The Prevention CAB!

Cholesterol, Aspirin Blood Pressure

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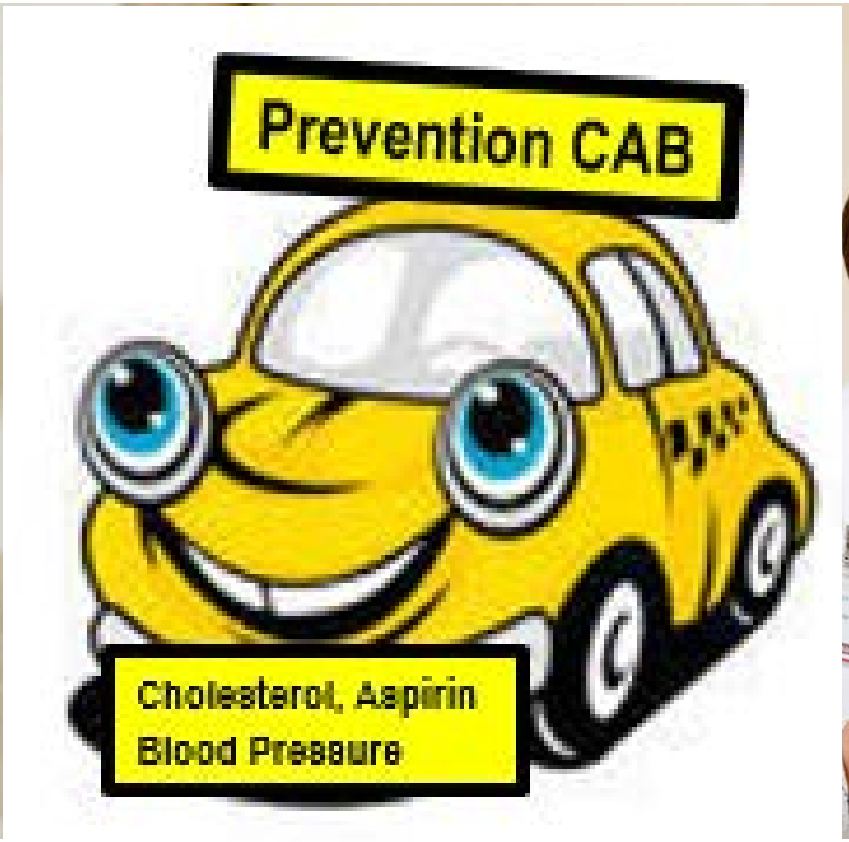
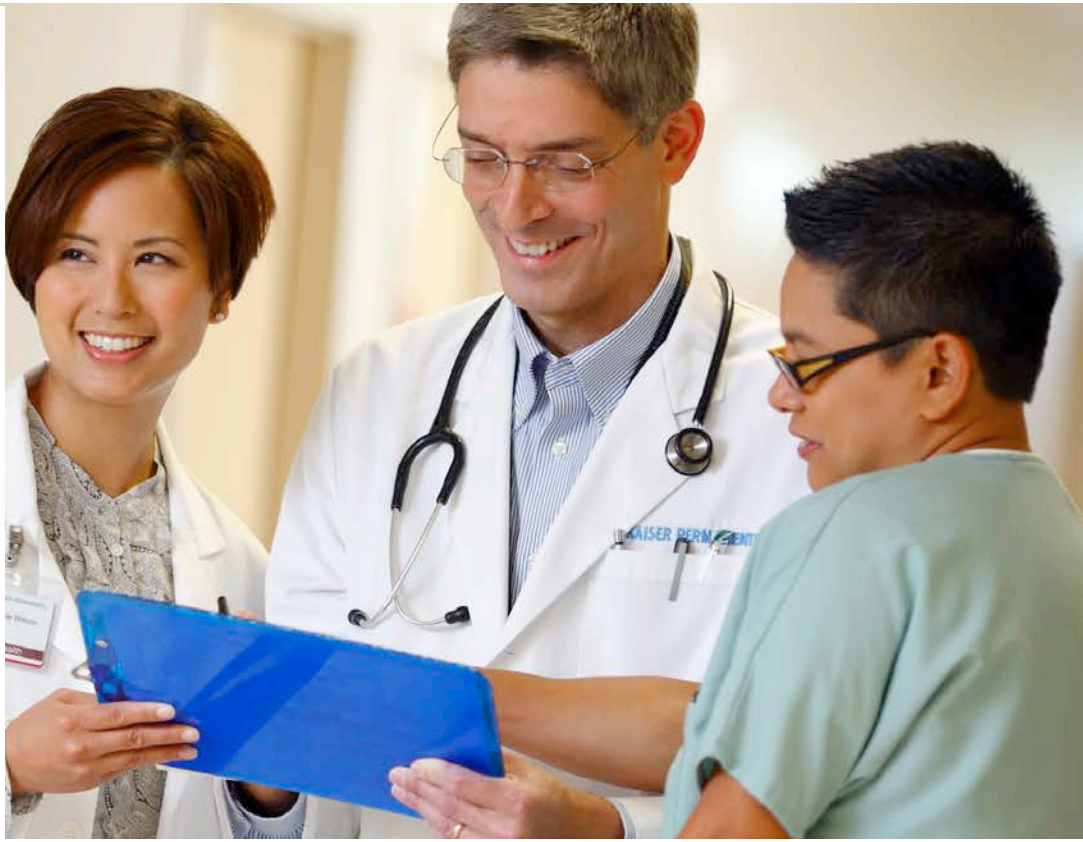
KP Southern California CV Co-Lead
KP National Cholesterol Lead



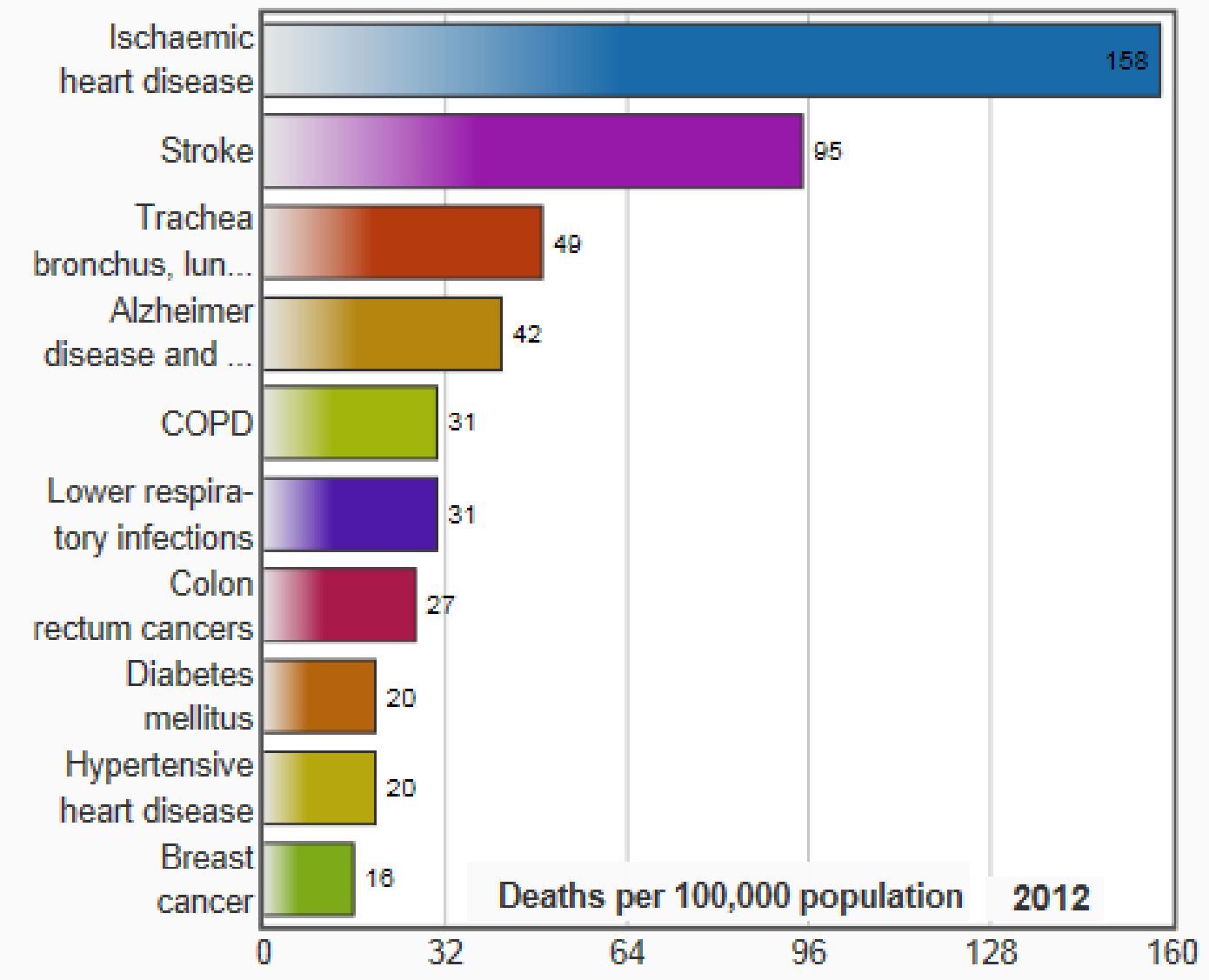


Prevention CAB

- Cholesterol
- Aspirin
- Blood Pressure

- Heart attacks and strokes are leading causes of death and disability. Over 80% of are preventable.
- **C**holesterol, **a**spirin and **b**lood pressure treatment are high impact prevention. Bundling simple protocols, consistent implementation and promotion, and working the barriers, helps achieve success and reduce disparities in care.
- Leveraging systems and teamwork can reduce heart attacks, strokes, revascularizations, and associated costs.

Top 10 causes of death in high income countries

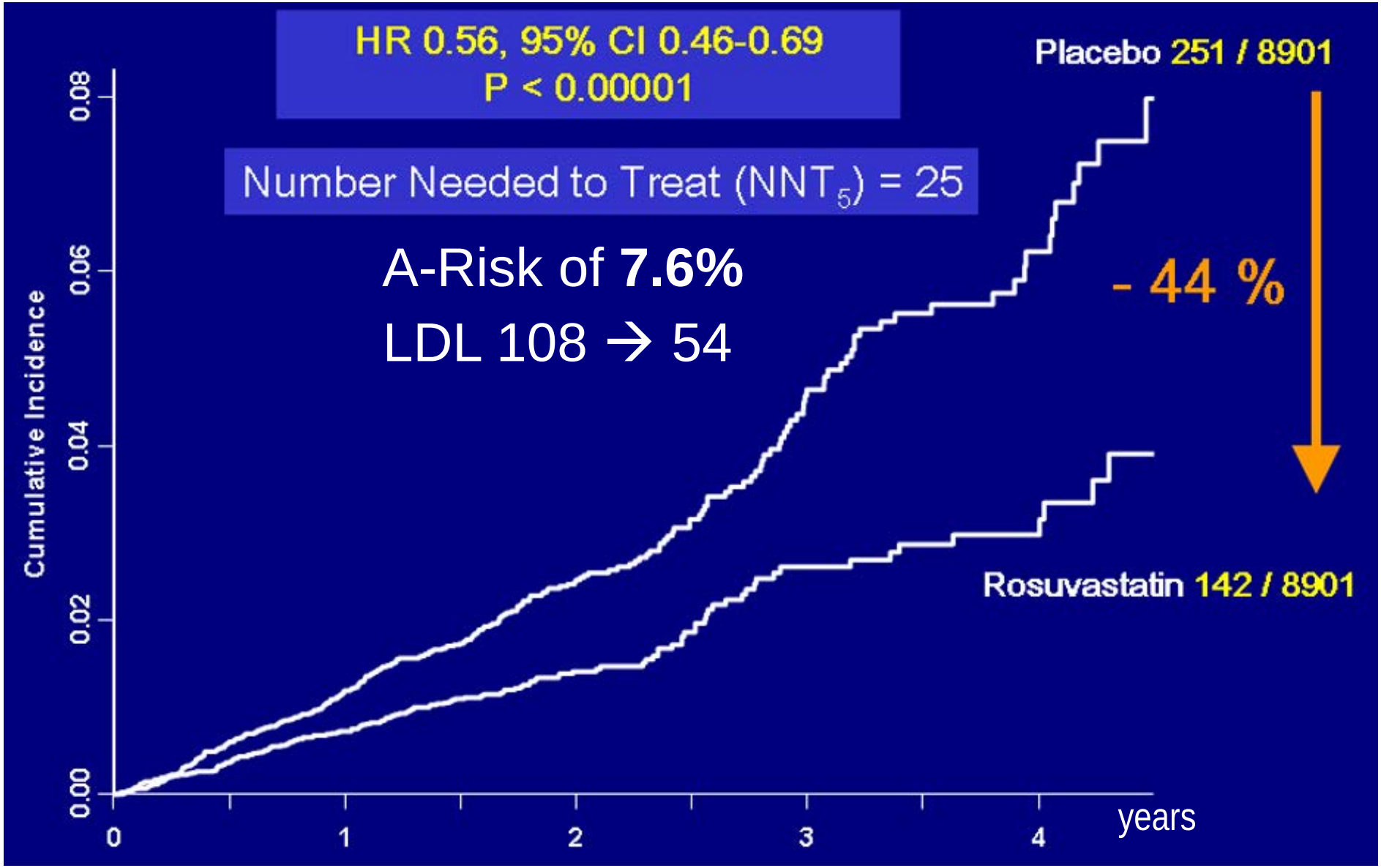


http://www.who.int/mediacentre/factsheets/fs310/en/index1.html

Lifestyle Promotion

- Physical Activity Promotion: Ask for ideas to help increase.
- Healthy Plate: Quick intervention that facilitates action.
- Tobacco Use: advise to quit and discuss strategies and medicines to help members quit.

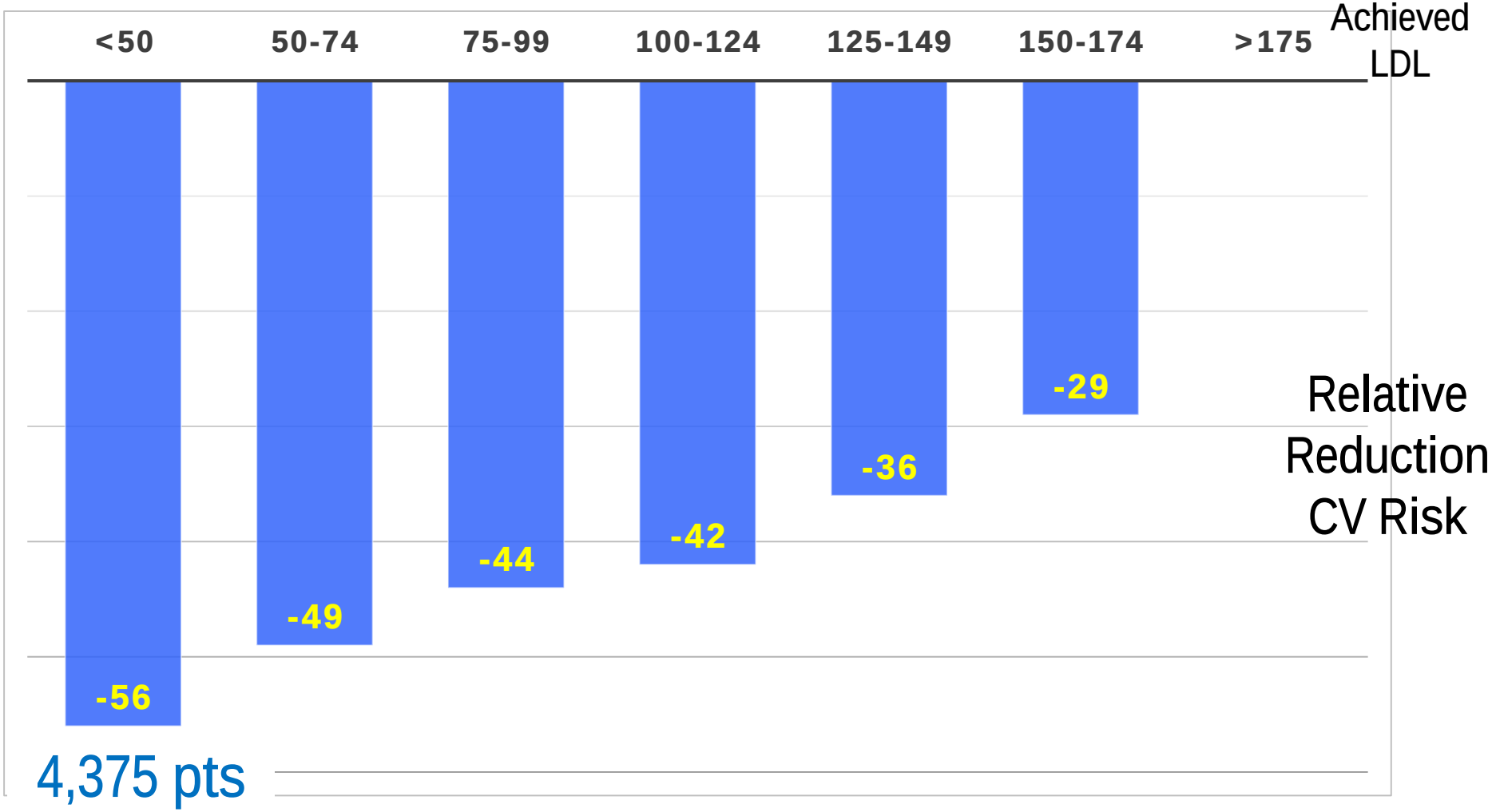
JUPITER Primary Endpoint: MI, Stroke, UA/Revascularization, CV Death



Ridker et al NEJM Nov 2008

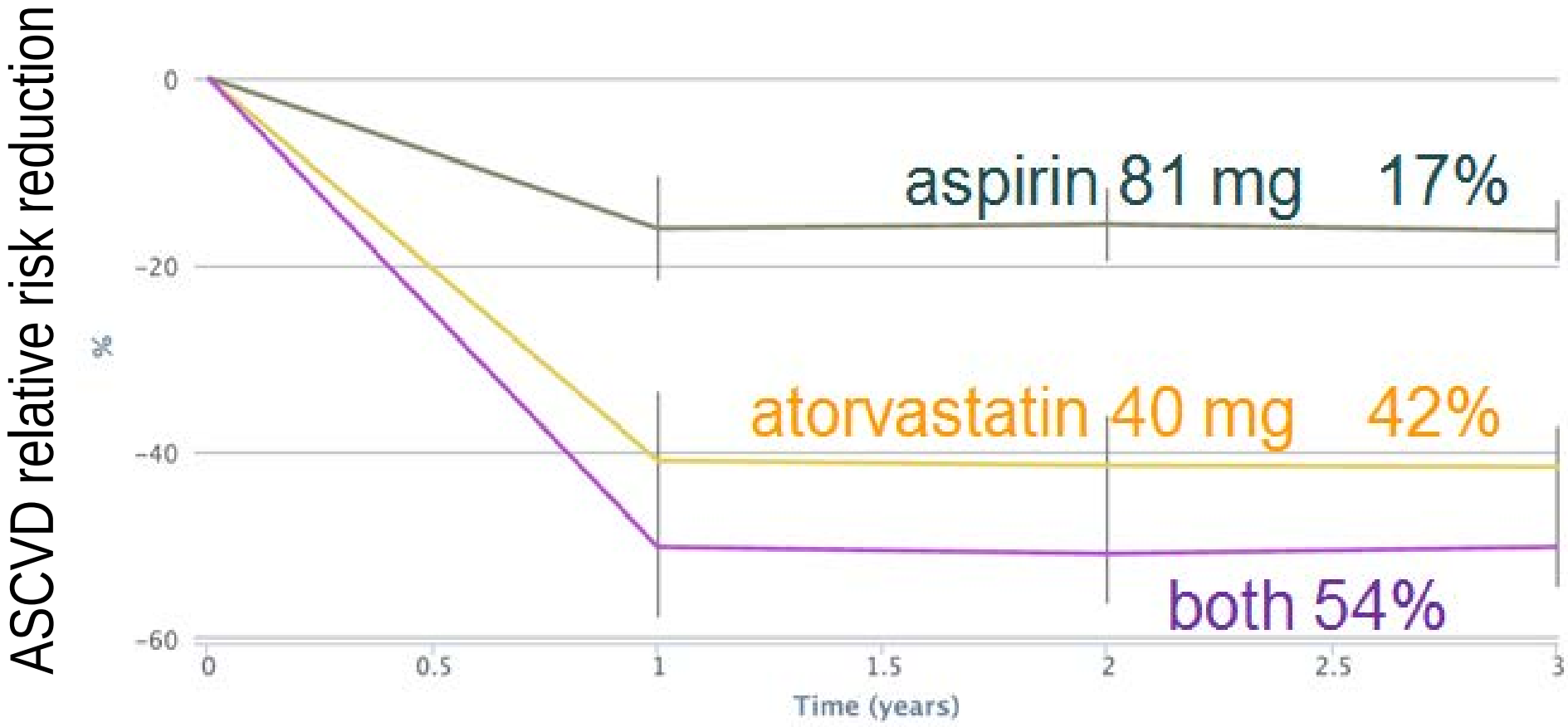
A-Risk is ACC/AHA 10 year risk of fatal or non-fatal MI or Stroke

Lower statin achieved LDL (<50) at lower risk



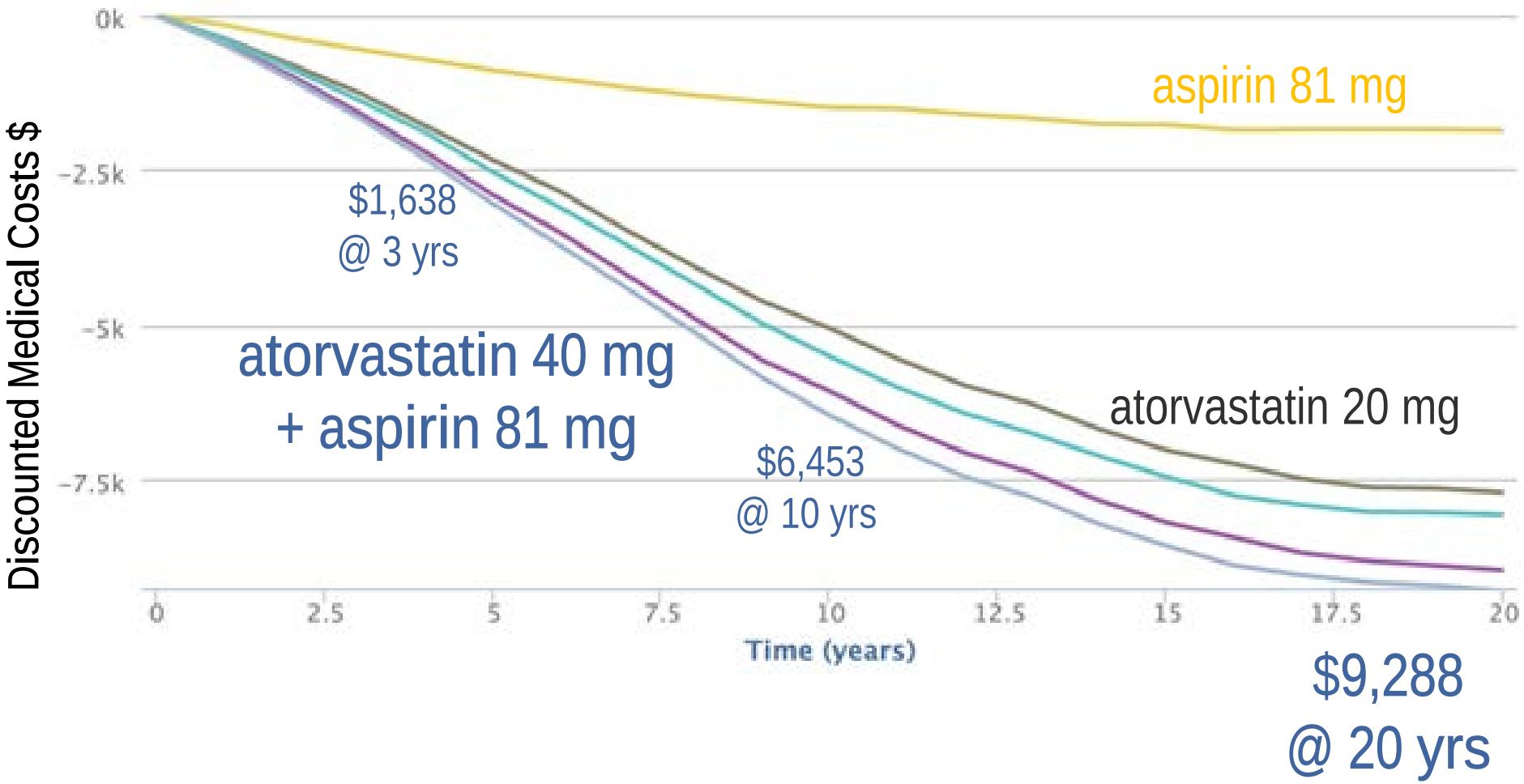
Boekholdt et al. JACC 2014;64:485-494. Individual level meta-anaysis.

Modeled Statin and Aspirin Risk Reduction, Primary Prevention. Archimedes ARCHeS



Dudl, Scott, Chan. AHA poster, Nov 2014

Cost Savings with Statin + Aspirin in Primary Prevention



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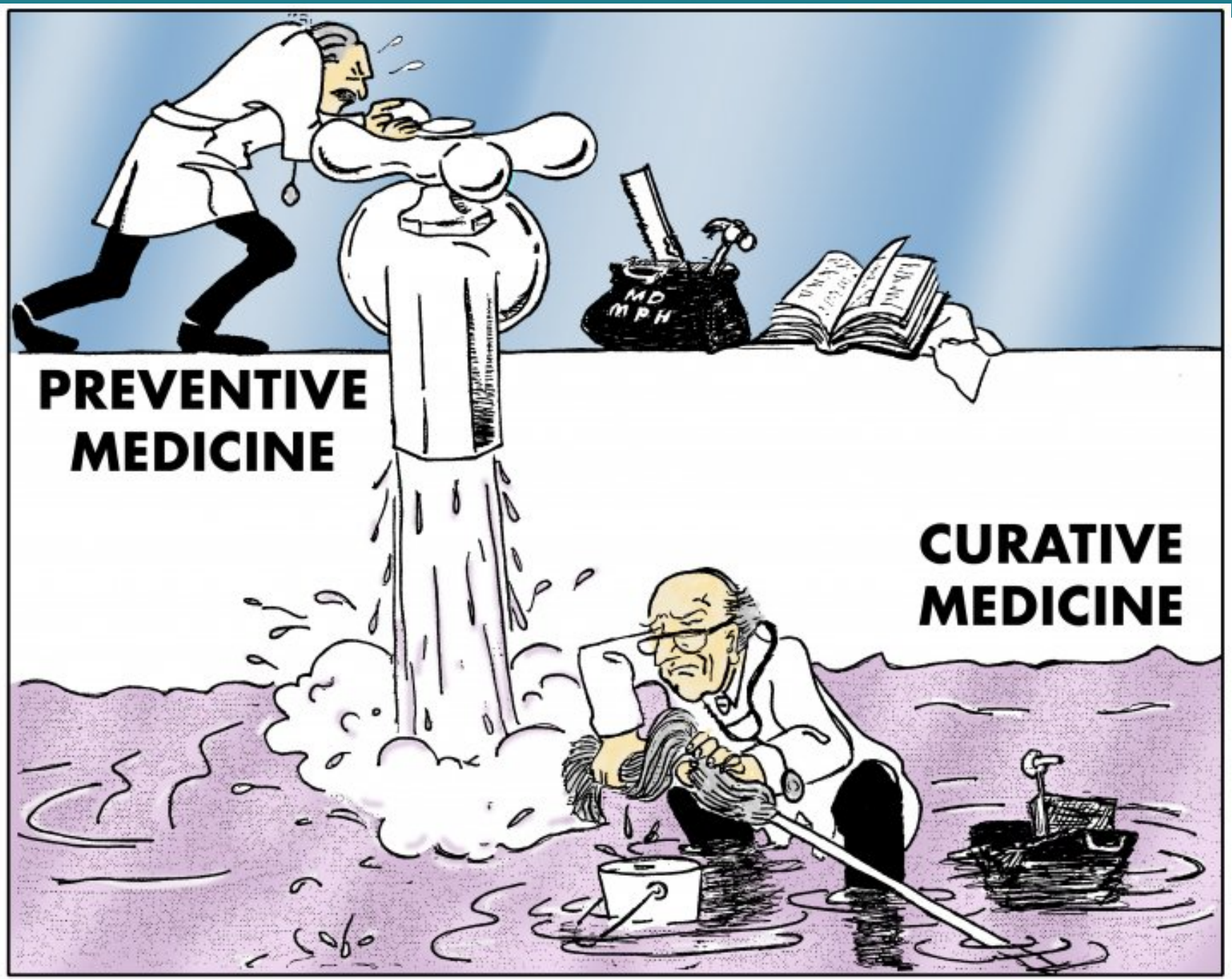

MD
MPH
PREVENTIVE MEDICINE
CURATIVE MEDICINE

Four Statin Benefit Groups. *Simple protocol*

1. **Clinical ASCVD, start atorvastatin 40-80 mg**
2. **LDL >= 190, start atorvastatin 40-80 mg**
3. **DM age 40-75**,

A-Risk	recommendation
≥ 7.5 or AA	Start atorvastatin 40 mg
< 7.5	Start atorvastatin 20 mg

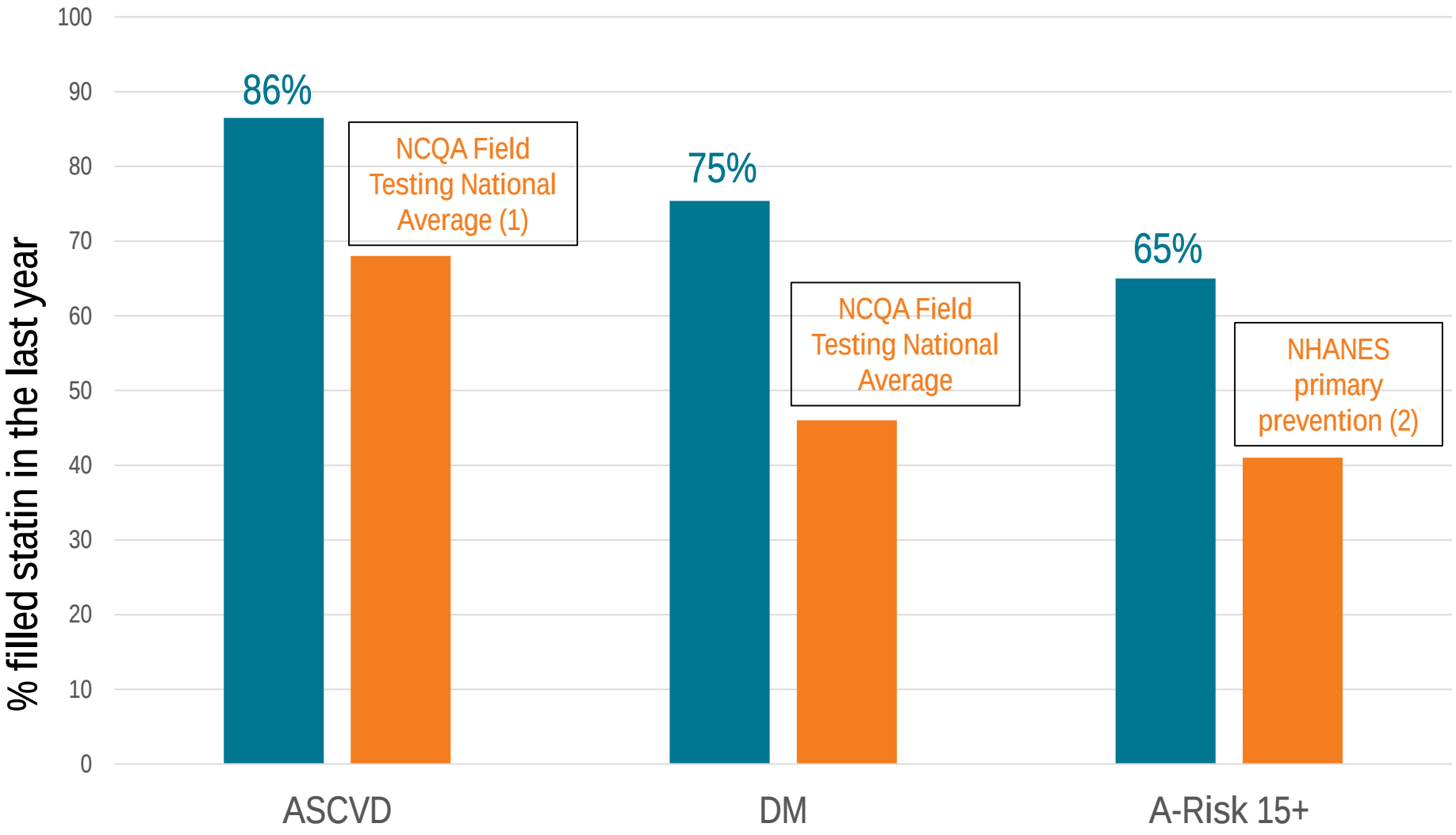
4. **"4th Statin Benefit Group"**,

A-Risk	recommendation
≥ 15 or AA	Start atorvastatin 40 mg
7.5 - 14.9	Discuss atorvastatin 40 mg
5 - 7.4	Consider atorvastatin 20 mg

KPSC Cholesterol Tip Sheet.

AA = Aortic Atherosclerosis in KPSC

Statin Use in KPSC vs National Average



1. NCQA Testing 4/9/15
2. Pencina et al. *N Engl J Med* 2014;370:1422-31.

Statin metrics by Med Center, monthly WebEx

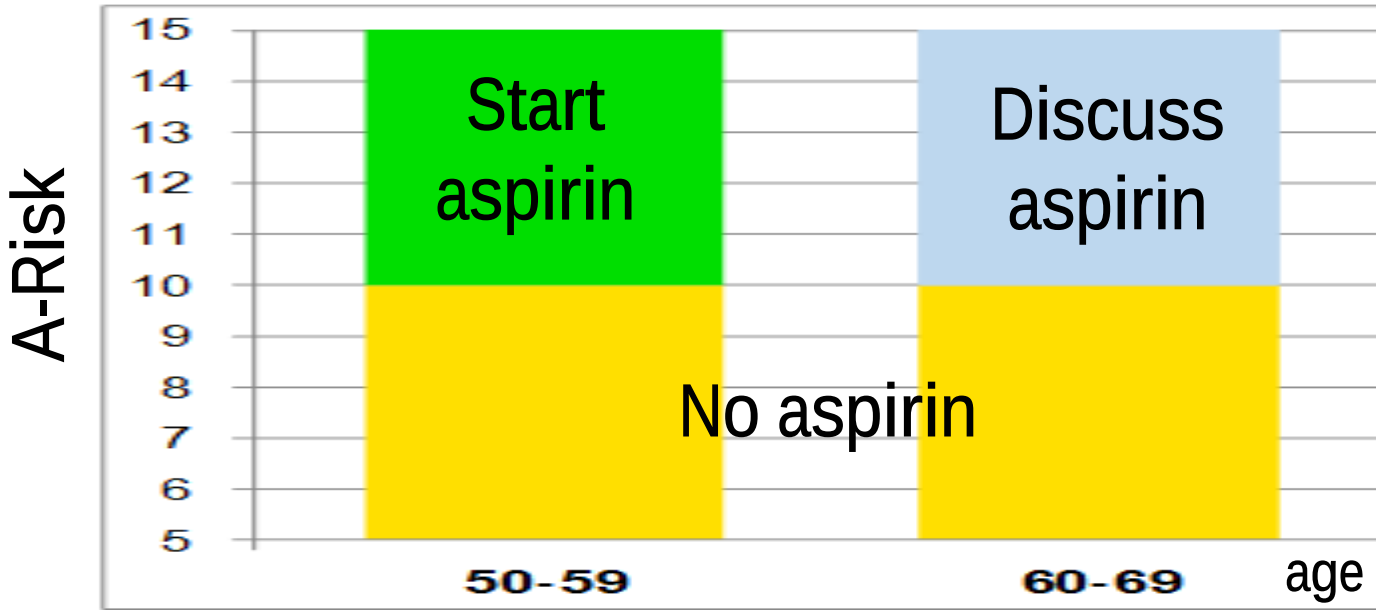
	MC 1	MC 2	MC 3	Region
Source: CSG/HEDIS Measures, All Members, through November 2016				
Diabetes - Statin Therapy *	77.1%	75.0%	75.9%	75.4%
Change from previous month	0.2%	0.0%	0.4%	0.1%
Diabetes - Statin Adherence *	64.4%	66.8%	64.4%	69.6%
Change from previous month	0.6%	0.3%	-0.3%	0.2%
CVD - Statin Therapy**	88.8%	87.3%	88.2%	85.7%
Change from previous month	-0.1%	-0.2%	-0.6%	0.0%
CVD - Statin Adherence **	74.9%	72.6%	69.1%	76.7%
Change from previous month	1.2%	-1.0%	-1.4%	-0.5%
Source: POINT Patient Safety Monitoring Tool - December 2016				
Medicare 5-Star Adherence to Statins	81.1%	82.1%	81.7%	84.2%
Change from previous month	0.7%	1.6%	1.5%	0.8%
A-Risk >=15% Age 40-75				
On Statin	69.2%	62.1%	66.7%	65.1%
Change from previous month	0.8%	1.0%	0.4%	0.8%
Last LDL >=190 Age 21-75	1.01%	1.29%	1.28%	1.17%
Change from previous month	-0.01%	0.00%	-0.11%	-0.01%

"To prevent a heart attack, take one aspirin every day. Take it out for a run, then take it to the gym, then take it for a bike ride..."

Aspirin - *simple protocol*

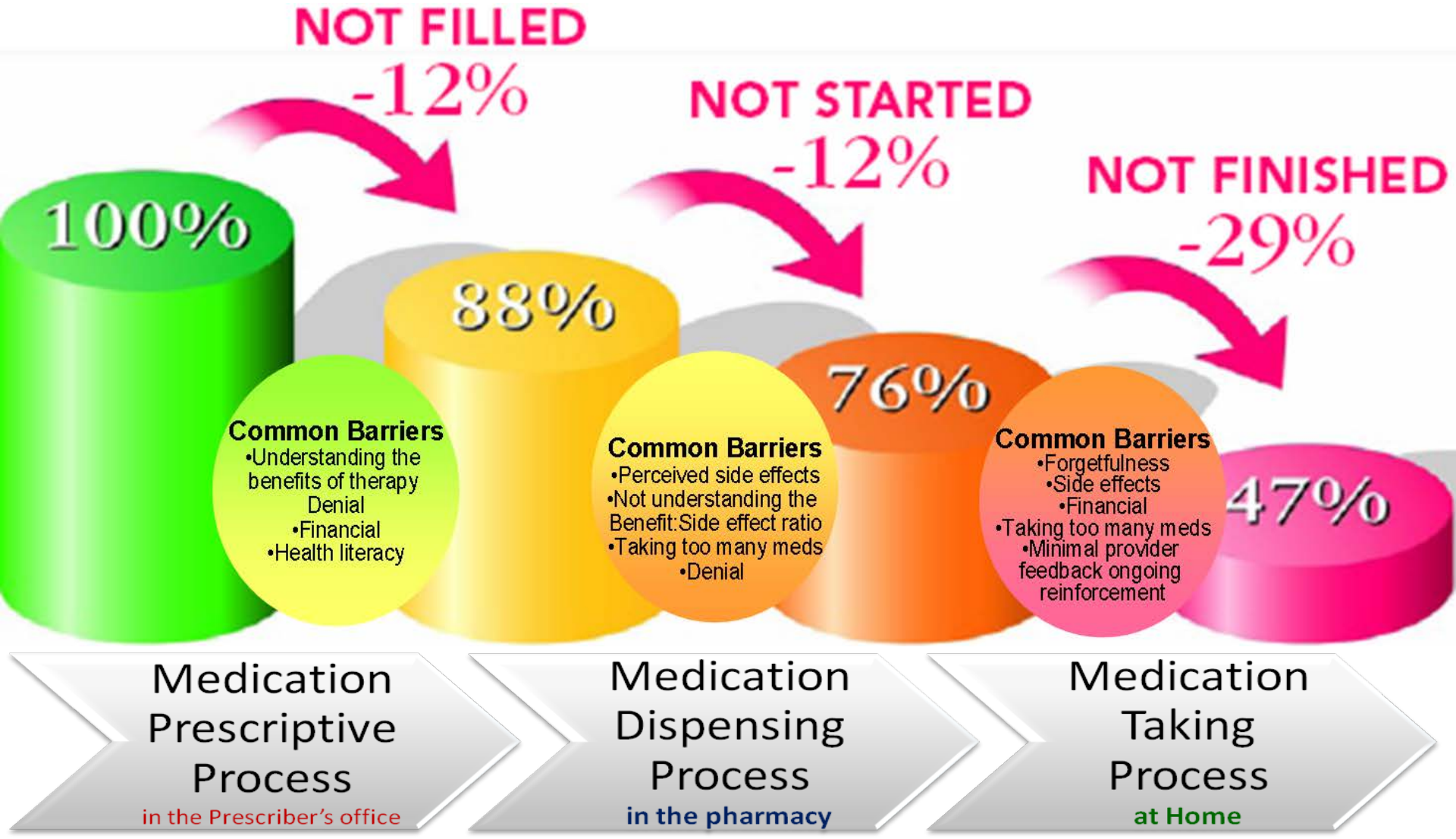
Aspirin Recommendations for the prevention of MI, Stroke, and Colorectal cancer:

- Age 50-59 with A-Risk ≥ 10%, start aspirin 81 mg.
- Age 60-69 with A-Risk ≥ 10%, discuss aspirin 81 mg.
- Exclude if hx GI bleed, or on medicines that raise bleeding risk (dabigatran, warfarin, etc). Avoid daily NSAID use while on aspirin



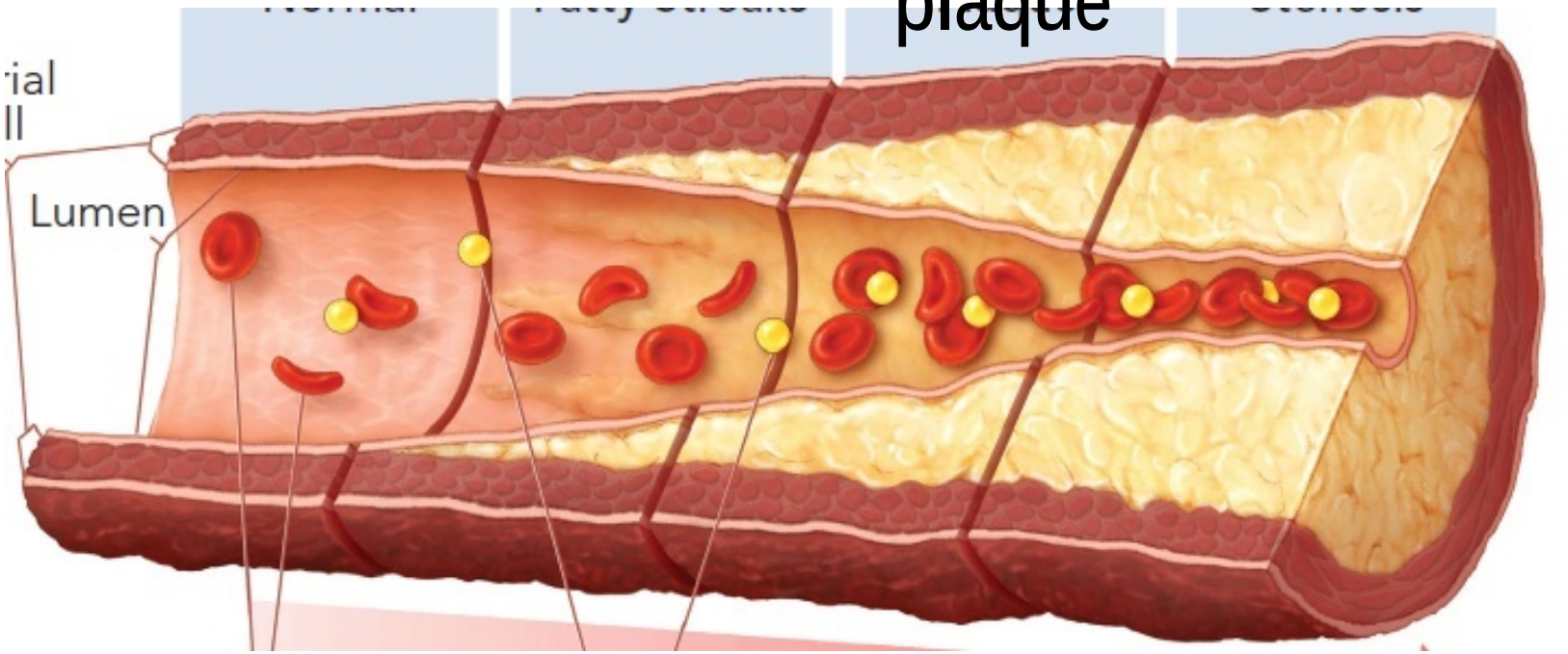
USPSTF, KP 2016

Where medication adherence breaks down



CV med adherence AHA 2010

Artery Graphic



- Tear-off pads to hand members graphic with bullets on back and exam room posters widely used.
- Helps overcome literacy barriers, facilitates recall, inspire behavior change. Impactful to promote statin and aspirin use.

Graphic KPSC Health Education. Houts et al. Education and Counseling, 35: 83-88 (1998).

Promote medicine use and adherence

- Build relationship “What do you enjoy?” Link meds to helping them live longer, enjoying what they enjoy, longer term, disability – free.
- Build relationship with family, spouse. Encourage involvement that facilitates health.
- Use “golden opportunities” when more receptive to behavior change: new diagnosis (ASCVD, Diabetes), new lipid panel (A-Risk) or imaging (AA).
- Pillbox “gift” builds bond. Train to use and learn from.

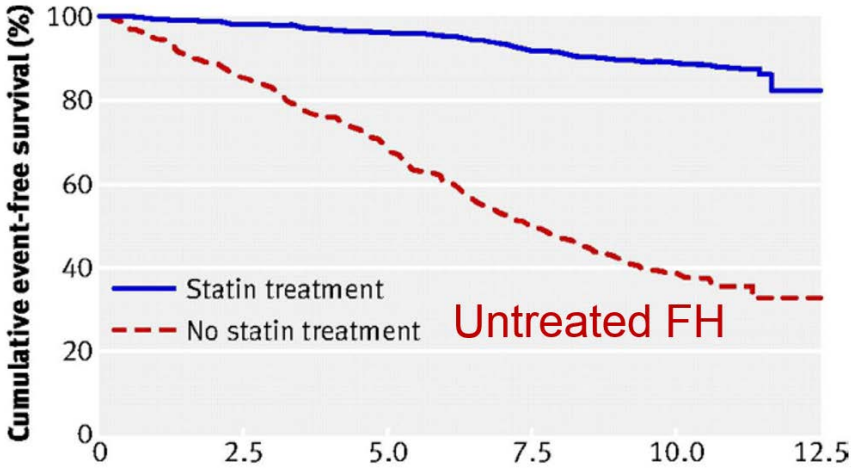
Sobel. Chi et al. Am J Manag Care. 2014. Harrison et al. Am J Man Care, April 2013.

Promote Medicine use

- Discuss a time that pt can take it consistently every day.
- Promote once daily bundle when possible.
- Try to work around cost barriers. Affordable Care Act $0 copay, Medical Financial Assistance.
- Majority of non-adherent feel “Medicine will do more harm than good”. Important to convey benefit.
- Encourage open communication. If possible side effect or other barrier, please contact you prior to stopping medicine. Assure that you can help them address and navigate side effects / barriers (other meds and doses) and still lower risk.

Chi et al. Am J Manag Care. 2014. Harrison et al. Am J Man Care, April 2013.

Feedback letter



Dear Mr. ,

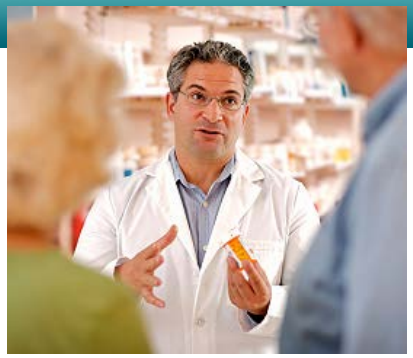
Your cholesterol is much improved! Congratulations! Continue your cholesterol medicine to help keep your arteries open.

Component *Latest Ref Rng*	1/11/2011	3/17/2011
CHOL *<200*	338 (H)	179
TRIG *<150*	268 (H)	184 (A)
HDL *>/=40*	49	48
LDL CALC *<100*	235 (H)	94
CHOL/HDL *<5.0*	6.9 (H)	3.7
ALT *17 - 63 units/L*	64 (H)	46

Be well,
Ron Scott, MD

kp.org
800-954-8000

Med Adherence Tactics



- Automated outreach calls for primary and secondary adherence increase fill rates
  - Increase fill OR 2.2. Spanish 3.0!
- KPSC outpatient pharmacists do targeted med adherence consultations in pharmacies.
- Using KP Mail-Order Pharmacy with free shipping achieved better cholesterol control, higher med adherence, and fewer ER visits.
- Increasing quantity from 30 or 90 to 100.

Derose et al, JAMA Intern Med 173:1, 2013. Cheetham et al, J Man Care Pharm 2013. Spence et al, *J Manag Care Pharm* 2014;20:1036-45. Schmittdiel et al, *JGIM* 2011; 26 (12) 1396-1402. Schmittdiel et al, Am J Manag Care. 2013;19(11):882-887.

Myalgia

- Often “multifactoral”. Treat hypothyroidism, low vitamin D, depression, pain syndromes to improve statin tolerance.
- Members with past intolerance often are able to tolerate low, infrequent dosing or different statin.
  - Rosuvastatin 5 mg (now generic) or atorvastatin 10 mg 1-2 x a **week** can lower LDL > 20%.
- “Nocebo effect” patients with past statin intolerance, randomized to placebo or statin. > 25% of each reported muscle pain.
- Post MI patients have much higher rates of statin tolerance. Shows importance of understanding benefit of medicine.

To Save More Lives . . .

TEST THE UNTESTED *to Facilitate* **TREAT THE UNTREATED**

adapted from M. Jaffe, KPNC

Lipid Panel Screening *simple protocol*

- Lipid Panel priority “test the untested”.
  - Age 40-79 every 4 to 6 years.
    - Age 40-55 KPSC at 80% screened in last 6 yrs.
  - Age ≤ 39 baseline test recommended. (KP at 65%)
    - Best way to catch LDL ≥ 190, >1% of population.
- May do lipid panel along with other labs for convenience. Fasting not necessary.
- Underserved, unengaged members lack of lipid panel contributes to health disparity.

Hypertension, striving for excellence

- High yield, once daily meds emphasized to promote adherence. More titration steps, more barriers.
- Engagement of staff with blood pressure checks, repeat if high, arranging follow up blood pressure every 2 weeks until at goal.
- Trust building with providers, AIDET model.
- Convenient options for patients: specialty HTN clinic, MABP or doc visits, online portal, email.
- Outreach to reduce those that have not had blood pressure in > 6 months.
- Reducing African American Disparity: metrics, targets, story telling videos, churches, barbershops, trust building.
- age disparity: younger members with worse control rates.

Speed Limit Principle: LDL or BP

- If patient feels like is close to goal, or “normal” often feels close enough and resists change.
- For statin, primary reason is to reduce heart attacks and strokes, reduce plaque. If patients persist on LDL target, use 50% LDL reduction, calculate for patient, and communicate that number as “goal”. If baseline 108, goal is 54 or “close to 50”.
- For blood pressure, if SBP > 140 and a good candidate for medicine, communicate that recent study showed benefit for SBP < 130. Distance from ideal helps inspire patient that medicine is necessary.

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