

AFib Podcast: Frailty

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FULL TRANSCRIPT (with timecode)

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Dr. Allred: Hello and welcome to today's episode of *The Four F's of Atrial Fibrillation* where we address gaps and barriers to care for the diagnosis and untreated AFib patient around the four key areas of concern: frailty, falls, fear of bleeding and forgetfulness. In this episode, we will focus on answering the question of frailty. My name is Dr. James Allred. I'm a cardiologist specializing in electrophysiology at Cone Health, and I'm your host for this podcast series.

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Dr. Allred: Today, we are joined by Jill Schaeffer from Penn Medicine, Lancaster General Health. Jill, welcome to the podcast today.

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Jill: Thank you very much. It's an honor to be here.

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Dr. Allred: When I think of AFib specialists across the country, Jill Schaeffer comes to my mind. I think back to about eight years ago when our practice was looking to better care for patients with atrial fibrillation, and we made a visit to Jill and her team at Lancaster General and were blown away at the great things that you were doing. It's a real privilege to have you on the podcast today.

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Jill: Oh, thank you very much. Has it been eight years?

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Dr. Allred: Been a long time

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Jill: Yes.

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Dr. Allred: So, as we think about frailty, what are the perceived and actual barriers to appropriate anticoagulation therapy?

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Jill: I think that it's multifactorial. I think from a provider perspective, we've just all been taught in our careers that we should first do no harm. So, there's always a concern that we don't want to make a patient worse. So many times, when we see folks who are elderly, they're frail, they have a fear of falling. I think the providers worry: Am I going to hurt the patient by providing anticoagulation? And I like a saying that is out there when it educates us on what's appropriate for anticoagulation that says: *We should fear the clot, not the bleed*. And I think that's very true. I think that we have to have a good education for ourselves so that we can help our patients understand what are the true risks and benefits because patients often fear bleeding as well. I hear things like, "But what if I bleed to death?" They watch commercials

regarding anticoagulants that are on the market, and those come with many caveats and concerns. And so, they're fearful of that. There's also worry about costs and co-pays and needs for testing. But in my experience, patients and families fear a stroke much more than they do the bleeding after you have a conversation about the risks and benefits.

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Dr. Allred: I think for the frail patient, it's often difficult to engage that patient, even, at times, for them to come to the office can be a challenge. As you think about that, often you're dealing with their family and you're dealing with their caregivers. Are there ways that you would approach the fragile or frail patient differently than other patient populations?

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Jill: I think, yes, that we go through the actual risks and benefits. I think we calculate the CHA₂DS₂-VASc score. We have that conversation with the patient and family. Through COVID time I've actually had some of the conversations on remote visits because people haven't been able to come to the office, mostly because of infectious concerns. Just had a call the other day where a daughter's in California, the gentleman's at his retirement community because we saw a long atrial fibrillation episode on his device. So as a nurse practitioner, I found it a challenge, a little bit, because it was a phone call. Patient didn't want to do a video call and patching those in, so sometimes that's a little bit more difficult if you're not able to lay hands on the patient and to look them in the eye. I find that a little bit of a challenge, but I think we're getting better at our skill set in doing remote monitoring and certainly including the family. My experience with that patient was unique in that the family was very open to conversations. The patient himself was frail just because of a history of some mild dementia, but he was also a retired psychiatrist. So, it was an interesting conversation because he certainly remembered his patients in the past being on warfarin, but he wanted to have a conversation of the new anticoagulants, and it was quite an interesting conversation. I like to tell the story of risk versus benefit. So, when we have the CHA₂DS₂-VASc score, we can actually cite a estimated risk of stroke and most patients, and families don't know that number. They don't know that. And in fact, there was a paper that was in the Heart Rhythm Society screening initiative. It was a screening and education program that's published that was led by both HRS and the Academy of Medicine. In that screening population, they interviewed patients that didn't have atrial fibrillation, but they were being screened for it. And they found a remarkable deficit in understanding the risks of stroke with patients who have atrial fibrillation.

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Jill: And I thought that was a really interesting revelation. And it just behooves us as caregivers. You know, this is everyday conversations for us. We have these conversations. We know the statistics, but our patients and family don't. So, I challenge myself each time I'm having these conversations to think that this is new to them. They may not know the information. They may have preconceived notions. So, we try to, at our visits, leave that at the door and start over and respect them, a patient's goals of care. We may have a very long conversation and the patient decides that the risks don't outweigh the benefits for them and having those conversations.

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Dr. Allred: No, I think you're absolutely right. Educating patients and giving them the opportunity, you know, empowering the patient to be part of the decision and making a shared decision-making conversation happen for these patients is so important. And I think sometimes as providers, we actually may underestimate the patient's ability when they're fragile or when they're frail. I recently had a conversation with a 100-year-old lady. We found AFib on her pacemaker, and I debated. Do I bring this 100-year-old lady into the office, or do I just leave her alone? And she came in, and she was so spry. Her daughter was with her. We had a very engaged conversation, and, at the end of the day, she started

anticoagulation and we almost, on my end, lost an opportunity because of some preconceived notions I might have had about her. And so I agree with you 100 percent. As we think about risk and benefits of anticoagulation to dive deeper. What are the greatest risks, and what are the greatest benefits of the therapies that we offer patients? And then you've mentioned CHA₂DS₂-VASc, but what type of data should be used to tell that story?

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Jill: I do agree that having that conversation, the literature that's out there about the risks and benefits so often was related to warfarin. And so certainly now that the direct oral anticoagulants have been available for years now, we're getting more information that the direct oral anticoagulants are often a different animal than it was with the warfarin and the variabilities. That's another conversation that I think is important to have with patients. I think sometimes an example that I use when I'm talking about risks and benefits, patients often say to me, "I'm already on an anticoagulant. I take an aspirin." And I tell them that aspirin is not sufficient in high-risk patients to prevent strokes. But then I often remind them or educate the patient about the risks of aspirin itself. I often use the story that if aspirin was released today, you would have the same commercials and the same warning label of potential bleeding as we do on these agents. People are sometimes surprised about that. To counteract the risk, the risk of bleeding, I think those bleeding scales are a little bit less helpful. HAS-BLED is the most popular or the most well-known, and certainly that can be calculated. But many of the agents that are listed in the CHA₂DS₂-VASc score are also listed in the HAS-BLED score. A high HAS-BLED score is rarely an indication to just totally dismiss the opportunity to provide anticoagulation. Outside of an intracranial hemorrhage or a recent intracranial hemorrhage, there's very few absolute contraindications to direct oral anticoagulants if the patient is willing. So again, that goes back to the shared decision-making conversation and having that. I'm surprised that even folks who've had neurological bleeds, when we consult with our neurosurgeons and our neurologists, many times they're very comfortable resuming direct oral anticoagulants to prevent again the stroke later on.

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Jill: And I think that's a real shift. Switching from warfarin, which had high variability, to the direct oral anticoagulants, is really a different animal.

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Dr. Allred: As I think back to our visit to your institution years ago, I remember that you had incorporated into your EMR a really nice CHA₂DS₂-VASc scoring system, even back then before any of us had thought about it. At this point, now down the road eight years later, is there a standardized way that you approach patients? HAS-BLED, CHA₂DS₂-VASc within your practice, especially to think about bleeding, frailty, forgetfulness or falls?

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Jill: That's a great question, and I have continued to use what you saw. We even have a dot phrase in Epic that we can pull up or we can do the clinical calculator, calculate the CHA₂DS₂-VASc right in front of the patient. And then, with their chart open, use a dot phrase to blow that score in, and it has the percentage of stroke risk. So it's a nice visual for patients and families to see when they're with you in the exam room. We don't routinely do the HAS-BLED score. That's not a standard. In preparing for this, we don't really have a frailty score, but I found that we probably should, or at least, have some conversation. The frailty indexes that are out there first made prominent by Dr. Fried, who is a prominent geriatrician who was a lead researcher. And she has a lot of predefined criteria, including unintentional weight loss, self-reported exhaustion, weakness by grip strength, slow walking, low physical activity. Those are all things that can be measured.

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Jill: Our institution doesn't routinely do that. Our structural heart team does a little bit more with that prior to TAVR workups, but they basically look at what's called the TUG test, which is a physical therapy, timed, get up out of the chair and walk. My physical therapy daughter taught me about that, and that's present in a lot of these frailties scores to basically get a sense of how well is the patient ready to go through those things. There's also on *MDCalc*, an Edmonton Frail score that can easily be calculated that's non geriatricians, and it correlates well with more intense evals. That includes the TUG test and a clock draw. I don't know anybody that's routinely doing those things, but I found it interesting to understand these frail indexes that are out there to say maybe that is something in the future. What our institution does have, if we're concerned about fall risk or we have that "You know it, if you see it" - this person's really frail - we do have a physical therapy option that our physical therapy team will come and evaluate the patient, give us some sense of that frailty and work with the patient with some strengthening. So that maybe with a little bit of physical therapy, a little bit more of supportive aides, there would be less concern about the risk of oral anticoagulation, and that's been very helpful in our population.

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Jill: I also thought it was interesting just this month, January, there is an article that's going to be released about frailty in our Watchman devices. I just read it this morning, and they actually used the Hospital Frailty Index that actually is taken from claims data and Medicare scoring. So, it really opened up my eyes about the opportunity in the future, of letting some artificial intelligence and claims data, maybe future state someday, will be able to have a little bit more of that frailty index that will be able to be automated based on what is in the electronic record already based on claims data.

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Jill: I think to expect, you know, electrophysiologists or busy AFib clinic folks to be able to be doing TUG tests and the more formal frailty assessments is probably not going to work out. But I think it's important that we know these things exist so that we can better have conversations and make decisions for our patients and understand. Like you said, your patient that you thought was 102 years old, just based on age, but then looking at that spry person, they were willing and able and looked good. It's a tough call, isn't it?

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Dr. Allred: Absolutely. I think as we've evolved over the last few years in health care, it's great to see that we do have a lot of new opportunities harnessing our EMR devices, such as Watchman, the DOAC family of medicines and potentially using, as you said, A.I. in the future. I think another resource that we could consider is our anticoagulation clinic, which has been around forever for warfarin management. I have found one opportunity for our frail and fragile patient is, as I start them on anticoagulation, to have them follow up in a month or two in our anticoagulation clinic just to make sure that they land safely. They're tolerating the medicine. There are no interactions with other medicines. They're not on aspirin or non-steroidals. All those things can be helpful too, as well.

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Jill: Yes. Is your clinic nurse-run or do you have a pharmacist?

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Dr. Allred: Yeah. So that's an anticoagulation clinic that's run by pharmacy. We do have nurses in the clinic, but it's honestly, it's your traditional Coumadin clinic that we've had in the practice for years without a lot of modification. It's just they know that Dr. Allred is going to send them patients from time to time that are on DOACs, and they just make sure they're safe.

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Jill: That's great to hear because we have a pharmacy-led clinic similar to yours, and that's a great resource. The PharmDs are just great resources, and they want to be involved in those conversations. That's a great resource to put out there.

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Dr. Allred: Jill Schaeffer, Nurse Practitioner from Penn Medicine, Lancaster General Health. I consider you one of the world's experts on AFib management. Thank you so much for joining us today to talk about best practices and insights on frailty on this podcast series.

00:14:51:16 - 00:14:53:21

Jill: Thank you so much for having me. It was a pleasure.

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Dr. Allred: Thank you for joining us, and please come back to listen to the other episodes in our series. *The Four F's of AFib*. This series was produced through support from the BMS Pfizer Alliance to learn more about the American Heart Association and its atrial fibrillation quality improvement efforts, visit heart.org/quality.