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Turning the Double Play – Comprehensive Secondary Prevention

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Dr. Malachowski:
Hello. I'm Dr. Matt Malachowski. Here with me today is Dr. Randy Englert. Today, we're focusing on secondary prevention and the systems that help reduce recurrent risk of major adverse cardiovascular events, or MACEs. In many ways, it takes a coordinated team effort, almost like turning a double play.

Randy, to start us off, what do we know about recurrent MACE risks in survivors of MIs?

Dr. Englert:
Well, the highest-risk period for recurrent ischemic events after an MI is in the first 90 days after a discharge from that first event, with risk remaining substantially elevated throughout the first year and persisting, even though not as high, for years thereafter. And so this is not just a survive-the-hospitalization sort of problem. There is risk that's ongoing.

And so the risk is there's ongoing systemic inflammation, there's persistent plaque vulnerability throughout the coronary tree, there's residual lipid burden, and there's also an increased thrombotic propensity. And so this pathophysiology is distinctly different from patients that have stable coronary artery disease who never had a prior event.

And so in order to demonstrate the importance of secondary prevention in this population, I'd like to start with the numbers. And so in that first year after having an ACS event, the risk of having another—meaning an MI, ischemic stroke or cardiovascular death—is 18%. Half of those events are going to happen in the first 90 days. And so for patients that get through the first year event free, the risk that they have a recurrence is about 5% to 7% per year, and that's pretty consistent across different countries and different cohorts.

And so in the late 1990s compared to the late 2010s, there has been an improvement in post-MI outcomes in terms of recurrent MIs. However, it's mild. And so these persistent event rates demonstrate that despite major advances in lipid therapy as well as catheter therapies, the residual risk persists and it demands ongoing attention.

And so additionally, we have comorbidities that are going to amplify this risk substantially. So heart failure, kidney disease, and diabetes are the strongest independent predictors of recurrent MACE, with each additional comorbidity incrementally increasing event rates.

And so it's important for our patients with ASCVD for shared decision-making to improve their outcomes. When patients with ASCVD

are actively involved in their care, they're more likely to adhere to their medications, including statin therapy, and they're also less likely to utilize the ER and have less hospitalization rates.

So after an MI, patients are often faced with treatment decisions that involve tradeoffs, such as the duration of dual antiplatelet therapy or up-titration of lipid-lowering therapy that might involve multiple medications. And you think about that with polypharmacy from common comorbidities that also have multiple medications. And so these are just some areas where shared decision-making is essential, as there might be multiple medically appropriate options that exist.

And so for our patients with a prior MI, they may benefit from a multidisciplinary approach.

Dr. Malachowski:
Randy, those are all very important points. I think when we're talking about turning a double play in clinical practice, coordination between cardiology, primary care, maybe the interventional lab, and pharmacy is essential to keeping patients on guideline-directed therapy. And being able to communicate the plan and the approach is just as important.

At Ochsner Health, we find that putting as much of this into our native EMR as possible keeps both the patient and the entire care team working in lockstep. So having the ability to document the plan and our expectation and then communicate when we need an escalation in that support. We use a referral called an eConsult that allows all of the members of our team to communicate with each other. Whether it's primary care reaching out to cardiology or cardiology reaching out to pharmacy, we can call for help and ask for a specific event, such as tagging up on a base without having to disrupt their daily care delivery. This is all done asynchronously, and we're able to do it without having to come out of our EMR, which ensures efficiency among our team members. But being able to document that and being able to assign tasks to care delivery partners that are best equipped to provide these outcomes leads to that long-term guideline-directed medication-therapy success.

Some other opportunities would be the ability to work the registries. And then to even have some pre-checked boxes, something as simple as after an ASCVD event, who is checking that LDL-C? Who is checking to see what agent the patient was on prior to? And then escalating where appropriate. After an event, secondary prevention is important, and the patient is declaring that they likely need an escalation in therapy if they were adherent to the previous regimen.

So pulling all of this together to make sure that we're able to continue to execute on these double plays are going to ensure that what may have been a hiccup before doesn't need to happen again.

Dr. Englert:
I would just like to highlight the importance of involving pharmacy in the management of our patients with ASCVD. Our pharmacists can be involved in so many ways. They can be involved not only with direct medication management, but they can help assist with the completion of prior authorizations. They can ensure that we're appropriately utilizing our specialty pharmacies. They can help participate in digital health programs such as our digital lipid program, digital hypertension program, digital diabetes programs to help with the longitudinal control of these cardiovascular risk factors.

One other area where I think they play a key role is in that bridge between the inpatient setting and the outpatient setting. That's where pharmacists can get involved and make sure that patients are actually receiving the medications that are being prescribed at the time of discharge, making sure those patients are receiving those medications, tolerating those medications, and on them, even before that patient shows up for their primary care or cardiology follow-up visit.

So just so many ways we should have our pharmacy team involved, and this collaboration between the different specialties is only going to benefit the patient.

Dr. Malachowski:
Thank you, Randy, for that great discussion and those kind words. Know your medicine, know your pharmacist. And we thank you in the audience for listening. We're heading back to the dugout, but we'll see you on our next inning.

Announcer:
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