

Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:

<https://reachmd.com/programs/cme/reducing-economic-burdens-in-pah-treatment-as-a-means-to-increase-access-to-care/14120/>

Released: 06/24/2022

Valid until: 06/24/2023

Time needed to complete: 1h 01m

ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

Reducing Economic Burdens in PAH Treatment as a Means To Increase Access to Care

Dr. Elwing:

So, let's talk about reducing economic burden to improve that access and overcome those economic barriers for PAH treatment as a means to increase access to care. Annual cost of PAH medications can be a demotivator for patients to seek and maintain their management of the disease. Socioeconomic reasons result in delays of care in PAH centers. A major concern impacting access to care is the cost of our medications. The mean retail 30-day cost of PAH therapies is more than \$5,000. And you look here in this table, the cost is extraordinary. And, of course, people will have insurance coverage and they may be eligible for assistance, but still these numbers are daunting. So, cost includes several things. You could pay for your insurance and then have co-payments, and you also have other costs like oxygen and transportation, and other non-PAH medications. And as I said, there is help, but still, this is a very daunting thing for our patients.

Transportation is also an issue, and this is another economic barrier to care. This is a major obstacle for low-income patients that live at distance from a PAH center. They need to arrange transportation. They need gas money, maybe a hotel stay, and meals during that time. So, a trip to the doctor may not just be that 120 miles. It could include all of those things and may also include hiring somebody to take you to your appointment if you're not able to drive or don't have your own transportation. Specialist outreach is an option but requires that the PAH specialist leave a busy practice to see one or two patients at a distant location. This problem can be avoided if the specialist has a focus clinic for PAH, where enough patients access that it makes it worth the time to take a day to go serve those patients while leaving other patients behind. So we have to look at this and try to really work with patients in a remote area and the physicians to develop a relationship, where we can see a number of patients at that remote clinic.

So shared care is a way to improve access. We need to be able to extend our reach through our partners in the community. Shared care between the primary provider and the PAH specialist is another option to increase access across physical barriers of time and distance. Patients can be seen locally with the input of their PAH specialist. This reduces the number of trips to the PAH center and provides for educational opportunities between the PAH specialist and the referring physician. There are barriers. Many community clinics and hospitals are not equipped to care for patients on parenteral prostanoid therapy. They lack the knowledge and exposure to this to provide safe care. But we can impact and reduce that risk by education, by educating our healthcare providers and EMS in those communities, to be able to see, assess, and then determine what the best management strategy is for patients on parental therapy and communicating with the PAH specialist to transfer patients when necessary.

So let's look at this model. We have two major groups of people. We have the physicians in the community and then the PAH center. Those physicians in the community are seeing the at-risk patient population. They're providing their day-to-day care. They are the ones that are going to identify the at-risk patients and screen them and then refer them to the PAH center, where the patients will have access to the PAH specialty-trained physician, advanced diagnostics, medications, and clinical trials, lung transplants, support groups, and advanced teaching. So this is a relationship that needs to be bidirectional because one group cannot do it without the other.

It's not just primary care physicians we need in this group. We need the patient's primary pulmonologist, their primary cardiologist, their rheumatologist, and their primary care physician to all interact in a positive way to allow the patient to have the best outcome.