Presenters

Ann Bullock, MD, Division of Diabetes Prevention and Treatment

Dena Wilson, MD, IHS Chief Clinical Consultant for Cardiology

Chris Lamer, PharmD, Division of Diabetes Treatment and Prevention

Alberta Becenti, MPH, Health Promotion/Disease Prevention

Objectives

1. Identify Million Hearts Initiative key clinical focus topics to improve cardiovascular health

2. Review the IHS Million Hearts Intensive

3. Identify resources for evidence-based treatment for hypertension and tobacco cessation

The Milliion Hearts Initiative

Leading cause of
Preventable Death
in people 40 – 65 years of age

American Indians and Alaska Natives die from heart diseases at younger ages than other racial and ethnic groups in the United States. 36% of those who die of heart disease die before age 65.

Million Hearts Initiative Summary

Environmental changes

- Smoke free public places
- Eliminating trans fats in foods
- Sodium reduction in diets

Healthcare system improvements

- Adoption of treatment protocols
- Optimizing care teams
- EHR optimizations
- Patient and community health education on ABCS

The ABCS to Prevent Heart Attack and Strokes

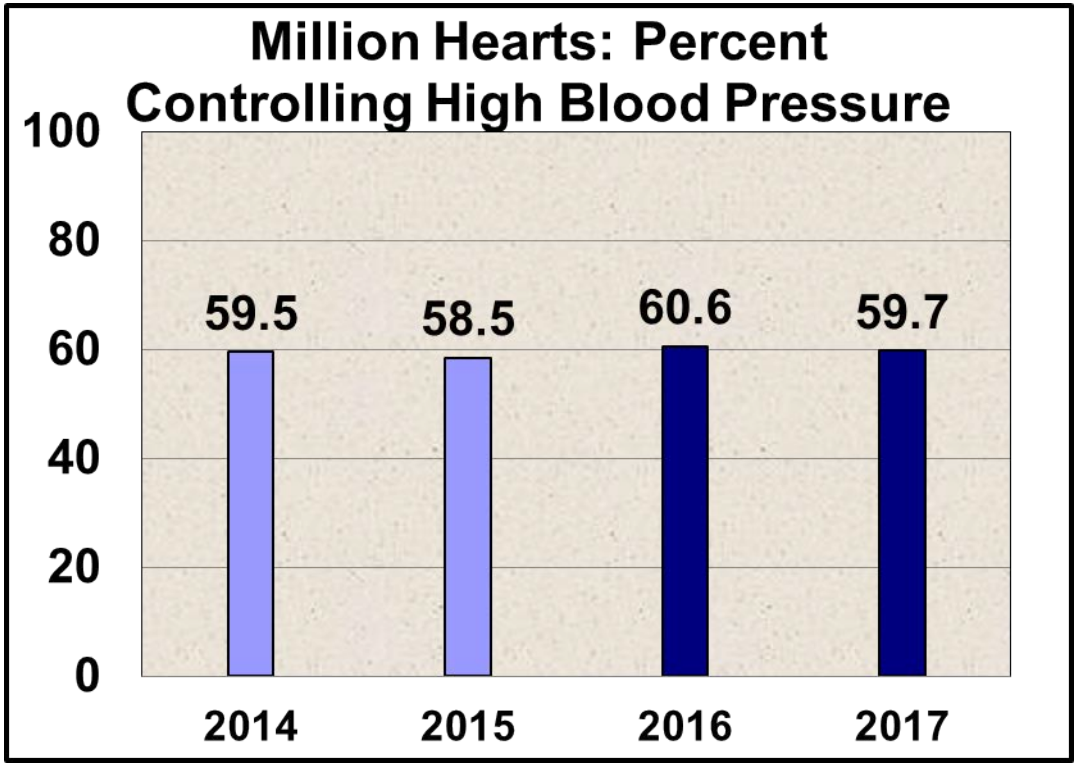
Aspirin	People who have had a heart attack and stroke who are taking aspirin
Blood Pressure Control	People with hypertension who have adequately controlled blood pressure
Cholesterol	People with high Cholesterol who are effectively managed
Smoking	People trying to quit smoking who get help

Optimizing Care Innovations

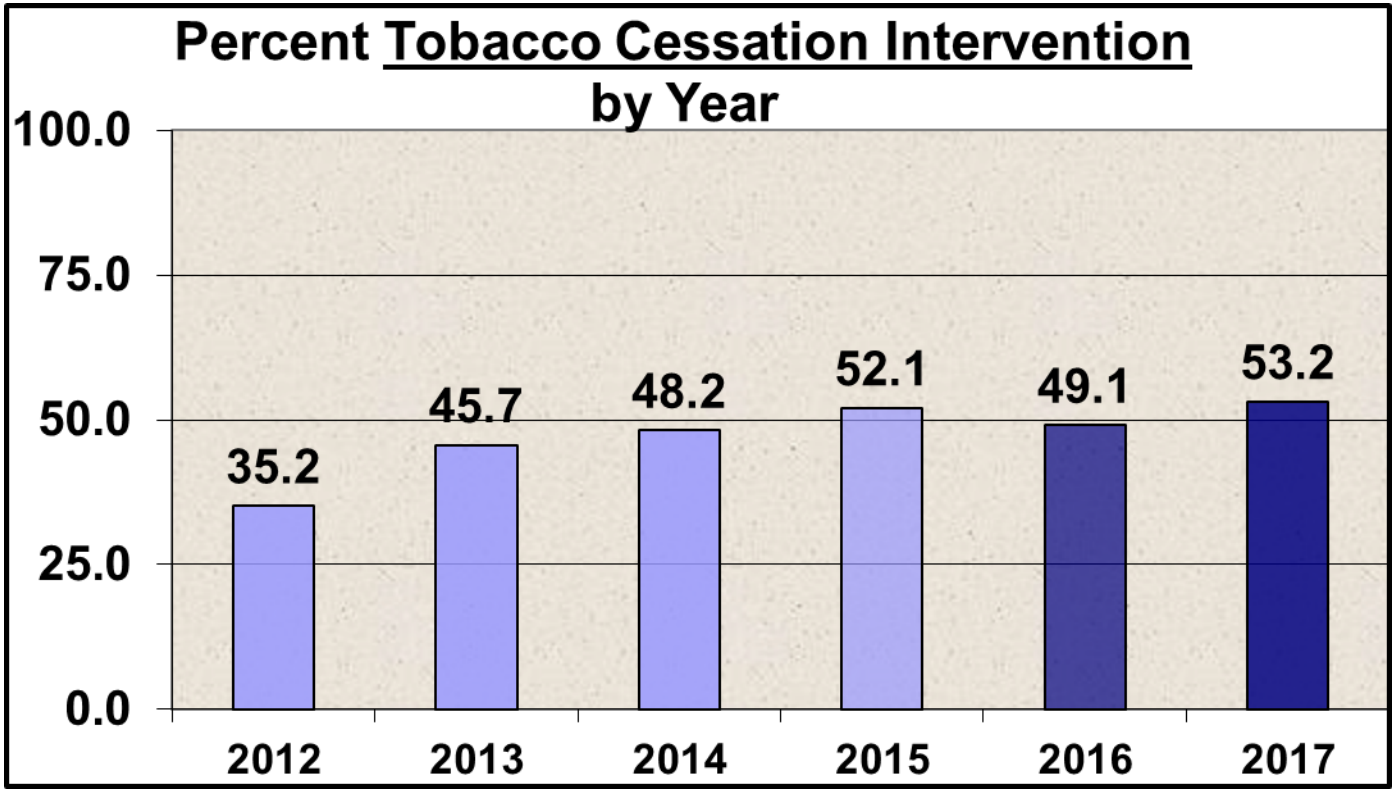
Team based care

- Utilizing full scope of practice
    - Collaborative drug therapy management
- Self blood pressure management with clinical support

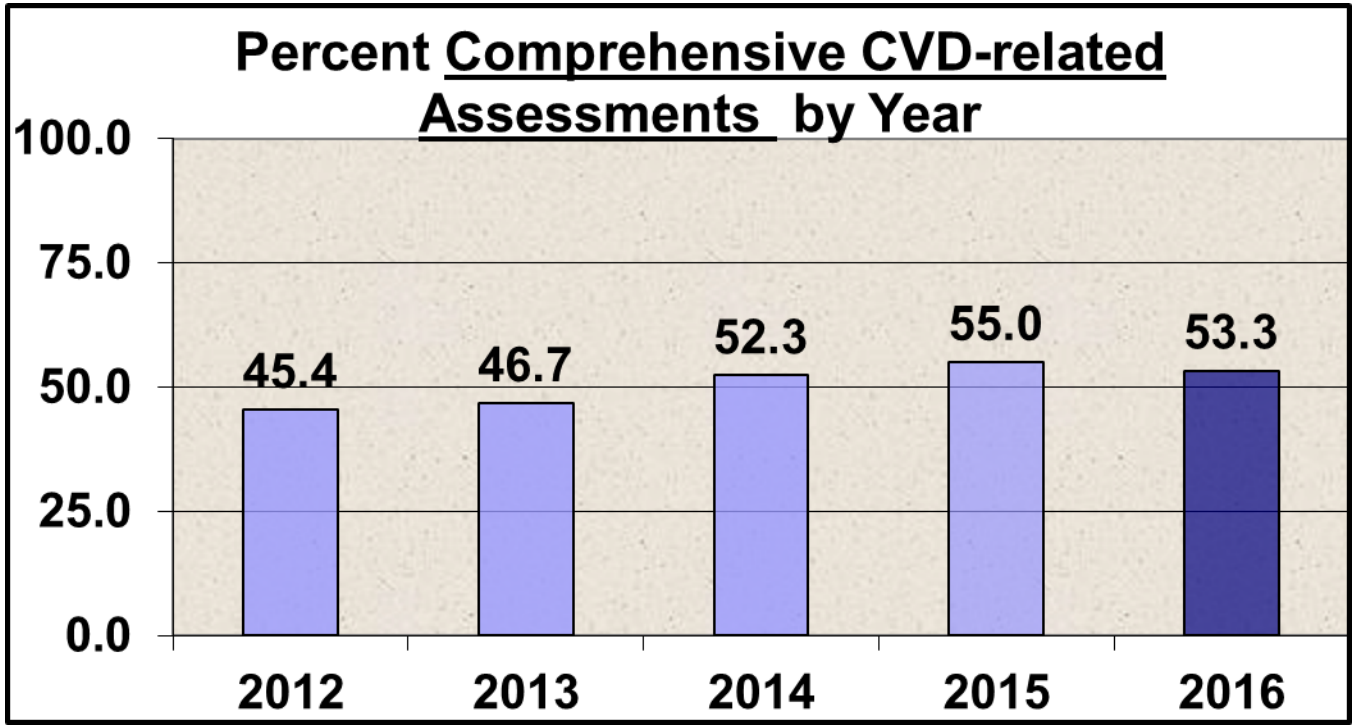
MH BP Measure Added to GPRA in 2014
2014 and 2015 Final Results; 2016 and 2017 Targets



Tobacco Cessation Results for 2012 – 2015; Targets for 2016, 2017



CVD-related Assessment Results 2012 – 2015, Target for 2016



2016 Quarter 2 Measure Results

GPRA Performance Measure	Q2 2016 Result	2016 Target
MH Controlling High Blood Pressure	54.5%	56.1%
Tobacco Cessation Intervention	37.7%	43.1%
CVD-related Assessment *(LDL removed from 2016 numerator. Measure retires after 2016 and is replaced by CVD Statin Therapy)*	43.5%	56.6%

IPC Million Hearts Intensive

Intensive Structure – IHS Million Hearts

- ♥ 16 weeks long
- ♥ Started September 1, 2015
- ♥ Ended December 15, 2015
- ♥ Webinars twice a month
- ♥ Office Hours between calls

Measurement Strategy

- The Intensive asked participants to track activity related to ensuring the population of focus received evidence based care for hypertension.
- Blood Pressure data had to be manually tracked

Million Hearts Intensive Evaluation

- 22 Teams participated in the Intensive
- Overall results showed marked improvement with reporting teams able to show improvement in delivering evidence-based care for individuals at risk for heart attack and stroke
- Recommendations received from the teams to continue hosting Intensives on topics of high importance
- Also recommendations were to devote more time to RPMS and iCare skills and increasing the use of case studies to highlight topics discussed

Addressing the
“ABCS”
in I/T/U Facilities

Aspirin Guidelines

Presenter:

Dena Wilson, MD, FACC
IHS Chief Clinical Consultant for Cardiology

ASA Summary Slide

ASA 75-162mg daily IF:

- Known CVD
- If 10 year risk >10%

Always use clinical judgement to assess risk/benefits.

If true ASA allergy, consider use of clopidogrel.

Blood Pressure Guidelines
and
Medication Adherence

Presenter:

Chris Lamer, PharmD

Pharmacy Consultant

Division of Diabetes Treatment and Prevention

Blood Pressure: JNC 8 Panel

2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults

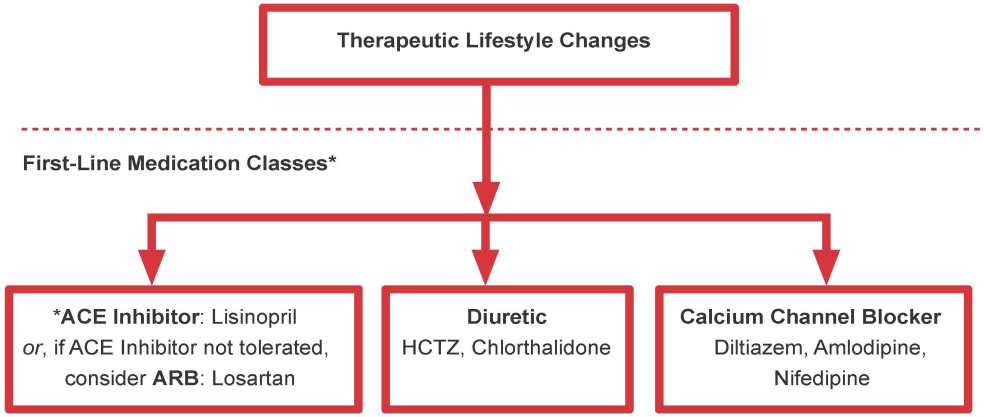
- Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8) *JAMA* 2014;311(5):507-520
- Very rigorous guideline development process

Target for all patients (including CVD, diabetes, CKD):

<140/90

Recommended medications:

- Thiazide diuretic, ACEI/ARB, Calcium Channel Blocker
- If CKD: start with ACEI or ARB
- Beta blockers no longer recommended for first-line treatment of hypertension (different issue from treating CVD)



**consider ACE Inhibitor or ARB as intial medication for patients with Chronic Kidney Disease*
Do not use an ACE Inhibitor and ARB together in the same patient.

If BP not at goal in one month, consider titrating dose up and/or adding medication from a different class above. Utilize these 3 classes before considering additional medication classes.

Consider Additional Medication Classes

If BP not at goal or unable to tolerate the first-line medication classes above, consider adding medications from additional drug classes. Base selection on individual patient indications.

Beta Blocker	Alpha Blocker
Metoprolol, Atenolol	Prazosin, Doxazosin

Treat BP to targets as tolerated:

Systolic BP target < 140**

Diastolic BP target < 90

** Individualize BP targets and medication therapy. Patients who are older and/or have significant comorbid conditions and cannot tolerate BP < 140/90, may require higher BP targets to prevent adverse effects (e.g. hypotension, fatigue, dizziness).

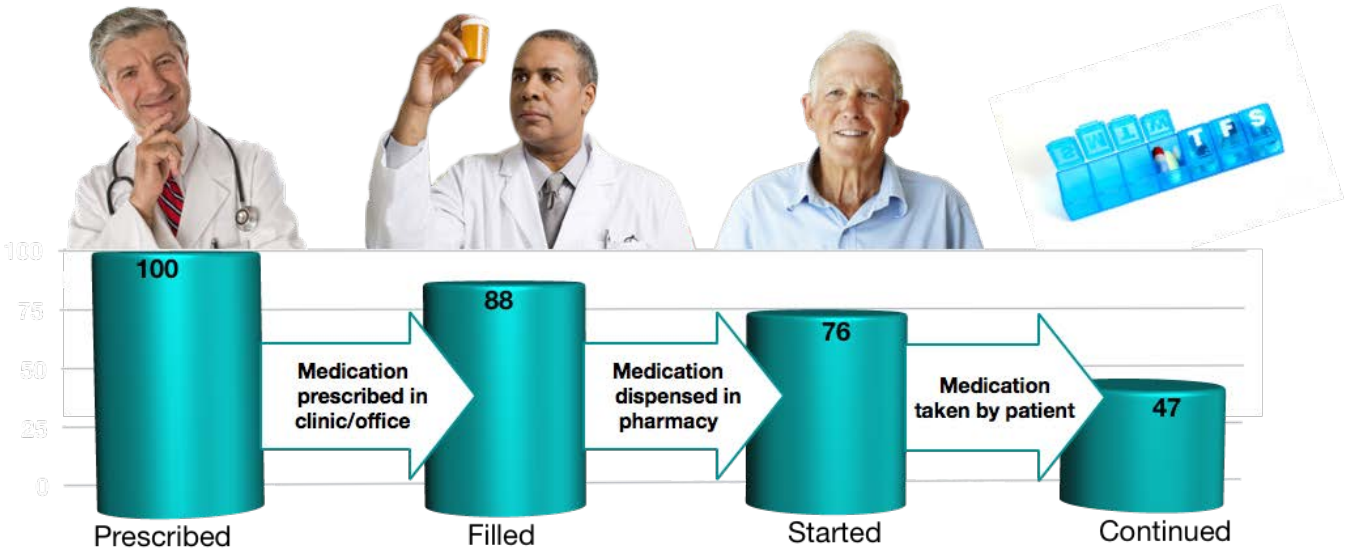
ACE Inhibitors (ACEI)/Angiotensin Receptor Blocker (ARBs) First line medication choice for patients with Chronic Kidney Disease Can cause ↑ K^+, ↑ creatinine; cough (with ACEI), rarely angioedema. Do not use an ACEI and an ARB at the same time.	
Lisinopril (Prinivil®, Zestril®)	Start 2.5-5mg daily; usually 20-40mg daily; max 80mg daily
Losartan (Cozaar®)	Start 25-50mg daily; max 100mg daily. Consider if unable to tolerate ACEI
Diuretics	
HCTZ	Start 12.5mg daily; usually 25-50mg daily; Can ↓ K^+ Higher doses may be used for other indications (e.g. edema)
Chlorthalidone	Start 12.5mg daily; usually 25-50mg daily; Can ↓ K^+ Higher doses may be used for other indications (e.g. edema)
Calcium Channel Blockers	
Amlodipine (Norvasc®)	Start 2.5-5mg daily; usually 5-10mg daily. Consider in patients with angina or CHF
Diltiazem (Cardizem®)	*Note*: multiple formulations exist: Immediate Release (TID-QID), SR/Sustained Release (BID), CD/Controlled Delivery (daily), and LA/Long Acting (daily) Consult your local formulary to assure appropriate selection and dosing For diltiazem CD start 180-240mg daily; usually 240-360mg daily; max 480mg daily
Nifedipine XL (Adalat®/ Procardia®)	Start 30mg daily; usually 30-90mg daily; max dose120mg daily Caution edema, CHF, and MI
Beta Blockers Don't use if bradycardia or 2nd/3rd degree block. Caution in severe CHF, asthma, or renal dysfunction.	
Atenolol (Tenormin®)	Start 25-50mg daily in 1-2 divided doses; usually 50-100mg/day Eliminated renally (caution Renal Failure)
Metoprolol (Lopressor®)	Start 50-100mg daily in 1-2 divided doses; usually 100-200mg/day. Max 450mg daily *XR formulation dosed once daily.* Eliminated hepatically (caution in Liver Failure)
Propranolol (Inderal®)	Start Long Acting 80mg daily or Immediate release 40mg BID; usually 120-240mg daily; max 640mg daily
Carvedilol (Coreg®) (Immediate Release Dosing)	Start 6.25mg BID; usually12.5-25mg BID. *CR formulation dosed once daily.* Also indicated for heart failure (start at 3.125mg BID)
Alpha Blockers	
Doxazosin (Cardura®)	Start 1mg immediate release at bedtime; Max dose 16mg daily Titrate up slowly; Can cause dizziness, drowsiness, and weakness
Prazosin (Minipress®)	Start 1mg PO BID-TID (first dose at bedtime); Max dose 15mg daily Titrate up slowly; Can cause dizziness, drowsiness, and weakness
Central Acting	
Clonidine (Captopres®)	Start 0.1mg BID (first dose at bedtime); usually 0.1-0.3mg BID; max 1.2mg BID Titrate up slowly; Can cause sedation/dizziness/weakness; Do not stop abruptly

Drugs in *italics* are **not** on the IHS National Core Formulary

Note: This is not a complete prescribing reference. This algorithm is not intended for treatment selection in children or in women who are or could become pregnant; some antihypertensive medications can cause fetal damage.

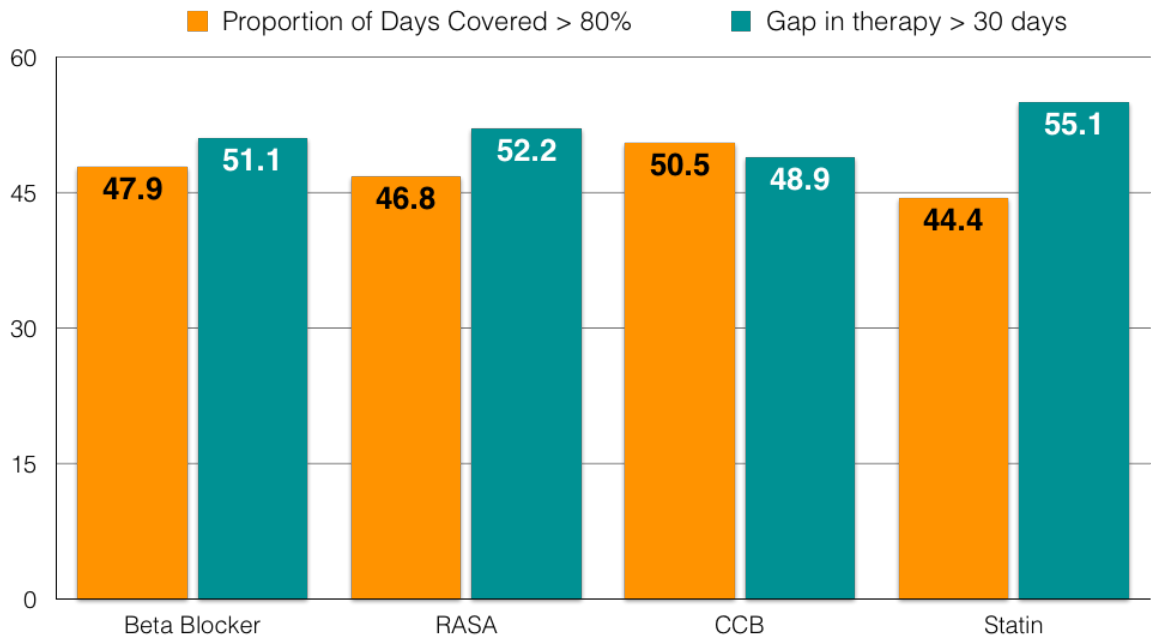
Ref: JNC 8 Panel: http://jama.jamanetwork.com/article.aspx?articleid=1791497.
ADA 2015 Clinical Practice Recommendations: http://care.diabetesjournals.org/content/38/Supplement_1.

Medication Adherence



>50% of patients stop taking chronic medications after their first prescription.

IHS Data



Proportion of days covered = have enough meds to cover 80% of days in the report period

Gap in Therapy = go more than 30 days without having medications during the report period

Cholesterol Guidelines

Presenter:

Dena Wilson, MD, FACC
IHS Chief Clinical Consultant for Cardiology

Cholesterol Guidelines Summary

- 4 treatment groups
  - Clinical ASCVD
  - LDL ≥190
  - DMII with increased risk
  - 10 year risk ≥7.5%
- Lipid panel at initiation, 4-12 weeks after initiation then yearly.
- Look for a decrease in LDL (30-50%)
- Add non-statins as needed
  - Zetia then BAS

Cholesterol Guidelines Summary

- Treat TG >1000
- If no secondary cause, refer to lipid specialist
- Consider treatment if TG >500
  - Use clinical judgement
  - Discuss treatment options with the patient
  - Patient should understand the importance of exercise/diet
  - Lack of guidelines for the treatment of TG in high risk patients

Tobacco Cessation

Presenter:

Alberta Becenti, MPH
Health Promotion/Disease Prevention

Tobacco Prevention and Cessation

To increase education, referral, and cessation services:

- 271 I/T/U health care staff received culturally sensitive *Basic Tobacco Intervention Skills* certification training.
- 62 staff received the *Instructor Basic Tobacco Intervention Skills* certification training.

- 506, 257 patients received tobacco related education in 2015

Tobacco Prevention and Cessation

Best and promising practices tobacco cessation webinars are conducted quarterly.

- Next webinar scheduled on Wednesday, June 28, 2016 at 3:00 p.m. ET
- Webinars are archived for later viewing.

Developed culturally appropriate posters, informational cards and public service announcement focusing on second and third-hand smoke.

- Plan to distribute to 741 programs and schools.
- Materials can be downloaded at: https://www.ihs.gov/hpdp/tobaccoprevention/tfcampaign/

In FY 2015, CDC Tips Campaign were aired for 3-6 months on Good Health TV.

- 18 sites in Great Plains, 1 site in Oklahoma, 2 sites in Tucson, and 1 site in Portland Area

Tobacco Prevention and Cessation

- Partnering with State Health Departments to plan and implement tobacco prevention and cessation.
  - Albuquerque Indian Health Center and Gallup Indian Medical Center partnered with NM Tobacco Use Prevention and Control Program to implement Systems Change.
  - Plan to implement at Santa Fe Service Unit.

- Area HP/DP Coordinators continues to collaborate with other partners to expand tobacco prevention efforts.

- Expanded HP/DP website to include tobacco prevention resources and materials.

- MH Tobacco Cessation Protocol is available at: http://millionhearts.hhs.gov/tools-protocols/protocols.html

Future Plans

- Support implementation of HUD's Smoke Free Public Housing Proposed Ruling.
- Support the Tobacco Free Campuses Initiative
  - Encourage Tribal Colleges to adopt tobacco-free policies.
- Implement youth-led tobacco prevention activities in 4 sites.
- Contact radio stations for public service announcement on the harms of second and third-hand smoke.
- Develop educational materials on e-cigarettes and hookah.