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**Cholesterol Management Work Group**

**Meeting Summary**

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| **Date** | 12/09/16 |
| **Time** | 2:00 – 4:00 PM EST |

**AGENDA**

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| * **Welcome and Introductions**
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| * **CDS Connect Project Overview**
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| * **CDS Cholesterol Management Work Group Overview and Planning**
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| * **CDS Cholesterol Management Environmental Scan Findings and Artifacts**
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| * **CDS Cholesterol Management Next Steps**
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**SUMMARY**

**Welcome and Introductions**

The CAMH team opened the CDS Cholesterol Management Work Group (WG) kick-off meeting with a welcome to the Cholesterol Management WG members and a description of the desired behaviors WG members should demonstrate in meetings (e.g., collaborate freely with one another, utilization of the WebEx meeting tools to participate in conversations). Each of the Cholesterol Management WG members on the call and the CAMH team introduced themselves.

**CDS Connect Project Overview**

CAMH presented an overview of CDS Connect, highlighting the overall goals for the project and the project timeline. CAMH reinforced the WG’s role in providing constructive critical feedback from the community to prioritize and guide the development of CDS artifacts in the cholesterol management domain.

CAMH has identified three Federally Qualified Health Centers (FQHCs) that are interested in piloting the CDS artifacts and have the potential capabilities to host the pilot. Discussions are underway to further explore each facility’s current CDS capabilities in the area of cholesterol management and how the CDS Connect artifacts can be incorporated in to their clinical practice.

**CDS Cholesterol Management Work Group Overview and Planning**

CAMH provided an overview of the WG purpose, expectations, governance, and communication vehicles for WG discussion between meetings (Handshake site). During the WG Overview, CAMH highlighted that this project’s clinical focus will be on adult populations to define and constrain the scope. It will likely not include cholesterol management in patients with complex comorbidities or the prescription of medication due to the need to balance resources and consider liability implications related to medication management.

The first WG meeting will be used to discuss the findings of the CAMH Environmental Scan on clinical decision support and identified artifacts, discuss and validate identified artifacts for potential CDS build out, and identify additional clinical resources for consideration.

Attendees agreed that identifying a recurring day and time for monthly meetings would be easiest to track and attend. Some attendees suggested that a cadence of 2 one-hour meetings/month may be easier to attend. Others felt that 1 two-hour meeting works well for them. The cadence may be revisited in the future.

WG members will be asked to submit their top preferences for meeting days/times, along with days/times that do not work based on existing responsibilities. This information will be compiled via email or doodle poll to determine subsequent meetings. Since some attendees reside on the west coast, WG meetings will not occur prior to 11 a.m. EST.

**CDS Cholesterol Management and Environmental Scan Findings and Artifacts**

CAMH provided an overview of the CAMH Environmental Scan Findings and introduced the Patient-Centered Outcomes Research Learning Network (PCOR LN). CAMH highlighted that previous CDS efforts around cholesterol management resulted in process improvements, as opposed to patient outcome improvements. Given the 1-year project timeline, we are likely to see process improvements as a result of CDS implementation, rather than improved outcomes.

* **Clinical Artifacts** - CAMH presented a list of artifacts identified during the environmental scan that included a wide variety of clinical practice guidelines (CPGs), several electronic clinical quality measures (eCQMs), ASCVD risk assessment tools, the Preventive Services Selector application that provides screening recommendations, and patient teaching materials.
	+ **The following artifacts were validated as beneficial CDS artifacts:**
		- 2013 ACC/AHA 10-Year ASCVD Risk Assessment Tool
		- Longitudinal Risk Assessment Tool (created by CMMI and the Million Hearts to evaluate ASCVD risk after interventions have been initiated)
		- PQRS #438 – Statin use for Primary Prevention of CVD
	+ **The following artifacts were identified as not aligning with current CPGs, therefore should be considered with caution and caveat:**
		- CMS 61 – LDL Screening (although initially considered as up to date based on the concept of screening, the numerator of this measure outlines treatments based on LDL levels)
		- CMS 64 – LDL Risk Stratified Cholesterol (since it centers on treating an LDL-C goal)
	+ **WG members went on to identify additional artifacts and clinical resources that might be considered:**
		- Risk Calculators:
			* 30-Year/Lifetime Risk Assessment Tool
				+ This would be of benefit to pediatric and adult providers since it takes in to account family hypercholesterolemia.
				+ Some WG members felt that the 30-Year Calculator may not be as accurate as the 10-Year one.
			* MESA CAC Score, which can double or triple a patient’s risk that was estimated by a calculator. This score uses a sub-clinical marker, but does not estimate the risk of stroke. Additional information is available at: <http://www.medscape.com/viewarticle/721013>
				+ Consider adding a space/field for atherosclerotic markers as they may come in to play more in the future and/or some clinicians may find them very useful.

https://www.ncbi.nlm.nih.gov/pubmed/26314356

* + - NCQA has quality metrics that may translate in to artifacts
			* There is one related to statin use for diabetics (which is a secondary prevention metric), and other related to aspirin (which is a primary prevention metric). The aspirin metric is based on the CAHPS survey and seems to parallel the aligned MU measures.
		- Million Hearts is updating their eCQM table to accommodate upcoming program changes (e.g., MIPS and MACRA). Changes to their recommended eCQMs will be posted in early 2017.
			* **NOTE:** If looking for additional artifacts on a broader scale the full list of eCQMs that address the ABCS of heart health listed on the Million Hearts website can be considered.
		- Rules
			* The Workgroup members suggested that one of the first filters for information for the base risk calculator should be– Does the patient have a history of ASCVD? If yes, the calculator is not appropriate. If no, proceed to use.
				+ **NOTE:** The ACC/AHA guidelines send the clinician directly to the calculator if the patient does not have ASCVD. The USPTF guidelines send the clinician to the calculator only if at least 1 risk factor is present. We will need to determine which one of these approaches we turn in to a rule.
			* Suggested creating rules to place patients in buckets based on the 4 risk groups that could benefit from lipid lowering therapy (LLT). This will ensure that the right person gets the right treatment.
				+ Individuals with clinical ASCVD
				+ Individuals with primary elevations of LDL-C>= 190 mg/dL
				+ Individuals 40-75 year of age with diabetes and LDL-C 70-189 mg/dL without clinical ASCVD
				+ Individuals without clinical ASCVD or diabetes who are 40-75 year of age and have LDLD-C 70-189 mg/dL and an estimated 10-year ASCVD risk of >= 7.5%. This requires a discussion with the clinician.
* Additional discussion topics
* The WG discussed the scope of CDS that may be developed in the area of cholesterol management (i.e. supporting the screening and prevention of ASCVD of adult patients in outpatient care settings)
* The WG felt that if we avoid the prompt to consider the initiation of statins where indicated for primary prevention then we are going to miss a huge component of care. They suggested that if we don’t go any further in to medications, we should consider a way to incorporate this recommendation.
* They recommended that CAMH also look in to supporting some components of secondary prevention. Even if medication management is not addressed, there may be other interventions and recommendations for patients that already have ASCVD or diabetes.
* Shared decision making (SDM) was discussed, along with how CDS can be used to facilitate SDM. It is envisioned that the new Longitudinal ASCVD Risk Assessment can be used to support SDM by allowing the provider and patient adjust the intervention values in the calculator (e.g., aspirin initiated, statin initiated) while discussing the benefits and harms of each intervention to facilitate an informed decision. It was noted that the way that data is displayed to both the provider and the patient can highly influence the decision. We will need to be very careful with the UI that is designed. Calibration is critical.
* CPG/eCQM alignment: We definitely want to consider this and ensure that we are not guiding clinicians towards care that is in disagreement with other rules that we implement and/or the most recent CPGs.
	+ All agreed with this. CQL was created for this purpose – to share logic. For this reason, CMS64 may be out of date since it prompts treatment against LDL goals instead of against risk score, therefore may not be included as an artifact.
* Provide actionable interventions. Create order sets and care plans that are indicated by clinical findings.
* Have someone from the CMMI team join the WG or provide insight on how they are conducting their RCT/implementation using the Longitudinal Risk Assessment Tool. They may be using different EHR systems. Can we leverage anything that they are doing?

**Next Steps and Close**

CAMH and the WG members closed out the meeting with a discussion about possible topics for discussion for the next WG meeting:

* + Build out CDS artifacts that center on the 2013 ACC/AHA 10-Year ASCVD Risk Assessment Tool and the Longitudinal Risk Assessment Tool
	+ Determine which CPGs (e.g., ACC/AHA, USPTF) and/or what portions of CPGs can be translated to CDS artifacts or rules (e.g., patient evaluation against the 4 risk groups)
	+ Research potential new CDS suggestions
	+ Monitor state of current quality measures and the early 2017 update from Million Hearts

Summary CDS Artifact Queue:

* + 2013 ACC/AHA 10-Year ASCVD Risk Assessment Tool (determine if use of this tool occurs immediately if no ASCVD or if at least 1 risk factor is present for USPTF recommendations)
	+ Longitudinal Risk Assessment Tool (created by CMMI and the Million Hearts to evaluate ASCVD risk after interventions have been initiated)
	+ CPGs (select portions). Sources TBD
		- Rules generated from CPGs
			* ASCVD – Yes/No
			* Determine 4 high risk groups for LLT consideration
	+ PQRS #438 – Statin use for Primary Prevention of CVD
	+ 30-Year/Lifetime Risk Assessment Tool
	+ MESA CAC Score
	+ Consider adding a space/field for atherosclerotic markers as they may come in to play more in the future and/or some clinicians may find them very useful
	+ HEDIS measure r/t Statin use for Diabetics
	+ ABCS measures listed on Million Hearts website: [here](https://millionhearts.hhs.gov/data-reports/cqm/measures.html)

CDS Artifact Caution List

* + CMS 61 – LDL Screening (although initially considered as up to date based on the concept of risk assessment, the numerator of this measure outlines treatments based on LDL levels)
	+ CMS 64 – LDL Risk Stratified Cholesterol (since it centers on treating an LDL-C goal)

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