

**Cholesterol Management Work Group**

**Meeting Summary**

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| **Date** | 02/08/2017 |
| **Time** | 1:30 – 3:30 PM ET |

## **AGENDA**

* **Welcome**
* **Discuss Remaining Repository Questions**
* **Clarify 10-Year Risk Assessment Details**
* **Discuss Statin Therapy for the Prevention and Treatment of CVD eCQM/CDS Artifact**
* **Discuss Next Artifacts for Development**
* **Next Steps and Close**

**SUMMARY**

**Welcome**

The Work Group (WG) Chair started the meeting, and all participants briefly introduced themselves for the benefit of WG members who had not participated in prior meetings.

**Discuss Remaining Repository Questions**

CAMH provided a brief overview of the metadata under current consideration for individual clinical decision support (CDS) artifacts in the repository. CAMH requested the WG members’ feedback on the [American Board of Medical Specialties’](http://www.abms.org/member-boards/specialty-subspecialty-certificates/) taxonomy for clinical domain/specialty, specifically on the appropriateness of including a subset hierarchy only for more comment specialties. The WG members offered a few comments:

* Consider a sub-hierarchy, 2 layers of specification, or other means to present domains (e.g., pediatric cardiology vs. adult cardiology).
* Consider starting with widely used taxonomies for specialties, such as the [Healthcare Provider Taxonomy Code Set](https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/taxonomy.html), which is used by the Centers for Medicare and Medicaid Services (CMS), to identify the provider type, classification, or specialty in the [National Plan and Provider Enumeration System (NPPES) Registry.](https://npiregistry.cms.hhs.gov/)

**Clarify 10-Year Risk Assessment Details**

**Evaluation of the patient record to appropriately identify risk assessment variables/data elements**

CAMH requested the WG members’ feedback on details related to the appropriate representation and constraints for certain data elements used to calculate the 10-year risk of atherosclerotic cardiovascular disease (ASCVD).

* **Discussion on LDL-c laboratory results to consider in the artifacts:**
	+ Considerations for timing of and availability of LCL-c results:
		- The WG members agreed on a lookback period of 6 years for the LDL-c laboratory result, citing the 2013 ACC/AHA guideline recommendation to assess risk every 4 to 6 years as a guide for a reasonable and appropriate time threshold.
		- There may be data availability and/or query response issues when considering lookback periods longer than 6 years and the specification needs to be practical.
	+ Considerations around the representativeness and accuracy of individual LCL-c results:
		- When multiple results are available, consider using the best representative value for the LDL-c result, which may not be the highest or most recent.
* **Discussion on blood pressure (BP) measurement results to consider in the artifacts:**
	+ Considerations for timing of available BP measurements:
		- The WG members agreed on a lookback period of 6 years for the BP measurements, citing the 2013 ACC/AHA guideline recommendation to assess risk every 4 to 6 years as a guide for a reasonable and appropriate time threshold.
	+ Considerations around the representativeness and accuracy of individual BP measurements:
		- Using the average BP within a specified timeframe may be more accurate, as BP measurements vary widely and depend on a variety of factors. However, a non-trivial representation of BP can be confusing for providers.
		- Recommend using on a single reading (e.g. last BP reading), but clearly convey the potential caveats of this approach and the importance of deliberate and accurate documentation of BP measurements, including best practices (e.g., retaking a BP that might be abnormally high or low for a patient later in the encounter to evaluate the validity of a result), to artifact implementers and users.
* **Discussion on the appropriate representation to identify patients being treated for hypertension:**
	+ The WG members commented on the difficulty associated with appropriately identifying this population using available data. After discussion, the WG members suggested the use of an explicitly documented hypertension diagnosis.
		- Using RxNorm codes for anti-hypertensive medications alone may compromise specificity since there is a fair amount of overlap in indications between hypertension and other conditions, such as heart failure.
		- Using diagnoses documented on the problem list alone may compromise sensitivity, as problem lists are not well maintained. However, there is significant movement to improve problem list maintenance. Consider additional sources for the identification of this diagnosis, including billing data.
* **Discussion on the approach to identify patients with a history of diabetes:**
	+ Similar to the hypertension population, the WG members suggested using an explicitly documented diagnosis of diabetes to identify this population.

Recommended intervention based on risk score

CAMH requested the WG members’ feedback on a layered approach to artifact design that addresses different triggers in separate artifacts, since subsequent interventions would be different. The WG members offered several considerations on the merits of different interventions and considerations for integration in provider workflow:

* **Consider various triggers to increase awareness in different contexts, such as:**
	+ A LDL-c test review activity outside of an encounter.
	+ A section in the record designed to display and assist in addressing known care gaps (e.g. vaccines).
	+ An on-demand request by the provider.
	+ A patient schedule review before patient encounters (e.g., in the morning before patients are seen, potentially presented as an additional column with a calculated score that can be right-clicked on for chart-based review and/or actionable interventions).
* **Consider separating interventions directed at supporting the provider during patient visits and interventions supporting population health management:**
	+ During active patient visits, recommend using visual cues and on-demand capabilities, as opposed to interruptive CDS. Strongly recommend against forcing a reaction from the provider. Suggestions included highlighting a field or section of the record yellow to indicate that a review is recommended or providing a “To Do Checklist”.
	+ There are mismatches between expectations and EHR capabilities. Currently, providers may have to navigate to a different screen/application to obtain the risk score, which they consider to be burdensome. Calculations can also take a long time, which can disrupt care and workflow. Long lookback times exacerbate this problem.
	+ Population management CDS artifacts would be innovative but will likely require significantly different representations.
	+ Consider ways to ensure that the highest risk patients are being identified and treated.

**Discuss Statin Therapy for the Prevention and Treatment of CVD eCQM/CDS Artifact**

Quality Insights of Pennsylvania (QIP) shared that MU eCQMs CMS 61 and CMS 64 will not be updated for the MU program since they are based on the Framingham risk scores and LDL targets, which are no longer recommended in the latest ACC/AHA guidelines. They provided an overview of a statin therapy measure available as a registry measure under the Physician Quality Reporting System(PQRS). QIP is currently developing an electronic version of the measure, and presented this version of the measure in draft form. The measure is based on the 2013 ACC/AHA guidelines but it focuses on high risk populations most likely to benefit from statins. Based on recommendations from the Technical Expert Panel (TEP) advising on the development of the measure, the specifications do not address statin intensity, lifestyle modifications and patient preference or refusal of treatment. The WG members asked several questions about the measure specifications, and the potential implications of the absence of patient preference exclusions on shared decision making. Although the metric does not preclude shared decision making, it is not incorporated in to the logic.

**Implementation questions to inform CDS artifact creation**

CAMH requested the WG members’ feedback on the appropriate triggers, expression logic, and interventions to represent the statin quality measure as a CDS artifact. The WG members offered several comments:

* **Triggers**
	+ Recommended strongly against interruptive interventions.
	+ Agreed that information on whether the patient would benefit from statins should be available at the encounter, as well as routinely population health management reports that could be managed outside of patient encounters via email or telephone.
* **Expression logic:**
	+ Both measure exclusions and exceptions should stop the CDS from presenting any interventions, with the exception of statin allergy or intolerance. Allergies are very rare and side effects can usually be discussed and worked through with the patient. For exceptions such as this, allow the provider to decide on a case by case basis what is appropriate for the patient and provide their rationale via documentation. Modeling certain persistent and debilitating side effects, such as myalgia, may also be considered.
* **Interventions:**
	+ WG members discussed the level to which the CDS artifact should mirror the quality measure, especially given the measure doesn’t take into account patient preference.

**Discuss Statin Therapy for the Prevention and Treatment of CVD eCQM/CDS Artifact**

Not discussed.

**Next Steps and Close**

Additional discussion topics on the agenda were deferred to the next WG meeting.

**Additional Topics**

**Transparency in conveying artifact design decisions to implementers and users**

While discussing specific implications of design considerations for CDS implementation, the WG members offered strong support for transparency in conveying potential caveats and limitations of CDS artifacts to implementers and users.

**Relationship between WG activities and the CDS Connect Pilot**

CAMH clarified that the scope of the pilot is currently under discussion with the proposed pilot site, and the artifacts tested will focus on CVD risk assessment in alignment with the needs of the pilot site. CAMH intends to request the WG members’ feedback on the pilot research questions to consider additional perspectives. A representative from the pilot site is joining the Work Group starting in March.

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