Brandon Walker: 00:00

Hi everyone, I'm Brandon Walker, learning and development trainer at the American Heart Association. Joining me for today's discussion on atrial fibrillation are AHA volunteers; Pamela McCabe, assistant professor of nursing at the Mayo Clinic College of Medicine and Science, Robert Page, professor of clinical pharmacy and physical medicine rehabilitation at the University of Colorado, and Annabelle Volgman, professor of medicine and senior attending physician at Rush Medical College and Rush University Medical Center.

Today we will be discussing the results of a recent AFib provider survey, conducted by the American Heart Association. This podcast has been made possible through a grant, from the BMS-Pfizer Alliance. In the second part, we'll discuss AJ's role in expanding the use of evidence based care for AFib, and what we could do to close the gaps.

Alright, well without further ado, let's go ahead and move to our third question today. The question is; although many are aware of the AFib treatment guidelines, full understanding and use seems to be lagging. Seven in ten claim awareness of the 2014 ACC/AHA/HRS guidelines, but only 19% of PCPs and 10% of nurses are very familiar with them. Let's start with Dr. Volgman on this one. What can we at the AHA be doing better to ensure that our AFib guidelines are used more widely within non-cardiological practices and general practitioners?

Dr. Volgman: 01:28

Thank you Brandon for that question. The AHA is already doing a lot of things in this arena. I know that there is a gap with the guidelines of atrial fibrillation, and I have been taking care of patients for the last 29 years, and what I think has really made a big difference in the practice of cardiology in taking care of women were the guidelines. They did, really, emphasize how important it was to treat patients; not just by sex but by disease. We used to think that heart disease was mostly a man's disease, and the guidelines clearly stated that if you don't do these things, they will have worse outcomes, and it was shown that when you use the guidelines, it really helped decrease that healthcare disparity between men and women.

I think that get with the guidelines of atrial fibrillation will help with that. The other thing that Dr. Page mentioned was shared decision making. That is such an important part of healthcare today, because we want to make sure that the patients feel comfortable with whatever the doctor, or healthcare provider, is recommending. But before we could make a good, shared decision making work, we need to educate and increase awareness about atrial fibrillation, not just in the primary care

physicians or healthcare providers, but in the patients who have atrial fibrillation. They need to know that if they are high-score or high-risk for atrial, they need to know that they are at high risk for stroke when they have atrial fibrillation, that there is a 70-80% reduction in the stroke risk. And I find that when we talk about patient's risk for stroke versus bleeding, the patient will always prefer to risk bleeding than a stroke. And we need to give that option to the patients, because most of us don't want to make anyone bleed, but we also don't want anyone to have a stroke. Strokes can be permanent, most bleedings are not permanent.

So I think that shared decision making would only be effective if the patient knows what the consequences are of making those decisions. The other thing about the AHA can do, of course, is to educate and make the public aware about what causes atrial fibrillation, and what causes stroke in atrial fibrillation. I know that they do public service announcements, and I think they're incredibly effective, so I think the AHA is doing a lot but they can also continue to do more about education, educating patients and healthcare providers. Thank you.

Brandon Walker: 04:16

Wonderful, thank you for your perspective, Dr. Volgman. Dr. McCabe, would love for you to weigh in on this same question, what can we at the AHA be doing better to ensure that our AFib guidelines are used more widely within non-cardiology practices and general practitioners?

Dr. Volgman: 04:31

Well thank you, Brandon. I think it's important to remember that the primary care providers have their own guidelines for management of atrial fibrillation. They were released in, they were revised in 2017 and they are, this is endorsed by the American College of Physicians, and the American Academy of Family Practice, and the 2017 guidelines are highly related to pharmacological management, which includes anticoagulation. And those guidelines are not exceptionally different in that first line, kind of therapy, from the AHA guidelines. So, it would be great if they could just follow their own guidelines because their clearly, their guidelines are to anticoagulate and use the scoring systems for understanding and predicting stroke risk. And there's guidelines for the type of medications that should be used for rate control.

I think there is a greater focus on the initial management of atrial fibrillation to be for a rate control, and I think this is based way back on the findings from a where in which there was no difference between pharmacological control, using rate control of rhythm control methods. So, it may become burdensome for

primary care providers to have to be looking in all kinds of different places, specialties to manage all of the clinical conditions that they have to manage. So, I'm not sure how realistic it is to ask primary care providers to know the AHA guidelines intimately. I think we could anticipate the better outcomes if they even just followed their own guidelines. So the AHA guidelines or their own primary guidelines.

Brandon Walker: 06:24 Excellent, thank you very much for your perspective as well. Dr. Page, how about you back clean up for us and weigh in?

Dr. Page: 06:31 Thanks so much, Brandon. So I know this is gonna sound very trite, but there is an app for that. I guess from the patient standpoint, I've been fortunate to be engaged in some of AHA population based grants, where we've been trying to engage patients. I can say from the pharmacist perspective, when the patients are engaged, they ask more questions and also, number one, and then also number two, they're more likely again to take their meds, so the more likely to be adherent.

And so, I never really do like these commercials for these new anticoagulants on the television, but actually they serve a purpose, and what I think is, it acts as a catalyst for patients to talk to their providers. If a patient engages their provider, also our data that we've been, from one of our grants, is that they're more likely to be put on evidence based therapy. So, which should be the AHA's, what else can they do? Well number one, I think engaging patients is one of the key things to open up that discussion. Then, number two, with regards to the providers.

Now as Dr. Volgman mentioned and Dr. McCabe mentioned, primary care, you have to treat just about everything, it's hodgepodge. You don't have a lot of time. And so, one of the aspects, one of the things that I think AHA can do is, again, they have some fabulous apps, with regards to guidelines, that are sweet, dirty and down with the point. And they're free, and they're also based upon medical condition. I use these apps with our medical residents, cardiology fellows, trainees, everything. To say this is a quick way just to click, boom, and also to access. So, making sure that these tools are made available to primary care docs and providers is very, very important.

And I also think that, and having worked with other cardiovascular organizations, trying to incorporate the general practice provider into the AHA fold, I think is something we need to do a little bit better job of, because they are the ones who are also taking care of hypertension, hyperlipidemia,

they're taking care of heart failure as well. And so, trying to include these individuals into the fold, I think will be also something that is very, very important. And that also then lends itself to what Dr. McCabe says as well, just so that primary care providers do know that the AHA is there to support them as well.

Brandon Walker: 09:10

Excellent, great perspective from everyone today so far, and let's go to another question here just regarding final thoughts on how we can begin to close some of these gaps that we're seeing in diagnoses and treatment within general practices. And I know we've heard a few thoughts a long those lines, but let's see if we can get any more, elaborate a little bit more. So, how about we hand it off to Dr. McCabe first, and then we'll go with Dr. Volgman, and then Dr. Paige, you can wrap us up on this last one.

Dr. McCabe: 09:38

Well, thank you. I think there have been some discussions about actually going to primary care practices, primary care organizations, to find out what they think would work for them, what their needs are, and having that collaborative discussion with how do we both be AHA and their particular organization, such as the family, Academy of Family Practice, and the American College of Physicians. How do we actually take on some of these challenges together to meet the needs of the patients? And rather than, maybe the American Heart Association not recognizing all of the challenges that primary care has, and I think having some insight and having those conversations with those groups would help to increase their awareness in some of the resources that you were talking about, Dr. Page. And then, maybe targeting what they think their needs really are.

Brandon Walker: 10:42

Very good. Dr. Volgman, would you like to weigh in?

Dr. Volgman: 10:45

Yes. Just wanted to inform everybody that the American Heart Association is already donating, or actually using, $10 million dollars towards efforts to figure out how to best get people who need to be anticoagulated on the right medication. The strategically focused research networks are concentrating on shared decision making, and two sides are actually doing intensive research into figuring out how to educate patients and healthcare providers, into making the right decision for each patient. So, I think that the American Heart Association should be commended for their efforts in this cause.

The other thing that Dr. McCabe mentioned was the AFFIRM study, which is the atrial fibrillation follow up and rhythm

management study, which was done in the early 2000s, where we randomized patients to rate control an anticoagulation, versus rhythm control with anti-rhythmic drugs and shocking the patient, but they left the decision to anticoagulate those patients to the health care provider. And surprisingly, there was no significant difference between the two decisions, whether to keep them just in atrial fibrillation but rate controlled, versus in sinus rhythm. But what we have to remember is that those patients who were referred for the study were mostly patients who tolerated both rhythms, so it is a little bit of a biased population. So I just wanted to remind people that in patients who are in atrial fibrillation, if they are symptomatic, they need more care. It's not always enough to just keep them in atrial fibrillation if they're not feeling well.

As you know, atrial fibrillation can cause not only strokes, but heart failure. And we looked at some data recently that showed that a lot of patients are being admitted to the hospital with heart failure and atrial fibrillation, so it a big problem and we do need to better treat these patients. Not just with rate control, but if they are having any heart failure or symptoms of fatigue, shortness of breath, palpitations, or just not feeling well, they may need more care to either convert them to sinus rhythm, using catheter ablation, or anti-rhythmic drugs. So, we really need to be taking good care of our patients because they do go into heart failure, and it's not easy for these patients to be in atrial fibrillation. Thank you.

Brandon Walker: 13:35 Thank you very much. Alright, Dr. Page, would like to hand you the final word here today. So if you have any thoughts, final thoughts on how [crosstalk 00:13:45] we can close these gaps.

Dr. Page: 13:46 Yes, thank you so very much. So kind of, one point just to add to Dr. Volgman's comment, I agree. I think some proprietors are a little bit scared with regards to using the anti-rhythmics, but we realize that they are highly efficacious. The one thing I will say, and I remember this from one of my EP cardiologists that I work with, he always says that everyone deserves at least one chance at normal sinus rhythm. And with that said, I think that also adds on Dr. McCabe's point with regards to referrals, and that we should be considering referrals fairly early on. You know, we think of remodeling the occurring post-MI, but it also occurs, remodeling occurs in the atrial with atrial fibrillation. And, if it's left untreated, that in and of itself can sometimes lead again to heart failure, which is the area that I primarily work in. So, I think that's one point I do want to bring out.

The other is with regards to overall, is anticoagulation. I think one of the reasons why we didn't see a lot of patients, probably in their early 90s, beginning 2000s, is primarily people don't want the monitoring, the drug interactions, and all these issues with regards to Coumadin, we now have these newer anticoagulants, I guess they're not as new, we'll call them the NOAC, DOAC, whichever one you want to say, to the direct oral acting anticoagulants. But, the caveat here is that while they are easier to use, you still need to make sure that you have to evaluate the patients risk factors, as well as potential drug drug interactions, as well as the dose is dependent upon the renal function. And so, also providing that education to providers, I think is very, very important. There are differences in terms of the pharmacokinetics, with regards to these new oral anticoagulants, but I believe that it is making anticoagulation a lot easier. But, nonetheless, there's several factors that need to be taken into account.

Dr. Volgman: 15:48 Dr. Page, I'm glad you said something about monitoring for renal function, because there was a study that showed in real world use of anticoagulants, the use of novel anticoagulants, or direct oral anticoagulants, were found to have more strokes, ischemic strokes, in patients compared to Warfarin, and are worried that patients are being under-dosed on these new anticoagulants for fear that they may cause more bleeding if they use the right dose. So, I think we need to keep following that, because real world, the brand must control studies using these drugs, showed that they were as advocatus as Warfarin, but if health care providers are using lower doses of these drugs, they may actually be causing more strokes than they're supposed to be.

Dr. Page: 16:43 Yes. Thanks so much Dr. Volgman, and then also, I guess on the other side, is with regards to reversal. That was when I talked of family medicine practitioners, they're always worried about that. And, so, now we have an adequate supply. We have two reversal agents now that are on the market that we can now get a hold of. I know there was a shortage in the very, very beginning, but now these are available. Of course, they are very costly, but nonetheless, those are now available. And so, I think also may allowing primary care to realize that as well. I know initially we only had the reversal agent for Dabigatran, but now we have them for the remainder. And so, getting that information out is also important.

Brandon Walker: 17:28 Fantastic. Well, I'd like to again give a special thanks to our volunteers for your time today. We absolutely appreciate the fact that you have taken time away from your busy schedule to

join us and provide us with this great information. Your participation and insights have been invaluable. So, thanks for listening everyone. This podcast has been made possible through a grant from the BMS-Pfizer alliance. Views expressed in this podcast do not necessarily reflect the official policy or position of the American Heart Association, and American Stroke Association. For transcripts of this podcast, and more information about AFib, please visit heart.org/afib. And thank you very much, once again.