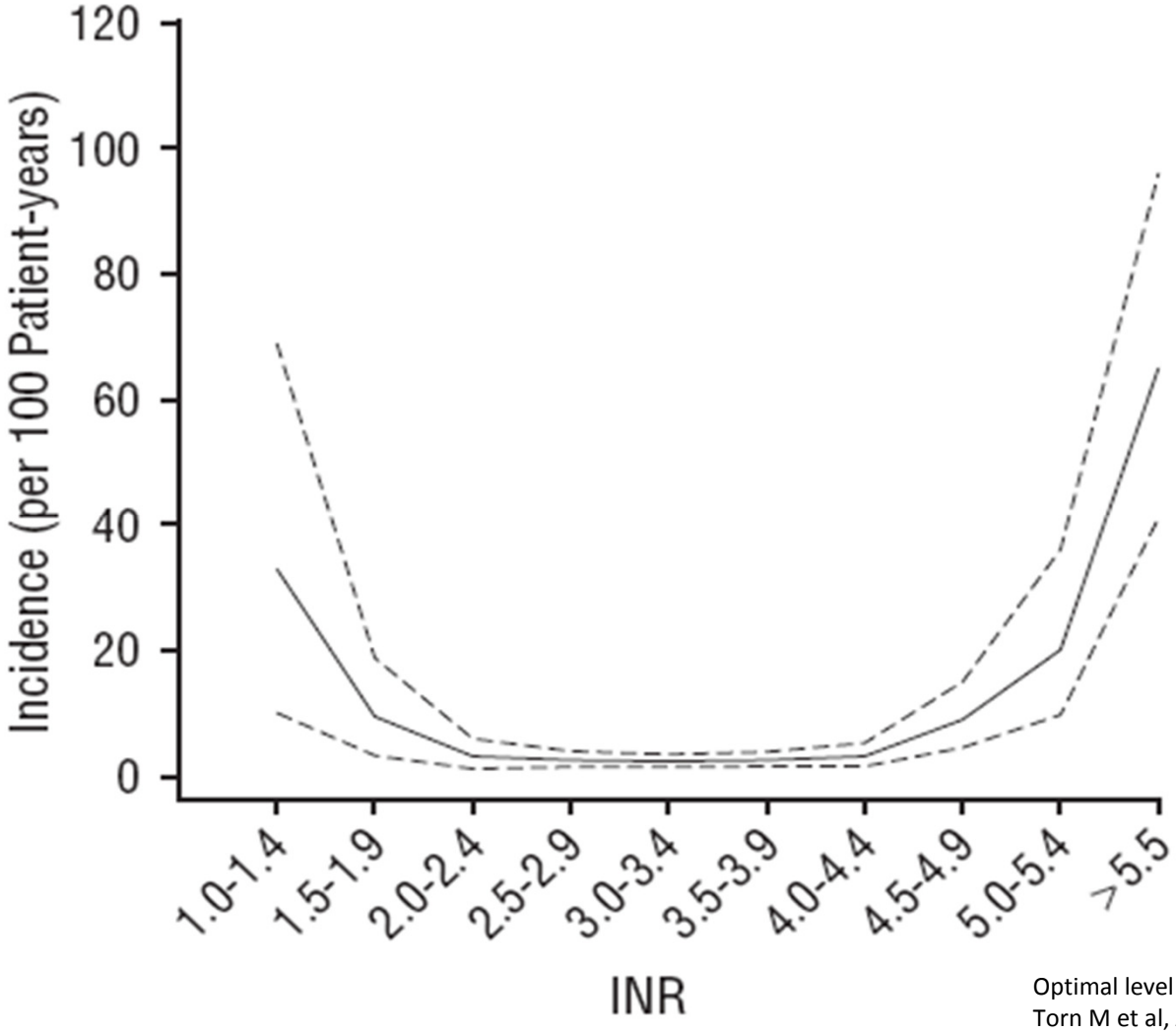
An early evaluation of the impact of the North Trent policy regarding the use of Non-Vitamin K antagonists for SPAF in a secondary care anticoagulation clinic

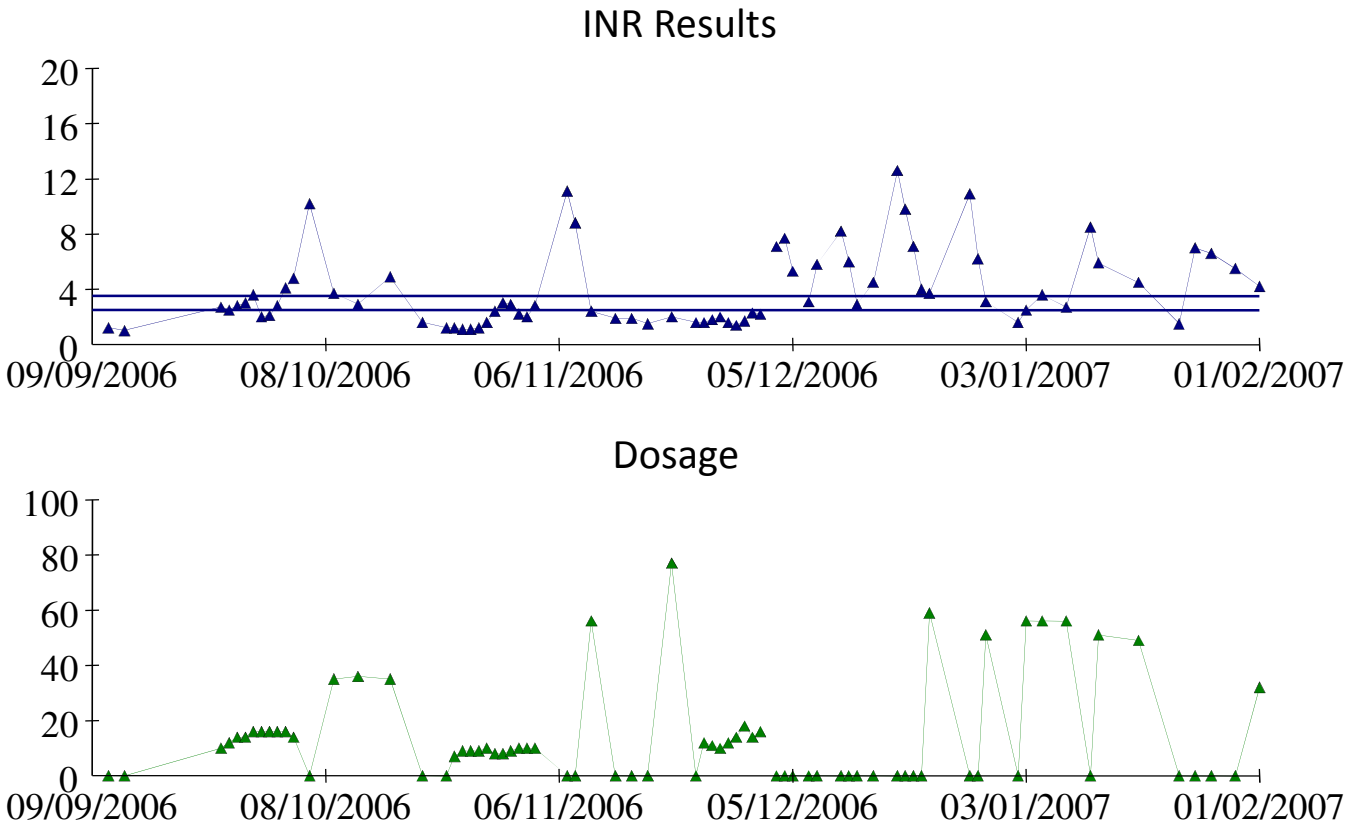
Rhona Maclean
Rhona.maclean@sth.nhs.uk

Risk of adverse events in patients with atrial fibrillation taking warfarin



Optimal level of oral anticoagulant therapy
Torn M et al, Arch Int Med 2009; 169:203-1209

Unstable Warfarin Anticoagulation



68 year old woman on warfarin for recurrent VTE INR 3.5

NORCOM

North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium

NORTH TRENT NETWORK OF CARDIAC CARE

NORCOM Policy Statement

NORCOM Policy Statement: Non Vitamin K antagonists for the Prevention of stroke and transient ischaemic attack (TIA) in patients with atrial fibrillation (AF) at increased risk of stroke

Ratified for implementation by the Cardiac Network Board on 13 June 2012

Patients will be prioritised on the basis of gaining the greatest benefit

Focussing initial prescribing on patients who stand to benefit the most from anticoagulation in atrial fibrillation will ensure those patients are prioritised by prescribers. For example although there is a clear benefit in patients at high risk of stroke (CHADS2 ≥2) unable to take warfarin, currently approximately 45% of all patients at this level of risk are not currently taking warfarin.

Warfarin remains the first line drug for those who are able to take it

The oral non vitamin K antagonists are new drugs and do not have the long term safety record of warfarin. They are considerably more expensive than warfarin. They do however offer substantial benefits to those unable to take warfarin. NICE TA256 states there was no statistical difference in outcomes between rivaroxaban and warfarin in patients previously taking vitamin K antagonists.

Rivaroxaban is recommended as the non vitamin K anticoagulant of choice for the prophylaxis of stroke and TIA in patients with AF

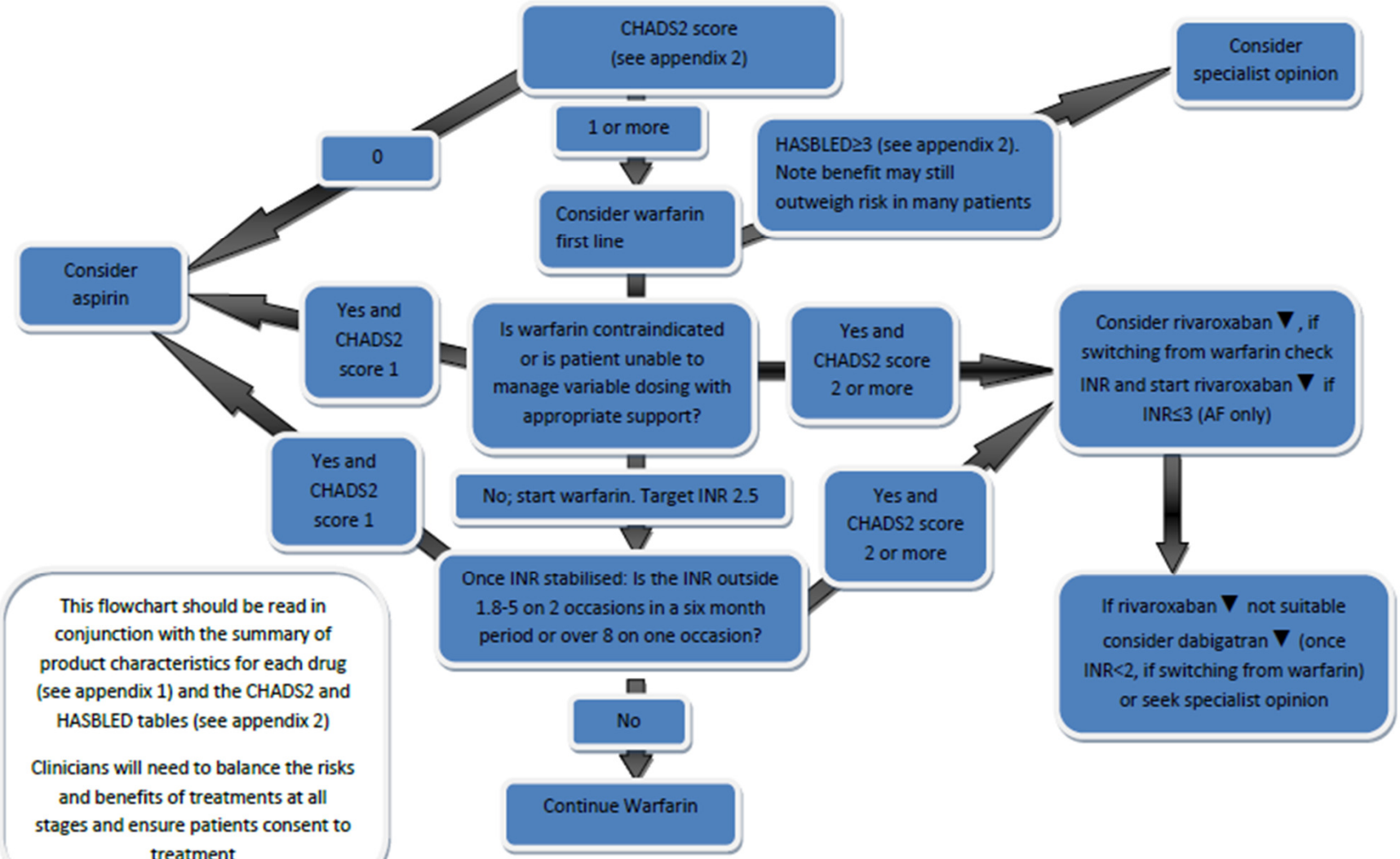
Patients will only be offered non vitamin K antagonists within their licensed indications at a CHADS2 score of 2 or more

Patients with a CHADS2 score ≥ 2 who are well controlled (defined by a lack of poor control below) should generally be maintained on warfarin

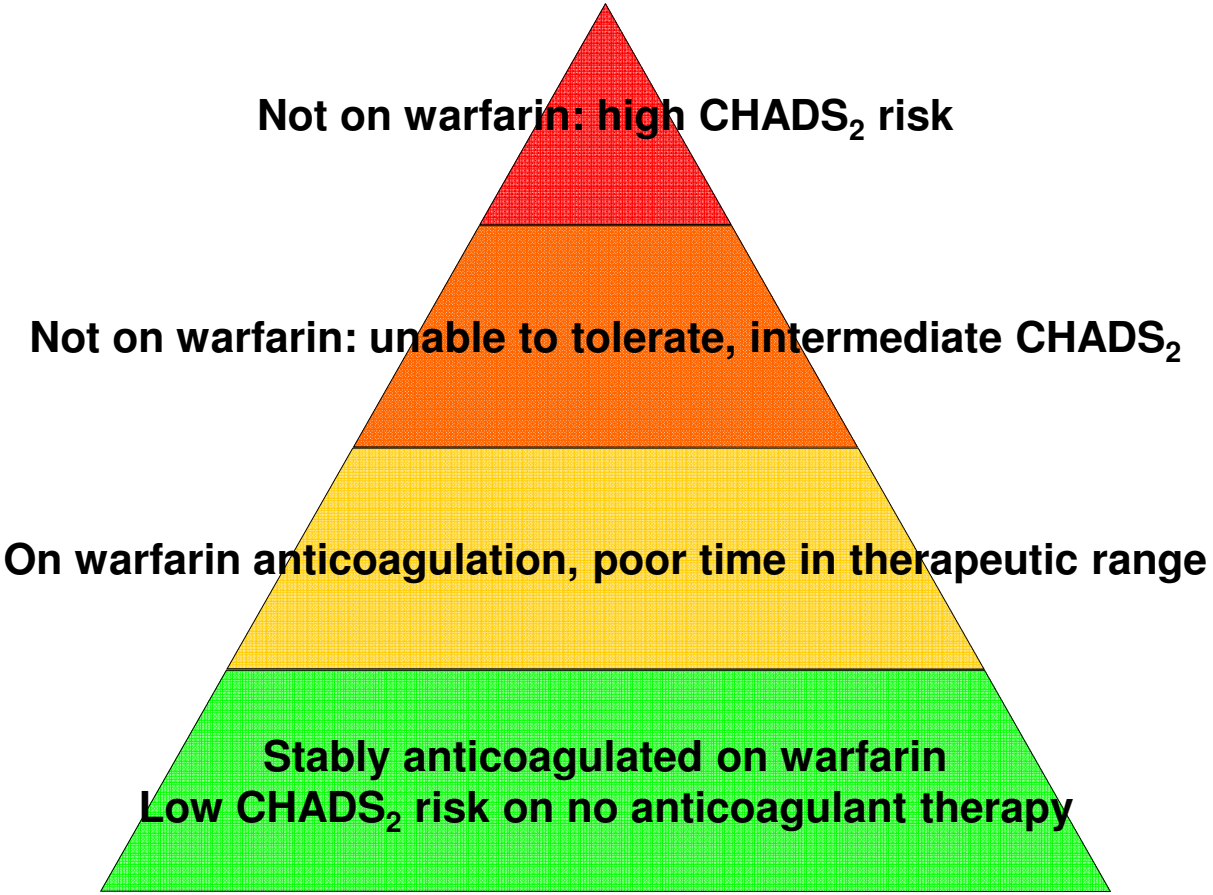
Patients with a CHADS2 score ≥2 who are currently prescribed warfarin with poor control, (defined as one INR above 8, or 2 readings outside the range of 1.8 to 5 in a six month period) should be considered for a non-vitamin K antagonist

Patients with a CHADS2 score ≥ 2 who are not currently treated with a vitamin K antagonist should be considered as to whether it is appropriate to start warfarin. If warfarin is contraindicated (see appendix 1) or patients are not able to take warfarin a non vitamin K antagonist within its licensed indications should be considered.

NORCOM primary care flowchart for the prevention of stroke and systemic embolism in Non Valvular Atrial Fibrillation: July 2012



Improving the health outcomes in patients with AF



QoF New Indicators 2012/13

- The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS2 score is greater than 1)
- In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1 **(latest in the preceding 15 months)**, the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy.
- In those patients with atrial fibrillation **whose latest** record of a CHADS2 score **is** greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy

Drivers for change in AF anticoagulation

- New data
  - Studies demonstrating benefit of anticoagulation in elderly patients with AF
- New targets
  - QoF
- New technology
  - New drugs

Sheffield Teaching Hospital Anticoagulant Clinic

- Approximately 3000 patients on oral anticoagulants (mostly warfarin) managed by the clinic
- +/- 140 new patients/month initiated on warfarin
- 75% of Sheffield primary care anticoagulation monitoring (<10% offer induction)
- Patients therefore are started on warfarin by clinic, transferred out to primary care when ‘stable’
- Most patients come to hospital for phlebotomy- postal service with INR result
- Limited community phlebotomy available- not offered by primary care

Clinic patient characteristics

- >1260 ‘maintenance’ patients have AF
- Approximately 400 AFnpatients have ‘community phlebotomy’
- AF patients aged between 24 and 97 years of age
- TTR 20%- 100%
- Number of visits in 6 months
  - 2 (100% TTR)
  - 23 (34% TTR)
- 243 had ≥10 INR checks within 6 months (26 weeks)

My predictions on impact on clinic of NORCOM guidance

- Most patients with AF will continue to be offered warfarin anticoagulation
  - Clinic numbers will continue to grow due to QoF changes/ demographics
- Patients intolerant/ unstable/ unable to follow instructions will be reassessed and considered for a switch to NOAC
  - Proportion of patients will be unsuitable for anticoagulation
  - Proportion of patients would benefit from a ‘switch’
- Increased quality of anticoagulation
- Fall in stroke/ systemic embolisation

Impact of NORCOM Guideline

- Increased numbers of ‘advice only’ referrals to haematology regarding suitability of NOACs for individual patients (younger/ well informed/ CHADS2 score 1)
- 8 anticoagulation clinic patients with AF switched to NOACs
  - 6 STH anticoagulation clinic patients were on phenindione
  - 2 others referred from GPs for assessment
- …and nothing else!...
- Haematologists using NOACs more widely in patients with VTE

Why has little happened?

- STH issues:
  - NORCOM only issued guidance mid/end June
    - Last minute, little time to work up strategy within organisation
  - DAWN v7 upgrade end July
  - Summer holidays
  - Anticoagulation Service structure
    - INR dosing service
    - Patients not seen by anticoagulant practitioners (but there is a sense of ‘ownership’)
  - Commissioning
    - Commissioners don’t want to pay any more for the service to develop..

Why has little happened?

- Primary care issues:
- NHS reorganisation
  - Trying to role out large changes in practice in primary care very challenging
- Primary Care Clinician Anxiety
  - Unfamiliar new medication. Anxiety about bleeding with anticoagulants. What is the ‘right’ thing to do. Education gap
- Finance
  - NOACs more expensive
  - Commissioners don’t want to pay for ‘new’ services or develop existing pathways
- Pathways need changing
  - Who will identify patients who should be considered for a switch?
  - Who will assess patient, determine suitability, counsel patient and switch?
- Visibility of Patients
  - Most AF patients not seen regularly by secondary care specialist
  - QoF will influence patient ‘visibility’ to primary care clinicians

Strategy for maintenance patients with AF

- Patients attending STH clinic
  - Their GPs usually do not manage anticoagulant therapy
- STH Clinic will identify patients with AF who could potentially benefit from NOAC and inform their GPs
  - Poor TTR
  - High INRs, low INRs, frequent INR checks
  - Review all patient records or opportunistic identification?
- Clinic offer to see patients and manage a ‘switch’?
- Provide GPs with advice on assessment
  - Rivaroxaban ‘tick sheet’

Future pathway?

- Counsel patients when starting warfarin that if do not stabilise/ intolerant will switch to NOAC?
- Who will undertake review?
  - GP?
    - With anticoagulant clinic generated report?
  - Anticoagulant clinic?
- Commissioning issues…
  - Anticoagulant clinic paid £20 per INR check and dosing instruction- if they provide patient review and undertake switch to NOAC will be out of pocket….

The ‘ideal’ pathway?

- Should meet the needs of the patient population
  - Predominantly elderly
- Trial of warfarin?
  - Initiated and monitored by staff with the relevant competencies, in an environment suitable to the patient
- Assessment as to tolerance/ stability of warfarin
  - At 3 or 6 months?
  - Manage a ‘switch’ if intolerant/ unstable
- If ‘switched’
  - Primary care to take on chronic disease management?
  - Care of the elderly role?
  - Anticoagulation clinic?
- If remains on warfarin- needs monitoring and annual review
  - If becomes unstable, should be considered for a switch

Conclusions

- In the 3 months since the NORCOM guidance has been published:
  - the NOACs have made next to no impact on patients with AF attending the STH anticoagulant clinic
  - Steps have been taken to identify patients who should be considered for a ‘switch’, and GPs are to be notified
  - Role of STH clinic in this is dependent on commissioning arrangements