American Heart Association
life is why™

CHOLESTEROL SUMMIT

TUESDAY, APRIL 11, 2017 · 8:00 am – 3:00 pm CST
GRAND HYATT D/FW AIRPORT [LOCATED AT TERMINAL D]

Summit Notes

Background:
SUMMIT OBJECTIVES

Help Americans achieve better Cholesterol Management by supporting the AHA/ASA 2020 Impact Goal to improve
the cardiovascular health of all AMERICANS by 20% by 2020.

The goal of the Cholesterol Summit is to develop tangible, actionable solutions for cholesterol management, aligning to AHA/ASA's 2020 Impact Goal to improve the cardiovascular health of all Americans by 20% by 2020. During the Summit, the participants will:

- Discuss gaps and barriers for healthcare providers in providing high-quality cholesterol management
- Identify innovative and actionable strategies to improve prevention, diagnosis, treatment and coordination of care
- Understand the role of the healthcare system in supporting guidelines based management
- Address the patient's role in self-management and how to offer support to address real-world barriers
- Help to determine how the AHA should prioritize activities/approaches to cholesterol management to ensure the patients we serve are receiving optimal care

As an outcome of the meeting, we will develop an action plan for the American Heart Association and other organizations to advance as we move forward.

WHY A CHOLESTEROL SUMMIT?

HIGH CHOLESTEROL is a major risk factor for cardiovascular disease and stroke, the No. 1 and No. 5 killers in the U.S. With support from Sanofi and Regeneron, the American Heart Association/American Stroke Association is launching a comprehensive cholesterol Initiative focused on improving cholesterol control. The **Cholesterol Summit** provides an opportunity to gather both healthcare professionals, organizations and patients in one room to discuss gaps and potential solutions in cholesterol management — from diagnosis to treatment to adherence.

ABOUT THE CHOLESTEROL INITIATIVE

The Cholesterol Initiative aims to improve awareness, detection, and management of high cholesterol by educating and empowering consumers, healthcare professionals, and patients with evidence-based information and tools, while also improving quality of care for patients via the AHA's quality improvement programs.

SCHEDULE

Tuesday, April 11

7:15 am — ***Networking Breakfast***

8:00 am — ***Welcome & AHA's 2020 Impact Goal –*** Meighan Girgus, AHA Chief Marketing & Program Officer

- *To improve the cardiovascular health of ALL Americans by 20%, while reducing deaths from CVD and stroke by 20%*
- *Increase adoption and utilization of treatment guidelines through quality improvement programs and professional education.*
- *Increase understanding of and adherence to evidence-based treatment guidelines through public and patient awareness and education.*
- *Summit is an opportunity to hone and refine the AHA's existing cholesterol plan. Discussion from the summit will help to inform the strategic roadmap for the Check. Change. Control. Cholesterol™ initiative.*
- *20+ organizations at the Summit. Key to success is leveraging our partnerships.*

8:10 am — ***Summit Overview & 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

- *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.*
- *62.6 M adults fit into 1 of the 4 statin-eligible groups (17 M with ASCVD, 5.5 M LDL 190mg/dL, 14M Diabetes Mellitus, 26M with 10 yr risk >7.5%)*
- *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.*
- *Goals of the Summit are to identify barriers and solutions, refine AHA's cholesterol plan and prioritize short-term and long-term solutions.*
- *Pre-Summit survey shows disconnect between patient and provider*

perceptions on cholesterol management. Providers believe gaps in cholesterol management are due to medications, treatment, and lack of coordination of care. Patients see medication side effects, don't understand their risk, fear, anxiety, and not knowing where to go for accurate information as biggest gaps. Providers think cost and side effects are why patients don't take medications. Patients would rather focus on diet, exercise and lifestyle and don't necessarily want to be on medications for life. Patients are also very focused on their numbers and targets.

8:30 am

Million Hearts' 2022 Plan **–** Janet Wright, MD, FACC, Executive Director, Million Hearts

- *Current state- CVD death is decreasing, however we are starting to see a plateau. 37% of U.S. adults (78 million) are eligible for cholesterol treatment, but only 55% of these adults are on medication.*
- *Familial Hypercholesterolemia is an important focus of the program.*
- *Lessons learned from MH 1.0:*
  1) *Partner up*
  2) *Focus on small set of high impact measures*
  3) *Be nimble because the science and measures can change*
  4) *Widely embed the high impact measures*
  5) *Drive use of evidence-based treatment protocols*
  6) *Apply "Hiding in Plain Sight" Tools for high LDLs*
  7) *Improvement is too slow*
- *MH 2022- 3 main priorities- Keeping people healthy, optimizing care, and improving outcomes for priority populations (Blacks/AA, 35-64 year olds, people who have had MI or stroke, people with mental illness and/or substance abuse)*

9:05 am

Patient Centeredness

Panel Discussion: Moderator – Stephen R. Daniels, MD, PhD

Understanding the barriers and facilitators to helping patients understand their risk of CVD and managing patient perceptions

Panelist 1 – Dennis Robbins, M.P.H., Ph.D.

- *Move from "the patient" to "the person"*
- *Make being healthy not daunting, unpleasant, or insurmountable but to make the healthy choice the easy choice*

- *Patients are not passive or subservient. Instead, they exercise freedom of choice and have personal responsibility in their own health*

Panelist 2 – Millie Henn – Mended Hearts

- *Patient experience is very variable*
- *Millie had to ask her doctor to check her cholesterol, taking charge when her doctor would not*
- *Numbers and targets are important, especially when trying to communicate risk to family members*
- *Patients are more and more informed. Go to websites, doctor's office, trusted peers/colleagues/family members for information*

Panelist 3 – Anne Goldberg, MD, FACP

- *Key components to the conversation about high cholesterol and ASCVD risk include:*
  - *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?*
    - *How data relate to his/her situation?*
    - *Safety concerns about medications?*
  - *What can we negotiate with regard to lifestyle changes and possible medication therapy?*
- *Families are important part of the conversation, especially for FH patients and children. Lifestyle change has to involve and engage the entire family.*
- *Change comes from creating an alliance, which includes listening, indicating understanding, encouraging participation, and working toward agreement and collaboration*

Question and Answer

- *Cultural barriers- need to be sensitive to this*
- *Supplements are OTC, but people believe in these drugs even though there is no data for them*
- *Statins have a lot of negative connotations, many patients fear being on drugs*
- *Solutions must address the following concepts: anxiety, social determinants of health, make it matter to the patient, needs to be a joint mutually agreed upon decision with the patient and doctor in collaboration*
- *Peer to peer support is very important*

	• *Patients need concise information about what questions to ask their doctors, what should I discuss with my family, what do I do with that information* **Break Out Session** ***(See attached documents for proposed short/long term solution ideas)***
10:05 am	***Break***
10:15 am	***Lifestyle, Evaluation and Counseling*** **Panel Discussion: Moderator – Ann Marie Navar, MD, PhD** **Panelist 1 – Martha Daviglus, MD, PhD** • *Health disparities exist. We must understand the personal, sociocultural, neighborhood level, and how access to care (health insurance) may impact cholesterol management.* • *Many culturally tailored and culturally relevant resources exist, need to bring them together in one central place for people to access* • *An example of a successful community-based exercise intervention called BAILAMOS (increased physical activity in Hispanic population)* • *Public Health is an important partner in this process- Healthy Chicago is an example of a successful partnership* • *Move from the individual to impacting social policies and programs* **Panelist 2 – Lilian Tsi (Stroke Survivor)** • *Sales people have 15 calls before they consider that prospect as being a "no." Healthcare providers need to have that same attitude to keep trying to engage the patient in making healthy lifestyle choices* • *Things that patients need: know your own family history, meet a peer who has had a similar event (e.g. stroke), encouragement, ask me what I care about and frame your instructions in a way that matters to me as the patient, follow-up calls and reminders* **Panelist 3 – Janet De Jesus, MS, RD – National Institute of Health** • *DASH and DELTA diets have shown improvements in LDL* • *Mediterranean diet is also very promising in reducing CVD risk by 30%* • *EARLY trials show that remote and in-person coaching can have an impact on weight change* • *Diet management innovations- mobile apps, meal delivery,*

	online/virtual support • *Implementation research is needed to increase adoption of dietary guidelines* • *Focus area to consider- pediatric populations and school-based initiatives* **Panelist 4 – Barbara Fletcher, RN, FAHA – Preventive Cardiovascular Nursing Association** • *Gap in literacy- most people read at a 6th grade level, medical resources for patients are written at 7th-9th grade level* • *Dyslexia- estimate about 40% of people* • *Keys to successful resources: 13-16 word font, examples, interactive areas, sentences under 15 words, repetition* • *Ways to motivate: goal setting, problem solving, short educational messages (1-3 min), teach back method, motivational interviewing, coaching* • *Ways to maintain motivation: self-monitoring tools, skills for long-term behavior change* • *Key points- Keep it simple, ask the patient how they learn best, motivate at the teachable moment* **Question and Answer** **Break Out Session** ***(See attached documents for proposed short/long term solution ideas)***
11:20 am	***The Counter Cholesterol Initiative***: *John Clymer, CEO and Debbie Martinez, Program Manager, at The National Forum for Heart Disease and Stroke Prevention* • *Make it a dialogue and think about others (one size fits approach may not be best)* • *People need: trusted, credible facts, to make a connection between high cholesterol and bad health outcomes* • *Key pieces of the program: focus groups with community members to ask what was needed, community partnerships to develop resources and to deliver them to key audiences* • *Parts of the Counter Cholesterol Program: champion videos, traditional/social media, template emails, newsletters, web announcements, partner collateral distribution, community events, and community health worker trainings*
11:45 am	***Networking Lunch***
12:20 pm	***Treatment & Adherence Barriers***

Panel Discussion: Moderator – Mary Ann Bauman, MD

Panelist 1 – Vera Bittner, MD, MSPH

- *High-intensity statins use is increasing post-MI*
- *ACC/AHA Guideline-directed care is increasing but still suboptimal*
- *Statin adherence at 5 years is low (approx. 40% overall)*
- *Poor adherence and statin intolerance in high-risk patients associated with increased risk of CVD events*

Panelist 2 – Steven Dunn, PharmD

- *Adherence strategy examples: educational tools, involvement of the patient in decision-making, regular frequent follow-up, simplifying taking medications, reminder systems*
- *Research shows that reminder systems, multidisciplinary educational activities and pharmacist interventions work*
- *Role of the community pharmacist- determine how to let physicians know if patients are taking meds, automate refills, reminder calls/texts*
- *Role of pharmacists in the clinic- improve adherence by talking to patients and medication management*
- *Role of hospital pharmacists- begin discussion about meds, allay fears/concerns about medications*
- *Improving adherence, strategies to consider- bidirectional flow of info from pharmacy records, toolkits for pharmacists to use with patient-specific populations, more research on novel intervention ideas, technology to improve adherence*

Panelist 3 – Ann Marie Navar, MD, PhD

- *PALM study: Statin under-dosing is more common than underprescribing; most patients who have never been on a statin have never tried a statin, 74% of providers know the ACC/AHA Cholesterol guideline, but only 17% always and 32% often calculate ASCVD risk*
- *PCSK9 data: Prior authorization is a big barrier to patients taking these meds, often left at the pharmacy secondary to long co-pays, can be 30+ days until the drug is approved, payor not patient determines access to these meds*

Question and Answer ***10 minutes***

Break Out Session ***(See attached documents for proposed short/long term solution ideas)***

1:20 pm	***Break***
1:40 pm	***Taking Action – Electronic Voting*** **Eduardo Sanchez, MD, MHP, FAAFP and Mary Ann Bauman, MD** -
2:15 pm	***Voting Results, Next Steps & Recap*** **Eduardo Sanchez, MD, MHP, FAAFP and Mary Ann Bauman, MD** -
3:00 pm	***Adjourn***

Patient Centeredness

A. Translate risks so people understand (#1 Short-Term (ST) strategy)

B. Improve patient/provider dialogue – cultural competency team approach (#2 ST strategy)

C. Peer-to-peer Support moderated by health professionals and other influencers (#2 ST strategy & #3 Long-Term (LT) strategy)

D. Social media tools to create awareness (#3 ST strategy)

E. Start early and young with education (#1 LT strategy)

F. Team approach with healthcare providers (#2 LT strategy)

G. Simple FAQs to provide information and empower people

H. Meet and engage patients where they are; e.g. outside the doctor's office

I. AHA developed patient education materials

J. Involve the entire family in lifestyle/educational counseling

Lifestyle, Evaluation and Counseling

A. Engage patients via social media, health portals, quick tips (#1 ST strategy)

B. Make messages more consistent and dynamic, multi-channel distribution (#2 ST strategy)

C. Providers to give lifestyle prescriptions (#3 ST strategy)

D. Lifestyle Rx eligible for reimbursement, incentives, rebates (#1 LT strategy)

E. Social advocacy/policy change; e.g. city councils, school boards (#2 LT strategy)

F. Integrate health education in the schools; after school programs and PE (#3 LT strategy)

G. Frame the message to individuals value/vanity

H. Develop support network

I. Employer incentives

J. Use a multi-generational and multi-cultural approach

Treatment & Adherence

A. Discharge with medication/easy to follow and mutually agreed upon treatment plan (#1 ST strategy)

B. Leverage technology to lower barriers (#2 ST strategy)

C. Education on risks and side-effects (#3 ST strategy)

D. Improve communication between the pharmacist and the physicians – automate (#1 LT strategy)

E. Targeted data/science for special populations; real world studies (#2 LT strategy)

F. Integrate community health workers into the process (#3 LT strategy)

G. Consider the supplement industry as a model

H. Predict misinformation; provide fact checker to combat myths online

I. Amazon-like services for delivery of medications

J. Improved access to social services