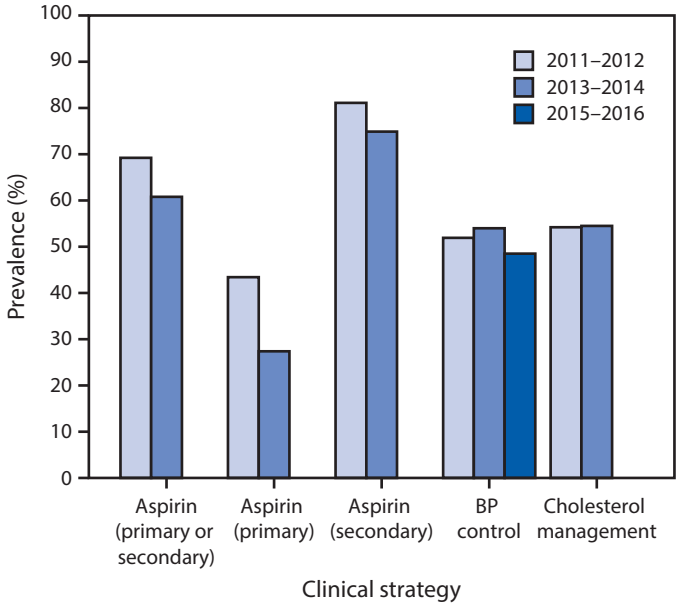
FIGURE 1. Prevalence of Million Hearts 2022 clinical strategies*,†,§ to prevent cardiovascular disease among adults¶, — United States, 2011–2012, 2013–2014, and 2015–2016**



Source: National Health and Nutrition Examination Survey, National Center for Health Statistics, CDC.
Abbreviation: BP = blood pressure.

* Aspirin use was defined by an answer of "yes" to the question "Doctors and other health care providers sometimes recommend that you take a low-dose aspirin each day to prevent heart attacks, strokes, or cancer. Have you ever been told to do this?" and an answer of "yes" or "sometimes" to the question "Are you/ now following this advice?"; an answer of "yes" to the question "On your own, are you now taking a low-dose aspirin each day to prevent heart attacks, strokes, or cancer?"; or aspirin identified in the prescription medication data files. Participants who reported taking an anticoagulant in the prescription medication files but not taking aspirin were excluded. Aspirin use for primary prevention includes examined adults aged 50–59 years without a history of cardiovascular disease (CVD) and with an American College of Cardiology/American Heart Association 10-year atherosclerotic CVD risk score ≥10%. Aspirin use of secondary prevention includes examined adults aged ≥40 years with a history of CVD.

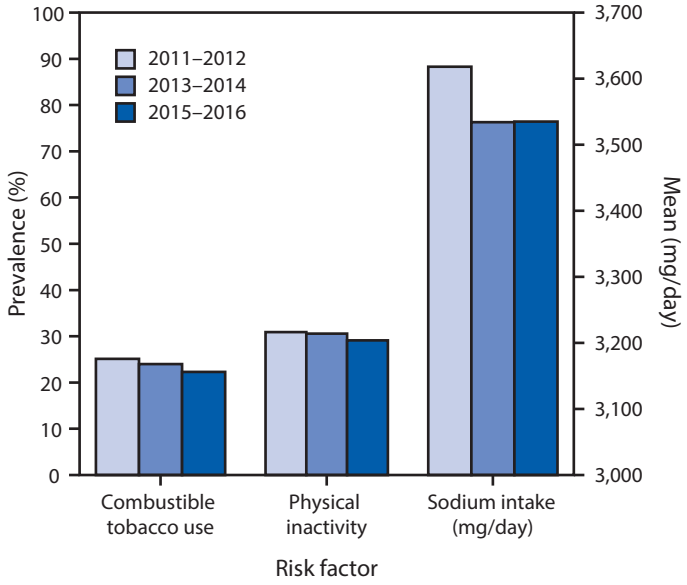
† BP control was defined as an average systolic BP <140 mm Hg and an average diastolic BP <90 mm Hg among adults aged ≥18 years with hypertension. Hypertension is defined as an average systolic BP ≥140 mm Hg, or an average diastolic BP ≥90 mm Hg, or self-reported current use of BP-lowering medication.

§ Cholesterol management is defined as current statin use, based on the prescription medication data files, among fasting adults aged ≥21 years for whom statin therapy is recommended.

¶ For aspirin (primary or secondary), t-test p-value <0.01 comparing 2013–2014 with 2011–2012, adjusted for sex, age group, and race/ethnicity.

** For aspirin (primary), t-test p-value <0.05 comparing 2013–2014 with 2011–2012, adjusted for sex and race/ethnicity.

FIGURE 2. Prevalence of Million Hearts 2022 community risk factors*,†,§ for cardiovascular disease among adults¶ — United States, 2011–2012, 2013–2014, and 2015–2016



Source: National Survey on Drug Use and Health; Substance Abuse and Mental Health Services Administration; National Health and Nutrition Examination Survey; National Center for Health Statistics; CDC; National Health Interview Survey (NHIS).

* Combustible tobacco use was defined as current use of combustible tobacco products (cigarettes, cigars, or pipe) among adults (aged ≥18 years) with complete data to determine tobacco use.

† The *2008 Physical Activity Guidelines for Americans* (http://www.health.gov/PAGuidelines/) recommend that all adults should avoid inactivity and that some physical activity is better that none. NHIS questions ask about frequency of participation in light to moderate-intensity and vigorous-intensity leisure-time physical activities for at least 10 minutes. Questions are phrased in terms of current behavior and lack a specific reference period. Physical inactivity is defined as reporting no light to moderate or vigorous leisure-time physical activity for at least 10 minutes.

§ Sodium intake (mg/day) was estimated among adults aged ≥18 years with a complete and reliable first day 24-hour dietary recall (collected in-person at the mobile examination center).

¶ For combustible tobacco use and physical inactivity, t-test p-values <0.01 comparing 2015–2016 with 2011–2012, adjusted for sex, age group, and race/ethnicity.

targets of 80% performance on the "ABCS" of CVD prevention: aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation. At the community level, a 20% reduction in the prevalence of combustible tobacco product use and of physical inactivity and a 20% reduction in mean daily sodium intake are targeted. These indicators, along with cardiac rehabilitation participation, are the focus of Million Hearts 2022; progress in reaching indicator targets has been shown to have a substantial effect on preventing acute cardiovascular events (*11,12*).

The data in this report serve as a baseline for Million Hearts 2022. These findings suggest that in addition to universal strategies aimed at the entire population with and at risk for CVD, there is a need to focus action on high-burden, high-risk subsets of the population. For example, opportunities for risk factor prevention and management among younger adults are of particular importance given the increase in heart disease mortality observed from 2010 to 2015 among adults aged 35–64 years in approximately half of U.S. counties (*3*). Compared with adults aged ≥65 years, younger adults were less likely to be using aspirin or taking a statin when indicated and were more likely to use combustible tobacco and have an elevated daily sodium intake. Furthermore, only approximately half of adults aged 35–64 years