**

Repository Work Group

Meeting Summary

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| **Date** | 03/08/2017 |
| **Time** | 1:30 – 3:30 PM ET |

## AGENDA

* **Clarify Details Related to Existing Artifacts**
	+ Logic exclusions, specification of conditions, lookback periods and the inclusion of parameters for scalar values
	+ Considerations for artifact translation to technical standards
* **Discuss Specification of New Artifacts**
* **Discuss Next Steps and Artifacts for Development**
* **Close**

## SUMMARY

## Clarify Details Related to Existing Artifacts

CAMH provided an overview of the collective artifacts developed to date for cholesterol management. CAMH solicited the WG members’ feedback on refinements to the artifacts. The WG members offered their comments on several topics:

* **Scenarios for calculation of ASCVD risk:**
	+ There should be a minimum set of data required to compute the risk score but most variables shouldn’t block the risk calculation.
		- Concepts that *should* block calculation: age (if age 39 or 80, then don’t calculate) and history of MI or ASCVD.
		- Concepts that should not block calculation include lab and BP values. For example:
			* Out-of-range LDL result – substitute with the closest end range value and display the original value beside the substituted value.
	+ If desired, limitations of the presented risk score could be conveyed, but should be kept to a clinically useful minimum. Example scenarios:
		- * History of Familial Hypercholesterolemia – caveat the calculated score with this information (indicating that the score likely under-represents the patient’s true risk).
			* Non-White or Non-Black race and Hispanic ethnicity- caveat the calculated score with this information (indicating that the score either over or under-represents the patient’s true risk).
* **Allowing users to select parameters for risk calculation**:
	+ Provide a small number of variations for providers to select, e.g. lookback period for LDL result or ASCVD score could be no more than 6 years for the entire available history. Intermediary values are less useful.
	+ Parameter ranges should be consistent with what the patient could find out on their own, e.g. using the online ACC/AHA calculator.
* **ACC/AHA guidelines vs. US Preventative Task Force (USPTF) Recommendations**:
	+ Consider reconciling the two guidelines in the same artifact, which can reinforce shared decision making by highlighting where the recommendations are similar and how they diverge.
	+ Some sites have extensive guideline vetting processes, and may want to rely on a specific guideline, the most conservative guideline, etc.
* **Statin therapy exclusions:**
	+ Pregnant, breastfeeding, cirrhosis, end stage renal disease, and hemodialysis patients should be categorically excluded. Other conditions and scenarios may too broad exclusions. For example:
		- A patient with a past rhabdomyolysis diagnosis due to a previous fall shouldn’t be excluded from a statin therapy recommendation.
		- Many people with liver disease other than cirrhosis, e.g. fatty liver disease, shouldn’t be automatically excluded from statin therapy consideration.
	+ Consider EHR limitations in detecting the target phenotype; consider other avenues to identify patient population, including marker laboratory tests, or providing the opportunity to answer additional questions after a preliminary recommendation is presented.
* **Statin orders:**
	+ Having the full array of medications available is reasonable. Formularies may vary.
	+ Because these are small orders and individual local builds will be required, order sets don’t provide much value.
* **ASCVD risk while on statins:**
	+ ASCVD risk artifacts should allow on-demand calculation, at the discretion of the provider, even if the patient is already on statins, which is not always easy to determine.
* **Specification of diabetes:**
	+ Diabetes should include Type 1 and Type 2 Diabetes, but not gestational diabetes.
* **Aspirin use to prevent cardiovascular disease**:
	+ Consider allergy as additional exclusion.
	+ Consider using aspirin 81mg as “default” dose.
* **Considerations for artifact translation to technical standards:**
	+ **Conditions**:
		- Clinical status (e.g. active/inactive) should be present for each condition.
		- Determining pregnancy can be challenging. May need to evaluate the encounter diagnosis and problem list, along with a flag that indicates pregnancy.
		- Eliminate unnecessary data constraints and provide flexibility, when possible, to minimize issues with local data capture/workflow practices.
	+ **Laboratory test results**:
		- Consider any laboratory test result, if status isn’t flagged as “cancelled” or “entered in error”.
	+ **Medications:**
		- Consider using medication list as primary source for information on whether the patient is on a medication, as opposed to medication orders. Determining fill status and patient compliance is too challenging to discern for most health systems.

## Discuss specification of new artifacts

This topic was not discussed at the WG meeting.

## Discuss next steps and artifacts for development

This topic was not discussed at the WG meeting.

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