BREAKOUT SESSION DISCUSSION QUESTIONS

To support interactive discussion, participants will be assigned to breakout rooms following brief presentations.

At the conclusion of the breakout session, participants will automatically rejoin the main session for report-outs and full-group discussion.

SESSION 1. Where ASCVD Primary Prevention Falls Short in Current Practice

Time: 9:30-10:05 a.m.

Interactive opener *(2 minutes)*: Quick round-robin—In one sentence, what is the most common reason ASCVD primary prevention gets delayed in your setting?

1. Where is decision-making least clear or most variable? Which patient scenarios create the most variation in action (eg, borderline LDL-C, "pre-" conditions, young adults with multiple risk factors, CKM risk signals)?

2. What specific decision point feels least supported (risk estimation, thresholds for meds, CAC use, follow-up cadence, addressing patient hesitancy/cost)? What would guidance that is "sufficiently clear to enable action" look like?

3. When new preventive measures are introduced to asymptomatic or borderline-risk patients, what reactions most commonly derail action, and what clinician behaviors or tools increase readiness? What is missing in routine care?

Output: A prioritized list of high-impact gaps, commonly encountered, and could realistically be addressed.

"If we focus on a small number of priorities to enable earlier and more effective primary prevention, what are the most important areas, and what specific guidance, tools, or clinic workflows would make them doable in a 15-minute visit?"

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SESSION 2. From Knowing to Doing: Sequencing Interventions for Lifetime Benefit

Time: 11:20-12:00 p.m.

Based on Session 1's prioritized list of gaps: ***WHEN*** and ***HOW*** to initiate preventive therapies, during a brief clinic visit—turning decisions into a practical sequence and follow-up plan.

1. When a patient presents with multiple risk factors, how to prioritize the highest-yield domains/frameworks for ASCVD risk reduction and set practical cadence for initiation/titration. What would trigger intensification/de-escalation. What is a practical follow-up cadence for reassessment of risk?

2. How to navigate clinical uncertainties that tend to undermine evidence-based primary prevention strategies (eg, statins, CAC, polypharmacy). What minimum evidence or risk signal warrants watchful waiting to action? What early-risk indicators should trigger intervention?

3. What would be a brief lifestyle assessment question set (diet, activity, sleep, tobacco, alcohol) that can be performed during a brief clinic visit, coupled with specific measurable action. How should clinicians prioritize and sequence lifestyle, pharmacological, and combination interventions over time?

4. How will you leverage shared-decision making strategies for an asymptomatic patient with low perceived risk? How do you address misinformation, cost concerns and medication hesitancy while still landing on a clear next step? What strategies most effectively maintain long-term patient adherence and engagement?

Outputs for consideration:

- Prioritized list of early risk indicators, each paired with a default next step the care team can decide and start during the visit (blood test, start meds, referral, schedule follow-up, document shared decision plan)

- Visit-by-visit checklist (with reassessment triggers and follow-up timing)

- Standardized set of patient tools for sustained adherence (education aids, monitoring plan, care-team touchpoints, affordability pathways, referrals).