

CHECKLIST FOR IMPROVING CARDIOVASCULAR RISK DISCUSSIONS

Make risk communication meaningful to each patient. With any risk discussion, pause and remember that each patient is unique. Discussions should be concordant with patients' values and preferences. Try to shape risk discussions to meet patients where they are in terms of their:

- Information needs and/or readiness to contemplate/make decisions and take action
- Experience, cultural background or beliefs
- Literacy level and ability to understand numbers

Lifetime risk of heart attack, stroke or related death may be a better motivator for younger patients whose more near-term risk may not be great enough to prompt initiation of efforts to reduce their cardiovascular risk.

Put risk into context. For example, a 10-year ASCVD risk score of 7.5 percent may sound small to some people, but it is the lower cut off for shared decision-making about whether to initiate a moderate- to high-intensity statin. Be sure to explain the score in simpler terms.

Patients with atrial fibrillation (Afib) should be educated about their vulnerability to stroke. They are five times more likely to suffer a stroke compared with those without a heart rhythm problem. And the types of stroke related to Afib tend to be more devastating than those from other causes. What does that mean? Without prophylactic anticoagulation, their odds of having a stroke that leaves them fully dependent on others are pretty high.

Use simple, "plain" language and active listening. Try to avoid medical terminology when possible. Provide educational materials like those at CardioSmart.org to empower patients to learn more.

What is meant by "plain" language?

Instead of...	Try...
Adverse effect	Side effect or bad reaction
Anticoagulant	Medicine that thins the blood to keep it from clotting or clumping together
Cardiovascular	The heart and blood vessels
Circulation	Blood flow
Coronary arteries	Arteries, or fuel lines, that supply blood to the heart
Edema	Swelling from a build-up of fluid
Standard of care	Treatment most clinicians accept as reasonable based on evidence

For additional tools, visit <https://www.cdc.gov/healthliteracy/developmaterials/plainlanguage.html>.

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- ❑ **Use a combination of approaches when discussing cardiovascular risk or how certain treatments can measurably modify risk.** Each of us receives and processes information differently. Try to explain risk with words coupled with visual aids or written materials. Some examples of visual aids include pictographs, including Cate's Plot and icon arrays that use a shape – whether it's a circle, faces or people – to show a proportion, usually by shading or using color.

Studies of breast cancer survivors show that those who had a more accurate idea of their risk of recurrence also reported having clear risk discussions with their clinician in which they used both words and numbers.

Simple numbers are easier for most people to understand. When possible:

- **Use round numbers.** For example, if the risk of Disease X is 24.8 percent, use 25 percent.
- **Put this percentage into perspective** and explain it in more than one way. You can say, it is expected that 25 percent of people like you will develop Disease X. But some patients may understand this more: 1 out of 4 people like you will likely develop Disease X. With either approach, be sure to confirm over what period of time.

There is some research that shows 1 out of 4 is more likely to elicit an emotional response from patients, 25 percent is more abstract.

- **Present the relative and absolute risks.** Patients will often come in with news reports that tend to give the relative risks. But that's only one part of the story. For example:
Relative risk: Medication B doubles the chance you will develop diabetes. That sounds scary!

Absolute risk: But if you present the actual numbers behind this statement, perhaps 3 out of every 10,000 patients develop the disease. If the risk doubles, that still means that only 6 out of every 10,000 patients who take the medication will develop this problem.

Here is another example:

Taking medication A can cut the chance that you will have a heart attack in the next 5 years by half. That sounds amazing!

But what if the risk was only 2 percent to start. That means that of 100 people, 2 people similar to you would have a heart attack. By cutting the risk in half, now only 1 out of 100 would have a heart attack. For some people, any risk lowering is meaningful. For others, the fact that 98 out of 100 people will not have an event is OK.

- **Be consistent with your use of denominators and time periods.**

It doesn't matter if we have risk scores that are fairly accurate in identifying people who are in need of more intensive cardiovascular risk reduction if we can't effectively communicate their score and what it means to them personally. How well we relay this information influences how likely someone is to engage in risk reduction strategies, including behavior change.

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- Give balanced information when explaining the advantages and disadvantages of therapies.** When possible, explain the potential pros and cons of a particular therapy. If the odds of experiencing a side effect is 10 percent, it means that of 100 people, 10 will have a bad reaction, but 90 will not. This number may be acceptable for some, and not for others.
- Use all cardiovascular risk discussion as an opportunity to empower patients to make heart healthy changes.** Be sure to identify and praise steps they are already taking to support their heart health. Doing so can help empower patients and gives them a sense of control to change risk.
- Acknowledge the emotional side of managing cardiovascular disease risk.** It's important to address patients' emotions and, to the extent possible, help put their mind at ease.
- There is always uncertainty when it comes to risk.** Remind patients that risk is a possibility – high or low – that something will happen based on what we know to be true. There is no way of knowing for sure and it's OK to be transparent about that.
- Check in to assess patients' understanding.** Use the “teach-back” method to ask patients to explain or restate in their own words what was explained to them about their cardiovascular risk and/or treatments to help lower their chance of developing new or ongoing heart problems. This gives clinicians an opportunity to clarify the information if needed.

Here's an example of how you might ask without sounding as though you are quizzing them. “We went over a lot of information today. Can you tell me what you heard about x, y, or z to be sure I explained it well enough?”

- Review goals at each visit and celebrate successes.** If the goal was to buy unsalted foods or to walk up the stairs instead of taking the elevator, ask how they are doing and praise them for their efforts. If there have been reductions in blood pressure, for example, help them tie that to their behaviors.
- Risk discussions should be revisited over time** Because cardiovascular risk is dynamic and ever-changing, it should be part of ongoing prevention and disease management discussions and care planning.

For example, strategies to assess cardiovascular risk and/or initiate or intensify treatments aimed at risk reduction may change based on:

- Patient priorities
- New health conditions or risk factors (e.g., sleep apnea, diabetes, arrhythmias, new onset hypertension or hyperlipidemia)
- Health behaviors and habits (e.g., sedentary lifestyle, smoking)
- Progression or exacerbation of disease
- Medication adherence or non-adherence
- Concomitant medications known to have cardiovascular effects (e.g., some cancer treatments, certain antidepressants and pain medicines)
- New or evolving evidence on benefits and harms of cardiovascular risk-reducing therapies