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FULL TRANSCRIPT (with timecode)

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Dr. Allred: Hello and welcome to today's episode of the Focus on Atrial Fibrillation, where we address gaps and barriers to care for the diagnosed and untreated afib patient around four key areas of concern: f Winston Salem, North Carolina. Welcome to today's podcast. Dr. Bradford, please tell us a little bit more about yourself.

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Dr. Bradford: Yeah, thank you so much for having me today. I'm an electrophysiologist at Atrium Health, Wake Forest Baptist. I specialize in irregular heart rhythms and I have a high level of interest in atrial fibrillation. I'm very honored to be participating in this and addressing gaps, barriers in care for our undiagnosed and untreated afib patients.

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Dr. Allred: Thank you, Dr. Bradford. We are excited to have you on the podcast today. As we think about great care in patients with atrial fibrillation, certainly Atrium Health, Wake Forest Baptist Medical Center comes to mind as we think about centers providing wonderful care. So today, as we talk about patients with falls, what are the perceived and actual barriers to appropriate anticoagulation for patients?

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Dr. Bradford: That's a great question. There are a lot of barriers and perceived barriers that the patients, family members and providers have. When we think about those barriers, they're similar to those groups in that there is concern for fears of falling, forgetfulness of taking their medicines, a big concern about cost of medicines and access to medicines. What I'm thinking about from the provider standpoint, and other providers concerns, I think the most common concern is that bleeding risk and the risk of falling being a large part of that.

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Dr. Bradford:

Dr. Bradford: And so that's a high concern for providers. And of course, providers also are really concerned about the future and possibility of not just falls, but motor vehicle collisions or some need that they are going to need to reverse an agent and what they're doing to kind of planning for the future for their patients. For patients, I think the biggest barrier that I hear is the concern of fears of falls but also cost. So patients are often concerned about how this is going to change their medical regimen and are they going to be able to afford this medicine and take it appropriately and regularly. When, particularly in elderly patients with fears of falls, they're also worried about this reversal and it's something that you can talk to them about what to do in case they do have a fall or when they need to seek medical attention. And for family members, they have those similar falls, but they also feel the burden of the potential forgetfulness of their family member. So if their family members are not taking their medicines appropriately, they may feel responsible. And so those are all barriers that have to be addressed in clinic. I think that that's something we're addressing with our atrial fibrillation patients on their first visit, but then in all of our subsequent follow up visits.

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Dr. Allred: So when a patient comes to your office and they bring up that fear of falling, how do you approach that patient? How do you decide whether or not maybe their falls are such that they shouldn't be anticoagulated? Or do you say, you know, this really is someone I think should be anticoagulated and how do you approach that?

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Dr. Bradford: Start with a good history. So I want to know more about their falls. How often are they falling and what is the cause of their falls? So there may be a treatable cause of their falls that can be easily identified and corrected, or there may be just a lifestyle aspect here or things that we need to work on as far as strength training, exercise programs, changing in what they have access to at home, support. And so getting a good history is the first step.

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Dr. Bradford: Then it's consideration of also how many times they fall when we're looking at an anticoagulation and the risk of falls and the risk of bleeding. The data shows it requires quite a few falls to have the risk of bleeding outweigh the benefits of anticoagulation. So you have to consider that and their risk of stroke. And that's where using those scores like the HAS-BLED score and the CHADSVASC score to kind of weigh, In your mind, their risk of bleeding and their risk of stroke. And then, taking into consideration where they are in that and their risk of falls, and of what you're able to help them correct or help them improve comes into play.

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Dr. Allred: So you mentioned a couple of scoring systems, CHADSVASC, HAS-BLED, how do you use those in your practice to manage these patients? And so as others are out there listening to this podcast, could you help us understand, you know, how do we put these in perspective, one of another when sitting down with a patient to determine what the right thing to do would be?

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Dr. Bradford: Yeah. So for my atrial fibrillation patients, I'm always calculating their CHADSVASC and their HASBLED score. I'm doing that because those variables can change between visits, but I'm doing that to estimate their risk of stroke and their risk of falls. Someone with a low CHADSVASC score may not require anticoagulation. But in the patients that we're talking about here, those that are fall risks are generally elderly and just by their risk factors alone, by having two points likely for age and often many comorbidities, they are at risk of stroke.

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Dr. Bradford: I'm looking at those two scores and I'm weighing what the concern is. And I am concerned highly about the risk of stroke in my atrial fibrillation patients. And so that often takes priority or something that we have to talk about: what a stroke could do, how that could change lifestyle, and taking that all into consideration, talking to the patient and the family about that. So once we look at those values, we look at what anticoagulation would do to reduce those risks, generally two thirds reduction in their risk of stroke. And which anticoagulant is appropriate for them and is the best agent because some of our agents are preferable.

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Dr. Bradford: Novel oral anticoagulants are recommended in this age group to have a lower risk of intracranial hemorrhage, in particular over vitamin K antagonists. So talking about what anticoagulant would be appropriate for them. So those scores really help guide us. And outside of that, if we're looking at someone who is a high risk of bleeding, that is also a high risk of stroke, this also comes the question on whether or not they be appropriate for left atrial appendage closure.

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Dr. Allred: No, I think part of the difficulty in using the scoring systems is that when you look at CHADSVASC, the higher the score, the higher the risk for bleeding. And when you look at HAS-BLED, the higher the risk for bleeding, the higher that HAS-BLED score is, also the higher the r7ki hileg. Airhl ,THAS

Dr. Allred: As I think about your institution. One thing that really stands out to me is the multidisciplinary approach that you guys take to patients with falls and anticoagulation. Could you speak to that?

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Dr. Bradford: I think that's really critical for our fall patients because once we determine they're at risk of stroke and at risk of bleeding and there's a fall risk, what we want to do is be able to continue anticoagulation but reduce their risk of fall. And as an electrophysiologist, that's not something I can always get to all the parts of the fall risk and help correct. I need a multidisciplinary approach. I need help