Enabling anticoagulated patients for a better compliance and medication adherence

What kind of anticoagulant is fitting for which patient?
presented by Jørn Dalsgaard Nielsen, MD, Head of Centre of Excellence for Anticoagulant Therapy, Copenhagen, Denmark:
New oral anticoagulants (NOAC’s)
- Explanation of acronyms:
  ▣ NOAC: New Oral AntiCoagulant
  ▣ NOAC: Non-vitamin K Oral AntiCoagulant
  ▣ ODAC: Oral Direct AntiCoagulant
  ▣ TSOAC: Target Specific Oral AntiCoagulant

Meta-Analysis of Randomized Controlled Trials on Risk of Myocardial Infarction from the Use of Oral Direct Thrombin Inhibitors

Am J Cardiol 2013; 112:1973-9:
“In conclusion, our data suggest that oral DTIs were associated with increased risk of MI. This increased risk appears to be a class effect of these agents.”

Choice of anticoagulant:
- Valvular heart disease: VKA
- Non-valvular AF or venous thromboembolism: VKA or NOAC
- Renal dysfunction may contraindicate the use of NOAC
- Unstable VKA therapy may indicate switch to NOAC. The assessment is based on the time in therapeutic range (TTI):
  ▣ TTI <50%: Switch NOAC
  ▣ TTI 50-70%: Consider switching to NOAC
  ▣ TTI >70%: VKA therapy is well regulated
- Patients where INR determination is problematic: Consider NOAC
- NOAC: Can the patient afford it?

Compliance, patient autonomy and paternalism
presented by Ron van’t Land, MD, Directeur Thrombosdienst Neder-Veluwe, Ede, The Netherlands:
“Keep a watch also on the faults of the patients, which often make them lie about the taking of things prescribed” (Hippocrates of Kos 460 - 370 B.C.)

How compliant are anticoagulated patients in real?
- AC-therapy can be as tricky as skidiving
- In AC-therapy compliance is a must to prevent accidents
- Autonomous (critical participating) compliant patients are the best
- Doctors must empower patient towards maximal autonomy
- A little bit of good hearted doctor’s paternalism is OK

Autonomy: What’s that for the AC-patient?
- In the decision to be treated with anticoagulants in the first place: This is a moral rationality based on knowledge, values and good thinking.
- “It is good for me to be anticoagulated”
- To live up to the requirements of the treatment with anticoagulants: This is an instrumental rationality about means and ends.
- “For a good AC-treatment I must comply to protocols and to what the doctor knows best.”

Is it reasonable to enter in anticoagulant treatment and then no to be compliant?
I don’t think so. It would be like skydiving without following rules and the teacher’s instructions

Over 90% of patients took their pills

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**Autonomy: What’s that for the AC-patient?**

But still there are two major problems:

**Problem 1:** The doctor does not always know or do what’s best. He/She:
- Can make a mistake.
- Can have less medical knowledge than you.
- Does not know all about your specific context.
- The right way to be autonomous is to be a critical participating patient that has a basic trust in the intentions and competences of his doctor.
- The doctor should accept and empower this attitude in the patient.

**Problem 2:** The patient often simply is not rational.
- Fear tends to undermine reason and that’s why the patient does not always decide and act in such a way as it is good for him/her.

**Paternalism:** To act against full autonomy of the patient because you, as a doctor, know better what’s good for the patient than he/she knows himself of herself (at the moment).
- Not telling the entire truth
- Emphasizing the danger of non-compliance
- Relativize the risks of the treatment
- To take a somewhat authoritarian stand

- The right way to be a good AC-doctor is not only to inform the patient well, but also to nudge the patient into the right direction if necessary.
- The patient should accept this well-meant paternalistic attitude in the doctor.

**Compliance: About what?**
- Taking pills
- Doing good measurements
- Following instructions for self-dosing
- Adherence to extern control
- Contacting the AC-clinic if necessary
- Providing information
- Lifestyle aspects.

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**Ron van’t Land: Threefold comment:**

Some things are not necessary
Some things are not safe
Some things are very expensive

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**How do the Dutch AC-clinics try to secure and improve their patient compliance.**

**Empowerment:**
- Information and explanation during first INR-control
- Documentation presented at first control
- Informative websites
- Patient entry for electronic web-based patient file
- Permanent education by skilled nurses during controls
- Patient meetings

**Controls:**
- „Regular“ patients every 1 to 6 weeks
- Possibility of home visits
- Compliance is a topic during all controls
- Feedback and questions about bad INR-values
- Good-hearted, concerned, paternalistic for all non-compliance
- Skilled nurses with good intuitions and knowledge
- Multi-agency health care (working from a chain perspective)

**Supervised self-management (15%)**
- 10% self-measurement + self-dosing
  - supervised dosing (webbased patient file)
  - correction and education if needed for every single act of dosing
- 5% self-measurement alone
- E-learning or group training
- Control visits every 6 months
- Identification of persistent non-performance

**Recommendations for all patients (Ceess N de Graaff, Stizan, The Netherlands)**

**Compliance:**
- Better attainability AC-clinics (by phone)
- See the patient more as equal and listen to his/her observations
- More flexibility in time and place for „regular“ controls
- Much more informational patient meetings
- 24/7 direct consultation function by AC-clinic for all patients

**In general:**
- Advising role for AC-clinc regarding therapy choice (incl. DOAC)
- Better communication about interfering treatment (dentists)
- Default distribution of an AC-“passport” to all new patients

**Recommendation for self-management patients:**
- More active attitude towards promoting self-management
- More autonomy and responsibility for patients
- Once a year e-training for already skilled, experienced patients.