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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Putting It All Together: Coordinating the Multidisciplinary Care Plan for the Elderly Patient With Atrial Fibrillation

Announcer:
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Dr. Patel:
Hi, my name is Manesh Patel. And thanks for joining us again as we talk about patients with atrial fibrillation. On this episode, we're going to put it all together, coordinating multidisciplinary care for our patient with uh – our elderly patient with atrial fibrillation. I'm joined by a friend, a colleague, and electrophysiologist, who's done research in this area, Sean Pokorney. Sean, thanks for joining me.

Dr. Pokorney:
Yeah, thanks so much for having me. I'm excited to talk through this. It's certainly a challenge to coordinate care in these older patients.

Dr. Patel:
Yeah, so, you know, we see a lot of different team mobili – you know, team structures for patients with atrial fibrillation. And we've seen an explosion of patients that have AFib, both by how we recognize it, as we've talked on one of these episodes, how we might think about how long they have AFib, and how we might think about treating them when remembering that the definition of elderly, at least as we're thinking about it for this, are people over 75. And there are many,

many millions of people over 75 that have families and all kinds of comorbidities. So, when you think about putting it all together to help decide this shared decision-making and then implementation of the right dose and therapy for atrial fibrillation anticoagulation, first, let's just start by naming all the team members. Who should be involved? Obviously, the patient and their family and you as the clinician. Who else?

Dr. Pokorney:
Yeah, I think, you know, there's a lot of people that probably need to be involved in this decision-making. So, including the primary care provider is really important. That's obviously the patient's quarterback and going to be an important person in their healthcare lives. I think that also getting the geriatrics team involved, whenever that's appropriate, especially as patients may develop cognitive impairment, for example, I think that the geriatrics team can be particularly important. And then I think, for patients that have mobility challenges, incorporating team members into the healthcare team that can help facilitate that, making sure to get them physical therapy and occupational therapy, and making sure that they have the support tools that they need to maintain their mobility, but not with increased risk of falls. And again, there's one of the reasons for undertreatment of these patients is the concerns around mobility and the concerns around falls. And so, I think, you know, in particular, getting physical therapy and occupational therapy involved and engaged when those concerns exist, I think is really important.

Dr. Patel:
Yeah, I think those are great people to be on the team. And some other members that people will be using across the spectrum, I can imagine are our colleagues in pharmacy, whether they're in the system, in the hospital, or at the pharmacy where they're getting their

medications, are really important colleagues to have both to check dosing and to make sure pill boxes and things can be thought of and other interactions. And then our advanced practice providers, many of whom partner with us to make sure that we're working to make sure we follow up some of these patients. So, that whole team is often important.

And maybe as we think about that multidisciplinary approach, as you highlighted, there's different aspects that we're leaning on each of those groups to be. And the first might be if we think about our journey, the decision to treat, and then I'll call it the implementation of treatment. And so, walk me a little bit through the decision to treat, how you think through that. And then we can talk about the implementation of treatment.

Dr. Pokorney:
Yeah, so this is important. You know, this comes up a handful of times every year that I see a patient in clinic. It tends to be elderly patients who have been seen by primary care, in some cases even been seen by general cardiology, and they're not on an anticoagulant, and even though they have a guideline indication. So, the first thing is making sure that we're using guideline-based treatment options for these patients. So, using CHADS-VASc score for patients that again are in this elderly population of 75 years or older, they all have a CHADS-VASc score of 2 or greater by definition, just based on their age alone. And so, they all have the class 1 indication for anticoagulation, both if they're men, they're going to have a CHADS-VASc of at least 2, and if they're women, they're going to have a CHADS-VASc score of at least 3. And so, all of these patients are patients that we need to engage and think about anticoagulation for stroke prevention.

I think that one of the things that I hear from some of these patients, particularly as they get into their late 80s, they say, 'Well, I don't want to take an anticoagulant; I have to die of something, so I'm not worried about it.'

But again, one of the things that we really need to emphasize to these patients about, you know, 1 in 4 patients that has an AFib stroke, dies within 30 days, but many of the other patients are heavily debilitated; these tend to be large strokes that dramatically affect patient's quality of life. And so, one of the things that I really engage with patients on when we're talking through this is what type of quality of life they want to live, how independent they're currently living, and how independent they want to continue to live. And I think making sure that they understand that having an AFib-related stroke really jeopardizes that independence, more than it – more potentially than it even affects mortality, I think it's something that really resonates with patients when I sort of engage them in that decision-making.

Dr. Patel:
Yeah, I think this is a key fact for all patients, but certainly our elderly patients who think about, I'll call it health span much more than lifespan. What do the healthy years look like, compared to the length of the number of years we live? And obviously, I think our elderly patients think a lot about that. But then the second point you really hit upon, which is, most people don't want to be a burden on their family. So, they'd rather figure out ways in which they can be independent, as you said. So, I think having that conversation is really important because I think shared decision-making, in its essence, is transferring information, making sure the person understands it, understanding their values, what they want, and then making a decision.

And let's say some of them now come to wanting to be treated. Then the second part of this is the multidisciplinary approach to treatment. And I think that is including, as you said, making sure the quarterback or the primary care provider knows what we're doing, the dose which you and the pharmacist and others will be working on, but we've talked a little bit about making sure to get the right dose. There's other things pharmacy helps us do sometimes in this approach, which is to reduce their risk for other things. And name some of those things that you get an eye – you keep your eye out for when you start treating these people to make sure they stay on therapy.

Dr. Pokorney:
Yeah, so I think one of the things that's really critical to keep in mind is the overuse of aspirin in combination with anticoagulation in these patients. Many of these patients will be on aspirin at the time that they're diagnosed with atrial fibrillation - many of them for very good, justifiable causes. But – but once those patients are then started on an anticoagulant, by and large, their aspirin should be stopped unless they've had an MI or PCI within the last year. Uh, potentially, if they've had CABG, there's maybe some data about vein grafts potentially staying more patent in the context of aspirin. But – but largely, for patients that are on an anticoagulant, we need to be getting them off aspirin because that aspirin therapy increases their bleeding risk by 50%, which is particularly meaningful in these patients.

And then something else that I focus on with patients is making sure to engage and hear what their concerns are about nuisance bleeding in particular. This is a very common reason why anticoagulation ends up being stopped. Patients complained of nosebleeds or gum bleeding. And again, nosebleeds are something that I want to make sure that patients are talking with me about because that's something that we can actually usually very easily treat. And for those patients, I'll just have them do an Ocean spray in their nose a few times a day to keep their nose moist and their mucosa moist. And largely, that eliminates most of that nuisance bleeding that's at least epistaxis related.

Dr. Patel:
Yeah, no. Critical issues, primary one being aspirin use. We've seen it in randomized trials, one which was stopped early with riva and aspirin versus riva alone for people with AFib and CAD history where, by itself, it helped. AUGUSTUS, other studies post PCI showing you can drop the aspirin and keep the clopidogrel. So, lots of strategies, but aspirin as an additional for chronic vascular therapy probably not used in patients with atrial fibrillation, should stop it, should stop NSAIDs, look for nuisance bleeding.

And then the last piece of implementation is just circling back, whether it's with your APP, geriatrician, primary care, whoever, to make sure they're taking it the way you want, with family. And that really helps close the loop long-term to get the best outcome. So, it's not just recognizing who needs to be treated, not just getting the right dose, not just stopping aspirin and other things to begin, but also keeping them on it.

Well, this has been fun. Uh, thank you for walking me through how we think about it. And hopefully you all can help build some multidisciplinary teams to make sure your AFib patients get treated. Thanks for joining us again for another MedEd On The Go. Uh, thanks, Sean, for joining me.

Dr. Pokorney:
Thanks so much for having me.

Announcer:
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