

# Coming Together to Ensure Neurological Treatment Access:

**Q&A** With Kavita V. Nair, PhD

INTERVIEW BY CHRISTINA MATTINA



NAIR

In 2025, each issue of *Population Health, Equity & Outcomes (PHEO)* will feature a profile of a health system leader transforming care in their area of expertise. This issue spotlights a conversation with Kavita V. Nair, PhD, FAAN, a professor in the Department of Neurology and the Center for

Pharmaceutical Outcomes Research at the University of Colorado (CU) Anschutz Medical Campus in Aurora. This interview has been edited for length and clarity.

**PHEO:** Could you tell me about your typical work day at CU Anschutz's Center for Pharmaceutical Outcomes Research and Department of Neurology?

**NAIR:** I spend the majority of my time within the Department of Neurology, but we have different aspects. I bring the partnerships from industry to the Department of Neurology. With newer drugs, even just understanding that there can be really good synergistic partnerships between the industry and neurology was fairly new to some of the subspecialties in neurology—so with MS [multiple sclerosis], with 22 drugs, the partnership was a lot easier. One aspect of my day, or my job, if you will, is working with industry and [neurology] to talk about: How do we design real-world studies or pragmatic trials, and where

are those synergies? What is the unmet need right now? Yes, it is sometimes comparing different kinds of drugs. But in the past few years, it's looking at other things. We have different populations within Colorado. So we have CU as the academic center, and as with most academic centers, all the subspecialties and the experts tend to be at the academic centers, but we have other sites of care that primarily see an underserved population, a Medicaid population. Regarding the availability of these FDA-approved drugs, for not only MS but also for Alzheimer disease or rare neurological diseases, they are FDA approved but tend to have a little bit of a sticker price shock for everyone. Are there differences in patients who come to the university and have the resources and the payer aspects to get those drugs? Are there disparities in who gets those drugs based on their payer type? More importantly, does it affect outcomes? That's an aspect that everyone's interested in. So that's one part of my day, getting stakeholders together with a common interest and putting those studies together.... It's putting the idea together and taking it from soup to nuts.

The other aspect is very policy-based, where we work with payers, sometimes in tandem and sometimes at the legislative level. I work a lot with the Colorado judiciary and the legislative group in different policy aspects to reform drug pricing policies. One of the efforts that I'm very involved in is gold-carding policies, which even payers are interested in, which asks: Is there a way to simplify prior authorization? For example, you're coming to see a neurologist to get an MRI. Do we really have to have prior

authorization if the neurologist orders the MRI? There are some common-sense solutions where you can get providers and payers together. We call it *payvider*. From a policy perspective, I'm actively involved in trying to conscript those policies and take them all the way to the legislative aspect, help craft bills, and maybe testify. I also encourage the neurology community to get involved at the state level because it really does matter.

**PHEO:** What is an initiative that your team is working on that you're passionate about?

**NAIR:** Excellent question. There are a couple things. One is that for the first time—and I've been on this campus as an academic for 27 years—we are able to really form partnerships. At CU, we have 3 hospital systems, and then we also have our largest disproportionate share hospital, Denver Health. Primarily, the patients who go to Denver Health are our indigent-care patients or those on Colorado Medicaid. And in the past year or so, for the first time, we've been able to really partner with them to look at

how neurological care is being delivered. Why I'm so excited about that initiative is that some of the providers in neurology at CU Anschutz or our central campus are also the same providers who staff clinics at Denver Health, so you have this great natural experiment where you have the same providers but different populations [and] different insurers, and you can really look at any impact of drug pricing policies or drug coverage policies on outcomes, with everything else being very similar.... Colorado is an opt-in state, so we have a large Colorado Medicaid population. To be able to really look at how drug policies and coverage policies affect outcomes in this kind of a natural experiment, and to be able to partner with Denver Health and get through all the paperwork, I'm very excited about that. Now we can really examine, if there are

any gaps, where they are, and if people are falling through the loopholes or the cracks, who they are and where we can intervene. Academic research is great—I've done 27 years of it—but we are at a point where we can actually look at research in a way in which we can identify care.

The other thing we're really excited about is that for the first time, we have this controversy: We're starting to have drugs [for patients with] Alzheimer disease, and we're going to have more. That dam has burst, and we are now having to figure out pathways to treat those patients. There might be different schools of thought on how effective these drugs are, but this has just opened

the floodgates. This is what the MS [field] was [experiencing] years ago, and we are now, again, taking the clinical piece and figuring out how to treat the number of patients when this is not a rare neurological disease. We don't have as many behavioral neurologists as we need, so how do we figure this out? Everyone is touched by Alzheimer disease and related dementias in some fashion. So, how do we take this increasing demand, with drugs we have now that have some benefit—people may disagree on what

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that level is—with other drugs coming in the pipeline? How do we see, treat, diagnose, and manage this largest segment of our population? It's not just the folks [older than] 75 years; it's Gen X. It's me; so it's very challenging, very exciting, very personal. My father passed away from Alzheimer disease 2 years ago. I am [in the] potential age demographic. It's exciting and challenging all at the same time.

**PHEO:** I can see why you're passionate about that. Are there any novel avenues of research on neurological treatments that you're excited to investigate?

**NAIR:** As I mentioned, in Alzheimer disease, there are new mechanisms of action. Again, I'm a health

outcomes researcher, so I leave that to the bench scientists, but we know in health services research that if you can't get access to a drug, then it just sits on a shelf. So, how do we get patients who can come from anywhere—from primary care or someone just sitting at home who feels like their partner or their parent [needs care]—and how do we wrap our heads around the problem? And it's not just one center. We are really coalescing around other centers, and everyone is coming together to try to figure out best practices. That's about as close as you can get to making an impact in people's lives, so I'm very excited about that.

**PHEO:** You touched on this earlier, but how can investigators and industry partners better collaborate to bring these neurology research insights to the patients in need?

**NAIR:** The collaborative relationship needs to go a little bit beyond, “Hey, we have a clinical trial; we need a PI [principal investigator].” I know that's the basis. We need to

expand beyond that because we need to be able to have researchers and industry come together and talk about all kinds of collaborative relationships. Those would be relationships when we're looking at a real-world study, or what is the need among the patient community, once a drug is approved or as you're waiting for the drug to be approved. You can't change what you don't assess. The Holy Grail is when we've decided that this chemical entity will be [investigated in] a clinical trial and we're recruiting for phase 1, phase 2, phase 3. We need investigators; that's the road well traveled. But I think if researchers and industry come together and start partnerships with a wider variety of researchers.... We love giants in our field. We love our mentors. But if you really want to know what patients feel and how to communicate, you need to get researchers who look like the patients they're treating. You need to get a

wider range of researchers of different ages, who look differently, who have different experiences, because that's how you really connect to who the patients are.

**PHEO:** Was there anything that you wanted to add?

**NAIR:** If there was a takeaway, for us as a neurology community, the broader neurology community, for everyone to move forward and capture the essence of how we can do this, we have to come together:

A neurologist, a payer, a PBM [pharmacy benefit manager], the pharmaceutical industry all have to come together. Neurology is mostly a noninterventional field; we don't do procedures. We treat through drugs. The starting point is the pharmaceutical industry. That's our unique health care system, and it's very complicated. Our drug distribution chain and everything in between has payers, whether it's specialty pharmacy payers, PBMs, all of the above, and pharmacy can be mail order, and then you have neurologist and patient, and so any picture [of the

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drug distribution chain], you'll see it in different versions, because that's the reality. For a practitioner or clinician to effectively prescribe drugs, for drugs to be accessible to the patient—a patient just doesn't get the [prescription] and go to a physical pharmacy for any of these drugs, because they're specialty drugs—everyone has to really come together. And the coming together doesn't necessarily always have to happen once a patient is prescribed [a drug]. We need to come together before that and talk about the things that work and don't work. I hope we can get there sooner rather than later when it comes to solutions. Because if we want to make sure that therapeutic innovation in neurology is really working for everyone, then the conversations need to happen, not when the patient goes to [fill] the drug and asks, “What, prior authorization?” That's my take; that's my one hope and wish. ▀