

High Burden, Great Opportunity: Preventing Heart Attacks and Strokes — What Clinicians Need to Know?

Clinician Outreach and Communication Activity
(COCA) Call
February 23, 2016



Accreditation Statements

CME: The Centers for Disease Control and Prevention is accredited by the Accreditation Council for Continuing Medical Education (ACCME®) to provide continuing medical education for physicians. The Centers for Disease Control and Prevention designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

CNE: The Centers for Disease Control and Prevention is accredited as a provider of Continuing Nursing Education by the American Nurses Credentialing Center's Commission on Accreditation. This activity provides 1.0 contact hours.

IACET CEU: The Centers for Disease Control and Prevention is authorized by IACET to offer 0.1 CEU's for this program.

CECH: Sponsored by the Centers for Disease Control and Prevention, a designated provider of continuing education contact hours (CECH) in health education by the National Commission for Health Education Credentialing, Inc. This program is designated for Certified Health Education Specialists (CHES) and/or Master Certified Health Education Specialists (MCHES) to receive up to 1.0 total Category I continuing education contact hours. Maximum advanced level continuing education contact hours available are 0. CDC provider number 98614.

CPE:  The Centers for Disease Control and Prevention is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This program is a designated event for pharmacists to receive 0.1 CEUs in pharmacy education. The Universal Activity Number is 0387-0000-16-076-L04-P and enduring 0387-0000-16-1076-H04-P. This activity is knowledge based.

AAVSB/RACE: This program was reviewed and approved by the AAVSB RACE program for 1.0 hours of continuing education in jurisdictions which recognize AAVSB RACE approval. Please contact the AAVSB RACE program if you have any comments/concerns regarding this program's validity or relevancy to the veterinary profession.

CPH: The Centers for Disease Control and Prevention is a pre-approved provider of Certified in Public Health (CPH) recertification credits and is authorized to offer 1 CPH recertification credit for this program.

Continuing Education Disclaimer

CDC, our planners, presenters, and their spouses/partners wish to disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters.

Planners have reviewed content to ensure there is no bias. This presentation will not include any discussion of the unlabeled use of a product or products under investigational use.

Objectives

At the conclusion of this session, the participant will be able to:

- ❑ **Describe the key components of Million Hearts® and the targets that must be met to prevent 1 million heart attacks and strokes**
- ❑ **Discuss the accomplishments of Million Hearts®**
- ❑ **State how evidence-based strategies can help identify and address the needs of those at greatest risk for heart attack and stroke**
- ❑ **Discuss the use of standardized treatment approaches to improve outcomes for patients at risk for heart attack and stroke**

TODAY'S PRESENTER



Janet S. Wright, MD, FACC

Executive Director

Million Hearts®

U.S. Department of Health and Human Services



***High Burden, Great Opportunity:
Preventing Heart Attacks and Strokes***

The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry.

Agenda

- ❑ Overview of Million Hearts
- ❑ Where We are Now
- ❑ What Works to Get to a Million
- ❑ Resources for You



Million Hearts®

**Goal: Prevent 1 million heart attacks
and strokes by 2017**

- National initiative co-led by CDC and CMS in partnership with federal, state, and private sectors
- To address the causes of 1.5M events and 800K deaths a year, \$312.6 B in annual health care costs and lost productivity and major disparities in outcomes



Key Components of Million Hearts®

Keeping Us Healthy
Changing the environment

**Health
Disparities**

Excelling in the ABCS
Optimizing care

Aspirin when appropriate

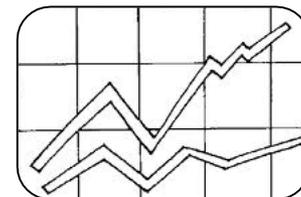
Blood pressure control

Cholesterol management

Smoking cessation



Focus on
the **ABCS**



Health
information
technology



Innovations in
care delivery



Million Hearts Progress to Date

- Engagement and activation
- Clinical Quality Measure alignment
- Understand what works, where, and why
- Resources that help
- Extraordinary support for Prevention

125 partners, 50 states, coalitions,
>63K subscribers, 246 Congregations

B, C, S

QIN-QIOs
Champions

Guides, Healthy Eating Center,
CQM Dashboard, Protocols

AHRQ's EvidenceNow: focus on the ABCS
CDC with ASTHO, NACDD, NACHC, SHDs
CMS Million Hearts CV Risk Reduction Model; QIN-QIOs
CMS Transforming Clinical Practice Initiative
PCORI/NIH: Hypertension in high risk populations; ADAPTABLE



Million Hearts® Accomplishments*

Changing the Environment

Reduce Smoking



Almost 4 million fewer cigarette smokers[†]

Reduce Sodium Intake



More than 2 billion meals/year will have reduced sodium[‡]

Eliminate Trans Fat Intake



Accomplished: FDA issued the final determination on artificial trans fat[§]



* Note this is a select set of notable Million Hearts® accomplishments.

† National Health Interview Survey, comparing 2011 data to 2014 data

‡ Aramark pledge <http://blog.heart.org/aha-aramark-join-on-meals-initiative/>

§ <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm372915.htm#top>

Million Hearts® Accomplishments

Optimizing Care in the Clinical Setting

Focus on the ABCS



Millions of Americans are covered by health care systems that are recognizing or rewarding performance in the ABCS^{**}

Health Tools and Technology



Over half a million patients have been identified as potentially having hypertension using health IT tools^{††}

Innovations in Care Delivery



Millions of dollars in public and private funds have been leveraged to focus on improving the ABCS^{††}



^{**} CMS Physician Compare and HRSA Uniform Data Set

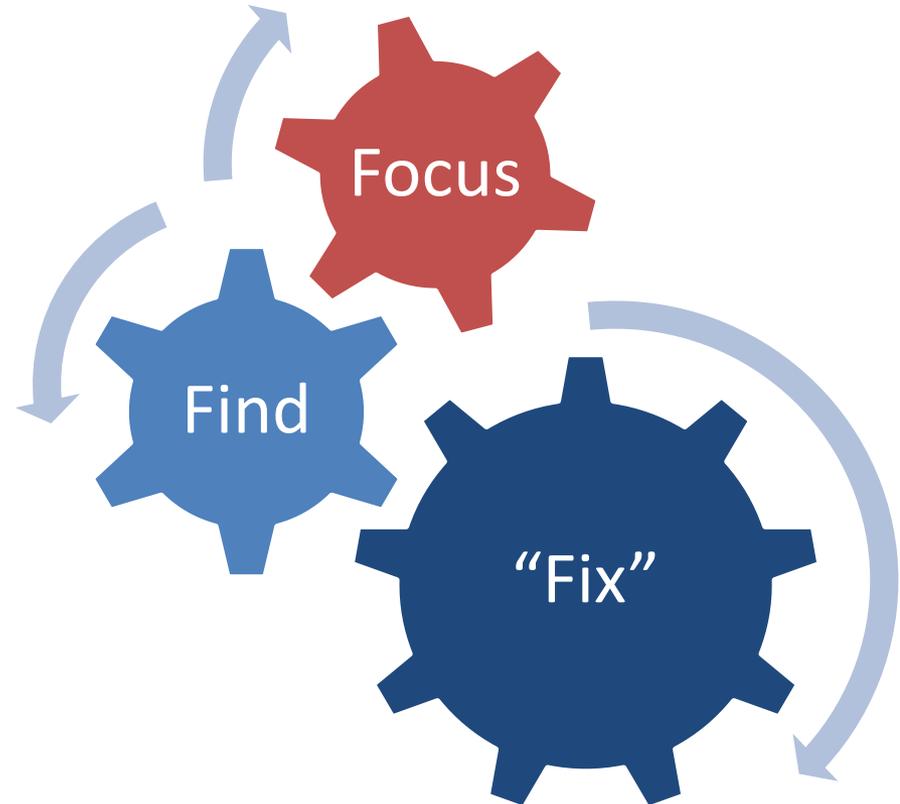
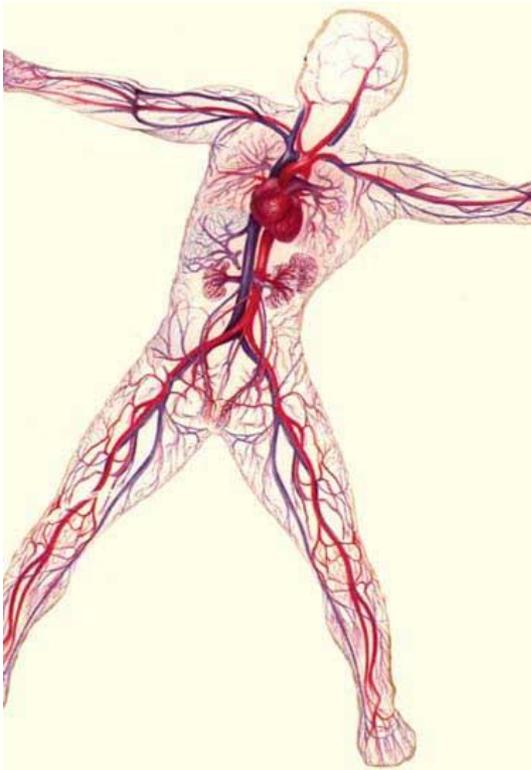
^{††} Unpublished data from AMGA/MUPD and NACHC HIPS project

^{‡‡} CMS Million Hearts Risk Reduction Model, AHRQ EvidenceNOW, AHA Southwest Affiliate HTN project

What Works to Prevent a Million?



Systemic Condition → *Systematic Approach*



Focus on What Matters



Getting to a Million by 2017: *Public Health Targets*

Intervention	Pre-Initiative Estimate 2009-10	2017 Target
Smoking prevalence*	26%	24%
Sodium reduction	3580 mg/day	2900 mg/day
Trans fat reduction	0.6% of calories	0% of calories

* Includes all forms of combustible tobacco – cigarettes, pipes, and cigars



Getting to a Million by 2017: Targets for the ABCS

Intervention	Pre-Initiative Estimate 2009-2010	2017 Population-wide Goal	2017 Clinical Target
A spirin when appropriate	54%	65%	70%
B lood pressure control	52%	65%	70%
C holesterol management	33%	65%	70%
S moking cessation	22%	65%	70%



What Must Happen To Prevent a Million?

Reduce Smoking

6.3M fewer smokers

- Year-round media campaigns; pricing interventions
 - Targeted outreach to drive uptake of covered benefits
 - Systematic delivery of cessation services through use of cessation protocols, referrals to quit lines, and training of clinical staff
 - Widespread adoption of smoke-free space policies
 - Awareness of risks of second-hand smoke and the health benefits of smoke-free environments
-

Control Hypertension

10M more patients

- Detection of those with undiagnosed hypertension
 - Systematic use of treatment protocols & other select QI tools
 - Practice of self-measured BP monitoring with clinical support
 - Recognition of high performers; dissemination of best practices
 - Connection of clinical & community resources to benefit people with HTN
 - Enhanced medication adherence
 - Intense focus on those with high burden and at high risk
-

Decrease Sodium Intake

20% reduction

- Adoption of Healthy Food Service Guidelines
- Voluntary sodium reduction and expansion of choices by food industry
- Recognition of high performers and dissemination of best practices
- Clear communication of the evidence supporting the health benefits of population-level sodium reduction



Events will also be prevented by improving aspirin use, cholesterol management, and utilization of cardiac rehab, and by eliminating artificial trans-fat consumption

What Must Happen To Prevent a Million? (cont.)

Reduce Smoking

6.3M fewer smokers

- Year-round media campaigns; pricing interventions
- Targeted outreach to drive uptake of covered benefits
- **Systematic delivery of cessation services through use of cessation protocols, referrals to quit lines, and training of clinical staff**
- Widespread adoption of smoke-free space policies
- Awareness of risks of second-hand smoke and the health benefits of smoke-free environments

Control Hypertension

10M more patients

- **Detection of those with undiagnosed hypertension**
- **Systematic use of treatment protocols & other select QI tools**
- **Practice of self-measured BP monitoring with clinical support**
- Recognition of high performers; dissemination of best practices
- Connection of clinical & community resources to benefit people with HTN
- Enhanced medication adherence
- Intense focus on those with high burden and at high risk

Decrease Sodium Intake

20% reduction

- Adoption of Healthy Food Service Guidelines
- Voluntary sodium reduction and expansion of choices by food industry
- Recognition of high performers and dissemination of best practices
- Clear communication of the evidence supporting the health benefits of population-level sodium reduction



*Events will also be prevented by improving aspirin use, **cholesterol management, and utilization of cardiac rehab**, and by eliminating artificial trans-fat consumption*

Find Those at Risk



Assess Risk

Starting the Conversation

- For those who have had a CV event
 - Check and address their ABCS
 - REFER TO CARDIAC REHAB!
- [NIH Tool](#): 10 year risk of heart attack
- [ACC/AHA ASCVD Risk Estimator](#)
 - 10 year and lifetime risk of heart attack and stroke
- [Mayo Clinic Risk Estimator](#): a composite
- [Heart Age](#): helps translate statistics into personal risk

Heart Age: Is Your Heart Older Than You?

- Heart age is the predicted age of a person's heart and blood vessels based on risk for heart attack and stroke.
- Most US adults have a heart age older than their actual age, increasing their risk for heart attack or stroke.
- Find more info and resources at [CDC Vital Signs: Heart Age](http://www.cdc.gov/vitalsigns/heartage)

SEPTEMBER 2015

CDC VitalSigns™

Heart Age

Is Your Heart Older Than You?

Her age is 53. But her heart is 75 years old because she smokes and has uncontrolled high blood pressure. She's not alone because most American adults have a heart that is older than their actual age. One way to understand your risk for a heart attack or stroke is to learn your "heart age." Heart age is the age of your heart and blood vessels as a result of your risk factors for heart attack and stroke. There are some things that put you at risk for a heart attack or stroke that you cannot change such as getting older or your family history, yet there are many others that you can change. If you smoke or have high blood pressure, your heart age will be much higher than your actual age. The most common reasons for a higher heart age that can be changed or managed are: high blood pressure, high cholesterol, smoking, obesity, unhealthy diet, physical inactivity, and diabetes. At any age, you can make your heart younger by making changes that reduce your risk. Even if you haven't had a heart attack or stroke, most US adults have a heart age older than their actual age placing them at greater risk of having one.

1 in 2
1 in 2 men have a heart age 5 or more years older than their actual age.

2 in 5
2 in 5 women have a heart age 5 or more years older than their actual age.

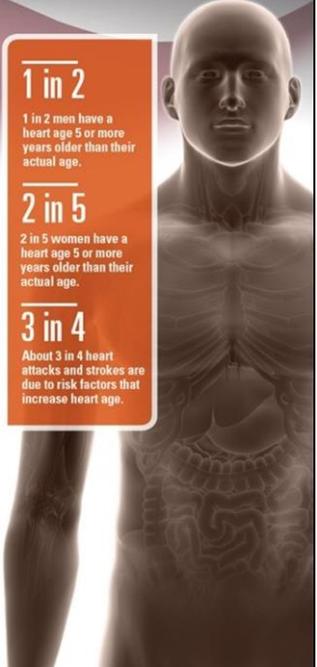
3 in 4
About 3 in 4 heart attacks and strokes are due to risk factors that increase heart age.

What you can do:

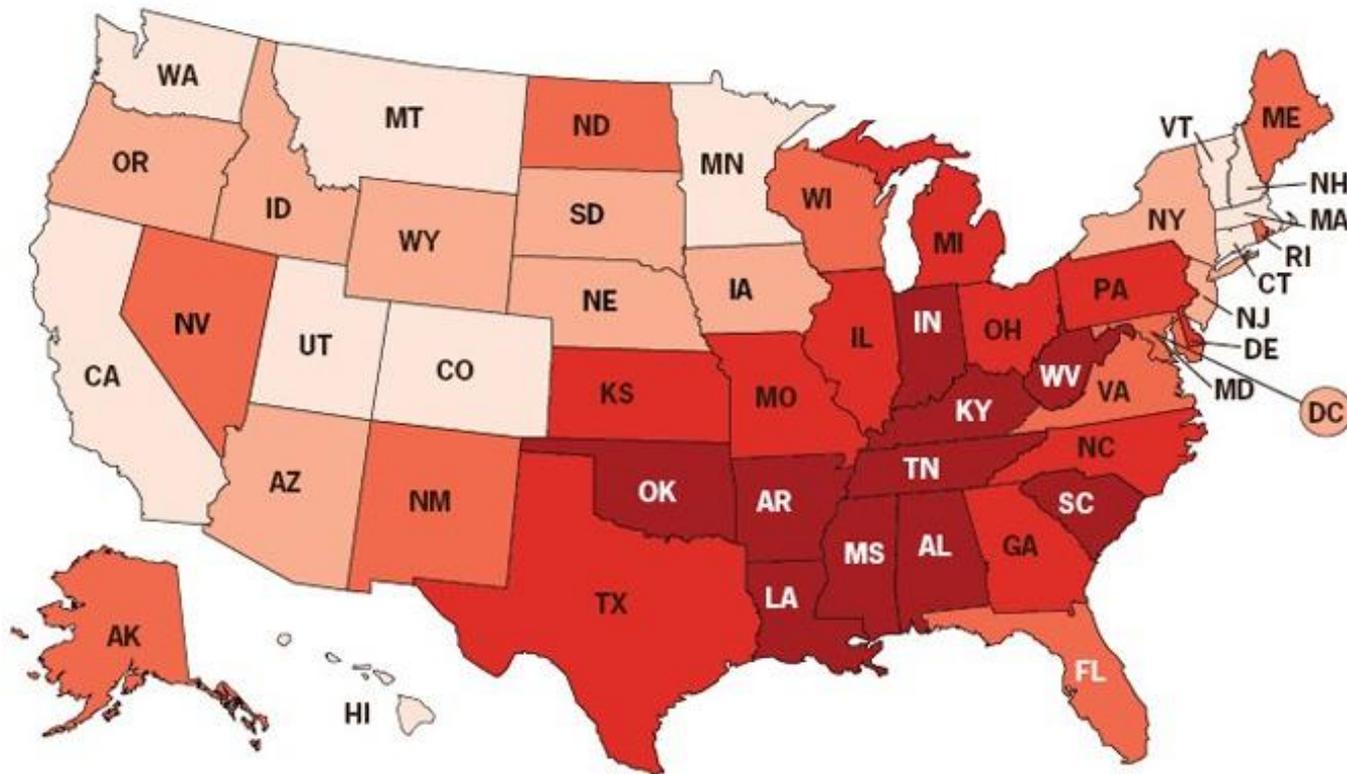
- Learn your heart age and how to improve it.
www.cdc.gov/heartdisease/heartage.htm
- Start by choosing a risk factor or two that you're ready to change, like smoking or high blood pressure, and focus on improving them first.
- Work with your doctor to make heart healthy choices for a lower heart age.
- Take action at any age to lower your heart age and keep it low over time.

Want to learn more? www.cdc.gov/vitalsigns/heartage

 Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion



Percentage of adults whose heart age is 5 or more years older than their actual age*



33.1%-39.6% 39.7%-42.7.6% 42.8%-44.3% 44.4%-47.9% 48.0%-56.5%

*Adults aged 30-74 with no history of heart attack or stroke.

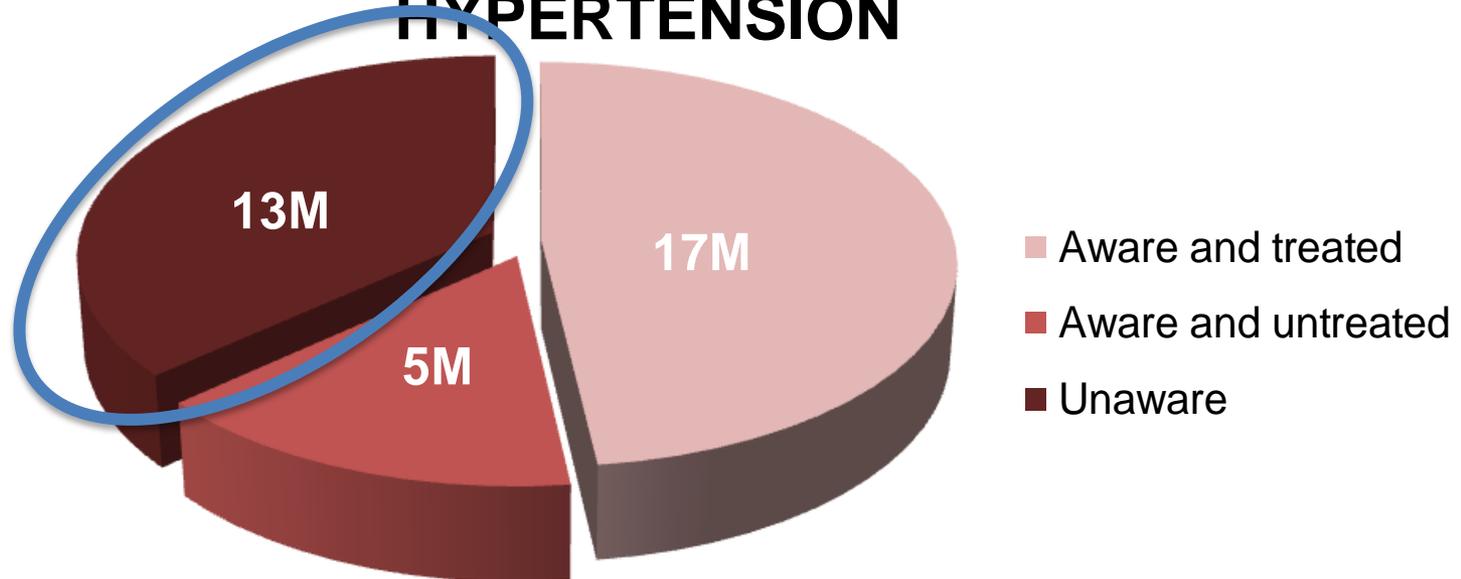


Source: Behavioral Risk Factor Surveillance System, 2011 and 2013.
National Health and Nutrition Examination Survey, 2007-2012.



A Population at High Risk *Those with Uncontrolled Hypertension*

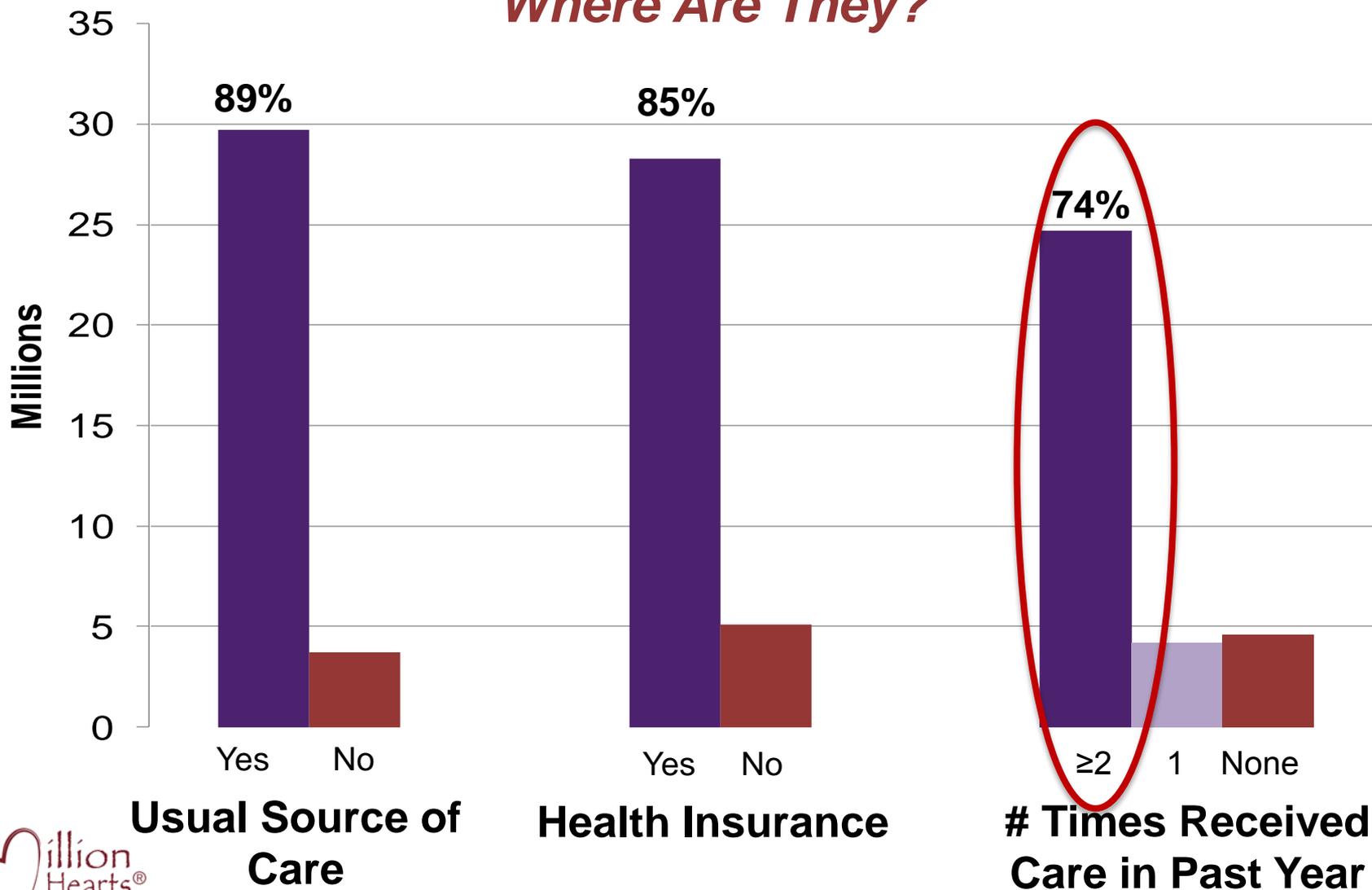
**35 MILLION
ADULTS WITH UNCONTROLLED
HYPERTENSION**



SOURCE: National Health and Nutrition Examination Survey 2013-2014, unpublished data, CDC.

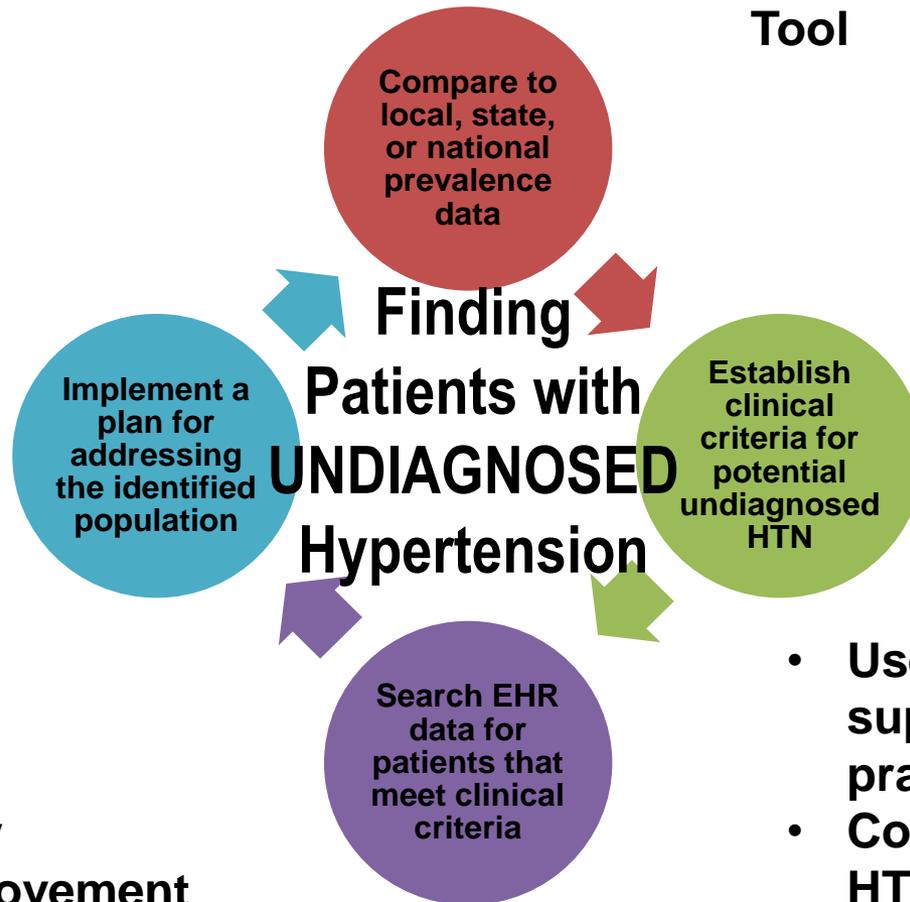
People with Uncontrolled HTN

Where Are They?



- **Confirmatory assessment**
- **Ambulatory or self-measured BP monitoring**
- **AOBP machines**
- **Timely follow-up**

- **Practice prevalence ((adult patients with a diagnosis of HTN / adult patients) × 100) vs. 31.6%**
- **HTN Prevalence Estimator Tool**



- **EHR registry**
- **Quality improvement software**
- **Embed automated algorithms into EHR**

- **Use guidelines supported by the practice**
- **Consider stages of HTN, # of abnormal values, time period**

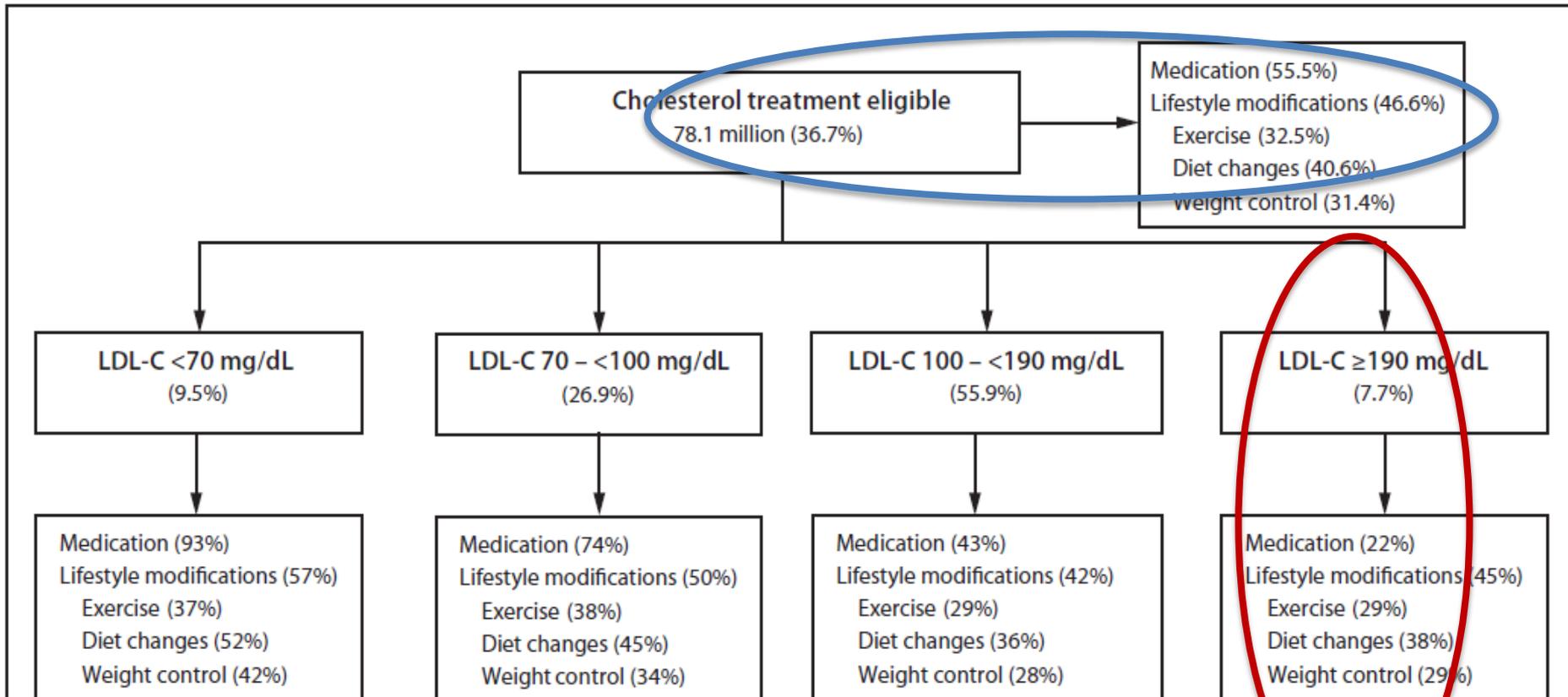
Hiding in Plain Sight: *Resources to Help Find the Undiagnosed*

- **Hiding in Plain Sight Whiteboard** - *an animated video that outlines concrete steps to find undiagnosed patients*
- **Hypertension Prevalence Estimator Tool** - *an online tool for calculating the expected prevalence in an ambulatory population*
- **National Association of Community Health Centers Undiagnosed Hypertension Change Package** – *a compilation of materials to help clinicians map and identify enhancements to clinical workflows that improve detection and diagnosis of HTN*

The Cholesterol Challenge

Finding Those Eligible for Treatment

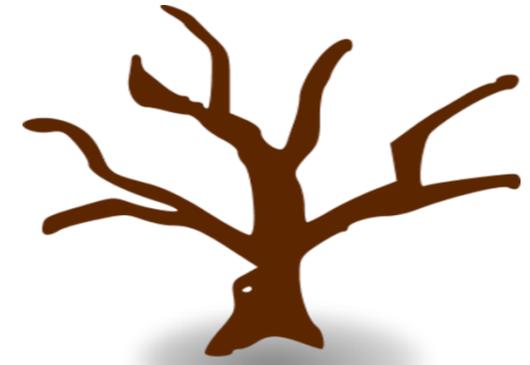
FIGURE. Number* and percentage of adults aged ≥21 years who are on or eligible for cholesterol-lowering treatment,[†] distribution of LDL-C[§] levels, and percentage taking cholesterol-lowering medication,[¶] making lifestyle modifications,^{**} or both — National Health and Nutrition Examination Survey, United States, 2005–2012



Familial Hypercholesterolemia

A Chance to Change a Family

- Genetic abnormality resulting in high LDL and untreated, a 20-fold increased risk of coronary heart disease
- ~600K adults and children in the US are estimated at risk for preventable events
- FH accounts for ~5% (13K) of annual heart attacks in those younger than 60 in the US
- Untreated men have a 50% risk of CHD by age 50 and women, 30% risk by age 60
- Optimal treatment, usually a generic statin-based regimen, reduces risk to that of the general population



Fewer than 10% have been diagnosed.....



CENTRAL ILLUSTRATION CR Referral in Heart Failure: Proportion and Predictors at Hospital Discharge

LESS LIKELY FOR CR REFERRAL



Higher burden of co-morbidities

i.e., History of hypertension, cerebral vascular accident (stroke)/transient ischemic attacks, chronic obstructive pulmonary disease, anemia, higher ejection fraction, and increased systolic blood pressure



Insurance coverage

Lower referral for Medicare patients



Older age

Median age: 74 (62-83)



Female sex

Lower referral for women



Mid-west geographic location

Lower referral among Midwest centers

MORE LIKELY FOR CR REFERRAL



In-hospital procedures

i.e., Coronary artery bypass grafting, percutaneous coronary intervention with/without stent, and cardiac valve surgery



Medical therapies

i.e., Angiotensin converting enzyme inhibitors/angiotensin receptor blockers, and aldosterone antagonists at discharge



Younger age

Median age: 70 (59-80)



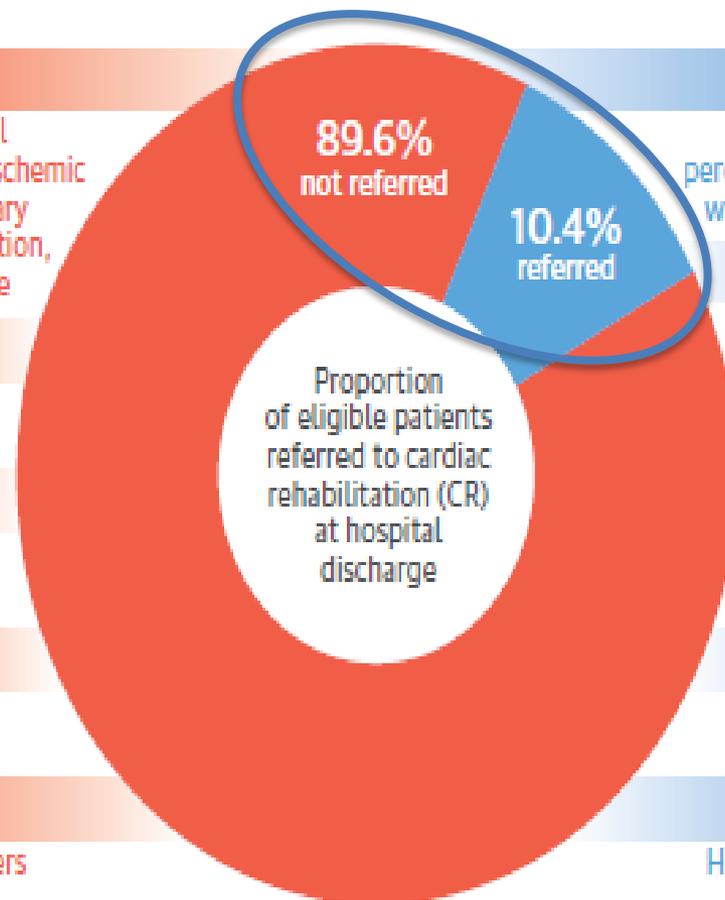
Male sex

Higher referral for men



Southern geographic location

Higher referral among Southern centers



Proportion of eligible patients referred to cardiac rehabilitation (CR) at hospital discharge

Golwala, H. et al. J Am Coll Cardiol. 2015; 66(8):917-26.

This chart represents the percentage of patients who were admitted to a hospital with heart failure who were referred for cardiac rehabilitation (CR) at the time of discharge from the hospital from 2005 to 2014 at 338 U.S. sites. Also depicted are positive and negative factors associated with CR referral at discharge that resulted in higher and lower likelihoods of CR referral, respectively.

“Fix” Those at Risk



Standardized Treatment Approaches

- Healthy lifestyle advice and assistance

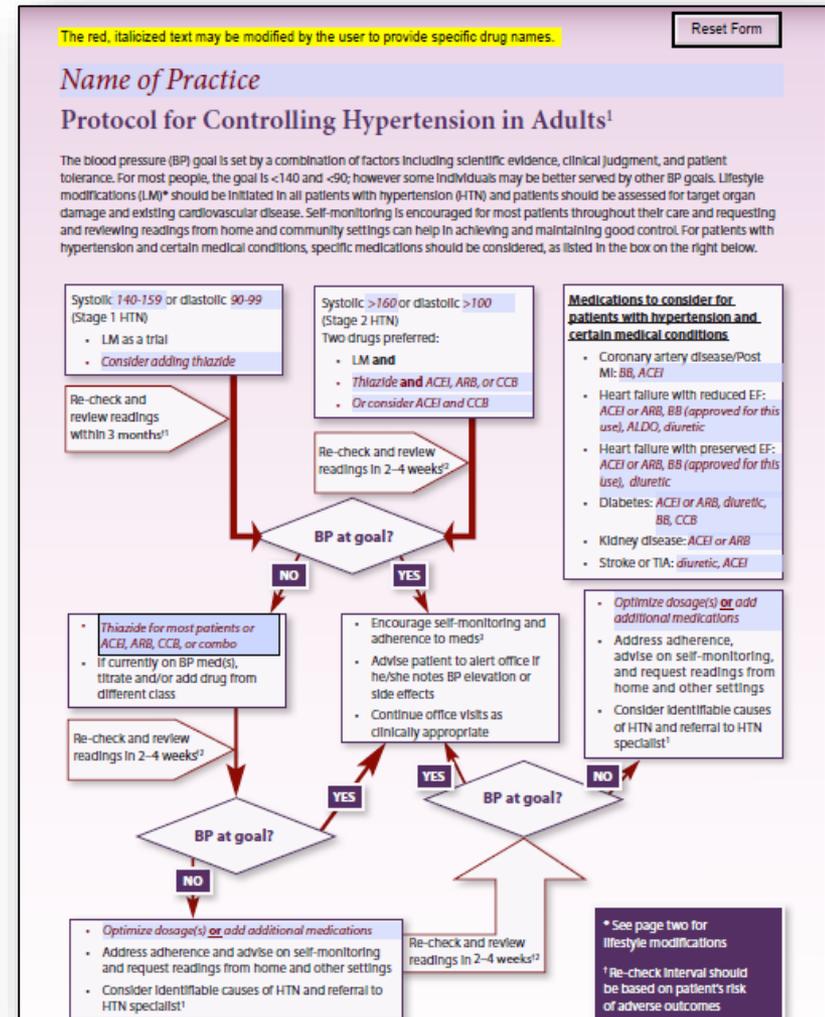
Standardized Treatment Approaches (cont.)

- Healthy lifestyle advice and assistance
- Hypertension
 - Treatment protocol
 - Self-measured BP monitoring

How Can a Protocol Help?

Move **10M** More People with Hypertension into the Safe Zone

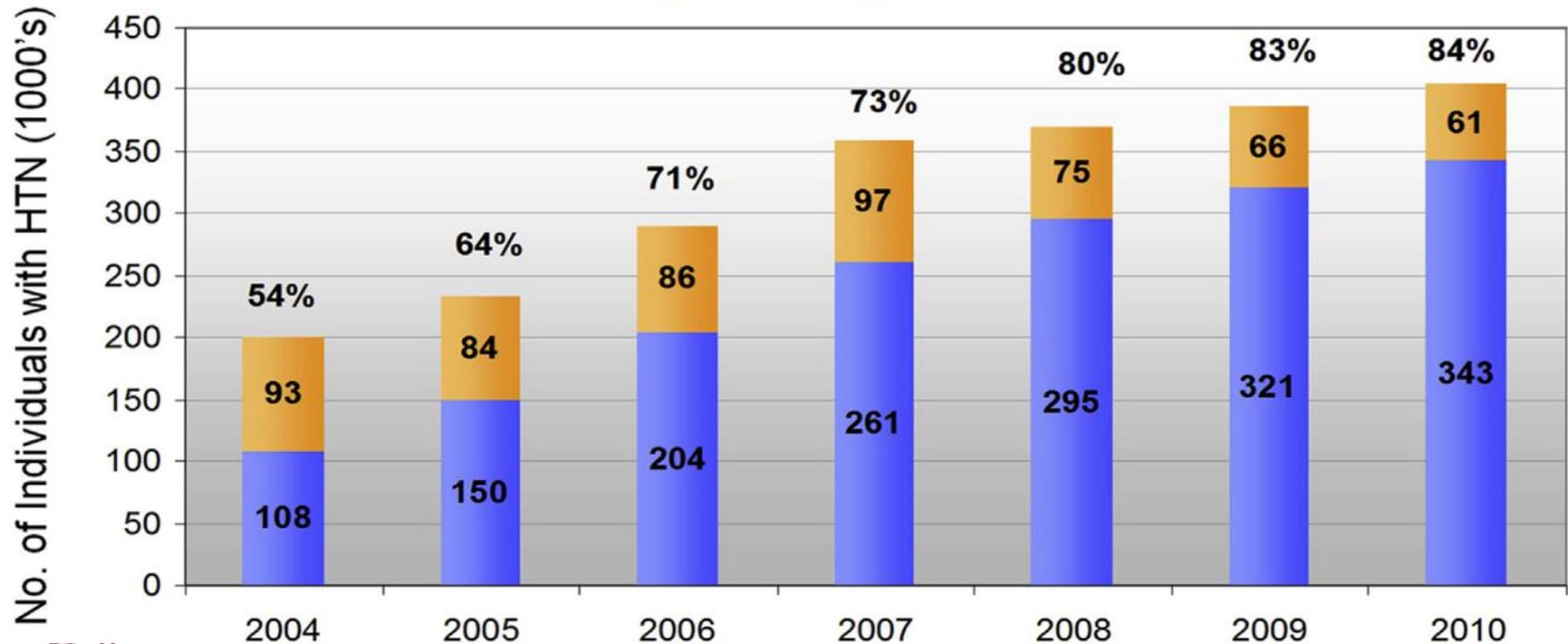
- Expands the care team that can assist in achieving control
- Standardizes the content and delivery of lifestyle modification advice
- Lends clarity, efficiency, and cost-effectiveness to selection of meds
- Specifies intervals and processes for patient follow up



Standardized Treatment Protocols Can Help Reduce Disparate Outcomes Kaiser Permanente Southern California

“To help ensure homogeneity of practice delivered, the hypertension treatment had to be standardized as well. This meant that an internal treatment guideline was needed.”

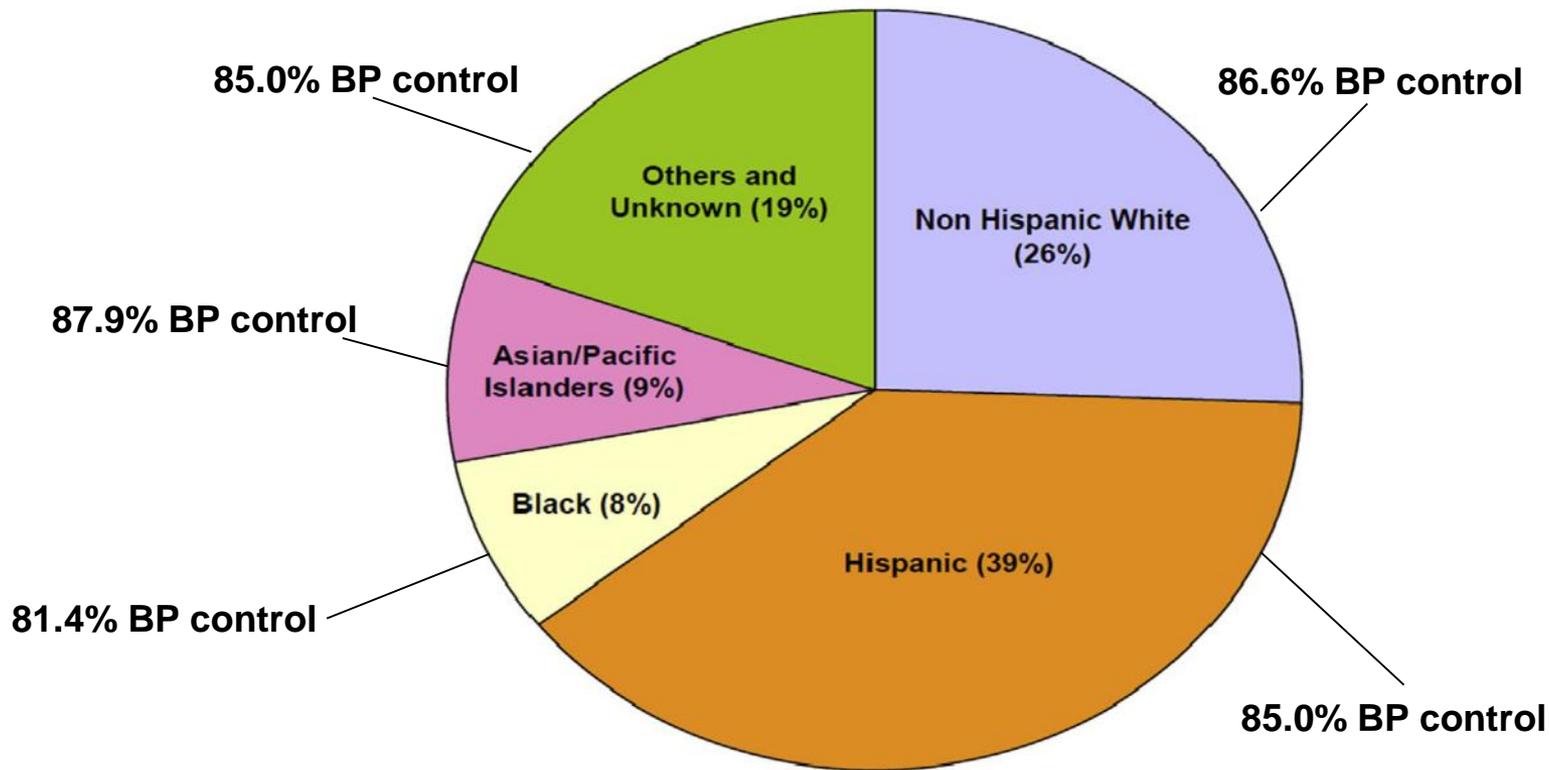
% = Controlled



Sim, et al. Systemic Implementation Strategies to Improve Hypertension: The Kaiser Permanente Southern California Experience. *Canadian Journal of Cardiology* 30 (2014) 544-552

Standardized Treatment Protocols Can Help Reduce Disparate Outcomes Kaiser Permanente Southern California (cont.)

“Across all ages, races, and sexes, hypertension control has exceeded 80%.”



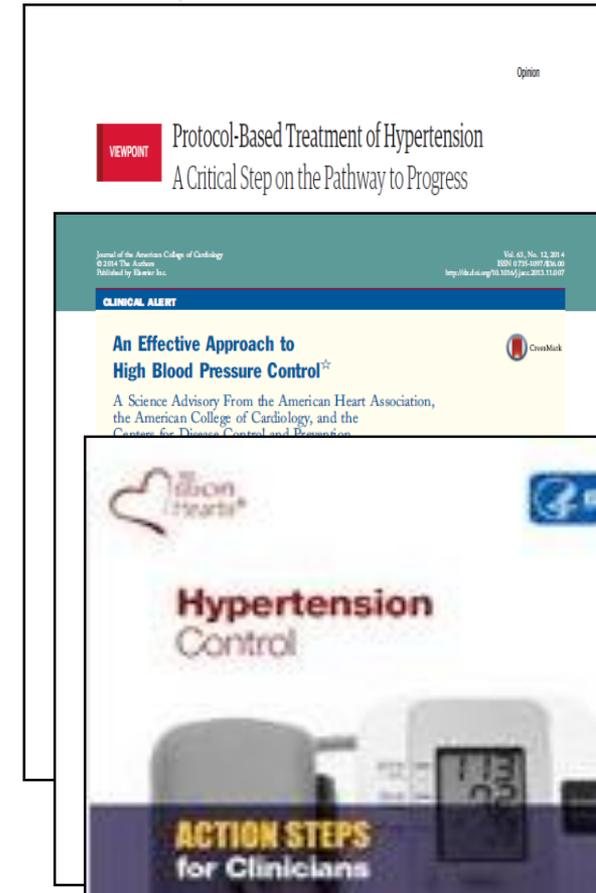
Standardizing Treatment

Hypertension Protocol Use is on the Rise

- All Indian Health Service clinical settings
- Many Federally Qualified Health Centers
- Participants in ACOs and CMS-funded models
- Practices supported by CMS' Quality Improvement Organizations
 - Q3 2015: 766 of 2911 (26%) were using a protocol
 - Q4 2015: 2399 of 7,058 (34%) were using a protocol
 - Those 2399 care for ~1.4M patients. Since ~ 1/3 are likely to have hypertension, ~488,000 patients are getting protocol-driven care
- Major contributor to success at Kaiser and in SPRINT

Protocol Implementation: *How Can A Practice Get Started?*

- ❑ Designate a Chief of Protocol and convene the team
- ❑ Pick a protocol and adapt it to fit your patients. Million Hearts website has protocols from
 - U.S. Department of Veterans Affairs
 - Kaiser Permanente
 - Institute for Clinical Systems Improvement
 - NYC Health and Hospitals Corporation
- ❑ Also available are
 - A customizable, downloadable protocol template
 - Helpful advice on how to make your own protocol
 - Literature outlining value and benefits



Protocol Implementation:

How Can A Practice Get Started? (cont.)

- ❑ Make decisions about roles, content, meds, more
 - *Workflow of BP measurement and recording*
 - *What lifestyle advice will you give? By whom? When? How?*
 - *Which medications will you use and at what dosages?*
 - *How will you monitor for medication adherence?*
 - *What are your target goals and for what ages?*
 - *How often to re-check and titrate? Who does this? How?*
 - *How will you define and manage resistance?*
- ❑ Track implementation weekly; share monthly control rates
- ❑ Celebrate your success along the way

Ask the Audience

Poll Question Number One



Self-Measured Blood Pressure Monitoring

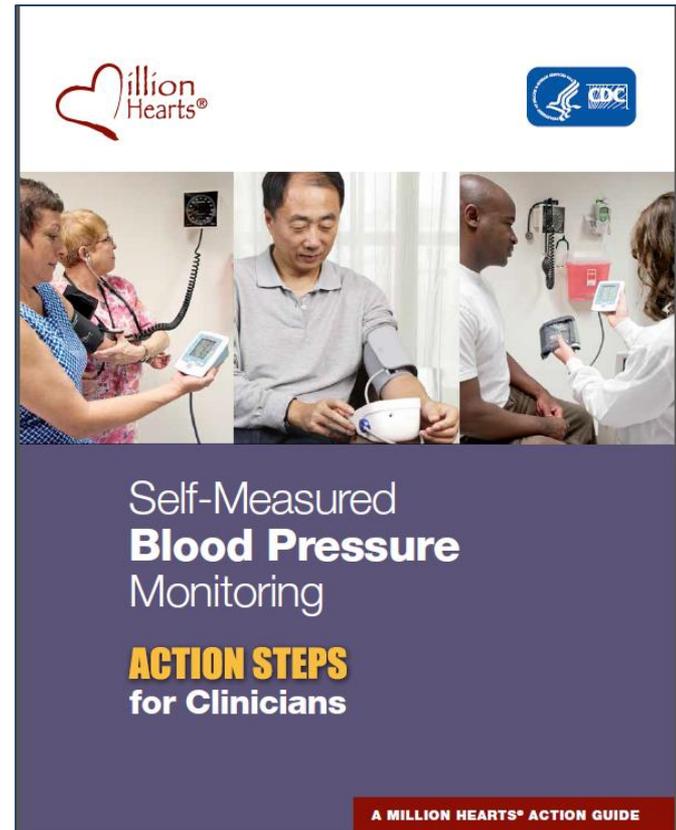
SMBP: the **regular** measurement of a patient's **own** blood pressure with a **personal monitor** outside a clinical setting, usually at **home**.

- ❑ One strategy to improve BP control-
when supported by clinical staff
- ❑ Also known as home monitoring
- ❑ Call to Action issued in 2008 and in recent guidelines



Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians

- ❑ Guidance for clinicians on SMBP
 - Prepare Care Teams to Support SMBP
 - Select and Incorporate Clinical Support Systems for SMBP
 - Empower Patients to Use SMBP
 - Encourage Coverage for SMBP Plus Additional Clinical Support
- ❑ Teach patients to use monitors
- ❑ Check home machines for accuracy
- ❑ Suggested protocol for home monitoring



Ask the Audience

Poll Question Number Two

Hypertension Control Change Package

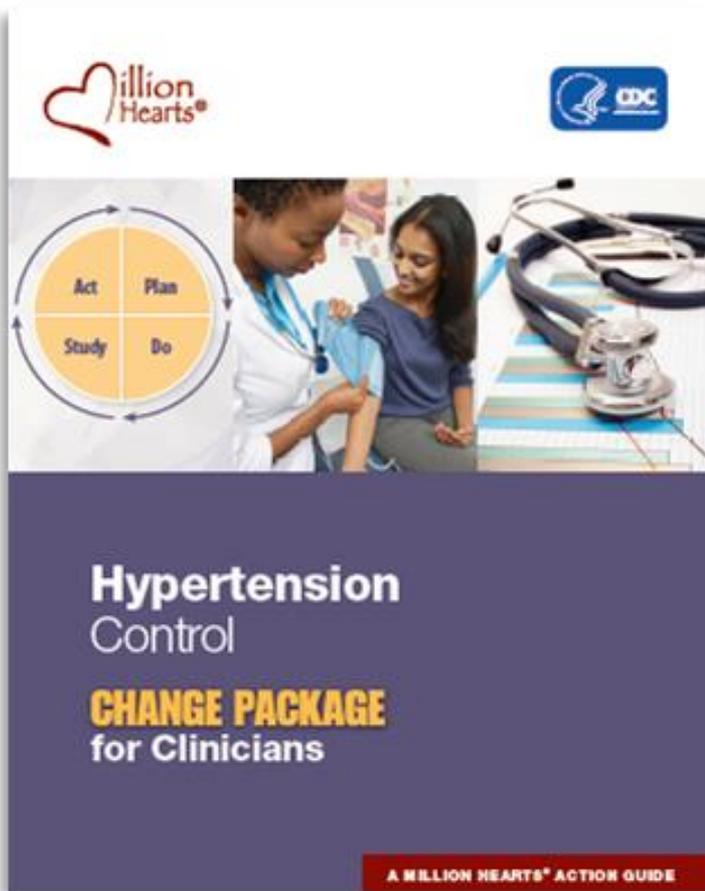


Table 1. Hypertension Control Change Package—Key Foundations (continued)

Change Concepts	Change Ideas	Tools and Resources
	Develop HTN control policy and procedures	<ul style="list-style-type: none"> American Medical Group Foundation. Provider Toolkit to Improvement Hypertension Control. BP Addressed for Every Hypertension Patient at Every Primary Care or Cardiology Visit: http://bit.ly/1zdx7Vh* Kaiser Permanente. Blood Pressure Check Visit Policy and Procedure: http://bit.ly/1nqETWj*
Implement a Policy and Process to Address BP for Every Patient with HTN at Every Visit	<ul style="list-style-type: none"> Leverage local Patient Centered Medical Home (PCMH) activities to help drive comprehensive approach to HTN management Develop a flowchart for how hypertensive patients will be proactively tracked and managed 	<ul style="list-style-type: none"> Washington State Department of Health. Improving the Screening, Prevention, and Management of Hypertension—An Implementation Tool for Clinic Practice Teams: PCMH Change Concepts, Ideas, and Resources (pp. 18-33): http://bit.ly/2Goede Health Resources and Services Administration. Implementation: Hypertension Control: Critical Pathway for HTN control (Figure 3.1):

Table 2. Hypertension Control Change Package—Population Health Management

Change Concepts	Change Ideas	Tools and Resources
Train and Evaluate Direct Care Staff on Accurate BP Measurement and Recording	Provide guidance on measuring BP accurately	<ul style="list-style-type: none"> American Medical Group Association. Registry Used to Track Hypertension Patients: http://bit.ly/1z9MT1* Health Center Network of New York. Undiagnosed Hypertension Registry: http://bit.ly/1sUmOPG Redwood Community Health Coalition. Hypertension Recall Instructions: see Appendix B. The Office of the National Coordinator for Health Information Technology. Quality Improvement in a Primary Care Practice: http://bit.ly/1tqdxJO American Heart Association. Heart360. An Online Tool for Patients to Track and Manage Their Heart Health and Share Information: http://bit.ly/1NVCWv
	Assess adherence to proper BP measurement technique	<ul style="list-style-type: none"> Minnesota Board of Nursing. FAQ: Use of Condition-Specific Protocols: http://bit.ly/1wfw8YD Kaiser Permanente. Protocol for Uncomplicated Hypertension: Registered Nurse Titration of Lisinopril, Hydrochlorothiazide, Atenolol, and Amlodipine: http://bit.ly/1u8SSrI UNC Health Care Center. Standing Order: Antihypertensive Initiation and Titration: http://bit.ly/1thlrE Agency for Healthcare Research and Quality. Blood Pressure Titration Protocol for Diabetes Planned Visit: http://1.usa.gov/1rABLmk Mercy Clinics, Inc. Hypertension Standing Orders: http://bit.ly/1032em6*
Use Practice Data to Drive Improvement	Determine HTN control metrics for the practice	<ul style="list-style-type: none"> Washington State Department of Health. Improving the Screening, Prevention, and Management of Hypertension—An Implementation Tool for Clinic Practice Teams: Measurement Worksheet (pp.12-15): http://bit.ly/2Goede Health Center Network of New York. Specifications Hypertension Measures: http://bit.ly/1xEnxU
	Regularly provide a dashboard with BP goals,	<ul style="list-style-type: none"> New York City Department of Health. Provider Dashboards: http://bit.ly/1wFB9Ao New York City Department of Health. John Doe Dashboard: http://bit.ly/1zK9Ssx More detailed Information: Your Practice Hypertension Panel Summary (http://bit.ly/1z31AD1) and Hypertension Panel Management Patient List



Standardized Treatment Approaches cont.

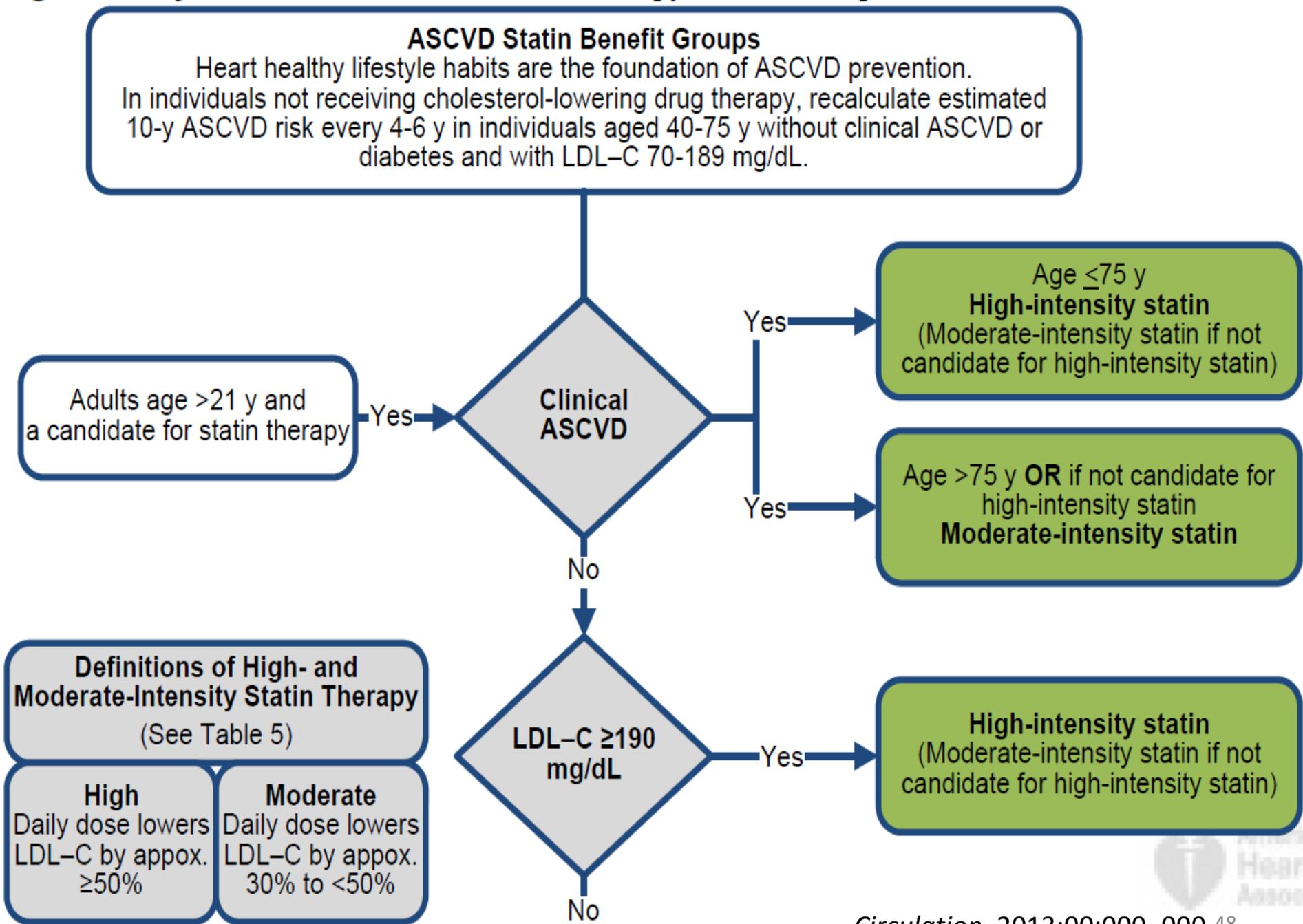
- Healthy lifestyle advice and assistance
- Hypertension
 - Treatment protocol
 - Self-measured BP monitoring
- Cholesterol
 - Statin benefit algorithm

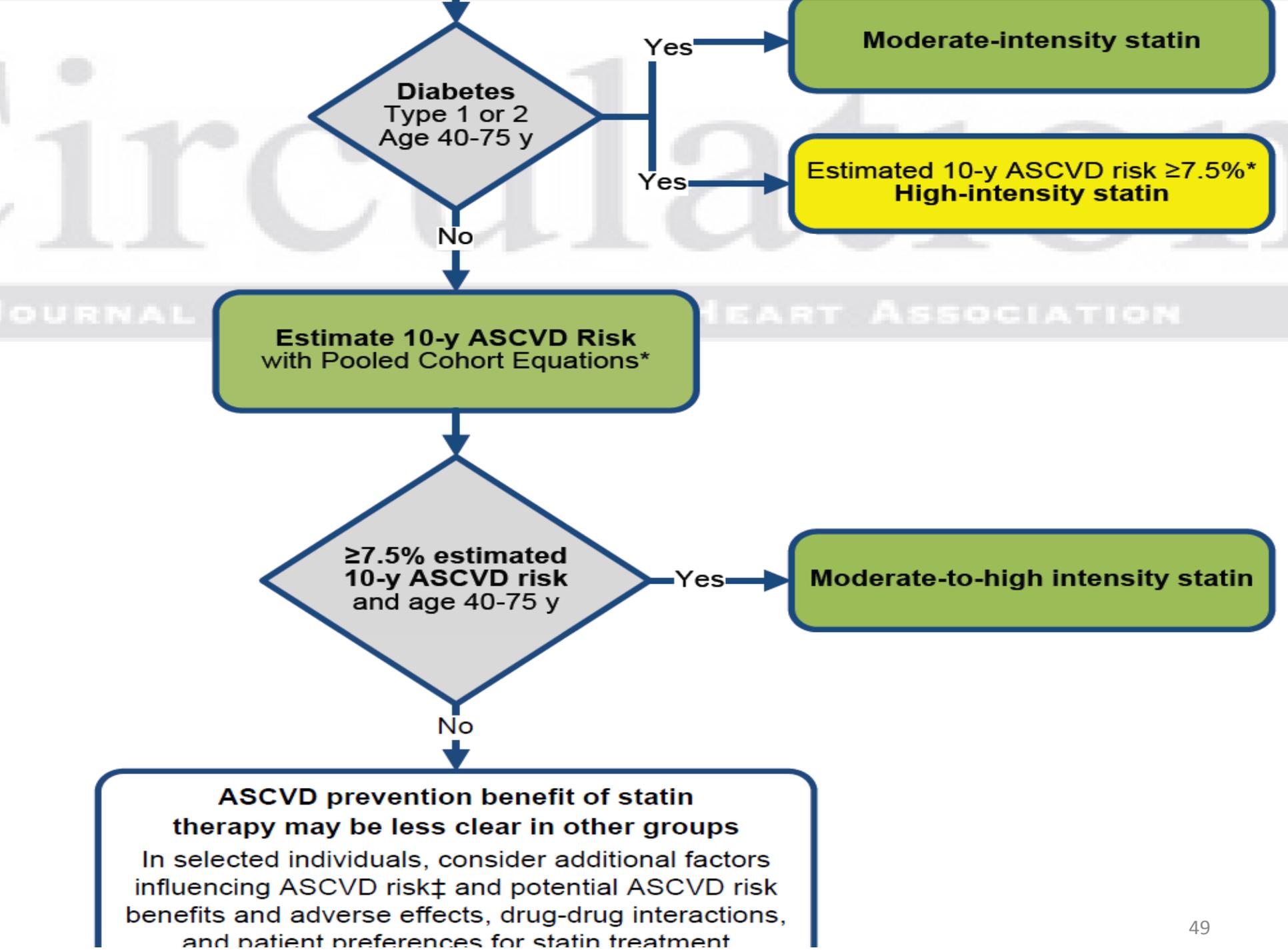
Cholesterol Management Recommendations: *Healthy Lifestyle for all, plus Statins for a Subset*

- Individuals with ASCVD *and* without NYHA class II-IV heart failure or receiving hemodialysis
- Individuals with LDL-C ≥ 190
- Individuals without clinical ASCVD, who are 40-75 years of age **with** diabetes, and LDL-C 70-189
- Individuals without clinical ASCVD or diabetes, who are 40-75 years of age with LDL-C 70-189 mg/dl, and have an estimated 10-year ASCVD risk of 7.5% or higher.



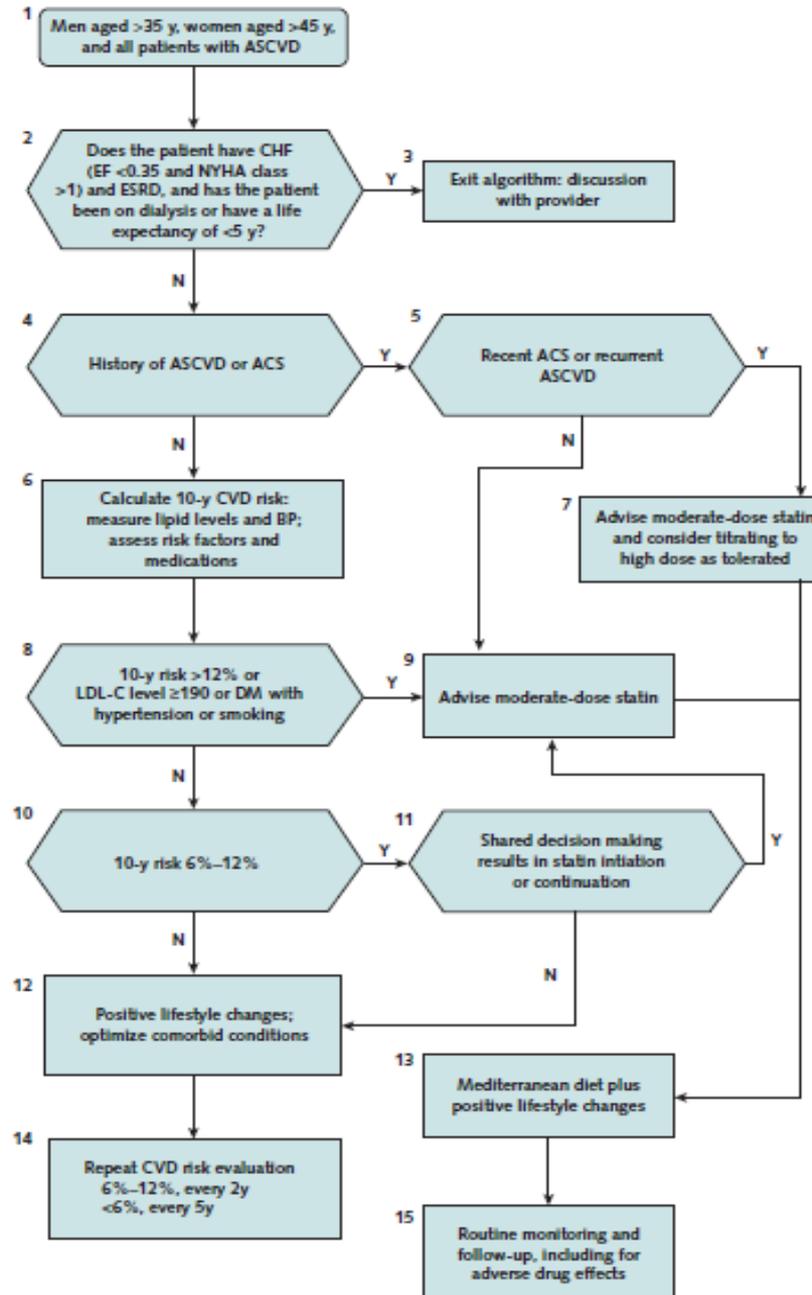
Figure 2. Major recommendations for statin therapy for ASCVD prevention





VA and DOD

Management of Dyslipidemia for CVD Risk Reduction: Synopsis of 2014 U.S Dept of Veterans Affairs and U.S. Dept of Defense Clinical Practice Guideline. *Annals of Internal Medicine* Online 23 June 2015



ASCVD and Equivalents*

All ACS or MI
CABG or PCI
Stable obstructive CAD (stable symptoms of angina or equivalent)
CVA or TIA
Atherosclerotic PVD (claudication or AAA)

Statin Dose, by 10-Year CVD Risk

10-Year Risk	Statin Dose
ASCVD (second prevention)	Moderate to high
>12%	Moderate
6%–12% (with shared decision making)	Moderate
<6%	None

Drug Doses†

Statin	Moderate, mg	High, mg
Generics available		
Atorvastatin	10–20	40–80
Simvastatin	20–40	
Pravastatin	40	
Lovastatin	40–80	
Fluvastatin	80‡	
Brand formulation only		
Rosuvastatin	5–10	20–40

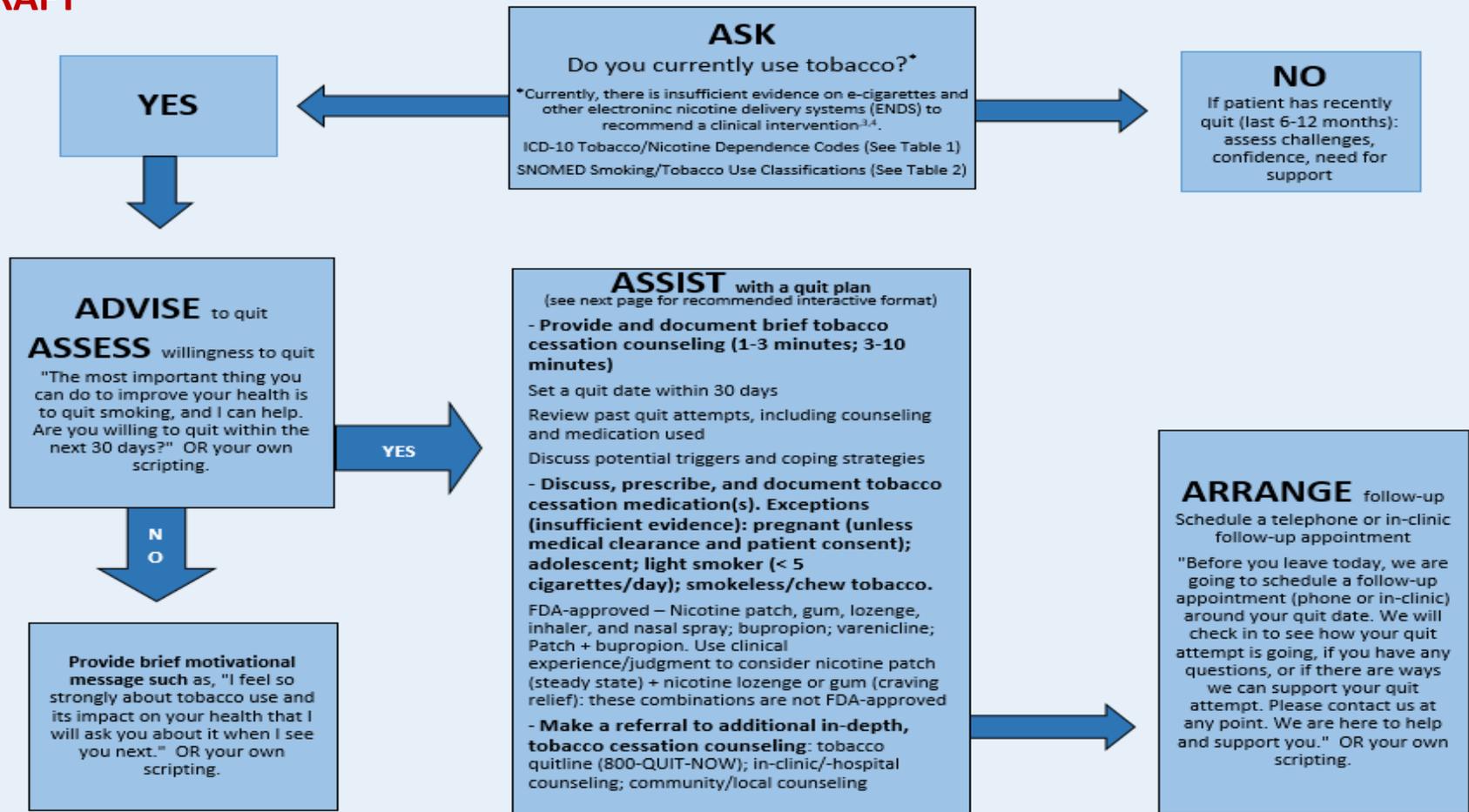


Standardized Treatment Approaches (continued)

- Healthy lifestyle advice and assistance
- Hypertension
 - Treatment protocol
 - Self-measured BP monitoring
- Cholesterol
 - Statin benefit algorithm
- **Smoking cessation protocol**

Tobacco Cessation Protocol

DRAFT



How is this protocol unique?

Updates 2008 Public Health Service Guideline protocol on treating tobacco use and dependence

- Accounts for developments not in place in 2008, such as the Affordable Care Act, Meaningful Use, ICD-10 codes
- Addresses Electronic Nicotine Delivery Systems
- Includes sample language; encourages tailored scripting
- Reflects package-insert changes for cessation medications related to duration and combination use

Tobacco Cessation: Action Steps for Clinicians

- Comprehensive, evidence-based strategies for cessation
- Specific strategies for each of the protocol steps
- Detailed medication chart with doses, usage length, availability (Rx or over the counter), warnings/cautions, and possible side effects
- A section on FDA-approved and individual medication combinations
- Links to clinical, systems-change, and patient resources.

Ask the Audience

Poll Question Number Three



Standardized Treatment Approaches (cont.3)

- Healthy lifestyle advice and assistance
- Hypertension
 - Treatment protocol
 - Self-measured BP monitoring
- Cholesterol
 - Statin benefit algorithm
- Smoking cessation protocol
- **Cardiac Rehab**



CARDIAC REHABILITATION

SAVING LIVES  RESTORING HEALTH  PREVENTING DISEASE

BENEFITS OF CARDIAC REHABILITATION

Benefits to People

Those who attend 36 sessions have a **47%** lower risk of death and **31%** lower risk of heart attack than those who attend only one session.



Benefits to Health Systems

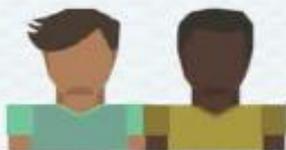
Costs per year of life saved range from **\$4,950 to \$9,200** per person. Cardiac rehab participation also reduces hospital readmissions.

REFERRAL



Many People Who Can Benefit Are Not Being Referred

We Know What Works To Improve Referral Rates



Minority status predicts lower referral and participation rates.

Women, minorities, older people and those with other medical conditions are under-referred to cardiac rehab



Automatic, systematic referral to cardiac rehab at discharge can help connect eligible people with these programs.



One of the best predictors of cardiac rehab referral is if the eligible person speaks English.

Asian Americans are 18 times more likely to have limited English, compared to whites.



Strong coordination between inpatient, home health, and outpatient cardiac rehab programs boosts referral rates, as well as participation rates and outcomes.

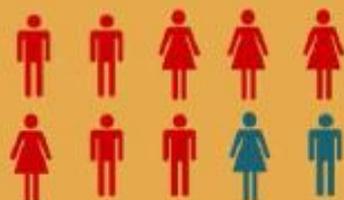


Black women are 60% less likely to be referred and enroll in cardiac rehab programs, compared to white women.

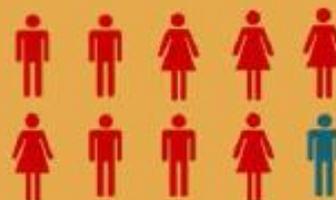


Patients' medical teams -- and families -- can support and encourage participation in cardiac rehab programs.

Awareness campaigns should be targeted to people and caregivers.



ONLY **20%** OF ELIGIBLE PATIENTS ARE REFERRED...



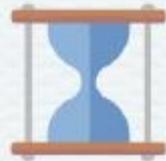
... AND ONLY HALF OF REFERRED PATIENTS ACTUALLY PARTICIPATE

PARTICIPATION AND COMPLETION

Reaching the 36 Session Threshold Is Challenging



We Know from Research How To Eliminate Barriers



Longer wait times following discharge reduce cardiac rehab enrollment.

For every day a person waits to start cardiac rehab, they are 1% less likely to enroll in cardiac rehab.



The greatest predictor of participation is the strength of the physician's recommendation.



People who live outside of metropolitan areas are 30% less likely to participate in cardiac rehab programs.



Reduce the interval between hospital discharge and cardiac rehab program orientation by formalizing enrollment practices.

Cardiac Rehab Participation Rates by Race (601,000 Medicare Patients)

19.6%
of eligible
white
patients
participate



7.8%
of eligible
black
patients
participate



Ensure access to services, through transportation options and extended hours.

Where possible, reduce or eliminate financial burden on cardiac rehab participants.



Support participation in cardiac rehab through community health workers, home health aides, and visiting nurses.

Million Hearts Cardiac Rehab Collaborative

Seize the Moment to Save Lives

- Stay tuned for the 2016 CRC Action Plan
- The CRC welcomes those ready to act
- CRC participants gather to share and accelerate progress quarterly from 1-2:30pm eastern
 - Feb 18, May 17, August 3, November 10
 - Questions to millionhearts@cms.hhs.gov



Million Hearts® Resources

- [Hypertension Treatment Protocols](#)
- [Finding those with Undiagnosed Hypertension](#)
- [John's Story" video: How I came back from a heart attack](#)
- ["It Takes a Team" video for Clinicians and Staff from AMGA](#)
- Action Steps and Guides
 - [Hypertension Control Change Package](#)
 - Self-Measured Blood Pressure Monitoring
 - [Hypertension Action Steps for Clinicians](#)
 - [Hypertension Action Steps for Employers](#)
- [Hypertension Control Champions](#)
- Spanish language [website](#)
- [100 Congregations for Million Hearts](#)
- [Million Hearts Healthy Eating & Lifestyle Resource Center](#)
- ["Million Hearts® E-update: SIGN UP TODAY!](#)



You Can Help Prevent a Million

Reduce Smoking

6.3M fewer smokers

- Year-round media campaigns; pricing interventions
- Targeted outreach to drive uptake of covered benefits
- **Systematic delivery of cessation services through use of cessation protocols, referrals to quit lines, and training of clinical staff**
- Widespread adoption of smoke-free space policies
- Awareness of risks of second-hand smoke and the health benefits of smoke-free environments

Control Hypertension

10M more patients

- **Detection of those with undiagnosed hypertension**
- **Systematic use of treatment protocols & other select QI tools**
- **Practice of self-measured BP monitoring with clinical support**
- Recognition of high performers; dissemination of best practices
- Connection of clinical & community resources to benefit people with HTN
- Enhanced medication adherence
- Intense focus on those with high burden and at high risk

Decrease Sodium Intake

20% reduction

- Adoption of Healthy Food Service Guidelines
- Voluntary sodium reduction and expansion of choices by food industry
- Recognition of high performers and dissemination of best practices
- Clear communication of the evidence supporting the health benefits of population-level sodium reduction



*Events will also be prevented by improving aspirin use, **cholesterol management, and utilization of cardiac rehab**, and by eliminating artificial trans-fat consumption*



Join Us



Subscribe—and Contribute to the E-Update



Become a Partner



Be One in a Million Hearts[®]



Million Hearts[®]



@MillionHeartsUS



CDC StreamingHealth

To Ask a Question

❑ Using the Webinar System

- “Click” the Q&A tab at the top left of the webinar tool bar
- “Click” in the white space
- “Type” your question
- “Click” ask

❑ On the Phone

- Press Star (*) 1 to enter the queue
- State your name
- Listen for the operator to call your name
- State your organization and then ask your question

Thank you for joining!
Please email us questions at coca@cdc.gov



**Centers for Disease Control and Prevention
Atlanta, Georgia**

<http://emergency.cdc.gov/coca>

Continuing Education for COCA Calls

Continuing Education guidelines require that the attendance of all who participate in COCA Conference Calls be properly documented. All Continuing Education credits/contact hours (CME, CNE, CEU, CECH, ACPE and AAVSB/RACE) for COCA Conference Calls/Webinars are issued online through the [CDC Training & Continuing Education Online system \(http://www.cdc.gov/TCEOnline/\)](http://www.cdc.gov/TCEOnline/).

Those who participate in the COCA Conference Calls and who wish to receive CE credit/contact hours and will complete the online evaluation by **March 22, 2016** will use the course code **WC2286**. Those who wish to receive CE credits/contact hours and will complete the online evaluation between **March 23, 2016** and **March 1, 2018** will use course code **WD2286**. CE certificates can be printed immediately upon completion of your online evaluation. A cumulative transcript of all CDC/ATSDR CE's obtained through the CDC Training & Continuing Education Online System will be maintained for each user.

Upcoming COCA Call: Update on Interim Zika Virus Clinical Guidance and Recommendations

- ❑ **Date: Thursday, February 25, 2016**
- ❑ **Time: 2:00 – 3:00 pm (Eastern Time)**
- ❑ **Presenters**
 - Dr. Katherine Fleming-Dutra – CDC
 - Dr. Emily Petersen – CDC

Registration Not Required

<http://emergency.cdc.gov/coca>

Join Us on Facebook

CDC Facebook page for clinicians! “Like” our page today to learn about upcoming COCA Calls, CDC guidance and recommendations, and about other health alerts



CDC Clinician Outreach and Communication Activity
<https://www.facebook.com/CDCClinicianOutreachAndCommunicationActivity>