Right Care Initiative Silicon Valley University of Best Practices

November 27, 2018, 3:45 to 7:30 p.m. PST (3:45 Sign in; 4-7 Program with Dinner; 7:00-7:30 Reception)

Stanford Neuroscience Health Center 213 Quarry Rd Palo Alto, CA 94304

Right Care Initiative Silicon Valley Goal: *Drive Toward Zero Preventable Heart Attack, Stroke, and Diabetes 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***
- ***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)***
- ***Proactive Community Outreach to Screen & Identify Vulnerable Patients to Connect to Treatment & Support***

3:45 - 4:00 p.m. ***Check-In, Coffee, Tea & Snacks - Boxed Dinners and Drinks Delivered***

4:00 - 4:30 p.m. ***Co-Chair Vision, Welcoming Remarks***

Nirali Vora, MD, - Co-Chair, Right Care Initiative Silicon Valley University of Best Practices; Associate Prof., Neurology, School of Medicine, Stanford University; Director, Global Health Neurology; Program Director, Adult Neurology Residency, School of Medicine, Stanford University

Eveline Stock, MD - Co-Chair, Right Care Initiative Silicon Valley University of Best Practices; Assistant Prof., Cardiology, School of Medicine, University of California, San Francisco; Cardiologist, Cardiovascular Care & Prevention Center, University of California, San Francisco

Scott Flinn, MD - Regional Medical Director, Blue Shield of California; Former Co-Chair, San Diego Right Care University of Best Practices (while Arch Medical Group CMO); Former U.S. Navy Medical Officer

Stephen M. Shortell, PhD, MBA - Chair, Right Care Technical Expert Group; Blue Cross Distinguished Prof. of Health Policy and Management and Dean Emeritus, School of Public Health, University of California, Berkeley; Co-Director, Center for Healthcare Organizational and Innovation Research; Prof. of Organization Behavior, Haas School of Business

Robert Kaplan, PhD - Right Care Initiative Technical Expert Group; Adjunct Prof., School of Medicine & Research Director, Clinical Excellence Research Center, Stanford University; Former Chief Science Officer US HHS AHRQ; Retired, Associate Director, National Institutes of Health

Hattie Rees Hanley, MPP – Director and Co-Founder, Right Care Initiative, UC Berkeley School of Public Health, Center for Healthcare Organizational and Innovation Research (CHOIR)

4:30 – 4:45 p.m. ***Family Perspective on Coronary Calcium Screening***

Victoria Dupuy - Founder & Executive Director, No More Broken Hearts Foundation; Along with Survivors

4:45 – 4:55 p.m. ***Coronary Calcium Testing at the Stanford Preventive Cardiology Clinic***

David J. Maron, MD - Director, Preventive Cardiology; Clinical Prof. of Medicine, School of Medicine, Stanford University

4:55 – 5:25 p.m. ***Evidence for Finding and Treating Atherosclerosis Before Patients are Symptomatic***

Matthew Budoff, MD – Prof. of Medicine, Endowed Chair of Preventive Cardiology, School of Medicine, UCLA; Program Director, Division of Cardiology Los Angeles Biomedical Research Institute; Steering Committee Member, Director CT Reading Center, Multi-Ethnic Study of Atherosclerosis (MESA) Trial

5:25 – 5:55 p.m. ***US Preventive Services Task Force's Insufficient Evidence Recommendation & Next Steps***

Doug Owexns, MD, MS – Prof., School of Medicine, Stanford University; Incoming Chair, US Preventive Services Task Force

5:55-6:15 **Facilitated Q&A and ACC/AHA Clip**

6:15 – 6:30 p.m. ***Payer Perspective***

Scott Flinn, MD - Regional Medical Director, Blue Shield of California; Former Co-Chair, San Diego Right Care University of Best Practices (while Arch Medical Group CMO); Former U.S. Navy Medical Officer

Carol Zaher, MD, MPH, MBA – Board Certified Cardiologist & Medical Director, Health Net California Medical Management, Centene; Los Angeles University of Best Practices Co-Chair, Right Care Initiative

6:30 – 7:00 p.m. ***Moderated Around-the-Room Q &A, Planning & Action Discussion: Silicon Valley Quest to Get to Zero Preventable Heart Attacks, Strokes & Diabetes Deaths and Disabilities***

Moderators: **Robert Kaplan, PhD** - Right Care Initiative Technical Expert Group; Adjunct Prof., School of Medicine & Research Director, Clinical Excellence Research Center, Stanford University; Former Chief Science Officer US HHS AHRQ; Retired, Associate Director, National Institutes of Health

David J. Maron, MD - Director, Preventive Cardiology; Clinical Prof. of Medicine, School of Medicine, Stanford University

7:00 – 7:30 p.m. ***Reception***

At Right Care Initiative gatherings, we follow the Warren Principle: ***we compete against disease and not each other.***

A Big Thank You to Stanford University for hosting the Right Care Initiative!

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).