NICE Evidence Search Student Champions
Learning about NICE

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Overview

- Summary
- Shared decision making
  - What is it? Why do it? How to do it?
- CG180 Atrial fibrillation: patient decision aid
- Next steps
- Questions
What is shared decision making?

Involvement of patients with their providers in making health care decisions that are informed by the best available evidence about options, potential benefits, and harms, and that consider patient preferences.
Shared decision making starts with the conversation between the person receiving care and the person delivering care.

Shared decision making puts people at the centre of decisions about their own treatment and care, by:

- exploring care or treatment options and their risks and benefits
- discussing choices available
- reaching a decision about care or treatment
together with their health and social care professional.
## Tools and resources

Tools to help you put the guidance into practice.

### Baseline assessment
- **Baseline assessment tool**
  - Baseline assessment tool
  - 04 July 2014
  - Excel 467.5 KB

### Costing report
- **Costing report**
  - Costing report
  - 18 June 2014
  - PDF 455.3 KB

### Costing template
- **Costing template**
  - Costing template
  - 18 June 2014
  - Excel 548.5 KB

### Tailored service improvement support
- **NIC consensus statement on the use of NOACs**
  - NIC consensus statement on the use of NOACs
  - 18 June 2014
  - PDF 751.63 KB

### Tailored education support
- **Tailored education support**
- **Patient decision aid**
  - Patient decision aid
  - 18 June 2014
  - PDF 610.48 KB
- **Patient decision aid user guide**
  - Patient decision aid user guide
  - 18 June 2014
  - PDF 222.95 KB

### Implementation advice
- **Endorsed resource - decision support tool**

### Research recommendations
- **Research recommendations information**

### 'Do not do' recommendations
- **'Do not do' recommendations**

### Shared learning
- **Shared learning information**

### Guidance into practice
- About the Into practice guide
  - Using NICE guidance and quality standards to improve practice
Patient Decision Aid

Atrial fibrillation: medicines to help reduce your risk of a stroke – what are the options?

http://guidance.nice.org.uk/CG180/PatientDecisionAid/pdf/English

Published: June 2014
Key Components

Information
Patient goals or values
Meaningful involvement
What does the option involve?

Will it reduce my risk of having a stroke?

Will I need any regular blood tests?

What are the other main side effects?

Will it increase my risk of having major bleeding?

What happens if I forget to take a dose?

Will I have to change what I eat or drink?

What happens if I need non-urgent surgery, including dental surgery?

Will the medicine interact with other medicines I take?

What happens if the effects need to be reversed in an emergency (for example, after an injury or before emergency surgery)?
How you feel about the options

You can use the table to help you think about how important the issues are to you.

<table>
<thead>
<tr>
<th>Issue</th>
<th>How important is this to me?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Important</td>
</tr>
<tr>
<td>What tablets or capsules I’d have to take, and how often</td>
<td></td>
</tr>
<tr>
<td>The effect on my risk of having an AF-related ischaemic stroke</td>
<td></td>
</tr>
<tr>
<td>The effect on my risk of having major bleeding</td>
<td></td>
</tr>
<tr>
<td>Other main side effects</td>
<td></td>
</tr>
<tr>
<td>The need for regular blood tests</td>
<td></td>
</tr>
<tr>
<td>What would happen if I forget to take a dose</td>
<td></td>
</tr>
<tr>
<td>The need to change what I eat or drink</td>
<td></td>
</tr>
<tr>
<td>Whether the medicine will interact with other medicines I take</td>
<td></td>
</tr>
<tr>
<td>What would happen if I need non-urgent surgery, including dental surgery</td>
<td></td>
</tr>
<tr>
<td>What would happen if the effects need to be reversed in an emergency</td>
<td></td>
</tr>
</tbody>
</table>
No treatment: CHA$_2$DS$_2$-VASc score 2

If 1000 people with AF and a CHA$_2$DS$_2$-VASc score of 2 take no anticoagulant, over 1 year on average:

- 975 people will not have an AF-related stroke (the green faces)
- 25 people will have an AF-related stroke (the red faces).
Anticoagulant: CHA$_2$DS$_2$-VASc score 2

If all 1000 people take an anticoagulant, over 1 year on average:

- 975 people will not have an AF-related stroke (the green faces), but would not have done anyway
- 17 people will be saved from having an AF-related stroke (the yellow faces)
- 8 people will still have an AF-related stroke (the red faces).
No treatment: HAS-BLED score 4

If 1000 people with AF and a HAS-BLED score of 4 take no anticoagulant, over 1 year on average:

- 987 people will not have a major bleed (the green faces)
- 13 people will have a major bleed (the red faces).
Anticoagulant: HAS-BLED score 4

If all 1000 people take an anticoagulant, over 1 year on average:

- 966 people will not have a major bleed (the green faces)
- 13 people will have a major bleed (the red faces), just as they would have done anyway
- An extra 21 people will have a major bleed (the green faces with the red cross)
Welcome

This decision support tool is designed to assist UK healthcare professionals in the appropriate prescribing of anticoagulation therapy for the prevention of stroke in patients with atrial fibrillation.

Developed by Prescribing Decision Support at Keele University’s Centre for Medicines Optimisation, the tool provides individualised prescribing recommendations based on NICE clinical guidelines and also incorporates a NICE patient decision aid to help patients weigh up the possible benefits, harms, advantages and disadvantages of different treatment options.

Each recommendation is supported by a reason, important management considerations, common treatment side-effects and appropriate references. To support joint decision-making, the tool allows patients to rate what is and isn’t important to them in stroke prevention and to also view visual representations of the risks and benefits of treatments.

Create New Patient Profile

This decision support tool for healthcare professionals supports the majority of recommendations relating to the diagnosis and assessment of atrial fibrillation, assessment of stroke and bleeding risks and anticoagulation in the NICE guideline on Atrial fibrillation. In addition it also supports the contents in the NICE patient decision aid for Atrial fibrillation.

Open Existing Patient Profile

This tool is for use with adults (aged 18 years and over) who have suspected or diagnosed non-valvular atrial fibrillation.

This tool should not be used by persons other than UK healthcare professionals in the appropriate prescribing of anticoagulation therapy for the prevention of stroke in patients with atrial fibrillation.

National Institute for Health and Care Excellence

October 2015

The tool was developed as part of a joint working group initiative comprising the National Institute for Health and Care Excellence (NICE), Boehringer Ingelheim Ltd and Prescribing Decision Support Ltd at the Centre for Medicines Optimisation, Keele University. All three parties committed resources to the joint working project in line with ABPI Code requirements.
Stroke Risk (CHA₂DS₂-VASc)

- Congestive heart failure or left ventricular dysfunction? YES NO
- Hypertension? YES NO
- Age ≥ 75 years? YES NO
- Diabetes mellitus? YES NO
- Prior stroke, TIA or thromboembolism? YES NO
- Vascular disease? Prior myocardial infarction, peripheral artery disease, aortic plaque. YES NO

CHA₂DS₂-VASc score: 3

Adjusted stroke rate: Ischaemic strokes per 1000 patients over 1 year: 37
### Patient Profile

#### Stroke Risk (CHA₂DS₂-VASc)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uncontrolled Hypertension?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eg. systolic blood pressure &gt; 160mmHg.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Abnormal Renal Function?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic dialysis, renal transplantation or serum creatinine &gt; 200 micromol/L.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Abnormal Liver Function?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic hepatic disease (eg. cirrhosis) or biochemical evidence of significant hepatic derangement (eg. bilirubin &gt;2 x ULN; in association with AST/ALT/ALP &gt;3 x ULN; etc.)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Stroke?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous bleeding history and/or predisposition to bleeding, eg. bleeding diathesis, anaemia, etc.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Bleeding?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labile INRs (if taking VKA)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstable/high INRs or poor time in therapeutic range (eg. &lt;60%).</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**HAS-BLED Score**

- Elderly? Eg. Age >65 years, frail condition.
- Antiplatelet Drugs? Concomitant use of aspirin, other antiplatelet drug or NSAID, etc.
- Alcohol Abuse?

**HAS-BLED Score**

- 1

**Bleeding Risk**

- Estimated rate per 1000 patients over 1 year

- 3
Decision Support

Anticoagulation therapy for the prevention of stroke and systemic embolism in atrial fibrillation.

Patient Profile

Stroke Risk (CHA₂DS₂-VASc)

Bleeding Risk (HAS-BLED)

Current Treatment

Contraindications

Interactions

Search drug:

Special Considerations

Treatment Recommendation

Offer Warfarin (or other VKA), Dabigatran 150mg bd, Rivaroxaban 20mg od or Apixaban 5mg bd. Take bleeding risk into account.

Discuss the options for anticoagulation with the patient and base the choice on their clinical features and preferences.

Note: you have indicated that the patient has one or more modifiable risk factor that may increase their risk of bleeding. Offer modification and monitoring of risk factors where appropriate.

When discussing the benefits and risks of anticoagulation, explain that for most people the benefit of anticoagulation outweighs the bleeding risk, but for people with an increased risk of bleeding the benefit of anticoagulation may not always outweigh the bleeding risk.

Reasons for Recommendation

You have indicated:

- That the patient has a CHA₂DS₂-VASc score of 2 or above. NICE recommends that anticoagulation should be offered to this patient (taking the bleeding risk into account).
- That the patient is able to receive either warfarin (or other VKA), dabigatran, rivaroxaban or apixaban.

In addition to warfarin; dabigatran, rivaroxaban and apixaban are recommended by NICE as options for the prevention of stroke and systemic embolism within their licensed indications.

For people who are taking an anticoagulant, review the need for anticoagulation and the quality of anticoagulation control at least annually, or more frequently if clinically relevant events occur affecting anticoagulation or bleeding risk.

References

Treatment Recommendation

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Reasons for Recommendation

You have indicated:

- That the patient has a CHA\(_2\)DS\(_2\)-VASc score of 2 or above. NICE recommends that anticoagulation should be offered to this patient (taking the bleeding risk into account).
- That the patient is able to receive either warfarin (or other VKA), dabigatran, rivaroxaban or apixaban.

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References

Were you involved as much as you wanted to be in decisions about your care and treatment? 

% responding ‘Yes, definitely’

Source: NHS inpatient surveys
Cochrane review March 2015

“We concluded that personalised care planning is a promising approach that offers the potential to provide effective help to patients, leading to better health outcomes”

Benefits:

- Physical
- Psychological
- Psychosocial

Effects of personalised care planning for people with long-term conditions, Cochrane Review March 2015
A cascade of wins for the NHS

The 2002 Wanless Report estimated the potential annual savings at £30 billion, or 16 per cent of the projected budget by 2022 (Wanless 2002). That estimate was based on an optimistic scenario of maximum patient engagement, but we believe nonetheless that the potential financial gain from stopping the silent misdiagnosis is comparable in magnitude to the potential financial gain from improved adherence to evidence-based clinical guidelines. Indeed, the two together could bridge the entire budget shortfall, and both opportunities should be pursued.

As yet, however, the NHS has acted only on the latter opportunity, through the creation, in 1999, of the National Institute for Health and Clinical Excellence (NICE) and its practice guidelines.
“… I believe that finding the sweet spot for shared decision making will require clinicians to work against their natural impulses to tell the patient what to do when they’re certain of what’s best, and to leave the patient to decide when they’re not

“...I’m not sure what the right answer is, so why don’t you decide”

can be replaced with:

“This is a really hard decision because we aren’t sure what will happen if you choose option x; let me show you how I think about this, and you can tell me whether it fits with what’s important to you.” And, equally important, “I’m recommending option x because it provides better outcomes than option y” can become “Let me tell you about the pros and cons of options x and y so that you can decide which one matches your priorities.”
Move from:
“What's the matter with you?”

To:
“What matters to you?”
"When we want your opinion, we'll give it to you."
Next steps…for everyone

Try it out!

Spread the word!

Get to know what decision aids are available

Watch this space
• Any questions?

• “What matters to you?”

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