

**Cholesterol Management Work Group**

**Meeting Summary**

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| **Date** | 01/11/2017 |
| **Time** | 3:00 – 5:00 PM ET |

## **AGENDA**

* **Welcome and introductions**
* **Discuss ACC/AHA 10-Year ASCVD Risk Assessment Tool Metadata and CDS creation**
* **Discuss Longitudinal Risk Assessment Tool Metadata, CDS Creation and Shared Decision Making**
* **Questions to the Work Group**
* **Determine Next Artifacts for Development**
* **Next Steps and Close**

**SUMMARY**

### **Welcome and introductions**

For the benefit of work group (WG) members who had not attended the first meeting, the group conducted introductions and CAMH provided a brief overview of the project, including project objectives, and main streams of work.

CAMH also provided a brief overview of the role and charge for the Cholesterol Management WG as one of two work groups convened to obtain broad community feedback to inform the development of CDS artifacts and the CDS repository.

## **Discuss ACC/AHA 10-Year ASCVD Risk Assessment Tool Metadata and CDS creation**

CAMH introduced a draft template used to populate metadata, artifact components and attributes, and other information necessary to fully define CDS artifacts, and elicited feedback from WG members on the content and process of translating narrative to well-defined CDS artifacts. Several WG members offered their comments:

On creating CDS artifacts:

* **Artifacts should be computable**: Artifacts should be defined at a level of specificity that enables execution (e.g. data elements defined using value sets);
* **Evidence needs to be contextualized to drive individual care decisions**: guidelines consolidate and grade evidence; in creating artifacts, it is important to parse the evidence into individual patient profiles.
* **Presentation of recommendations should be driven by strength and context**: different presentations of recommendations may yield different results. For example, a risk score is associated with a gradient of shared decision making, and it is important to consider presentation according to this gradient, especially around threshold values for different recommendations.
* **CDS tools should be considered for use outside of clinical visits**, such as in preparation for visits, or as population health management tools.

On the ACC/AHA 10 Year ASCVD Risk Assessment artifact:

* The WG discussed appropriate scenarios for risk calculation and/or presentation of the risk assessment tool:
	+ **Application as a population health management tool:** this would have the largest impact as a proactive approach to risk stratify and identify potential interventions to target care improvement outside of individual visits.
	+ **Allow for flexibility in application as decision aid during visits**, e.g. Kaiser has both an on-demand risk calculator that can produce real-time risk scores but no recommendations, and a SMART app where risk scores and accompanying recommendations are refreshed every two days.
	+ **Consider clinical workload when embedding tool into clinical workflow**: facilitating documentation can motivate clinicians to use the tools, e.g. linking recommendations to medication orders, when appropriate.
	+ **Cast a broad net for risk calculation/presentation but include appropriate caveats:** excessive requirements around triggers can be frustrating to clinicians, e.g. when a patient is missing a risk factor, the clinician may still want to see the calculated risk. For this reason, the USPTF recommendation to calculate ASCVD risk only when 1 or more risk factor is documented presents a challenge and additional burden to providers and IT systems (e.g., problem lists are not always maintained, the definition of dyslipidemia is unclear). Potential caveats associated with a risk score calculated based on missing, edge or out of range data should also be presented.
* The WG provided recommendations on interventions/actions to consider for patients with ASCVD:
	+ **Do not present the calculated risk for ASCVD patients, but provide recommendation for statin therapy**. The risk score is invalid for these patients, as they already have ASCVD; however, they would still benefit from statin therapy.
* The WG also offered considerations surrounding the provision of medication recommendations based on cardiovascular risk:
	+ **Allergy checking is important, and ideally would be integrated in artifacts providing medication recommendations, but this may pose implementation challenges given current reality**.
		- Sophisticated systems would embed allergy checking prior to the medication recommendation, instead of relying on other artifacts to verify the patient should receive the medication.
		- Aim is to develop standards-based, EHR-agnostic artifacts, recognizing some decisions will have to be made at a local level.
	+ **Consider a phased approach to artifact development**, starting with basic information (and appropriate disclaimers) and increase the precision and integration of additional checks/actionable interventions over time.

The WG also debated the merits of using multiple risk tools for cardiovascular risk, and whether there would be value is using both the ACC/AHA 10-Year ASCVD Risk Assessment Tool (targeted at patients who are not currently being treated) and the Longitudinal Risk Assessment Tool (targeted at patients already following statin and/or aspirin therapy). The group agreed that providers should select their preferred tool based on their practice and intention for ascertaining risk (e.g., post initiation of a statin). Note: it is unclear whether licensing restrictions will allow the creation of both risk tools, therefore each will be developed independently for the time being.

**Discuss Longitudinal Risk Assessment Tool Metadata, CDS Creation, and Shared Decision Making**

The WG discussed two use cases for the longitudinal risk assessment tool in their organizations/initiatives:

* The [Million Hearts® Cardiovascular Disease (CVD) Risk Reduction Model is conducting a randomized controlled trial](https://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/) that aims to study the impact of a payment structure incentivizing a team‑based care model to identify and manage high risk populations. The tool will be used risk stratify the population and measure overall risk reduction in the population over a period of four years.
	+ Organizations participating in the clinical trial will enter information to obtain the risk scores trough a registry. CMS is interested in lowering the effort for trial participants by embedding the tool within EHR systems, rather than maintain it in a standalone registry.
	+ The longitudinal risk assessment tool is currently available as part of a [published article in JAMA](https://www.ncbi.nlm.nih.gov/pubmed/27438118), but not currently available as a standalone tool outside of the clinical trial.
* The [Statin Choice Tool](https://statindecisionaid.mayoclinic.org/)is one of many [Mayo Clinic Shared Decision Model National Resource Center](http://shareddecisions.mayoclinic.org/)tools to promote conversations with patients during clinical visits.
	+ The tool has undergone many iterations and has been refined over time with input from clinicians and patients.
	+ Lessons learned:
		- **Effective risk communication requires analogies** (e.g. patients like you) and in whole numbers instead of probabilities (e.g. 1 in 10 patients vs. 10% of patients);
		- **Shared decision making must include not just the risk of cardiovascular disease, but the potential impact of statin therapy, and in turn, the risks associated with the therapy.**

**Questions to the Work Group**

This topic was not covered in the meeting.

**Determine Next Artifacts for Development**

The WG briefly discussed artifacts in queue for development, particularly those related to existing quality measures. Two existing measures were ruled out since they were not aligned with the latest clinical evidence:

* Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed (CMS 61)
* Preventive Care and Screening: Risk-Stratified Cholesterol -Fasting Low Density Lipoprotein (LDL-C) (CMS 64)

The group agreed on pursuing development of artifacts in alignment with other quality measures:

* Statin use for primary prevention (PQRS#438)
* Aspirin when appropriate (CMS 164)
* Blood pressure screening and follow up (CMS 22)
* Blood pressure control (CMS 165)
* Smoking assessment and treatment (CMS 138)

Million Hearts representatives will provide an update on CMS 164, CMS 22, CMS 165 and CMS 138 and where they fall in new alignment efforts as soon as the information is available.

**Next Steps and Close**

CAMH thanked the WG members for their feedback and active participation in the discussion.

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