

NBCH action brief

Combating America's Great Killer: *CARDIOVASCULAR DISEASE*

Heart disease accounts for one of three deaths in the United States each year. Over 30 million US adults have a type of heart disease caused by buildup in the arteries, known as atherosclerotic cardiovascular disease (ASCVD).¹ These conditions can lead to costly procedures, medications, disability, or even death. One of the most significant risk factors is high cholesterol (specifically LDL-C), which nearly doubles the risk for heart disease, compared to people with optimal cholesterol levels.² Nine modifiable risk factors are responsible for over 90% of risk for a first heart attack—high cholesterol, tobacco, diabetes, high blood pressure, obesity, stress, poor diet, inactivity, and excessive alcohol.³

Fortunately, risk factors for ASCVD can be lowered/changed, by treating cholesterol, quitting tobacco, managing comorbid conditions such as diabetes, and taking prescribed medications.

WHAT'S THE ISSUE?

WHILE AN ESTIMATED 71 MILLION AMERICANS HAVE HIGH CHOLESTEROL (LDL-C), LESS THAN HALF ARE TREATED. EVEN FEWER ARE TREATED TO RECOMMENDED LEVELS.⁴ COMPOUNDING THE PROBLEM, HALF OF ADULTS TAKING STATINS DO NOT RETURN TO THEIR PHYSICIAN WHEN THEY SHOULD AND STOP TAKING THE MEDICATION AS PRESCRIBED.⁵

WHY SHOULD EMPLOYERS CARE?

The cost of an employee suffering a major cardiovascular event, such as heart attack or stroke, can be catastrophic to plan costs.

- ▶ Between 2010 and 2030, total direct medical costs of cardiovascular disease are projected to triple, from \$273 billion to \$818 billion. Indirect costs (due to lost productivity) are estimated to increase from \$172 billion to \$276 billion, an increase of 61%.⁶
- ▶ A 1% reduction in excess weight, cholesterol, elevated blood pressure, and glucose has been shown to save \$83 to \$103 annually in medical costs per person.⁷
- ▶ The risks for cardiac events begin to climb steadily by age 45.⁸ Individuals who reach middle age with normal levels of all major risk factors show a lifetime risk of developing cardiovascular disease of only 6% to 8%.⁹

WHAT CAN BE DONE?

- ▶ A combination of reducing risk factors and medical therapies can lead to a 95% reduction in death from ASCVD.¹⁰
- ▶ Lifestyle modification of risks including obesity, poor diet, and nutrition is the first line of prevention, and should be followed by cholesterol-lowering medications to further reduce the risk.¹¹
- ▶ Adults over 20 years old should have cardiovascular risk factors assessed by a physician at least every 4 to 6 years. For those over 40, tools are available to assess 10-year risk of developing cardiovascular disease.¹²
- ▶ In 2013, the American Heart Association and American College of Cardiology released updated guidelines to address use of statins to reduce the risk of ASCVD in adults.

MEASURING UP

HEALTH PLANS ARE HELPING MANAGE ASCVD, BUT THERE IS STILL OPPORTUNITY TO IMPROVE QUALITY AND ADHERENCE TO GUIDELINES. BASED ON eVALUE8 DATA THERE'S ROOM FOR IMPROVEMENT IN HELPING MANAGE HIGH CHOLESTEROL IN PATIENTS WITH HEART DISEASE. KEY FINDINGS INCLUDE:

- ▶ On average 86.7% of members diagnosed with coronary artery disease received at least one prescription for a statin medication (based on plans reporting in eValue8 2015).
- ▶ Unfortunately, less than 1 in 3 plans (30%) had over 60% of their CAD patients' cholesterol under control (from eValue8 2014 and 2015).

- ▶ Plans have the power to help support physicians in managing their patients, and the majority of all plans (90%) reported providing that support to practitioners for CAD management. Plans support doctors through the following activities:
 - Reminders for screening members (90%) and treating members (87%)

- Materials for educating members (53%)
- Providing progress updates on members through an outbound telephone program (47%).
- ▶ Physicians should be rewarded for better CAD treatment, but less than two-thirds of plans (60 %) provide incentives to obtain NCQA recognition for heart /stroke management.

EMPLOYERS TAKE ACTION

ACTION ITEM #1: Assess your population by requesting data from your health plans or PBM to define burden of ASCVD within your population.

- ▶ Understand how prevalent ASCVD is within your workforce by requesting key metrics from your health plan(s) or PBM.
- ▶ Recognize that a lower than expected percentage of your workforce diagnosed with ASCVD or high cholesterol may indicate the need for additional screenings.
- ▶ Consider increased focus on cholesterol screening during worksite health promotion activities, including education and scheduled screening events.

ACTION ITEM #2: Ensure your health plans are working with providers to increase those treated for high LDL.

- ▶ Review quality indicators such as eValue8, HEDIS, and Heart Disease and Stroke Recognitions Program to identify trends in clinical management of high cholesterol, and heart disease overall.
- ▶ Request additional provider engagement, such as medication therapy management and appointment reminders to increase medication adherence.

ACTION ITEM #3: Reduce out-of-pocket costs for medications and treatments associated with controlling high cholesterol.

- ▶ The Community Preventive Services Task Force recommends reducing patient out-of-pocket costs for medications to control high cholesterol, in combination with additional interventions, such as team-based care with medication counseling, and patient education.
- ▶ Employers should review and update benefit coverage for statin therapy and newer classes of targeted medications, such as PCSK9 therapies.

ACTION ITEM #4: Leverage local collaborations to lead community change.

- ▶ Employer-based health coalitions serve as vehicles for improving workforce and community health at the local level by leveraging the voice and power of their employer members to achieve the most value for every health care dollar spent.

Endnotes

- 1 Go AS, Mozaffarian D, Roger VL, et al. *Heart Disease and Stroke Statistics - 2014 Update; A Report from the American Heart Association*. *Circulation*, 2014; 129:e28-292.
- 2 Ibid-1
- 3 Yusuf S, Hawken S, et al. Investigators IS. *Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study*. *Lancet*. 2004;364: 937-952.
- 4 Stone N, Robinson J, Lichtenstein A, et al. *2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults*. *J Am Coll Cardiol*. 2014;63:2889-2934.
- 5 *High Blood Pressure and Cholesterol: Out of Control*. CDC Vital Signs, 2011.
- 6 Heidenreich P, Trogdon J, Khavjou O, et al. *Forecasting the Future of Cardiovascular Disease in the United States: A Policy Statement From the American Heart Association*. *Circulation*, 2011; 123: 933-944.
- 7 Henke R.M., Carls G.S., Short M.E., Pei X., Wang S., Moley S., et al. *The Relationship between Health Risks and Health and Productivity Costs Among Employees at Pepsi Bottling Group*. *J Occup Environ Med*. 2010;52(5):519-527.
- 8 Sandmaier M., *Your Guide to a Healthy Heart*; National Institutes of Health, National Heart, Lung, and Blood Institute Publication No. 06-5269 December 2005.
- 9 Lloyd-Jones DM, Leip EP, Larson MG, et al. *Prediction of lifetime risk for cardiovascular disease by risk factor burden at 50 years of age*. *Circulation*. 2006;113:791-798.
- 10 Ford ES, Ajani UA, Croft JB, et al. *Explaining the decrease in U.S. deaths from coronary disease, 1980-2000*. *N Engl J Med*. 2007;356:2388-2398.
- 11 Kannel WB, Dawber TR, Kagan A, Revotskie N, Stokes J III. *Factors of risk in the development of coronary heart disease-six-year follow-up experience. The Framingham Study*. *Ann Intern Med*. 1961;55:33-50.
- 12 Goff DC Jr, Lloyd-Jones DM, Bennett G, Coady S, et al. *2013 ACC/AHA guideline on the assessment of cardiovascular risk: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines*. *J Am Coll Cardiol*. 2014;63:2935-2959.