discharge. So, the meds to beds at discharge so you don't have to go find their Walgreens or CVS. So, it gets delivered in that manner.

And then of course, it shared decision-making. So, you - whether it was here's why what we think is good, or the limitations of the VKA is the good, and the limitations of name the DOAC, and just kind of march them through with whatever evidence you think they could comprehend. And then we do a repeat-back. And I always like to say: What have you heard me say? And then does that sound reasonable? Will you comply?

Dr. Patel:
Great forum and really valuable because let's say you make a decision, everybody's agreed we're going to use a DOAC, and it's apixaban maybe. And you're going to make sure that they can get that in the outpatient. And they're going to make sure that they can actually get access to it. And then with your pharmacist, you're going to make sure they get the right dose of it; they meet two out of those three criteria. They're not getting underdosed. And then they go home.

And I'll just say the last part of implementation, if you've got that therapy going, is closing that loop. As you said earlier, when we were talking, it's not a transition, it's not a handoff, I guess it's a handover. Tell me a little bit of how you handover to the primary care physicians or the cardiologist to make sure that this happens?

Dr. Deitelzweig:
I'm sure you do this at Duke as well, and do it probably just expertly, and that is using our version, and it's not off-the-shelf version of Epic, as you know, you have to individualize, even if you have all the bells and whistles. But then to have an expectation that we're outlining and know that handover, not just having a discharge summary at time of discharge available to the next coalition, whether it's tomorrow or a week from tomorrow, but to have it really crystallize. And I would be remiss to say that we do it perfectly every time. But we do have templates that we try to strive for. And part of that is in a discharge management tool that has different milestones that the case manager needs to check off on to see what's there as barrier – if you did have barriers, you look at as opportunities to get better and better and better over time.

And certainly, the last thing we ever want to see happen is say we start on one DOAC and they get transitioned to another DOAC, that is really a danger zone for patients. And so, we really - we've published on that, we've presented on that. We don't like switches. And so, that's one other thing that we really spend some time on.

Dr. Patel:
I think it's a really great point and switching inherently carries risk. And we've seen that in multiple trials, we know that in clinical practice; it leads to confusion. And fundamentally, we've walked through that inpatient, but almost all the same things are happening in the outpatient arena and addition is just maybe getting compressed because you have to identify, discuss, do shared decision-making, and then have a mechanism by which the therapy is going to continue, which is at the right dose with some feedback.

You know, for us, what we found is both at that time and then closing that loop, whether we're doing it automated or we're having some group or some way in which that patient's getting retouched, them in their family to get therapy. Essential, right?

Well, I'll just say thanks for joining me. These kinds of systems that you build at your system and our system and others, I don't - you know, I say this all the time, it doesn't matter to me what your system is, I just want to make sure you do have a system with multiple different aspects of people with different viewpoints helping care for that patient. Because that then leads to that model of multiple checkpoints to prevent that error from happening where the patient who meets an indication doesn't get the therapy at the right dose at the right time.

Dr. Deitelzweig:
Alright, well thank you.

Dr. Patel:
Thanks, Steve, for joining me. Thank you all for listening and we hope you'll continue to follow us on MedEd On The Go, as we think more about how to best care for patients with atrial fibrillation.

Dr. Deitelzweig:
Until next time.

Announcer Close:
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Dr. Patel:

Until next time.