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Gazing into the Cardiology Crystal Ball: The Future of Preventive 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, let's talk a little bit about the way things are moving in health care and how that might affect preventative cardiology and the health of the population. You know, I'm interested in the sort of dilemma that we're dealing with, where 90% of our business is fee for service in health care still, but yet everybody knows we're gonna be heading towards more of a value-based care, where we're gonna probably get more of a capitated fee and guarantee better outcomes for our patients, which should do a lot of things, not the least of which focus on the patient as the main goal rather than revenue generation from services we provide. But we're a long ways from there. So, I wanted to just start to talk with you about what do you see as the future of maintaining health in a world where that is really gonna mean survival for the health care system and better outcomes for patients.

Dr. Sorrentino:
No, I think you're absolutely right, Alan. We definitely have to focus on prevention, and I think that this is all just good for our patients. If we focus more on outcomes, that's going to benefit all of our patients, and I think some of these different payers are sort of forcing our hand to do that. We have to look at our own patient populations. We have to look at our data. For example, we've done a program at the university where we're looking very carefully at blood pressure. The first thing we wanted to do is make sure we check blood pressure more than once in somebody who had an elevated blood pressure coming into the clinic. And so, we put a protocol in place where our nurses and our MA's have to repeat a blood pressure if it's elevated. And we got to over 90-95% just re-checking a blood pressure. Well, once we knew that we had good blood pressure data, the next was, let's see if we can increase the number of our patients who have elevated blood pressure to get under control. And we picked control of 140/90 – not even the 130/80 that a lot of people are recommending as the blood pressure now. So by putting these protocols in and these mandates in, we're seeing consistently better and better numbers and better control – well that's what the payers are asking us. They're gonna ask what is your percentage of patients whose blood pressure is controlled? What are your percentage of patients whose hemoglobin A1C is below 7%? So if they're asking us to do that and that's good patient care, we should all be doing that.

Dr. Brown:
Yeah, I think of that almost like tells in the water of where we may be going. All of these things that we're doing with payers asking us to be responsible for outcomes are good for the patient. And what we're looking at ten years from now, and maybe sooner, is patients having wearables that monitor their blood pressure on a regular basis, possibly the Apple watches now can monitor O2 saturation. You can potentially monitor blood glucose in real time, and very likely, chemistries in the future. So, I am imagining a world where our patients who are covered have wearables and all of that information is being fed into a database. And just like now, when you order a pair of underwear online, you get seventeen ads for underwear immediately thereafter if they're willing to trust us with their privacy, the potential for looking at patients, real time, and maybe identifying that the PSA went up the day that it went up, instead of at the annual visit, all those things are exciting but they will be associated with privacy issues.

Dr. Sorrentino:
Well, we are starting to do some of that already. The higher end of it is the CardioMEMS program that we've got a fairly large number of patients in CardioMEMS, and they're getting checked every day, and looking at their filling pressures. And we've markedly reduced the readmission rate of heart failure by using CardioMEMS. I think it's just that you're contacting the patient every single day. I'm sure you've got a huge number of phone calls from your patients, who'd say that "I'm sure I'm in AFib. My watch says I'm in AFib." So there's a lot of these phone apps which are now telling us that, and at first it was annoying because many times it was wrong. But it's amazing, with the newer technology, how many times when it says AFib, it actually is AFib, and if we get these patients treated early, maybe we're gonna prevent the strokes that are gonna happen.

Dr. Brown:
Yeah, that's a great example. We also very aggressively use CardioMEMS, but again, those are all coming from the health care system, whereas the AFib app is coming from Apple, right? And one could imagine that there could be a big disruption in health care, where some big company says, "You know what? We're gonna take care of all our employees. Or, we're gonna offer care on an ambulatory basis for lots and lots of people." There's an interesting scenario in Milwaukee where a printing company just decided they're gonna reduce their health care costs. And they bought clinics, and hired docs on salary, and said, "Free for all the employees. We're gonna insure our employees for all their routine stuff. You just go to the clinics for your routine care." The doctors were paid again by salary rather than fee for service. And then they contracted with tertiary care centers for the more complicated stuff, like surgery. But they cut their health care costs dramatically. So one could imagine an Amazon, a Google, or an Apple embarking on that adventure. I keep thinking, as a health care system, we're gonna have to think about how we would interact with such an opportunity, especially when the ability to digitize health care is gonna be in the hands of these big players, I think.

Dr. Sorrentino:
There may even be more simple ways of reducing costs. You may remember many years ago now, there was a cost-effectiveness analysis of statin therapy. And this is even when statins were still branded drugs and were still more expensive; the cost-effectiveness analysis showed that it saved money. And so I had heard of some pharmacy plans that gave the statins away for free. And by giving the statin for free, you had a lot more patients who were gonna take it. Obviously they could afford it, and it could reduce the number of heart attacks and strokes, and thereby reduce the cost to that plan significantly. So we should be doing more of this – you know, free statins, the free polypill that just at the last AHA sessions showed is very effective. If you gave a free polypill to people and get their blood pressure and statins under control, think of how it could prevent costs down the road.

Dr. Brown:
For those just tuning in, you're listening to Heart Matters on ReachMD. I'm Dr. Alan Brown, and here with me is one of our other Heart Matters hosts, Dr. Matthew Sorrentino, and we're discussing the future of health care and the movement towards value.

So, we spoke a little bit earlier about possibly where the health care system is going, and pay for value rather than paying for service. And you had gave a beautiful segue, which was the statin discussion about how cost-effectiveness data suggests that it reduces costs, and there's very few things in health care where we actually make money by doing an intervention. Which brings me to something that I think is at the top of both of our minds, which is the adherence issue. So if we calculate a cost-effectiveness for statins or any other medication, but patients only take it half the time, and we know that at a year, less than half of people are still on their statins, and the ones that we prescribed high-dose, according to guidelines, they drift down pretty quickly, so that only about 40% are still on high-dose statins at a year. So how do we deal with that?

Dr. Sorrentino:
Yeah, compliance with medications has always been a problem, and even with medications that have minimal to no side effects. The compliance is inverse related to the number of pills and the number of dosing intervals, and so we make it difficult for patients, many times, because we have these crazy dosing intervals, and drugs that you need two, three times a day, and some you need with food and some without food, and it becomes really complicated. When statins first came out, as you may remember, we told patients to take them after the evening meal or before bedtime. Well if they're taking their other medicines in the morning, they're not gonna take it, and I know a lot of patients who, they're told to take medicines before bedtime, they fall asleep before they open their pill bottle, so they never take it. So it's a terrible time for many patients to take it. So part of it, I think, is our fault. We need to come up with simple regimens, once a day dosing, long-acting pills so you don't need multiple dosing intervals. But then it's education. I think we need to educate our patients why you're on this medicine, why it's important, and what the outcomes are going to be. With preventive medicines, we're usually giving medicines to patients who feel fine. They're not having a symptom. They're not having chest pain necessarily. They're not having shortness of breath. They're not having an infection. They feel fine, and we want to give them a medicine they're gonna take the rest of their lives. And half the time we give it to them, it makes them feel worse. Their muscles hurt, they feel fatigued, they have

symptoms. And so that's why they don't take it. And so, they're feeling fine until we give them a preventive modality. So, how can we convince them to take these things? I briefly mentioned earlier the polypill. I was never a big advocate, years ago, of combination pills, because I'm an academic, I like to titrate each aspect of my medication. But I've completely gone about-face. I like combination pills, because I cut my pill doses down to one pill, so the polypill approach really is gonna help compliance.

Dr. Brown:
Yeah, well said, Matt. I think every compliance study shows that number of doses a day is in the top three reasons why people don't take their pills. I think our messaging needs some work too. We were never trained in what's the best message to get a patient to understand. So, if you tell somebody, "I want you to take this medicine to lower your cholesterol," they may not be that worried about their cholesterol. That's not a great message. But if you tell them, "You've had a bypass surgery. If you take this pill, your chance of having a heart attack or stroke in the next five years is cut nearly in half," they're more likely to take it as a way to reduce their risk of a stroke or heart attack, versus their cholesterol, and probably we could do a lot more studying about what messages have traction. I tell my patients that their statin is a 401k plan, and the more they invest early, the better the benefit over time, and try to explain to them that every day you take this medicine, your risk goes down.

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