Together 2 Goal®

AMGA Foundation National Diabetes Campaign

Monthly Campaign Webinar

April 21, 2016

TODAY'S WEBINAR

- Together 2 Goal® Updates
  - Campaign Toolkit
  - Discussion List
  - Data Submission
  - MU/PD National Day of Action
- Assess & Address Risk of Cardiovascular Disease Presentation
  - R. James (Jim) Dudl, MD (Kaiser Permanente)
- Q&A
  - Use Q&A or chat feature

TOGETHER 2 GOAL® CAMPAIGN TOOLKIT

To access the *Together 2 Goal® Campaign Toolkit*:

- **Online:** Visit www.Together2Goal.org and select “Improve Patient Outcomes” &“Campaign Toolkit” in the navigation bar
- **Print:** Send your address to your Regional Liaison (Primary Contacts only)
  - Limited to one print copy per organization
  - All addresses received by Friday, April 22 will be sent the week of April 25th

Together2Goal®

NEW RESOURCE:
CAMPAIGN DISCUSSION LIST

Together2Goal®

CAMPAIGN DISCUSSION LIST: INSTRUCTIONS ON SENDING A MESSAGE

To send a message to the discussion list:

- Email members directly at AMGA-T2G@amgalist.org
- Email your regional liaison or Together2Goal@amga.org if you prefer anonymity on an issue

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CAMPAIGN DISCUSSION LIST: ETIQUETTE

- **Signature:** Include a signature tag on all messages. Include your name, affiliation, location, and e-mail address.
- **Subject Line:** State concisely and clearly the specific topic of the comments in the subject line. This allows members to respond more appropriately to your posting and makes it easier for members to search the archives by subject.
- **Replying:** Include only the relevant portions of the original message in your reply, delete any header information, and put your response before the original posting. Only send a message to the entire list when it contains information that *everyone* can benefit from.

  Send messages such as "thanks for the information" or "me, too" to individuals--not to the entire list. Do this by using your e-mail application's forwarding option and typing in or cutting and pasting in the e-mail address of the individual to whom you want to respond.

  Do not send administrative messages, such as remove me from the list, through the discussion list. Instead, contact AMGA directly to change your settings or to remove yourself from a list. If you are changing e-mail addresses, you need to advise AMGA to remove you from the list and rejoin under your new e-mail address.

CAMPAIGN DISCUSSION LIST: RULES

- As with any community, there are guidelines governing behavior on the discussion lists. For instance, violating antitrust regulations, libeling others, selling, and marketing are not permissible. Please take a moment to acquaint yourself with these important guidelines. If you have questions, contact the list manager noted in your welcome instructions. AMGA reserves the right to suspend or terminate membership on all lists for members who violate these rules.
- Do not challenge or attack others. The discussions on the lists are meant to stimulate conversation not to create contention. Let others have their say, just as you may.
- Do not post commercial messages. Contact people directly with products and services that you believe would help them.
- The discussion list is not to be used for posting job positions. We ask if you have job listings or are looking to recruit employees to please use AMGA's professional opportunities page found on www.amga.org
- Use caution when discussing products. Information posted on the lists is available for all to see, and comments are subject to libel, slander, and antitrust laws.
- All defamatory, abusive, profane, threatening, offensive, or illegal materials are strictly prohibited. Do not post anything in a discussion list message that you would not want the world to see or that you would not want anyone to know came from you.
- Please note carefully all items listed in the disclaimer and legal rules below, particularly regarding the copyright ownership of information posted to the list.
- Remember that AMGA and other e-mail list participants have the right to reproduce postings to this discussion list.

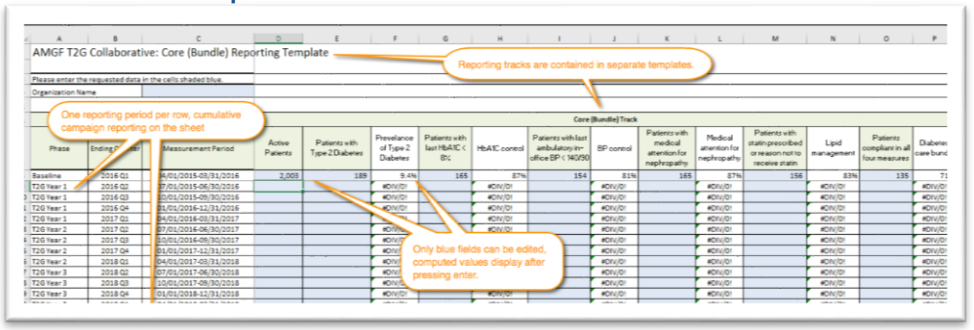
DATA REPORTING

Data Tools & Resources Are Now Available!

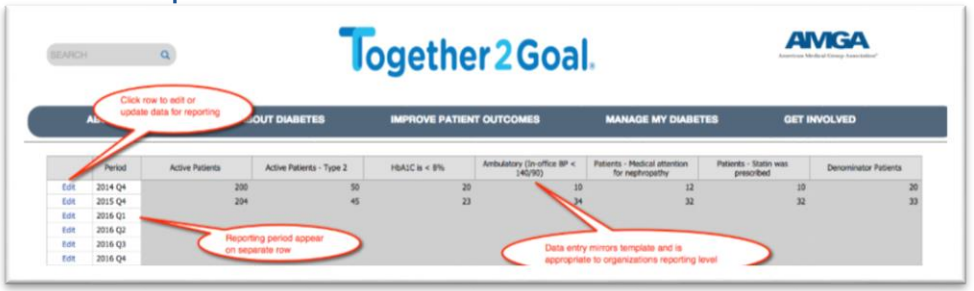
- Excel template
- Data portal
- User guide
- Reporting deadlines
- Measurement specs

For data assistance contact:
DataHelpForT2G@amga.org

Excel template:



Data portal:



**Note: As a benefit to Anceta participants, AMGA Analytics (Anceta) will automatically report data on your organization's behalf according to the Core Track. Anceta will reach out in advance of the reporting deadline to review your data.*

Together2Goal®

MEASURE UP/PRESSURE DOWN®
NATIONAL DAY OF ACTION

Take an "action" for high blood pressure awareness, detection, or control on Thursday, May 5, 2016!

To learn more:

- Visit www.MeasureUpPressureDown.com/NDA2016/
- Email MUPDNationalDayofAction@amga.org

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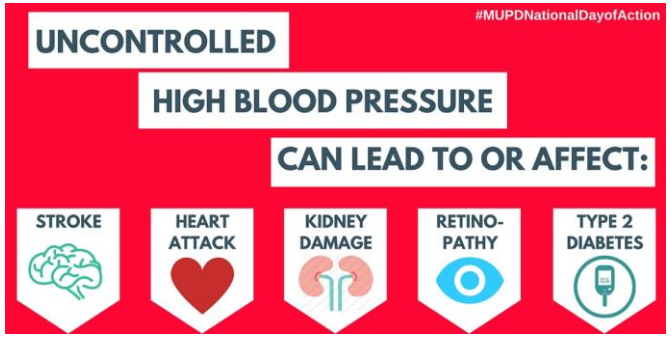
NATIONAL DAY OF ACTION: WHY PARTICIPATE?

By participating on May 5, you'll:

- Have a sneak peak of what the Together 2 Goal® National Day of Action will be like in November 2016
- Receive visibility in conjunction with this important event
- Help us reach million of Americans with high blood pressure
  - 141 million collective Americans impacted by this event in 2014 & 2015

Together2Goal®

NATIONAL DAY OF ACTION: DIABETES-RELATED "ACTIONS"

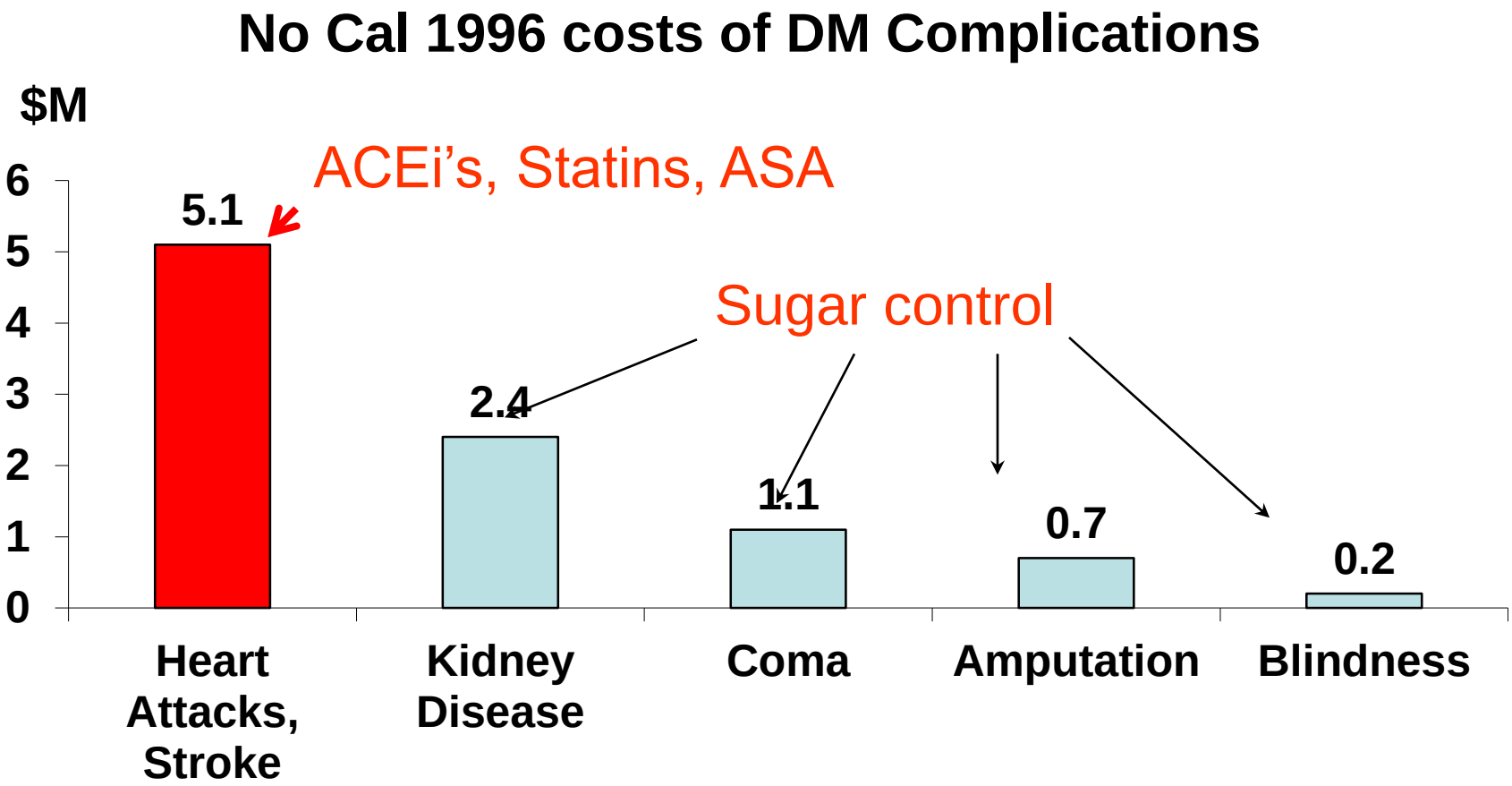


To access these "actions" please email MUPDNationalDayofAction@amga.org

DM: To Prevent CVD “Bundle Up!”

Jim Dudl MD, DM lead &
Community Benefit Kaiser Permanente

Why Focus On Heart Attacks & Strokes in DM? It's Almost a CVD Risk Equivalent and…



If you focus on CVD prevention you will do the most good possible
If you do not you will miss the biggest opportunity. To help your pt.

Change From Lowering Chol & BP to Preventing CVD in High Risk Pts

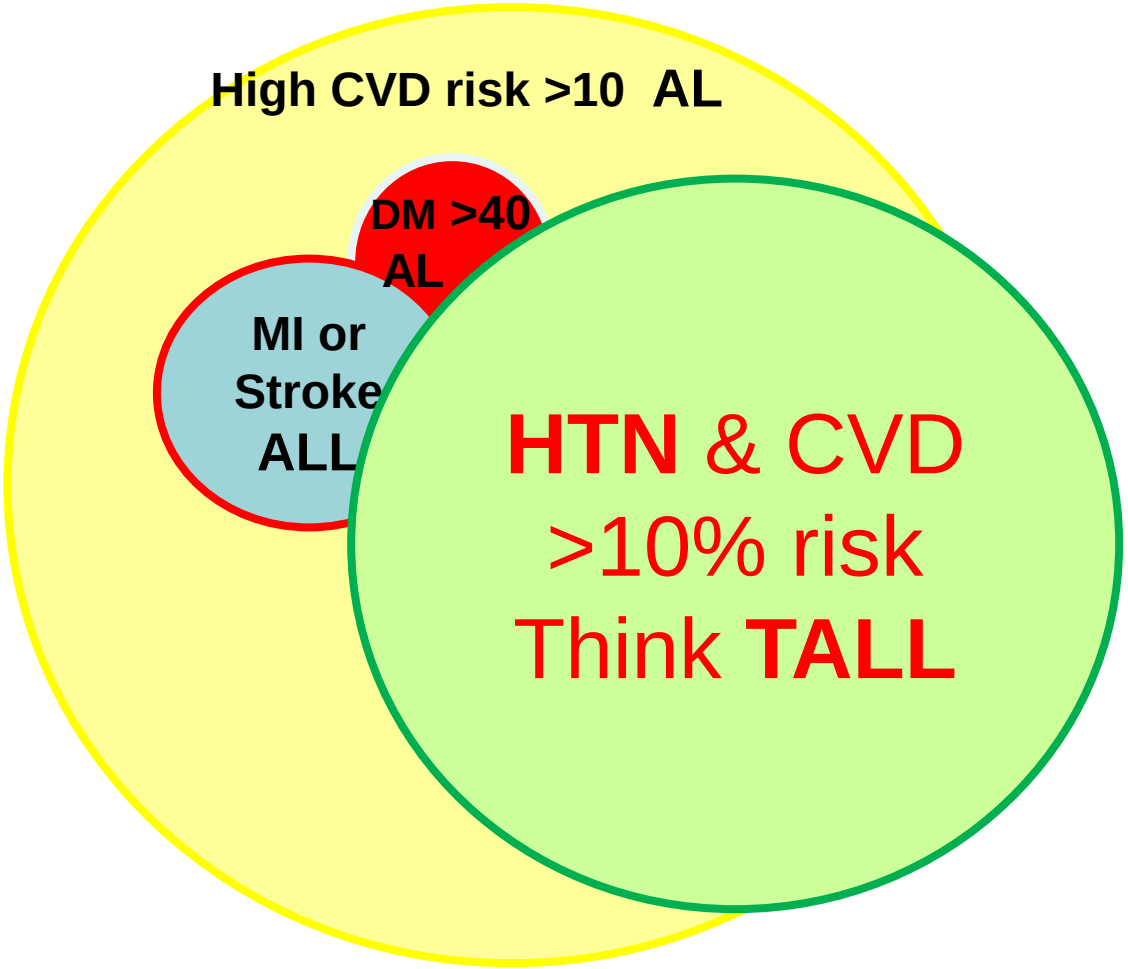
- AHA/ACC guidelines: Treat High CVD risk not LDL levels
  - How do you calculate high CVD risk?
  - What Does ADA AHA say about DM pt over 40?
  - If you don't have the calculation what comes close? 55yo
- What is a very simple way to do prevention for all high CVD risk pts? DM and
  - With HTN -- TALL
  - With CVD -- ALL
  - Over 40? --- AL
- But how can you get people on the meds?
  - Start the bundle all at once
  - How to check on adherence? Ask Educate Ask
    - Teach-back

ALL VIDEO:

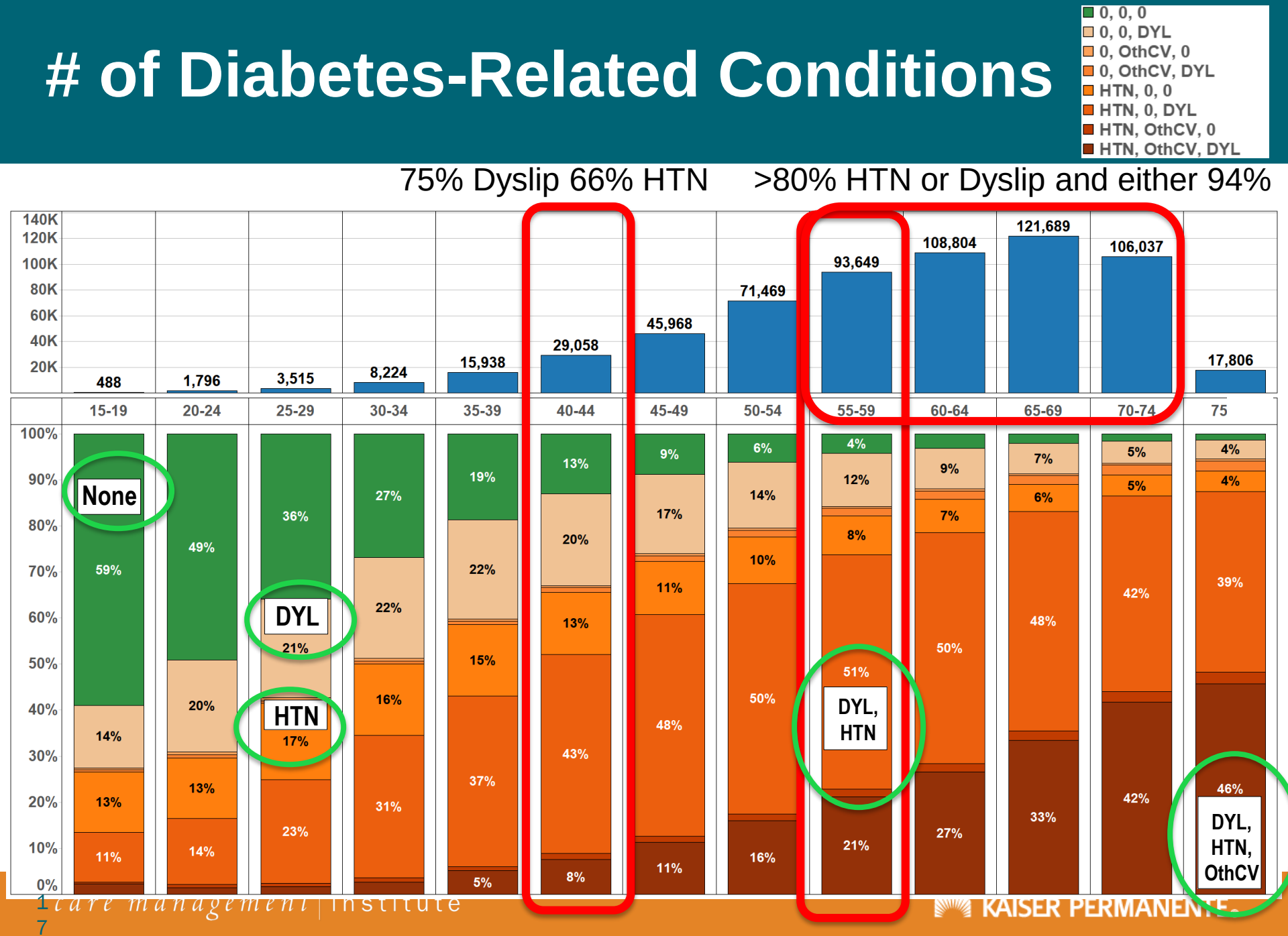
- https://www.youtube.com/channel/UCSALjVDfoKWsVS8FdYUnfng/videos
  - Or
- https://www.youtube.com/watch?v=3sjyb_trTno

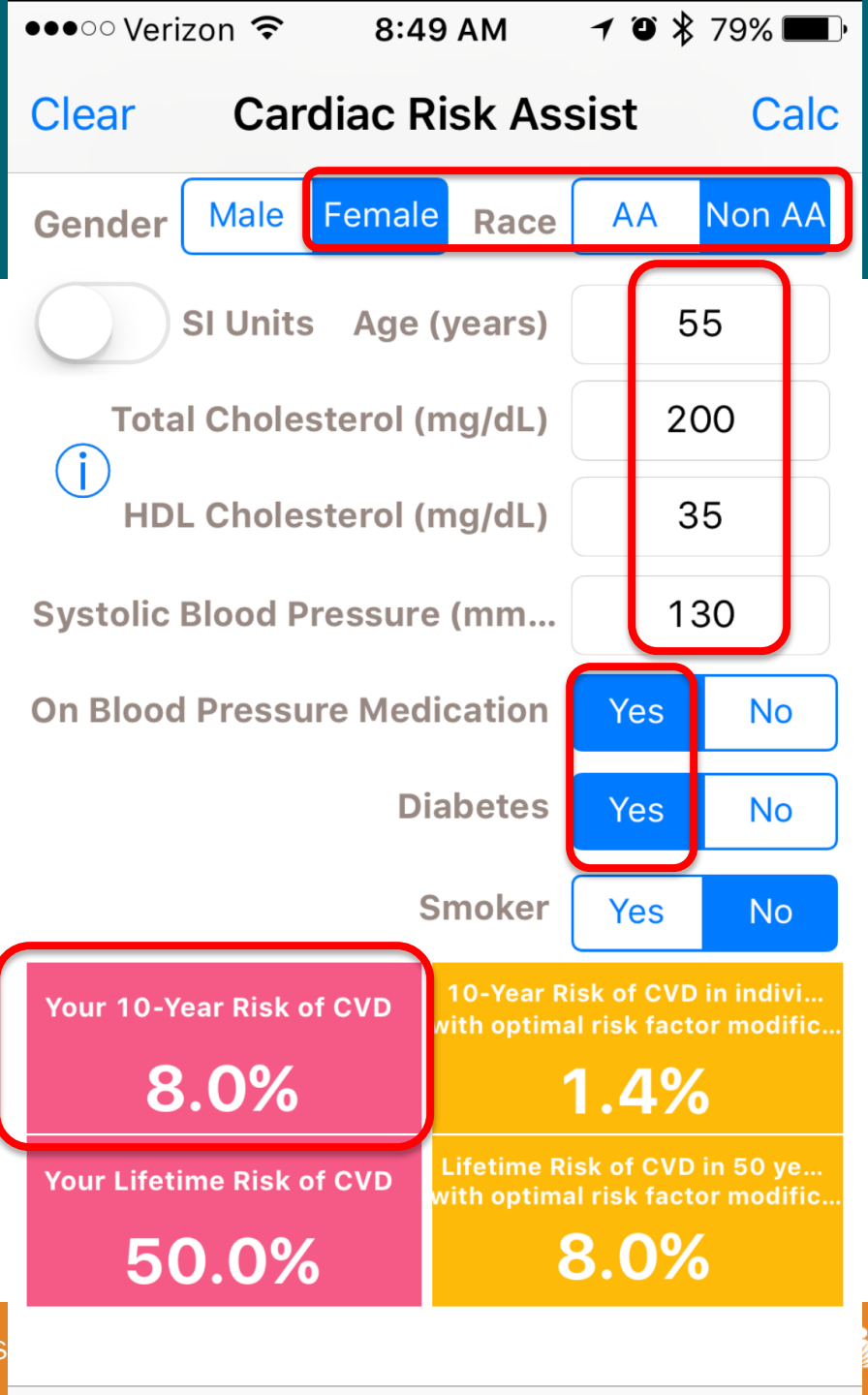
Who is Hi Risk? Hypertension & Hi CVD Risk are the Biggest Risk Groups for a Heart Attack or Stroke

Thiazide
Aspirin
Lipid lowering
Lisinopril ACE or
ARB



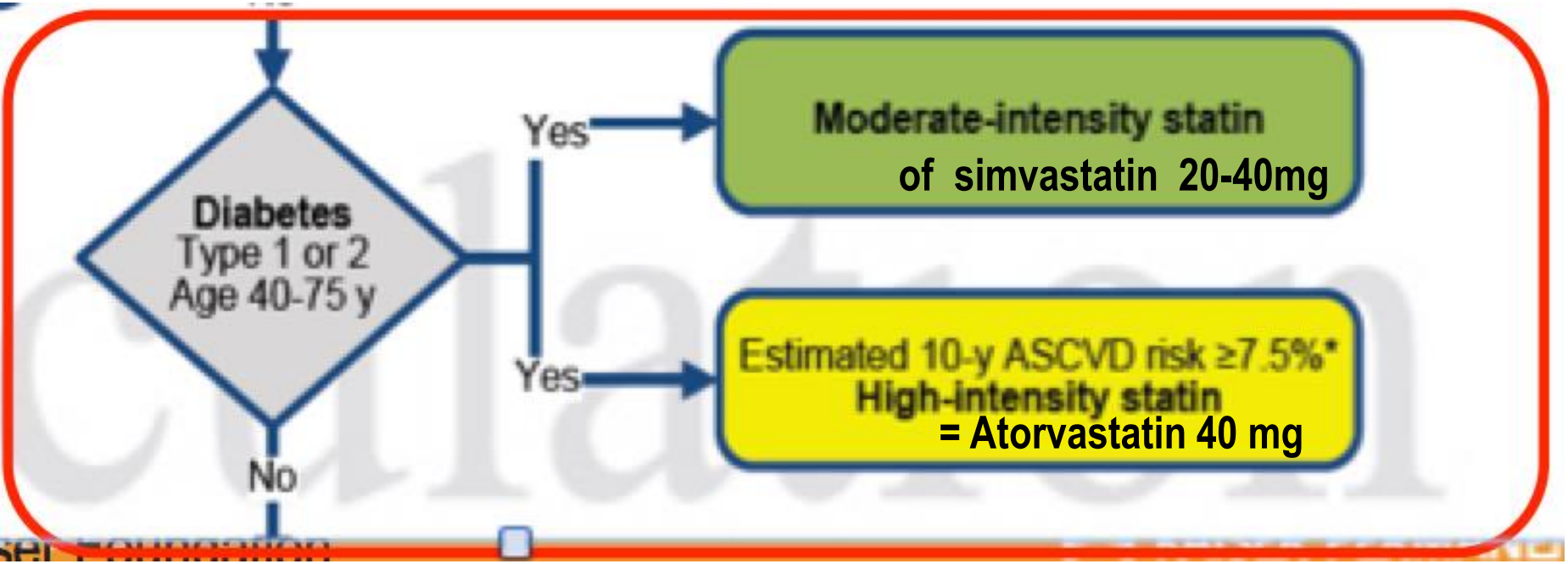
of Diabetes-Related Conditions





Rx
High Intensity
Statin
ie Atorva 40

AHA/ACC Rx Recommendation:

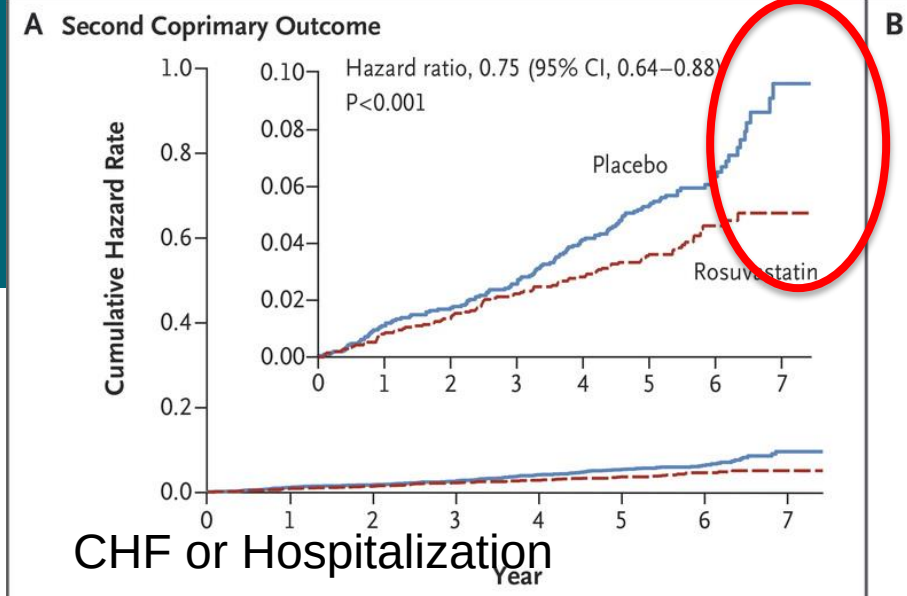


HEDIS & Medicare will look for 80% adherence to any statin

HOPE 3 Evidence Statins Work In Intermediate Risk Pts w/o Lipid Levels

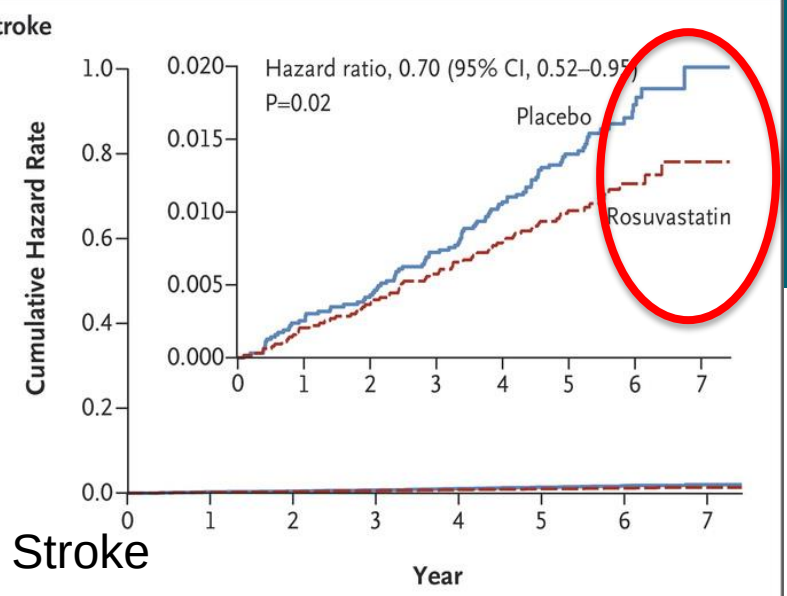
- HOPE3 trial: no **lipid** or BP criteria
  - Criteria Men >55 women >65 with 1 of
    - Waste /hip ratio >.8
    - HDL < 40
    - Smoker
    - Dysglycemia [pre-diabetes or DM on no meds]
    - FH CVD: male <55 female <65
  - Exclusion
    - Any group already proven to benefit: [DM & CVD]
  - LDLC 127 but <112 group did better than rest

published on April 2,2016, at NEJM.org. DOI: 10.1056/NEJMoa1600176



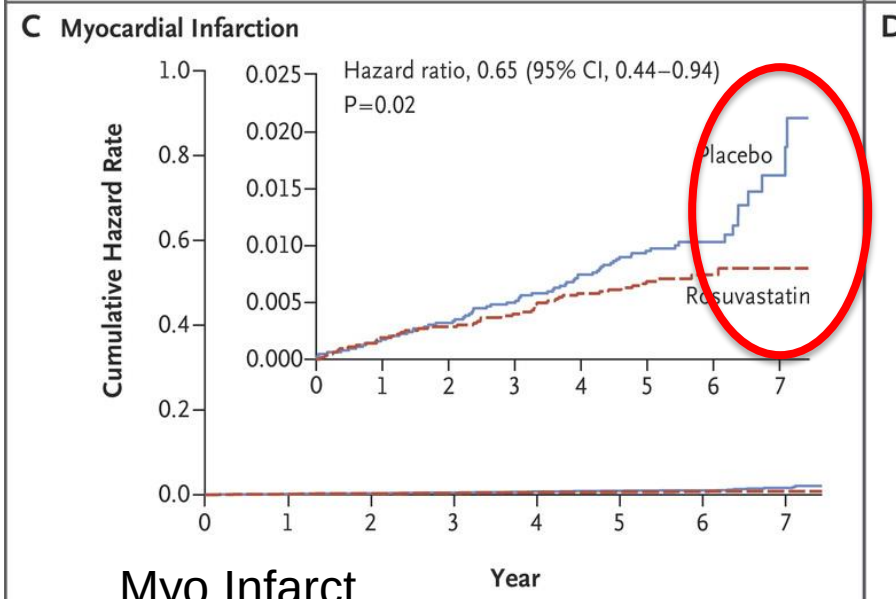
CHF or Hospitalization

No. at Risk								
Placebo	2118	2083	2055	2018	1967	1638	674	164
Rosuvastatin	2117	2091	2068	2034	1999	1662	694	165



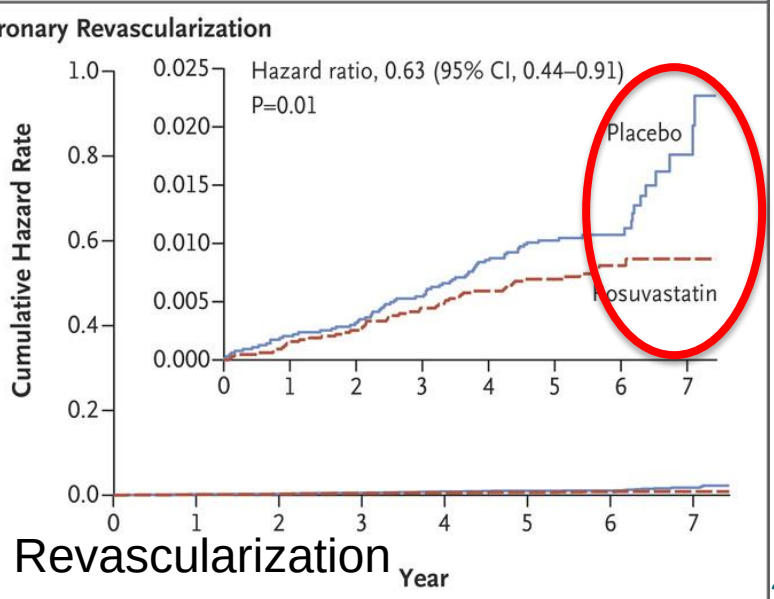
Stroke

No. at Risk								
Placebo	6344	6275	6210	6126	6010	5013	2094	505
Rosuvastatin	6361	6308	6259	6176	6069	5074	2132	534



Myo Infarct

No. at Risk								
Placebo	6344	6278	6215	6132	6019	5024	2091	504
Rosuvastatin	6361	6306	6257	6177	6067	5075	2135	534

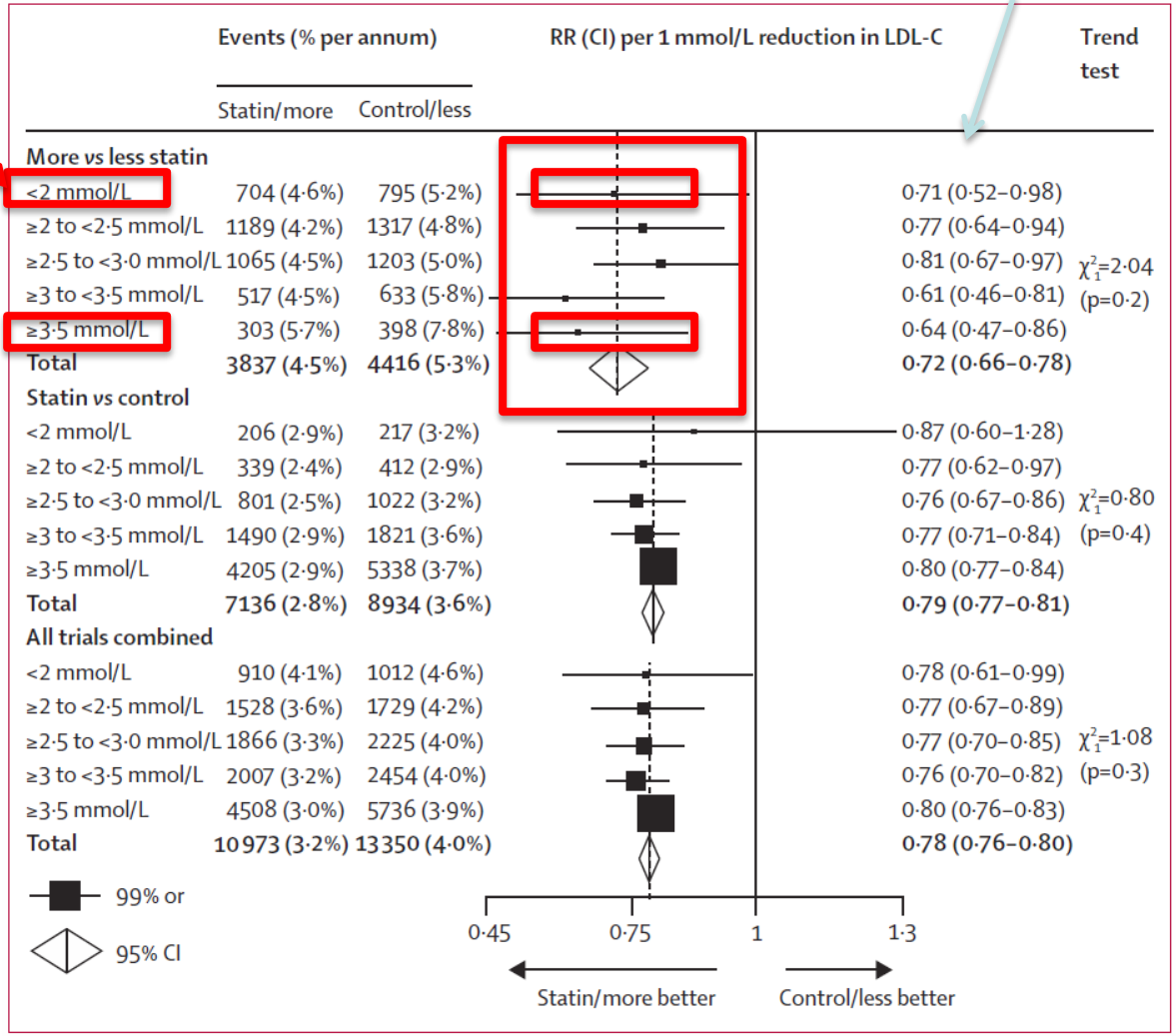


Revascularization

No. at Risk								
Placebo	6344	6276	6213	6127	6010	5015	2085	496
Rosuvastatin	6361	6309	6259	6174	6063	5069	2125	530

Lowering LDL-C reduced CVD events Even When Starting LDL Was Below 77 mg%

Meta analysis of 170,000 pts in RCTS



CTT. Lancet 2010; 376: 1670-1681 170,000 pt meta analysis 26

New : Aspirin: USPSTF recommends it if 50-60yo & if >10% CVD risk*

Adults ages 50 to 59 years	The USPSTF recommends low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer in adults ages 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B

*Similar recommendation 60 to 70 yo but "C" evidence
No specific DM recommendation

JNC8 advice is Compatible with Lisinopril use in DM HTN pts.

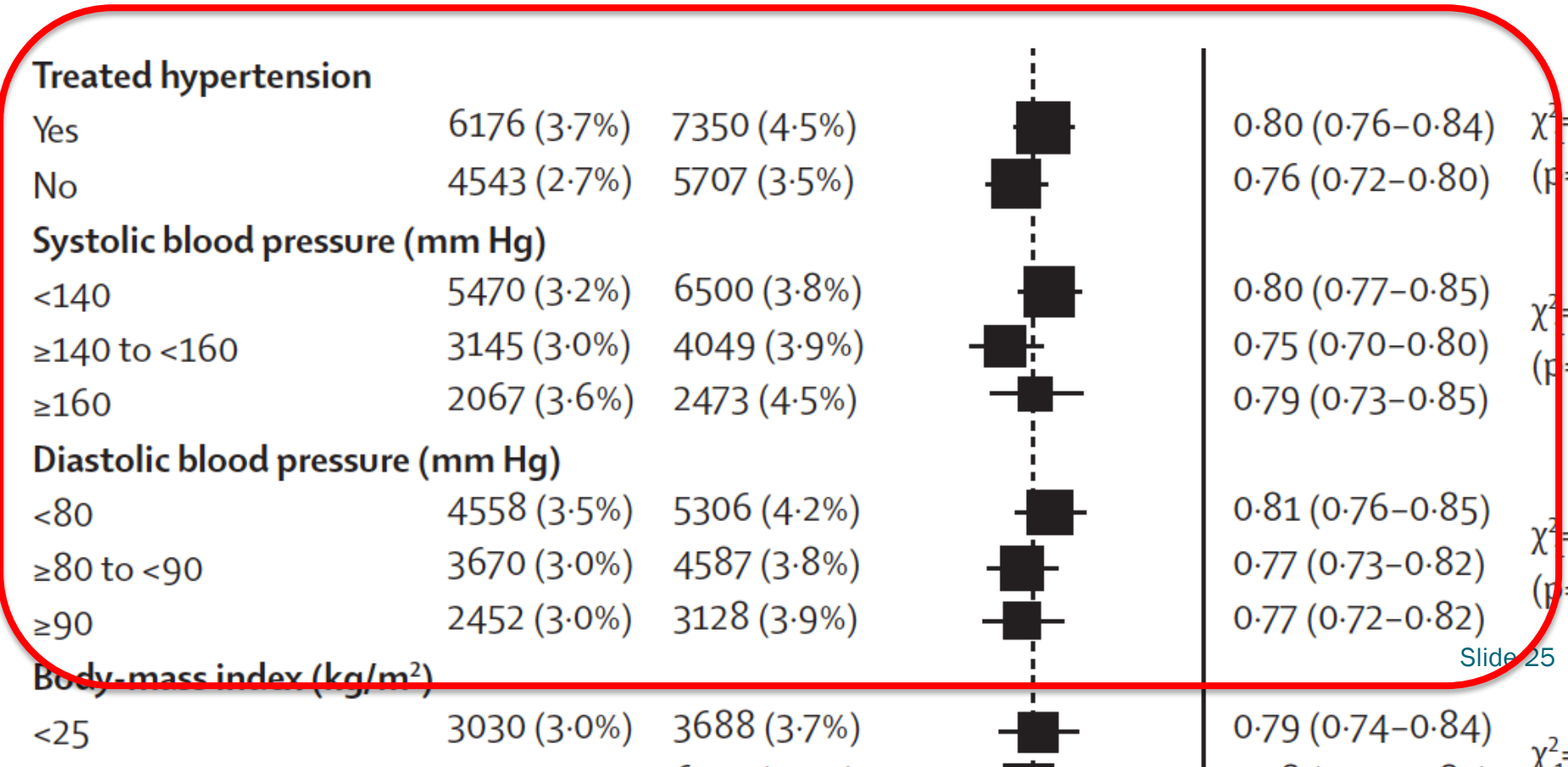
- "treat to **SBP <140mmHg**"
- "… **initial** antihypertensive **treatment should include** a thiazide-type diuretic, (CCB), **(ACEI), or (ARB**)".
- "c- **Begin with 2 drugs** at the same time, either as 2 separate pills or **as a single pill combination**

No where in JNC8 does it say to use, or not To use STATINS!

What's the Evidence for Statins if HTN?

Effects on major vascular events per 1.0 mmol/L reduction in LDL cholesterol 22%

Lancet 2010; 376: 1670–81



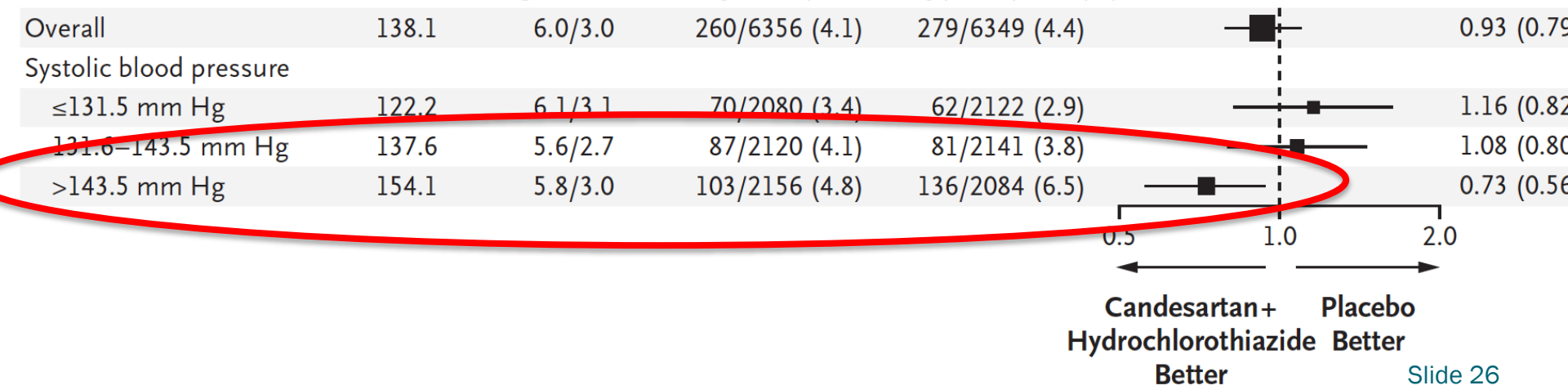
Slide 25

But if no HTN or CVD BP meds don't work, but if HTN they are Also Effective

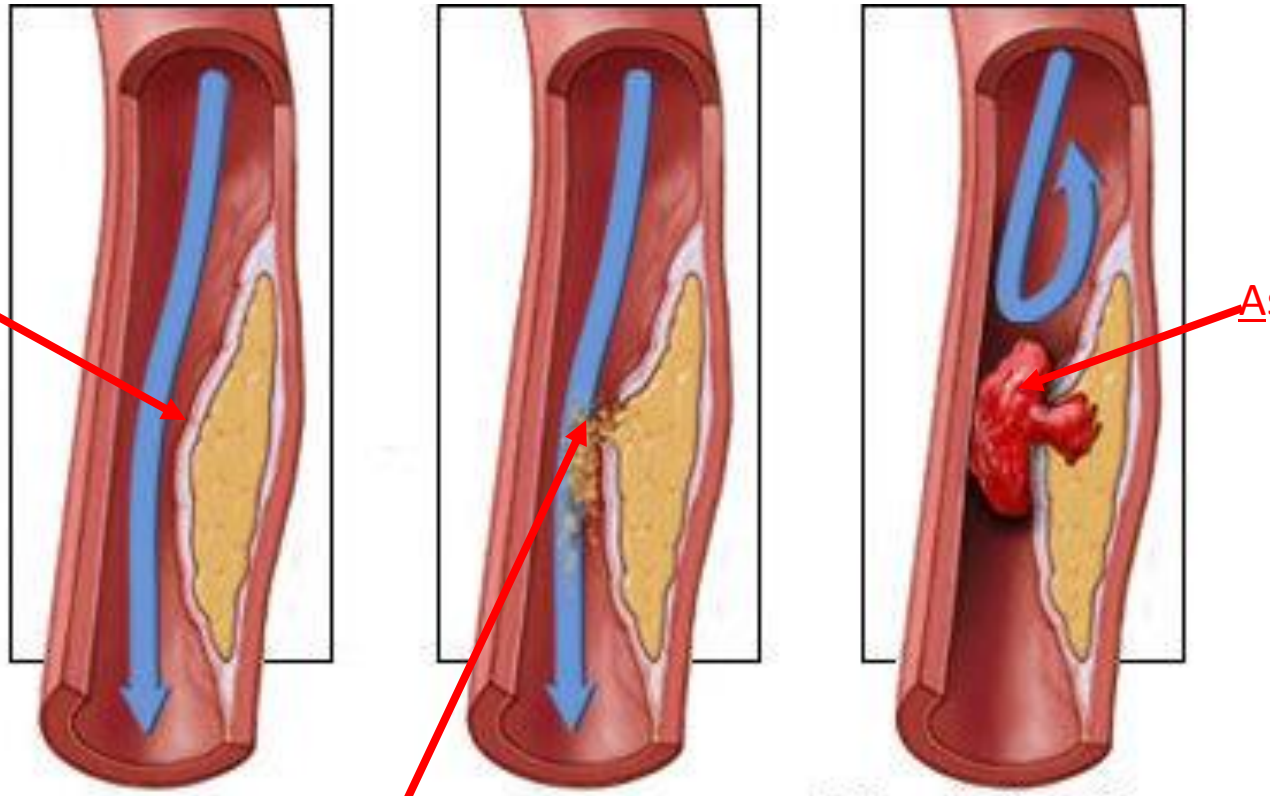
MI or Stroke or death from them BP Rx only siginficant in BP >143 Systolic

A First Coprimary Outcome

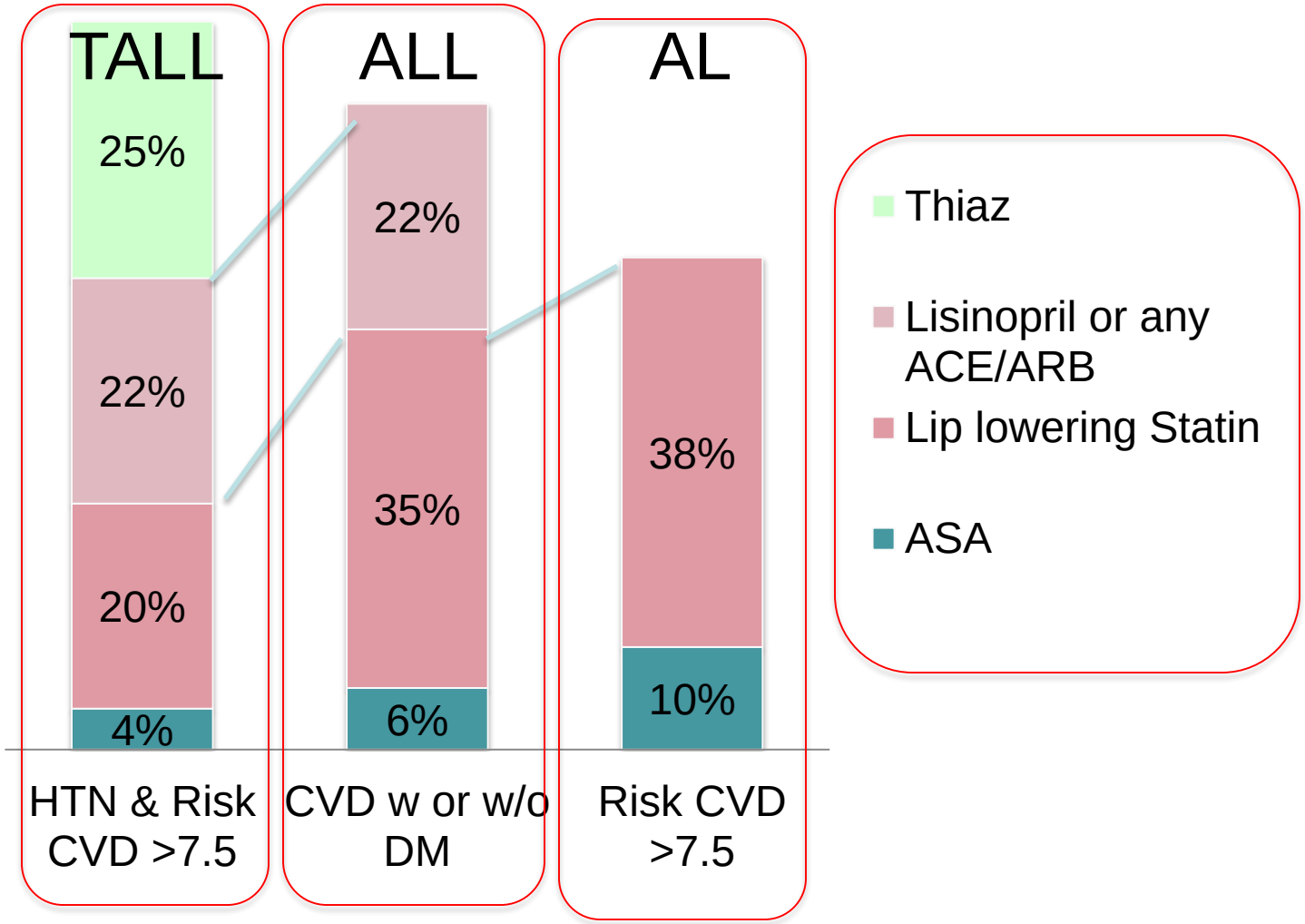
Subgroup	Mean Systolic Blood Pressure	Difference in Blood Pressure	Candesartan+ Hydrochlorothiazide	Placebo	Hazard Ratio (95% CI)
	mm Hg		*no. of events/total no. of participants (%)*		
Overall	138.1	6.0/3.0	260/6356 (4.1)	279/6349 (4.4)	0.93 (0.79
Systolic blood pressure					
≤131.5 mm Hg	122.2	6.1/3.1	70/2080 (3.4)	62/2122 (2.9)	1.16 (0.82
131.6–143.5 mm Hg	137.6	5.6/2.7	87/2120 (4.1)	81/2141 (3.8)	1.08 (0.80
>143.5 mm Hg	154.1	5.8/3.0	103/2156 (4.8)	136/2084 (6.5)	0.73 (0.56



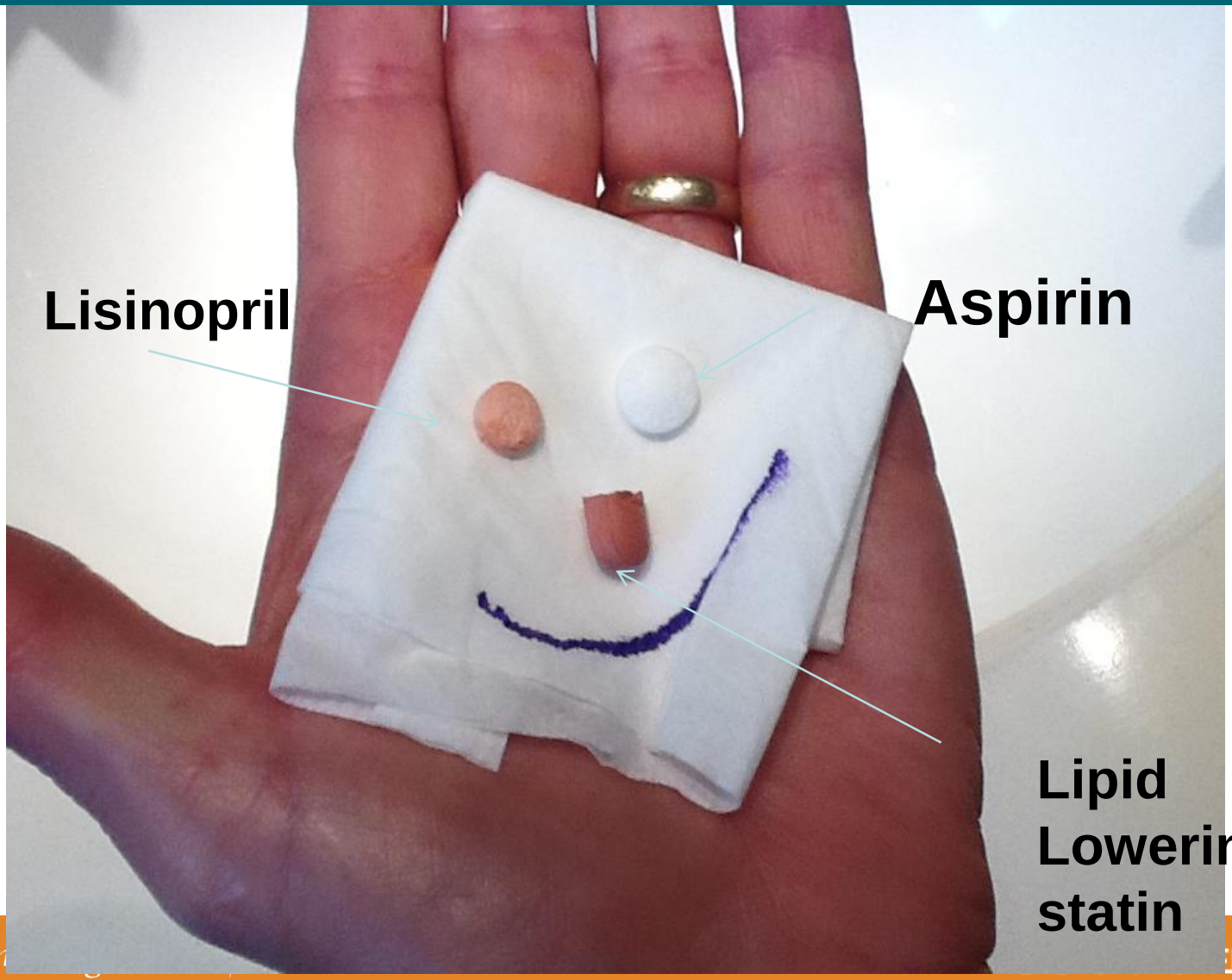
Principle 4: Causes OF a Heart Attack or Stroke in a Pt with DM, HTN or High CVD RISK is the SAME, why not reuse the same treatments?



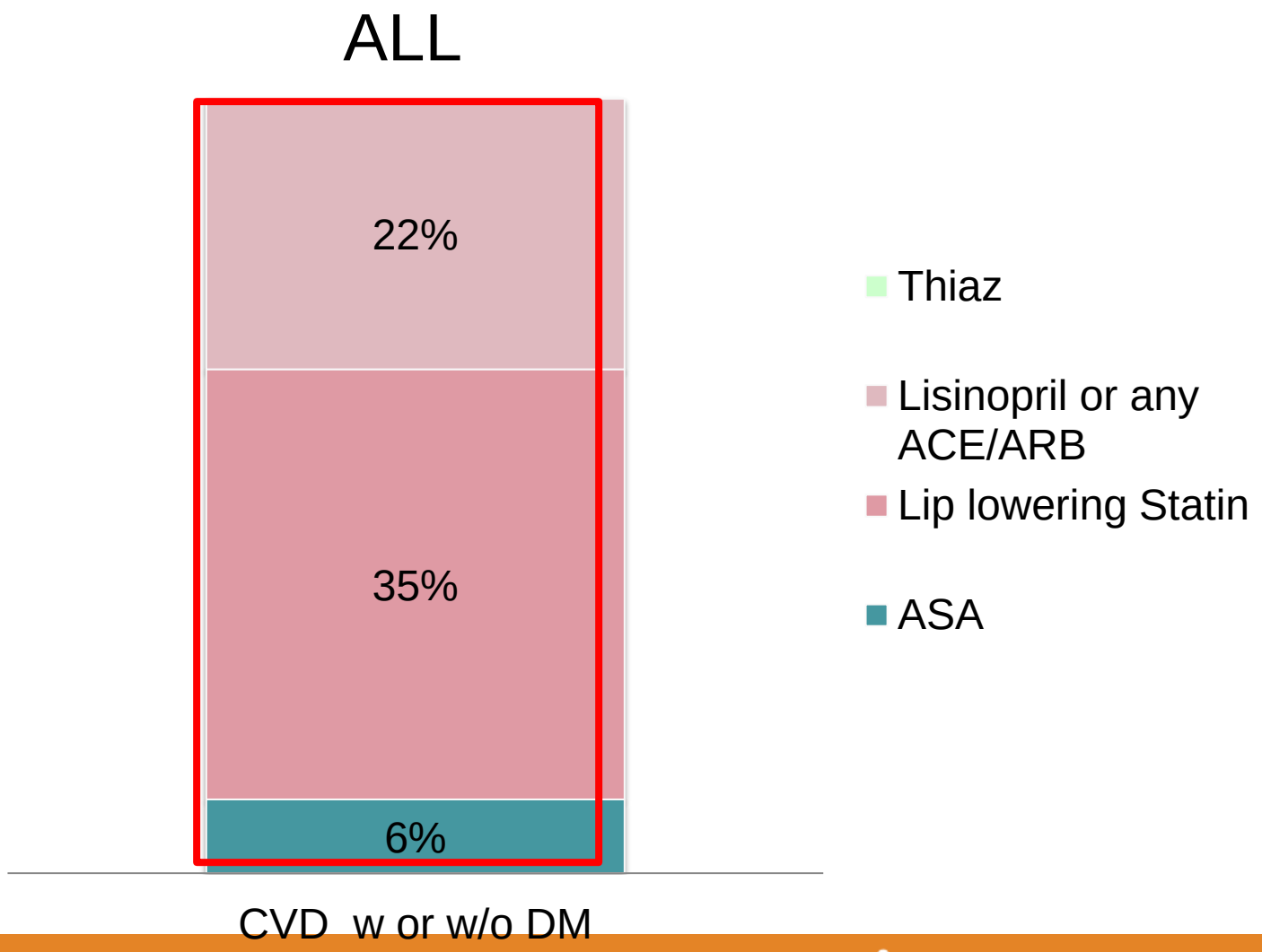
What are AL, ALL and TALL? Bundles of Meds that Prevent Heart Attacks & Strokes



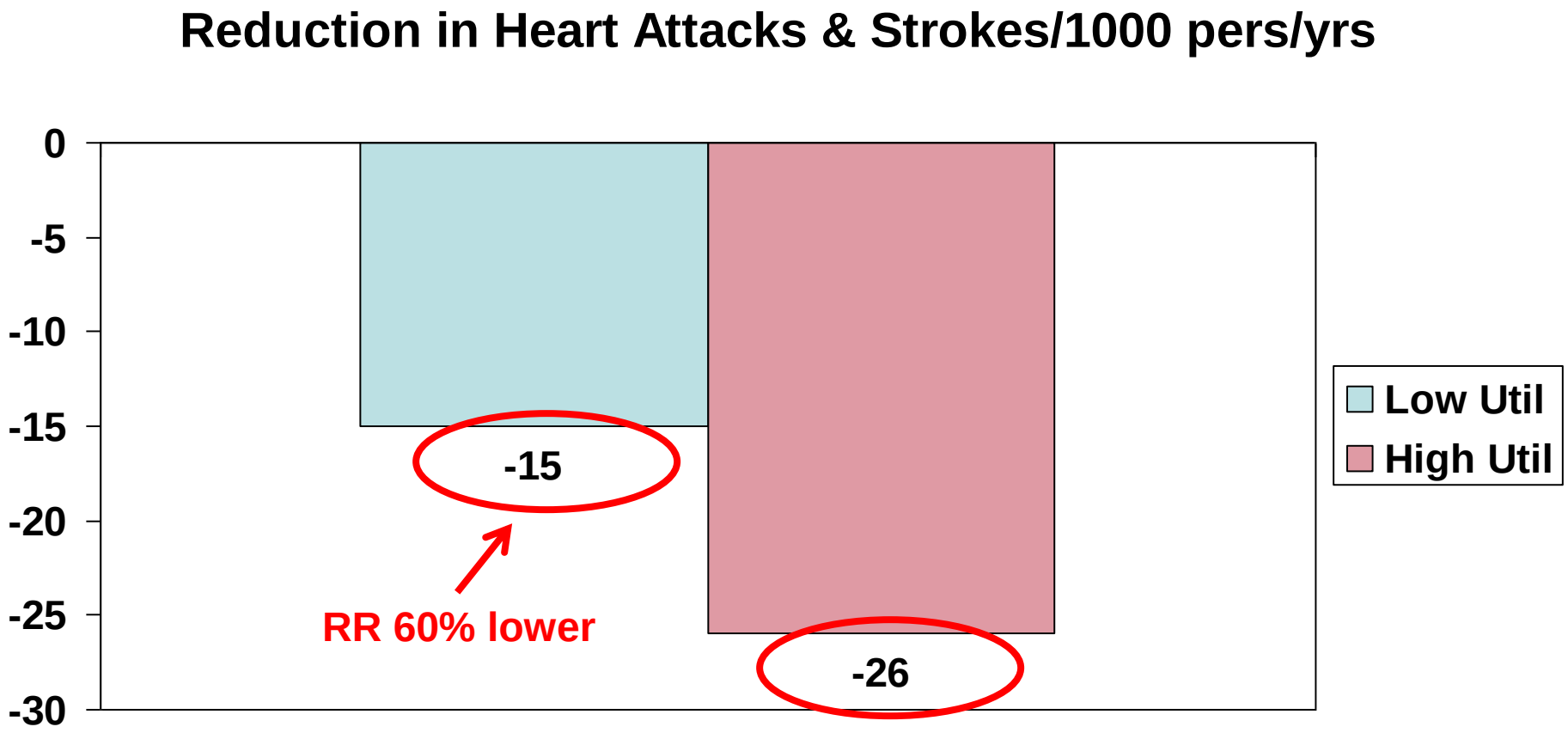
Principle 1: Simplicity. What Could Be Simpler Than Taking 3 Pills at Once?



In People with CVD w or w/o DM Did ALL Decrease Heart Attacks & Strokes?



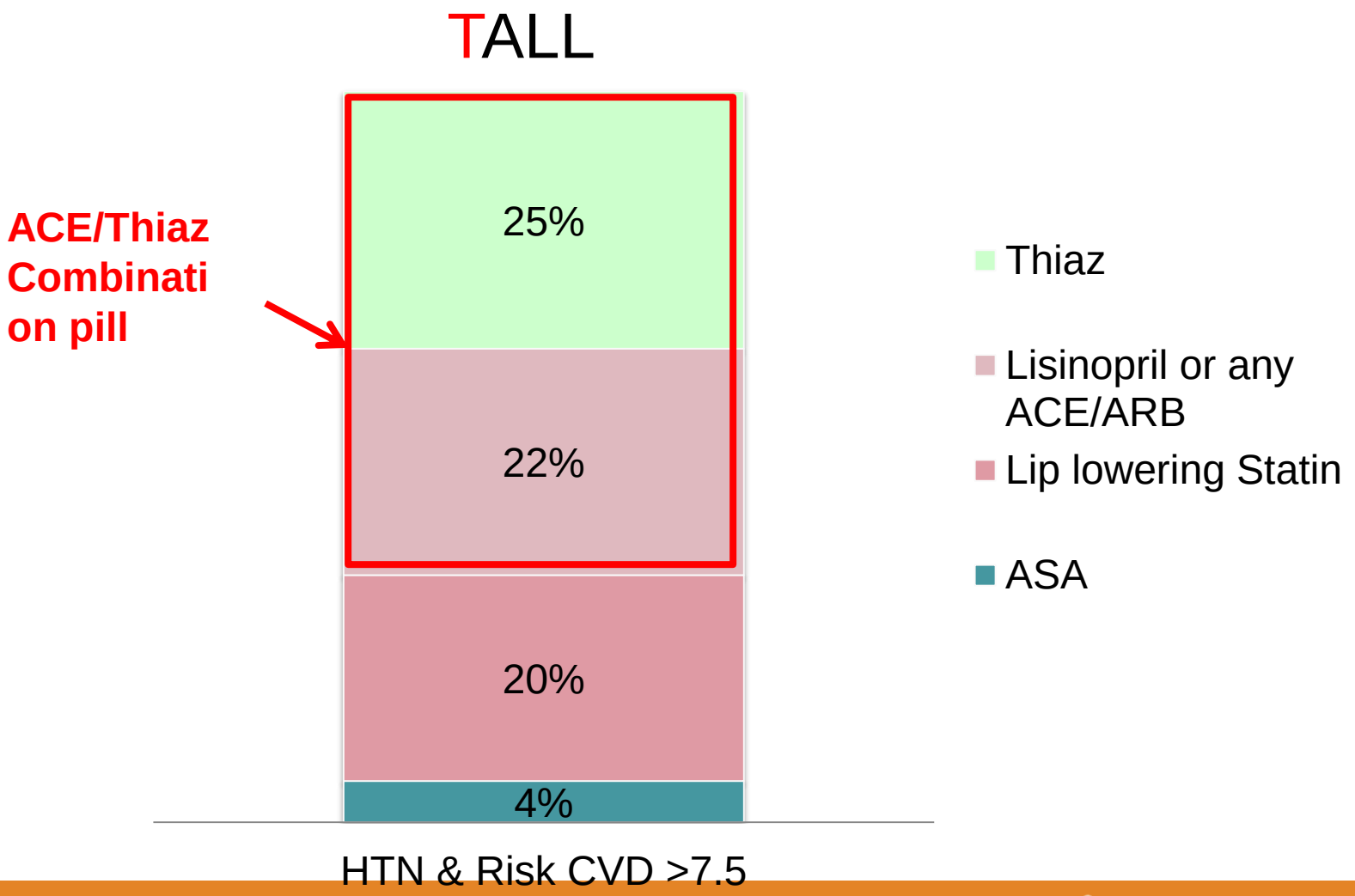
In 70,000 People with CVD or DM>55yo ALL Dropped Events >60% in 3 yrs



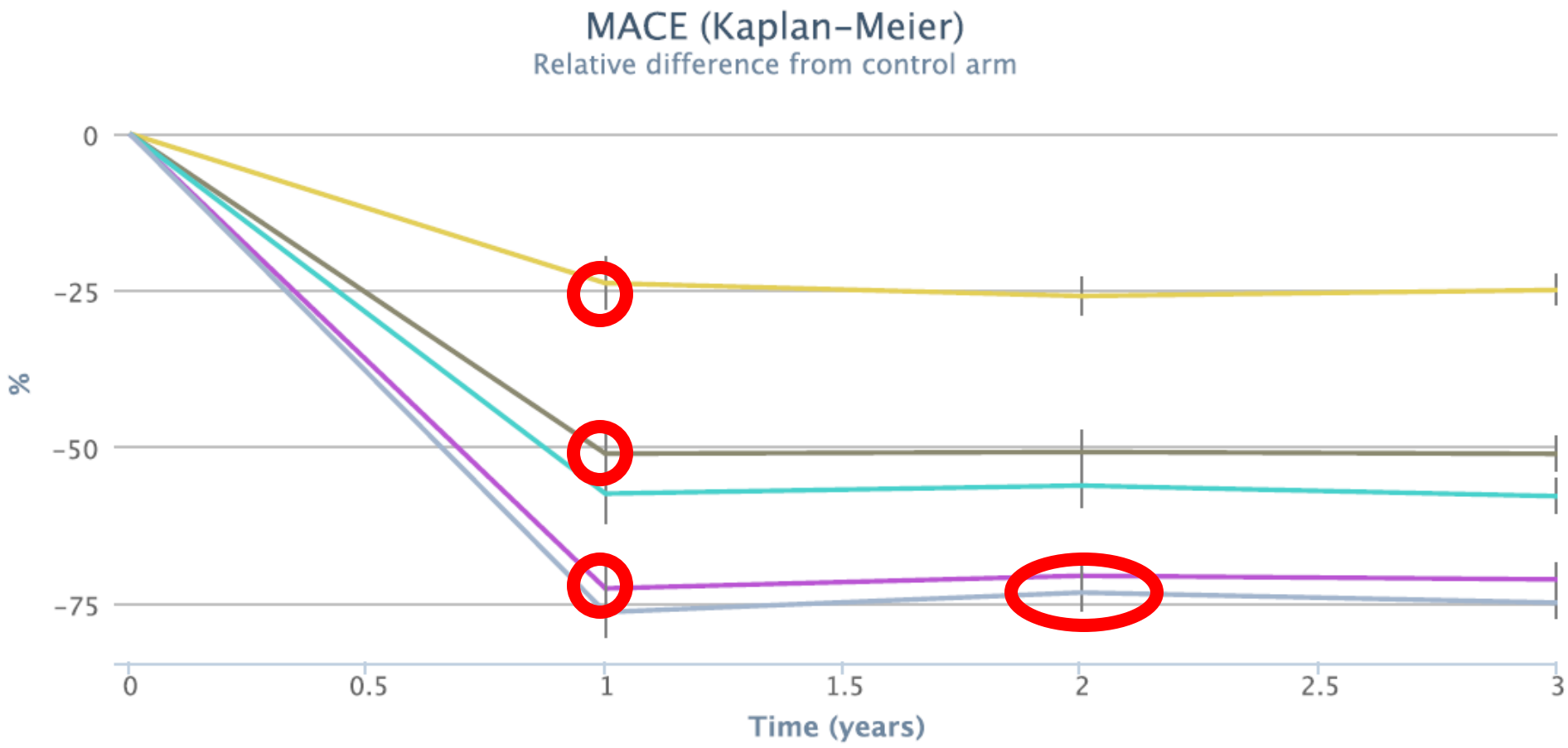
- Even 1 day of 5 utilization was significant
- But taking it 2/3 of the time was much more beneficial

Am J Manag Care. 2009;15(10):e88-e94

For Hypertension A combination of ACE/Thiazide with Statin ASA Models drop in CVD events of 75%

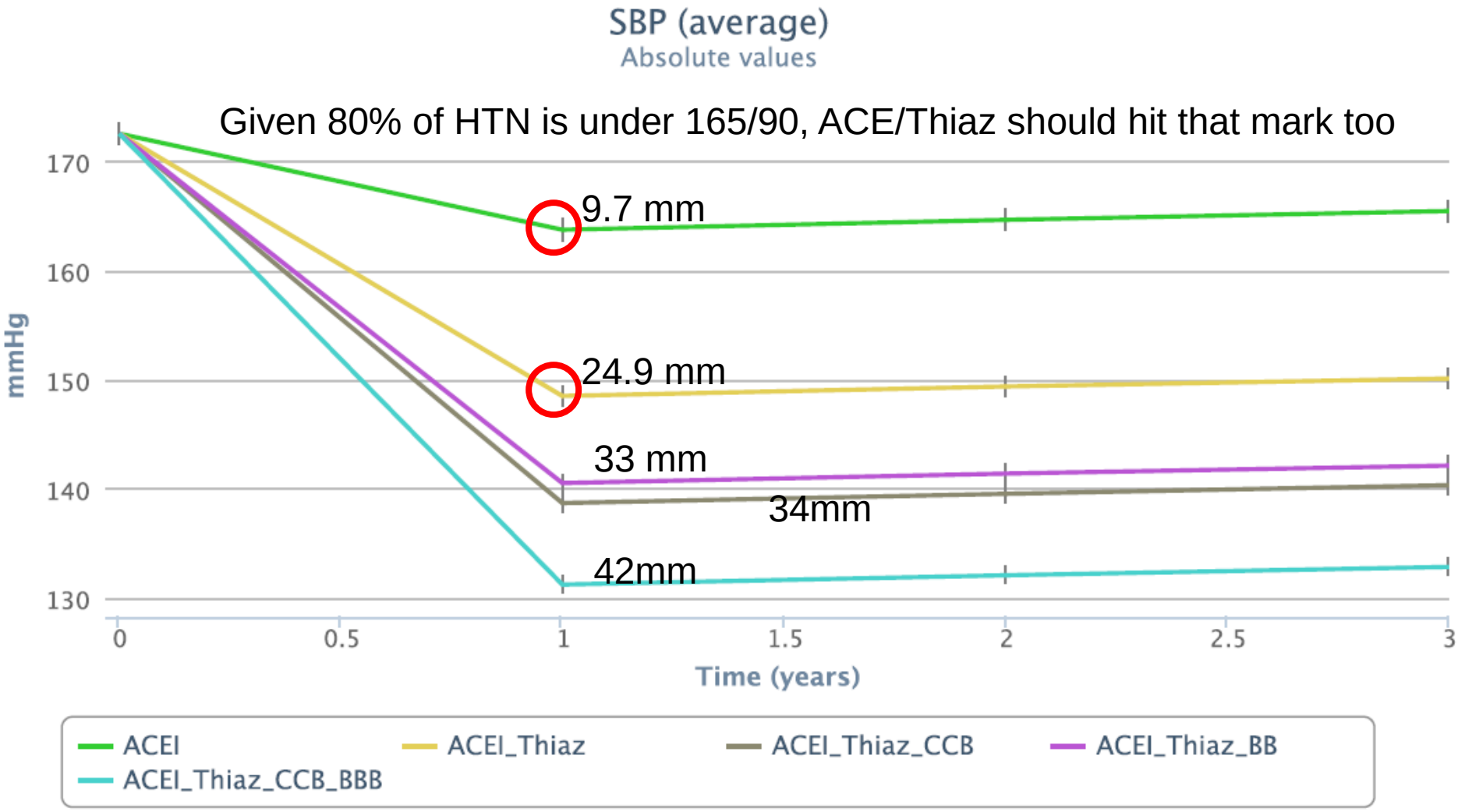


It Can Decrease Heart Attacks, Strokes or Death from them [MACE]*

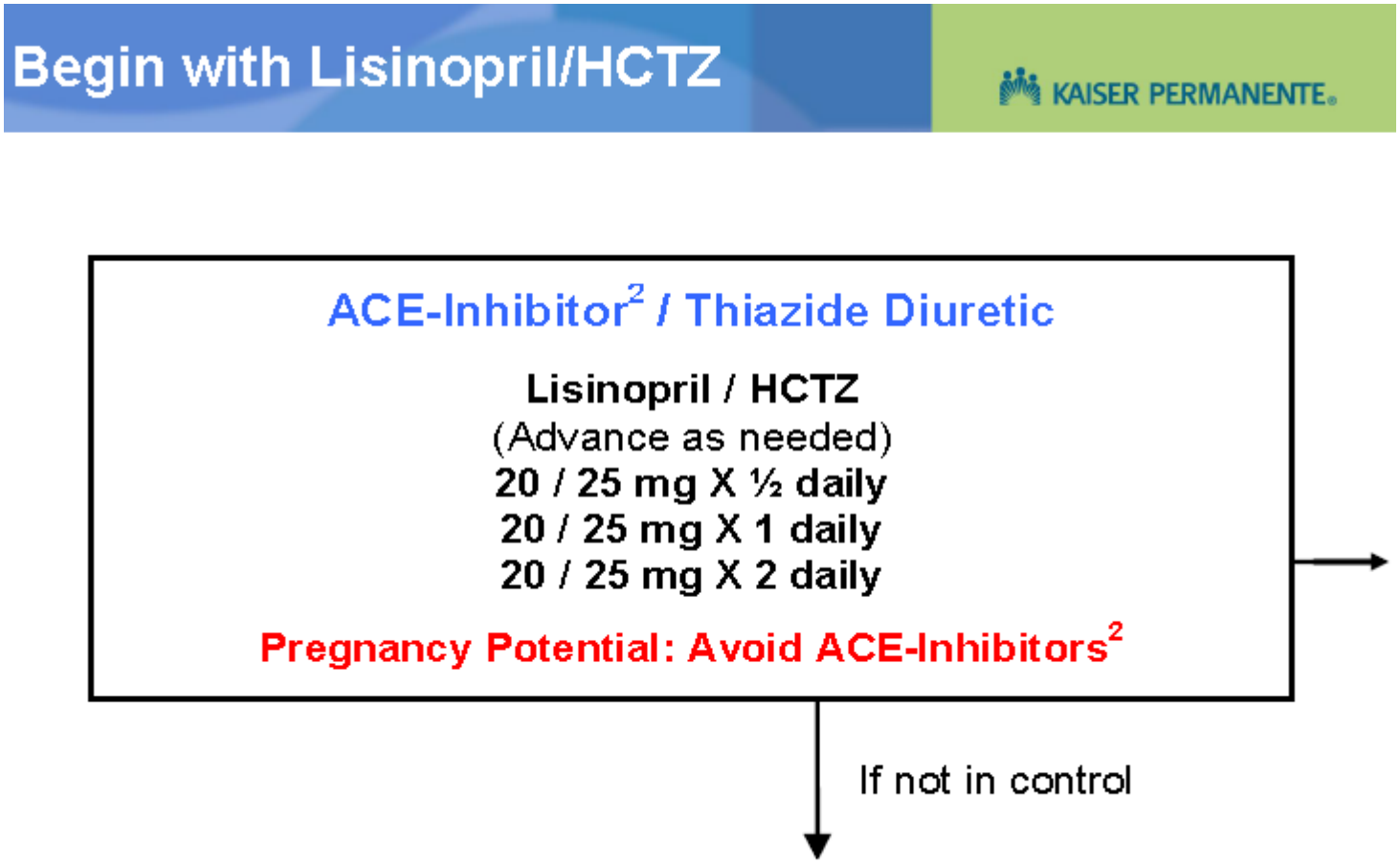


* Population: SBP >140 & age>55yo Major Adverse Coronary Eve

Effect Of Therapies On Systolic Blood Pressure



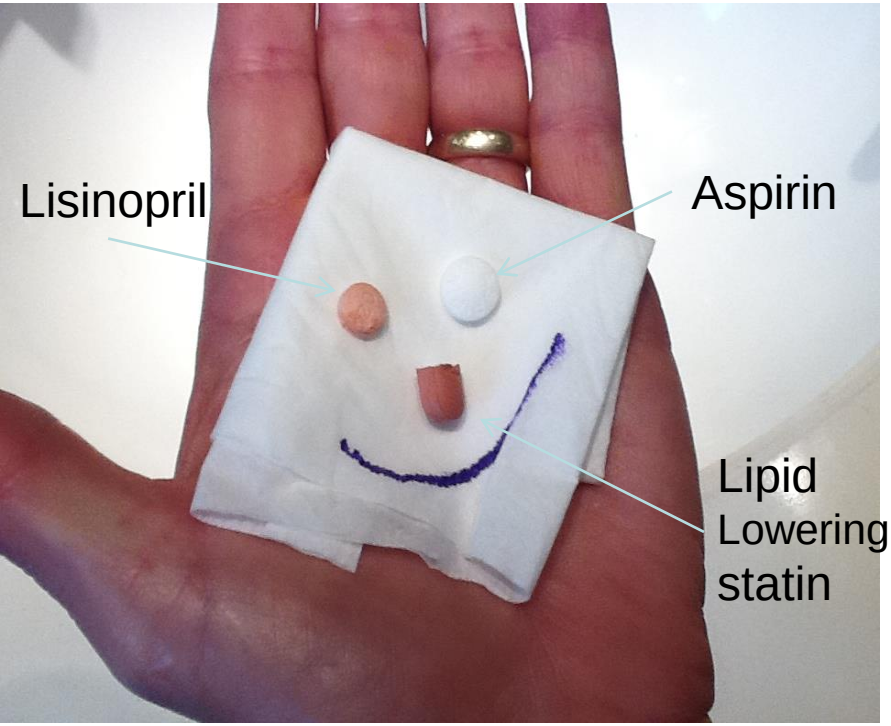
And Its OK to Begin treatment Using ALL's Lisinopril & Add a Thiazide combined in a single pill

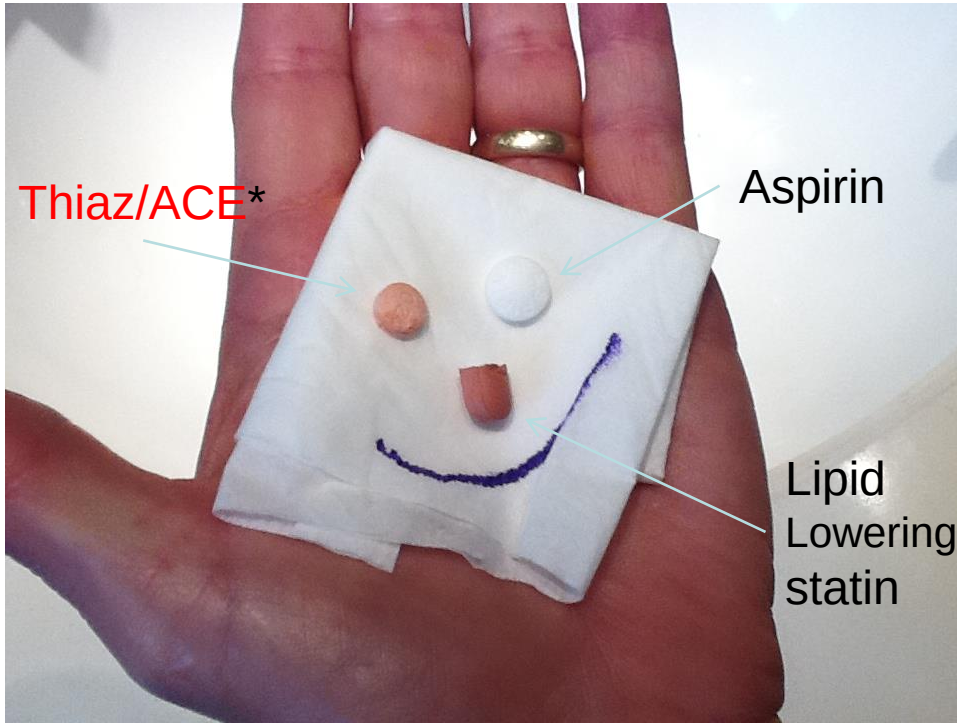


Why is that Important? It makes it EASY

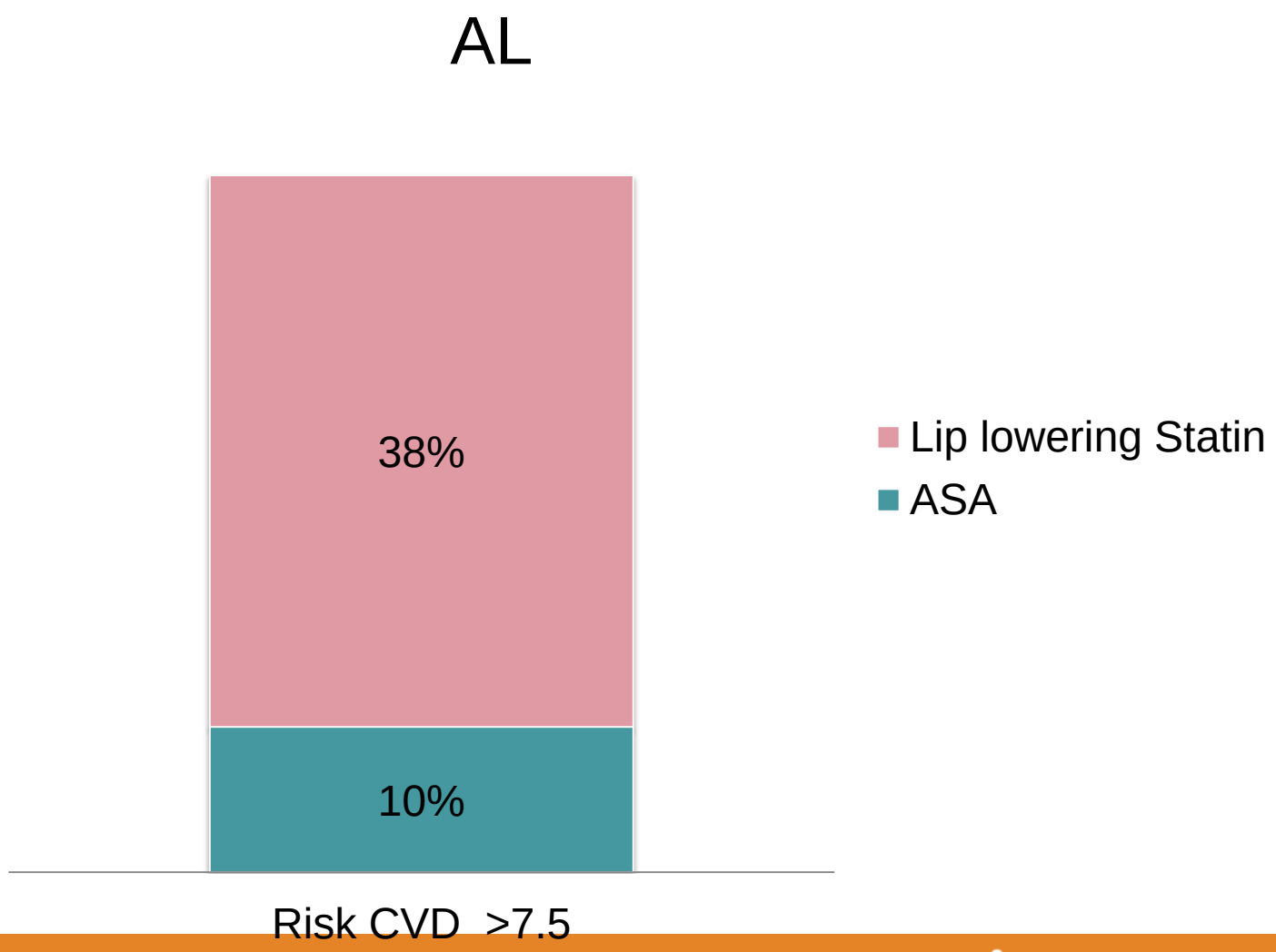
Summary: For HTN to get 75% less MI's & strokes, For the first visit, *simply* change From

ALL to TALL



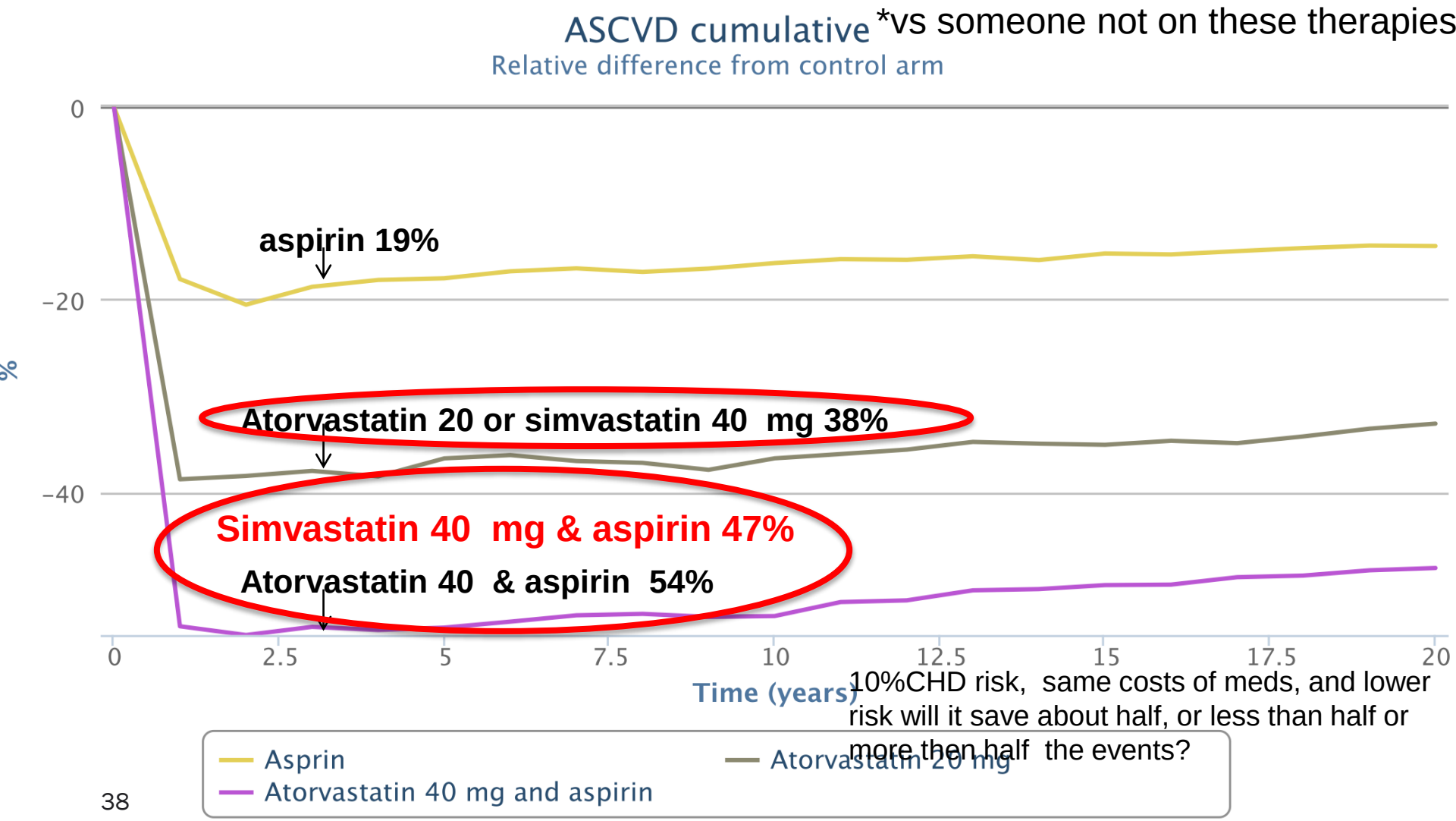


& If Just High CVD Risk, You Can Still Drop Heart Attacks & Strokes



If DM >40yo w/o HTN, CVD can be decreased by AL ~50% in 3 yrs*

*vs someone not on these therapies



10%CHD risk, same costs of meds, and lower risk will it save about half, or less than half or more then half the events?

If BP or Chol still High, More Treatment?

What if the LDL is still over 100 mg/dl or SBP still over 140 AFTER ALL TALL or AL, should we treat with more?

Evidence: CVD decreased 50- 75% already but another 5-25% can be had by adding more BP &/or stronger lipid meds like atorvastatin 40 or 80 mg/d

Principle #5: Get The Biggest Gain for Everyone Before Trying to Get everyone to Goal

Do NOT try to get each person “to target” before offering your high CVD risk pts AL ALL or TALL

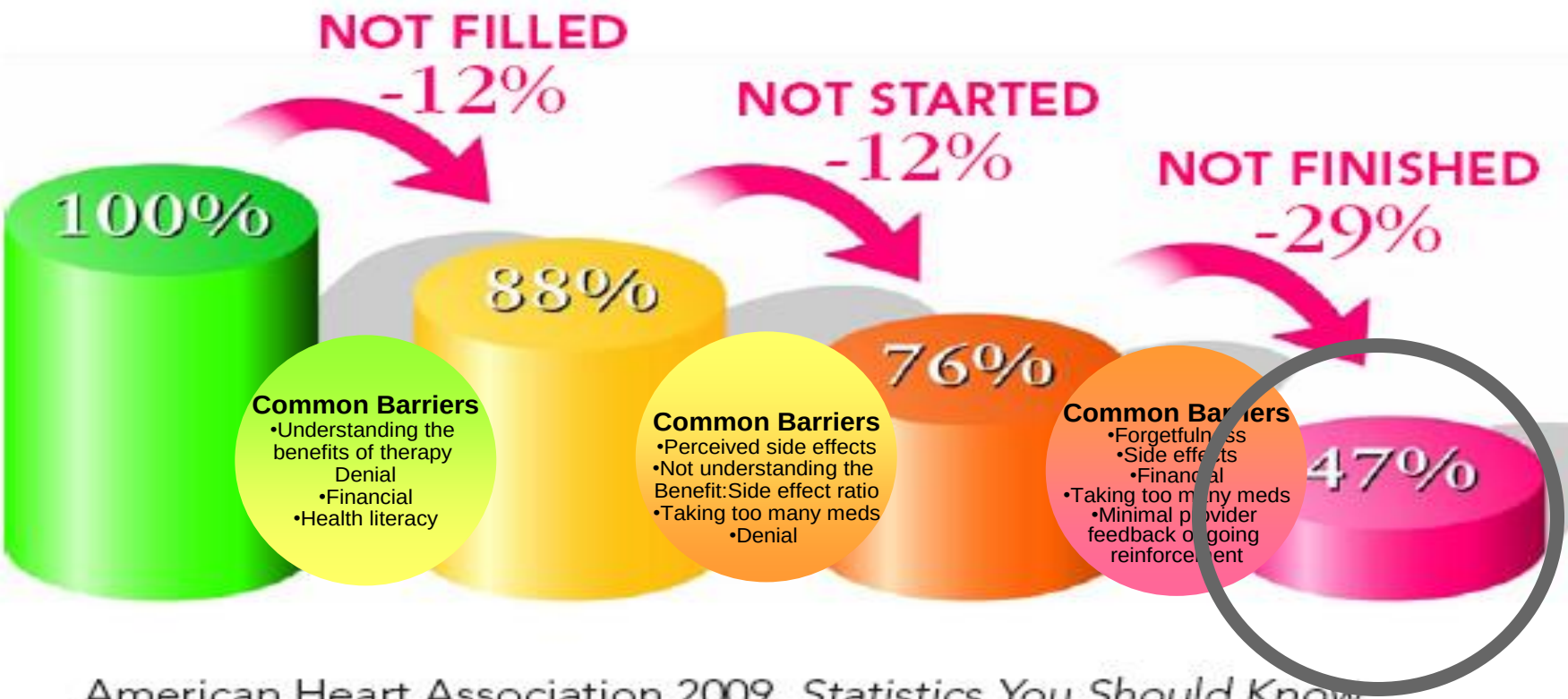
What if they Can't Take a Statin?

- Retry Retry Retry :
  - even if "proven" intolerant, when re-challenged ½ were able to tolerate it.
  - Stop and restart ½ dose
  - Try another type statin like pravastatin, or resuvastatin [crestor] 2x/wk at ¼ lowest dose
- Consider ezetimibe [Zetia]
- PCSK9's: Rarely indicated if severe recurrent CVD or familial hypercholesterolemia, not approved for use in "statin intolerant"

Can We Safely Start The 4 drug Bundle at 1 visit? YES!

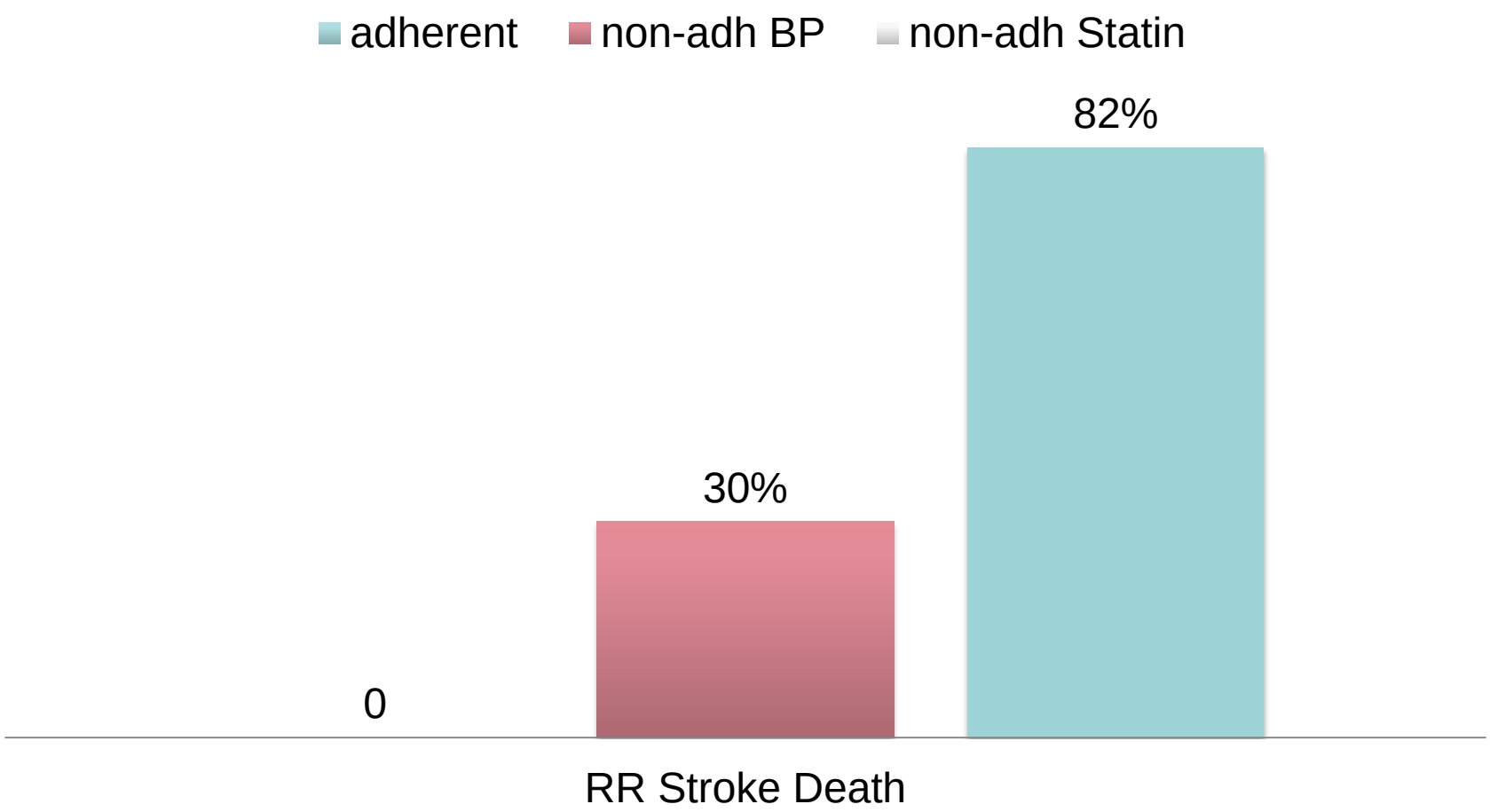
- We do it all the time,
  - in patients admitted for MI's" BALL
  - HTN combination meds are standard of therapy
  - We start bundles for TB and AIDS
  - When explaining drugs just say
    - "This bundle protects against heart attacks & strokes three ways.
    - If you get muscle aches, or a cough or bruising stop and contact us, and read this pamphlet for other side effects".

Medication Non-Adherence is often ~50% in a year



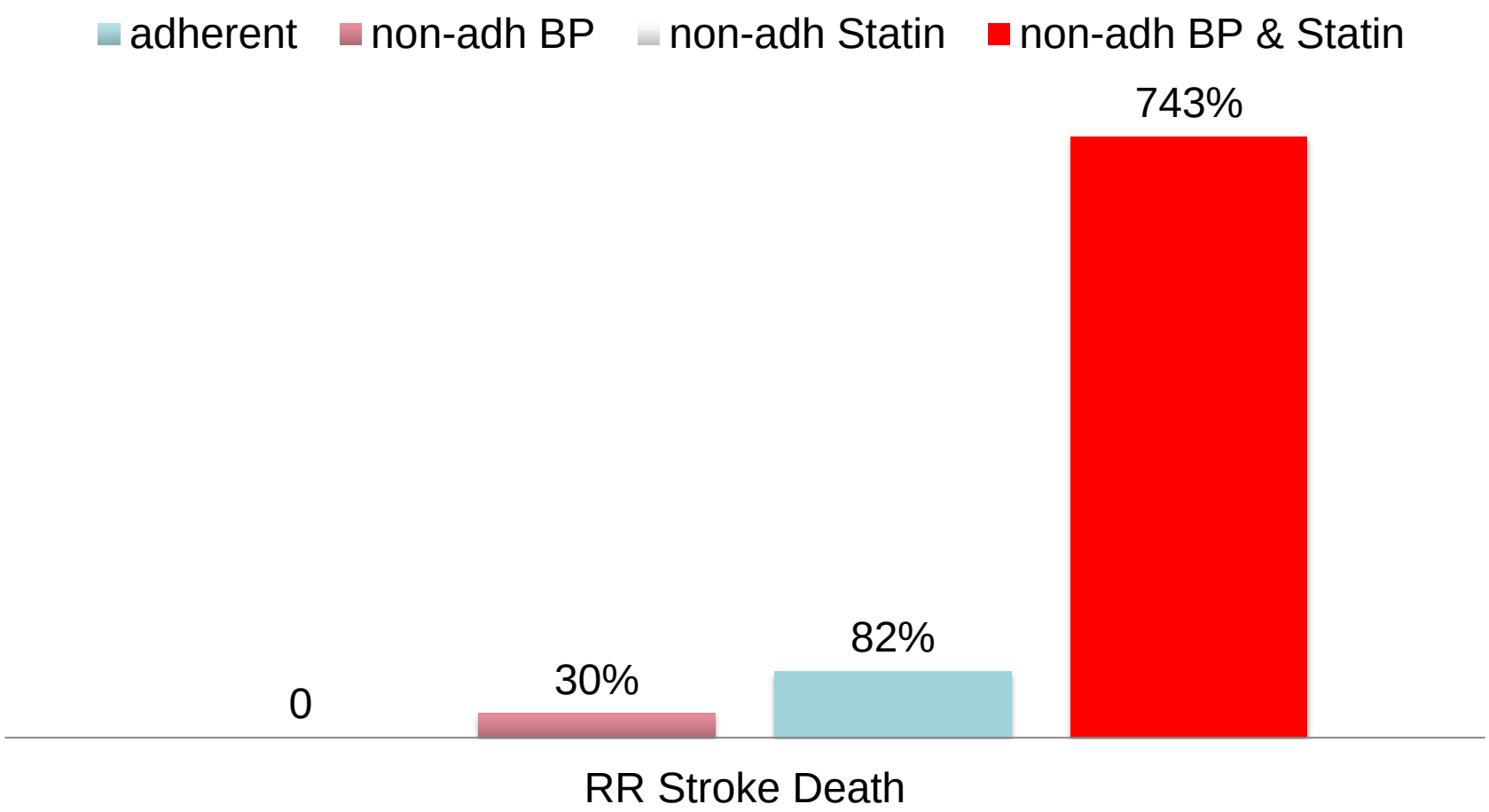
American Heart Association 2009, *Statistics You Should Know,* http://www.americanheart.org/presenter.jhtml?identifier=107.

% Relative Risk of Death from Stroke if Non-Adherent: BP or Statins



J Am Coll Cardiol. 2016;67(13):1507-1515

Relative Risk Death from Stroke if Non-Adherent to Both BP & Statin Meds



J Am Coll Cardiol. 2016;67(13):1507-1515

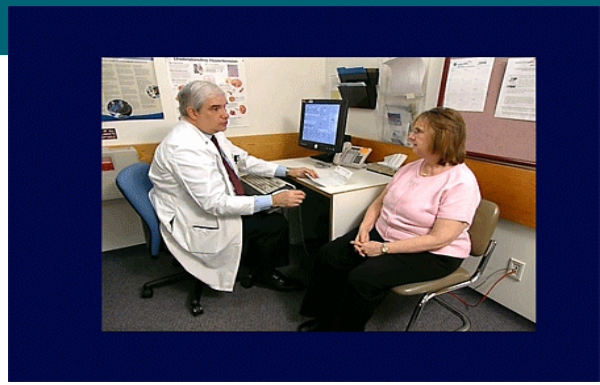
Barriers to medication adherence

Patient-related

- **Forgetfulness**
- Lack of knowledge
- **Value of therapy**
- Cultural/Ethnic
- Denial
- Financial
- **Health literacy**
- Social support

Medication-related

- **Complex regimens**
- **Side effects**
- **Taking multiple medications**
- **Length of therapy**



Provider-related

- **Poor relationship and / or poor communication with healthcare provider**
- Disparity between provider and patient around cultural / religious beliefs
- Lack of feedback and ongoing reinforcement from the provider
- Providers / pharmacists emphasizing negative aspects of the medication (side effects with minimal solutions) vs benefits

How to Treat Non-Adherence?

- Didn't pick up the first Rx: Patient Reminders letter/cal
- Didn't pick up refill due: effect of electronic/letter contact
- Pharmacist consultation at time of a pharmacy visit
- For all practitioners a technique: Ask-Educate-Ask

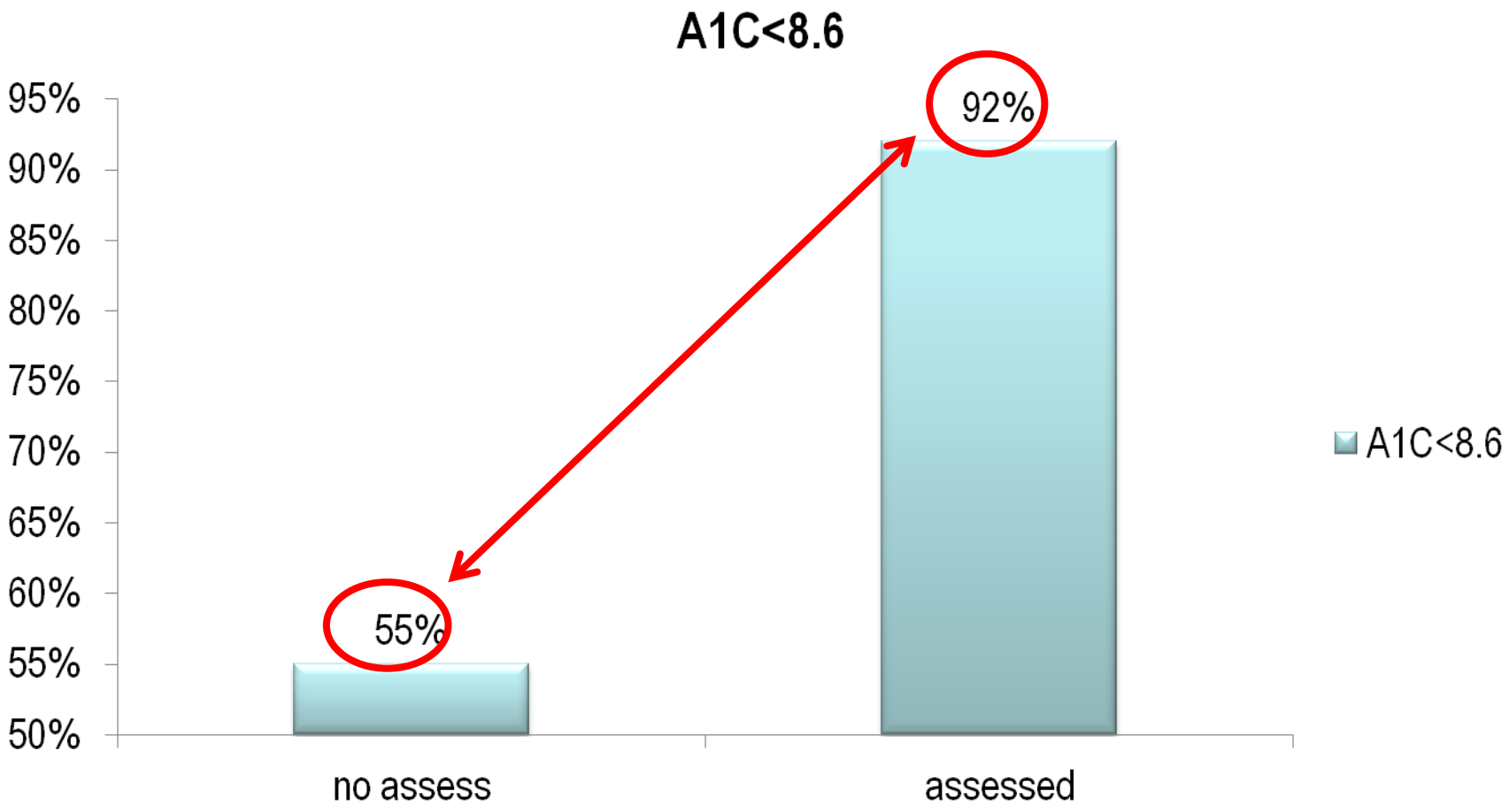
Clinician Tool Ask Educate Ask: Ask 75% of the time

- ASK - EDUCATE - ASK
  - **ASK** about the barriers
    - "In order to start taking your medication regularly tomorrow, what problems questions or concerns do you need to deal with now?"
  - **EDUCATE** around the point then
  - **ASK** about their next steps [talk back]:
    - "What would work for you?
    - What will you do now to make that happen?
    - What else?"
    - What are you going to DO [Teachback]

What is TEACH-BACK?

- Ask the person to tell back to you what they agreed to do.
- Why is this critical to action? It insures three things happened
  - The person must have
    - **heard** what you said, must
    - **understand** it &
    - **agree** to it!
  - What evidence is there that it works?
    - A randomized study at improved A1C
      - One group left after usual care
      - Second group with the same care were asked what they were going to do. Only 1/3 got it right the first time! Only 2/3 after re discussion. And a third took 3 or more repeat attempts

% A1C < mean with Teach Back..



Arch Intern Med. 2003;163:83-90

Can You Tell Us:

- What 1 thing did you hear that has moved you toward new treatment process?
  - And if any,
- What will be your next step?

Appendix

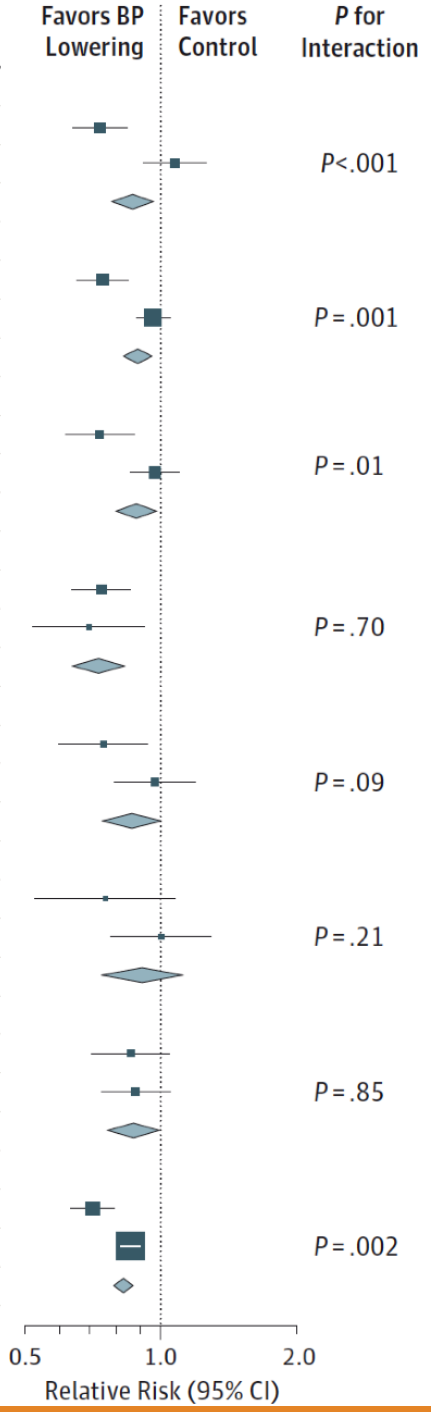
- ACEi & DM if nephropathy or retinopathy
- Evidence BP meds don't work in normotensive people w/o CVD

If DM & Stroke, Retinopathy/ Albuminuria add ACE/ARB

- Stroke RR signif if range <1
  - =>140/90 0.74 (0.64-0.86)
  - <140/90 0.69 (0.52-0.92)
- Albuminuria
  - =>140/90 0.71 (0.63-0.79)
  - <140/90 0.86 (0.81-0.90)

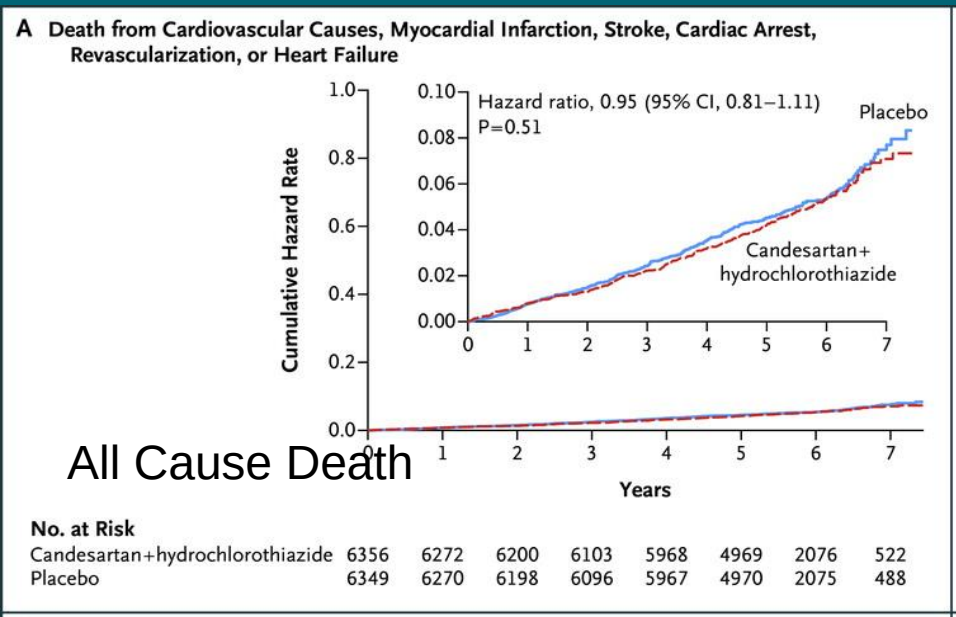
JAMA. 2015;313(6):603-615

Outcome	No. of Studies	Baseline SBP, Mean, mm Hg	BP Lowering, No. Events	BP Lowering, No. Participants	Control, No. Events	Control, No. Participants	Relative Risk (95% CI)	P for Interaction
Mortality, mm Hg								
≥140[16, 18, 19, 27-30, 35, 39-41, 51, 55, 56, 64, 65, 77-80]	13	149	1614	16 418	1626	14 580	0.73 (0.64-0.84)	
<140[17, 31, 36-38, 58-60, 80, 81]	7	137	720	1275	693	11 284	1.07 (0.92-1.26)	P<.001
Overall							0.87 (0.78-0.96)	
Cardiovascular disease, mm Hg								
≥140[16, 18, 19, 27-30, 35, 39-41, 46, 47, 51-53]	11	148	1861	14 976	1918	14 068	0.74 (0.65-0.85)	
<140[17, 31, 36-38, 58-60, 80, 81]	6	137	1369	10 780	1362	10 794	0.96 (0.88-1.05)	P=.001
Overall							0.89 (0.83-0.95)	
Coronary heart disease, mm Hg								
≥140[16, 18, 27, 29, 30, 35, 39-41, 47, 51, 64, 65]	10	148	858	14 875	931	13 477	0.73 (0.61-0.87)	
<140[17, 31, 36-38, 43, 58-60, 80, 81]	7	137	532	11 275	518	11 284	0.97 (0.86-1.10)	P=.01
Overall							0.88 (0.80-0.98)	
Stroke, mm Hg								
≥140[16, 18, 19, 27, 29, 30, 35, 39-41, 45-47, 51, 55, 56, 63-65]	14	148	1129	19 066	1245	17 868	0.74 (0.64-0.86)	
<140[31, 36-38, 58-60, 80, 81]	5	137	221	8548	230	8579	0.69 (0.52-0.92)	P=.70
Overall							0.73 (0.64-0.83)	
Heart failure, mm Hg								
≥140[16, 18, 29, 30, 35, 39-41, 46, 47, 64, 65]	8	146	774	13 592	814	12 676	0.75 (0.59-0.94)	
<140[31, 42, 43, 58-60, 80, 81]	5	137	461	8092	534	8115	0.97 (0.79-1.19)	P=.09
Overall							0.86 (0.74-1.00)	
Renal failure, mm Hg								
≥140[16, 18, 29, 30, 35, 40, 41, 64, 65]	6	147	389	12 475	346	11 530	0.75 (0.52-1.08)	
<140[31, 58-60]	3	138	207	7360	214	7382	1.00 (0.77-1.29)	P=.21
Overall							0.91 (0.74-1.12)	
Retinopathy, mm Hg								
≥140[16, 29, 30, 64, 65, 77-80]	4	146	564	7946	586	7753	0.86 (0.70-1.04)	
<140[36-38, 59, 60, 80, 81]	3	137	280	1835	319	1813	0.88 (0.74-1.05)	P=.85
Overall							0.87 (0.76-0.99)	
Albuminuria, mm Hg								
≥140[16, 28-30, 64, 65]	4	146	1681	8447	1898	7647	0.71 (0.63-0.79)	
<140[17, 36-38, 59, 60]	3	137	1118	5357	1265	5174	0.86 (0.81-0.90)	P=.002
Overall							0.83 (0.79-0.87)	

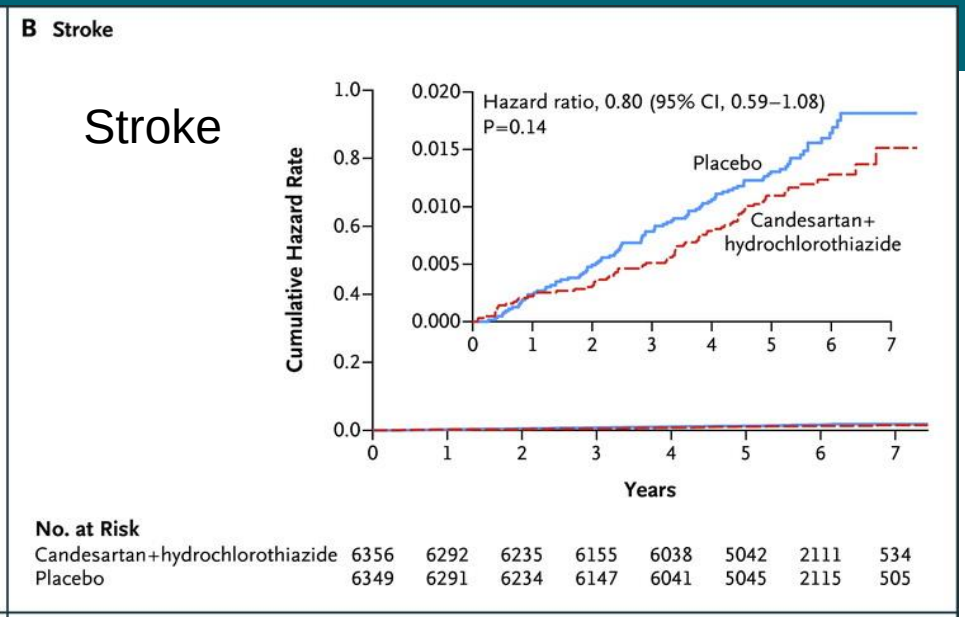


IF NOT HTN the BP meds didn/t work

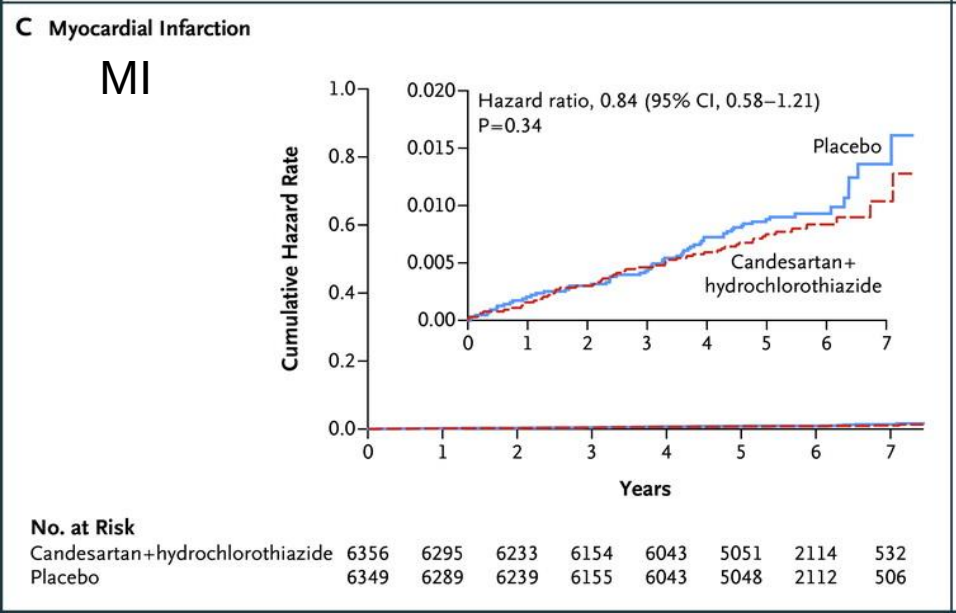
BP 138 fall 6/3 ARB & Thiaz Rx



All Cause Death



Stroke



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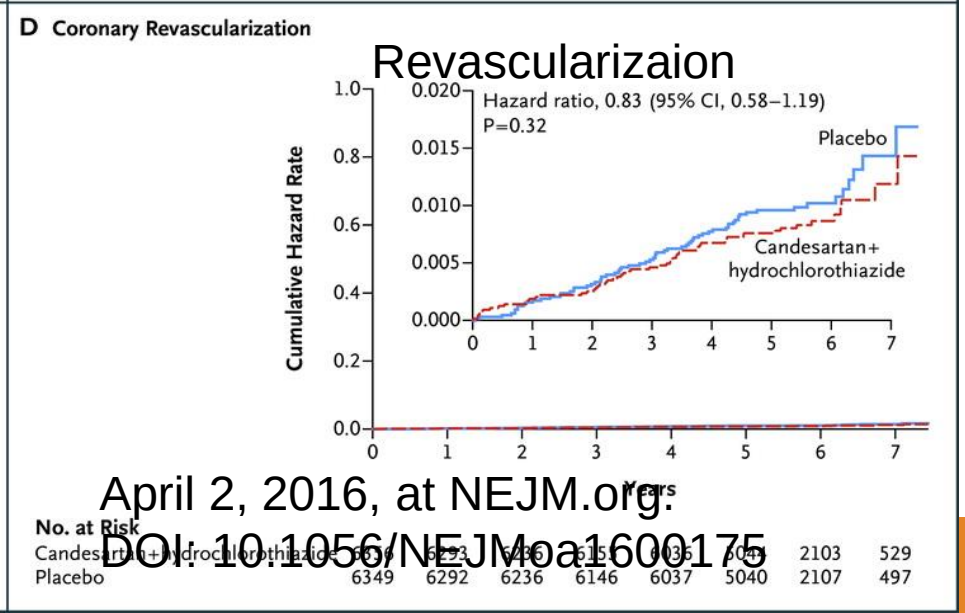

Revascularizaion

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Questions?