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Motivating Patients to Get Involved in Their Health:

Dr. Michael Cobble, Director
******@***canyonsmedical.com

Director - Canyons Medical Center

Euro Aspire III Trial Mirrors US Struggle to Empower Patients

This article addresses early identification and prevention of cardiovascular disease, to highlight the challenges in motivating patients to participate in their health and well being and focus on motivating insurance companies and national healthcare to empower, enable and encourage better health.

National policies have been ineffective at promoting lifestyle changes that could extend both the quality and quantity of one's life. My father suffered an unstable angina event in his early 50's. He is healthier today than 20 years ago through optimal medical management, surgery and lifestyle management – all complementary to each other. This however could not have been accomplished without his active participation or the medical resources at our disposal.

ABCs of CV Risk Reduction

In his case, we implemented the ABCs of cardiovascular (CV) risk reduction (RR) based on the continuing body of evidence based medicine (EBM). These are:

A. ASA (acetyl salysilic acid – aspirin), ACEI (angiotensin converting enzyme inhibitor) or ARB (angiotensin receptor blocker) if ACEI intolerant or both if indicated, ADPI (adp inhibitor) if indicated, Aldol (aldosterone inhibitor) if indicated;

B. BB (beta blocker - preferably not atenolol or bucindolol);

C. Cholesterol modification therapy based on national and international guidelines;

D. Dietary changes – DASH diet, Mediterranean diet, etc;

E. Exercise changes;

F. Fibrate therapy if appropriate based on guidelines;

G. Glucose therapy if appropriate based on guidelines, and

H. Healthy lifestyle changes such as annual physicals, cancer screening, tobacco cessation, salt reduction, alcohol modification, safety counselling (seat belts, helmets, etc.), multivitamin therapy, medication compliance, clinical visit compliance, etc.

Despite national and international guidelines targeting blood pressure goals, blood sugar goals, tobacco cessation goals, weight loss, exercise, nutrition goals and lipoprotein goals, still less than 50% of our populations reach such goals. Managed care to date after three decades has not been proven effective in assisting with goal achievement.

Insurance companies often penalise the patient, the clinician and the healthcare system. This discourages patient compliance, clinician medical delivery and when added to limited resources of access and affordability, harms our ability to limit major adverse coronary events (MACE).

Euro Aspire III Trial Reinforces Guidelines Failings

EUROASPIRE III presented at the recent European Society of Cardiology (ESC) Congress reinforced how, for patients with risk factors for ASCVD, lifestyle changes and efforts to meet prevention guidelines are abysmal. For those patients with risk for ASCVD only 1 in 10 smokers have quit, nearly 50% are overweight, over 75% have blood pressure and lipoprotein values exceeding goals, less than 30% of people with DM2 are meeting fasting glucose goals and barely over 50% are reaching A1C goals.

EUROASPIRE III is in line with struggles faced in the United States showing less than 40% of our high risk patients meeting guidelines and less than 20% of very high risk patients meeting guidelines. The real surprises were that over 80% of patients wanted to know their risk score for heart disease and more than 80% had not been provided professional risk factor management programmes or lifestyle counselling.

The other issues for risk reduction include clinician lack of inertia and patient compliance. Two major factors for noncompliance by patients were:

1. ‘My clinician did not tell me how important the treatment was.’
2. ‘My clinician did not tell me how long I would need to follow this treatment.'

Three major factors for optimal glucose management in DM2 were:

- Explaining to the patient what the A1C value represents: ‘3-month glucose average’.
- Explaining to the patient what their current A1C value was.
- Explaining to the patient what their A1C target goal was.

We must discuss goals in terms the patient will understand: “Each of these medications and changes will make you live better and longer. They along with lifestyle changes will add quality and quantity to your life”. Also, we can show a before and after risk prediction which is very powerful.

Screening for ASCVD Risk

The best way to screen for ASCVD risk is risk screening tools such as Framingham risk scoring (FRS) or Reynolds risk scoring (RRS), or SCORE, HEARTSCORE, QRISK, ASSIGN, PROCAM, etc… The more recent general cardiovascular disease risk profile giving a heart age/vascular age (GCVDR or CVRS – cardiovascular risk score) has been most complementary for us in addition to the FRS and national cholesterol education programme (NCEP) risk factors and risk assessment.

For baseline risk we use NCEP, FRS and CVRS to give us a baseline for ten year risk and heart age/vascular age as well as evaluating if one has low risk, moderate risk, moderate high risk, high risk or very high risk. Sharing numeric and visual values with patients is very motivating for prevention, risk stratification and risk reduction strategies.

This is part of our ‘simple’ approach to risk assessment and takes less than five minutes to provide a score. The next approach (intermediate) is if a person shows moderate or higher risk based on any of these three simple tools (NCEP, FRS, CVRS) we will perform moderately advanced testing (expanded lipids and glucose testing) to better stratify risk. These can be included based on cost, access and regional availability.

Vascular imaging can include CIMT, EBT CACS, ABI or in symptomatic patients – stress echo, MPI, CTA, CCA. We favour non invasive tests for asymptomatic patients for obvious reasons and find them to be inexpensive. Each of these imaging studies has shown independent risk stratification and ASCVD identification further motivating the clinician and patient. Biomarker testing depending on patient risk and symptom profiles includes: UMA, LpPLA2, HSCRP, BNP, expanded lipid testing, serum Cr for estimated GFR. Each of these tests also helps direct medical care. Finally the ‘advanced’ approach after simple screening and intermediate testing would be to develop a plan with each patient using the ABC’s of CV RR with EBM.

Empowering Patients

We must implement evidence-based strategies to reduce risk and monitor patients for compliance and adherence. Reward, encourage and empower patients, develop mutually acceptable strategies that will benefit them over the long run. Prevention both primary and secondary is invaluable. Risk assessments, risk stratification, simple imaging, advanced imaging, simple biomarker testing, empowering the patient to be involved and compliant, frequent reinforcement, and finally some motivation for insurances and national health policy to commit for life > 80-90 years to improve the health and welfare of the community is crucial.

It’s time to implement policies that avert the event. If this is not done we won’t have the resources to address those events that do occur. Our responses to cardiovascular events are applauded with faster response times, greater awareness and technological advances. To be even more progressive, action must be taken to identify risk and disease earlier and encourage all entities to implement changes we know limit such risk.

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