AHA’s 2020 Impact Goal

• 8:00 am
Welcome to the Cholesterol Summit

Meighan Girgus
Chief Marketing & Programs Officer
American Heart Association/American Stroke Association
Dallas, TX
Path to 2020 Health Impact Goal

To improve the cardiovascular health of ALL Americans by 20%, while reducing deaths from CVD and stroke by 20%

Focus on managing cholesterol will drive big wins on both sides of our goal – improving health and saving lives.

Life's Simple 7
- Manage Your Blood Pressure
- Manage Your Blood Cholesterol
- Manage Your Blood Sugar
- Eat A Healthy Diet
- Maintain A Healthy Weight
- Keep Up Physical Activity
- Manage Your Smoking Status
5 Near Term Impact Strategies
Nationally supported by Sanofi and Regeneron & supporting the 2020 AHA/ASA Impact Goal, Check. Change. Control. Cholesterol™ will empower all Americans to better manage their cholesterol through the knowledge, tools, and resources needed to reduce their risk for cardiovascular disease.
Strategic Approach

**Public Health Summit:** Convene thought-leaders to discuss gaps in care to drive better cholesterol management.

**Quality Improvement & Professional Education**
- eCQM & PROM development
- Pilot measures and quality improvement program in an Integrated Delivery Network
- National rollout of measures and quality improvement program
- Continuing education

**Increase adoption and utilization of treatment guidelines through quality improvement programs and professional education.**

**Public Awareness & Patient Education/Empowerment**
- Informed by patient and provider market research
- Awareness and educational messages deployed via a robust campaign

**Increase understanding of and adherence to evidence-based treatment guidelines through public and patient awareness and education.**
20+ Organizations Represented Today

Sample organizations
Your Role & Expectations

• 8:10 am
The State of Cholesterol in the U.S.

Eduardo Sanchez, MD, MPH, FAAFP, AHA
Chief Medical Officer Prevention and
Chief of the Center for Health Metrics & Evaluation
American Heart Association
Dallas, TX
About 94.6 million, or 39.7 percent, of American adults have total cholesterol of 200 mg/dL or higher.

About 28.5 million, or 11.9 percent, of American adults have total cholesterol of 240 mg/dL or higher.

Source: NHANES 2013-2014
New added focus on primary prevention of cardiovascular disease

2013 ACC/AHA Prevention Guideline

2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults

A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines

Lifestyle Is a Critical Component in ASCVD Risk Reduction
Four Major Statin - Benefit Groups

New Guidelines identified patients that would benefit from therapy, with a new 4th additional patient group:

- Adults with a previous or active diagnosis of clinical ASCVD
- Adults with a direct LDL-C $\geq$ 190mg/dL
- Adults with diabetes and a direct LDL-C of 70-189mg/dl - Aged 40-75yrs
- ASCVD at risk with no diagnosis; ASCVD 10-year risk $\geq$ 7.5% - Aged 40-75yrs
Prevalence of 4 Eligible Statin Groups in The U.S.

62.6 M adults fit into 1 of the 4 statin-eligible groups, NHANES 2011-2012.*

Extrapolated U.S. Population Estimates (Millions)**

<table>
<thead>
<tr>
<th>17M ASCVD</th>
<th>5.5M LDL-C 190 mg/dL (4.9 mmol/L)</th>
<th>14M Diabetes Mellitus</th>
<th>26M 10-year risk &gt;7.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASCVD aged &gt;21 yrs Past CHD, MI, angina pectoris, or stroke</td>
<td>LDL-C 190 mg/dL (4.9 mmol/L) &amp; aged 21 yrs</td>
<td>Aged 40-75 yrs with LDL-C 70 to 189 mg/dL (1.8–4.9 mmol/L)</td>
<td>Primary prevention aged 40-75 yrs with 10-year ASCVD risk score &gt;7.5% &amp; LDL-C 70 to 189 mg/dL (1.8–4.9 mmol/L)</td>
</tr>
</tbody>
</table>

Recent AHA Survey on 800 individuals with high LDL and Total Cholesterol levels:

- Most with high cholesterol understood the importance of cholesterol management. However, many expressed being confused (39%), discouraged (44%), and not confident (45%) about their ability to do so.

- 82 percent of all respondents identified a link between cholesterol and risk for heart disease and stroke.
Among survey respondents with a history of CVD, stroke, and/or with CV risk factor, most had lower perceptions of their real medical risk of CVD.

Among individuals with a history of clinical atherosclerotic cardiovascular disease (45% of overall sample),

- 14% thought they were at low risk
- 50% thought they were moderate risk
- 29% thought they were high risk
- 7% didn’t know
Help Americans achieve better Cholesterol Management by supporting AHA/ASA 2020 Impact Goal to improve cardiovascular health of all AMERICANS by 20% by 2020.

Opportunity to make an impact to 2020 Impact Goal requires a thoughtful plan for Check. Change. Control. Cholesterol
Summit Objectives

• Discuss **gaps and barriers**
• Identify innovative and actionable strategies
• Address the **patient’s role and real-world barriers**
• Prioritize approaches
Our Process

- **Cholesterol Advisory Group** has provided volunteer oversight
- **Completed market research**
- **Conducted pre-Summit surveys**
- **Today, Summit will provide a road map** for key deliverables for the next 3 years
What are the biggest gaps in managing your cholesterol today?
What are the biggest gaps in cholesterol management today?
What are the barriers to managing your cholesterol and taking medications regularly?
What are the barriers to cholesterol management, including adherence to medications?
• Hear from **key allies**
• Listen to **3 panel sessions**
• **Participate in action planning** breakout sessions
• **Help us prioritize opportunities** by electronic voting

*Adjourn by 3:00 PM*
Tweet #UnderstandCholesterol

Provide additional feedback at toni.a.ford@heart.org
Let’s Begin
Million Hearts Plan

• 8:30 am
Million Hearts and Cholesterol

Janet Wright, MD, FACC

Executive Director, Million Hearts
Million Hearts and Cholesterol From 1.0 to 2022

American Heart Association
Cholesterol Summit
April 11, 2017

Janet Wright, MD, FACC
Executive Director, Million Hearts
Disclaimer and Disclosure

The opinions expressed by the speaker do not necessarily reflect the opinions of the US Department of Health and Human Services, the Centers for Disease Control and Prevention, or the Centers for Medicare and Medicaid Services. Use of trade names is for identification only and does not imply endorsement.

Dr. Wright has no relevant conflicts.
Today’s Key Questions

• What is the current state of cholesterol management?
• What lessons from Million Hearts 1.0 are relevant?
• How will Million Hearts 2022 contribute to progress?
The Cardiovascular Disease Headwind

Why We All Care about Cholesterol

Cholesterol Treatment Eligibility

Prevalence of treatment eligibility among adults aged ≥21 years, NHANES 2005–2012

Overall 36.7

Sex
- Male 40.8
- Female 32.9*

Age in years
- 21–39 4.0
- 40–64 44.4*
- ≥65 80.7*

Race-Ethnicity
- Non-Hispanic White 38.4
- Non-Hispanic Black 39.5
- Mexican-American 24.2*

* Significantly different

### Cholesterol-lowering medication use among adults on or eligible for treatment, NHANES 2005–2012

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td>55.5</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>52.9</td>
</tr>
<tr>
<td>Female</td>
<td>58.6</td>
</tr>
<tr>
<td><strong>Age in years</strong></td>
<td></td>
</tr>
<tr>
<td>21–39</td>
<td>41.3</td>
</tr>
<tr>
<td>40–64</td>
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<td></td>
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<td>58.0</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>46.0*</td>
</tr>
<tr>
<td>Mexican-American</td>
<td>47.1*</td>
</tr>
</tbody>
</table>

* Significantly different

Cholesterol Management Snapshot

78.1 M Adults Aged ≥21 Years Who Are On Or Eligible For Cholesterol-Lowering Treatment

- 11.9M Taking meds (17.8%)
- 7.5M Modifying lifestyle (9.6%)
- 29M Doing both (37.1%)
- 27.7M Doing Neither (35.5%)

The Cholesterol Challenge
Getting Those Eligible on 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
- >800K (1 in 250) adults 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...

CDC Familial Hypercholesteremia - http://www.cdc.gov/genomics/implementation/toolkit/fh_1.htm
Circulation. 2016;133:1067-1072. DOI: 10.1161/CIRCULATIONAHA.115.018791.
Lessons from Million Hearts 1.0
Lesson #1: Partner Up
Lesson #2
Focus on a Small Set of High Impact Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Number</th>
<th>Million Hearts 1.0 Clinical Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin When Appropriate</td>
<td>NQF 0068</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic</td>
</tr>
<tr>
<td>Blood Pressure Control</td>
<td>NQF 0018</td>
<td>Hypertension: Controlling High Blood Pressure % of patients aged 18 - 85 years with a diagnosis of HTN and an office BP of &lt;140/90 during the measurement year</td>
</tr>
<tr>
<td>Cholesterol Management</td>
<td>NQF 0075</td>
<td>Ischemic Vascular Disease: Complete Lipid Panel and LDL-C Control % of patients aged 18 years and older with IVD who received at least one lipid profile within 12 months and had most recent LDL-C level &lt; 100 mg/dL.</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>NQF 0028</td>
<td>Preventive Care and Screening: Tobacco Use % of patients &gt;18 years who were screened about tobacco use one or more times within 24 months and who received cessation counseling intervention if a tobacco user</td>
</tr>
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</table>

NOTE: ABCS included in Cardiology, Internal Medicine, and General Practice/Family Medicine Specialty Measure Sets
# Lesson #3a
Be Nimble because Science--and Measures--March On

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Lesson #3b
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<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Number</th>
<th>Million Hearts 2022 Clinical Quality Measures</th>
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</thead>
<tbody>
<tr>
<td>Aspirin When Appropriate</td>
<td>NQF 0068</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic&lt;br&gt;Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic</td>
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<td>NQF 0018</td>
<td>Hypertension: Controlling High Blood Pressure&lt;br&gt;% of patients aged 18 - 85 years with a diagnosis of HTN and an office BP of &lt;140/90 during the measurement year</td>
</tr>
<tr>
<td>Cholesterol Management</td>
<td>PQRS 438</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease&lt;br&gt;% who were prescribed or on statin therapy during the measurement period:&lt;li&gt; Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease; OR&lt;/li&gt;&lt;li&gt; Adults aged ≥ 21 years with a fasting or direct LDL-C level ≥ 190 mg/dL; OR&lt;/li&gt;&lt;li&gt; Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL</td>
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NOTE: ABCS included in Cardiology, Internal Medicine, and General Practice/Family Medicine Specialty Measure Sets
Lesson #4
Widely Embed the Small Set of High Impact Measures
Focuses Action, Reduces Reporting Burden, Strengthens Performance Assessment

### Million Hearts® Quality Measure Alignment in National Quality Reporting Systems

<table>
<thead>
<tr>
<th>Quality Reporting Initiative</th>
<th>Aspirin when Appropriate</th>
<th>Blood Pressure Control</th>
<th>Cholesterol Management</th>
<th>Smoking Assessment and Treatment</th>
<th>Cardiac Rehab Referral</th>
<th>BMI</th>
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<td>CMS Quality Payment Program</td>
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<tr>
<td>ABFM Prime Registry</td>
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<td>✓</td>
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<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>AHA Guideline Advantage</td>
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<td>✓</td>
<td>No</td>
<td></td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>ACP Genesis Registry</td>
<td>✓</td>
<td>✓</td>
<td>No</td>
<td></td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>ACC PINNACLE Registry</td>
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<td>✓</td>
<td>No</td>
<td>✓</td>
<td>✓</td>
<td>No</td>
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<tr>
<td>CMS ACO Shared Savings</td>
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<td>✓</td>
<td>No</td>
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<td>TCPI</td>
<td>✓</td>
<td>✓</td>
<td>No</td>
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<td>No</td>
<td>✓</td>
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<tr>
<td>CMS Home Health CV Data Registry</td>
<td>✓</td>
<td>✓</td>
<td>No</td>
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<td>No</td>
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<tr>
<td>HRSA Uniform Data System</td>
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<td>✓</td>
<td>Pending†</td>
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<tr>
<td>Comprehensive Primary Care</td>
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<td></td>
<td>No</td>
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</tr>
<tr>
<td>IHS RPMS</td>
<td>No</td>
<td>✓</td>
<td>Pending†</td>
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<tr>
<td>Medicaid Adult Core Set</td>
<td>No</td>
<td>✓</td>
<td>No</td>
<td></td>
<td>0027†</td>
<td>No</td>
</tr>
</tbody>
</table>

* ✓ Indicates measure alignment as of February 2017
* † Measure is not identical, but similar and meets stakeholders needs
* ‡ Measure will be added for reporting in 2019 after e-specifications are released in May 2017

**NOTE:** ABCS measures are in the Cardiology, Internal Medicine, and General Practice/Family Medicine Specialty Measure Sets
Lesson #5

Drive Use of Evidence-Based Treatment Protocols

• 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
Lesson #6
Apply “Hiding in Plain Sight” Tools for High LDLs

Undiagnosed Hypertension

Are there patients in your practice with undiagnosed hypertension who may be “hiding in plain sight”?

- Video: Finding Undiagnosed Hypertensive Patients
- Hypertension Prevalence Estimator Tool
- References, Resources, and Case Studies
Lesson #7
Improvement is TOO Slow

Figure 2. Prevalence of statin use among adults (≥21 years) for whom statin therapy is recommended, NHANES*, 2005-2016

* National Health and Nutrition Examination Survey (NHANES)
Million Hearts® 2022 Aim:
Prevent a Million Heart Attacks and Strokes in Five Years

Keeping People Healthy
Optimizing Care

COMMUNITY

Improving Outcomes for Priority Populations
### Million Hearts® 2022

**Priorities and Goals**

<table>
<thead>
<tr>
<th>Keeping People Healthy</th>
<th>Optimizing Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Sodium Intake</td>
<td>Improve ABCS*</td>
</tr>
<tr>
<td>Decrease Tobacco Use</td>
<td>Increase Use of Cardiac Rehab</td>
</tr>
<tr>
<td>Increase Physical Activity</td>
<td>Engage Patients in Heart-healthy Behaviors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving Outcomes for Priority Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blacks/African-Americans</td>
</tr>
<tr>
<td>35-64 year olds</td>
</tr>
<tr>
<td>People who have had a heart attack or stroke</td>
</tr>
<tr>
<td>People with mental illness or substance use disorders</td>
</tr>
</tbody>
</table>

*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation*
## Optimizing Care

<table>
<thead>
<tr>
<th>Goals</th>
<th>Effective Healthcare Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve ABCS*</td>
<td>High Performers Excel in the Use of.......</td>
</tr>
<tr>
<td>80% Targets</td>
<td>• <strong>Technology</strong> – decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care</td>
</tr>
<tr>
<td></td>
<td>• <strong>Teams</strong> – including pharmacists, nurses, community health workers, cardiac rehab professionals</td>
</tr>
<tr>
<td></td>
<td>• <strong>Processes</strong> – treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use</td>
</tr>
<tr>
<td>Increase Use of Cardiac Rehab</td>
<td>• <strong>Patient and Family Supports</strong> – training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab</td>
</tr>
<tr>
<td>70% Target</td>
<td></td>
</tr>
<tr>
<td>Engage Patients in Heart-healthy Behaviors</td>
<td></td>
</tr>
<tr>
<td>Targets TBD</td>
<td></td>
</tr>
</tbody>
</table>

*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation*
Cholesterol Management
Questions and Gaps

• What is your biggest obstacle/tip related to cholesterol management?
• How—and by whom--can the value proposition be best conveyed?
• What are measureable actions that qualify as patient engagement in cholesterol management?
Patient Centeredness

- 9:05 am
- Panel
- Stephen Daniels, MD, PhD
Millie Henn

Mended Hearts
It’s All About the Person

Dennis Robbins, MPH, PhD

www.DennisRobbins.com
Leveraging The Person to Add Years to Our Lives & Life to Our Years
Healthy Living: Clues from Aristotle and Hippocrates

- Health and the “good life” of the ancient Greeks was based on the mean between the extremes of self-indulgence and self-neglect.
- Hippocrates Diatia
- Movement from “Healthcare” and Episodic Unhealth to Health and Helping The Person to Become and Remain Healthier
- Each of us is the key to add *Years to Our Lives & Life to Our Years*
Unpacking the Baggage of the Patient: A Glimpse into the Psychology of Disease

• The patient is a consequence of our reductionist approach to medicine, tied to the pathophysiology of disease where, in essence, the patient is the disease.

• This magical transformation into disease results in the person relinquishes their responsibility to the clinician(s)s rather than it being their problem to resolve.

• Patients become/are expected to be passive & subservient
It’s All About The Patient Person!

• We must move from the concept of the patient as passive, subservient, wounded, and vulnerable to the person who can do ANYTHING they find to be important sufficiently meaningful or that matters enough

• We must work to make being healthy not daunting, unpleasant, or insurmountable, but to make the healthy choice the easy choice

• Small Changes Incrementally Can Make Huge Differences

• By putting the whole person in the game we can help to create a Behavioral Symphony of Wellness
I Create My Own Destiny and Future

• It is presumptuous to think we know what the person really wants better than the person him or herself, and we are often astonished by those presumptions

• I am the person most interested in their own well-being

• We can no longer jeopardize our personhood by passively and involuntarily restricting our identity by being defined by disease, condition, or body part.
Everything that makes me... ME!

- Aspirations
- Idiosyncrasies
- My memories
- What’s important to me
- My values
- My history

- The way I see myself
- Preferences
- My personality
- What makes me distinctive

Healthcare De-Personalizer
Optimizing, Maximizing, and Savoring Life
It's All About

the

person
Thank you!
Dennis A. Robbins
www.dennisrobbins.com
Talking About Risk

Anne Carol Goldberg, MD, FACP, FAHA, FNLA

Professor of Medicine
Washington University School of Medicine
• The person sitting in the chair in my office wants to know:
  o What should I do about my (or my spouse’s or my child’s) cholesterol?
  o Do I need to do anything?
  o Can I lower my levels without medication?
  o Can I prevent a heart attack or stroke?
  o What about my family members?
Talking About Risk

- How do we assess risk?
  - ASCVD calculator—for people without vascular disease and without very high LDL levels or diabetes
  - Lifetime risk
- Putting risk into context
  - Age, long term risk, inherited cholesterol problems
- Additional factors: family history, cluster of risk factors, personal preferences for treatment
The Conversation

• What is the person most worried about?
• Does his or her perception of risk agree with mine?
• Can I provide information to help with our decision-making process?
  o How data relate to his/her situation?
  o Safety concerns about medications?
• What can we negotiate with regard to lifestyle changes and possible medication therapy?
Risk reduction is often a family issue

Lifestyle change can involve the whole family

Inherited cholesterol disorders

- Familial hypercholesterolemia—increased risk, finding affected family members, deciding to treat children
Creating an Alliance

- Listening
- Indicating understanding of concerns, fears, and needs
- Encouraging participation and autonomy in decisions
- Working towards agreement and collaboration
Creating an Alliance

• It’s not about the clinician
• It’s about the person who wants to take charge of her/his health
• 10:05 am
• 10:15 am
• Panel
• Anne Marie Navar, MD, PhD
Lifestyle Management

Martha L. Daviglus, MD, PhD, FAHA

Edmund Foley Professor of Medicine
University of Illinois at Chicago
Race/Ethnic Disparities and the Role of Lifestyles
Serum Total Cholesterol $\geq 200\text{mg/dL}$

Age-Adjusted Trends in Prevalence of Serum Total Cholesterol $>200\text{mg/dL}$

Benjamin et al. Heart Disease and Stroke Statistics—2017 Update
A Report From the American Heart Association. Circulation 2017
Mean Serum Total Cholesterol Levels

Among HCHS/SOL Participants by Sex and Hispanic/ Latino Background

- Men
- Women

*Age standardized to the Census 2010 US population

Daviglus et al. JAMA 2012;308:1775-84
Challenges to Overcoming Disparities

Persons from race/ethnic minority backgrounds may experience barriers to physical activity and healthy diets.

• **Personal-level Barriers**
  - Health literacy
  - Lack of time (work or family/caregiver commitments)

• **Sociocultural barriers**
  - Access to culturally appropriate dietary guidelines
  - Culturally acceptable types of physical activity

• **Neighborhood-level barriers**
  - Residence in food desert areas
  - Lack of sidewalks, green space, or recreational facilities
  - Neighborhood crime

• **Health insurance and access to care**
  - Awareness of cholesterol levels
  - Medication affordability
Culturally Specific Lifestyle Strategies
Culturally Specific Lifestyle Strategies

BAILAMOS: Balance & Activity In Latinos, Addressing Mobility in Older Adults

- Innovative culturally appropriate dance program developed by Dr. David Marquez at UIC based on focus group input from older, sedentary community-dwelling Latinos in collaboration with accomplished Latin dance instructor.
- A pre-post 3-month pilot of BAILAMOS demonstrated program feasibility.
- Improvements in self-reported lifestyle physical activity and physical function.
Comprehensive public health agenda established in 2011. Recognizes that “the improvement of the public’s health in Chicago requires a commitment to health equity and the elimination of racial and ethnic disparities.”

Strategies include:
For smoking cessation: expansion of smoke-free environments; support for vulnerable populations (smoking cessation clinics, nicotine patch therapy).
For obesity prevention: expansion of access to health foods in food-desert areas; healthy vending; pedestrian plan; promotion of bicycling.
Measurable targets to be achieved by 2020.
Healthy Chicago - Initiatives

Increasing Access to Healthy Food

Citywide Food Plan
- A Recipe for Healthy Places
  - Build healthier neighborhoods
  - Grow food
  - Expand healthy food enterprises
  - Strengthen the food safety net
  - Serve healthy food and beverages
  - Improve eating habits

Healthy Vending
- Healthy vending machines in all City buildings
- Launched Healthy Vending Challenge
- Follow efforts of Parks and CPS

Increasing Access to Healthy Food

Produce Carts
- 15 carts in neighborhoods for 2013
- 15 planned for 2014
- ~20 jobs created
- 40 persons trained in retail sales

Urban Farms
- Farmers for Chicago
  - Partnership with Growing Power
  - 5 acres of vacant lots available
  - Training for local farmers and help installing equipment
  - 15 acres overall operate as farms or breaking ground

From: “Healthy Chicago: 2013 Year in Review.” A presentation by Bechara Choucair, MD, Commissioner, Chicago Department of Public Health, March 2014
Healthy Chicago - Initiatives

Increased Opportunities for Physical Activity

Divvy Bike Share Program
- 2,035 bikes, 100 stations
- 121,333 annual memberships
- 131,964 24-hour passes
- 763,760 trips, >1.7 million miles

Dearborn St. Complete Street
- 200 miles of on-street protected, buffered and shared bike lanes
- More than 13,000 bike racks, and sheltered parking
- A 645-mile network of biking facilities by 2020 will provide a provide a bicycle accommodation within half mile of every Chicagoan

From: “Healthy Chicago: 2013 Year in Review.” A presentation by Bechara Choucair, MD, Commissioner, Chicago Department of Public Health, March 2014
Effective incorporation of culturally sensitive approaches to increase physical activity and promote healthy diets among race/ethnic minority groups in the US is required.

Comprehensive, multifaceted public health approaches – both targeting individuals and aimed at upstream factors such as neighborhood structures, programs, and policies -- are necessary to prevent development of adverse cholesterol levels starting early in life.

Departure from focus on individual responsibility to emphasis on social determinants and on social policies and programs.
Lifestyle Management

Lilian Tsi Stielstra

Stroke Survivor
Janet M. de Jesus, MS, RD*
Program Officer, Implementation Science

National Institutes of Health
National Heart, Lung, and Blood Institute
Center for the Translation Research
and Implementation Science

*No conflicts. The information presented does not necessarily represent the NIH, NHLBI.
Discussion Overview

• Role of diet in cholesterol management
• Research on innovative diet management
• NIH nutrition research
### Lipid Effects in Diet Trials*

<table>
<thead>
<tr>
<th>Diet</th>
<th>Total Fat (% kcal)</th>
<th>SFA (% kcal)</th>
<th>Carbohydrate (% kcal)</th>
<th>Protein (% kcal)</th>
<th>Baseline LDL-C of Participants</th>
<th>Effect on LDL-C (Compared With Control)</th>
<th>Effect on HDL-C and/or TG (Compared With Control)</th>
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</thead>
<tbody>
<tr>
<td>DASH</td>
<td>27</td>
<td>6</td>
<td>55</td>
<td>18</td>
<td>&lt;160 mg/dL</td>
<td><strong>−11 mg/dL</strong></td>
<td>HDL-C: −4 mg/dL</td>
</tr>
<tr>
<td>DASH: Sodium: Control</td>
<td>36</td>
<td>14</td>
<td>51</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DASH: Sodium: Control</td>
<td>27</td>
<td>6</td>
<td>58</td>
<td>15</td>
<td>&lt;160 mg/dL</td>
<td><strong>−13 mg/dL</strong></td>
<td>HDL-C: −4 mg/dL, TG: +5 mg/dL</td>
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<tr>
<td>DELTA: Low Saturated Fat:</td>
<td>38</td>
<td>15</td>
<td>49</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DELTA: Step 1</td>
<td>26</td>
<td>5</td>
<td>59</td>
<td>15</td>
<td>“Healthy”</td>
<td><strong>−11%</strong></td>
<td>HDL-C: −11%, TGs: No change</td>
</tr>
<tr>
<td>DELTA: Control</td>
<td>29</td>
<td>9</td>
<td>55</td>
<td>15</td>
<td></td>
<td><strong>−7%</strong></td>
<td>HDL-C: −7%, TG: +9%</td>
</tr>
<tr>
<td>DELTA: Control</td>
<td>34</td>
<td>15</td>
<td>48</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

-Supplementation of olive oil or nuts

-Behavioral counselling

-Reduced the risk of cardiovascular disease by approximately 30%.

“Toward testing the effects of a Mediterranean dietary pattern on cardiovascular and other diseases in the United States.”

**Summary**

- Discussed the feasibility of, and provided recommendations for, testing the effects of a Mediterranean dietary pattern on CVD and other disease morbidity and mortality in adults in the US.
NIH Trials – Behavior Change

- Power Practice-based Opportunities for Weight Reduction (POWER) Trial*

- Early Adult Reduction of weight through Lifestyle intervention (EARLY) Trials: Using Innovative Technologies in RCTs
  - 7 trials - modestly effective
  - Conclusion:
    “Effective intervention may require the efficiency of technology, the social support and human interaction of personal coaching,...” (Svetkey, PI)

Diet Management Innovations

• Mobile applications for diet and physical activity tracking
• Online and virtual social support
• Meal delivery
The Nutrition Research Task Force - established to coordinate and accelerate progress in nutrition research and guide the development of the first NIH nutrition-research strategic plan.

The Task Force charge:

- Identify scientific opportunities and research gaps and promote interdisciplinary work to achieve common goals in nutrition.
- Solicit feedback from the scientific community
  
  ➢ https://ideabuzz.com/a/buzz/nih/strategic-plan

- Appoint a senior leadership group to guide implementation of the plan.
Estimated NIH Nutrition Research Funding, FY 2018

Nutrition Research
Total $: ~1.6 Billion
Total # grants: 4211

NIH Institutes and Centers

www.niddk.nih.gov/about-niddk/advisory-coordinating-committees/nih-nutrition-research-task-force/
Implementation Research

NHLBI Role

Collaborative Partners’ Role

Knowledge Generation

Evidence Synthesis

Implementation Research

Practice Guidelines
- Writing guidelines
- Disseminating guidelines
- Helping implement guidelines

Gaps in Evidence

Gaps in Implementation

• Lifestyle change is critically important in cholesterol management.

• New strategies for lifestyle management have been studied but personal/human (remote or in person) interaction is still important.

• Behavior/nutrition counselling should be incorporated in healthcare systems.

• Implementation research is needed to identify strategies to speed up widespread adoption of dietary guidelines.

Thank you
Enhancing Communication & Motivation to Help Patients Lower their Cholesterol

Barbara J. Fletcher, RN, MN, FAHA, FAAN
University Of North Florida
Jacksonville, Florida
Communication Methods

Communication Mainly Occurs Through:

- Written Word
- Spoken Word
- Visuals

*To motivate, one must communicate*
20% of adults read at or below a 5th grade level

For those over 65 or inner-city minorities, 40% read below a 5th grade level

75-80% of individuals read materials easily at a 6th grade level

Healthcare professionals write at a 7-9th grade level

Low literacy costs millions of $$ in longer hospital stays and readmissions
Dyslexia

• Is a reading disorder associated with impairment of the ability to recognize and comprehend the written word
• Results from how the brain processes the written word
• Estimated prevalence in our population with dyslexia is 40%
• Does Not Reflect One’s Intelligence
Written Communication to Lower Cholesterol

• Use 13-16 type font
• Use short words and sentences (under 15 words)
• Give examples to explain hard words
• Include interaction
• Repeat important information
Motivating People to Lower Cholesterol

- Goal Setting
- Problem Solving
- Short Educational Messages (1-3 Minutes)
- Teach Back Method
- Motivational Interviewing
- Coaching
Maintaining Motivation for Lowering Cholesterol

• Self-Monitoring Tools
• Skills for Long Term Behavior Change
  • Relapse Prevention
    • Self Monitoring
    • Problem-Solving Support
Key Points

- Keep the Message Clear and Simple
- Ask the Patient How they Learn Best
- Motivate at that Teachable Moment
The National Forum

- 11:20 am
- John Clymer, CEO
- Debbie Martinez
Counter Cholesterol is made possible through support from Sanofi and Regeneron
• **About the National Forum for Heart Disease and Stroke Prevention**
  - Independent non-profit, 501(c)(3), voluntary health organization
  - Over 80 member institutions, organizations, governmental agencies, and companies
  - Leads collaborative action and builds a collective voice for the prevention of heart disease and stroke
  - Based in Washington, DC
Project Overview

1. Develop enduring evidence-based messaging and communications tools that raise awareness among a high impact target audience to address their and their families’ LDL risk

2. Establish and disseminate a cholesterol awareness toolkit for use by national and local NF members and partners

3. Support recognition of partners’ commitment to raising high-risk patient awareness of cholesterol risk

**Primary audience:** Mothers aged 35-54 years of age (beginning with those at highest risk for high LDL-C)

**Secondary audience:** Their families (i.e. spouses, partners, parents)

**National Forum’s “mother” definition:** Any woman who has a child, biological, step or other, as their own
- 80% make health care decisions
- 50% more likely to be caregivers
- 1 in 3 households are mother-only
Focus Group

• Our strategy to get women thinking about what would happen to their loved ones if they weren’t around works very well to compel women to learn their and their family’s risks.

• Facts and statistics are essential to engaging and educating our target audience.

• The concepts compel women to learn more and to share their new knowledge with others (spouses, family, and friends).
About Travis County Females, Ages 35-54, Population: ~163,000

Females who had cholesterol checked in past 5 years: 87.8%

Female prevalence of high cholesterol: 38.7%

Pilot site: Austin, TX
Pilot length: 6 mo.
Communication Tools

1. Website
2. Infographic
3. Champion video clips
4. Traditional media
5. Social media
6. Template campaign announcements
Cardiovascular disease kills almost half a million women annually.

Be there for the people you love the most. Talk to your healthcare provider today!

Caring for yourself = Caring for your family. We can help.

Need a healthcare provider but you’re uninsured?

SEARCH FOR LOCAL CLINICS & RESOURCES ZIP CODE MANAGE YOUR CHOLESTEROL RISK TODAY
• Clearly links risk between cardiovascular disease and cholesterol
• Promotes latest research on cholesterol risk (5x versus 2x)
• Race/ethnicity neutral
Champion Videos
Traditional media relations outreach focused on local Austin media, utilizing the Counter Cholesterol campaign data points to support messaging and champions and partners as key spokespersons.

July 9, 2016
KTBK-TV (FOX)
Counter Cholesterol campaign kicks off in Austin
(website UVM: 205,751)
Reach - 11,184 households*
(video segment: 4 minutes)
*according to the July 2016 TV ratings

July 9, 2016
KXAN-TV (MSNBC)
Counter Cholesterol Campaign launches in Austin
(website UVM: 724,774)

Aug. 25, 2016
KAKW Univision 62/KTFO Univision 31
Reach: Univision reaches up to 14% of U.S. Hispanic television households.
KAKW Univision Austin finished 2015 as the #1 early newscast in the Austin market, regardless of language, and as the 2nd most watched late newscast among adults 18-49.
Juan Rosa on Despierta Austin (this segment is not available online. Screen grabs were pulled from broadcast monitoring service TV Eyes).

Sept. 6, 2016
Health Professional Radio (website UVM: 516)
Counter Cholesterol Campaign Encourages Women’s Proactive Management of their Heart Health

Oct. 4, 2016
We Are Austin – KEYE (CBS)
(website UVM: 250,890)
Reach - 5,219 households*
*according to the September 2016 TV ratings
Social Media

Facebook

Twitter
Social Media: Graphics

DID YOU KNOW?
Cardiovascular disease kills almost half a million women annually.

DID YOU KNOW?
People with high cholesterol are at least five times more likely to have cardiovascular disease, the No. 1 cause of death among women.

¿SABÍA USTED QUE?
Enfermedades cardiovasculares son la causa Nu. 1 de muerte entre mujeres, tomando más vidas que todas las formas de cánceres combinadas.

SABÍA USTED QUE
Enfermedades cardiovasculares son el Nu. 1 matador de mujeres causando 100 de cada 400 muertes al año.
Additional Partner Opportunities

- Template email, newsletter, web announcements
  - Target audience, i.e. mothers
  - Partners
- Partner collateral distribution
- Community events
- Examples:
  - Launch event and announcement to target audience
  - Partnership opportunities for local organizations
  - Campaign update, e.g. CHW program to begin
Traditional Social &
Traditional Coverage

13 stories including major networks

50K estimated coverage views

FOX kxan

CBSO

79 social media shares

96% of U.S. Hispanic television households

UNIVISION
Facebook Coverage

LIKES
- July: 9
- Aug.: 25
- Sept.: 404
- Oct.: 638
- Nov.: 916
- Dec.: 1112

REACH
- July: 151
- Aug.: 742
- Sept.: 71545
- Oct.: 120231
- Nov.: 99764
- Dec.: 50516

ENGAGEMENTS
- July: 149
- Aug.: 152
- Sept.: 3404
- Oct.: 3130
- Nov.: 3200
- Dec.: 2938
Next Steps
For more information contact Debbie Martinez:
Debbie.Martinez@NationalForum.org
Networking Lunch

• 11:45 pm
Treatment & Adherence Barriers

• 12:20 pm
• Panel
• Mary Ann Bauman, MD
Statin Use in the U.S.

Gaps, Barriers and Opportunities

Vera Bittner, MD, MSPH, FAHA
Section Head
General Cardiology, Prevention and Imaging
University of Alabama at Birmingham
Utilization of High Intensity Statins After MI Is Improving

Utilization higher in:
- Men: RR 1.16
- Age <65: RR ~1.3 (depending on age)
- Prior high intensity statin Rx: RR 1.52

Rosenson RS et al. Poster at ESC 2016 paper in press
Adoption of 2013 ACC/AHA Guidelines
Data from PINNACLE

**Pokharel Y et al JAMA Cardiol 2017**
Online 3/1/2017

161 Cardiology Practices
Time periods: 2012/2013 vs 2014/2015
### Discharge Dx Determines Statin Use
Medicare Data 2007-2009

<table>
<thead>
<tr>
<th></th>
<th>No Prior Statin Use</th>
<th>Prior Statin Use</th>
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<tbody>
<tr>
<td>Primary D/C dx of MI</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Secondary D/C dx of MI</td>
<td>0.59 (0.54 to 0.65)</td>
<td>0.89 (0.82 to 0.97)</td>
</tr>
<tr>
<td>PCI</td>
<td>1.00 (0.91 to 1.09)</td>
<td>1.01 (0.93 to 1.10)</td>
</tr>
<tr>
<td>CABG</td>
<td>1.08 (0.95 to 1.23)</td>
<td>0.99 (0.88 to 1.11)</td>
</tr>
</tbody>
</table>

Absolute rates of statin use:
Incident users: 60% for 1° MI dx, 31.2% for 2° MI dx; 67.6% CABG, 63.9% PCI
Prevalent users: 84.1% for 1° MI dx, 71.8% for 2° MI dx; 83.8% CABG, 87.3% PCI

Yun H et al. Jaha 2015;4:e001208
Statin Adherence is Poor

Statin Discontinuation Over Time

Adherence Matters

- Aetna Claims Database 2010-2013
  - A. Post MI Cohort
  - B. Atherosclerotic Disease Cohort

- ACE-I and Statin

- PDC (proportion of days covered)
  - ≥80% fully adherent
  - 40-79% partial adherent
  - <40% non-adherent

- MACE during F/U
  - All cause mortality
  - Hospitalization for nonfatal MI
  - Stroke
  - Coronary revascularization

Bansilal S et al. JACC 2016; 68:789-801
Statin Intolerance and Outcomes

- Medicare beneficiaries who started statin post MI
  - High Adherers: 52.8%
  - Intolerant: 1.65%
- Follow-up 1.9-2.3 years
- Outcomes:
  - Recurrent MI
  - CHD events
  - All cause mortality

Intolerance and Outcomes
(High adherers are the referent group)

<table>
<thead>
<tr>
<th></th>
<th>Fully adj. Hazard Ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent MI</td>
<td>1.50</td>
<td>1.30, 1.73</td>
</tr>
<tr>
<td>CHD Events</td>
<td>1.51</td>
<td>1.34, 1.70</td>
</tr>
<tr>
<td>All Cause Mortality</td>
<td>0.96</td>
<td>0.87, 1.86</td>
</tr>
</tbody>
</table>

Colantonio et al. CV Drugs Ther 2016;30:525-33
Serban, M.-C. et al. JACC 2017;69:1386–95
Summary

- Guideline-appropriate statin therapy is increasing, but remains suboptimal
- Adoption is heterogeneous among patients and sites of care
- Adherence to statins is poor
- Poor adherence and statin intolerance among high risk patients are associated with higher risk of events
Thank You

UAB COMPREHENSIVE CARDIOVASCULAR CENTER

Knowledge that will change your world
Pharmacists and Adherence

Steve Dunn, PharmD, FAHA, BCPS

Clinical Coordinator for Pharmacy Services
University of Virginia Heart and Vascular Center
Scope of the Problem

- Chronic cardiovascular disease is largely asymptomatic
- Preventative dyslipidemic pharmacotherapy does not result in symptomatic improvement
- Pharmacotherapy may result in adverse drug reactions
- A high-risk patient is prescribed a statin:
  - The short-term (6-month to 1-year) likelihood the patient will continue to take the drug is approximately 50-60%
  - The long-term likelihood ranges between 15-50%
    - Primary prevention <<< Secondary prevention

**Adherence Strategy Examples**

- **Educational Tools**
  - Videos, apps, handouts

- **Involvement of the patient in decision making**
  - Identifying medication benefits
  - Employing motivational interviewing
  - Empowering patients through discussion of risk

- **Regular, frequent follow-up**
  - Reinforce adherence, identify barriers

- **Simplifying taking medications:**
  - Long-acting injectables may offer an adherence advantage
  - Pill boxes, blister packing, combination pills
  - Transitional care from hospital to home: meds to bedside

- **Reminder systems:**
  - Simple to complex
Which Strategies Work Best?

• van Driel et al. Cochrane review (2016)
  • Evaluated 35 randomized, controlled studies of interventions designed to improve adherence to lipid-lowering therapy comprising over 925,000 patients
  • In a meta-analysis of 7 studies, patients receiving an intervention had greater adherence (OR 1.93, 95% CI 1.29-2.88) and improved lipid parameters over the short and long-term (> 6 mos)
  • Interventions that consistently showed improvement:
    • Reminder systems (telephone, calendar, technology)
    • Integrated multidisciplinary educational activities
    • Pharmacist-led interventions (counseling, follow-up, reinforcement, visits, etc.)
  • Interventions that were inconsistent:
    • Decision support systems
    • Drug-regimen simplification
    • Complex behavioral approaches
    • Administrative improvements
    • Large-scale pharmacy automated telephone intervention

Cochrane Database Syst Rev. 2016 Dec 21;12:CD004371
Viswanathan et al. systematic review (2012)
- Evaluated 62 trials of interventions designed to improve adherence to medications for chronic diseases
- Identified general benefit across disease states for:
  - Reducing out-of-pocket expenses
  - Case management
  - Patient education with behavioral support
How Pharmacists Can Help

- Partner with community pharmacists for first-line detection and troubleshooting of adherence issues
  - Are patients refilling prescriptions on time?
  - Are patients unable to afford prescribed therapy?
  - Utilize community pharmacists for follow-up if no dedicated clinic infrastructure to address adherence
    - Automatic refills, reminder calls/texts, packaging, etc.
  - Synchronize and simplify medication refills
How Pharmacists Can Help

• Utilization of a pharmacist in-clinic
  • Detailed medication history
  • Dedicated follow-up/time to improving adherence on a patient-specific basis
  • Medication management through collaborative practice or state licensure

• Utilization of pharmacists in-hospital
  • Pharmacists are in one of the best positions to identify medication changes pre- and post- hospitalization and articulate these to the patient
  • Get an early start on medication education
  • If possible, partner with outpatient pharmacies to dispense and educate patients before they are discharged
How Can The System Be Better?

- There isn’t a “silver bullet” for adherence and each patient must be approached as an individual
- Promote healthcare models that enable financial viability of true population health so that primary care offices can dedicate resources to adherence
  - “Adherence champion”
  - In-office tools
- Promote full integration of electronic health records that include bi-directional pharmacy records
- Development of toolkits that promote best practices, resources, and tools for patient-specific scenarios
- Continued funding of novel research ideas that specifically explore improvement in cholesterol adherence, utilizing a patient-specific approach
  - What specific elements in multi-pronged interventions are effective?
- Continue exploring the role of technology in improving adherence
Barriers to Treatment Initiation

Ann Marie Navar, MD, PhD
Assistant Professor of Medicine
Duke Clinical Research Institute
Break

• 1:20 pm
Electronic Voting

• 1:40 pm
• Eduardo Sanchez, MD, MPH
• Mary Ann Bauman, MD
Strategic Prioritization

The Impact/Effort Matrix

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<thead>
<tr>
<th>Impact</th>
<th>Low</th>
<th>Med</th>
<th>High</th>
</tr>
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<tbody>
<tr>
<td>Effort Required</td>
<td>Low</td>
<td>Med</td>
<td>High</td>
</tr>
<tr>
<td>Impact</td>
<td>Effort Required</td>
<td>Effort Required</td>
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<tr>
<td>--------</td>
<td>----------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Low Effort Low Impact Why Bother?</td>
<td>High Effort Low Impact Better Elsewhere?</td>
<td></td>
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<tr>
<td>Med</td>
<td>Low Effort High Impact Quick Wins</td>
<td>High Effort High Impact Requires Plans</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Low Effort High Impact Quick Wins</td>
<td>High Effort High Impact Requires Plans</td>
<td></td>
</tr>
</tbody>
</table>

**Strategic Prioritization**

- **Low Effort, High Impact:** Quick Wins
- **Low Effort, Low Impact:** Why Bother?
- **High Effort, High Impact:** Requires Plans
- **High Effort, Low Impact:** Better Elsewhere?
1. Quick wins or low-hanging fruit. These would be high-impact solutions that would require fewer resources, as well as less effort to plan or organize.

2. Strategic next steps that require planning. These would be high impact solutions that require more resources, as well as more effort to organize and plan.
Participating with Poll Everywhere

Text voting
How's my presentation so far?

Respond at PollEv.com/preserterpete  Text PRESENTERPETE to 22333 once to join, then A, B, or C

It's amazing.  A
It's incredibly amazing!  B
It's aw'right  C
Voting Results and Recap

• 2:15 pm
Adjourn

• 3:00 pm
• Adjourn
THANK YOU!

WORKING TOGETHER, WE’RE IMPROVING THE WAY AMERICANS MANAGE THEIR CHOLESTEROL.

American Heart Association® | Check. Change. Control. CHOLESTEROL™

life is why*

National Supporter
SANOFI REGENERON