

PLENARY SESSIONS

Health Care in the New Millennium: Vision, Values, and Leadership

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Health care is in a state of flux. Managed care has faltered as it comes under increasing scrutiny by the media, the consumer, and the regulators. Health care costs are rising, and the burden is increasingly being shifted to consumers. Large-scale vertical integration in health care has not taken place, rather we have seen massive horizontal consolidation of health plans, hospital systems, and, to a lesser extent, physician groups. Increased consumerism amplified by the Internet creates new opportunities and new challenges. The industry is looking for a new direction and a new vision, but we fall prey to fads, as organizations are stretched thin by the roller coaster of change in management philosophy, reimbursement, and medical technology. This presentation will focus on the political, economic, and strategic context of change in health care and will examine how the various actors are preparing for the future. It will identify the leadership challenges and opportunities that lie ahead and will provide strategic insights on how organizations and individuals can prepare for the new millennium in health care.

Mobilizing All Communities To Value and Promote Cardiovascular Health

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The mass elevation of cardiovascular disease (CVD) risk in the U.S. population and the continued dominance of this as a cause of morbidity and mortality demands populationwide strategies for prevention and control. Those populationwide programs to prevent disease by promoting healthy lifestyles are well studied and widely applied. However, while there has been progress, there is currently less effort and less known than for individual strategies for CVD prevention. The modest success and variable results of the major community trials of the 1980s (Stanford 5 Cities Project, Minnesota Heart Health Program, Pawtucket Heart Health Program) have led to some discouragement in the health community regarding this approach, leading to reasonable questions: Is it possible? Do we know how to do it? The substantial progress over the past three decades implies an affirmative answer to the question of the possible. However, changing social, cultural, and environmental factors raise new questions regarding relevant community approaches. The current status of the field, changing risk characteristics, and strategies to improve populationwide disease prevention will be discussed.

Environmental Approaches to Risk Factor Change

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Environmental and policy approaches to disease prevention tend to have a greater impact on the whole community than individually oriented approaches. In the United

States, much of the decline in overall mortality since 1900 has been attributed to improvements in the macro-environment that enhanced sanitation, water supply, and food quality.

To help in achieving public health goals related to cardiovascular disease, environmental and policy strategies are aimed at changing the physical and sociopolitical environments. The purpose of this presentation is to describe the potential impacts of changes in the environment that have potential for improving cardiovascular health. Recent literature and empirical studies will be reviewed, using physical activity as a case example. Examples of environmental and policy approaches to increase physical activity include walking and bicycle trails, funding for public facilities, zoning and land use that facilitate activity in neighborhoods, mall walking programs, building construction that encourages activity, policies and incentives promoting physical activity during the workday, and policies requiring comprehensive school health programs. Although such environmental and policy interventions to promote cardiovascular health are being promoted widely, there are sparse data on the patterns and effects of these approaches on a population-wide basis.

Achieving Optimal Cardiovascular Health Outcomes for Americans at Risk

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Patients at risk for cardiovascular disease (CVD) can be divided into those at high short-term risk (< 10 years) and those at high long-term risk (> 10 years). Patients at high short-term risk include those at high risk (10-year risk for hard coronary heart disease [CHD] > 20%) and those at moderately high risk (10-year risk 10–20%). The absolute risk for all cardiovascular events, including stroke, is approximately twice the risk for hard CHD. High-risk patients include those with established CHD (history of myocardial infarction, unstable angina, stable angina pectoris, coronary artery procedures, and documented myocardial ischemia). Other high-risk patients are those without established CHD but with a 10-year risk > 20%. These patients are called CHD risk equivalents. They include those with other forms of atherosclerotic disease (peripheral arterial disease, abdominal aortic aneurysm, and carotid artery disease); diabetes mellitus; and 10-year risk greater than 20% by Framingham risk scoring. Patients at moderately high risk are those with 2+ CHD risk factors and one of the following:

- (a) 10-year risk 10–20% by Framingham scoring and
- (b) metabolic syndrome

All patients at high risk should be treated according to the guidelines outlined for secondary prevention by the American Heart Association (AHA). Slight adjustments of the AHA algorithm are required for some patients with CHD risk equivalents. For patients at moderately high risk, similar therapies are employed, but therapies need not be as intensive. Patients at high long-term risk are those with 2+ risk factors or 0–1 risk factors (with single severe risk

factors) whose estimated 10-year risk is < 10%. In both cases, attention turns to modifying individual risk factors rather than focusing on absolute 10-year risk.

Emergency Medical System Response to Patients With Suspected Acute Coronary Syndromes

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The traditional prehospital approach to the patient with chest pain has involved applying oxygen, starting an IV lifeline, checking vital signs, administering nitroglycerin if not contraindicated, placing the patient on a cardiac monitor, and transporting him or her to the hospital. More recently, advanced EMS systems have begun to administer aspirin routinely and to use prehospital electrocardiograms and fibrinolytic checklists to help guide therapy. This presentation will review the traditional prehospital approach and its limitations to the evaluation and treatment of chest pain patients. The role of prehospital 12-lead ECGs, fibrinolytic and antiplatelet therapy, and other emerging pharmacotherapeutic approaches will be discussed. In addition, a state-of-the-art approach to the evaluation and treatment of chest pain patients involving field telemedicine and technologically advanced emergency department risk assessment will be described.

Variability in Cardiovascular Care: Geography Is Destiny

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Health disparities in the United States are widespread. Their consequences include both over and under treatment of cardiovascular disease. This presentation will emphasize population-based comparisons of the use of secondary prevention activities. Specific topics will include the care of myocardial infarction, the use of coronary revascularization and carotid endarterectomy, and the care of congestive heart failure. I will also present data on the variability of smoking cessation advice, the treatment of hyperlipidemia among patients with coronary artery disease, and referral for cardiac rehabilitation. The magnitude of geographic variability in the care of cardiovascular disease is large, as is their effect on population-based health.

Secondary Prevention of Cardiovascular Disease

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This year, more than 1 million Americans will suffer a first or recurrent myocardial infarction (MI). The opportunity to initiate or further optimize risk factor management in these individuals should not be missed. Patients with a prior MI are up to seven times more likely to experience a cardiovascular event compared with those who do not have established cardiovascular disease (CVD). The American Heart Association (AHA) and the American

College of Cardiology have published joint recommendations to help guide physicians in the appropriate management of risk factors that have been shown to save lives, improve angina, reduce the need for coronary revascularization, lower the number of hospitalizations, and enhance the quality of life among individuals with CVD. Unfortunately, implementation of these secondary prevention strategies has been documented to be sub-optimal across the United States. There are numerous barriers that impede the effective adoption of therapies proven to benefit patients with CVD, and chief among them is a lack of infrastructure within hospital systems and physician practices to ensure uniform application of prevention guidelines. A "systems" approach to prevention may be one way to overcome such a barrier. The Los Angeles Cardiovascular Hospitalization Atherosclerosis Management Program (CHAMP) afforded proof of this concept. The study showed that systematic in-hospital initiation of lipid-lowering medications and other secondary prevention measures improved treatment rates and long-term compliance with national prevention guidelines among patients with CVD, compared to conventional management before CHAMP was instituted. Based on this study and several other studies, the AHA has launched a national program called "Get With The Guidelines," which is an acute care hospital-based intervention to help physicians manage risk factors in patients with CVD. The next generation of studies to test the efficacy of systems approaches to prevention should be randomized controlled trials that examine not only hospital-based programs, but also reach out to patients with CVD in other health care settings. The emphasis of these studies should be on novel interventions and the demonstration of the feasibility of widespread implementation, cost-effectiveness, and added value to conventional strategies to achieve secondary prevention goals. If shown to be effective, novel programs to increase adherence to secondary prevention recommendations may substantially reduce the burden of CVD in the United States.

****Additional plenary session abstracts may be found in the Program Guide Addendum.***

