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

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

- Aspirin when appropriate
- Blood pressure control
- Cholesterol management
- Smoking cessation

Excelling in the ABCS
*Optimizing care*

- 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

**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

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* 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

1. Find
2. Focus
3. “Fix”
Focus on What Matters
Getting to a Million by 2017: **Public Health Targets**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Pre-Initiative Estimate 2009-10</th>
<th>2017 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking prevalence*</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Sodium reduction</td>
<td>3580 mg/day</td>
<td>2900 mg/day</td>
</tr>
<tr>
<td>Trans fat reduction</td>
<td>0.6% of calories</td>
<td>0% of calories</td>
</tr>
</tbody>
</table>

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

National Survey on Drug Use and Health, National Health and Nutrition Examination Survey
Getting to a Million by 2017: 
*Targets for the ABCS*

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Pre-Initiative Estimate 2009-2010</th>
<th>2017 Population-wide Goal</th>
<th>2017 Clinical Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin when appropriate</td>
<td>54%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>52%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Cholesterol management</td>
<td>33%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>22%</td>
<td>65%</td>
<td>70%</td>
</tr>
</tbody>
</table>

National Ambulatory Medical Care Survey, National Health and Nutrition Examination Survey
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.)

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

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

A Population at High Risk
Those with Uncontrolled Hypertension

35 MILLION
ADULTS WITH UNCONTROLLED HYPERTENSION

People with Uncontrolled HTN

Where Are They?

- Usual Source of Care:
  - Yes: 89% (90 million)
  - No: 11% (11 million)

- Health Insurance:
  - Yes: 85% (85 million)
  - No: 15% (15 million)

- # Times Received Care in Past Year:
  - ≥2: 74% (74 million)
  - 1: 19% (19 million)
  - None: 7% (7 million)

Source: National Health and Nutrition Examination Survey 2011-2014, unpublished data, CDC
• Confirmatory assessment
• Ambulatory or self-measured BP monitoring
• 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

Wall HK, Hannan JA, Wright JS. *Patients with Undiagnosed Hypertension: Hiding in Plain Sight*. JAMA. 2014; 312 (19); 1973-1974
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

Cholesterol treatment eligible
78.1 million (36.7%)

- LDL-C <70 mg/dL (9.5%)
  - Medication (93%)
  - Lifestyle modifications (57%)
    - Exercise (37%)
    - Diet changes (52%)
    - Weight control (42%)

- LDL-C 70 – <100 mg/dL (26.9%)
  - Medication (74%)
  - Lifestyle modifications (50%)
    - Exercise (38%)
    - Diet changes (45%)
    - Weight control (34%)

- LDL-C 100 – <190 mg/dL (55.9%)
  - Medication (43%)
  - Lifestyle modifications (42%)
    - Exercise (29%)
    - Diet changes (36%)
    - Weight control (28%)

- LDL-C ≥190 mg/dL (7.7%)
  - Medication (22%)
  - Lifestyle modifications (45%)
    - Exercise (29%)
    - Diet changes (38%)
    - Weight control (29%)
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


CDC Familial Hypercholesteremia - http://www.cdc.gov/genomics/implementation/toolkit/fh_1.htm
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:
89.6% not referred, 10.4% referred.


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
How Does a Protocol Improve Control?

Move 10M More People with Hypertension into the Safe Zone

• Outlines process for management of patients resistant to treatment

• Raises patient and team “radar” about hypertension

• Reduces variation in clinical practice and ensures evidence-based care for all patients with hypertension
“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.”
“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)

<table>
<thead>
<tr>
<th>Change Concepts</th>
<th>Change Ideas</th>
<th>Tools and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement a Policy and Process to Address BP for Every Patient with HTN at Every Visit</td>
<td>Develop HTN control policy and procedures</td>
<td>- American Medical Group Association, Registry Used to Track Hypertension Patients: <a href="http://bit.ly/2sWn7j">http://bit.ly/2sWn7j</a>*</td>
</tr>
<tr>
<td>Train and Evaluate Direct Care Staff on Accurate BP Measurement and Recording</td>
<td>Leverage local Patient-Centered Medical Home (PCMH) activities to NED drive comprehensive approach to HTN management</td>
<td>- <a href="http://bit.ly/2sWn7j">http://bit.ly/2sWn7j</a>*</td>
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<tr>
<td></td>
<td>Leverage local Patient-Centered Medical Home (PCMH) activities to NED drive comprehensive approach to HTN management</td>
<td>- Health Resources and Services Administration, Implementation: Improving Care and Outcomes Among Patients with Hypertension: <a href="http://bit.ly/2sWn7j">http://bit.ly/2sWn7j</a>*</td>
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Table 2. Hypertension Control Change Package—Population Health Management

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</thead>
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<tr>
<td></td>
<td>Use a Registry to Identify, Track, and Manage Patients with HTN</td>
<td>- American Medical Group Association: Registry Used to Track Hypertension Patients: <a href="http://bit.ly/2sWn7j">http://bit.ly/2sWn7j</a>*</td>
</tr>
<tr>
<td></td>
<td>Use a defined process for outreach (e.g., via phone, in-person, email, text) to patients with uncontrolled HTN and those otherwise needing follow-up</td>
<td>- <a href="http://bit.ly/2sWn7j">http://bit.ly/2sWn7j</a>*</td>
</tr>
<tr>
<td></td>
<td>Use protocols to cover proactive outreach driven by registry-use and疑似 to patient-submitted home BP readings</td>
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</tr>
<tr>
<td>Use Practice Data to Drive Improvement</td>
<td>Determine HTN control metrics for the practice</td>
<td>- <a href="http://bit.ly/2sWn7j">http://bit.ly/2sWn7j</a>*</td>
</tr>
<tr>
<td></td>
<td>Regularly provide a dashboard with BP goals</td>
<td>- <a href="http://bit.ly/2sWn7j">http://bit.ly/2sWn7j</a>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- More detailed information: Your Practice Hypertension Panel Summary (living/20170920) and Hypertension Panel Management Patient List</td>
</tr>
</tbody>
</table>
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**

**ASCVD Statin Benefit Groups**
Heart healthy lifestyle habits are the foundation of ASCVD prevention. In individuals not receiving cholesterol-lowering drug therapy, recalculate estimated 10-y ASCVD risk every 4-6 y in individuals aged 40-75 y without clinical ASCVD or diabetes and with LDL–C 70-189 mg/dL.

- **Adults age >21 y and a candidate for statin therapy**
  - Yes: Clinical ASCVD
  - No: LDL–C ≥190 mg/dL

**Clinical ASCVD**
- Yes: Age ≤75 y
  - High-intensity statin
    - (Moderate-intensity statin if not candidate for high-intensity statin)
- Yes: Age >75 y OR if not candidate for high-intensity statin
  - Moderate-intensity statin

**LDL–C ≥190 mg/dL**
- Yes: High-intensity statin
  - (Moderate-intensity statin if not candidate for high-intensity statin)
- No:

**Definitions of High- and Moderate-Intensity Statin Therapy**
(See Table 5)

- **High**
  - Daily dose lowers LDL–C by approx. ≥50%
- **Moderate**
  - Daily dose lowers LDL–C by approx. 30% to <50%

*Circulation. 2013;00:000–000.*
Diabetes
Type 1 or 2
Age 40-75 y

Yes

Moderate-intensity statin

Yes

Estimated 10-y ASCVD risk ≥7.5%*
High-intensity statin

No

Estimate 10-y ASCVD Risk with Pooled Cohort Equations*

≥7.5% estimated 10-y ASCVD risk and age 40-75 y

Yes

Moderate-to-high intensity statin

No

ASCVD prevention benefit of statin therapy may be less clear in other groups
In selected individuals, consider additional factors influencing ASCVD risk‡ and potential ASCVD risk benefits and adverse effects, drug-drug interactions, and patient preferences for statin treatment.
VA and DOD


Annals of Internal Medicine Online 23 June 2015
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

ASK
Do you currently use tobacco?*

*Currently, there is insufficient evidence on e-cigarettes and other electronic nicotine delivery systems (ENDS) to recommend a clinical intervention3,4.

ICD-10 Tobacco/Nicotine Dependence Codes (See Table 1)
SNOMED Smoking/Tobacco Use Classifications (See Table 2)

NO
If patient has recently quit (last 6-12 months): assess challenges, confidence, need for support

ASSIST with a quit plan
(see next page for recommended interactive format)
- Provide and document brief tobacco cessation counseling (1-3 minutes, 3-10 minutes)
  - Set a quit date within 30 days
  - Review past quit attempts, including counseling and medication used
  - Discuss potential triggers and coping strategies
    - Discuss, prescribe, and document tobacco cessation medication(s). Exceptions (insufficient evidence): pregnant (unless medical clearance and patient consent); adolescent; light smoker (< 5 cigarettes/day); smokeless/chew tobacco.
    - FDA-approved – Nicotine patch, gum, lozenge, inhaler, and nasal spray; bupropion; varenicline; Patch + bupropion. Use clinical experience/judgment to consider nicotine patch (steady state) + nicotine lozenge or gum (craving relief): these combinations are not FDA-approved
    - Make a referral to additional in-depth, tobacco cessation counseling: tobacco quitline (800-QUIT-NOW), in-clinic/hospital counseling; community/local counseling

ARRANGE follow-up
Schedule a telephone or in-clinic follow-up appointment
"Before you leave today, we are going to schedule a follow-up appointment (phone or in-clinic) around your quit date. We will check in to see how your quit attempt is going, if you have any questions, or if there are ways we can support your quit attempt. Please contact us at any point. We are here to help and support you." OR your own scripting

DRAFT

YES

ADVISE to quit
ASSESS willingness to quit
"The most important thing you can do to improve your health is to quit smoking, and I can help. Are you willing to quit within the next 30 days?" OR your own scripting.

NO

Provide brief motivational message such as, "I feel so strongly about tobacco use and its impact on your health that I will ask you about it when I see you next." OR your own scripting.
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

- Minority status predicts lower referral and participation rates.
- Women, minorities, older people and those with other medical conditions are under-referred to cardiac rehab.

- 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.

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

We Know What Works To Improve Referral Rates

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

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

- 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

- 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.

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

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

- 19.6% of eligible white patients participate
- 7.8% of eligible black patients participate

We Know from Research How To Eliminate Barriers

- The greatest predictor of participation is the strength of the physician’s recommendation.
- Reduce the interval between hospital discharge and cardiac rehab program orientation by formalizing enrollment practices.
- 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®
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
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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
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