TABLE 1. Current prevalence of Million Hearts 2022 clinical strategies to prevent cardiovascular disease among adults — United States, 2013–2014 and 2015–2016

Clinical strategy/Demographic group	% (SE)	(95% CI)	No. (millions)*	t-test p-value†
Aspirin use§ when appropriate for primary or secondary prevention¶ among adults aged ≥40 years — NHANES, 2013–2014				
Total	**60.8 (2.1)**	**(56.5–64.9)**	**14.0**	—
Sex				
Male	58.0 (2.8)	(52.2–63.5)	8.5	reference
Female	65.6 (3.3)	(58.6–72.0)	5.4	0.566
Age group (yrs)				
40–64	43.7 (3.3)	(37.1–50.4)	5.4	reference
65–74	78.9 (4.3)	(68.9–86.3)	4.6	<0.001
≥65	81.4 (2.7)	(75.3–86.2)	8.8	<0.001
≥75	84.8 (3.1)	(77.4–90.1)	4.3	<0.001
Race/Ethnicity				
White, non-Hispanic	65.9 (2.1)	(61.5–70.1)	10.7	reference
Black, non-Hispanic	51.0 (5.3)	(40.5–61.5)	1.8	0.621
Asian, non-Hispanic	42.2 (8.8)	(26.0–60.2)	0.4	0.016
Hispanic	45.4 (3.6)	(38.3–52.6)	0.9	0.061
Other	56.2 (15.7)	(26.1–82.3)	0.2	0.348
Aspirin use§ when appropriate for primary prevention¶ among adults aged 50–59 years — NHANES, 2013–2014				
Total	**27.4 (4.1)**	**(20.0–36.3)**	**1.9**	—
Sex				
Male	27.6 (4.4)	(19.7–37.1)	1.6	reference
Female	26.6 (6.0)	(16.3–40.2)	0.3	0.688
Race/Ethnicity				
White, non-Hispanic	27.9 (4.1)	(20.3–36.9)	1.1	reference
Black, non-Hispanic	28.8 (6.8)	(17.2–44.0)	0.6	0.809
Asian, non-Hispanic	—**	—**	—**	—**
Hispanic	32.4 (9.7)	(16.4–54.0)	0.2	0.617
Other	—**	—**	—**	—**
Aspirin use§ when appropriate for secondary prevention¶ among adults aged ≥40 years — NHANES, 2013–2014				
Total	**74.9 (1.8)**	**(71.1–78.4)**	**12.1**	—
Sex				
Male	78.0 (2.5)	(72.6–82.5)	6.9	reference
Female	71.2 (3.6)	(63.6–77.8)	5.2	0.277
Age group (yrs)				
40–64	63.2 (4.5)	(53.9–71.5)	3.5	reference
65–74	78.9 (4.3)	(69.1–86.2)	4.6	0.108
≥65	81.4 (2.7)	(75.4–86.1)	8.8	0.018
≥75	84.8 (3.1)	(77.5–90.0)	4.3	0.004
Race/Ethnicity				
White, non-Hispanic	77.9 (1.7)	(74.2–81.1)	9.6	reference
Black, non-Hispanic	80.9 (4.6)	(70.3–88.4)	1.2	0.266
Asian, non-Hispanic	64.3 (8.4)	(46.5–78.8)	0.4	0.116
Hispanic	51.5 (4.4)	(42.8–60.2)	0.7	<0.001
Other	*57.4 (17.4)*††	*(24.9–84.6)*††	0.2	0.242
Blood pressure control§§ among adults aged ≥18 years with hypertension¶¶ — NHANES, 2015–2016				
Total	**48.5 (2.1)**	**(44.4–52.6)**	**37.9**	—
Sex				
Male	45.2 (2.7)	(40.0–50.6)	16.9	reference
Female	51.6 (2.7)	(46.4–56.8)	21.1	0.036
Age group (yrs)				
18–24	—**	—**	—**	—**
25–44	41.6 (3.1)	(35.6–47.8)	4.4	0.012
18–44	40.0 (3.1)	(34.1–46.1)	4.6	0.004
45–64	53.8 (2.8)	(48.1–59.3)	18.1	reference
65–74	51.5 (3.6)	(44.5–58.4)	8.7	0.307
≥65	45.9 (3.1)	(39.8–52.1)	14.0	0.009
≥75	38.4 (3.3)	(32.1–45.0)	5.2	<0.001

See table footnotes on next page.

TABLE 1. (*Continued*) Current prevalence of Million Hearts 2022 clinical strategies to prevent cardiovascular disease among adults — United States, 2013–2014 and 2015–2016

Clinical strategy/Demographic group	% (SE)	(95% CI)	No. (millions)*	t-test p-value†
Race/Ethnicity				
White, non-Hispanic	50.9 (2.8)	(45.4–56.4)	26.7	reference
Black, non-Hispanic	44.3 (1.6)	(41.2–47.5)	5.1	<0.001
Asian, non-Hispanic	38.2 (4.1)	(30.4–46.6)	1.3	0.012
Hispanic	44.2 (3.0)	(38.3–50.3)	3.9	0.126
Other	46.5 (6.7)	(33.8–59.6)	1.0	0.493
Cholesterol management: statin use* among eligible adults††† aged ≥21 years — NHANES, 2013–2014**				
Total	**54.5 (1.8)**	**(50.9–58.1)**	**46.9**	—
Sex				
Male	51.5 (2.1)	(47.3–55.7)	23.8	reference
Female	58.1 (2.5)	(53.0–63.0)	23.1	0.089
Age group (yrs)§§				
21–24	—**	—**	—**	—**
25–44	37.7 (5.7)	(27.0–49.8)	2.6	0.083
21–44	35.7 (5.4)	(25.6–47.2)	2.7	0.028
45–64	50.3 (2.5)	(45.4–55.3)	21.8	reference
65–74	52.7 (3.0)	(46.5–58.8)	11.8	0.787
≥65	63.5 (2.2)	(59.0–67.8)	22.3	<0.001
≥75	86.2 (3.2)	(78.2–91.6)	10.7	<0.001
Race/Ethnicity				
White, non-Hispanic	58.3 (2.1)	(54.0–62.6)	35.8	reference
Black, non-Hispanic	44.3 (4.0)	(36.3–52.5)	4.6	0.013
Asian, non-Hispanic	49.2 (4.0)	(41.2–57.2)	2.0	0.092
Hispanic	33.7 (3.2)	(27.6–40.4)	2.8	<0.001
Other	—**	—**	—**	—**

Source: NHANES, National Center for Health Statistics, CDC.

Abbreviations: CI = confidence interval; NHANES = National Health and Nutrition Examination Survey; SE = standard error.

* Population counts are calculated using the American Community Survey 2013 or 2015 annual Public Use Microdata Sample files, the latest available file after data collection in the 2013–2014 and 2015–2016 survey cycles, respectively. https://wwwn.cdc.gov/nchs/nhanes/ResponseRates.aspx.

† P-values adjusted for sex, age group, and race/ethnicity using logistic regression.

§ Aspirin use was defined by any of the following: 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?" Aspirin identified in the Rx medication data files. Participants who reported taking an anticoagulant (as identified in the prescription medication files) but not taking aspirin were excluded.

¶ Primary prevention: includes examined adults aged 50–59 years for whom aspirin is recommended by the U.S. Preventive Services Task Force, without a history of cardiovascular (CVD) and with a 10-year atherosclerotic CVD (ASCVD) risk ≥10%. (Bibbins-Domingo K. Aspirin Use for the Primary Prevention of Cardiovascular Disease and Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med 2016;164:836–45; U.S. Preventive Services Task Force (USPSTF) Recommendation Summary: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer: ASCVD risk score is calculated based on the equations published in Goff DC Jr, Lloyd-Jones DM, et al. 2013 ACC/AHA guideline on the assessment of cardiovascular risk: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014;129:S49–73.) Secondary prevention: includes examined adults aged ≥40 years with a history of cardiovascular disease. A history of CVD is defined as an answer of "yes" to any of the following questions: "Has a doctor or other health professional ever told you that you had angina, also called angina pectoris?", "Has a doctor or other health professional ever told you that you had coronary heart disease?", "Has a doctor or other health professional ever told you that you had a heart attack (also called myocardial infarction)?", "Has a doctor or other health professional ever told you that you had a stroke?"

** Statistically unreliable estimates (relative standard error >40%) are suppressed.

†† Estimates are statistically unstable by National Center for Health Statistics standards (relative standard error >30%).

§§ Blood pressure (BP) control defined as an average systolic BP <140 mm Hg and an average diastolic BP <90 mm Hg. Calculated among adults with hypertension. Includes non-pregnant examined adults aged ≥18 years with ≥1 complete blood pressure measurement and information to determine BP-lowering medication use.

¶¶ 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. Current use of BP-lowering medication is defined as an answer of "yes" to the questions: "Because of your high blood pressure/hypertension, have you ever been told to take prescribed medicine?" and "Are you currently taking medication to lower your blood pressure?"

*** Statin use is defined using the prescription medication files.

††† Includes non-pregnant fasting adults (≥21 years) for whom a statin is recommended, based on their risk for ASCVD, as defined in: Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation 2014;129:S1–45.