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**Cholesterol Management Work Group**

**Meeting Summary**

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| **Date** | 04/19/2017 |
| **Time** | 01:00 – 3:00 PM EST |

**AGENDA**

* **Welcome**
* **Brief Overview of Existing CDS Connect Artifacts**
* **Clarify Logic Details for USPTF-related Artifacts**
* **Discuss Best Approach for Transforming eCQM Specifications into CDS Logic**
* **Next Steps and Close**

**SUMMARY**

**Welcome**

CAMH started the meeting and all participants briefly introduced themselves for the benefit of work group members who had not participated in prior meetings.

**Brief Overview of Existing CDS Connect Artifacts**

CAMH provided a brief overview of the existing CDS Connect artifacts, with a focus on the newest artifacts under development: Statin Use for the Primary Prevention of CVD in Adults and Aspirin Therapy for Primary Prevention of CVD and Colorectal Cancer. Both artifacts support USPSTF recommendation statements.

The work group members offered a few questions and comments on the original artifacts that align with ACC/AHA and Million Hearts recommendations:

* Consider representing the lesser grade ACC/AHA and USPSTF recommendations for future artifact development. The ACC/AHA provides a statin recommendation for risk scores 5-<=7.5% and USPSTF provides one for 7.5<10%.
  + CAMH may consider a way to allow users to change the risk score parameter if the appropriate strength of recommendation can be displayed with the notification (e.g., “start” statin for a stronger recommendation and “discuss” statin for a lesser one).
* Providers prefer information on all sub-sets of patients, even if the strength of the recommendation is lower. They can then determine the best path forward for care. Use weaker wording when appropriate (“consider” or “discuss” versus “start” based on the risk score/threshold)
* Provide transparency of data elements used to generate the recommendation so providers can evaluate the accuracy of the input data and override or re-evaluate as indicated
* Anita from QIP clarified that Hypercholesterolemia should be defined as ‘pure’ or ‘familial’ in the eCQM artifact, along with the associated diagnosis codes. They have received several comments on this concept.

**USPSTF Statin Use for Primary Prevention of CVD in Adults**

* Feedback on value set selection to represent Diagnosis: CVD
  + There is no good way to handle sub-clinical ASCVD that is detected on imaging studies. It influences a patient’s risk, but not as much as someone with a clinical event. Also, a longer lookback for a diagnosis and fewer required appearances of the diagnosis reduce the accuracy.
  + Some favor ASCVD because it includes atherosclerosis. CVD can include CHF in some interpretations and statins are not as effective at treating heart failure. That is why the ACC/AHA specifies ASCVD as opposed to CVD.
  + The USPSTF does not consider an abnormal diagnostic result alone (e.g., a CAC score) as evidence of disease. However, once a provider evaluates the full patient condition and determines that a diagnosis of atherosclerosis and PAD is appropriate, these codes would be valid to include in a value set that represents CVD.
  + The updated NCQA value set is worth considering to represent CVD. The initial version included aortic atherosclerosis, which is a sub-clinical disease. This has been removed, along with other sub-clinical codes.
    - QIP did not use the original NCQA value set for this reason. Upon reviewing the updated value set, they determined it was best to create a new value set to represent ASCVD.
* Feedback on inclusion criteria
  + The USPSTF defined LDL-C > 130 as a risk factor to represent the ‘average’ risk for primary prevention
    - The upper limit of LDL-C <=190 in the logic makes sense for the overall artifact, in that it ensures that a patient with a higher risk is not under-treated, however it is **better placed as an exclusion** to keep the definition of LDL-C as a risk factor distinct from other logic specifications. Placing individuals with an LDL-C >=190 in the exclusion criteria with familial hypercholesterolemia makes sense because it may warrant treatment earlier than age 40
    - This is philosophical, but probably best aligns with the USPTF recommendation
    - Ultimately, look towards a suite of messages that would present to a provider (i.e., give 1 message for LDL-C 130-189 and another for 190 and above). Could do this for USPTF. Separately could do this for ACC/AHA recommendations.
  + Smoking should be defined as smoking cigarettes (only), not an overall ‘tobacco user’.
* Feedback on exclusion criteria
  + The following are all valid
    - Diagnosis of CVD or Familial Hypercholesterolemia – pulled directly from the USPSTF document
    - Diagnosis of Active Pregnancy or Breastfeeding
    - Diagnosis of ESRD or Actively receiving dialysis (w/in past 7 days)
    - Diagnosis of Active Cirrhosis
    - Receiving Palliative Care
  + Already receiving Low-Moderate Intensity Statin
    - Recommend replacing low-moderate with **all** **intensity statins**. You might not want to trigger a recommendation to lower statin therapy if a patient was started on a high intensity statin b/c their LDL was > 190. If the LDL lowers on treatment, a lower intensity may not be indicated. This is very nuanced and should be left to provider discretion.
  + Capturing procedures in an outpatient setting (e.g., dialysis or palliative care)
    - It is likely that only large health systems that provide inpatient and outpatient care will have record of these types of procedures. It doesn’t hurt to leave them in so that instances that are picked up will be considered. Most agreed that there could be challenges in capturing these concepts.

**USPSTF Aspirin Use for Primary Prevention of CVD and CRC**

* Feedback on exclusion criteria
  + Specifying **UGI pain** – all agreed that this is very challenging and none have attempted to specify this to implement CDS. (One system has specified codes for GI bleed and ulcers, not UGI pain)
    - Could use epigastric or regional pain diagnosis’ and high level ‘bleeding disorder’ codes, but that will only get us so far
    - From their experience with eCQM feasibility testing in ‘average’ clinical settings (vs. large Mayo-like settings), QIP noted that many of the exclusion concepts are captured as free text
  + Overall feedback
    - Would have to define the lookback period, and even then, it would be hard to determine what was transient and is no longer a risk or issue and what is relevant (e.g., a healed ulcer or bleed)
    - Would lab values be included in the exclusions to indicate a specific diagnosis (e.g., thrombocytopenia), as opposed to the diagnosis code itself? If so, a lookback would have to be defined. This becomes complicated.
    - Inpatient DVT prophylaxis efforts and eCQMs may have compiled bleeding disorder specifications. More work has been done on the inpatient side related to bleeding risks. It is more challenging on the outpatient side.
    - **Kidney and liver disease** might be defined by lab values also, as opposed to just diagnosis codes
    - **No matter what is implemented, it will need to be noted that an aspirin recommendation does not apply to individuals at high risk for bleeding.** Also, given the logic, there is a chance that an aspirin recommendation is withheld for an individual that has a specified condition, but it is no longer relevant (e.g., a healed ulcer).
    - While talking about the balance between sensitivity and specificity, one thought was to specify as written, but add a caveat with all aspirin notification that “this is not indicated for individuals at high risk of bleeding (as outlined in the exclusion logic)”
    - **Anticoagulants and NSAIDs** – if the meds are Active at any dose, frequency or duration they should be included in the exclusion. This is a primary prevention recommendation. Beware of new agents that may not be included in value sets. Consider flagging the med that is triggering the exclusion to allow the provider a chance to clean up the med list if it is no longer active.
    - Consider specifying a lab level to represent **thrombocytopenia** for a specified period (TBD), or the diagnosis.
    - **Consider excluding active inpatient status**. This recommendation is not appropriate in a hospital setting, given other care may be provided/impacted.
    - It was clarified that addressing the moving target of risk given the new Million Heart model and its ability to lower risk after treatment is out of scope for the current USPSTF recommendation
  + **Do not include male sex and older age**
  + **Uncontrolled HTN** – you may not have a code for uncontrolled HTN and only the SBP value.
    - Any message that appears during a visit is distracting. Cut down noise where obvious instead of displaying a long list of caveats. At a certain point, an elevated SBP is risk.
    - From a primary prevention perspective, all agreed that a threshold SBP >=160 should be implemented as an exclusion. No lookback or average value. To keep it simple, use the MOST RECENT.
    - A concurrent diagnosis of HTN should not be required.
  + **Severe liver disease** – can be characterized by Active Cirrhosis. This will be consistent with the statin artifact also. Do not include Hepatitis, chronic hepatitis is not a contraindication for aspirin.

**Implementation of both USPSTF artifacts**

* Trigger can be either encounter driven or data driven (usually a new LDL-C result)
  + One system’s CDS presents during visits *and* during lab reviews (e.g., an ASCVD risk score is presented close to the lipid result). Patients can receive the score in numerous ways also.
    - Include labs as a part of the clinical encounter
    - QIP (a measure developer) still sees many labs results returned as PDFs and not integrated in the EHR with manual effort which will be a limiting factor for some organizations
    - Often labs are ordered during a visit and results come in 2 days later. When communicating the results (2 days later) that is when a statin or aspirin should be discussed with the patient. This is not easy to implement, but would be helpful to patients and providers.
    - One system displays a best practice alert and the provider can click on ‘Accept’ to stage the order. The provider can then document the reason why the med (i.e., aspirin) is not ordered OR close the box if they don’t want to document the reason.

**Discuss Best Approach for Transforming eCQM Specifications into CDS Logic**

CAMH asked the WG for feedback on translating eCQM specifications into CDS Logic:

* Overall, it is more helpful to be as aligned to the guideline as possible (e.g., recommend a high intensity statin when the ACC/AHA outlines this).
* Metrics allow for discussion and negotiation with the patient for softer contraindications. The CDS can be consistent with the guideline, and the metric have a lower bar and they both have a place.
* Concerning exclusions: it is reasonable to specify the exclusions listed below, as opposed to listing all the criteria that is outlined in the eCQM. Some eCQM items, like Hepatitis A and B, are lesser considerations and don’t need to be included.
  + Diagnosis of Active Pregnancy or Breastfeeding
  + Diagnosis of ESRD or Actively receiving dialysis (w/in past 7 days)
  + Diagnosis of Active Cirrhosis
  + Receiving Palliative Care
  + Already receiving a Statin

**Next Steps and Close**

* + Next month we may consider doing a brief demo of one or more systems that have implemented cholesterol CDS to inform the CDS Connect pilot

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