A G E N D A

Wednesday, March 20, 2019 | 12:00 to 2:00 p.m.

(Networking lunch served at 11:30 a.m.)

RAND Corporation | 1st Floor at The Forum
1776 Main St. Santa Monica, CA 90401

Right Care University of Best Practices Care Management Goals: Prevention and High-Quality Management of Heart Disease, Strokes, and Diabetes

Metrics targets:

75% of cardiovascular disease and/or diabetes patients meeting the following targets (or national 90th percentile of performance on these HEDIS measures, whichever is greater):

- **Blood pressure (BP)** controlled: **<140/90 mm Hg**
- **Diabetic** patients with **blood sugar** controlled: HbA1c <8
- **Consistently taking intensive cholesterol medication** appropriate to clinical targets

12:00 to 12:05 p.m. **Welcome, Introductions and Chairpersons' Remarks**

Chloe Bird, PhD, MA, Co-Chair, Right Care Initiative University of Best Practices--Los Angeles; Senior Social Scientist, RAND Corporation

Steve Chen, PharmD, FASHP, FCSHP, FNAP, Co-Chair, Right Care Initiative University of Best Practices--Los Angeles; 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, Co-Chair, Right Care Initiative University of Best Practices--Los Angeles; Director, Division of Chronic Disease and Injury Prevention, Los Angeles County Department of Public Health; Co-Program Leader, Population Health Program, UCLA Clinical and Translational Science Institute

LaVonna Blair Lewis, PhD, MPH, Co-Chair, Right Care Initiative University of Best Practices – Los Angeles; Teaching Professor of Public Policy and Diversity Liaison, USC School of Public Policy

Carol Peden, MBChB, MD, MPH Co-Chair, Right Care Initiative University of Best Practices – Los Angeles; Executive Director, University of Southern California Center for Health System Innovation; Professor, Keck School of Medicine

Carol Zaher, MD, MPH, MBA, Co-Chair, University of Best Practices, Heart Failure Work Group Co-Chair, Right Care Initiative—Los Angeles; Medical Director, Health Net California Medical Management, Centene

Hattie Rees Hanley, MPP, Director, Right Care Initiative, University of California, Berkeley

12:05 to 12:50 p.m. ***Results from the Hypertension Barbershop Project: Caring for the Patient in the Community***

Florian Rader, MD, Co-Director, Clinic for Hypertrophic Cardiomyopathy and Aortopathies; Assistant Professor of Medicine, Cedars Sinai

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

12:50 to 1:35 p.m. ***Innovations in Care Management: TALL/ALL Medication Bundle***

Jim Dudl, MD, Retired Diabetes Lead and Bundled Medication Champion, Care Management Institute and Community Benefits, Kaiser Permanente

1:35 to 2:00 p.m. **Group Discussion, Announcements and CME**

Thank you, RAND Corporation, for hosting The Right Care Initiative LA University of Best Practices!

County of Los Angeles Public 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).