

# Opportunities & Challenges in Patient Care, Prevention & Adherence



**Fifth Annual AMCP Foundation Symposium**  
**October 26, 2015**

**AMCP 2015**  
**NEXUS** *Orlando*

**AMCP** | Academy of  
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# Fifth Annual AMCP Foundation Symposium



**Edith A. Rosato, RPh, IOM**

Chief Executive Officer, Academy of Managed Care Pharmacy &  
Chairman, Board of Trustees  
Academy of Managed Care Pharmacy Foundation



# Fifth Annual AMCP Foundation Symposium



**Fauzea Hussain, MPH – Symposium Moderator**

Senior Vice President, Avalere Health



AMCP Foundation would like to thank the following companies for their support of the symposium:



# Program Objectives

The symposium will convene experts from the public and private sectors who will present innovative ways to take on the chronic disease challenge through prevention. A focus of the symposium will be the landmark report *A Prevention Prescription for Improving Health and Health Care in American*, issued by the Bipartisan Policy Center examines the growing impact of chronic disease treatment on the American economy. Speakers will address the importance of medication adherence as it relates to obesity and other chronic diseases. They will also examine the historical perspective of treatment management; review what has worked, what has not, and what is needed; and investigate such barriers as plan design, care coordination, and the patient's role in chronic disease care.

Symposium topics to be addressed include the following:

- How to drive systemic change through collaboration in managed care plans
- Use of predictive analytics to identify at-risk populations for a particular chronic disease
- Managed care pharmacy's MTM role in coordination of care in the evolving patient-centered care models
- Managed care pharmacy's impact on health plan Medicare Star ratings, as related to adherence
- Steps taken when identifying patients at risk for non-adherent, and addressing factors influencing patient behavior
- Opportunities for new technology in patient monitoring and patient practices
- Measuring and communicating ROI findings for health promotion via managing chronic disease

A summary of the symposium proceedings, as an abbreviated written document, will be produced and made available to the public.



BIPARTISAN POLICY CENTER

# **A Prevention Prescription for Improving Health and Health Care in America**

ACADEMY OF MANAGED CARE PHARMACY SYMPOSIUM  
G. WILLIAM HOAGLAND  
OCTOBER 26, 2015

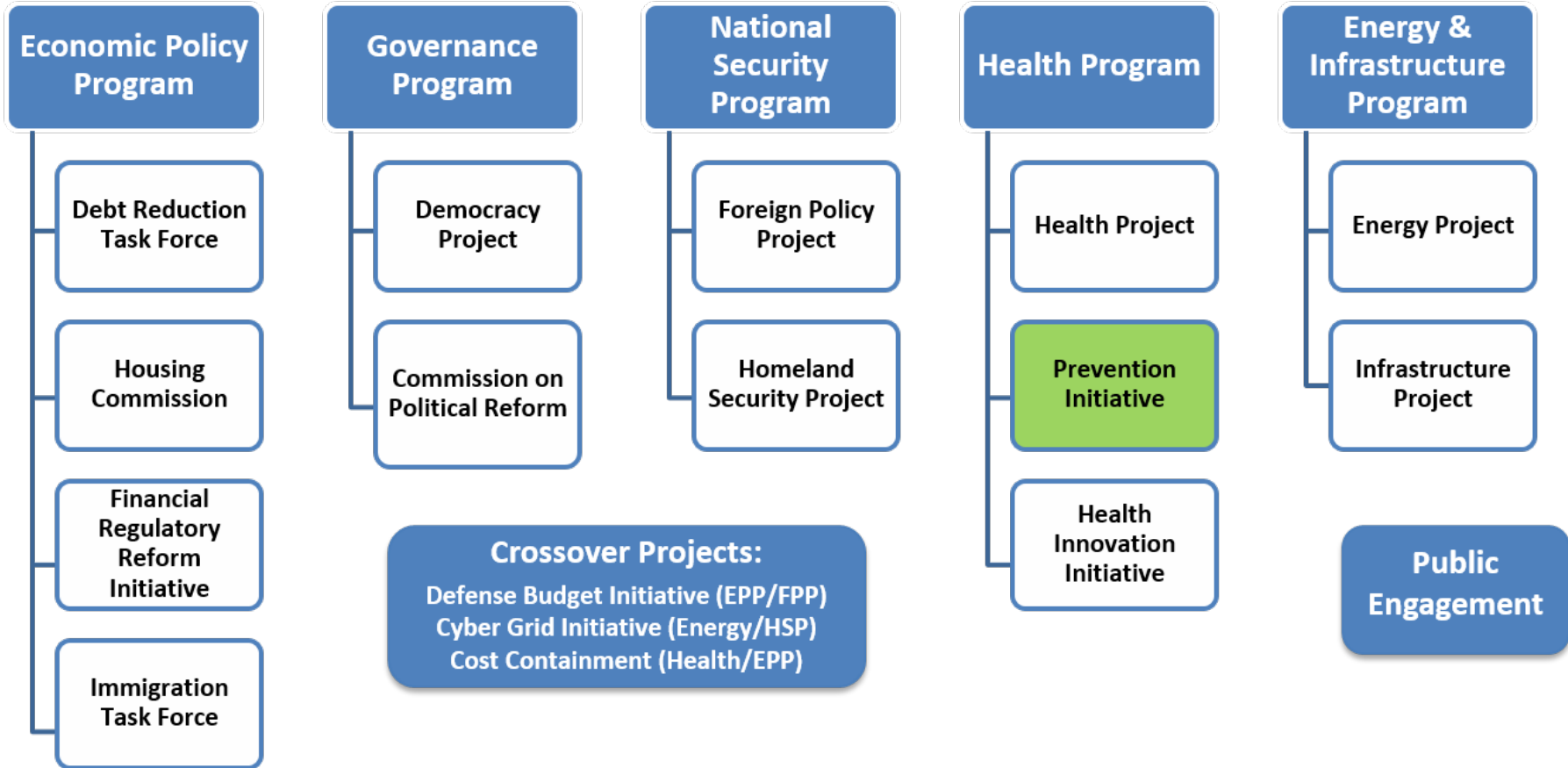
[bipartisanpolicy.org](http://bipartisanpolicy.org)





**The Bipartisan Policy Center drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue.**

# ABOUT BPC







## Task Force Members

### **William H. Dietz, M.D., Ph.D.**

Director, Sumner M. Redstone Global Center for Prevention and Wellness; Milken Institute School of Public Health at the George Washington University

### **Ron Goetzel, Ph.D.**

Senior Scientist, Department of Health, Behavior and Society; Bloomberg School of Public Health at Johns Hopkins University

### **Jeff Levi, Ph.D.**

Executive Director; Trust for America's Health

### **Matt Longjohn, M.D., M.P.H.**

National Health Officer, YMCA of the USA

### **Tracy Orleans**

Senior Program Officer and Senior Scientist; Robert Wood Johnson Foundation

### **Murray Ross, Ph.D.**

Vice President; Kaiser Foundation Health Plan, Inc.  
Director; Kaiser Permanente Institute for Health Policy



## Senior Advisors

### **Senator Bill Frist, M.D.**

Former U.S. Senate Majority Leader  
BPC Senior Fellow

### **Alice M. Rivlin, Ph.D.**

Senior Fellow, Economic Studies Program;  
Brookings  
BPC Health Project Leader, Delivery System Reform and Long-term Care

### **Secretary Dan Glickman**

Former U.S. Secretary of Agriculture  
BPC Senior Fellow



## PREVENTION DELIVERS VALUE

As Americans, we spend an enormous amount of health care dollars treating largely preventable chronic conditions. Prevention can reduce demand on the health care system. To access the value of prevention, we must shift our focus to keeping people healthy. We also need a payment system that incentivizes the types of upfront investments that reduce downstream treatment costs.



**A Prevention Prescription  
for Improving Health and  
Health Care in America**

May 2015





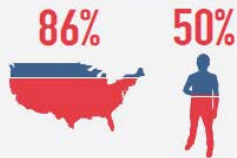
## PREVENTION DELIVERS VALUE

### FACING FACTS



#### Americans Spend Twice as Much on Health Care as Citizens of Other Developed Countries

Yet we have shorter life expectancies, and higher rates of infant mortality and diabetes.



#### Chronic Disease Dominates Health Care Costs

Chronic diseases account for 86 percent of U.S. health care costs and affect 50 percent of the adult population.



#### Social, Environmental, and Economic Factors

Where people live, work, learn, and play has a greater influence on their health than what goes on in the doctor's office, yet the health care system bears the brunt of these problems when they ultimately lead to poor health outcomes.



#### Structural Barriers

The health care system has few structural or financial mechanisms for connecting effectively with the broader community beyond the clinic walls or leveraging resources to maximize health outcomes.



## PREVENTION DELIVERS VALUE

### THE CHALLENGES



The emerging evidence base around prevention is fragmented and lacks cost metrics, which are very important to policy makers.



Current fee-for-service payment models do not reward health care systems for working upstream to prevent illness.



There are opportunities through current Affordable Care Act provisions to better align incentives.





## PREVENTION DELIVERS VALUE

### ✓ Recommendations

1

#### **Continue building the evidence base on the value of prevention.**

Federal agencies, philanthropies, public health research journals, and Congress all have roles to play in supporting the development of robust economic analysis of prevention interventions and the promotion of strategies that are proven to improve health and cut costs.

2

#### **Make prevention a key part of health care delivery system reform.**

The Centers for Medicare and Medicaid Services has several ways to advance this, including population-based quality measures and promising models such as the Accountable Health Community model that could be tested on a broad scale through its Center for Medicare and Medicaid Innovation. On the ground, stakeholders can better capitalize on new opportunities such as the Community Health Needs Assessment to collaborate on common goals in their communities.

# BUILDING THE EVIDENCE BASE



The task force recommends the following specific changes and actions be taken to build the evidence base on the value of prevention:

- 1. The Centers for Disease Control (CDC) and the National Institutes of Health (NIH) should** include a requirement for economic analysis in clinical and public health funding opportunity announcements.
- 2. The Centers for Medicare and Medicaid Services (CMS) should** include a requirement for economic analysis in funding opportunity announcements.
- 3. Public health journals should** give priority to, and thereby encourage, economic analysis in studies of prevention strategies.
- 4. Public and private funders should** encourage and fund studies of the health and economic effects of proven and emerging population-level interventions and prevention strategies.
- 5. Congress should** assure adequate funding for the CDC Community Preventive Services Task Force with the aim of expanding the number of community-level public health interventions.
- 6. Congressional budget committees should** direct the Congressional Budget Office (CBO) to use “present discount accounting” to bring long-term savings from prevention “up” in time and to align better with CBO’s 10-year scoring window.





## Commonly Used Prevention Metrics

- **Effectiveness** – better health outcomes
- **Cost** – monetary value
- **Cost-Effectiveness** – investment required to achieve one unit of improvement in a given health outcome
- **Cost-Benefit/Return on Investment (ROI)** – total economic outcome

# EMBEDDING PREVENTION



The task force recommends the following specific changes and actions be taken advance the goal of embedding prevention in the U.S. health care delivery system:

1. **CMS should** integrate at least two population health care quality measures into the next iteration of accountable care organizations.
2. **CMS, through its Center for Medicare and Medicaid Innovation (CMMI) should** invest in a robust demonstration of an accountable healthcare community model.
3. **CMS should** invest in evaluation of accountable healthcare community models that focus on establishing funding mechanisms that can be both scaled and sustained over time.
4. **CMS should** support efforts to synthesize and translate lessons learned from CMMI and other programs, including investing in infrastructure to help spread and scale what works.
5. **Communities, public health officials, and hospitals should** collectively explore ways to improve Community Health Needs Assessments and better use them as a tool for aligning goals and implementation plans. Also, these groups should engage with other stakeholders to identify existing organizations that could function as integrators.



Hennepin County, MN

Seattle/King County Group Community  
Health Needs Assessment

## YMCA of the USA Diabetes Prevention Program

- YMCA-trained lifestyle coaches administer a one-year, group-based intervention promoting healthy eating and physical activity for pre-diabetics
- Results: participants lose 5-7% of their bodyweight, which NIH found reduces the incidence of type 2 diabetes by 58%
- HealthSpan, the only 5-star ranked Medicare plan serving Ohio, decided to cover the cost of participation as a benefit for subscribers at-risk for diabetes
- Avalere Health analysis indicates the Medicare Diabetes Prevention Act could produce long-term cost savings for Medicare on the order of \$1.3 billion over 10 years

Nemours' Navigators Take on Asthma

Nashville Collaborative



BIPARTISAN POLICY CENTER

**teaques mondogue**

**Latin proverb: Prevention is better than the cure**

FOR MORE INFORMATION PLEASE  
CONTACT:

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bipartisanpolicy.org

# Opportunities & Challenges in Patient Care, Prevention & Adherence

## LUNCH BREAK

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# Opportunities and Challenges: Medication Management and Patient Medication Adherence



**Tom Hubbard, MPP**

NEHI-The Network for Excellence in Health Innovation

**Fifth Annual AMCP Foundation Symposium**

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# Taking stock....

## Looking Back

- Medicare Part D and E-prescribing catalyze metrics, new services
- Medical cost offsets from Rx become “A Thing”: the 2012 CBO 2012 ruling and related studies
- Payment reform prompts harder look at “better use of meds”

## Looking Ahead

- New impetus to integrate medical and pharmacy benefits and services
- New goal: engineer continuity of medication care to optimize the patient medication regimen and enhance adherence

# Part D and E-prescribing



## Medication Therapy Management Programs: Promises and Pitfalls

Amy L. Ai, PhD; Henry Carretta, PhD, MPH; Leslie M. Beitsch, MD, JD;  
Leah Watson, MSW; Jean Munn, PhD, MSW; and Sarah Mehriary, MSW

JMCP, December 2014

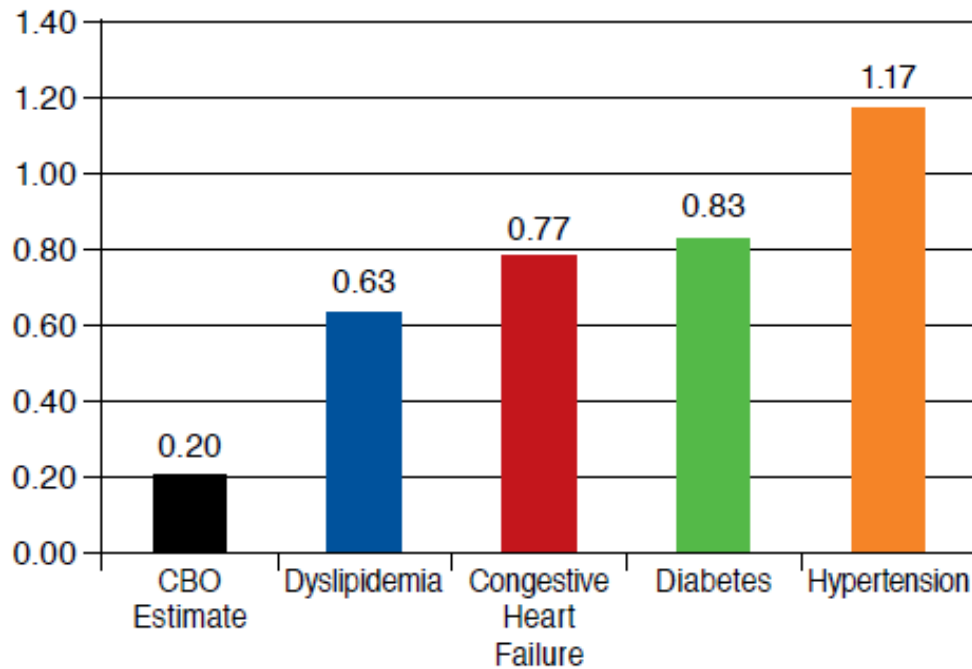
## Meaningful Use Stage 2 E-Prescribing Threshold and Adverse Drug Events in the Medicare Part D Population with Diabetes

Powers et al, Journal of American Medical Informatics Assoc,  
March 2015

# Rx and Medical Cost Offsets

**FIGURE 1**

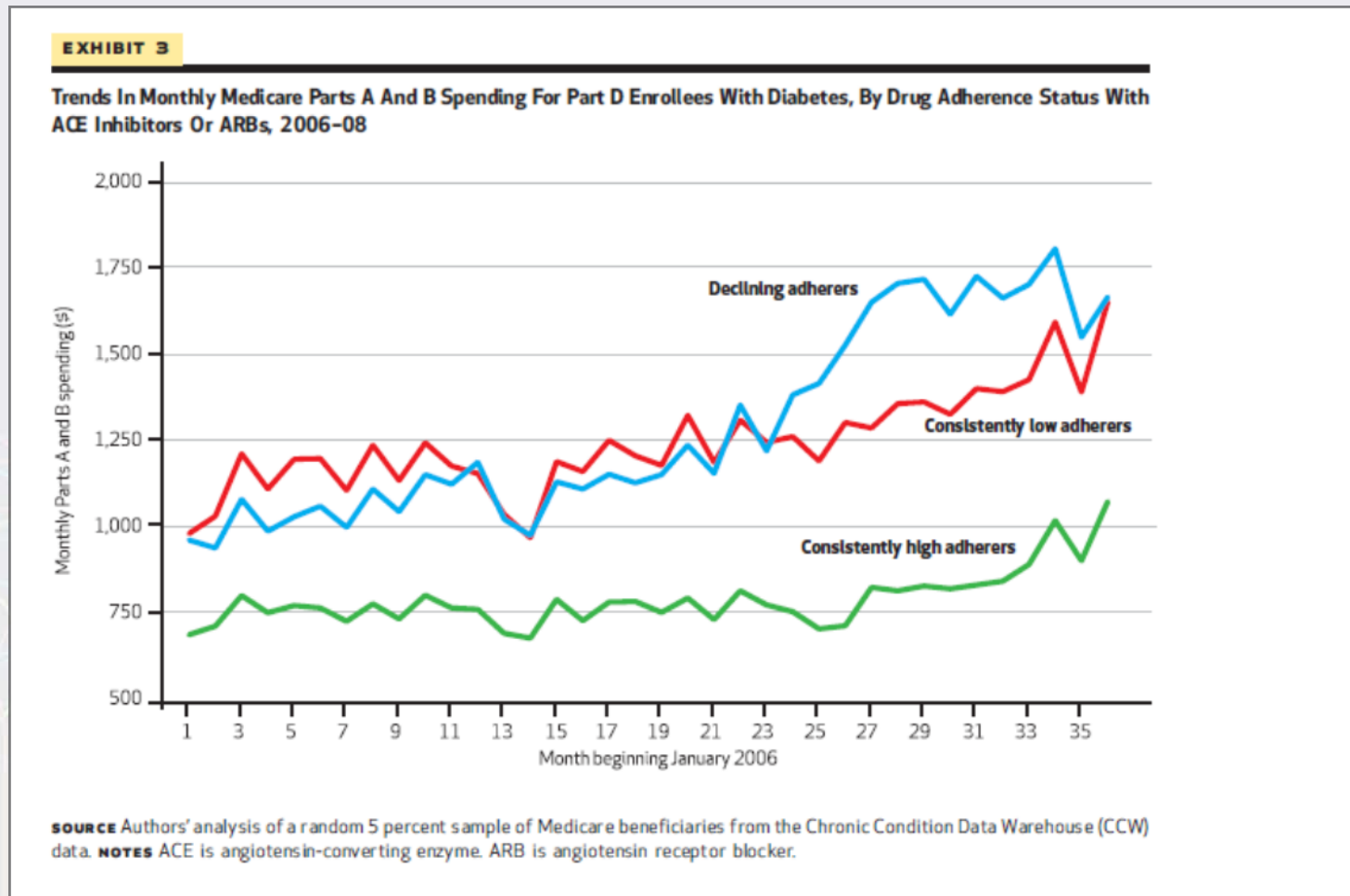
Percentage Decreases in Medical Costs Associated with a 1% Increase in Prescription Drug Utilization Among Seniors



CBO = Congressional Budget Office.

Christopher Roebuck,  
“Medical Cost Offsets from Prescription Drug Utilization Among Medicare Beneficiaries,”  
JMCP, October 2014

# Total Cost of Care and Use of Meds



Stuart et al, "Increasing Medicare Part D Enrollment in Medication Therapy Management Could Improve Health and Lower Costs," Health Affairs, July 2013

# Medical-Pharmacy Integration

**CMS.gov**

Centers for Medicare & Medicaid Services

[Home](#) > [Newsroom](#) > [Media Release Database](#) > [Press releases](#) > [2015 Press releases items](#) > [CMS announces Part D Enhanced Medication Therapy Management Model](#)

## **CMS announces Part D Enhanced Medication Therapy Management Model**

**Date** 2015-09-28

**Title** CMS announces Part D Enhanced Medication Therapy Management Model

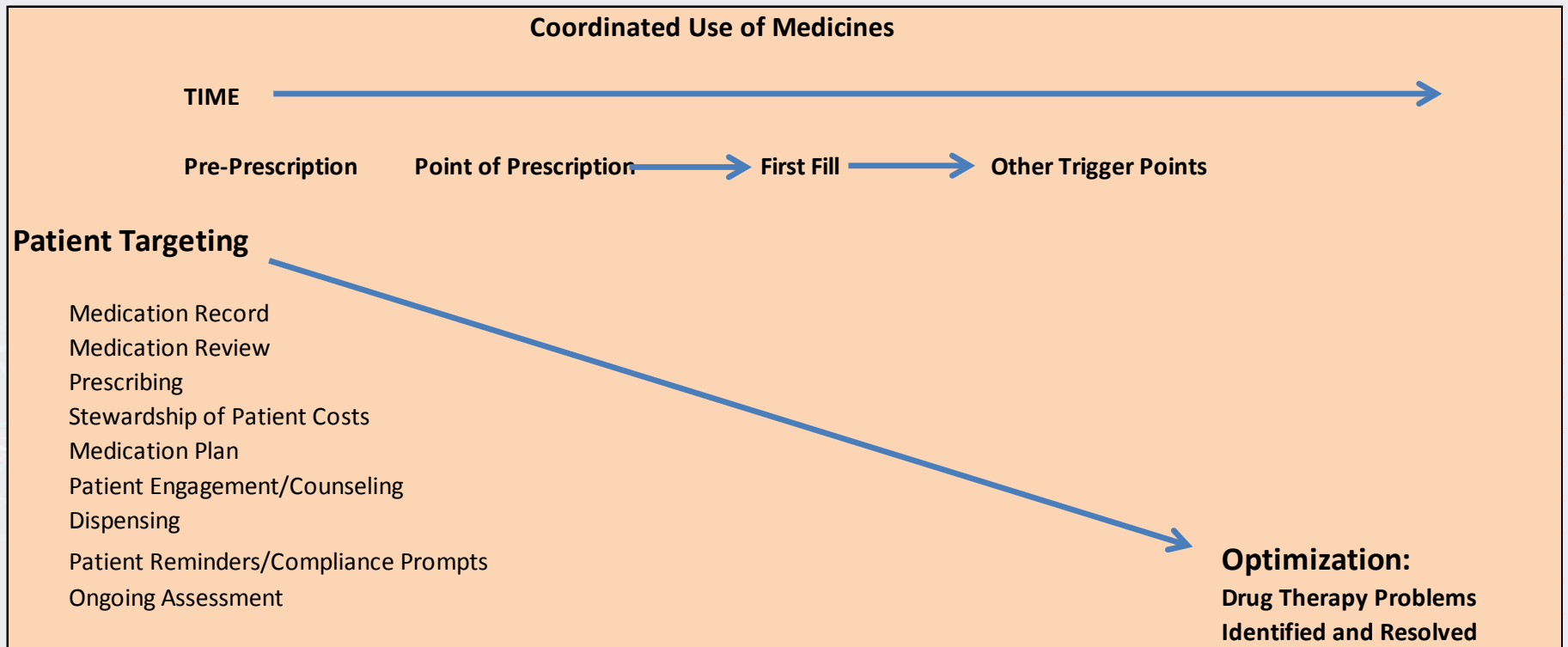
**Contact** [press@cms.hhs.gov](mailto:press@cms.hhs.gov)

### **CMS announces Part D Enhanced Medication Therapy Management Model**

*Model's goal is to improve care, reduce costs in Medicare*

Today, the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) announced a model to test strategies to improve medication use among Medicare beneficiaries enrolled in Part D. Medication therapy management, when implemented effectively, can improve health care and outcomes for patients and has the potential to lower overall health care costs.

# Continuity of Medication Care



*With thanks to the Community Pharmacy Foundation for its support*



# Policy Levers and Policy Opportunities

- U.S. House Energy & Commerce Committee – pending proposal on MTM
- U.S. Senate Finance Committee- Work Group on Chronic Care
- CMS Enhanced MTM Model (2017)
- CMS Medicare Advantage VBID Pilot (2017)
- National Academy of Medicine/Bipartisan Policy Center Project on High Need Patients
- Continuing annual revisions to Part D (e.g. addition of completion-of-medication-reviews measure, 2016)

# Trends to watch ....

- Medicare Part D and E-prescribing catalyze metrics, new services - how deeply will this extend into Medicaid and commercially-insured populations?
- Better use of medicines generates medical cost offsets – how rapidly can targeted strategies for better use of medicines be operationalized?
- Will integration (formal or virtual) of medical and pharmacy management become a robust tool for controlling Total Costs of Care?
- How can routine processes be turned into better opportunities to pull up the medication performance of patient populations ? ( See: Fill Status feeds to prescribers, medication synchronization, appointment-based reviews at the pharmacy, better use of packaging, etc.)

# Thank You

Tom Hubbard

Vice President of Policy Research

NEHI- Network for Excellence in Health Innovation

[thubbard@nehi.net](mailto:thubbard@nehi.net)

[www.nehi.net](http://www.nehi.net)

# Obesity As a Chronic Disease



**Scott Kahan, MD, MPH, FTOS**

Director, National Center for Weight and Wellness

Medical Director, Strategies To Overcome and Prevent (STOP) Obesity Alliance

George Washington University

Washington, DC

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# Disclosures

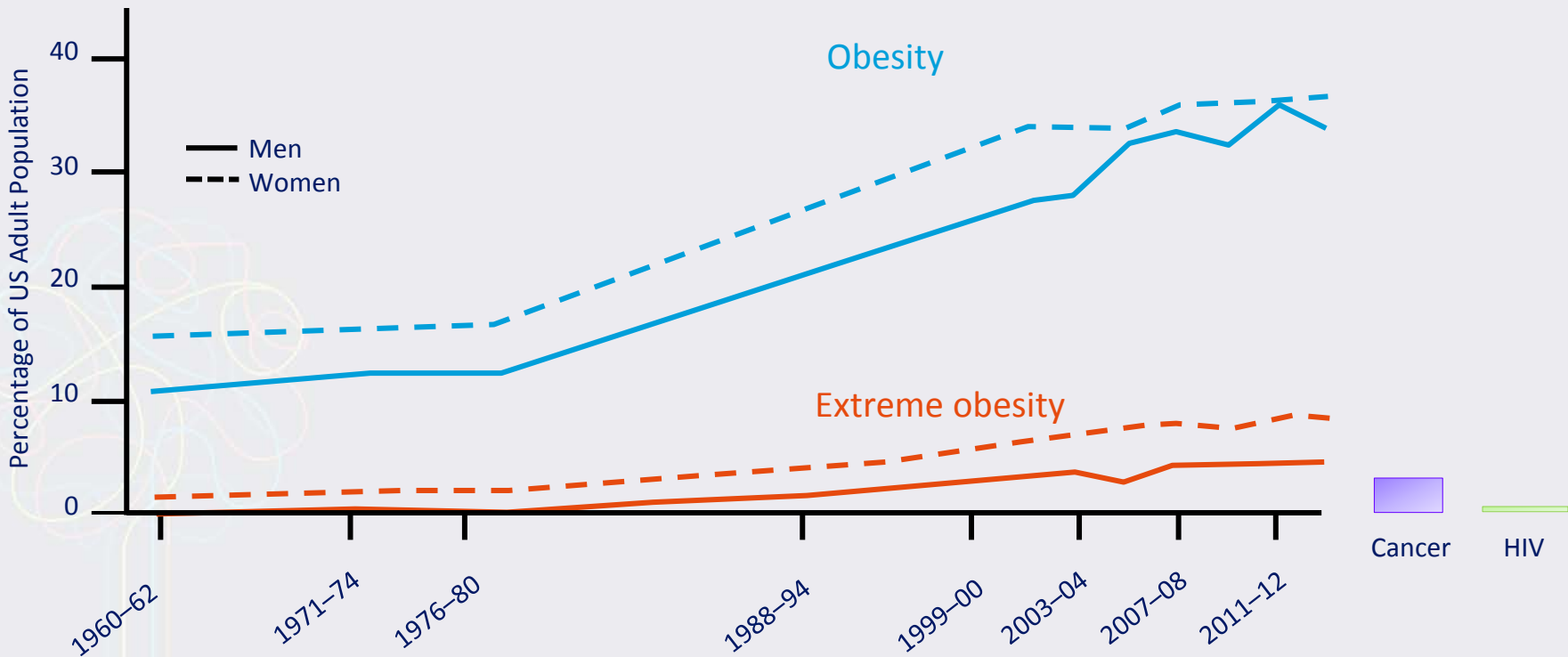
- Consulting/Advisory boards/speaking/research: Novo Nordisk, Takeda, Vivus, Eisai
- Board of Directors: American Board of Obesity Medicine, Playworks DC
- Book royalties: Lippincott, Williams & Wilkins, Johns Hopkins University Press, Wolters-Kluwer

# Overview

- Obesity negatively and strongly affects society and individuals
- Obesity should be treated as we do other chronic diseases
- We know a lot about what works



# Prevalence of Obesity in US Adults



Fryar CD *et al.* NCHS Health E-stat. September 2014. [http://www.cdc.gov/nchs/data/hestat/obesity\\_adult\\_11\\_12/obesity\\_adult\\_11\\_12.htm](http://www.cdc.gov/nchs/data/hestat/obesity_adult_11_12/obesity_adult_11_12.htm)

# Economic Costs

## DIRECT COSTS OF OBESITY INCLUDE:<sup>9</sup>



HEALTH CARE  
SERVICES



MEDICAL  
TESTS



DRUGS TO TREAT  
COMORBIDITIES

## INDIRECT COSTS OF OBESITY INCLUDE:<sup>11</sup>



VALUE OF  
LOST WORK



INSURANCE  
PREMIUMS AND  
COMPENSATIONS



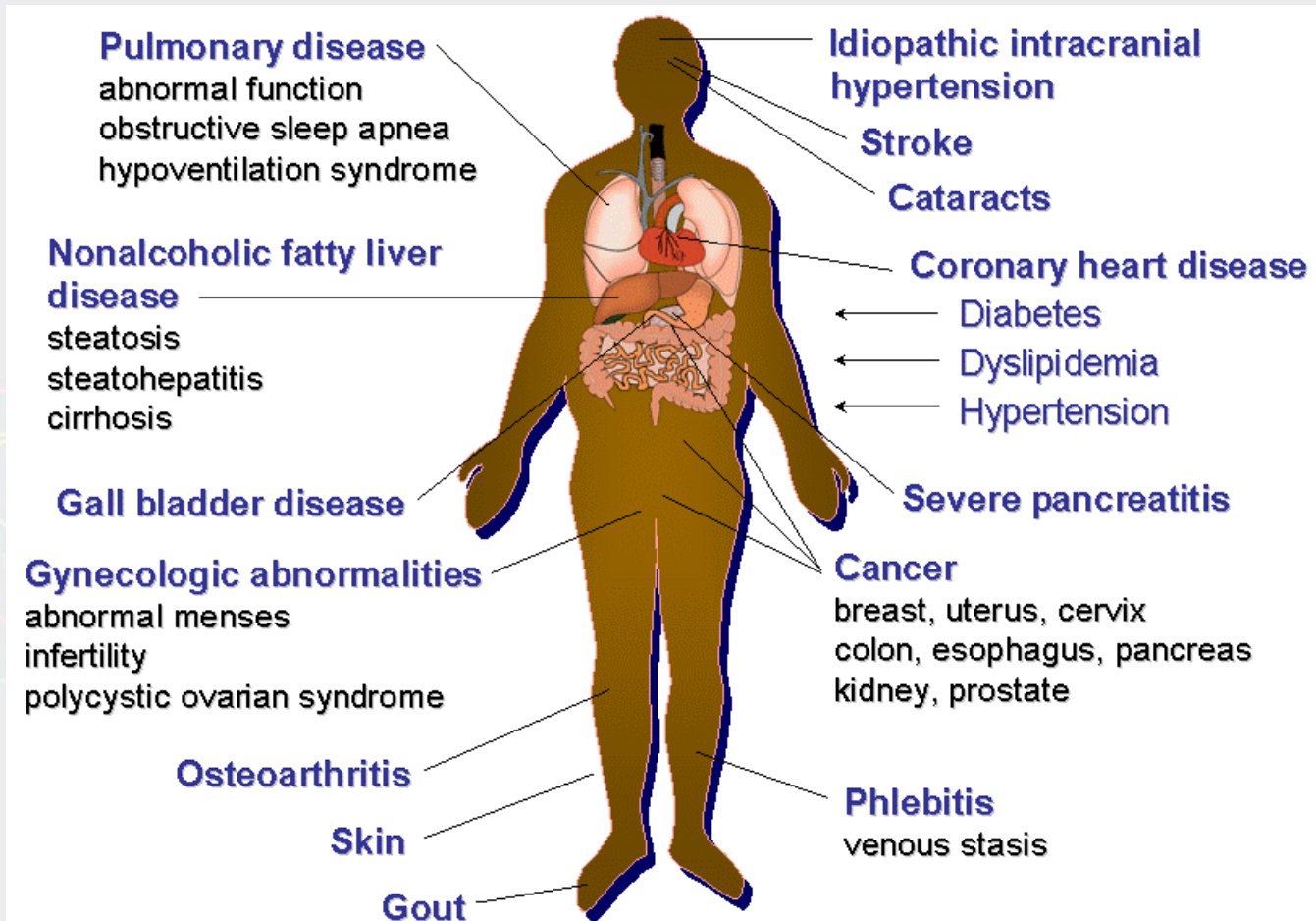
LOWER  
WAGES

~\$200 Billion

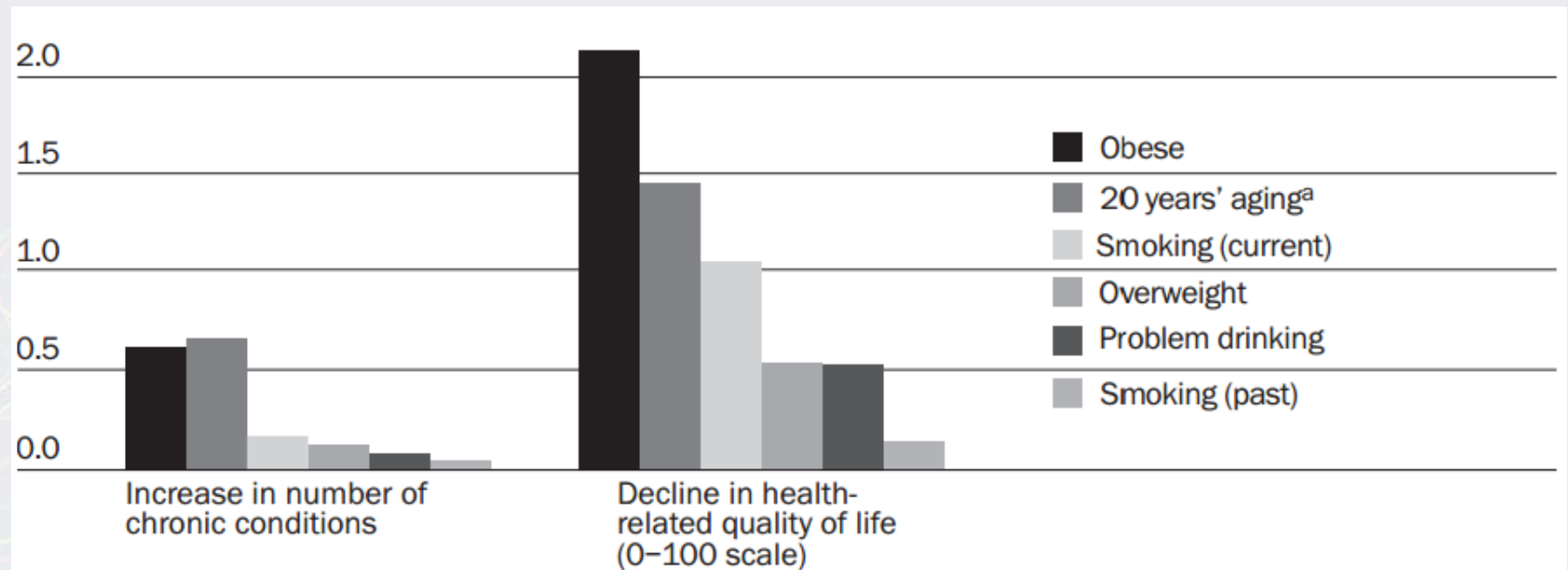
~\$65 Billion

George Washington University, National Public Health Week, 2013. Finkelstein EA et al. *Health Aff (Millwood)* 2009;28:w822-31. Cawley J, Meyerhoefer C. *J Health Econ* 2012;31:219-30. The Fiscal Times, June 19, 2014, [www.thefiscaltimes.com/Articles/2014/06/19/Budget-Busting-US-Obesity-Costs-Climb-Past-300-Billion-Year](http://www.thefiscaltimes.com/Articles/2014/06/19/Budget-Busting-US-Obesity-Costs-Climb-Past-300-Billion-Year)

# Obesity Comorbid Conditions



# Effect of Obesity, Aging, Smoking, Drinking on Health and Quality of Life



Sturm R. Health Aff 2002;21(2):245-53.

# Obesity Is Globally Recognised As a Chronic Disease and Health Issue



"Obesity is a chronic disease, prevalent in both developed and developing countries, and affecting children as well as adults."



"Obesity is recognised as a chronic clinical condition and is considered to be the result of interactions of genetic, metabolic, environmental, and behavioural factors and is associated with increases in both morbidity and mortality."



"Overweight and obese people are a majority today in the OECD area. The obesity epidemic continues to spread, and no OECD country has seen a reversal of trends since the epidemic began."

**AMA**

"Recognizing obesity as a disease will help change the way the medical community tackles this complex issue that affects approximately one in three Americans"

**AACE**

"...obesity is a primary disease, and the full force of our medical knowledge should be brought to bear on the prevention and treatment of obesity as a primary disease entity..."

**CMA**

"It is important for health care providers to recognize obesity as a disease so preventive measures can be put in place and patients can receive the appropriate treatment."



**Letter No. 2014-04**

**Date: March 20, 2014**

Fee-for-Service [3]    Experience-rated HMO [3]    Community-rated [3]

**SUBJECT: Supplemental Guidance: Management of Obesity in Adults**

Carrier Letter 2013-10 summarizes the management of adult obesity within the FEHB program. This letter provides new, supplemental information in the areas of weight loss medications and preferred facilities for bariatric surgery. All other information in Carrier Letter 2013-10 remains current.

**Weight Loss Medications**

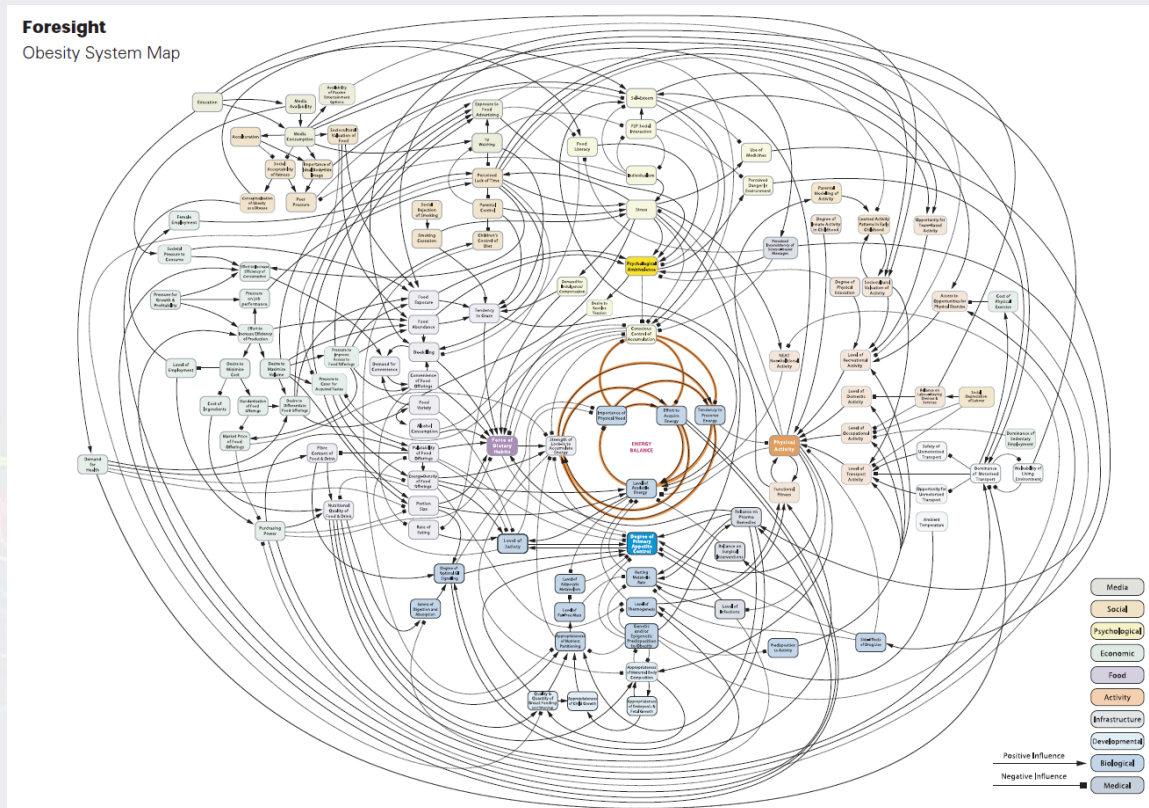
Diet and exercise are the preferred methods for losing weight. We appreciate that FEHB plans have refined wellness activities, health coaching, nutrition counseling and disease management to achieve a greater focus on obesity. Additionally, drug therapy can assist obese adults who do not achieve weight loss goals through diet and exercise alone. The Food and Drug Administration (FDA) has approved several anti-obesity drugs, including two new ones in 2012. Complete prescribing information for Belviq (Lorcaserin) and Qsymia (Phentermine/topiramate ER) is available at [www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm](http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm)

It has come to our attention that many FEHB carriers exclude coverage of weight loss medications. Accordingly, we want to clarify that excluding weight loss drugs from FEHB coverage on the basis that obesity is a “lifestyle” condition and not a medical one or that obesity treatment is “cosmetic”- is not permissible. In addition, there is no prohibition for carriers to extend coverage to this class of prescription drugs, provided that appropriate safeguards are implemented concurrently to ensure safe and effective use.



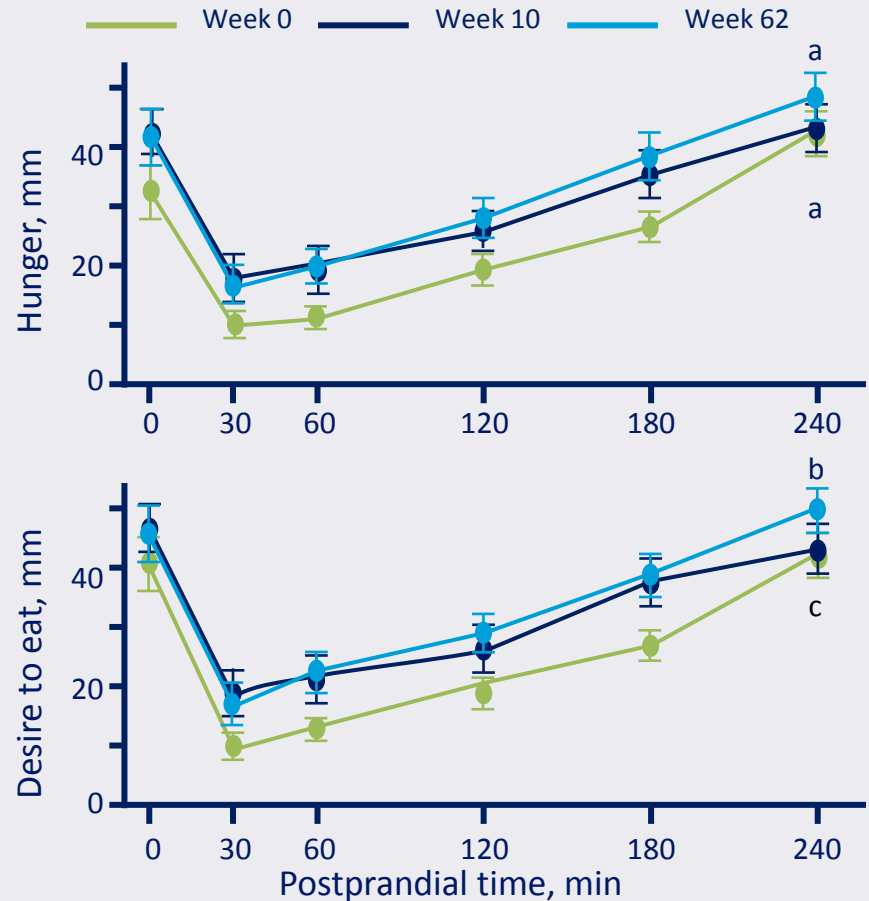
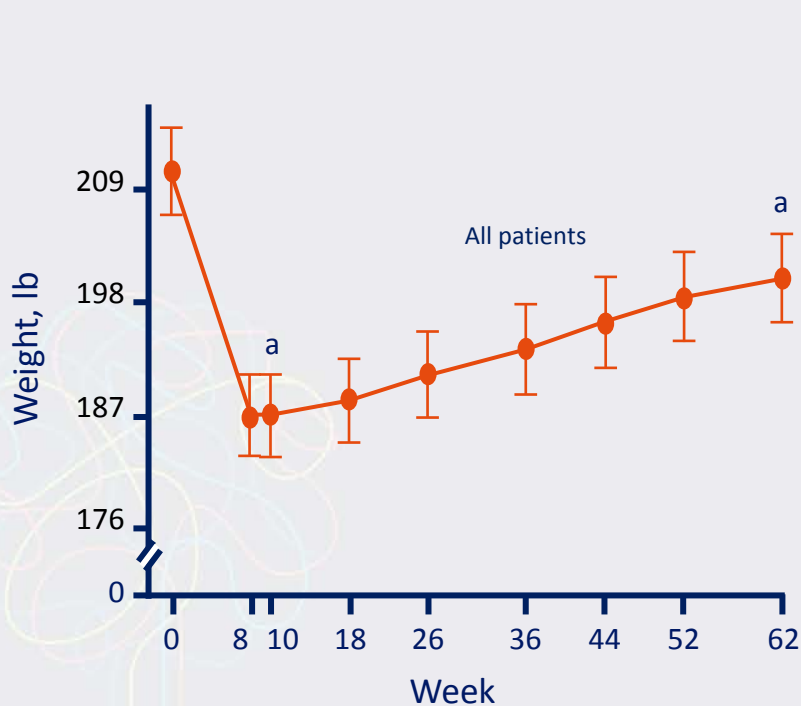


# Why Is It So Hard To Manage Weight?



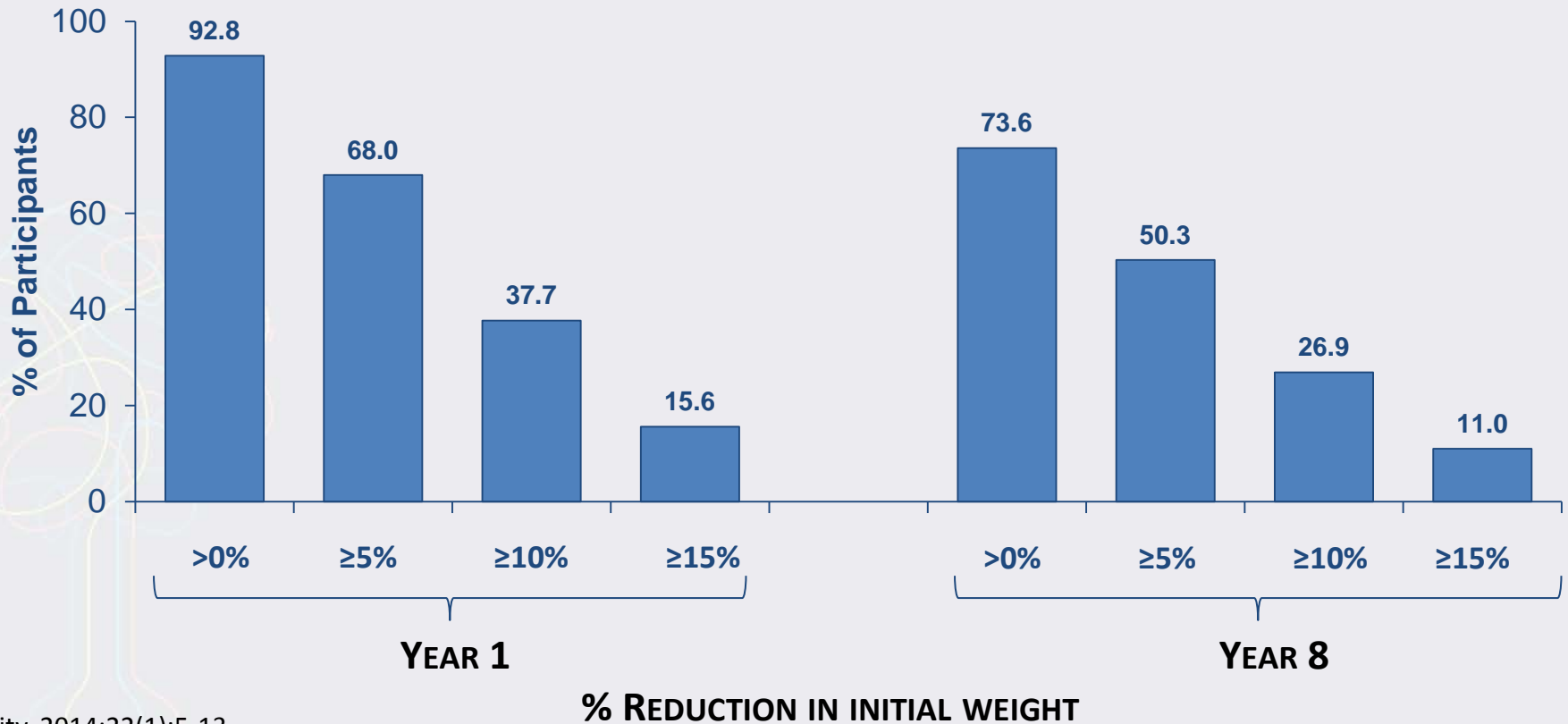
Kahan S, et al. Health Behavior Change in Populations. Johns Hopkins Univ Press, 2014.

# Hormone Changes and Hunger Persistently Oppose Diet-Induced Weight Loss



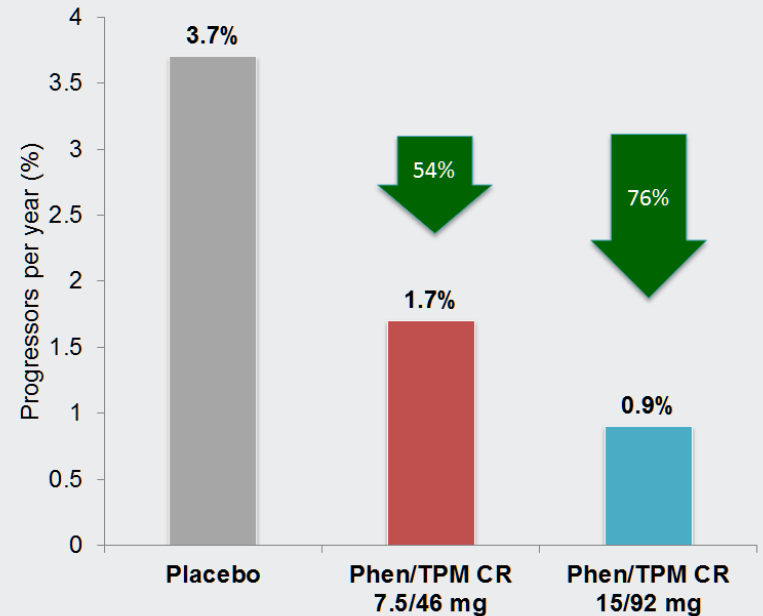
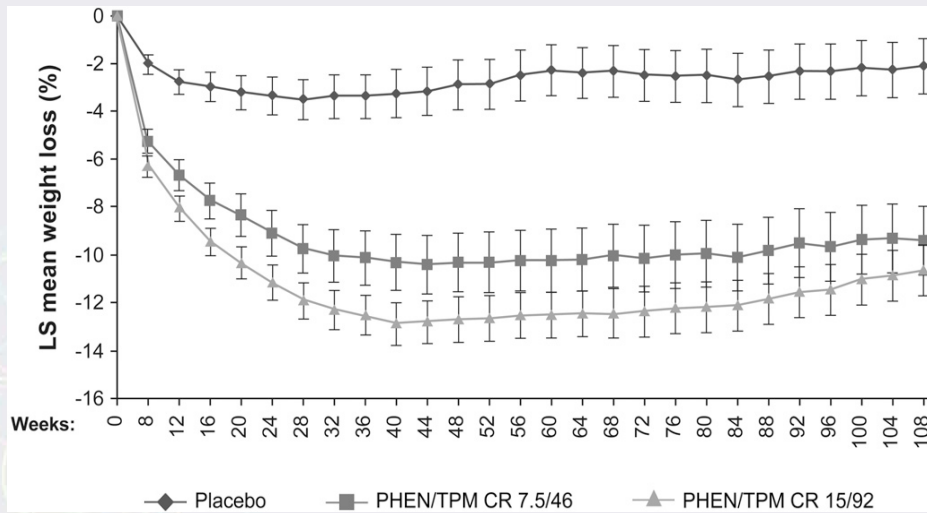
Sumithran P et al. *N Engl J Med.* 2011;365:1597–1604.

# Lifestyle Intervention for Obesity



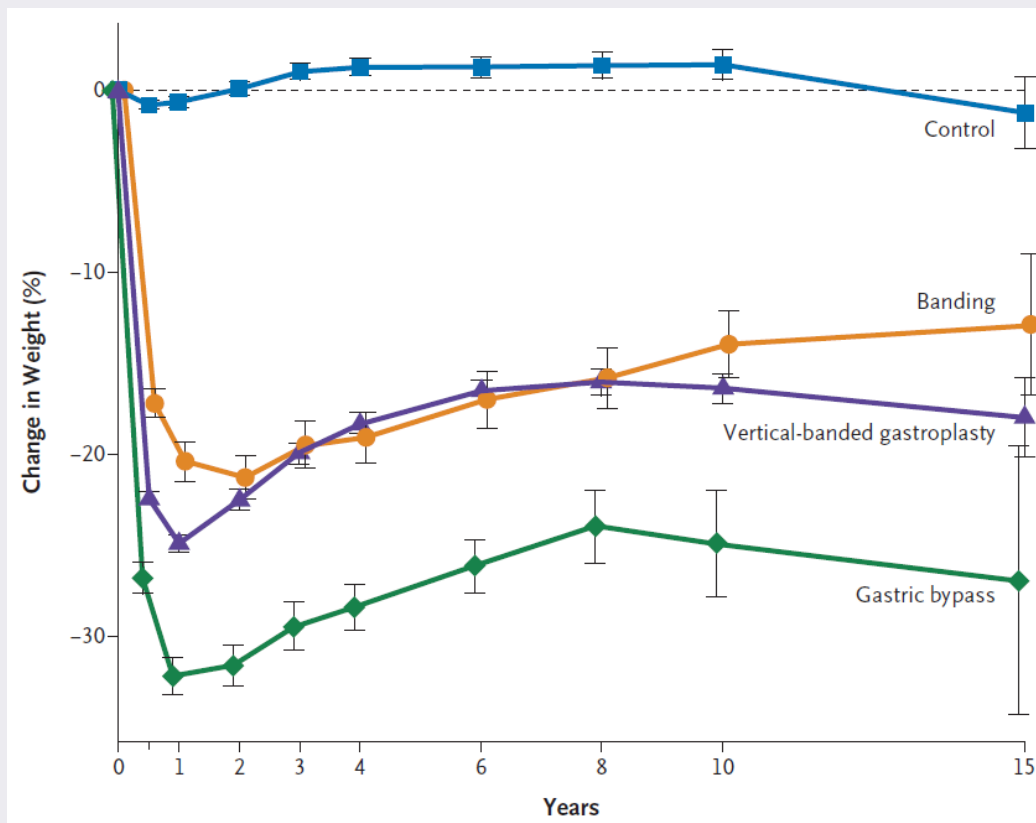
Obesity. 2014;22(1):5-13.

# Obesity Pharmacotherapy



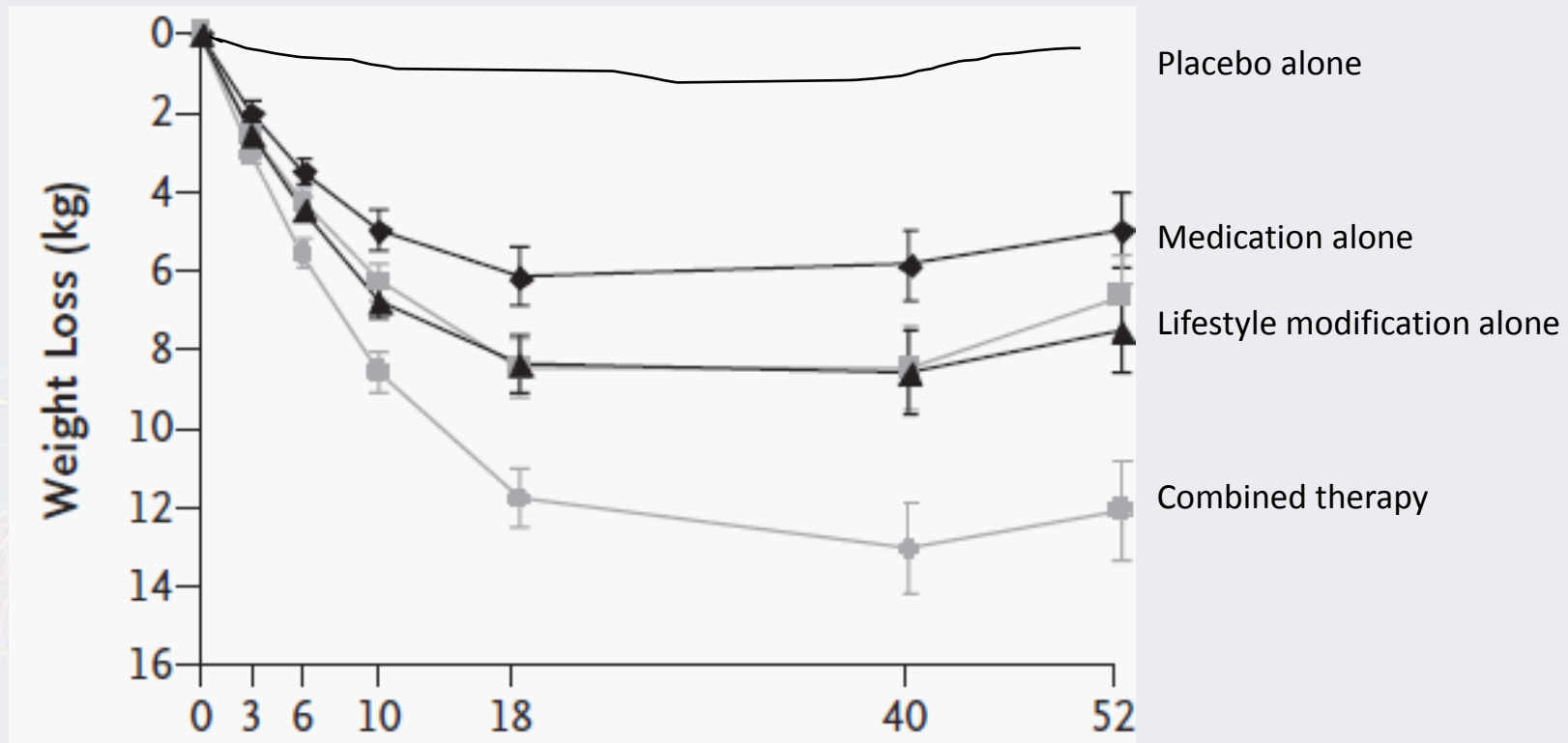
Garvey WT, et al. Am J Clin Nutr. 2012;95(2):297-308.

# Bariatric Surgery



NEJM, 2007.

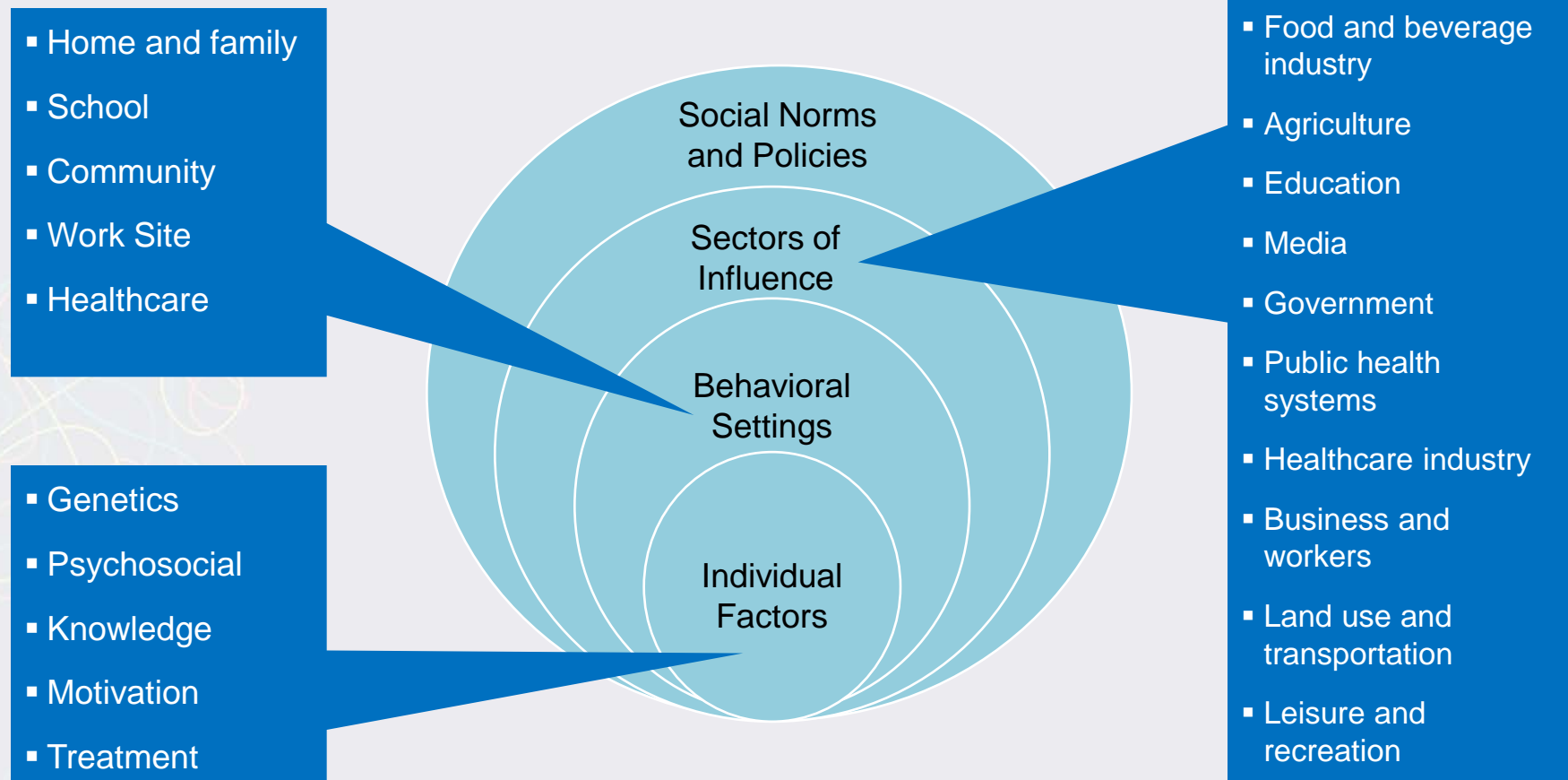
# Combining Treatments Works Even Better



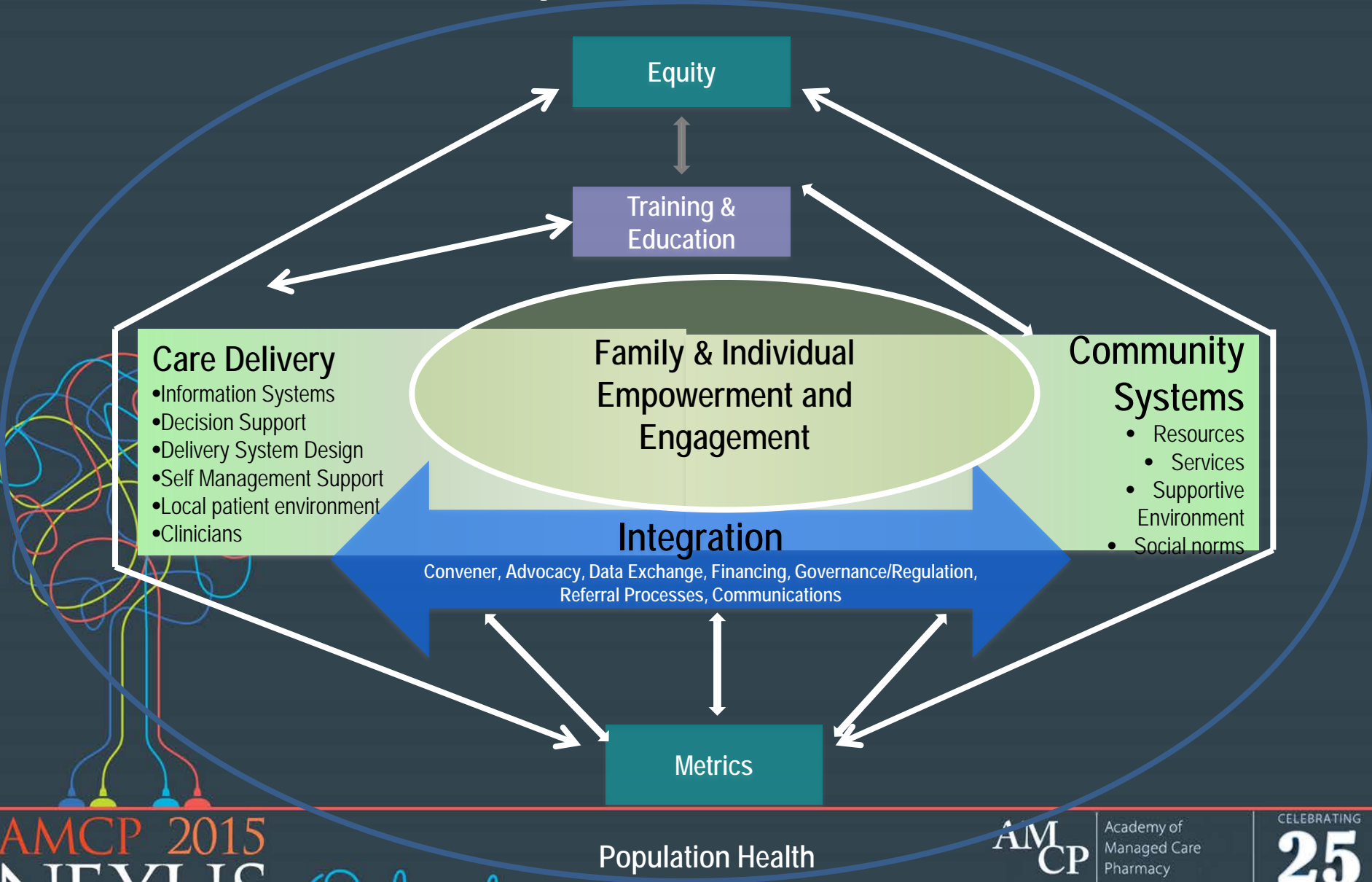
Adapted from Wadden, et al. NEJM, 2005.



# CDC Framework for Addressing Obesity



# Framework for Integrated Clinical and Community Systems of Care



*Thank you.*

Scott Kahan, MD, MPH  
kahan@gwu.edu



# Stumbling Toward Access to Evidence Based Care for Obesity



**Ted Kyle, RPh, MBA**  
Principal  
ConscienHealth  
The Obesity Society

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# Disclosures

- **Consulting Fees**
  - 3D Communications
  - Eisai
  - EnteroMedics
  - Novo Nordisk
  - The Obesity Society

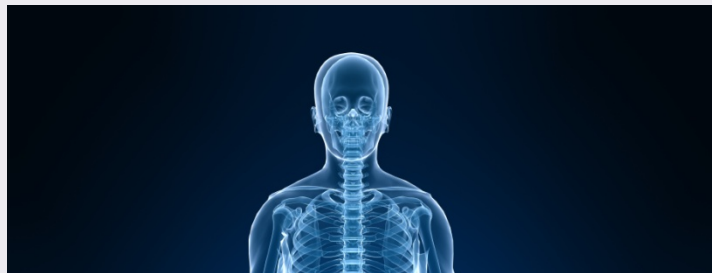


# Take Home

- Obesity is a complex, costly, chronic disease
- Without good care costs mount
- Access to care limited and extremely variable
- Evidence-based options & guidelines evolving
- Good care can deliver good value



# Untreated Obesity Harms Nearly Every Organ System

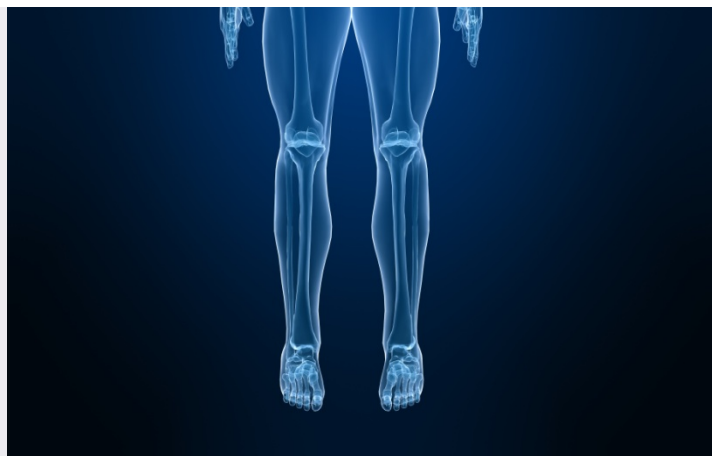


- Pulmonary
- Nonalcoholic fatty liver disease
- Gallbladder disease
- Gynecological issues
- Osteoarthritis
- Dermatologic conditions
- Gout

- Intracranial hypertension

## Annual Cost \$500 Billion

Source: *The Fiscal Times*, Scott Kahn - GWU, American Society of Actuaries, 2014



- Diabetes
- Pancreatitis
- Cancer
- Phlebitis

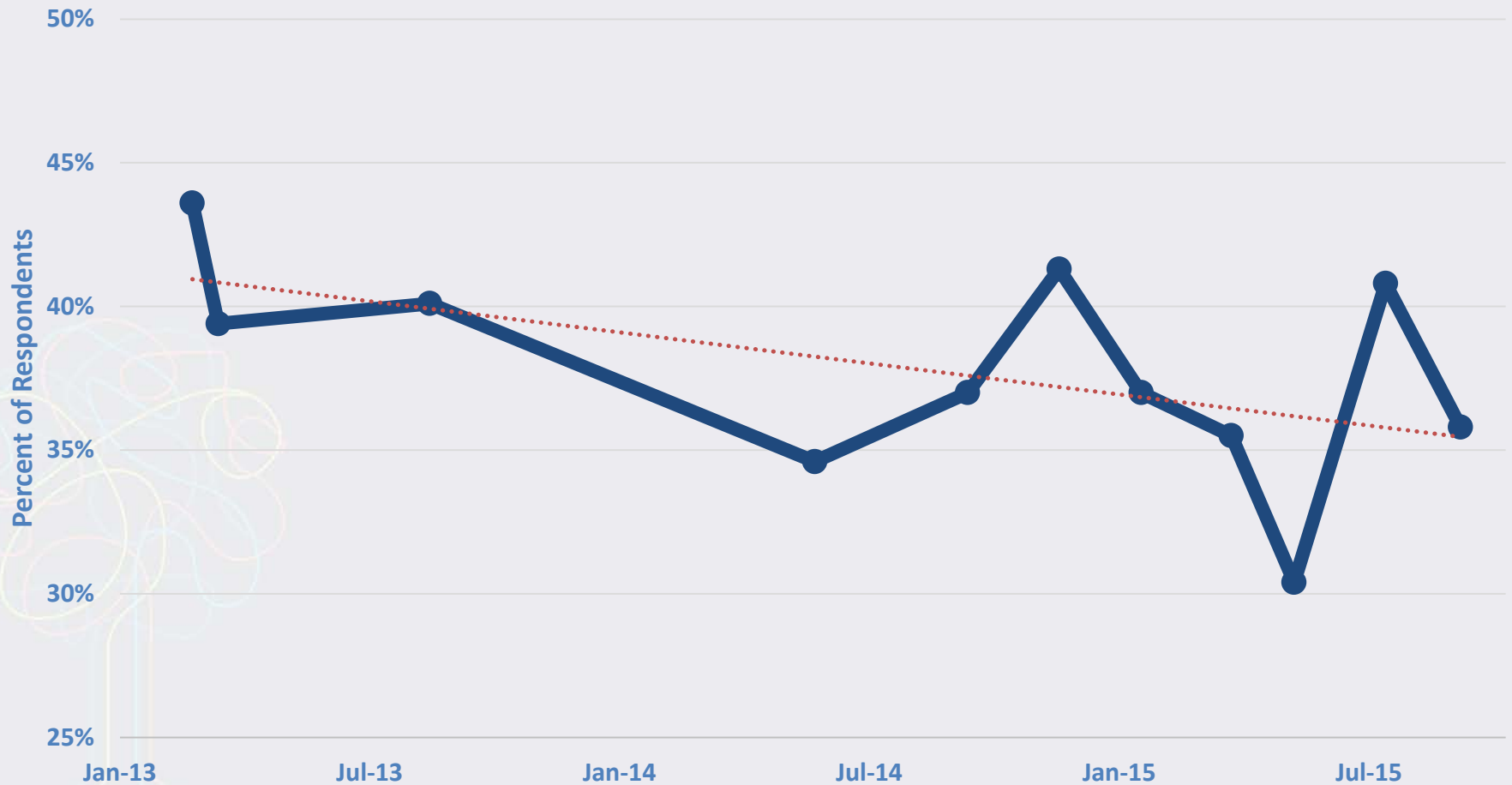


# Health Plans Often Discourage People from Addressing Obesity

- Routine policy exclusions for obesity  
“Regardless of any potential health benefit”
- Lifetime procedure caps
- High out of pocket costs
- Problematic reimbursement rates and procedures



# Bias that Obesity Is Simply a “Personal Problem of Bad Choices” Is Fading



Source: OAC/ConscienHealth weight bias tracking.

# Evolving Evidence-Based Obesity Care

- 2013 AMA determination:  
“Obesity is a complex chronic disease.”
- TOS/AHA/ACC guidelines
- Endo/TOS pharmacotherapy guidelines
- Seven new FDA-approved treatments since 2012



# Priorities for Better Access to Care

- Health plans that address obesity
  - Medicare (TROA)
  - State employee benefit plans
  - Essential health benefits & state benchmark plans
  - Discriminatory plan design
- Ongoing progress
  - The emerging specialty of obesity medicine
  - Allied health professionals
  - Slowly but steadily improving access to care



# Good Care Delivers Good Value

- Reversal or prevention of complications
  - Diabetes
  - Heart disease
  - Musculoskeletal
  - Even cancer
- Reduction in medication requirements
- Substantial improvements in quality of life
- Better physical function & productivity



Source: McCombie, L., Lean, M. E., & Tigbe, W. W. (2015). Cost-effectiveness of obesity treatment. *Medicine*, 43(2), 104-107.





# Take Home

- Obesity is a complex, costly, chronic disease
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# More Information

- [www.conscienhealth.org/news](http://www.conscienhealth.org/news)
-  Facebook.com/ConscienHealth
-  @ConscienHealth
- For these slides:  
<http://conscienhealth.org/wp-content/uploads/2015/10/AMCP.pdf>



# Understanding Obesity: Weight Bias and Its Consequences



**Joe Nadglowski**  
President/CEO  
Obesity Action Coalition

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# What is Weight Bias?

- Negative attitudes toward individuals with obesity
- Stereotypes leading to:
  - stigma**
  - rejection**
  - prejudice**
  - discrimination**
- Verbal, physical, relational, cyber
- Subtle or overt



# Weight Bias in the Media

- Stereotypical portrayals
- Abundant but often ignored
- Reinforces social acceptability of bias
- Affects public perceptions about obesity



# Weight Bias In Employment

## Population Studies

## Experimental Research



Inequitable hiring practices  
Prejudice from employers  
Lower wages  
Disciplinary action  
Wrongful job termination



# Healthcare Providers Express Bias Against People with Obesity

**Non compliant**

**Lazy**

**Lacking in self-control**

**Awkward**

**Weak-willed**

**Sloppy**

**Unsuccessful**

**Unintelligent**

**Dishonest**

Ferrante et al., 2009; Campbell et al., 2000; Fogelman et al., 2002; Foster, 2003; Hebl & Xu, 2001; Price et al., 1987; Puhl & Heuer, 2009; Huizinga et al., 2010





# Weight Bias Matters Because:

- It's no different from any other bigotry
- Violation of human dignity
- Dehumanizes people
- Waste of Human Potential
- Barrier to overcoming obesity

# Expect for our Biases, Obesity is much like other Diseases:

- Biology is the dominant driver
- Environment shapes biological responses
  - Food supply
  - Microbes
  - Barriers to physical activity
  - Trauma and stressors
  - Environmental pollution
  - Many other factors
- Personal choices can help or hurt

# Impact on Care

***Patients with obesity are less likely to obtain...***

- Preventive health services & exams
- Cancer screens, pelvic exams, mammograms

***and are more likely to...***

- Cancel appointments
- Delay appointments and preventive care services



Adams et al., 1993; Drury & Louis, 2002; Fontaine et al., 1998; Olson et al., 1994, Ostbye et al., 2005; Wee et al., 2000; Aldrich & Hackley, 2010.

# Health plans discourage people from seeking obesity treatment:

- Routine policy exclusions for obesity “regardless of medical necessity or potential health benefit”
- Lifetime procedure caps
- High out of pocket costs
- Problematic reimbursement rates

# Bias Compromises Quality of Care

- Less empathetic care
- Less preventive care
- Patients feel berated and disrespected
- Obesity blamed for every symptom

“You could walk in with an ax sticking out of your head and they would tell you your head hurt because you are fat.”

# Using Shame and Blame against Obesity is a Lie

- Research shows that weight discrimination doubles the risk of developing obesity
- and triples the risk of persistent obesity
- Encouragement, not blame is needed!

Gudzune et al, Prevent Med, 2014



# Summary

- Bias compromises research, care, health and policy
- Humanizing obesity is key to reducing bias
- A strong voice for people with obesity is essential
- Progress is coming from empowering people, confronting bias, access to care and innovative research.



# Tackling blood pressure at the community-level by linking clinical and community programs, data: American Heart Association's C2C2 Project

**Kathleen Shoemaker, PharmD, MBA**  
Director  
Quality Integration

**Kirstin Siemering DrPH, RD**  
Health Initiatives Manager  
Patient & Healthcare Innovations



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## *Our Discussion:*

- *Population health urgency of high blood pressure*
- *Background: AHA's evidence-informed action in clinical settings*
- *Background: AHA's evidence-informed action in community settings*
- *Vision and progress toward building on and bridging clinical and community settings*



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## Two Key Points

- ▶ **One out of every three adults in the United States has high blood pressure.**
- ▶ **Half of them do not have their blood pressure adequately controlled.**



# ▶ 80 million adults have HBP



**1 IN 3**  
AMERICANS  
IS LIVING WITH HBP  
TODAY

Blood Pressure Category	Systolic (mmHg)		Diastolic (mmHg)
Normal / Ideal	less than 120	and	less than 80
Prehypertension	120-139	or	80-89
Hypertension stage 1	140-159	or	90-99
Hypertension stage 2	160 or higher	or	100 or higher
Hypertensive crisis	higher than 180	or	higher than 110

## The Urgency Around High Blood Pressure Control

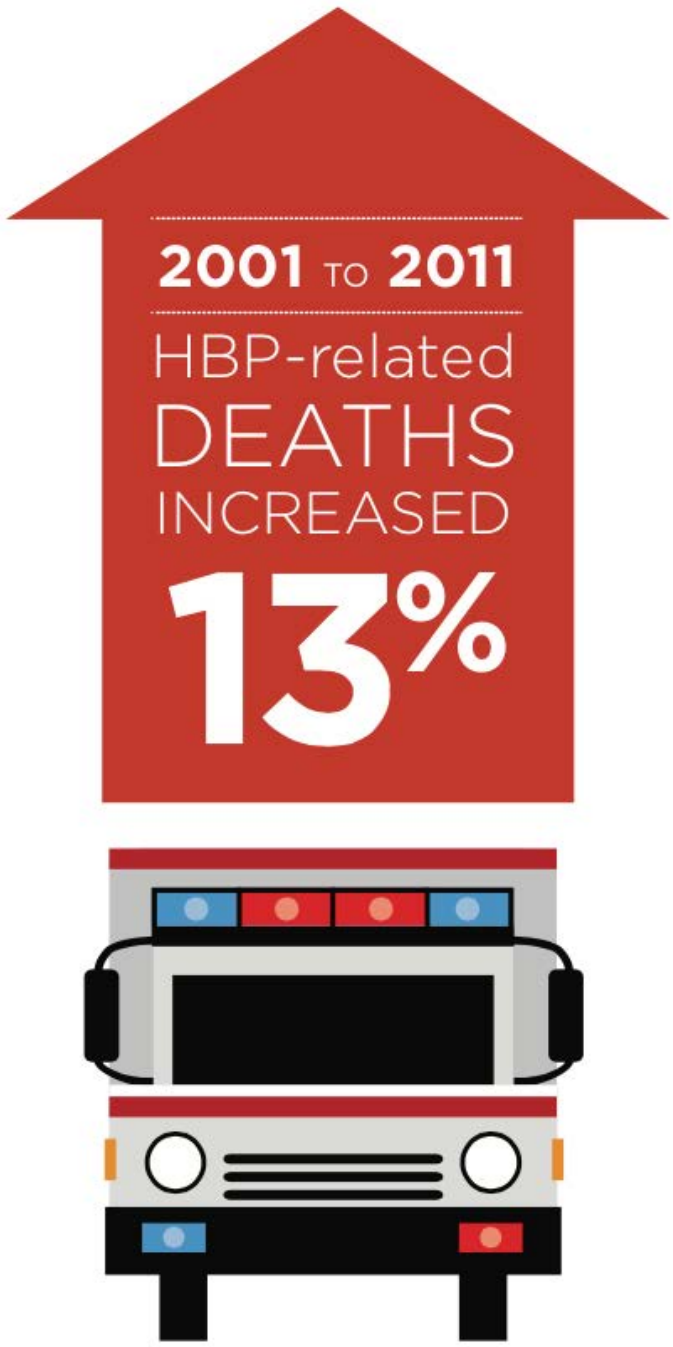
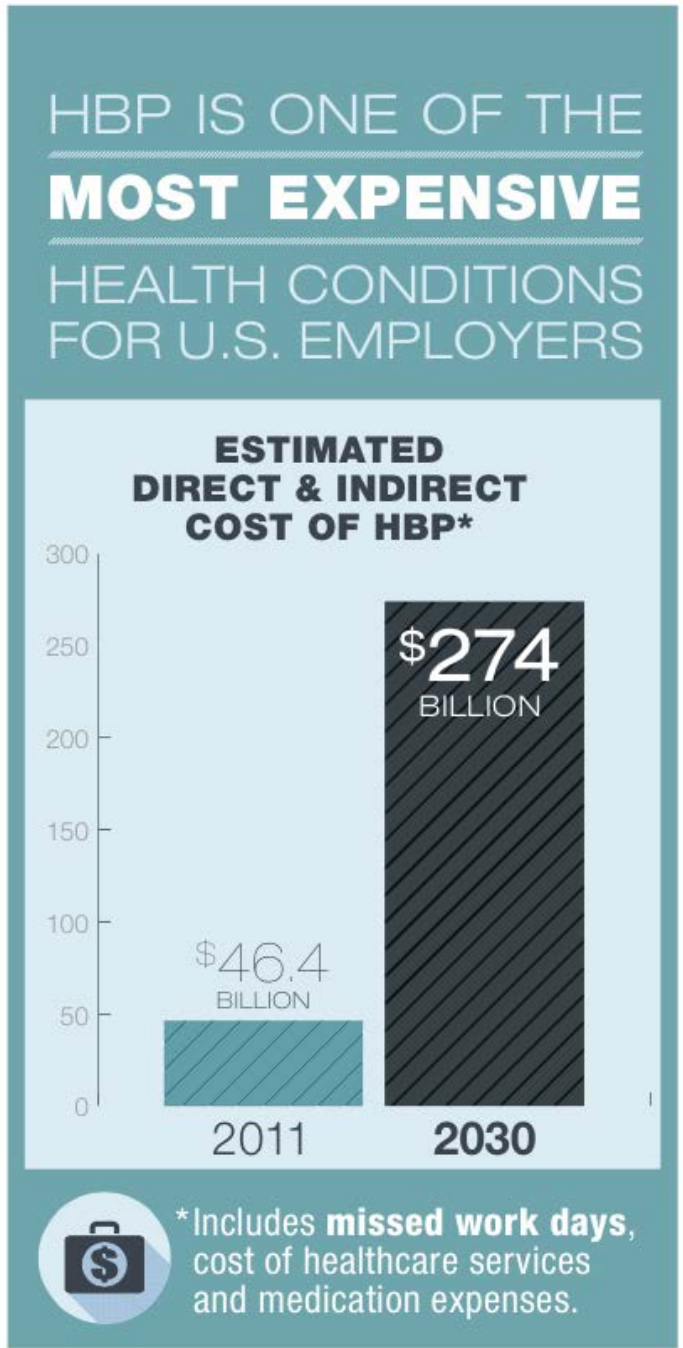
EVERY  
**10**  
POINT  
DROP  
in systolic BP



≈

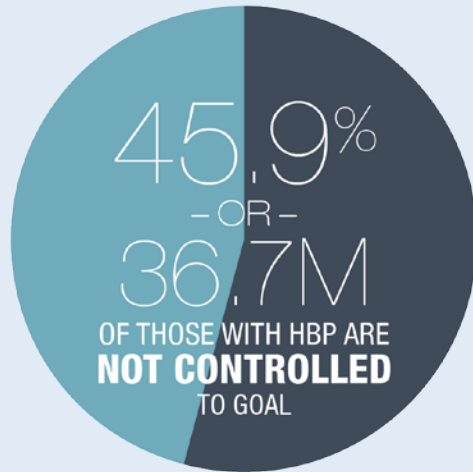
**30-50%**  
drop in risk  
of cardiovascular  
disease & stroke.

# The Urgency Around High Blood Pressure Control





# Our Goal for Better Control



## GOAL

- MOVE -  
**13.6M**  
**PEOPLE**  
**TO CONTROL**  
- BY 2020 -



From 2009 to 2012 among US adults with HBP



**54.1%**  
HBP is  
controlled



**76.5%**  
currently  
treated



**82.7%**  
are aware  
they have HBP



**17.3%**  
remain  
undiagnosed





# Our Strategic Multi-modal Approach to BP Management

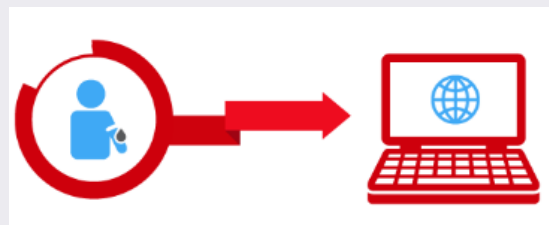
Equipping Providers



Activating Communities



Motivating & Connecting Consumers



Enhancing Systems of Care



Bringing this multi-modal approach for high blood pressure control to life in Atlanta and San Diego

► **Check. Change. Control.**  
**Connecting Communities and Care (C2C2)**



The American Heart Association and Kaiser Permanente have come together with a vision for creating systematic linkages between COMMUNITY and CLINICAL settings to eliminate DISPARITIES IN BLOOD-PRESSURE CONTROL in African-Americans.



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## What is the vision for C2C2?

### ▶ **Transforming clinical settings**

creating integrated and seamless systems for identifying, treating, and tracking patients with high blood pressure according to scientific best practices and state-of-the-art technologies

### ▶ **Transforming community settings**

such that regular blood pressure monitoring and education become a natural part of physical, social, and virtual landscapes

### ▶ **Strengthening existing and creating new linkages and relationships**

between and among clinical and community settings to raise awareness and invite access to resources

### ▶ **Using blood pressure to spark dialogue and action**

toward building a culture of health that translates to improved quality and length of life for all

C2C2



Key  
Clinical  
Resources

▶ **The Guideline Advantage**

HBP Treatment Algorithm (AHA/AAC/CDC)  
Population Manager (Forward Health Group)  
M.A.P. Curriculum (AMA)  
Heart360 health tracker (AHA)



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C2C2



Key  
Community  
Resources

► **Check. Change. *Control.***

Evidence-based community activation

Deploying Heart360 tracker in community settings

Harnessing the power of volunteers to promote

~ Blood pressure monitoring

~ Lifestyle education and support



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# ► Importance of reducing barriers to healthy living

Integrating lifestyle approaches for both treatment and prevention

## LIFESTYLE MODIFICATION OPPORTUNITIES

Learn more about the following recommendations for lowering SBP

<b>REDUCE WEIGHT</b>	<b>PHYSICAL ACTIVITY</b>
Can Lower 5-20 mmHg/10 Kg	Can Lower 4-9 mmHg
<b>ADOPT DASH*5 EATING PLAN</b>	<b>MODERATION OF ALCOHOL CONSUMPTION</b>
Can Lower 8-14 mmHg	Can Lower 2-4 mmHg
<b>LOWER SODIUM INTAKE</b>	
Can Lower 2-8 mmHg	



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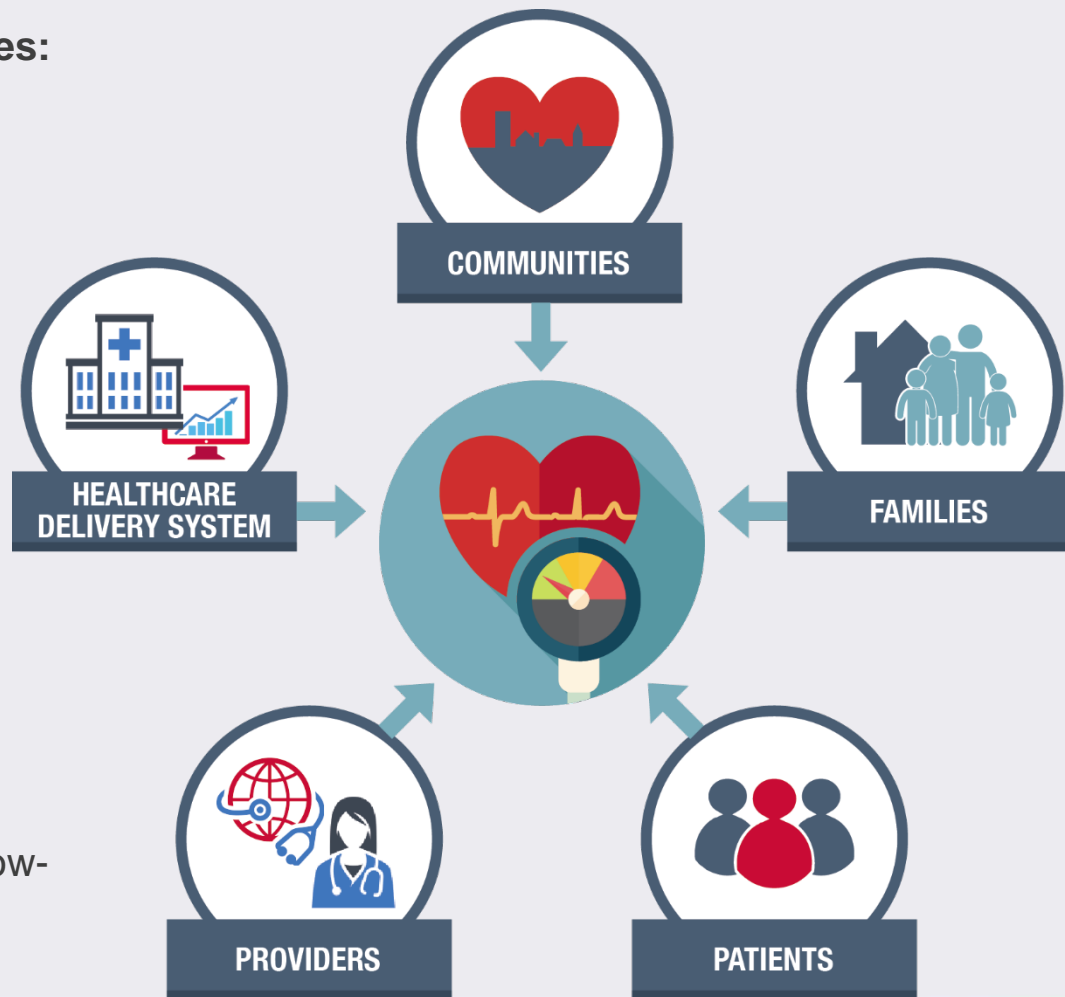




# ► Importance of broad engagement

## Approach includes:

- Expanding PT and HCP awareness
- Lifestyle modifications
- Access to care
- Evidence-based algorithm for treatment
- Medication adherence & follow-up strategies



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# Women Living with Heart Disease

A patient perspective  
on improving care



**Lisa C. Clough, MS Ed., CHES**  
Vice President, Public & Patient Programs



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# WomenHeart: The National Coalition for Women with Heart Disease

- Nation's first and still only patient-centered organization supporting women living with heart disease (1999)
- Heart disease is the leading cause of death in women
- Educate, advocate and support
- Many challenges with co-morbidities, medication management, early and accurate diagnosis and proper treatment
- WomenHeart national patient education campaigns shedding light on challenges for women heart patients



# What do women living with heart disease need to take charge of their heart health

- March 2015 survey of women heart patients
- Access to primary care
- Prompt referrals to specialty care
- Referral to subspecialty care as needed
- Coverage for cardiac testing, treatments and devices
- Access to medications as prescribed
- Referral to cardiac rehabilitation
- Availability of mental health/counseling





# Additional services to improve outcomes

- Care coordination among all providers
- Assistance with additional services, if needed (nutrition, smoking cessation, home health)
- Access to health records including test results to better assure communications and information among care providers
- Availability of Support Networks



# What affects their decision on selecting a health plan

- Choice of providers
- Actual out of pocket cost
- Predictability of costs
- Continuity of care with providers
- Availability of additional services



# Medication Adherence

- Pre-test for January 2015 national patient education webinar
- Women heart patients report:
  - 82% are on medication for heart disease
  - 41% take more than 4 medications
  - Good news:
    - 81% review their list of medications at every doctor visit
    - 95% understand what their medications are for
    - 70% understand why medication adherence is important



# Medication Adherence

- Bad news:
  - 23% had elected to not fill a prescription
  - 29% stopped taking their medication before they were supposed to
  - Negative side effects and cost were leading reasons for not adhering to medication



# National patient survey: Heart Failure

- Heart failure is leading cause of hospitalization for women age 65+
- November 2014
- Women heart patients
- 255 respondents
- Mean age 52
- All had diagnosed heart failure



# Heart Failure: National Survey

- Results – women heart patients need:
  - Reduced misdiagnosis
  - Address mental health issues associated with heart failure
  - Enhance patient education
  - Remove barriers to cardiac rehabilitation
  - Improve access to support
  - Better patient/physician communication
  - Expanded access to insurance coverage





# Heart Failure: KOL Workshop

- Recommendations from the Key Opinion Leader Workshop to improve care and outcomes
  - Implement policies to remove barriers to proper treatment
  - Improve access to affordable and accessible care
  - Increase participation of women in clinical trials
  - All stakeholders work together to support and optimize care for women living with heart failure



# National patient survey: Cholesterol

- February 2015
- Women heart patients
- 795 respondents
- Mean age 59
- All had elevated LDL, FH or both



# National patient survey: Cholesterol

- Results
  - 62% adherence (compared to 30-50% of patients across all disease states)
  - 83% reported taking statins
  - 61% with FH reported taking FH specific medication
- Barriers to medication adherence
  - 23% forget to take medicine
  - 21% experience muscle or bone pain
  - 16% intolerance
  - Poor patient/physician communication



# Cholesterol: KOL Workshop

- Recommendations
  - Access to medication and specialty care is essential for proper treatment
  - Address barriers to medication adherence and treatment – vital to reduce risk for cardiovascular disease
  - Screening important to enact early treatment





*“My cardiologist saved my heart,  
but WomenHeart saved my life.”*

WomenHeart Champion

Lisa C. Clough, MS Ed. CHES

Vice President, Public & Patient Programs

[lclough@womenheart.org](mailto:lclough@womenheart.org) or 202.464.8734



**Fifth Annual AMCP Foundation Symposium  
Opportunities & Challenges in Patient Care, Prevention & Adherence**

# **The Patient Perspective**

**October 26, 2015**

**Eleanor M. Perfetto, PhD**

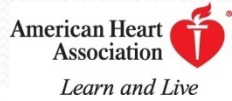
**Senior Vice President for  
Strategic Initiatives**



**The mission of the National Health Council is  
to provide a united voice for  
people with chronic diseases and disabilities.**



# NHC Membership

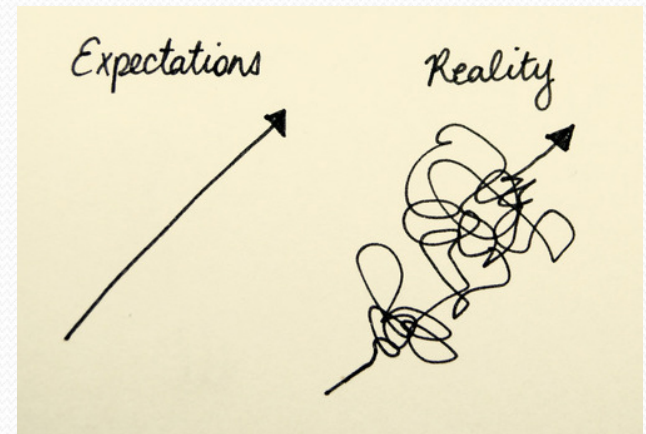




**When contemplating solutions for  
patient care, prevention & adherence,  
don't forget the voice of the patient!**

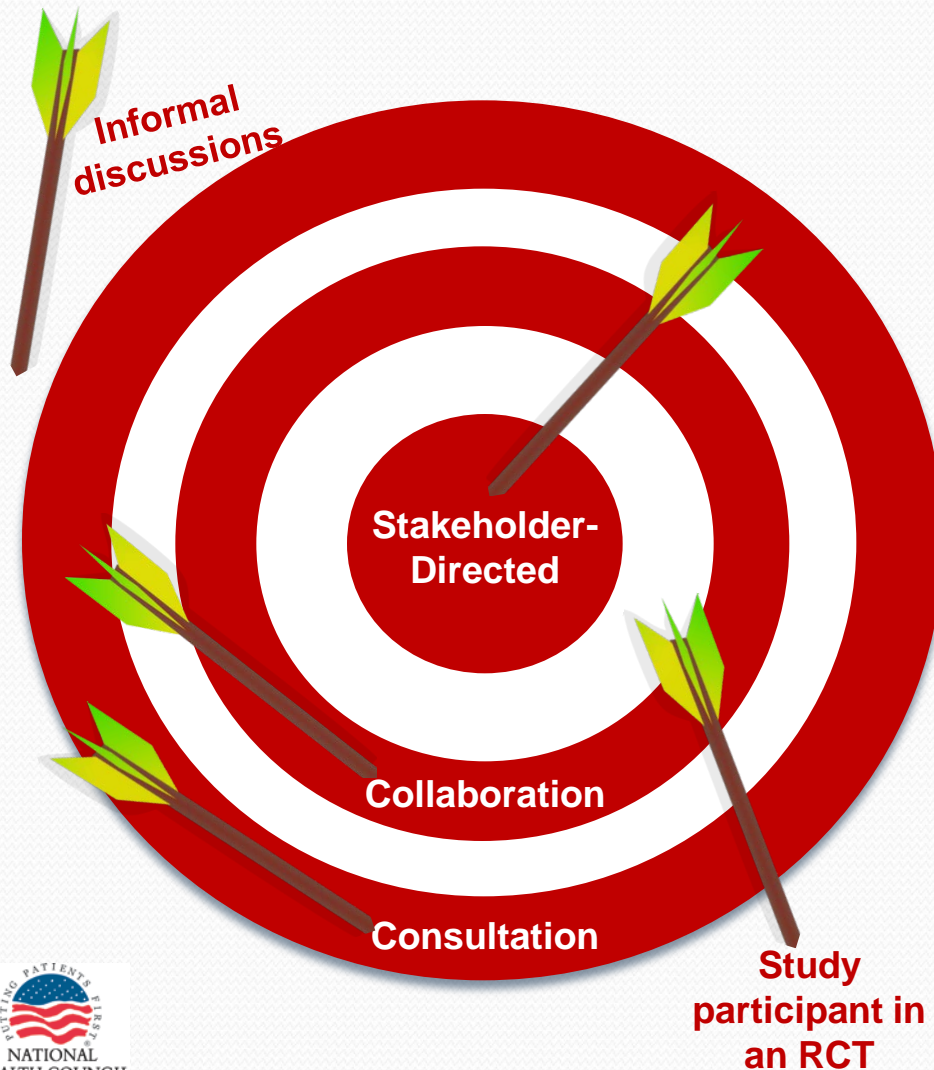
# Patient Centeredness

- Active involvement of patients and families in the design of new care models and in decision-making
- Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- Care that is truly patient centered cannot be achieved without active patient engagement at every level of care design and implementation.





# Levels of Patient Engagement



- **Stakeholder-Directed**
  - Patient/Patient group led
- **Partnership**
  - Investigator/Co-investigator
- **Collaboration**
  - Advisory committee member
- **Consultation**
  - Consultant
  - Interviews
  - Focus groups
  - Surveys
- **Informal**
  - Unstructured discussions
- **Study participant**

# Fifth Annual AMCP Foundation Symposium

## Opportunities & Challenges in Patient Care, Prevention & Adherence

### Topics Covered Today

- Adherence
- Obesity
- CVD
- Data sharing

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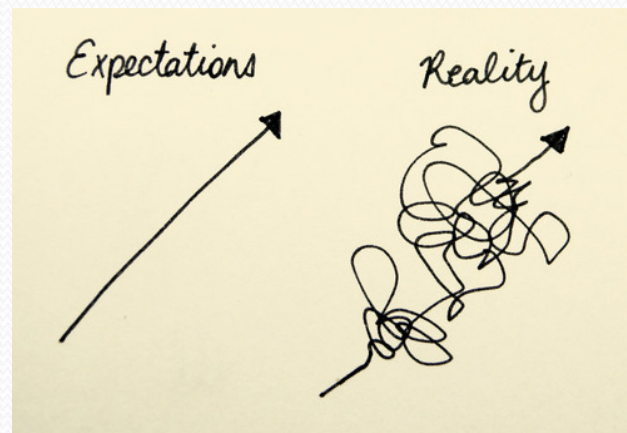
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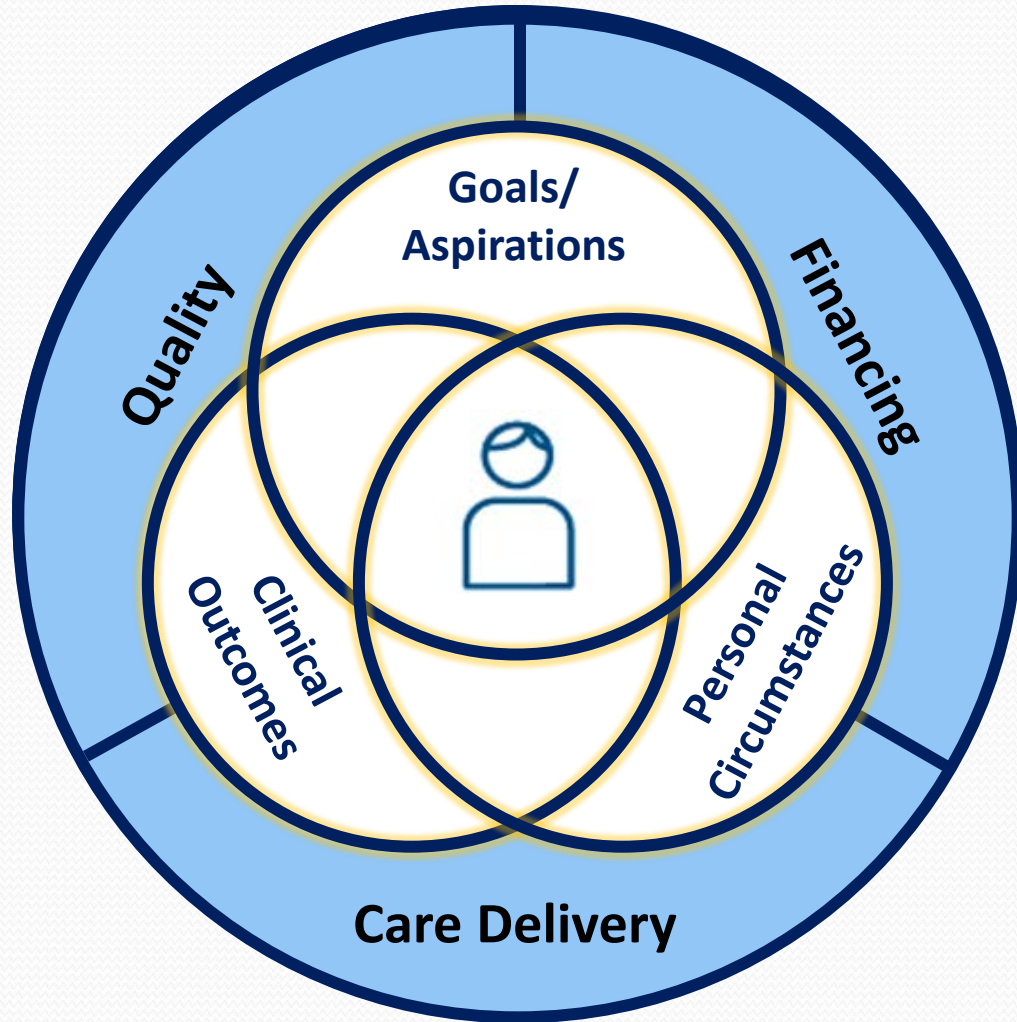
- ✓ Adherence
- ✓ Obesity
- ✓ CVD
- ✓ Data sharing



**Patient care, prevention and adherence-  
improvement programs designed and  
implemented without patient partnership  
will continue to have limited success  
and ROI.**



# Creating a Patient-Centered Health Care Ecosystem





# Contact Us

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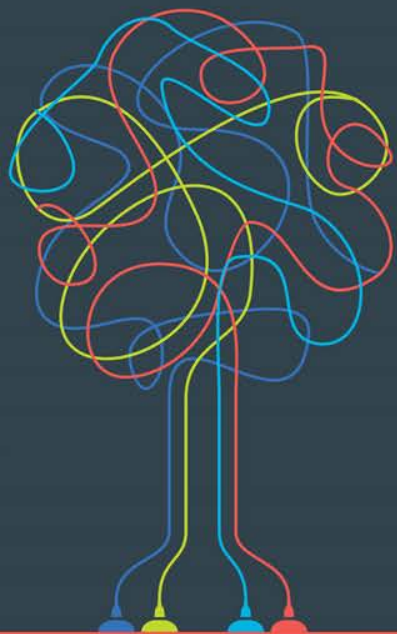






# Opportunities & Challenges in Patient Care, Prevention & Adherence

## PUTTING IT ALL TOGETHER



**Fauzea Hussain, MPH**  
**Senior Vice President**  
Avalere Health

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