



# Online Survey among Primary Care Physicians and Geriatricians on Their Attitudes and Practices Diagnosing and Treating Atrial Fibrillation

June 2012



# Objectives and Methodology

## Objectives

- Achieve better understanding among primary care physicians and geriatricians of:
  - Attitudes and behaviors in diagnosing AFib
  - Attitudes and behaviors in treating AFib
  - Awareness of various treatments, their benefits and risks
  - Use of risk assessment tools in decision-making
  - Patient compliance and perceived barriers
  - Interest in/potential usage of new guidelines and treatment tools
- Inform the creation of a patient survey on AFib treatments and risk factors

## Methodology

- 405 PCPs: Family physicians/General Practitioners (249), Geriatricians (119), and Internists (37) from a nationwide online panel.
- Invites were sent to 2,110 physicians nationwide, specifically targeting PCPs and Geriatricians based on information the panel has on file. 633 respondents accessed the survey. Of those 633 who accessed the survey:
  - 116 were terminated based on screening criteria,
  - 90 started but did not complete the survey,
  - and 23 were disqualified for taking the survey too quickly (quality control measure).
  - We also monitored open-ended responses to ensure respondents were actually reading and responding appropriately.

# Summary of Key Findings

## AFib DIAGNOSIS

- Most of these physicians report checking for AFib symptoms in older patients at all or most visits, and feel confident in their ability to diagnose.
- More than half say they refer AFib patients to cardiologists at least some of the time.

## AFib TREATMENT

- Overwhelmingly, the tendency among physicians in this survey is to anticoagulate, and experience with patient outcomes generally supports this judgment.
- Yet the number of guidelines causes confusion, and less than half are familiar with any one of the guidelines tested.

## MEDICATION OPTIONS

- Warfarin, though far from perfect, is the preferred anticoagulant.
- These doctors report cautious optimism about new medications, but say little is known and worry these have different downsides than Warfarin.

## RISK ASSESSMENT TOOLS

- Half are using CHADS<sub>2</sub> at least some of the time, and majorities who are find it helpful. Other risk assessment tools for stroke and bleeding risk are not used as much.
- Majorities see these risk assessments as limited, and do not feel they apply to all risk factors/patients.
- Individual factors like fall risk, frailty, cognition, etc. are viewed as most important when determining treatment for AFib.
- Consensus, CME (particularly online resources), and building risk assessment tools into electronic medical records are potential ways to increase their use.

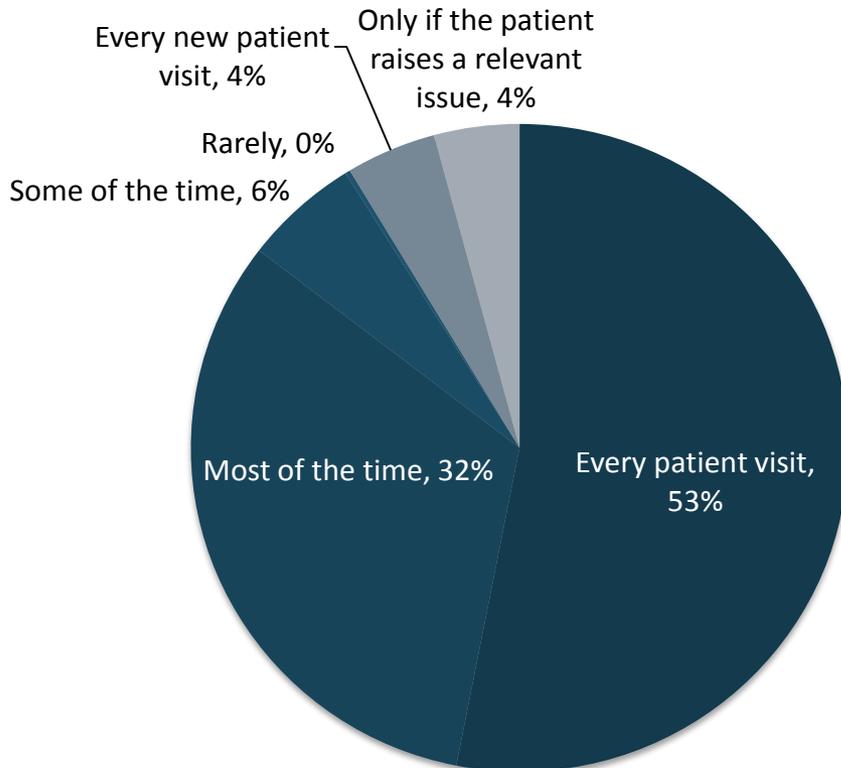
# Diagnosing AFib



# Diagnosis

- The vast majority of physicians check for AFib signs/symptoms in their older patients on a regular basis.
- Doctors with more confidence and experience are more likely to check often.

## When Check for AFib Signs/Symptoms in Patients Over 65



### Most likely to check at every visit:

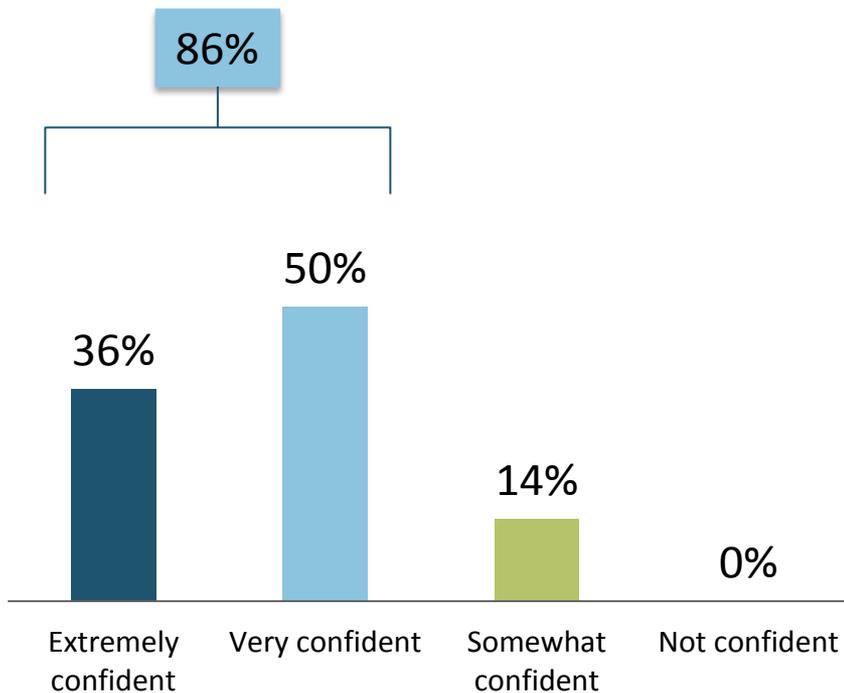
- Doctors in practice for 20+ years (66%)
- Those who are extremely confident in treating AFib (67%)
- Doctors practicing in hospital settings (60%)

No one checks “only if patient is over a certain age.”

# Diagnosis

- Most are confident in their ability to diagnose, but only a third are extremely confident.
- Those with more experience, more patients, or in private practice are more confident.

**Confidence in Diagnosing AFib**



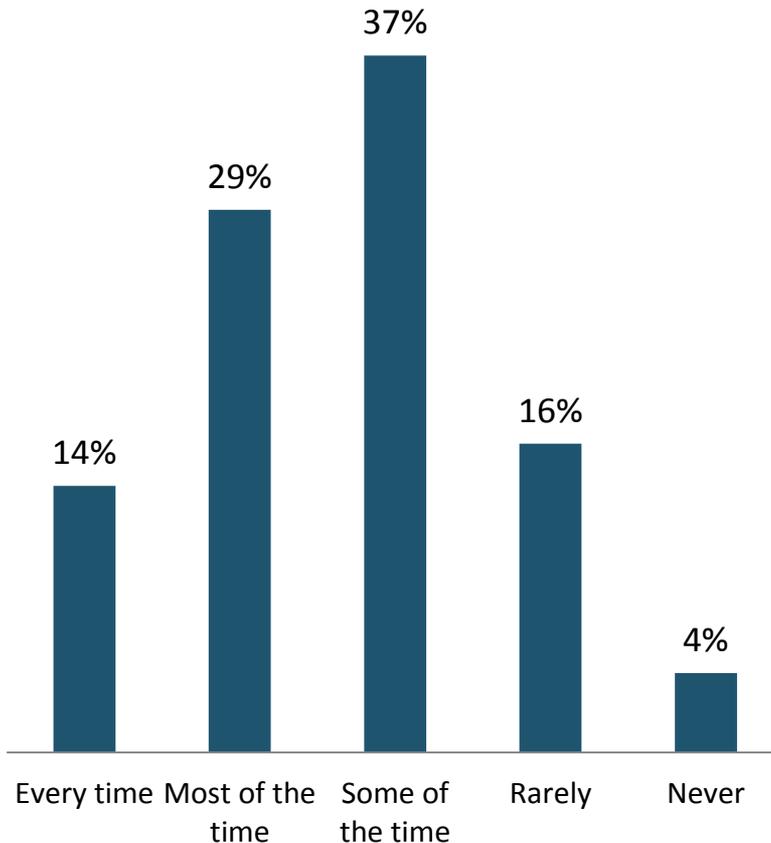
**“Extremely confident”:**

- Practicing 20+ years (46%)
- 301+ patients per month (43%)
- Those with 41-70% of their patients 65+ (42%)
- In private practice (42%)
- Male doctors (40%)

# Diagnosis

- More than half refer AFib patients to cardiologists at least some of the time.
- Age is a definite factor in referrals.

## How Often Refer to Cardiologist for AFib Diagnosis?



### Physicians are more likely to refer under the following conditions:

- Patient is young (under 50) or over 75
- Complex medical history/other complications
- History of cardiovascular/valvular problems
- High/uncontrollable heart rate
- Possible candidate for cardioversion
- Don't respond to therapy

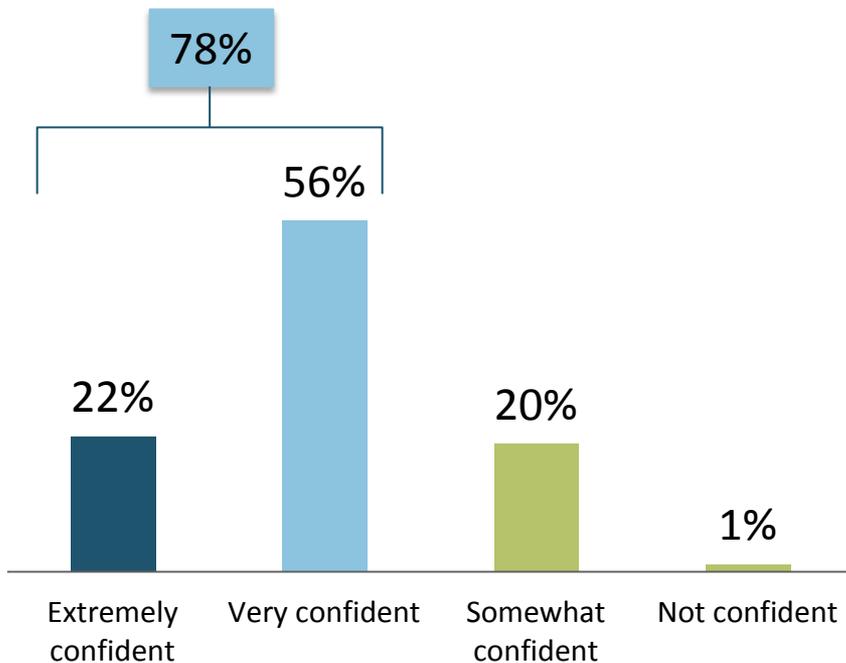
# Treating AFib



# Confidence in Treatment

- Physicians are somewhat less confident in their ability to treat AFib than their ability to diagnose it.
- The number of guidelines tends to create some confusion about treatment; lack of specificity or ambiguity are less of a factor.

## Confidence in Treating AFib



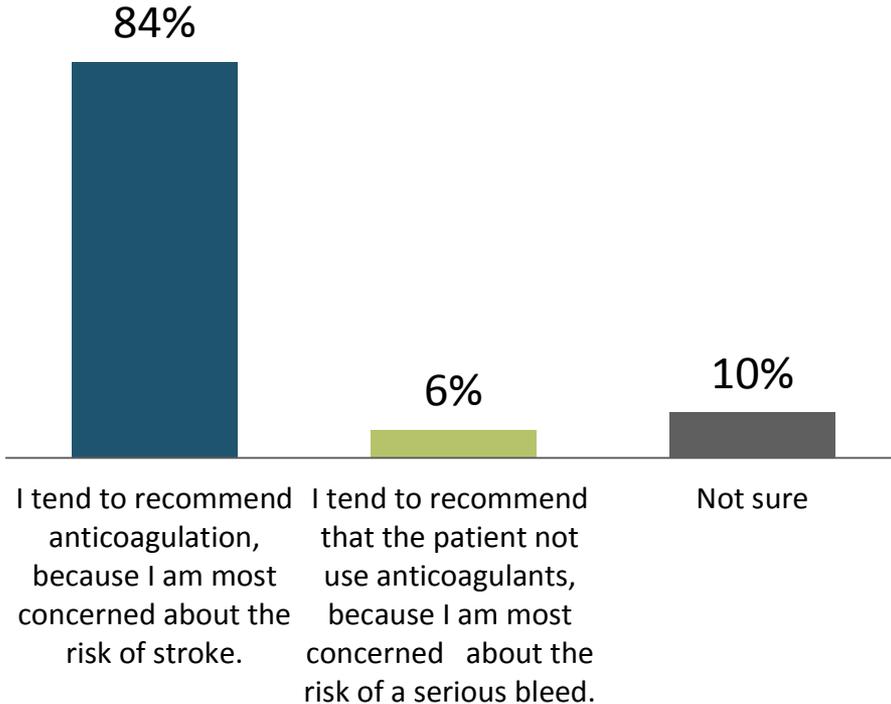
## Factors Affecting Ease of Treatment Decisions



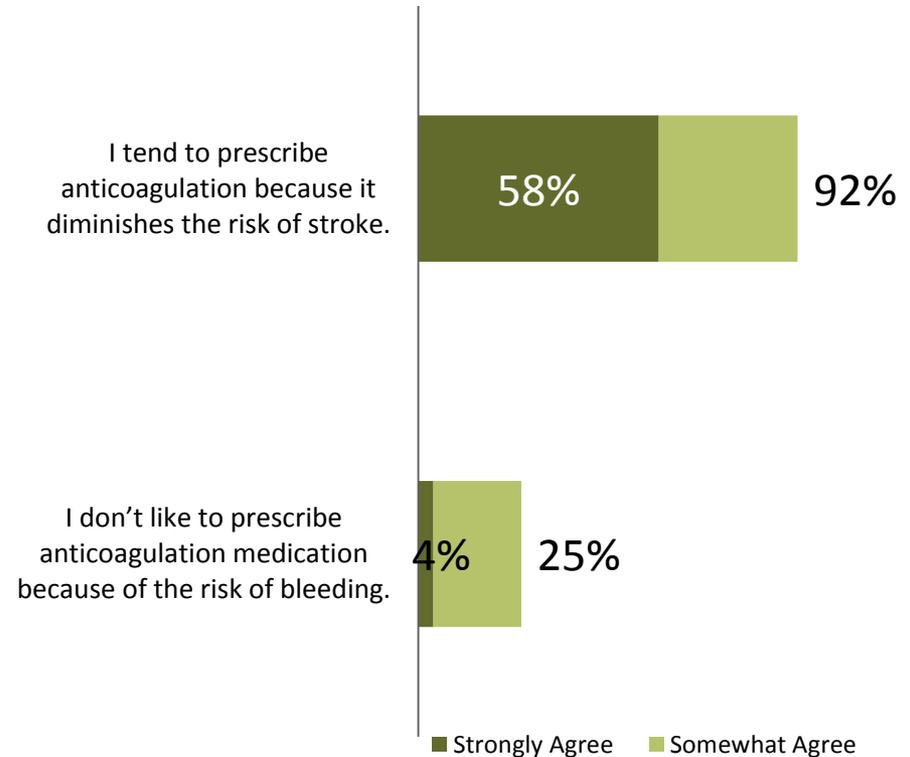
# General Treatment Philosophy

- Overwhelmingly, the tendency among these physicians is to anticoagulate.
- However, a quarter indicate concerns about anticoagulating because of the bleeding risk.

**General Tendency: Anticoagulate or Not?**



**Statements on General Tendency**

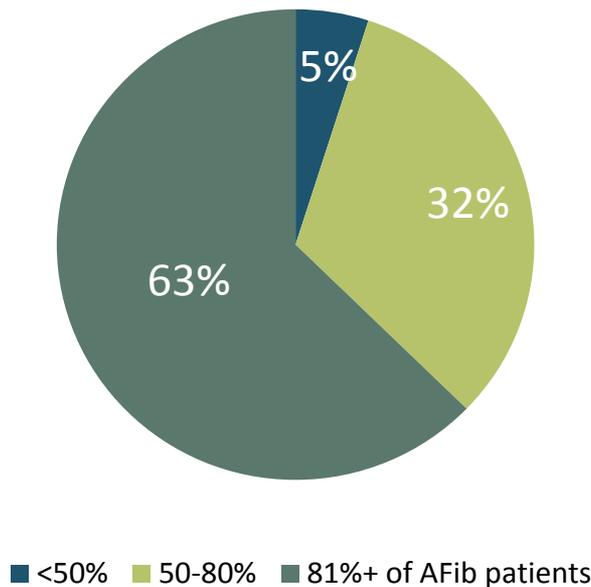


Q26: When you have an atrial fibrillation case and the best treatment option is not clear after looking at risk factors and/or existing guidelines, what do you tend to recommend?  
 Q25: For each of the following, please indicate how much you agree or disagree with that statement.

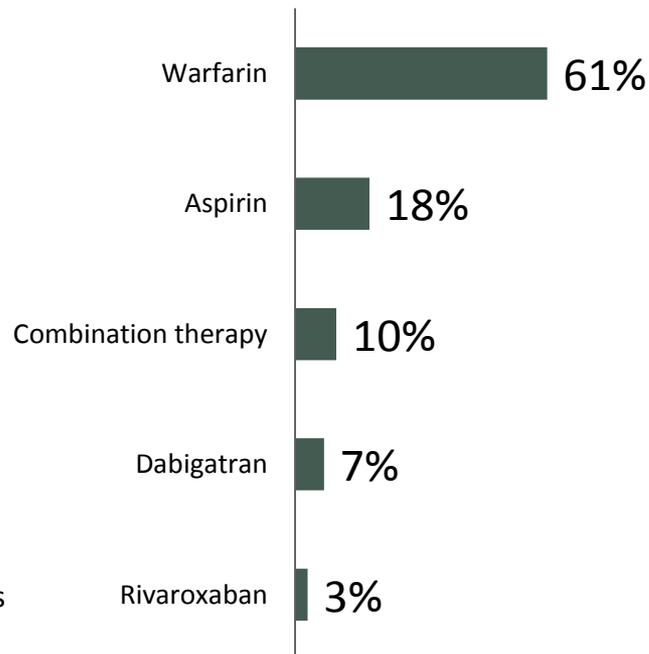
# Anticoagulant Medications

- Most of these physicians prescribe anticoagulants for at least 80% of their patients with AFib.
- Warfarin is by far the most chosen option. New drugs are used by doctors with more AFib patients and more confidence in their ability to treat.

## Use of Anticoagulants



## Use of Anticoagulant Options (mean rate of use in anti-coagulated patients)



### Most Likely to Use New Drugs (Dabigatran/Rivaroxaban)

- **The more AFib patients you have in a year, the more likely you are to prescribe the newer drugs.**
- 301+ patients
- In private practice
- 41-70% patients over 65
- Extremely confident in their ability to treat AFib
- Male doctors

**HOWEVER, all mean rates of use still at or below 10%.**

Q12: For what percentage of your patients with atrial fibrillation do you recommend anticoagulation treatment? Please enter a number between 0 and 100. If you are not sure, please give your best estimate.

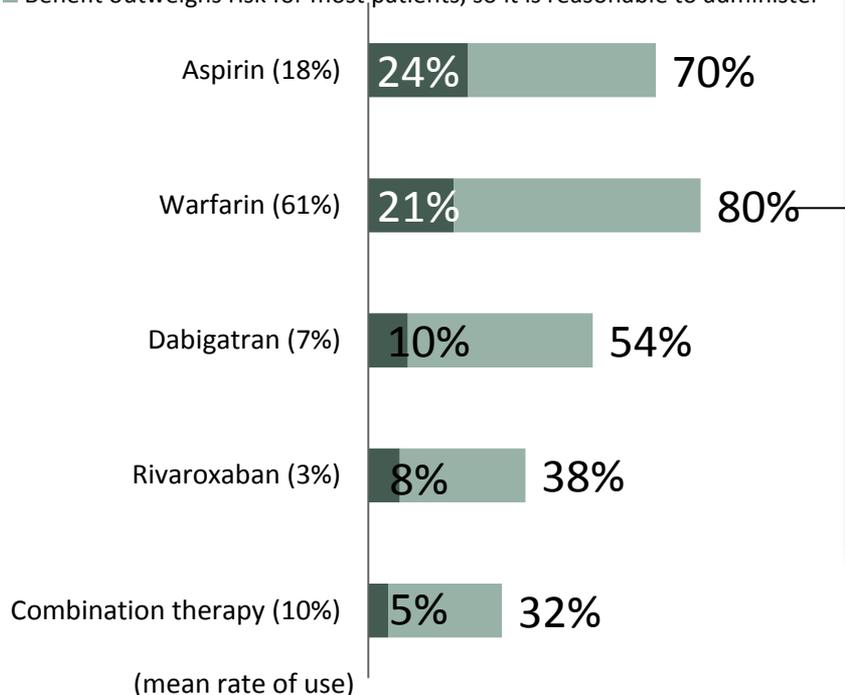
Q13: Please estimate the percentage of those anticoagulation patients for whom you prescribe each of the following: Please enter a number between 0 and 100 for each.

# Anticoagulant Medications

- These physicians are most comfortable prescribing Warfarin or Aspirin.
- Doctors in private practice or with fewer patients to manage are more comfortable prescribing anticoagulants.

## Views on Current Anticoagulant Options

- Benefit greatly outweighs the risk and it should be administered
- Benefit outweighs risk for most patients, so it is reasonable to administer



### Some physicians are more comfortable with Warfarin than others:

- 11-20 yrs practicing (27% top box)
- 20+ yrs practicing (23%)
- Private practice (24%)
- FEWER patients per month (200 or fewer: 24%; 201-300: 25%)
- 41-70% of patients are 65+ (27%)
- Male doctors (25%)

**These patterns hold true for the other *prescription* options as well. Attitudes about aspirin are more flat across subgroups.**

# Anticoagulant Options: Old Standbys

- Physicians describe the pros and cons of different options in their own words.

Medication	Pros	Cons
Warfarin	<p><i>"It is a tablet, that both the PROVIDER and the PATIENT are familiar with. It has YEARS of accepted use, and is inexpensive for those who can easily have their Protimes kept controlled. I have faith in it."</i></p> <ul style="list-style-type: none"> <li>Low cost/cheap</li> <li>Effective at reducing stroke risk/incidence</li> <li>Known/ well understood/ studied/ documented</li> <li>Convenient (available, easy to administer, no pre-authorization required)</li> <li>Involves monitoring/follow-up with patient               <ul style="list-style-type: none"> <li>Some said no or little monitoring and saw that as a positive.</li> </ul> </li> </ul>	<p><i>"Noncompliance with pills and/or diet, risk of falls in elderly, risk of GI bleed, annoying to monitor INR and adjust dosing regularly."</i></p> <ul style="list-style-type: none"> <li>BLEEDING (bleeding from falls mentioned specifically)</li> <li>Compliance issues (both with dosage/diet issues and monitoring)</li> <li>Extensive monitoring needed</li> <li>Drug/food interactions</li> <li>Dosing concerns: hard to determine proper dosage, patients could over- or under-dose</li> <li>Cost               <ul style="list-style-type: none"> <li>Some just said "cost"</li> <li>Cost to the institution</li> <li>Cost of blood tests/monitoring</li> </ul> </li> </ul>
Aspirin	<p><i>"Easy to get, easy to understand (easy for doctors and patients to understand and understand how it works), inexpensive; can make minor adjustments to dose depending upon other diagnoses. OTC status. Track record is GOOD."</i></p> <ul style="list-style-type: none"> <li>SAFE</li> <li>Cheap</li> <li>Good for prevention</li> <li>Easy dosage</li> <li>No/little monitoring</li> <li>Patients comfortable with</li> <li>Good alternative when warfarin is not an option</li> </ul>	<p><i>"Doesn't really offer much stroke prevention in AFib. I will usually only use this in very elderly patients who are not candidates for another medication."</i></p> <p><i>"Not as good as warfarin at stroke prevention. Still significant bleeding risks."</i></p> <ul style="list-style-type: none"> <li>LESS EFFECTIVE</li> <li>Bleeding (especially GI bleeding)</li> <li>Effect on kidneys</li> </ul>

# Anticoagulant Options: New Options

- Newer options are less well known/understood but many believe they are at least as good as Warfarin at preventing stroke.

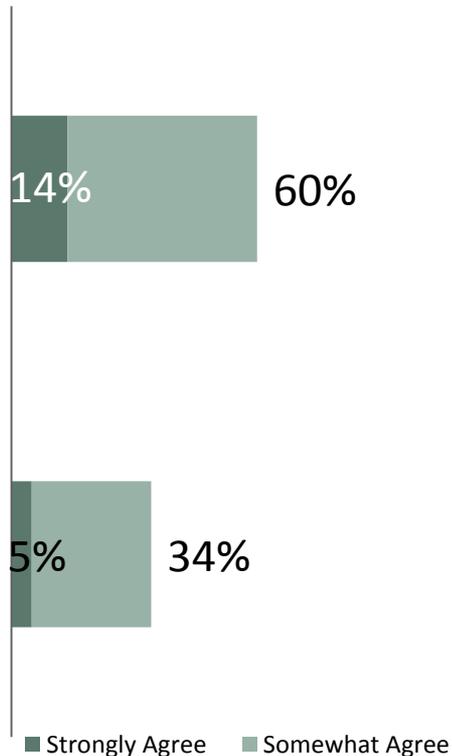
Medication	Pros	Cons
Dabigatran	<p><i>“Single dosing, no need to monitor with frequent INR checks, stroke prevention, can be used if allergic to Warfarin, and can be used in those who have difficulty sticking to dietary restrictions.”</i></p> <ul style="list-style-type: none"> <li>• EASY, better compliance</li> <li>• No monitoring</li> <li>• As-good-as/better than Warfarin for preventing stroke</li> <li>• Less bleeding risk</li> </ul>	<p><i>“I don’t really know enough about it.”</i></p> <p><i>“Cannot reverse easily in patients with bleeding side effects, have now had patients with bleeds on this .”</i></p> <ul style="list-style-type: none"> <li>• CAN’T REVERSE QUICKLY</li> <li>• Bleeding risk</li> <li>• Cost, not covered by insurance</li> <li>• Too new, limited data, no long-term track record</li> <li>• Unfamiliar with it, don’t know much about it</li> <li>• GI issues/bleeds</li> </ul>
Rivaroxaban	<p><i>“Fewer strokes than Warfarin and less serious bleeds. Ease of administration and lack of frequent monitoring. “</i></p> <ul style="list-style-type: none"> <li>• NEW DRUGS VIEWED VERY SIMILARLY AT THIS POINT</li> <li>• EASY, better compliance</li> <li>• No monitoring</li> <li>• As-good-as/better than Warfarin for preventing stroke</li> <li>• Less bleeding risk</li> </ul>	<p><i>“Same as Dabigatran”</i></p> <p><i>“See answer to Dabigatran.”</i></p> <ul style="list-style-type: none"> <li>• NEW DRUGS VIEWED VERY SIMILARLY AT THIS POINT</li> <li>• CAN’T REVERSE QUICKLY</li> <li>• Bleeding risk</li> <li>• Cost, not covered by insurance</li> <li>• Too new, limited data, no long-term track record</li> <li>• Unfamiliar with it, don’t know much about it</li> </ul>

# Attitudes toward Medications

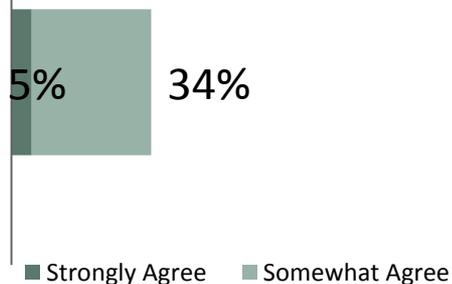
- Despite Warfarin’s popularity, a majority of doctors are somewhat likely to agree that it is complicated and there are compliance issues.
- Despite drawbacks, majorities are cautiously optimistic about new alternatives to Warfarin.

## Warfarin

Warfarin places too many restrictions on a patient’s diet and lifestyle due to frequent monitoring, making it hard for patients to comply with the treatment.’



Patients on Warfarin today can now self-monitor more easily and affordably, and that negates most of my concerns about patient compliance with Warfarin treatment.’



## New Medications

New anticoagulation drugs offer much needed alternatives to Warfarin.



New anticoagulants offer more personalized options for patients.



New anticoagulation options are still “untested” -- we won’t know the real risks and benefits for at least a few more years.



I feel comfortable prescribing new anticoagulation drugs.



I don’t know enough about new anticoagulation drugs to feel comfortable prescribing them.

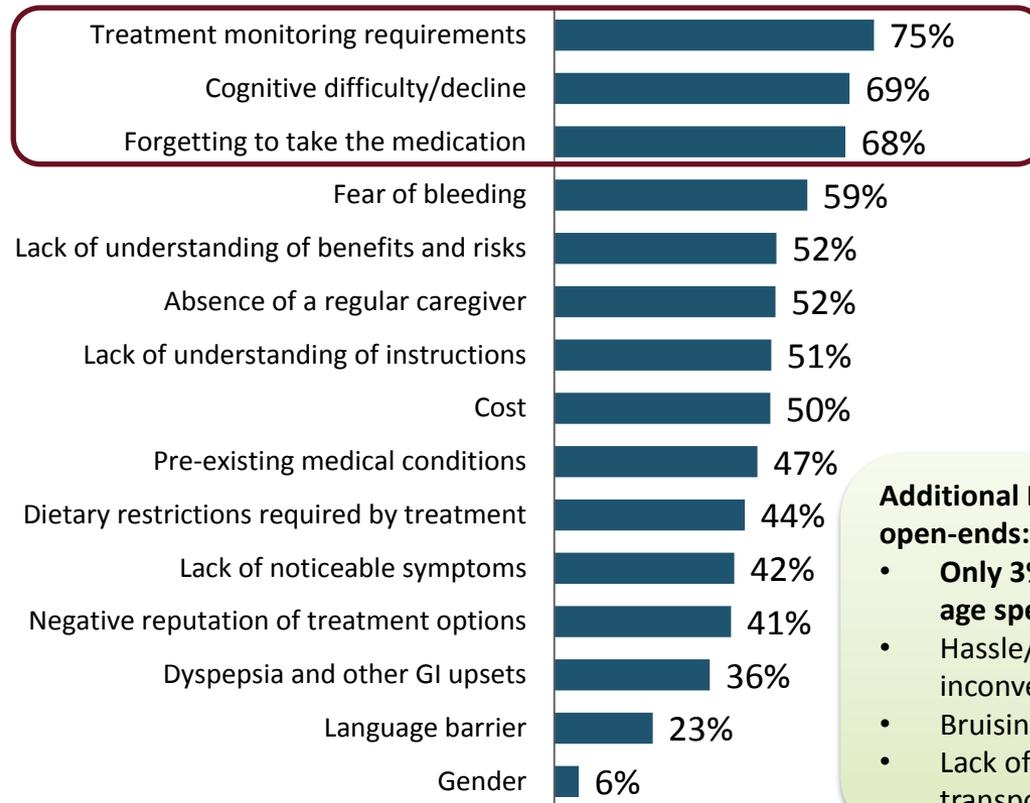


■ Strongly Agree ■ Somewhat Agree

# Patient Compliance with Anticoagulant Treatment

- Most physicians see good compliance rates among AFib patients on anticoagulants.
- Monitoring is the biggest barrier to compliance, but cognitive factors are also a concern.

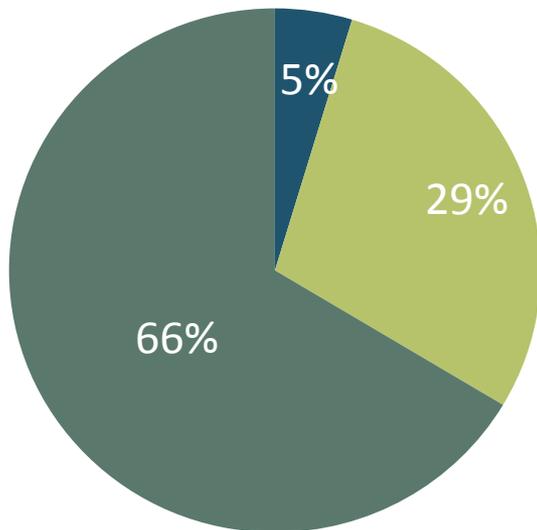
## Barriers to Compliance (top 2 box)



### Additional Barriers from open-ends:

- Only 3% mention age specifically
- Hassle/inconvenience
- Bruising
- Lack of transportation

## Compliance with Treatment



- 0-40% of treated patients comply
- 41-70%
- 71%+

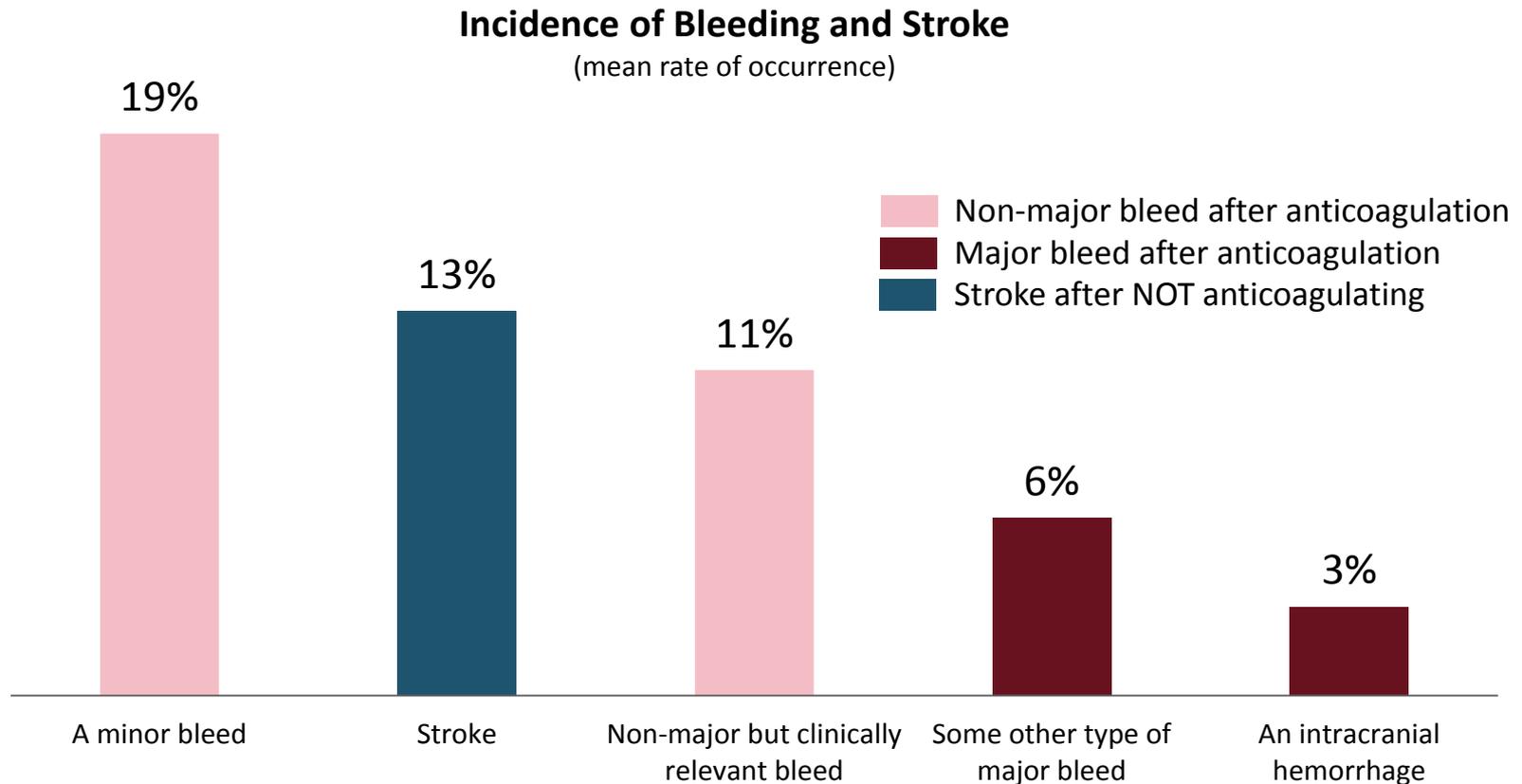
Q27: In the last five year period, what percentage of your atrial fibrillation patients on anticoagulation treatment have successfully complied with their treatment? Please enter a number between 0 and 100. If you are not sure, please give your best estimate.

Q29: Here is a list of things physicians have said effect patient adherence with anticoagulation treatments. Thinking about your patients, please indicate how significant that barrier is. Use a scale from 1 to 5 where a 5 means "an extremely significant barrier" and a 1 means "not a barrier at all."

Q28: What are the most common reasons why patients do not comply with their treatment?

# Patient Outcomes

- Among potentially life-threatening problems, these doctors report stroke occurring among the untreated more often than major bleeds occur among those on anticoagulants.



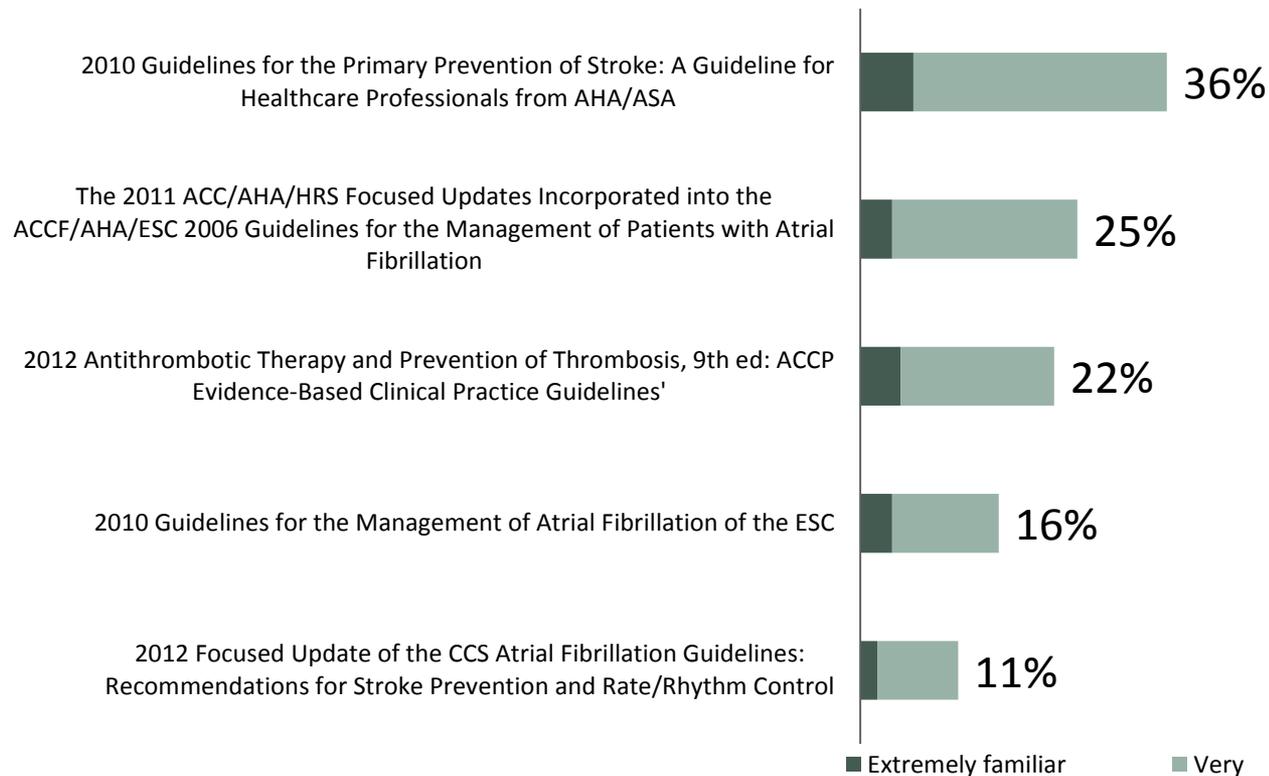
Q36: In the last five-year period, what percentage of your atrial fibrillation patients who were not on anticoagulation treatment had a stroke? Please enter a number between 0 and 100.

Q41B : In the last five-year period, what percentage of your patients on anticoagulation treatment developed each of the following. Please enter a number between 0 and 100 for each. If you are not sure, please give your best estimate.

# AFib Treatment Guidelines: Familiarity

- Few are very familiar with existing AFib treatment guidelines.

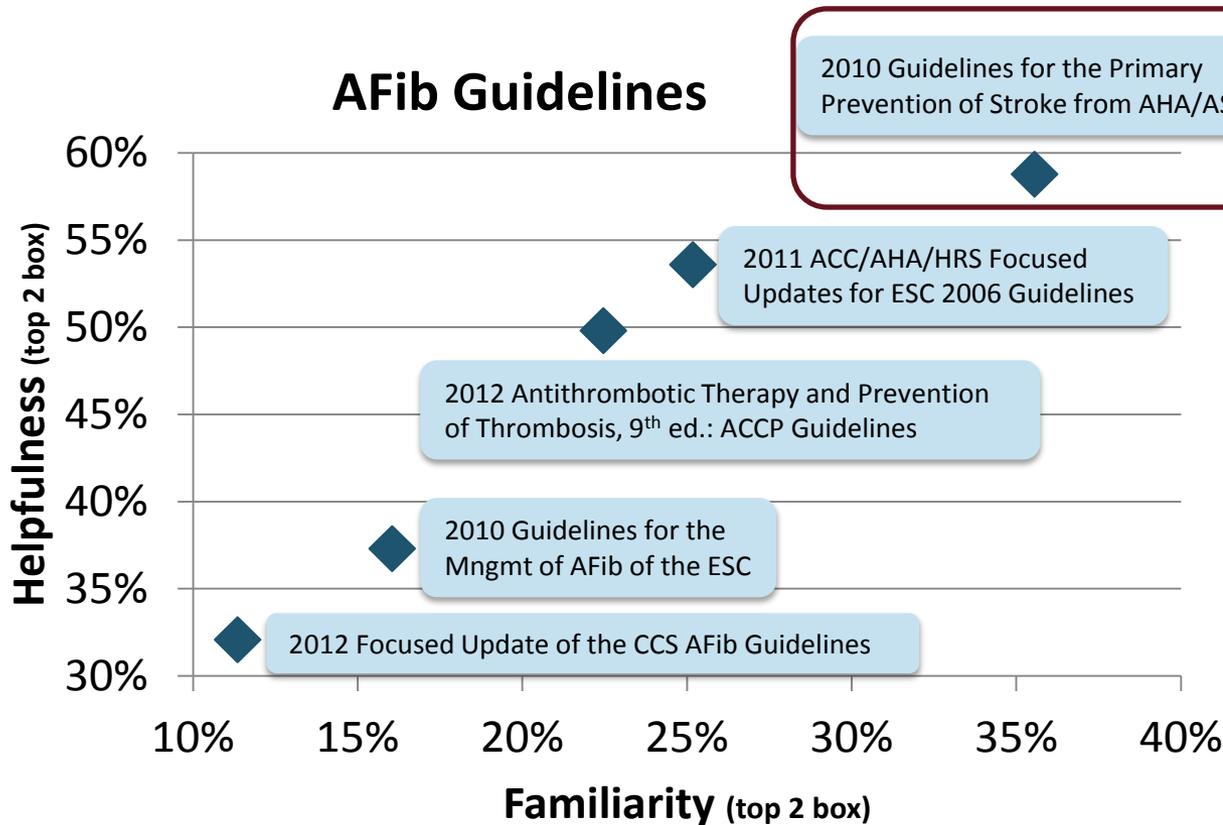
## AFib Treatment Guidelines



*“This is a lot to keep up on; I don't know much about these things.”*

# AFib Treatment Guidelines

- Of the guidelines tested, more are familiar with the 2010 AHA/ASA and find them helpful.
- Fewer than 2/3 of those who are at least somewhat familiar with the guidelines find them very helpful.
- Many are more likely to rely on their general training than any particular set of guidelines.



**Top testing:**  
 36% extremely/very familiar  
 59% find extremely/very helpful

**“Other” mentions:**

- Residency training
- Dynamed
- USPSTF
- SAFETY
- ROCKET-AF

Q30: How familiar are you with each of the following current practice guidelines?

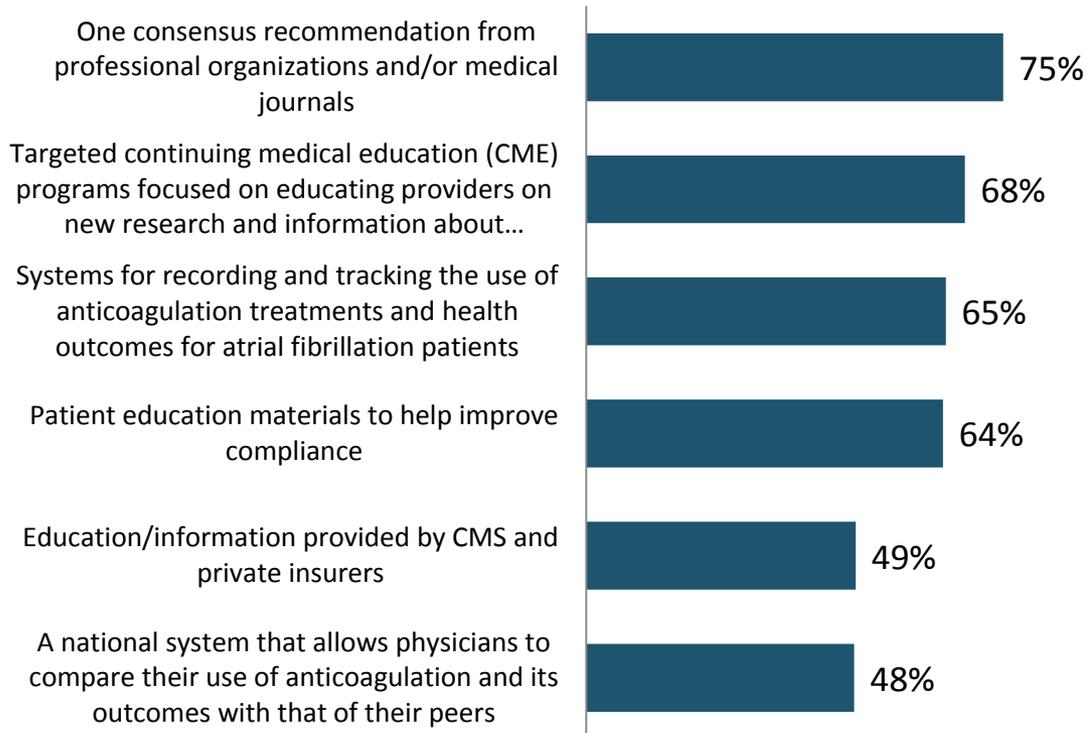
Q31: [AMONG THOSE FAMILIAR WITH EACH] How helpful is each set of these guidelines to you personally when it comes to assessing and treating patients with atrial fibrillation for stroke prevention?

# How to Educate on Treatment Options

- Consensus is the best way to increase comfort with treatment options for AFib.
- CME is also popular, including online CME resources or apps.
- A tracking system and patient education materials are also popular.

## Increasing Comfort with Treatment Options

(% rated 4-5 on increasing comfort level)



### In their own words:

- Reiterate need for consensus and CME
- Also want online resources/apps/CME
- Also mention better cooperation from insurance co.
  - lower cost of meds
  - less pre-authorization
  - reimbursement for monitoring of patients, etc.

Q45: Here are some ideas about ways to better educate physicians about anticoagulation treatment options. For each, please indicate how much it would impact your comfort level in determining whether or not to recommend anticoagulation treatment for your patients. Use a scale from 1 to 5 where 5 means "a lot more comfortable" and 1 means "no impact at all on my comfort level."

Q46: Please share any other ideas you have about ways to better educate physicians about anticoagulation treatment options.

# Risk Assessment for AFib Patients



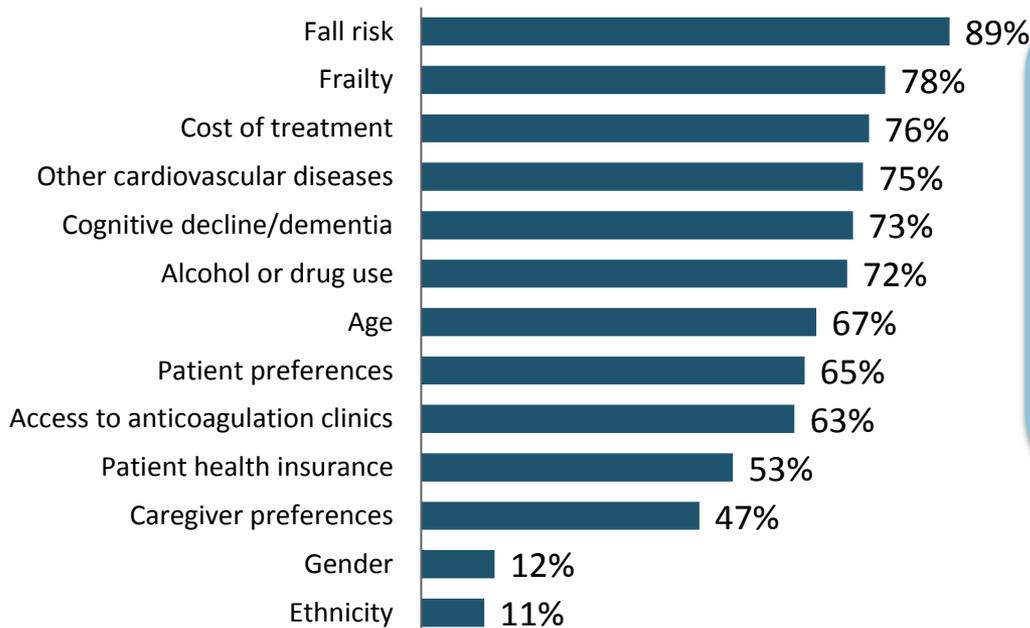
# Individual Risk Factors

- Individual factors are used more than risk assessment tools; they offer a more individualized approach.
- Fall risk tops the list, but many other factors are important.

**68%** agree that “**Risk assessment** tools are useful, but they are **only a small part of how I determine** whether or not to recommend anticoagulation treatment for patients with atrial fibrillation.”

**67%** agree that “**The risk assessment tools currently available only account for physiological factors and fail to recognize additional factors** like dementia, presence of a caregiver, or patient reluctance to use medications that can affect compliance.”

## Factors to Consider when Treating AFib



### Additional factors:

- Activity level/ bed-ridden/ lifestyle
- History of bleeding disorders
- History of stroke
- Likelihood/ history of compliance
- Cholesterol
- Hypertension
- Cancer
- Diabetes
- GI issues
- Diet
- Other medications
- Obesity
- Renal function
- Smoking

Q42: For each of the following, please indicate how much you agree or disagree with that statement.

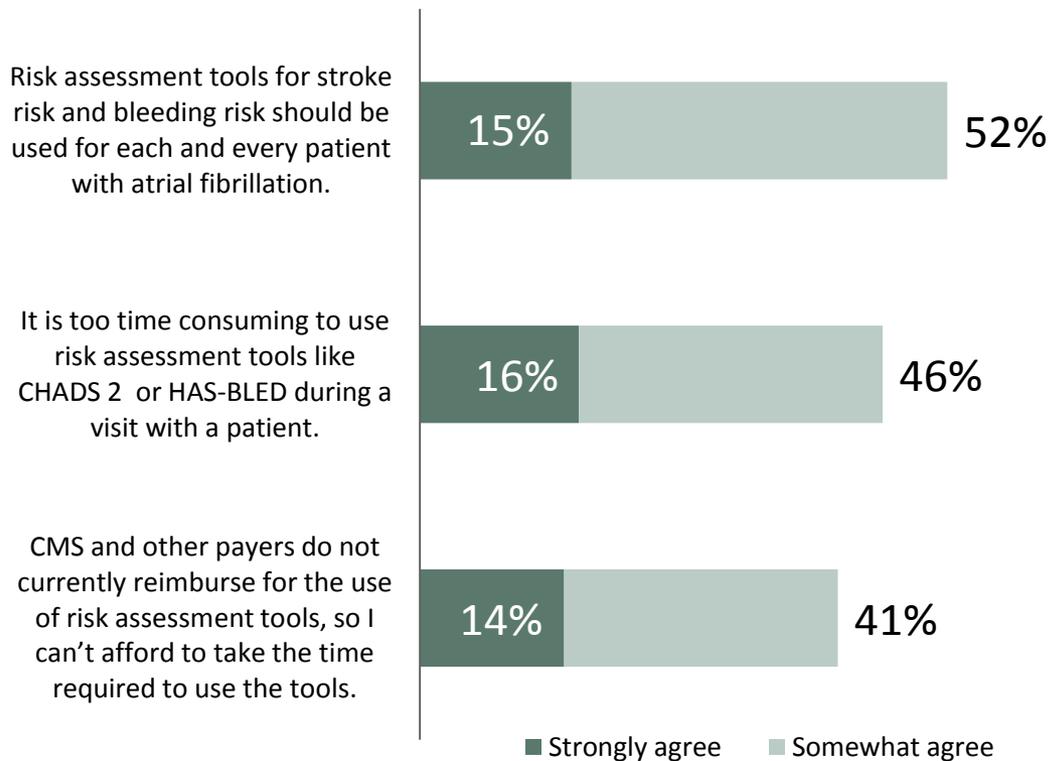
Q23: Please indicate how important each of the following factors is when determining recommended treatment for atrial fibrillation. Use a scale from 1 to 5 where a 5 means “extremely important” and a 1 means “not important at all.”

Q24: What other risk factors or health conditions, if any, do you consider important when determining treatment for atrial fibrillation?

# Attitudes on Risk Assessment Tools

- About half believe (though not strongly) that risk assessment tools should be used with every patient.
- However, almost as many also feel that the time and cost involved is too high.

## Use of Risk Assessment Tools



*“Take up lots of time .”*

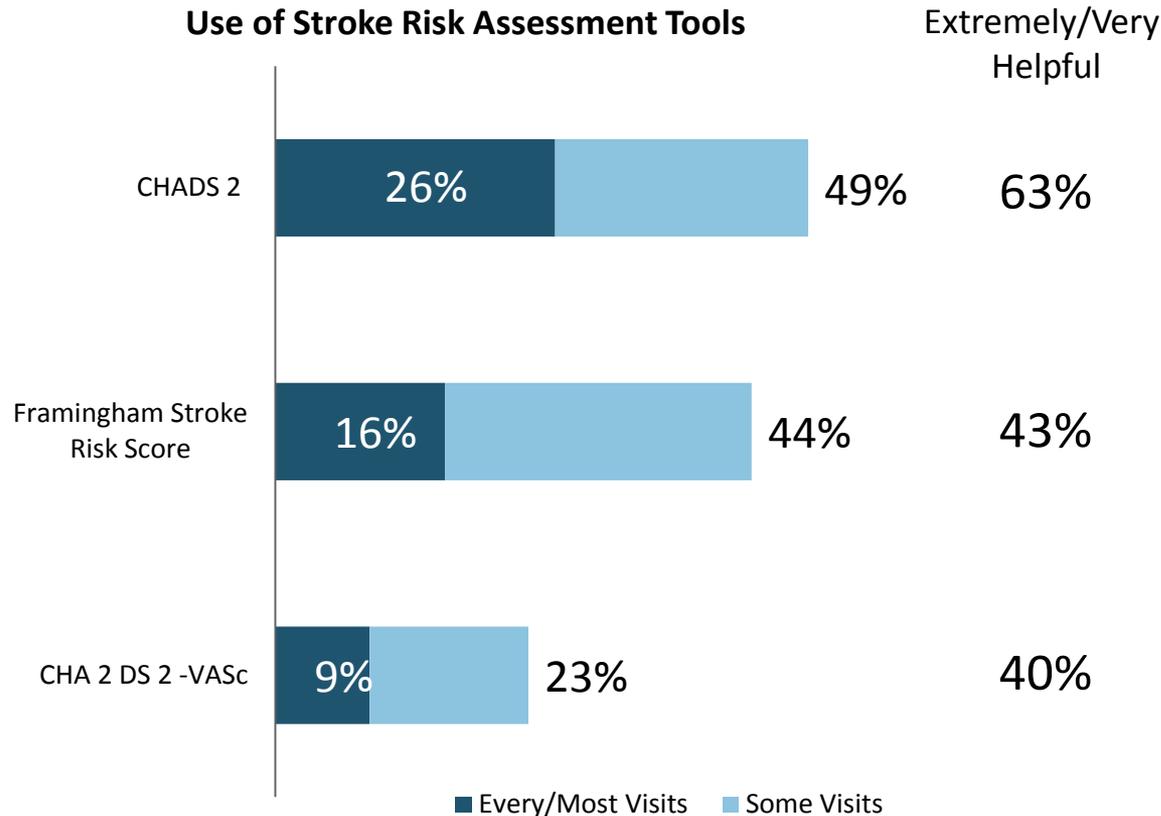
*“Time consuming, confusing .”*

*“Cumbersome, costly.”*

# Risk Assessment Tools - Stroke

- Fewer than half of these physicians use stroke risk assessment tools regularly.
- The simpler CHADS<sub>2</sub> tool is more popular than the more complex version.

**Use of Stroke Risk Assessment Tools**



*"[They're] easy to document in the EHR, makes the decision less subjective."*

*"[I] use to try and convince the patient to use therapy as directed. They like to see the numbers and risk."*

*"Difficult to apply accurately to patients over age 75 and especially in setting of mild to moderate dementia."*

*"They do not take the place of history and assessment by physician."*

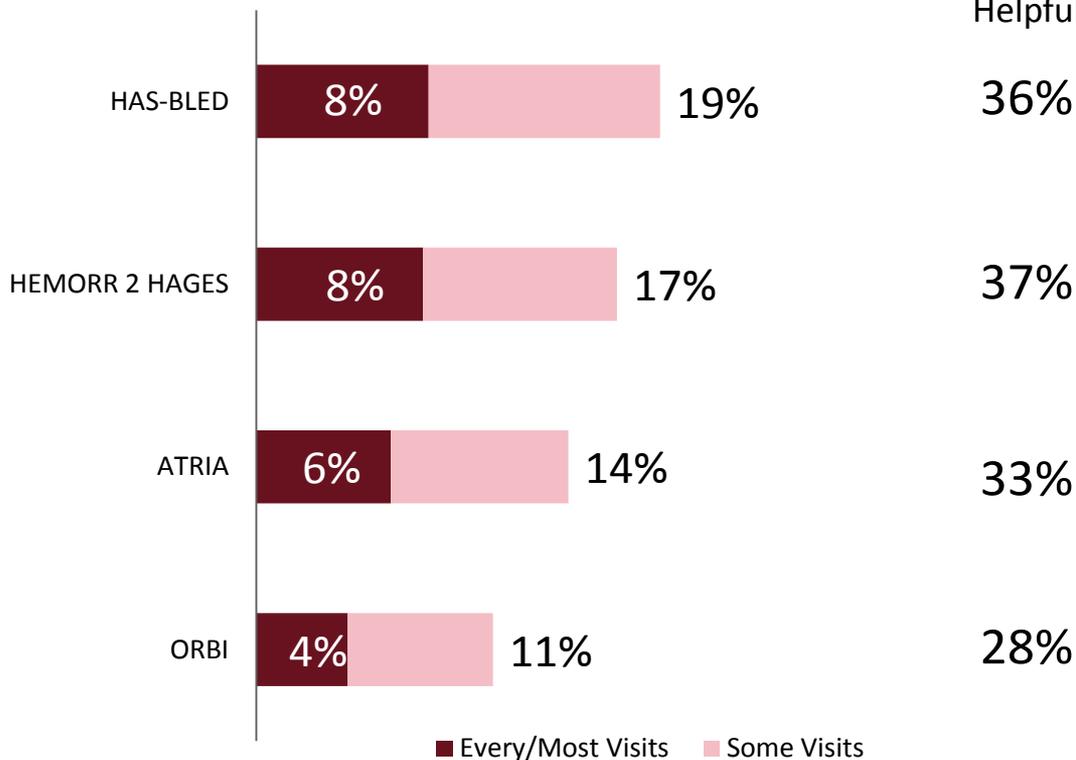
66% agree that, "None of the available risk assessment tools can fully assess the stroke risk of any and all patients."

Q32: How often do you use each of the following stroke risk assessment tools for patients with atrial fibrillation?  
 Q33: How helpful is each assessment tool to you personally when it comes to assessing patients with atrial fibrillation?  
 Q42: For each of the following, please indicate how much you agree or disagree with that statement.

# Risk Assessment Tools - Bleeding

- Bleeding risk assessment tools are even less used/helpful.
- They don't offer the individualization that physicians prefer.

## Use of Bleeding Risk Assessment Tools



*"[They] objectify, quantify risks."*

*"Validation of a decision not to anticoagulate."*

*"Difficulty employing in clinical practice."*

*"I'd rather completely individualize it."*

67% agree that, "None of the available risk assessment tools can fully assess the bleeding risk of any and all patients."

Q37: How often do you use each of the following bleeding risk assessment tools for patients with atrial fibrillation?

Q38: Here is the same list again. How helpful is each assessment tool to you personally when it comes to assessing patients with atrial fibrillation?

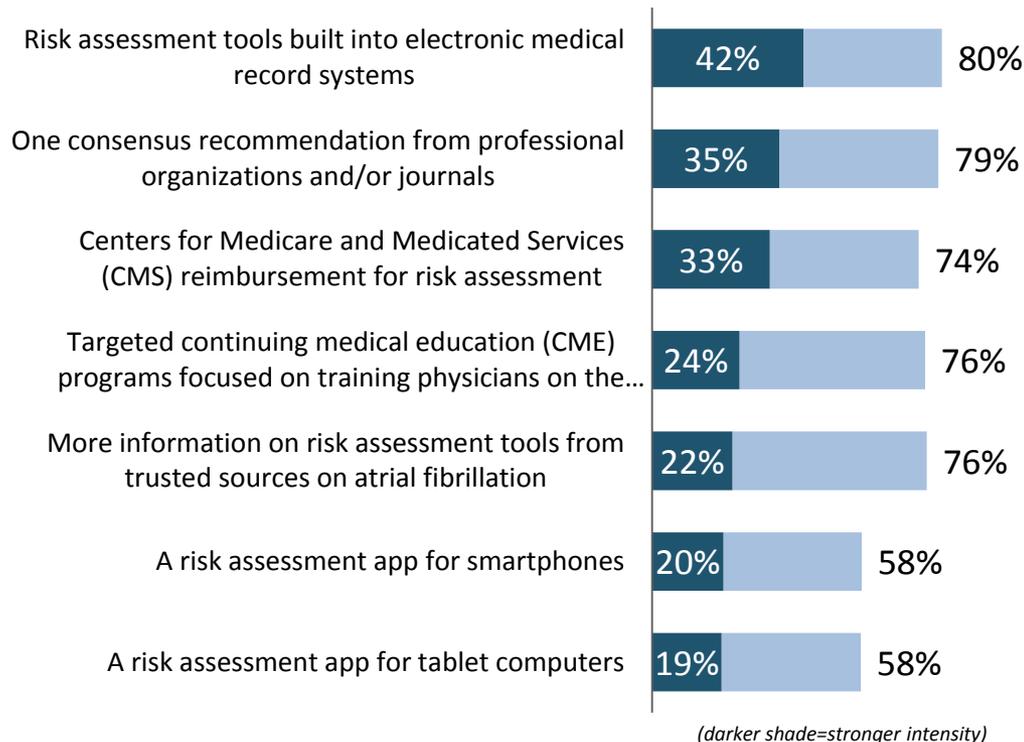
Q42: For each of the following, please indicate how much you agree or disagree with that statement.

# Increasing Risk Assessment for AFib Patients

- Ease of use is important, particularly through electronic systems/devices.
- Consensus is again a popular solution.

## Ideas to Improve Use of Risk Assessment Tools

(much/somewhat more likely to use)



- **81%** use tools during visit (when they use at all)
- **46%** access patient information on an electronic device at the bedside.
- **88%** from elsewhere in the medical office

Q44: Here are some ideas physicians have suggested to improve risk assessment tools and increase their use. For each, please indicate whether it would make you more or less likely to use stroke and bleeding risk assessment tools for patients with atrial fibrillation.

Q43: When you use risk assessment tools for stroke or bleeding risk, do you use them during the visit with the patient or after?

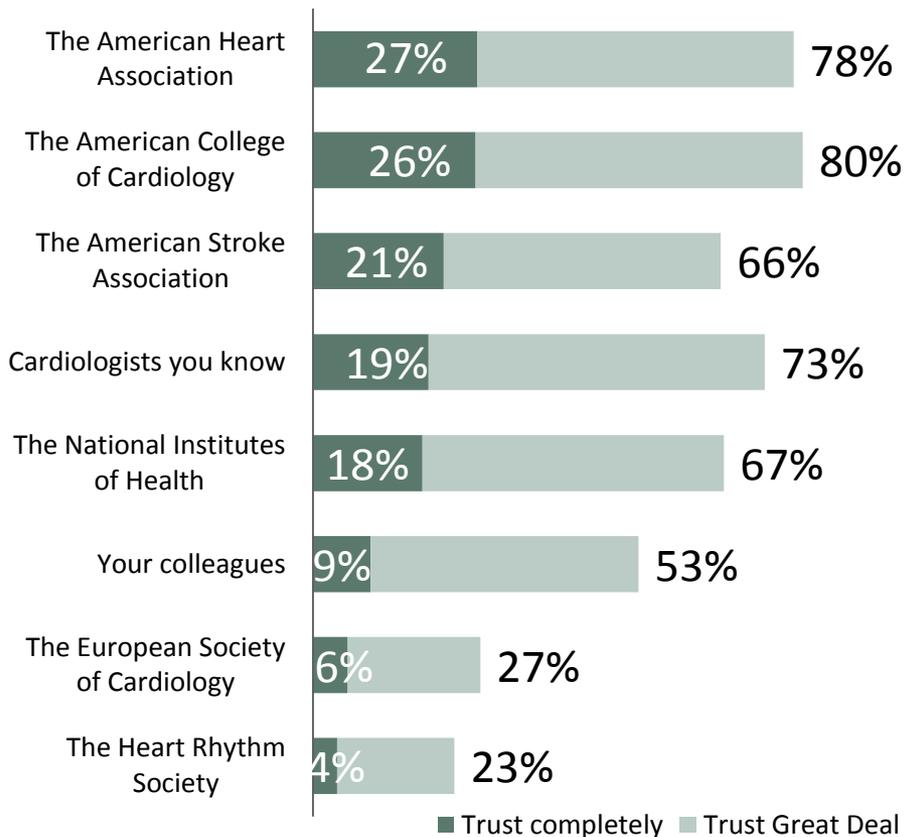
Q56: At which locations do you access patient-related information and/or guidelines on a computer/electronic device? Select all that apply.

# Appendix: Sources of Information



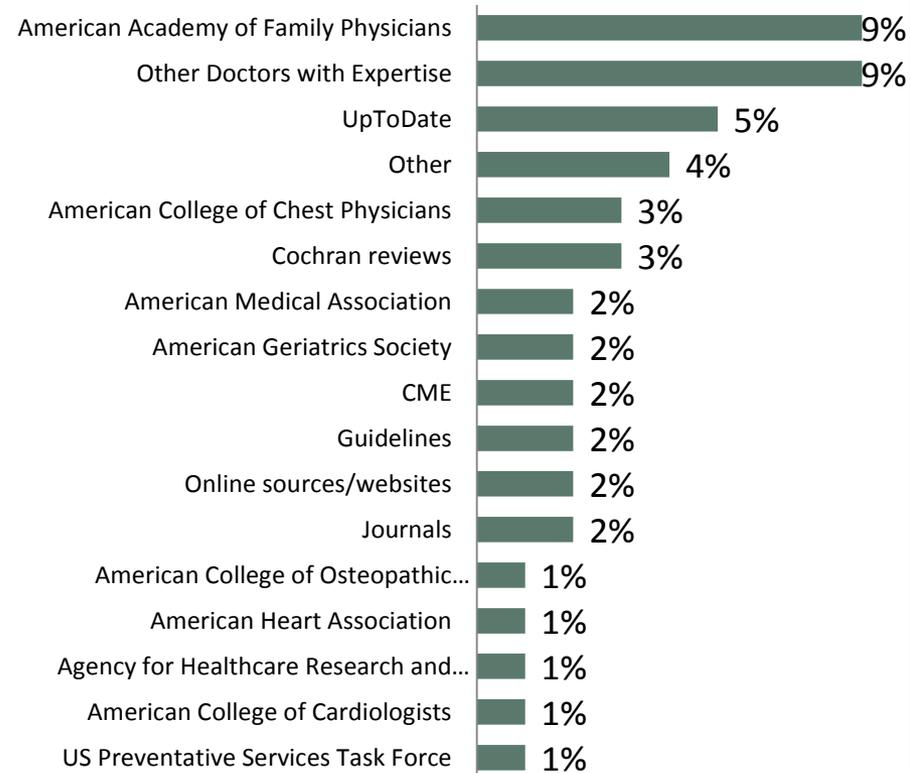
# Sources of Information

## Sources of Information on AFib



## Mentions of Other Sources

(coded open-end)

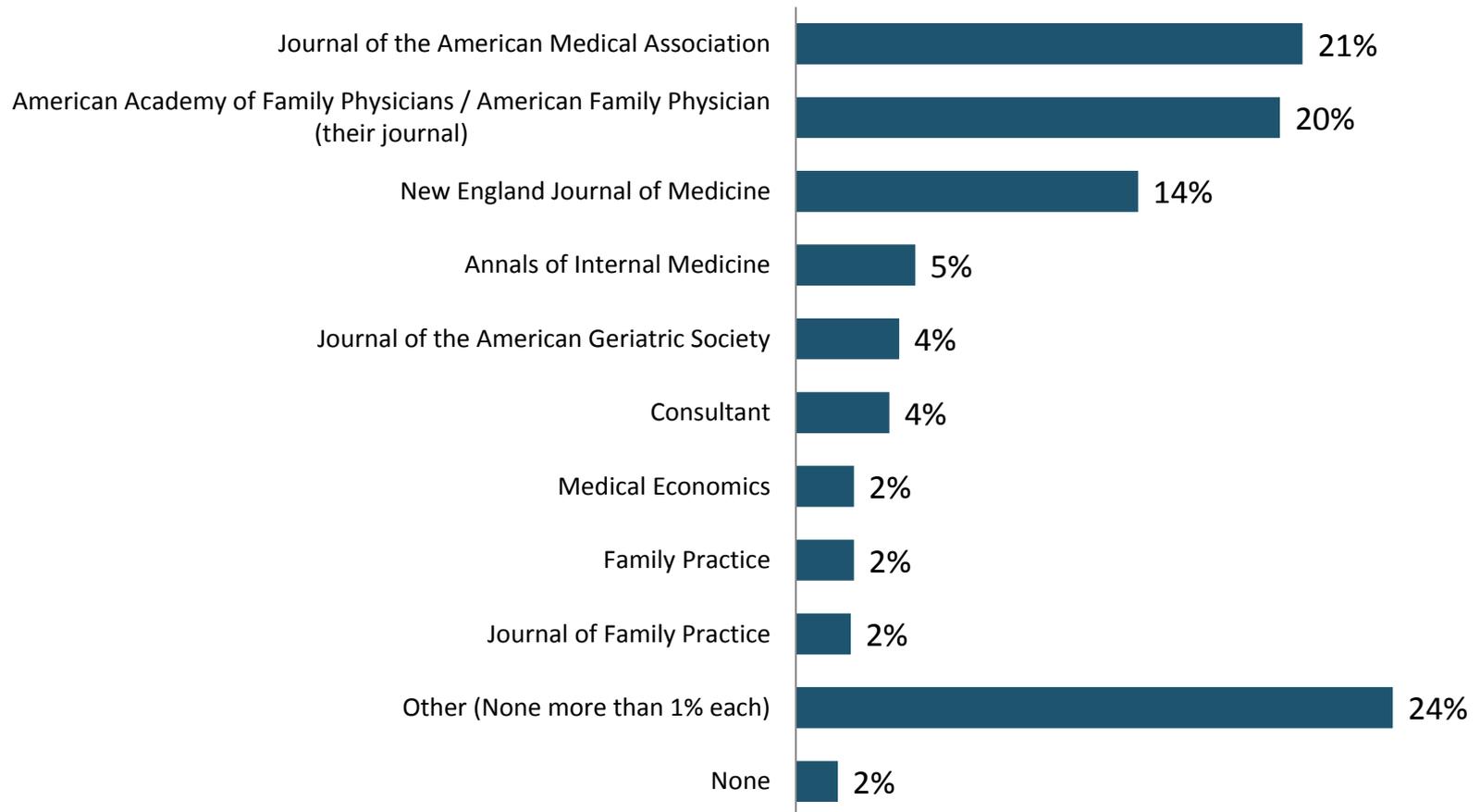


Q47: Below are some types of people or organizations who might provide information on the treatment of atrial fibrillation. Please indicate how much you trust the information provided by each source.

Q48: Please share any other sources you trust for information on the treatment of atrial fibrillation.

# Journals Read Regularly

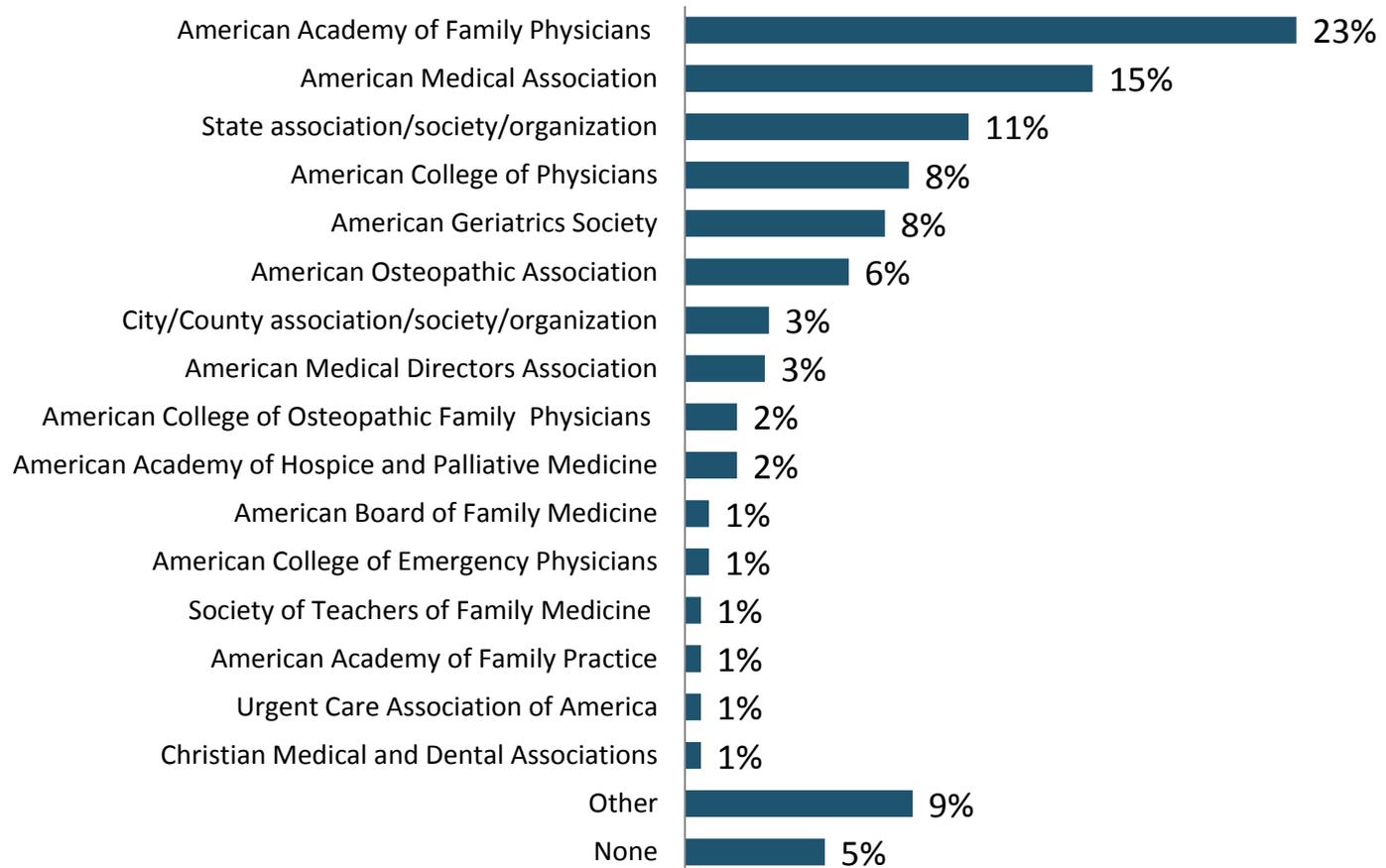
**Journals Read Regularly**  
(coded open-end)



# Professional Organizations

## Professional Association Memberships

(coded open-end)



# Appendix: Demographics



# Demographic Profile of Respondents

## GENDER

Male: 68%  
 Female: 32%

## TYPE OF PHYSICIAN:

Family physician/GP: 61%  
 Internist: 9%  
 Geriatrician: 29%

## YEARS PRACTICING

0-5 years 15%  
 6-10 years: 19%  
 11-20 years: 30%  
 20+ years: 37%

## PRACTICE SETTING

Hospital: 28%  
 Health clinic: 20%  
 Private practice: 57%  
 Nursing home: 18%  
 Ambulatory: 15%  
 Other: 4%

## LOCATION

Urban: 37%  
 Suburban: 43%  
 Small town: 9%  
 Rural: 12%

## NUMBER OF PATIENTS PER MONTH

Fewer than 100: 9%  
 101-200: 15%  
 201-300: 20%  
 301-500: 42%  
 501+: 14%

## MEAN % OF PATIENTS USING PAYMENT TYPE

Patient pay/full fee for service: 9%  
 Private insurance: 30%  
 Medicare: 36%  
 Medicaid: 11%  
 Other: 15%

## TECHNOLOGY USED IN PRACTICE

Desktop computer: 78%  
 Laptop: 52%  
 Handheld wireless device: 43%  
 Tablet: 20%  
 None: 3%

## WHERE ACCESS INFO/TOOLS/GUIDELINES

At bedside/operator: 46%  
 Elsewhere in office: 88%  
 Home: 60%  
 None: 2%