

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/heart-matters/at-the-heart-of-healthcare-addressing-the-future-of-cardiology-care/12055/>

ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

At the Heart of Healthcare: Addressing the Future of Cardiology Care

Dr. Brown:

Hello, This is Heart Matters on ReachMD. I'm Dr. Alan Brown, and today I'm sitting down with my fellow host and good friend, Dr. Matthew Sorrentino, and we're going to discuss an unusual topic, which is the future of health care and how preventative cardiology may look in the future. So Matt, would you like to introduce yourself to our audience?

Dr. Sorrentino:

Thanks Alan. I'm Matthew Sorrentino. I'm a Professor of Medicine in Cardiology at the University of Chicago Hospitals and like my friend Alan here, we've both devoted our careers to preventive cardiology.

Dr. Brown:

So Matt, I'm intrigued by some of the newer lipid-lowering agents that are gonna be given by someone in the health care community, potentially at the doctor's office or at Walgreens or through their APN where you only give the medication every six months, and some drugs on the horizon that might only be once a year. And I'm intrigued by that because I think that that might improve compliance, and if you try to model out how many events are you gonna save in the future, if you could go from 50% adherence to the medicine to even 90%, assuming 10% of people don't show up at the office, and so you do lose some. They're not all gonna go get their shot but potentially you could save a lot more events. So I just wonder what your thoughts are for some of these newer entries into the marketplace that look like they're around the corner.

Dr. Sorrentino:

Yeah, it's exciting. Some of these new agents and the ability of giving something twice a year, the one I'm thinking of is these small interferon RNA molecules that work with the PCSK9 protein. I think they studied it initially every three months, but it looks like every six months will work just as well, and you get a 40+% lowering of LDL. My only concern with this is if you're gonna be having a new drug like this, that's gonna be given once every six months, my guess is it's gonna cost even more than the PCSK9s do now, which are given every two weeks. And so, how much will price be a limiting factor here? But in terms of having a long-term effect, for six months, having your LDL down, and just coming to your doctor's office or, as you said, even the Walgreens and getting a quick injection once every six months, I mean, that's real exciting way of beating this compliance issue.

Dr. Brown:

Yeah, it's interesting. I had the privilege of talking with the head of the original company that came up with the mRNA for PCSK9, who told me that they could price it however they want, because it's very inexpensive to make it. Now, that'll come back, probably, to haunt me, because that company's been purchased, and there may be a different strategy with the new company, though I'm not sure of that. But, speaking from a health care system perspective, my thought, which is we as a health care system could purchase the drug directly from the manufacturer, not have it go through the insurers, the pharmacy, and all of that and as part of our population health strategy, we could then deliver that drug to our patients that we are responsible for, at a fraction of the cost of having it go through the usual pathway, through a PBMs and pharmacies and everyone taking a cut of the price. So, the potential for something like that to be disruptive, if there's a way to actually do it, is very interesting to me, and what's also interesting is that the people making the new small inhibiting mRNA for PCSK9 have already made an agreement with the British National Health to do something similar to that, and provide them with the drug. So I think, with those kinds of volumes the potential to keep the costs down, and then to really reap the benefits of the outcome data, looks good. We don't have outcome data yet, but the potential to have better outcomes, compared to drugs that patients don't take is pretty exciting.

Dr. Sorrentino:

Well, I especially think this particular one is very intriguing, because of how surprisingly positive the outcome studies were with the PCSK9 inhibitors. The small interfering RNAs for PCSK9, do the same thing. You're getting the exact same result. You're getting reduction of the PCSK9 molecule so your LDL receptors are recycled, and you're pulling LDL out of the circulation. So if you're doing the same physiology, we should get the same results with very little side effects. But I agree with you, I think what we need to think about is ways of changing the current paradigm thinking about ways of delivery of therapeutics to our patients. In a sense, we're doing it a little bit already. I tell my patients, go to your local Walgreens and get your flu shot. It'll be probably cheaper, it'll be quicker, you don't have to come in to the office so we're already giving things that in the past, we only gave in the office, and we can give them in different ways. So, we gotta think of these new paradigms.

Dr. Brown:

Yeah, I appreciate that. I mean, as of today, I heard on the news that Amazon's home prescription delivery is cutting into the traditional pharmacy's stock value, and what did Amazon do? They made a little pill pack that has exactly your pills all lined up for when you're supposed to take them, and it comes in the mail, and that's an example of disruption. And I can't help thinking about Uber, who never bought a taxi. They own no vehicles, and yet they completely disrupted the travel business and they do it without a big expense. They've lowered the price and provided a service that most people need. And that's why I feel like there is opportunity for similar disruption in health care, and someone's gonna do it. It may well come from outside of the health care arena and I know that many companies, including Apple and Google, are very interested in that, as is Microsoft. So, a lot of people are very depressed about the future of health care, and when they hear about value-based care, it makes them nauseated. But actually, there's a lot to be excited about, and it'll be fun to see what happens in the future, and as we get older, fun to know that hopefully we'll be cared for based on our outcomes and not on our insurance.

Dr. Sorrentino:

Well, and at least a better care. We did, about five years ago, a very simple survey in our hospital looking to see how many patients with heart failure, with reduced ejection fraction, were discharged on a beta blocker. And we thought, "Oh, we're a big academic center. It's gotta be 90%," and when we found that we were much, much lower than that, we were very surprised. But part of the reason why is all the patients who come in with heart failure are treated by different groups some are treated by interns, some by the hospitalists, some by the cardiologists, some on the surgical service. And yet, they have heart failure and that's what they're discharged from, and they're not on what is considered Class 1, guideline-directed therapy. So we put a protocol in place, and we more than tripled our beta blocker use for heart failure with reduced ejection fraction post-protocol throughout the hospital. So, I think this value-based approach is really what we want to do. We want to do better care for our patients, and by evaluating it and seeing what we're doing, and making sure that we're meeting these benchmarks, we're all gonna get better care.

Dr. Brown:

That's very well said. I remember vividly when Gregg Fonarow, our colleague out in California, just put a simple protocol in place that everyone with vascular disease go home on aspirin, beta blocker, statin and ACE inhibitor – many years ago. And you could argue about those details now, but that was the basis of appropriate therapy at that time. And just by having a discharge protocol, they not only made sure patients were treated on the right drugs, but they were able to show a reduction in readmission and death over the subsequent several years for patients who had been treated based on that protocol. So Gregg's famous saying is that systems turn good doctors into great doctors. Then I have quoted him on that many times, and your example's another outstanding example of how having a systematic approach is gonna be the key to the future. And as we get bigger and bigger abilities on the data side, and become more digital, our ability to identify problems and manage patients on a mass scale are gonna improve. So, it should be fun.

Dr. Sorrentino:

Absolutely.

Dr. Brown:

So that's a great way to round out our discussion on the future of health care, and particularly the topic of prevention. I wanna thank Dr. Sorrentino for joining me to discuss this topic, and for providing us with some insight into the field of cardiology. Thanks very much, Matt, for taking the time to speak with me today.

Dr. Sorrentino:

Thank you.

Dr. Brown:

I'm Dr. Alan Brown. To access this episode and others in this series, visit reachmd.com/heartmatters, where you can be part of the knowledge. Thanks very much for listening.