HEART HOUSE ROUNDTABLES

AMERICAN COLLEGE of CARDIOLOGY®

KEY TAKEAWAYS

Heart House Roundtable on
Sequenced CV Interventions for Lifetime Benefit: Primary Prevention Across the CKM Spectrum
identified the following key takeaways.

1 **Take earlier action on ASCVD risk by considering CKM-related risk factors, not just calculated risk.**
Atherosclerotic cardiovascular disease (ASCVD) risk often emerges from overlapping cardio-kidney metabolic (CKM) conditions that amplify lifetime exposure and accelerate disease progression. Delayed intervention, particularly in younger, borderline, or asymptomatic individuals, results in avoidable cumulative burden.

2 **Make risk assessment more actionable by simplifying how risk is evaluated in practice.**
Risk calculators are essential, but inconsistent use and conflicting results can make decision-making harder. They also may not fully capture KM-related risk, which can contribute to delays in care.

3 **Clarify when imaging and biomarkers should be used to better understand risk.**
Tools such as coronary artery calcium scoring, biomarkers, and imaging of early disease can help refine risk, but there is still uncertainty about when to use them and how to interpret the results consistently. Clearer guidance could help these tools support better decisions in practice.

4 **Strengthen guidance on therapy initiation, intensification, and sequencing in ASCVD primary prevention.**
Many patients now qualify for more than one evidence-based therapy, but clinicians often lack clear guidance on which intervention to initiate first, when to intensify treatment, and how to sequence therapies over time.

5 **Use risk as a continuum instead of waiting for patients to cross a threshold.**
Participants noted that strict cutoffs can slow action when patients fall just below a treatment threshold, even when their overall risk is still meaningful. A more continuous, risk-informed approach could support earlier and more individualized care.

6 **Make prevention conversations more meaningful by connecting risk to patients' real lives.**
Risk scores alone rarely motivate action. Conversations are more effective when they connect risk to what patients care about most, including daily life, future health, competing priorities, and prior experiences with care.

7 **Address medication concerns and lifestyle fatigue as central barriers to prevention.**
Reluctance to start or intensify treatment is often shaped by mistrust, past experiences, cost, treatment burden, and the difficulty of sustaining lifestyle changes over time.

8 **Make prevention easier to deliver through optimized workflow, team-based care, and digital infrastructure.**
Time constraints, fragmented workflows, and limited decision support continue to delay preventive action and limit consistency in care. Leveraging tools such as the EMR to embed risk assessment, decision support, and follow-up within clinical workflows can help standardize implementation, enable team-based care, and support earlier intervention.

9 **Separate gaps in evidence from gaps in execution and address both.**
Many shortcomings in ASCVD prevention reflect underuse of evidence that already exists, while other questions still require new data, especially around CKM integration and therapy sequencing. Both evidence generation and implementation support are needed.

10 **Position the ACC to lead with practical, integrated prevention strategies across the CKM spectrum.**
The growing complexity of ASCVD prevention across the CKM spectrum calls for coordinated leadership, practical tools, and clear messaging.