The Next Top Model: Activating & Improving Systems of Care
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FULL TRANSCRIPT (with timecode)

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Narrator: The 2018 American Heart Association/American College of Cardiology Guidelines on the Management of Blood Cholesterol set a new emphasis on patients at very high risk for future atherosclerotic cardiovascular disease, or ASCVD, events and appropriate guideline directed therapies based on risk. We aim to have constructive conversations about caring for these patients throughout the continuum of care for longer, healthier lives. Through support of Amgen, the American Heart Association has created a three-part podcast series that discusses models for treating to guidelines and patient experiences as they are diagnosed with ASCVD.

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Narrator: This series elaborates on helping all members of the care team to properly manage and support their patients from all socioeconomic backgrounds diagnosed with ASCVD.

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Dr. Haft: Hi everyone. My name is Dr. Howard Haft, and I'm the senior medical advisor at the Maryland Department of Health and also the chair of the American Heart Association Outpatient Quality Advisory Committee. I'll be hosting a series of conversations with our special guests focused on patients with diagnosed atherosclerotic cardiovascular disease, better known as ASCVD, and the barriers and challenges health care providers face when supporting their patients. Today's topic is The Next Top Model: Activating and Improving Systems of Care.

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Dr. Haft: And I'm really happy today to be joined by Dr. Tracy Yu-Ping Wang, who's a professor of medicine in cardiology at the Duke University. Dr. Wang currently chairs the Counsel Operations Committee at the American Heart Association and previously served as the chair of the American Heart Association's Quality of Care Outcomes Research Council from 2017 to 2019. Hi, Dr. Wang, thank you for joining us today. And I'm really eager to talk to you about your experience and your perspective on managing lipids from a system's perspective and the best practices that you've learned along the way.

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Dr. Wang: Thank you so much, Dr. Harf, for having me on, and thank you to the American Heart Association for inviting me to this conversation.

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Dr. Haft: So, Dr. Wang, given your really dual experience in both inpatient and outpatient services, what's the biggest barrier that you find in managing lipids as people transition from the inpatient setting to the outpatient setting, and how do you manage around that?

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Dr. Wang: Well, I think there is definitely reasons to celebrate these days because from the inpatient side, I think we've really successfully closed the gap in terms of optimizing lipid management, particularly for patients who have been hospitalized with acute myocardial infarction. I think we're seeing that, you know, rates of in-hospital lipid measurements are pretty high and at discharge, the use of statin therapy, as well as other lipid-lowering therapy to try to optimally manage these patients has been pretty high. And a lot of this has been attributed to various quality improvement initiatives and performance measures that have really incentivized both patients, as well as health care providers in getting that conversation done in the in-hospital setting while patients are a captive audience and making sure that these, from a checklist standpoint, that the lipid management checkpoint has been checked.

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Dr. Wang: So this is, I think, cause for celebration. But I think we're still seeing some gaps as patients transition to the outpatient setting. And I think a lot of this, I don't know what your opinion of this is Dr. Haft, but I think a lot of this may be related to sort of still some fracturing in how we transition patients from the hospital setting to the clinic. What's your thought on that?

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Dr. Haft: Yeah, I think you're certainly right. And, you know it's, it was a challenge, and you've met that challenge in terms of being able to put into play in the inpatient setting those quality improvement processes that assure that people are paying attention to lipid management for patients with ASCVD. But in the hospital, it is in some ways, facilitated because you do have the opportunity to have the patient, as you said, as a captive audience. You have their labs right there in front of you. You have nurses that will deliver the medications that you prescribed on a regular basis, and you do have the opportunity to chat with the patient on a regular basis.

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Dr. Haft: But you're right, as soon as you transition out of that very enclosed environment, it becomes much more challenging. So how do you start with engaging families in the hospital? And then once they begin that transition process, how do you make sure that you're going to be able to connect with the community providers or bring them back to your providers and your campus? What does that all look like?

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Dr. Wang: Well, I think you're right. The opportunity is there to engage with patients, as well as their caregivers, their family members, their friends, and really try to educate so that when they transition from a very controlled setting, which is, you know, a hospital ward to their home, they're able to maintain some forward momentum. But I think it's also, you know, it's a little bit more complicated as patients transition to the outpatient space, right? Because now we're not just talking about single prescription of therapy.

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Dr. Wang: We're talking about continuing the drug on a longitudinal basis. And it's not a nurse that's handing a medication to the patient. This requires the patient or their designated caregiver to go to the pharmacy, pick up the prescription every 30 days, every 90 days. And reminding themselves that they need to take this medication every single day. And then, if there is a complication of some sort or a question of some sort, again, there's no nurse around the corner who can come in, and you can ask that question.

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Dr. Wang: They would somehow need to be able to find resources to be able to address their questions. And sometimes those resources aren't immediately available, or they may be reading something online that guides them in a direction that perhaps is not the direction that a clinician might guide them into. So, I think it's fraught with a lot of reasons for why sometimes there is just this downtick in the quality of lipid management as patients transition from the inpatient to outpatient setting.

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Dr. Wang: And I think this is probably something you see from a public health perspective when you're looking at lipid management across an entire population. Do you see any differences across different states or in different sort of healthcare settings where some are doing better than others?

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Dr. Haft: There's an easy answer for that. And the easy answer is that, yes, every state is different and they're all different in their own ways. A lot of that is driven by a lot of underlying social dynamics, those things we call the social determinants of health, but also by sometimes by the level of engagement that a state has in terms of providing insurance coverage for their patients. Some states have broader coverage. Some have expanded Medicaid. Some have not. Some have used more engagement with Medicare Advantage plans than others.

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Dr. Haft: You know, all of those really describe different sort of outcomes in terms of this ability of patients to continue the good work that's done in the hospitals in terms of the quality assurance of making sure that everyone is taking their optimal therapy when they leave the hospital. So along those lines, I'd have to say on my side that every state is different. And I couldn't give you a simple answer about why they're all different other than all of those factors. But looking at it from your hospital perspective, how do you make that warm handoff to the community providers in one setting when it's your own Duke providers that you know are part of the family, and you have good connections in terms of electronic health record sharing and in confidence in the work that they're doing.

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Dr. Haft: On the other hand, those that you don't know about, who are the community providers who are not digitally connected to you, and you're not sure how they're managing their processes. What does that look like from your perspective?

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Dr. Wang: Yeah, well, at my institution, which is Duke University, we definitely see a wide mix in patients here. And I would say communication is really the key because about a third of our patients, probably more than that, are patients that do come into the hospital for their cardiovascular procedure but will leave the hospital and get followed up by their primary care physician and by their cardiologist outside of the Duke Health System.

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Dr. Wang: And so this is really been a challenge that we have taken on over the last decade to really facilitate that communication. And having an electronic health record is helpful because it's really facilitated a lot of that communication. We're now starting to see EMRs connect to each other a lot more. But in a way, sometimes these electronic health records can be a deterrent because you often hear from clinicians and especially primary care providers that they're inundated with messages coming through the EMR.

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Dr. Wang: And it's a little hard sometimes to prioritize things because there's just this information overload here. But, when I'm a clinician that's rounding in the hospital and I'm discharging a patient, especially to a system outside of Duke, I think there is definitely some very clear things we try to do to try to facilitate that communication. One is, you know, having more contact with the patient and with the patient caregiver to make sure that they're understanding what's going on and more importantly, that they feel that there is someone to talk to when they leave. And they're not caught between systems and not knowing who's primarily responsible for answering questions about their health.

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Dr. Wang: So, this is where we have really good in-depth conversations at the bedside. We bring in that family member. We do extensively explore some of the social determinants of health that you mentioned in terms of affordability of medications, where their pharmacy is so that we can get their medications to the pharmacy in a timely matter so that when they're leaving the hospital, it's right then, right there. And they don't have to worry about any complications and making sure that they've got a follow-up phone number to call if they need anything.

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Dr. Wang: And for many of these patients, we often follow up three days after discharge with a phone call from one of our quality improvement nurses that just really checks in with the patient to make sure that they've settled home okay. And, if they have any questions about their medications that they have an opportunity to be able to address some of those questions even before they've had a chance to touch base with their regular physicians. So that's certainly one of the things we do.

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Dr. Wang: The other thing that we do that's much more on a communication standpoint is, this is where I pay closer attention to my discharge summary. Obviously, these are summaries that are also cc'd to the patients, to the receiving provider, so that they're in the loop here. But here is where I tend to be a little bit more explicit about what I would suggest in the post hospitalization course. So for example, if someone is newly prescribed statin therapy, I'm actually pretty concrete in the discharge summary to say this is a new medication for the patient, and I think this patient might benefit from repeat lipid testing within a certain timeframe, including perhaps liver function testing to ensure that the drug is being safely applied in this particular situation.

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Dr. Wang: And spell out what I think are lipid goals for that patient, as well as other secondary prevention goals for that patient in the follow-up visit. And again, this is something that I do with the provider in that communication, but I also communicate to the patient so that the patient can expect that that is probably the response that he or she is going to get if they ask the same questions of their outpatient provider. So, we've got hopefully not so much confusion on the patient's side and an alignment, and we're building that alignment between the inpatient and outpatient setting.

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Dr. Haft: You know, that's great. It sounds like you're doing an awful lot of things to make sure that there's good continuity and compliance with the medications. Is there any auditing that you do on that? Or have you done any studies to see what, after making those major contributions to assure compliance, if and how effective they really are?

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Dr. Wang: Yeah, we actually have. So, one of the studies we did here before was actually giving patients a report card of outlining some of those things. And it's one of those report cards that basically has a green light, red light, and yellow lights: red light are things you really need to pay attention to, green light is you're in a good state and just something to monitor over time. And we would send patients home with that, and we'd follow their medical record over time in a passive way to see, you know, how they've been treated.

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Dr. Wang: Obviously, these are patients who are within the electronic health record and were able to see that a little bit more clearly. It's a little harder to do this when patients transition out of the system. But I think one of the things we were able to see is that there is pretty good communication, and therefore, great persistence in evidence-based medication use after hospitalization. So that's a very positive sign. We designed the report card in a way for the patients to actually be able to use that report card.

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Dr. Wang: And we found interestingly that when patients go home, the report card gets tossed on the kitchen table and then buried. So even though it's something that we had hoped would be helpful to patients to help them give them some tools to come to their next clinic appointment and to sort of follow along longitudinally, that this kind of tool was perhaps not the most effective one to help facilitate care. So, we've stopped doing that.

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Dr. Wang: But then, in other studies where we've surveyed our physicians, and actually, I shouldn't say physicians, I would say all clinicians, including our advanced practice providers who are sharing the load in taking care of these ASCVD patients as they leave the hospital. In our health system, sometimes it's a little harder to get a follow-up appointment with a physician within a week or two weeks after hospitalization. So a lot of these patients are seeing nurse practitioners or physician assistants, and we look at that transition from the hospital to the post-hospital setting as they're seeing physicians, as they're seeing nurse practitioners, physician assistants, and cardiologists that are connected with the Duke health system, but not directly within the Duke health system.

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Dr. Wang: We do see very nice transitions of care with a sustained use of these evidence-based therapies for these patients. So I do think that these measures that we're implementing here is helping in maintaining these patients with optimally managed risk factors here. So all of that is quite reassuring.

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Dr. Haft: You know, that is very reassuring and not surprising that printed materials that you give to patients on discharge, you send to them, wind up in a stack of other things on their kitchen table gets ignored. I think that's, that's what we've grown to understand overall. But it sounds like you're doing everything that you can do to assure that continuity of care. Do you have access to external data, laboratory data from the large labs that you can follow up, even in the absence of being able to be directly connected to those patients to see what the overall outcomes might be from the lipid management?

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Dr. Wang: Yeah, I think that is still a work in progress here. We don't always have access to that. Nationally, when we look at these registries that are connected to these large laboratory networks, what we're seeing is that there is definitely room for improvement there because even something like follow up

lipid testing is being done fairly infrequently and inconsistently. So, for patients who either started a statin in the hospital or had their statin dose adjusted in the hospital or started another lipid-lowering drug in the hospital, these are patients where you might expect should have something within the next 90 days, hopefully, that tells the clinician what kind of progress the patient has made and whether or not there's still more room for improvement. But what we're seeing is probably only half of these patients are getting that follow-up testing when we look at sort of nationally connected data here. So this is still a gap that needs to be better addressed. And there are a number of studies that I think that are in place to think about how do we improve this? Something as simple as follow up lipid testing that hopefully, even leads to better lipid control that could be effective for this population.

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Dr. Haft: Yeah. Thank you very much for that comment because I think we all recognize that what we feel is, and what we know is ideal, is not what we see in reality on a broad basis across the country. There are places where it's better than others, but our goal is to have the entire nation be able to be as healthy as possible. And we can't get there unless we're getting closer to meeting all of our guideline objectives. But I think that this is a good segue to ask a really important question. And I know that you are really an incredible investigator, and you've been published many, many important papers.

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Dr. Haft: And is there something right now that you're involved in, any particular study or trial, that you want to share with the listeners that you think is really, really exciting? Something that either is in the works or something that has been recently completed. I know there probably are a lot of things in those categories, but let's light one that we can leave people with as a, as a going away message.

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Dr. Wang: Well, I think there really is a lot of great studies out there, particularly on lipid management. We're in a very exciting time period where we are faced with an abundance of options for optimal lipid control. So many of these therapies have proven to lower lipids, and we're in the phase of trying to figure out if these therapies are able to, in fact, improve patient outcomes. We're also, you know, thinking about ways where we can improve patient adherence to medication therapies.

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Dr. Wang: So there are a number of therapies out there that are easier to administer and also might be administered on a less frequent basis. There are also therapies that have new lipid targets here, so things that could really help overall and improve the lipid profile as well as reduce cardiovascular risk. So lots of stuff going on there. But, you know, even taking a step backwards and saying let's not worry about the new fancy kid on the block.

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Dr. Wang: Let's think about: How do we more optimally utilize what we already have? One of the trials, for example, Duke is doing currently is one looking at statin therapy in the very old patient. This is an area that is fraught with a lot of questions and concerns. You know, for those old patients, what's the bang for their buck? And using statin therapy, especially when it may be associated with some side effects, such as muscle cramps and other things. So that's the PREVENTABLE trial, and this is a trial that's been going on for more than a year now. It's actively recruiting. It's actually a pretty hard trial to do because it is involving patients who are older and have to meet study, but also comply with study activities. So it's a little bit of a challenging trial to recruit in, but I think it's answering a really, really important question. And then finally, I'm part of a team that's also trying to think about what are some of the myths about statin therapy.

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Dr. Wang: So, for example, I have a patient that I saw in clinic today who really does not want anything pharmaceutical. So there, you know, her lipids are in fact elevated, but she would rather take something off the counter that's not coming from a pharmacy, something like turmeric, for example, and fish oil to help her with her lipid lowering because there's this perception that this is something that would be a whole lot safer than statin therapy.

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Dr. Wang: And so we've got a study being run out of Cleveland Clinic that is looking at many of these over-the-counter supplements that people are using, quote-unquote, to lower their cardiovascular risk in lieu of statin therapy. And what we're trying to do here with that study is really show in a rigorous way what kind of lipid lowering these over-the-counter therapies are providing, in contrast to a very low dose statin medication, and so that we can really provide objective data.

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Dr. Wang: There's also going to be a very detailed quantification of reported side effects associated with that therapy. And it's also important to know that taking things, for example, like turmeric or over-the-counter fish oil may also have their own side effect profile that we just don't talk about because it's not as FDA regulated as statin therapy could be. And so there's not as much of that transparency about these side effects. So, lots of very exciting studies.

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Dr. Wang: I know you asked for one, and I gave you several, but there's just so much out there. So I think we're living in very exciting times, and I really believe that these therapies will contribute to better management of lipids in the ASCVD patient and especially better outcomes for these patients over the long run.

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Dr. Haft: Well, Dr. Wang, I am not surprised that you had more than one study to report on. So thank you. Thank you for that. And thank you so much for just giving us the opportunity today to discuss this topic of lipid management. It's been really a pleasure chatting with you and thank you for sharing your experiences, your expertise, and your great depth on lipid management. And mostly, thank you for everything that you've done for many, many years in advancing this particular issue.

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Dr. Wang: Well, thank you, Dr. Haft. I really enjoyed this conversation.

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Dr. Haft: I did also. And thank you all for joining us. And remember to share this broadly with your colleagues. To learn more about the American Heart Association and its quality improvement efforts, you can also visit www.heart.org\changecholesterol and by visiting this website and joining *Check Change Control Cholesterol Initiative* you'll be able to gain even more informative resources and timely updates about cholesterol like the easy-to-follow treatment algorithms we spoke about today on this webcast.

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Dr. Haft: And you can also receive special recognition for your efforts in supporting evidence-based care. Thank you all and see you next time.

00:25:20:09 - 00:25:46:29
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