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Why Aren't All Physicians Using Regular and Consistent Risk Assessment Protocols With Their PH Patients?

Announcer:
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Dr. McLaughlin:
So hello, and welcome to this roundtable discussion really entitled: Why Aren't All Providers Using Regular and Consistent Risk Assessment Protocols for Their Patients with Pulmonary Hypertension? I'm Val McLaughlin from the University of Michigan. And I'm thrilled today to be joined by Jean Elwing from the University of Cincinnati, and Martha Kingman from UT Southwestern.

So Jean, start with you, is there a lack of belief? Is it time? Like, why aren't people using risk assessment tools in clinical practice?

Dr. Elwing:
That's a question, right? I think we all believe they work. I think they accurately assess our patients' risk. But if you look at surveys, we did one recently with CHEST, about a third of experienced PH providers are not using them. They think Gestalt is accurate and adequate. But that was also assessed by Dr. Sahay, and it showed that it's not accurate. And it's going to either under or over treat patients. So it's a problem.

Dr. McLaughlin:
Yeah, I agree. I mean, we've got great tools. We've got great calculators, we've got lots of data behind it. Martha, so what's the main barrier in clinical practice?

Ms. Kingman:
Well, when we looked at this in 2019, the main barrier was time. But I would say perceived lack of time, because really, it takes 1 or 2 minutes, right, to do a risk assessment. But when you asked providers, the most common reason was they don't have time.

Dr. McLaughlin:
Well, right. But we're seeing these patients in clinic and some of the more recent tools are so simple. And there are things we do in clinic every day; we assess the functional class, we do a hall walk, we get blood, we have a biomarker, you can create a flow sheet in your EMR. It doesn't really take that much time. So Jean, how do we convey this to people? How do we increase the utility of risk assessment in everyday practice?

Dr. Elwing:
Well, I think that we've done a great job educating, right, we've talked about it multiple times. It's in every guideline, we're including in clinical trials. Now it's up to us to change our practice patterns. We have to take that extra minute and believe that that will help our patient outcome. So if we believe in the risk assessment tools, we've got to be willing to take that step. So it's us. It's on us to make a change now.

Dr. McLaughlin:

Yeah, I would also say that the patients really enjoy it, right?

Dr. Elwing:
Absolutely.

Dr. McLaughlin:
Like, when you try to talk to your patient about why you're recommending a specific therapy, or why you think that they don't need something else, showing them their risk assessment and showing them, you know, their prognosis based on that can be really powerful. Do you do that in your practice, Martha?

Ms. Kingman:
I do do that. Not every patient, because some patients, you know, don't want that much information. But I have found most patients really are interested in it, and it does help, especially if you're going to advance their therapy to the more, you know, I.V. therapies, subcutaneous therapies, and you're able to show them we're not where we are, or we're not a goal, we're not at low-risk status.

Dr. McLaughlin:
Do you incorporate it into your medical record the way I was mentioning as well?

Ms. Kingman:
Well, we do have it in the medical record. We have - and we have some providers that use REVEAL and some that use ERS/ESC. But what we haven't accomplished completely is having the variables automatically input, so we have to enter them. And functional class will always have to enter, right, because it's so subjective. But we're looking at trying to figure out a way to get those variables automatically put into the calculator and so that we don't have to do it by hand. Right?

Dr. McLaughlin:
So that should get rid of the time barrier.

Dr. Elwing:
Right. Yeah.

Dr. McLaughlin:
You know, one other potential barrier is that really the risk assessment only takes into account those few things, right? And there's some limitations of that. It doesn't really take into account RV function, or if the patient has other comorbidities that might influence that objective score. Jean, is that possible that that's one of the objectives and objections and why people don't use it as regularly?

Dr. Elwing:
Possibly, they feel like it's not as robust as their clinical assessment. But I think you have to take it as one piece of the puzzle, right? It's not the whole answer. But it certainly can help guide. If it's going in the wrong direction, we've got to respect that it's showing us there's something negative going on for that patient, maybe they're not taking their meds, maybe they're not following up enough and they need to know that their risk assessment is worsening. But then you have to add the imaging and all of that data together to make the whole package for the patient.

Dr. McLaughlin:
Yeah. So I'm going to ask both of you the same question: If you could give our audience one take-home message that you want them to hear about incorporating risk assessment into your everyday practice, what would it be?

Ms. Kingman:
I would say it really only takes a minute or two, and clinical Gestalt has been shown to not be as accurate as doing formal risk assessment.

Dr. McLaughlin:
Okay. Jean?

Dr. Elwing:
I would say try it for 6 months and see if it makes a difference in the outcomes of how you're responding to those individual patients. And I think it'll sell itself to you.

Dr. McLaughlin:
Yeah, that's brilliant. So to wrap up, you know, we know how important risk assessment is, as we take care of our patients and we make treatment decisions. We have wonderful risk assessment tools that really don't take that long and can be incorporated into the electronic medical record. And we need to complement those risk assessment tools by other factors that influence our treatment decisions such as

comorbidities and RV dysfunction.

So, Jean, Martha, thank you so much for joining me today.

Dr. Elwing:
Thank you for having us.

Announcer:
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