0:04
Sure.
0:06
Hello, everyone. And on behalf of the American Heart Association, I'd like to welcome you to today's webinar, our national introduction, to Target Aortic stenosis.
0:16
My name is Gary Myers, and I am the Senior Program Manager with the American Heart Association's Target, Aortic Stenosis Initiative.
0:27
A few items today before we begin, to let you know how to participate in today's event.
0:33
If you'd like a copy of today's presentation, you can download a PDF version of it in the handouts section on your attendee control panel.
0:41
If you have experienced technical difficulties, most user issues can be resolved by refreshing your browser, but if that doesn't work, please contact the go to goto Webinar Customer Service team found in your confirmation or reminder e-mail that you already see.
0:57
At the conclusion of today's presentation, you'll receive a link to access today's recordings, as well as an invitation to complete our feedback survey.
1:06
Welcome you to submit text questions for your presenters at anytime in the chat panel of the control Panel.
1:13
We will collect your questions and address them during the Q&A session at the end of today's presentation, or in the chat box, during as we are able.
1:24
So let me, please introduce the two speakers for today.
1:28
Yeah, doctor ... is the Chief of Cardiology at north-western University, Feinberg School of Medicine and an Associate Director of Bloom Cardiovascular Institute, at north-western Memorial Hospital, ..., endowed professor of medical chair and professor of medical social sciences. It currently serves as Vice Dean of Diversity and Inclusion, north-western University.
1:49
Feinberg, School of Medicine, is an honors graduate of Southern University of Baton Rouge Alpha Phi Omega honors graduate of Tulane University of Medicine, and Beta Sigma Honors graduate of the University of Texas at Dallas

School of Business and Management. As research interests are in heart failure, clinical guidelines, generation, outcome sciences and health care disparities.
2:10
He has extensively publishable over 500 peer reviewed publications and has been named among the top 1% of sighted scientific authors.
2:17
His Deputy Editor of JAMA, Cardiology, Seniors, Section Editor, Heart Failure, Journal of American College of Cardiology, serves on the editorial boards for circulation, circulation, heart failure, and the American Heart Journal, and the Journal of American College of Cardiology Heart Failure.
2:33
He has served the NIH, and I, excuse me, NHLBI, Macquarie FDA and AHRQ in a variety of service and leadership roles.
2:44
He's a Master of the American College of Cardiology, Fellow of the American Heart Association, a Master of the American College of Physicians, and a fellow of the Heart Failure Society. And America is the Chair of the ACC slash aha Heart Failure Guideline writing committee, chair of the ICC Heart Failure Clinical Pathway writing committee, and co-chair of the Aortic Stenosis Advisory Group.
3:03
He is former President of the American Heart Association, as well as a past recipient of the HA National Physician of the Year, and the Gold Hard Award is the recipient of an overhaul best.
3:13
Doctor and that's Teacher Awards and Health has held a number of visiting professorships at leading academic medical centers.
3:20
In 20 16 he was elected to the National Academy of Medicine, one of the top, most tears of recognition for physicians. In 20 18, he was named a member of the Minority subcommittee on Health, the Department of Health and Human Services. Thank you, doctor Nancy, for joining us today.
3:35
Doctor J Matthew Brennan.
3:37
As an interventional cardiologist at Duke, University School of Medicine, specializing in the treatment of complex coronary artery disease, and the clinical management of valvular heart disease.
3:47
His research research interests include shared decision making, particularly as it relates to coronary heart disease, and the use of statistics, statistical techniques, and study design to provide non biased estimates and comparative effectiveness analysis using large randomized observational databases.

4:05
Doctor Brennan has served as the Director of the Duke Analysis Center for Trans Catheter about Therapy Therapy CVT Registry and co-director of the Analysis Center from the Society of Thoracic Surgeons STS Database.
4:18
He was the P one of R 0 1 Grant from the US. FDA for the use of Medicare Data for Comparative Effectiveness Research and ... Award for Comparison of Tavern versus Savva using STS and ... Registry data dependence. Research has most recently focused on defining the scale of, under treatment of aortic valve stenosis in the United States and bringing awareness to the issue. Thank you, doctor Brennan, for joining us today as well.
4:48
Doctor Nancy, I'll turn it over to you for opening comments.
4:53
Well thank you very much, mister Mar. It is really a delight to be with you today.
4:58
You being all the persons in attendance and sharing with you what we think is an exciting new initiative under the auspices of The American Heart Association with very generous support from Industry Partners. We really do believe that, there are some great opportunities in the treatment of books, Gnosis, and that we can use some of the tried and true methods that have been pioneered and perfected by the American Heart Association To close gaps in care.
5:24
Deliver equitable care and substantially make a difference.
5:28
in a technology that can fundamentally change the natural history of a certain condition aortic stenosis, but more importantly, can change the life and living circumstances of so many people in our country that are impacted by the heft of Yorks Gnosis.
5:44
Doctor Brennan is going to be our first discuss, and I'm delighted that I'm working with him today. He and I both have spent time in the Deep South, mere Tulane here at the University of Mississippi.
5:55
We both have spent time in Chicago. I'm still Chicago, but he was originally at the University of Chicago before heading to Duke, and, of course, a Duke. He has interact with so many of my friends and colleagues and he is highly regarded by his peers and I'm delighted that he's working with us and looking forward to this discussion.
6:12
Gaps in the journey of the Arctic stenosis patient impact and importantly, implications, Matthew.

6:19
Thank you, doctor Nancy. And thank you, mister Myers, for putting all of this together.
6:23
And thank you to all of our participants for joining us in today's discussion that's the American Heart Association for the Opportunity to present on this topic.
6:34
This is one that I've spent a lot of time at and hopefully, can help you to understand the picture on the landscape.
6:40
The way that I do, if I do my job correctly.
6:42
So today, I'll highlight gaps in the journey of the aortic stenosis patients.
6:47
And I'd like to discuss the impact and the implications of those gaps specifically to both our health care system center, to our patients in particular.
6:58
My contact information is listed below in this slide, and if anyone wants to reach out after this presentation and continue the discussion, I'm happy to talk with you further.
7:09
I enjoyed this, this topic and moving it forward. So these are my disclosures. Importantly, today's slides were created in collaboration with the team at Edwards Life Sciences and Boston Consulting Group.
7:22
And they were reviewed by the Scientific Oversight Committee.
7:27
Today, I want to accomplish three primary goals.
7:31
The first one is to present the case for change, and the care of our patients with severe aortic stenosis and then to discuss the barriers to appropriate management and the pathway of those patients. And then finally, we'll look forward to opportunities to improve care.
7:51
So let's get started with the case for change.
7:54
Just a little background to bring everybody up to speed.
7:57
Aorta valve stenosis is simply a pathologic, calcification, or hardening of the aortic valve which is the last doorway or last stop on the way out of the heart.
8:08

It is a progressive illness and in its most severe forms, it occurs in somewhere between five and 10% of our older patients.
8:18
As it progresses the left ventricle, which is the pumping chamber of the heart muscle, the left ventricle, deckhands, hypertrophy, and eventually fibrosis.
8:28
And it fails, and this failure, fibrosis and failure leads to the classic triad of symptoms, including chest pain or ..., passing out or sing.
8:40
And Breathlessness are heart failure symptoms.
8:45
And once a patient develop symptoms within two years.
8:51
one out of every two patients with severe aortic stenosis won't die if they don't undergo aortic valve replacement.
8:59
So make no mistake. This is a progressive terminal illness.
9:05
That requires treatment.
9:07
And by the time that we, as clinicians recognize the symptoms of aortic stenosis, patients are often into that two year clock.
9:16
A fair ways.
9:18
Now valves the valve aortic valve disease can be treated primarily through aortic valve replacement.
9:25
In fact, that's the only effective treatment that's ever been shown to work for a Nordic bowel disease that can be achieved either through an open chest procedure.
9:35
Or through a variety of minimally invasive placement procedures, including trans catheter aortic valve replacement.
9:43
Nordic valve replacement substantially attenuates the effect of this disease process.
9:48
In fact, it places patients back on essentially an age adjusted survival curve.
9:55
The data shown here from the partner one trial. These data have been replicated in multiple settings, including real-world settings.

10:02
They show the impact of a trans catheter valve replacement, as compared to what, well, we would have called watchful waiting, or still would call watchful waiting, which is really not effective.
10:13
This impact has been shown across nearly every patient cohort that's been evaluated, and particularly in our older patient cohorts.
10:25
But the benefit of valve replacement is not just for survival, the benefit of valve replacement is also, For physical functioning and for social interactions.
10:35
And, importantly, these benefits translate to more time out of the hospital, reducing the cost of care and also improving the quality of life for these patients and their families.
10:48
However, despite a poor prognosis of severe aortic stenosis, and the proven benefits of them, even a minimally invasive procedure, Less than one in two patients.
11:00
Muslim one of every two patients with known severe aortic valve disease receives treatment within a year after symptom development.
11:09
This is the problem.
11:12
So, while under treatment is observed across all patient groups, women and black patients are the hardest hit. And although aortic stenosis would be expected to affect all patients equally.
11:25
A woman is 36%, less likely to be diagnosed with aortic stenosis, and 20% less likely to be treated than a man.
11:37
Likewise, black patients are 65% less likely to be diagnosed than white patients, and 23% less likely to be treated than white patients.
11:48
Now, interestingly, racial disparities in treatment have begun system have begun to narrow over the past decade with more widespread availability, minimally invasive tran's, catheter therapies, but they still have not come back To get to equitable treatment rates.
12:07
These data really beg the question, Why? Why is it that?
12:11
we have so many missed opportunities both to save lives and relieve suffering?

12:16
and so I'll spend the next several slides, reviewing the highlights of what we know about the gaps in care.
12:22
And I'm going to argue that there is no single silver bullet, that, in most systems, there are multiple opportunities for improvement at every step in the care pathway from awareness, to detection and diagnosis, to referral and treatment.
12:38
But a true fix to this problem really can only happen through a systematic approach to the care of these patients.
12:46
So first, let's start with public awareness. As with any disease state, an informed populace will drive action.
12:55
Breast cancer awareness is a prime example of this, when patients ask healthcare systems and physicians respond.
13:06
Unfortunately, public awareness for valvular heart disease remains abysmally low, despite a decade of taboo related literature, both in the medical and the lay press.
13:17
Moving this needle is going to take a co-ordinated Public Awareness Campaign, both nationally and within each of our individual communities.
13:27
And low public awareness means that diagnosis and treatment of this disease process falls back squarely on the shoulders of the medical system, And as we know, there are holes throughout that system.
13:42
For starters, our trainees and clinicians are not widely comfortable with the use of a stethoscope.
13:49
And this is a problem here.
13:50
Data from two separate studies demonstrating poor accuracy of identification of a ..., and graduating trainees and still low accuracy among practicing clinicians.
14:04
And this is not just a problem among primary care physicians.
14:08
You could argue that this is, the skills are best given through at the GMB level.
14:17

But among our colleagues and our referral bases awareness to move forward with an echocardiogram for patients with unexplained Murmurs is important.
14:27
And perhaps, just as important as a community is reframing this disease.
14:35
Reframing this disease is a progressive terminal illness and need a routine surveillance even in its mildest forms with an average time for progression from mild to severe disease of roughly 5 to 8 years.
14:52
So, as the cardiac physical exam has been de-emphasized, we have necessarily as a community, fallen back on echocardiography for diagnosis and surveillance, but the accuracy of the echocardiogram is only as good as the skill at the technician than the reader.
15:09
And this is a challenge for health care systems. Not just small but also large systems.
15:15
These are two studies that highlight.
15:17
This issue, the first, the left-hand panel, emphasized the importance of getting multiple Doppler views for the appropriate braiding of aortic valve stenosis severity, with nearly a quarter of severe cases missed.
15:30
If the standard apical window is the only one that's used for Doppler signals the second emphasizes the importance of taking into account the full spectrum of echo criteria when deciding the origin is a severity with a wide range and sensitivity on the individual metrics.
15:49
And yet in many Eko Labs, these are not standard.
15:55
And as any clinician will tell you, the recognition of symptoms from our patients is an imperfect surrogate for weapon turkey or strain, although it is the primary driver of an indication for aortic valve replacement with patients often minimizing symptoms in their clinical encounter.
16:14
So exercise stress testing and the use of biomarkers like Probe BMP had been adopted for further risk stratification of, apparently, asymptomatic patients with severe aortic disease.
16:27
These modalities are under used with guideline recommended, almost stress testing used and less than 10%, a patient with severe aortic disease, which brings us to the final step in the care pathway.

16:42
Even among those for whom a diagnosis is made, referral and treatment rates remain suboptimal.
16:51
Recent data showed that the majority of patients with severe or symptomatic aortic stenosis who are not treated have been referred to and evaluated by a cardiologist.
17:03
Now aortic valve replacement in these patients is a class one indication with proven benefits.
17:10
And yet these patients are not making it past the point in the care pathway that should be best equipped to direct them. Why is that?
17:20
A number of studies have shed light on this question, and I'll highlight two here.
17:24
In this study of roughly 350 untreated patients with severe symptomatic aortic stenosis, the investigators found that once a patient reached the cardiologist or the valve team, the primary reason given what patients were not treated ultimately, it was a refusal of care.
17:45
Now, in a world of shared decision making, maybe you take a step back, and you say, We're done.
17:52
The problem is, a basic tenant of shared decision making involves the need for effective patient education.
18:00
And patients have to, first, understand, but the disease state, its implications, as well, as it's treat the treatment options for them to apply their value systems.
18:11
And, when we dig deeper, we find an ample reason to believe that patients, the communication is simply not effective for many of them.
18:20
With data highlighting the lack of understanding and awareness by our patients and their families.
18:28
Physician beliefs and communication styles, influenced treatment decisions and treatment discussions. We know that from our own clinical experience.
18:38
This contributes to considerable variation in the Nordic bout Treatment rates across cardiologists in the United States, such as the managing cardiologist.
18:48

The managing cardiologist is among the strongest determinants of whether a patient gets a treat.
18:57
And as you would expect, this variation affects patient outcomes with patients who are cared for a 22% increase in risk for patients who are cared for by cardiologist in the bottom quartile of treatment rates.
19:13
Randomly, you walk into a cardiologist's office, and your likelihood of death is 22% higher than had you walked in to the cardiologist's office down the hall.
19:23
There's something wrong with that.
19:25
And, as if this problem wasn't complex enough, now we throw in a global pandemic, with de facto calls for treatment rationing and deferral, which has led many in our field to ask a question about the flip side of this equation. What happens to those for whom treatments are heard?
19:46
Well, the answer is that the harm from delay is measurable.
19:50
The study on the right-hand panel are data presented from a research letter that was published in JAMA last year.
19:56
This is out of Switzerland.
19:58
The investigator's compared patients with less severe but severe aortic valve disease, and aortic valve area between zero point six and 100 centimeter square with stable symptoms, who, by policy, by national policy, their treatment was deferred, versus the outcomes with patients with more severe critical disease with unstable symptoms or expedited treatment.
20:23
Now, naturally, you would expect that the patients with more severe disease would do worse.
20:28
But what they found is that the patients who had deferral of their treatments, at a 15% increased absolute increased risk of the rate of death.
20:39
Stroke, an unplanned rehospitalization via month one month after that decision was made.
20:48
Here, again, the measurable cost of delay in treating these patients. These are data from doctor Nancy ... own hospital from north-western Hospital in Chicago.

20:57
Chris Malaise race group, published there showing that for every five weeks of treatment delay, there's an 8% reduction and the probability of survival, so once this diagnosis is made, as systems, we have to be ready to get these patients timely treatment.
21:16
Over the past several minutes, I've tried to highlight the case for change and some of the many opportunities for intervention.
21:24
In partnership with the American Heart Heart Association, we as a professional community, have an opportunity to reflect deeply within our own systems to take stock of the opportunities for change, and to implement programs to improve care for our patients with valvular heart disease.
21:44
We know that our system is broken.
21:47
But it can be fixed.
21:49
The American Heart Association efforts have led to improve treatment of heart failure, stroke, myocardial infarction, care, no doubt, shining a light is the first step and finding a path forward.
22:02
In just a few minutes, doctor Nancy will highlight the exciting first steps that the American Heart Association's Target Aortic Stenosis Initiative will take to shine the light and walk the path to improvement as we continue to work together to build better healthcare future for our patients and for our communities.
22:24
Why do we take these steps?
22:29
While the answer to that is easy, we take these steps, because our patients are worth it.
22:34
Thank you for your time.
22:38
Thank you very much, doctor Brennan. Appreciate that Fellows.
22:42
A great insight into what we know now leading into where we want to go. So again, thank you very much for joining us today. Doctor Yan see any comments there?
22:51
So thank you. There are a couple of comments that I think are very important.
22:55

I hope that everyone who has engaged with us today: recognize the preceding Graphic and understands what the aspiration is, goal level, care, understanding that by achieving gold level care, best possible performance, we can fundamentally change the lives of humans.
23:14
I think that last graphic was spectacular, the older and Cradling, the younger Hanh.
23:20
We have to have respect for this generational Legacy that exist in every family and for that legacy to be intact, to be celebrated. We really have to provide best care for all members of the family.
23:36
We saw the playful children.
23:38
Now we see the older person, and we see that hand reaching out to the next generation. We want to enable then hand a big, big part of who we are as American Heart Association is to really embrace the span.
23:53
How long can we achieve healthy lifestyles, healthy lifespans for the community?
24:01
Yes, illnesses are inevitable, but can we compress those illnesses that really is an overarching theme of who we are.
24:09
As American Heart Association we're relentlessly pursuing this ability to extend the health spent.
24:15
I think about, for a moment, think about for a moment.
24:18
But Matthew shared with us, doctor Brennan did a spectacular job of reflecting something that really is of historical importance in a very short period of time.
24:30
We took, we being the scientific community, an absolutely fatal and treatable disease, critically Orix, Gnosis and the Harvest Person and changed it into a manageable condition. With the ability to extend life. That is a big pause moment.
24:50
I must tell you, I've been an active Cardiologist's now for 31 years.
24:55
In the first third of my career, unless those patients went to the operating room, there was simply no hope. And many of those patients that went to the

operating room in the first and second third of my career. The challenges ..., were profound.
25:11
In this last third of my career, I hope there's another he's been a bit of my career left, but in this current part, we can do so much more, for so many more. And so I really applaud doctor Brennan Articulation of this journey that we've been on this journey in science, Which is another big piece of who we are as American Heart Association. We endorse science, because with science, we expose answers, and with answers, we can help people live and do better.
25:42
The other thing that doctor Brennan Rylee developed for us is a challenge. We have a challenge with the diagnosis.
25:50
We have a challenge with the recognition.
25:52
We have a challenge with the implementation and we have a unique, compelling challenge with equity by which we deploy the most successful treatments for Gnosis. So all of those things taken together, taking best advantage of the science, Understanding the just right now of ideal gold level care. The need for better implementation and accepting the challenge to do this more equitably.
26:18
Working with our partners, we've developed target aortic stenosis. I want to share with you the initiative.
26:27
Thank you, doctor ..., you should have control of the slides.
26:30
Thank you.
26:40
I have no relevant disclosures. Let me start with the initiative objectives.
26:46
How will we get to this goal level care that I'm thinking about?
26:50
How will we enable this vision of lowering cardiovascular mortality? How can we establish a new standard of care and structural heart disease?
26:58
Pretty lofty goals We'll get there the way we've done it before. And we've executed brilliantly on this many times over.
27:06
First, we will take a quality improvement approach.
27:09
This has been tried and true.

27:12
It's all predicated on a simple phenomenon, which is the Hawthorne Effect.
27:15
If we make data available to responsible teams, too, physician leaders, to nurse directors, say, These are your metrics right now, These are the standards by which we should all behave.
27:32
There is a disconnect.
27:33
What can you do with this?
27:35
It has been remarkable to recognize how the organic process where someone sees their performance recognizes the standard and makes immediate, real-time changes, sometimes even subliminal, to get their works.
27:49
Second, we understand but this is still not a widely known treatment option.
27:57
The public needs to be aware of this sometimes, when a grandparent starting to slow down, starting to become forgetful, started to have symptoms.
28:05
It may not just be old age, I frankly don't know what old age is, I think, would we have to help people appreciate?
28:12
Is it there, or biological conditions?
28:16
That are the underpinnings of these age related changes?
28:19
And we should make people aware of the, the whole portfolio of circumstances that may be responsible for this.
28:27
Then partnerships.
28:29
We've learned a long time ago that we can't go it alone.
28:34
Things more complicated today. Things are more costly today. And there are too many stakeholders in the mix to not bring everyone into the mix that's got a relevant stake in this whole issue and deploy resources accordingly.
28:49
So let's continue to explore exactly how we'll get there.
28:55
What do you see here now, or parallel statements? Important parallel statements.

29:00
one is from one of our industry partners that very much particulates, the intention to have a truly positive impact.
29:10
When people live in with structural heart disease, the other from the CEO of the American Heart Association explicitly says we have a shared vision that we're engaging in a partnership to effect change for all of the many millions of Americans that are impacted by structural heart disease. This whole initiative began about 13 months ago. We've come forward in our planning process, and I want to continue to share that with you.
29:39
So what is the initiative?
29:43
Increase awareness of the signs and symptoms.
29:46
Increase the percentage of those patients with your org's Gnosis who are correctly identified and diagnosed.
29:53
improve the clinical pathways and processes of care to enable better outcomes and increase compliance with guidelines.
30:00
So, this initiative is beginning with these four very bold agenda items.
30:07
If we execute on each of these, we will fundamentally change the health and living circumstances for those with structural heart disease.
30:15
Important part of this, an important part of the leverage that the Heart Association has used in our quality improvement programs, has been to refer too sweet SWAT of guideline statements.
30:31
These guidelines, statement's, recall, are developed by teams, committees, of persons, deeply versed and the science and the implementation and execution of the clinical trial in the application of the data.
30:46
It's these teams come together managing their relationships with the external community carefully.
30:51
There are refereed statements that reflects the agree of alignment.
30:57
What's the impact of a certain statement and reflect the degree of certainty based on the evidence that that statement is, in fact, true.
31:07

So, understand there's a dichotomy in the decision making.
31:10
one is the conviction that the team has given a certain intervention can the extent to which the intervention will be helpful.
31:20
The second is an assessment, not a conviction, an assessment of the supporting evidence that prevails.
31:27
Sometimes the supporting evidence is just plain common sense. We call it consensus or expert opinion.
31:32
But other times is deeply embedded in well executed large format, clinical trials, the best level up, and say, sometimes a recommendation is, this is a must do. This is Class one.
31:45
Nothing else matters.
31:46
This is a must do physical us, too.
31:50
That's bifurcated into two way here to be with varying degrees of certainty. And if it's close three, basically as you should not do this either because it's not beneficial, or because there's Honk quite intuitive.
32:02
Very beneficial for the community to help understand how best to deploy these strategies.
32:07
Look at these statements for severe aortic stenosis for asymptomatic patients with severe aortic stenosis in impaired.
32:16
Currier performs For severe reduce Gnosis when undergoing other cardiac surgery for asymptomatic severe aortic stenosis and low surgical risk for symptoms of, it would extend OSA severe in a peculiar format known as low flow low gradient, typically, women with smaller ventricles and even for moderate yorkston aosis undergoing other critic surgery.
32:40
This really is a moment, not for pause, but for applause.
32:44
All of these statements were driven by relevant, well conducted, randomized controlled trials. This is not a sophisticated guessing exercise.
32:55
This is based on data, data which, or adjudicated issue, see, parenthetically.
33:01

The data that nonetheless, directors on where we should go and how we should best treat patients that have structural heart disease. This really does enable our ability to establish a quality improvement program.
33:15
Look at the participating pilot sites.
33:18
I can tell you, I have personally, then each of these sites, with 4 or 5 exceptions.
33:27
And I can confidently tell you that there are leaders in each of these sites that are as committed to changing the natural history of structural heart disease, as I am. And as doctor Brennan is, we believe that this kinda quality initiative is a huge step in that direction.
33:46
So how does this all come about? It almost seems as if I'm talking about sprinkling some magic dust in the equation, I'm not.
33:53
It's a very calculated, very deliberate process distorts by developing measures. What are we going to measure? What will the data be?
34:02
How will we make that Hawthorne effect happens.
34:05
What data what we've put in front of teams and leaders is say, This is your performance. This is where it should be. This is the benchmark. This is where you are.
34:15
Once we've developed those measures, then we deploy those measures as statements, to documents, as online resources. But it doesn't stop there. What we've learned, over 15 years of quality improvement, the word association, and I've been present for all 15 of those years, is that it takes renewed, training, recalibrated, awareness. Stakeholder training becomes incredibly important.
34:41
The champions needed to be reacquainted with the science, and then the sites themselves, the team members, the administrative group, they all need to participate in a training exercise, that then allows us to deploy the measures in the pilot sites, 15 sites, make the measurements, and is the aero suddenly dictates.
35:05
We then return back to the beginning. And we'd look at the measures. We have to decide if those measures have been helpful.
35:16
I want you to pay attention to the arc that doctor Brennan introduce earlier.
35:21

Want you to recognize the continuous floor dot org, awareness, detection, diagnosis, referral, treatment, Good monitoring.
35:32
It isn't just a pathway. It is an art towards excellence.
35:36
Because it allows us to target each component of the arc, identify how best to raise community awareness, how best, to exercise the right diagnosis, the detection, the examination, the ecko.
35:52
How best to overcome barriers in workflow that prevent us from making these diagnoses.
35:57
Think about that.
35:59
Now listen to group of physicians. It's reluctance or refer, we have to understand what's embedded in that group.
36:06
And then how do we make the referral an easier process?
36:10
And how do we understand which patient requires which therapy with what level of conviction supported by what evidence that's deploying the guidelines? And then, it is continuously monitoring outcomes. And, unlike where we've been before, we have your heart outcomes. We've always heard that is deaf and hospitalization.
36:30
But now, we have very sophisticated tools to understand quality of life.
36:35
Specifically, the Kansas City questionnaire Kacey CQ.
36:39
So, this gives us a tool we've never had before.
36:42
Because, honestly, at a certain age, patients, the most important in this. Am I going to feel better. Sub has been a difficult thing to answer.
36:51
It's been a subjective response. Well, do you feel better?
36:53
Well, now, we have a validated tool, particularly in structural heart disease studies, this is as you change your performance on the ... kirshner, guess what, you are feeling better.
37:04
And so, that gives us a target for this intervention.
37:10

So, how will this all take place?
37:13
So, we will develop these measures, and embed these measures in the patient care pathway.
37:21
Look at the measures. Look that have already been considered for diagnosis.
37:25
Was the percent of moderate snow suspicious getting a follow up becker, was the percent of ... that hit a critical threshold for diagnosis.
37:36
What is the percent of patients with this unusual representation?
37:38
I call it a phenotype where it's a small, vertical low flow low gradient, but still severe errors.
37:45
What is it that we can do to better assess the number of asymptomatic patients with severe aortic stenosis?
37:53
And are we able to document then, in those asymptomatic patients with severe works and aosis, as doctor Brennan introduced you, are they going forward with stressors? What about the referral? Here's another candidate measure.
38:07
Can we identify the percent of patients diagnosed with severe stenosis, who actually going forward with a multi-disciplinary heartfelt team assessment within 14 days of the initial diagnosis? You saw the penalty of waiting. You saw that penalty. So, this is a very important.
38:26
What about treatment?
38:27
This is the guts of it.
38:29
Those patients who have a diagnosis, severe aortic stenosis.
38:34
How many of them within 30 days have a definitive direction in the surgical aortic valve replacement, trans catheter, ... replacement, or palliative care if that in fact is appropriate.
38:46
And then, what's the ongoing monitoring? Well, we have three measures.
38:50
We can look at the percent of patients who actually complete the quality of life questionnaire.
38:56

We can look at the percent of patients completed at baseline and within 90 days after valve replacement.
39:04
Then we can look at the percent of patients who had the critical tinplate, delta change in the quality of life questionnaire consistent with deriving a benefit.
39:15
And this would be measured at 30 days after turbid. So we've got, I think, a suite of measures that when deployed were really help us change the workflow, This is part of this patient care pathway.
39:28
Here is how measures are developed.
39:30
There is a broad environmental scan, typically in the literature, looking at the relevant guidelines and the other published literature. And then we go through a process that ultimately gets us to number four.
39:42
This is where everything becomes critical.
39:46
We have to define the denominator, those patients at risk.
39:50
Then we have to define the numerator. What are we measuring?
39:53
This really allows us to have valid measures that we can deploy broadly.
39:58
Once we've gone through that process, you see this acronym Sag, S A G, that's the team, the Advisory Group, that is overseeing how this all comes together.
40:12
That team plays an incredibly important role because once it's approved by a team of individuals, professionals, with content expertise, then we get into the development of the registry.
40:26
Then we get into implementation, and then we go beyond the pilot project, Then started to refine the measure's, understand best practices in deployment.
40:39
These are the members of the scientific advisory Group. I'm speaking to the present, one of my closest friends or colleagues, ..., who is the Acting Chief at UCLA, is a key member, Suzanne Arnold's champion. Doctor ...
40:55
has been trained at the University of Missouri, Kansas City, by the team that has developed the K C CQ Questionnaire.
41:03

Her research has been pivotal and helping us understand how best to deploy this questionnaire.
41:09
Joan Spertus has been her mentor and she has executed brilliantly.
41:14
Wilson said, so, is the chief of cardiovascular surgery at pin, Pin Presbyterian Medical Center and has been invaluable in helping us understand from the surgeons, Lance how best to do this.
41:27
Kathryn Otto is one of the most brilliant imaging cardiologist in the country. She's at the University of Washington. She's a past president of the imaging societies in their country, contributes substantially to the imaging guidelines. Doctor ...
41:43
really has a very strong voice, how best to diagnosis condition, then doctor Peanut Shaw.
41:51
Who was at Harvard.
41:52
It's really that guy in a cath lab that understands exactly what's involved in doing these trans catheter procedures.
42:00
You then look at the suite of individuals we've brought together, imaging expertise, quality of life expertise, surgical expertise, cath lab expertise, in the heartfelt lyrics parties. You begin to recognize that we've amassed a group.
42:16
This should people who help us zero point this initiative exactly in the right direction.
42:23
So, let me end with this, share with you already.
42:27
We've had a 15 year experience in American Heart Association focusing on quality, in, so doing stroke outcomes are better, specifically because of Get With The Guidelines stroke.
42:40
Acute and my coronary disease outcomes are better, specific because of lessons learned from the guidelines coronary disease, and because of mission Lifeline.
42:51
Resuscitation outcomes are decidedly better because we measured how we resuscitate patients, We understand the demographics, epidemiologists, sudden critic deaths and, you know, what resuscitation outcomes are no.
43:06

And yes, the space that I represent, which is heart failure, because we've got one point four million patient records, on an annual basis, we bring to bear about 15 publications. We have Inform the community and portfolio outcomes, or even better.
43:23
I submit to you, then, that, this paradigm, this model.
43:27
This evolved over 15 years, and it has been time and time again.
43:32
Tested and shown to be effective, or, once again, proved to be effective at improving outcomes for structural heart disease.
43:40
Greatly appreciate the opportunity to share with you this initiative. It's been enjoyed working with doctor Brennan to bring this information for a yield of control of this program back to mister Myers. Thank you very much for your time and attention.
43:55
Thank you, Doctor Nancy, I'm going to skip ahead to a slide.
43:58
I just want to make sure that we make the audience aware of an upcoming webinar that we'll have as well, on the new guideline update guideline, update doctor, Brennan, anything to add or comment on for doctor Nancy?
44:14
I just want to say that was a terrific reflection and introduction of this effort, which is exciting.
44:20
I hope the participants on this webinar can recognize the parallels between the pilot measures, and the gaps in care that I highlighted.
44:32
They're directly related, and, you know, this is an initiative that I think both our patients and our communities desperately need, so I'm excited to see this move forward.
44:42
I think there's a lot of good that can be done across our country and in our health care system by this initiative.
44:49
So thank you.
44:51
Thank you, doctor Brennan?
44:53
So, gentlemen, we have no questions. I'm going to give it just a second to see if any pop up from our audience, but if there are any questions, best, to type

them into the chat box. and we can pose them out loud, to either directly answer your doctor Brennan, or we can answer those in the chat box.
45:12
So, doctor Brennan, while we're waiting for questions, kind of strategies, do you think, will work to better deploy terror for women with critical or severe aortic stenosis?
45:23
Any ideas about what we can do differently for that very special group of patients?
45:30
Part of it, at least the early challenges in that patient population had to do with vasculature and size of your access point.
45:38
So, as the devices have gotten smaller, that, I would expect, and as they continue to get smaller, that'll be better, but I think beyond the technology itself, as with any of these servings categories of patients or groups, cohorts of patients who are being underserved, I think it's important to recognize that, we need to figure out how to communicate to these patients better, to speak to, um, the particular challenges of that patient cohort. So, I think it's a public awareness piece, is probably, if you want to target women, they're certainly terrific.
46:17
Venues that you can use to speak directly to women, but also try to speak to the things that are unique about are older women who are often caregivers themselves or for their families.
46:33
I think there are there are ways through a public awareness campaign to try and reduce those discrepancies.
46:41
So on the treatment side, I think it's a technology issue, primarily, but then beyond that, I think it's communication as it is with, with other groups.
46:50
I think we need to recognize, get out of this mold where we think that no, all communication is equal, so how you speak to one community necessarily needs to be different than how we speak to or to other communities.
47:07
So people just respond differently and have different histories, different legacies, different priorities. So I think trying to understand that a little bit better on the important.
47:19
So let me add to that and thank you for your answer. What you didn't say which I think is incredibly important.

47:26
So we have no evidence that the biology of robotics, Gnosis varies at all by gender or *** or race or ethnicity. It's the same condition did is this calcification of your ...
47:42
typically associated with the same risk factors that we talk about as the underpinning of cardiovascular disease?
47:48
And so to believe that one group doesn't experience essential history, is a misrepresentation of the truth. The truth is that the biology is the same amongst groups. Sort of highlight your point. We need to understand who are the decision makers. We need to understand how best to communicate with them.
48:05
We need to understand what communication strategies work best in what environments and with what communities think that so we can begin to think differently about so process and where that becomes really germane in our target keyword Gnosis Initiative.
48:21
If we have to rely on local answers to these problems, we can't rely on a national response.
48:30
That's why Teams is so important to help us understand what needs to be done. in your center.
48:35
It's been one of the really important assets. we've evolved within the whole gear up with the guidelines family.
48:42
So, we use the local teams, nurses, in particular, to tell us what resonates, what works for their groups. So, I think that's been a big part of this.
48:52
Yeah, I think that's right that, you know, Kevin Thomas do, who's one of the, The outcomes investigators have spent a lot of time looking at development of shared shared decision making tools or decision aids in minority populations in particular.
49:11
And has some really unique findings, I think, both for, from ICDs, as well as looked atrial appendage occlusion that would translate here.
49:21
And so I think, you know, we have shared decision making tools or decision aids, that can be applied and used in clinic.
49:29

But I think one of the things that we need to be looking at, in addition to engaging our local communities, is having those educational pieces that speak, actually, to a community, uniquely in place. And so that's something that, as a national community, that we can work on, I completely agree with you, It really is a local level.
49:51
So that's a big part of the stakeholder training, right?
49:54
Everyone believes they know the guidelines for valvular heart disease but actually when we sit down and go over the detailed information There's a lot of space that it's covered.
50:05
There was not a previously recognized the same thing Everyone nice three head when you say shared decision making conversation But the important attributes to qualify as a shared decision making conversation have to be better promulgate.
50:19
It Did you think about something like a quality of life questionnaire?
50:22
There's almost a whole hom statement.
50:26
Are you going to measure Koirala that's a good Think no, no, no, when you look at the specificity of the questionnaire and understand how carefully it's configured, how capable, it allows us to really understand who's thriving in who's not, getting gives us an opportunity to overcome the subjectivity.
50:44
That's our own bias. Yes. Well, you know, I had the produce procedure. I think I'm OK.
50:49
Or I don't really want the procedure sometime pretty well.
50:53
Know when someone goes through the KC CQ Questionnaire, we get to the truth pretty quickly, and so that's why the stakeholder training and the team indoctrination happens to be so important.
51:05
Gary, are there any questions, doctor Brennan, and I could probably talk for a little bit longer. But we did want to highlight these important other issues of how we get to targeted communities.
51:15
What it means to have this shared decision making moment, and, in particular, how this KC CQ model differs from just saying, how are you doing?
51:25

Are there any other thoughts or questions that anyone wants to share with us?
51:29
Nothing in the chat box, but you both have shared your contact information as well as mine. So if anyone has any questions about the presentation today or about the Target Aortic Stenosis Initiative, they can contact any of us and we'll get them the answers. So thank you both for today's presentation. Any final thoughts before I give my wrap up statement?
51:51
Yeah, I just want to thank everyone who, not only has been an intense day, but will listen to us in the future.
52:00
I want to thank you for your attention.
52:02
As someone who has seen the evolution of this science, this has been remarkable, and the best use of this size is deployed and deployed correctly and broadly.
52:13
We basically are deputizing all of you, to make us a better vehicle for better health for our patients, and I'll go back to my opening statement, who we are, as American Heart Association, is a group that is serving as a champion of the health span.
52:29
This is another way that we can restore health, and those that have stroke or heart disease, and enhance at ..., doctor Brennan, and I didn't want to usurp, frontal worse from here, but I just really wanted to speak on behalf of the Heart Association and say, this is really important. Where you find a worse or components?
52:45
I couldn't say, better. Thank you.
52:48
Thank you, both. Really appreciate the time for today's, both in the audience, as doctor Nancy pointed out. And I'd really like to thank doctor Nancy and doctor Brennan for taking the time to have this presentation today On our new initiative target aortic stenosis for those of you attending after today's webinar, you will receive a follow-up e-mail with a survey on the presentation. And we would appreciate it if you would complete that and provide your feedback back in that e-mail. You will also receive a link to view the recording of today's presentation. So on behalf of the American Heart Association, our presenters, thank you for joining us today. Have a great day. This concludes our presentation.