AGENDA

Thursday, March 12, 2020 | 11:00 a.m. to 2:30 p.m.

Right Care Initiative Goal: Drive Toward Zero Preventable Heart Attack, Stroke, Diabetes, and Heart Failure Deaths & Disabilities Through Best Available Science Combined with Proactive Screening & Outreach

Achieve 80 % in good control, or "A Grade" (90th Percentile) HEDIS levels for Cardiovascular Disease and Diabetes, whichever is greater.

Priorities:

- *80% of hypertensive patients with blood pressure (BP) controlled: <140/90 mm Hg (Optimally 130/80 per 2018 American College of Cardiology Guidelines, endorsed by ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA)*
- *80% of diabetic patients with blood sugar controlled: Hemoglobin A1c<8*
- *80% of patients with diabetes and/or cardiovascular conditions on appropriate cholesterol therapy (proxy, LDL controlled: LDL-C<100mg/dL. Or for very high risk ASCVD, LDL-C<70mg/dL or lower)*
- *Proactive Community Outreach to Screen & Identify Vulnerable Patients to Connect to Treatment & Support*

11:00 to 11:10 a.m. — ***Welcome, Introductions, and Chairpersons' Remarks***

Carol Zaher, MD, MPH, MBA, Los Angeles UBP Co-Chair, Right Care Initiative; Medical Director, Health Net California Medical Management, Centene

Steve Chen, PharmD, FASHP, FCSHP, FNAP; UBP Co-Chair, Right Care Initiative; Associate Dean for Clinical Affairs; William A. and Josephine A. Heeres Chair in Community Pharmacy; Associate Professor of Clinical Pharmacy, University of Southern California

Tony Kuo, MD, MSHS; UBP Co-Chair, Right Care Initiative, Director, Chronic Disease and Injury Prevention, Los Angeles County Department of Public Health; Co-Program Leader, Population Health Program, UCLA Clinical and Translational Institute

Carol Peden, MB ChB, MD, FRCA, FFICM, FFMLM, MPH, Los Angeles UBP Co-Chair, Right Care Initiative; Executive Director, USC Center for Health System Innovation, Keck School of Medicine, USC

Statewide Right Care Initiative Updates

Hattie Rees Hanley, MPP, Co-founder and Director, Right Care Initiative, Center for Healthcare Organizational and Innovation Research, University of California, Berkeley School of Public Health

11:10 to 11:25 a.m. — ***COVID-19 Update & Cardiovascular, Influenza Nexus***

William J. Bommer, MD, FACP, FACC, Chairman, Right Care Initiative Capital Region University of Best Practices; Executive Committee, American College of Cardiology, California Chapter; Professor, Division of Cardiovascular Medicine, University of California, Davis

11:25 to 11:35 a.m. — ***Prediabetes and Diabetes Prevalence and Programming in LA County***

Alissa Maier, MPH, Project Manager, Quality and Population Health, University of Southern California Gehr Center for Health System Science and Innovation

11:35 a.m. to 12:15 p.m. — ***Programming Across the Continuum of Care: National Diabetes Prevention Program (NDPP) and the Diabetes Self-Management Education and Support (DSME/S)***

Bernadette Mejia, PhD, MS, RD, Director of Preventive Health Services, Watts Healthcare

12:15 to 1:05 p.m. — ***Diabetes Programming – A Payor's Perspective***

Christopher Tompkins, MS, MBA , Health Promotion Manager, Clincial Strategy and Innovation, Anthem

1:05 to 1:25 p.m. — ***Group Discussion***

1:25 to 2:25 p.m. — ***Innovations in the Diagnosis and Management of Heart Failure with Reduced Ejection Fraction***

Evan Kransdorf, MD, PhD, Cardiologist, Smidt Heart Institute, California Heart Center, Cedars-Sinai

2:25 to 2:30 p.m. — ***Takeaways and Reminders***

Upcoming Meeting Date: May 21, 2020 - Los Angeles University of Best Practice @ RAND (Womens Heart Health)

Top 10 Take-Home Messages to Reduce Risk of Atherosclerotic Cardiovascular Disease through Cholesterol Management

Grundy SM, et al. 2018 AHA/ACC Cholesterol Clinical Practice Guidelines

1. In all individuals, emphasize a heart-healthy lifestyle across the life course. A healthy lifestyle reduces atherosclerotic cardiovascular disease (ASCVD) risk at all ages. In younger individuals, healthy lifestyle can reduce development of risk factors and is the foundation of ASCVD risk reduction. In young adults 20 to 39 years of age, an assessment of lifetime risk facilitates the clinician–patient risk discussion (see No. 6) and emphasizes intensive lifestyle efforts. In all age groups, lifestyle therapy is the primary intervention for metabolic syndrome.

2. In patients with clinical ASCVD, reduce low-density lipoprotein cholesterol (LDL-C) with high intensity statin therapy or maximally tolerated statin therapy. The more LDL-C is reduced on statin therapy, the greater will be subsequent risk reduction. Use a maximally tolerated statin to lower LDLC levels by ≥50%.

3. In very high-risk ASCVD, use a LDL-C threshold of 70 mg/dL (1.8 mmol/L) to consider addition of non-statins to statin therapy. Very high-risk includes a history of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions. In very high-risk ASCVD patients, it is reasonable to add ezetimibe to maximally tolerated statin therapy when the LDL-C level remains ≥70 mg/dL (≥1.8 mmol/L). In patients at very high risk whose LDL-C level remains ≥70 mg/dL (≥1.8 mmol/L) on maximally tolerated statin and ezetimibe therapy, adding a PCSK9 inhibitor is reasonable, although the long-term safety (>3 years) is uncertain and cost effectiveness is low at mid-2018 list prices.

4. In patients with severe primary hypercholesterolemia (LDL-C level ≥190 mg/dL [≥4.9 mmol/L]), without calculating 10-year ASCVD risk, begin high-intensity statin therapy without calculating 10- year ASCVD risk. If the LDL-C level remains ≥100 mg/dL (≥2.6 mmol/L), adding ezetimibe is reasonable. If the LDL-C level on statin plus ezetimibe remains ≥100 mg/dL (≥2.6 mmol/L) and the patient has multiple factors that increase subsequent risk of ASCVD events, a PCSK9 inhibitor may be considered, although the long-term safety (>3 years) is uncertain and economic value is low at mid-2018 list prices.

5. In patients 40 to 75 years of age with diabetes mellitus and LDL-C ≥70 mg/dL (≥1.8 mmol/L), start moderate-intensity statin therapy without calculating 10-year ASCVD risk. In patients with diabetes mellitus at higher risk, especially those with multiple risk factors or those 50 to 75 years of age, it is reasonable to use a high-intensity statin to reduce the LDL-C level by ≥50%.

6. In adults 40 to 75 years of age evaluated for primary ASCVD prevention, have a clinician–patient risk discussion before starting statin therapy. Risk discussion should include a review of major risk factors (e.g., cigarette smoking, elevated blood pressure, LDL-C, hemoglobin A1C [if indicated], and calculated 10-year risk of ASCVD); the presence of risk-enhancing factors (see No. 8); the potential benefits of lifestyle and statin therapies; the potential for adverse effects and drug–drug interactions; consideration of costs of statin therapy; and patient preferences and values in shared decision-making.

7. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels ≥70 mg/dL (≥1.8 mmol/L), at a 10-year ASCVD risk of ≥7.5%, start a moderate-intensity statin if a discussion of treatment options favors statin therapy. Risk-enhancing factors favor statin therapy (see No. 8). If risk status is uncertain, consider using **coronary artery calcium (CAC)** to improve specificity (see No. 9). If statins are indicated, reduce LDL-C levels by ≥30%, and if 10-year risk is ≥20%, reduce LDL-C levels by ≥50%.

8. In adults 40 to 75 years of age without diabetes mellitus and 10-year risk of 7.5% to 19.9% (intermediate risk), risk-enhancing factors favor initiation of statin therapy (see No. 7). Risk-enhancing factors include family history of premature ASCVD; persistently elevated LDL-C levels ≥160 mg/dL (≥4.1 mmol/L); metabolic syndrome; chronic kidney disease; history of preeclampsia or premature menopause (age <40 years); chronic inflammatory disorders (e.g., rheumatoid arthritis, psoriasis, or chronic HIV); high-risk ethnic groups (e.g., South Asian); persistent elevations of triglycerides ≥175 mg/dL (≥1.97 mmol/L); and, if measured in selected individuals, apolipoprotein B ≥130 mg/dL, high-sensitivity C-reactive protein ≥2.0 mg/L, ankle-brachial index <0.9 and lipoprotein (a) ≥50 mg/dL or 125 nmol/L, especially at higher values of lipoprotein (a). Risk-enhancing factors may favor statin therapy in patients at 10-year risk of 5-7.5% (borderline risk).

9. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels ≥70 mg/dL- 189 mg/dL (≥1.8-4.9 mmol/L), at a 10-year ASCVD risk of ≥7.5% to 19.9%, if a decision about statin therapy is uncertain, consider measuring **CAC**. If **CAC** is zero, treatment with statin therapy may be withheld or delayed, except in cigarette smokers, those with diabetes mellitus, and those with a strong family history of premature ASCVD. A **CAC** score of 1 to 99 favors statin therapy, especially in those ≥55 years of age. For any patient, if the **CAC** score is ≥100 Agatston units or ≥75th percentile, statin therapy is indicated unless otherwise deferred by the outcome of clinician–patient risk discussion.

10. Assess adherence and percentage response to LDL-C–lowering medications and lifestyle changes with repeat lipid measurement 4 to 12 weeks after statin initiation or dose adjustment, repeated every 3 to 12 months as needed. Define responses to lifestyle and statin therapy by percentage reductions in LDL-C levels compared with baseline. In ASCVD patients at very high-risk, triggers for adding non-statin drug therapy are defined by threshold LDL-C levels ≥70 mg/dL (≥1.8 mmol/L) on maximal statin therapy (see No. 3).

Continuing Medical Eduation Credits

Objective: Evaluate ability to adopt evidence-based practices and interventions for preventing and better managing premature heart attacks, strokes and diabetes.
Educational Format: This activity will be include didactic lectures with Q&A. This activity will be evaluated by each participant at the end of the fiscal year.
Target Audience: The activity content is oriented to address the educational needs of attending physicians/faculty, residents/fellows and other allied health care professionals.

Accreditation Statement: The Keck School of Medicine of the University of Southern California is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation: The Keck School of Medicine of the University of California designates this live activity for a maximum of 3.5 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Allied Health Care Professionals: Registered nurses may report up to 3.5 credit hours toward the continuing education requirement for license renewal by their state Board of Registered Nurses (BRN). CME may be noted on the license renewal application in lieu of a BRN provider number. ♦ The National Commission on Certification of Physician Assistants states that AMA accredited Category 1 courses are accepted for re certification.

Disclosure:

As an organization accredited by the ACCME The Keck School of Medicine of the University of Southern California requires everyone who is in a position to control the content of an education activity to disclose prior to the activity all relevant financial relationships with any commercial interest. All disclosed relevant financial relationships would have been resolved prior to the commencement of the activity.

Presenters: Evan Kransdorf, MD, PhD has indicated he has nothing to disclose.
Alissa Maier, MPH has indicated she has nothing to disclose.
Bernadette Mejia, PhD, MS, RD has indicated she has nothing to disclose.
Christopher Tompkins, MS, MBA has indicated he has nothing to disclose.

Course Director/CME Planners: The course director and CME planners have indicated they have nothing to disclose.

During the course of this activity, there may be report and/or discussion of unlabeled or unapproved uses of pharmaceuticals and/or medical devises. All such report and/or discussion are attested to be based on evidence that is generally accepted within the profession of medicine and conforms to the generally accepted standards of experimental design, data collection and analysis.

Support: None.

In accordance with the Americans with Disabilities Act (ADA), please call the CME office at (323)442-2555 should you require special assistance or need additional information regarding this activity.