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**Cholesterol Management Work Group**

**Meeting Summary**

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| **Date** | 05/09/2017 |
| **Time** | 5:00 – 7:00 PM EST |

**AGENDA**

* **Welcome**
* **Gather Feedback on Lookback Periods, Notifications for the USPSTF Artifacts and Value Sets**
* **CDS Connect Pilot Overview**
* **Statin CDS Demos: Options for Providing CDS Notifications**
* **Next Steps and Close**

**SUMMARY**

**Welcome**

CAMH started the meeting with an overview of the agenda topics for the meeting.

**Gather Feedback on Value Sets, Lookback Periods, and Notifications for the USPSTF Artifacts**

CAMH provided an update on the current stage of development for the Statin Use for the Primary Prevention of CVD in Adults Artifact and the Aspirin Therapy for Primary Prevention of CVD and Colorectal Cancer Artifact, since the previous work group meeting. CAMH provided an overview of the next phase of artifact development for these USPSTF-based artifacts.

The work group members offered their feedback on the following topics:

Lookback Periods and Exclusion Clarifications

* Six years is appropriate for a lookback period; Consider establishing a prompt for providers to order a new LDL or lipid panel if values within the last six years are not available.
* Be aware that establishing lookback periods have been difficult for some EHR vendors.
* ACC/AHA time interval to reassess risk is 4-6 years, so a 6-year lookback aligns with this. If a site is unable to support lookback periods, that will be a limitation of the site to work around.
* Representing dialysis as hemodialysis and peritoneal dialysis is appropriate.

Notifications for the USPSTF Artifacts

* All recommendations related to initiating statins should be discussed with the patient first.
* Different perspectives were shared on the wording of the notification:
  + Use “consider” statin for 7.5%-9.5% risk and possibly use “discuss” statin for a risk > 10%. Stronger wording may move physicians to make recommendations as opposed to letting patients have a say.
  + Another perspective:
    - “Discuss” and “consider” map more to Grade C
    - “Start” maps to Grade B (aligning with the recommendation words: use, start or initiate)
    - It is reasonable to translate “recommends use of” as “start” in the USPSTF Grade B recommendation, and a discussion should take place for the Grade C recommendation.
  + It is reasonable to interpret Grade B and C USPSTF recommendations in the same way (therefore if a Grade B BP recommendation aligns with “start” a Grade B statin recommendation might be the same).
* By adding context to the notification presented to providers to first have a conversation about statins, and based on the outcome of shared decision making, before just starting a statin made some members more comfortable.
  + A statement like: “Start low-medium intensity statin based on outcome of discussion and shared decision making with patient” would be better than simply stating “Start low-medium intensity statin”. It aligns with the intention and context of the recommendation.
* Regarding a resource that provides a strength of recommendation with a verb:
  + Look at the GRADE system (e.g., SHOULD means that 90% of the patients would choose/receive that treatment). There should not be as many of the strongest recommendations
  + USPSTF grade definitions are A, B, C, D, and I, where A means there is a high certainty of substantial benefit to the patient, B means there is moderate certainty of benefit, C means there is less than moderate benefit, D means net harm and I means the evidence is insufficient to determine potential benefit.

Statin Artifact Specifications

* Define hypertension as primary (essential) and secondary HTN
* Hypertension: 2013 NCQA Hypertension value set vs 2017 QIP value set.
  + Both represent primary and secondary hypertension but QIP’s value set includes *findings* represented by SNOMED codes.
  + Thoughts included:
    - Codes that represent *findings* may not be captured in an EHR as regularly as a diagnosis code.
    - Ensure that NCQA’s VS includes ICD10 codes before strongly considering
    - Consider QIP’s 2017 VS if that is the most up to date.

Aspirin Artifact Specifications

* No concerns were raised about changes to the logic that were made based on last month’s conversation, including:
  + Male sex and old age were removed from exclusions
  + Upper GI pain was removed from the exclusions due to constraints in representing this in a structured way.
  + A caution will be added to the artifact suggesting implementers use the artifact in outpatient settings only.
* Dialysis - There was agreement that dialysis should be added as an exclusion since it indicated ESRD which is also an exclusion
* Wording of notifications – follow same methodology as the statin medication: either represent Grade B as “discuss” and Grade C as “consider” OR represent Grade B as “start aspirin based on outcome of shared decision making between provider and patient”. The Grade C recommendation should be more individualized since not every patient is the same – either “consider” or “discuss”.
* Thresholds for Thrombocytopenia
  + Usually lab values are flagged in/by the EHR, either by the lab or by the EHR system itself as being above the normal or out of range on the high side. Recommend that each implementer sets this value based on their unique system otherwise there could be divergence between CDS message/logic and flag markings of abnormal lab values.
  + It is reasonable to include and specify lab values to depict thrombocytopenia and bleeding disorders, but ultimately this is something that each implementer should review and revise based on their practice and system.
* Anti-coagulant value set selection
  + The anti-coagulant medications provided by a work group member are appropriate medications to include, along with Heparin, argatroban, lepirudin, dalteparin, and tinzaparin, which are present in The Joint Commission value set created on 1/17.
* NSAID value set selection
  + Ergot and Triptan medications should not be included in an NSAID value set for our purposes since they don’t impact bleeding times. The NSAID list provided by a work group member are appropriate meds to include.

CQL Logic Requirements

* Use “Confirmed” for Verification Status over the other options. “Provisional” and “Differential” are not used, for the most part. The work group members did not have enough experience of how data is captured on the back end of their systems to advise on “Unknown”. Consider evaluation of the availability of data with this status during testing.
* For clinical status, consider “Active”, “Resolved” and “Absent” for the Conditions listed in the PPT. “Relapse” and “Remission” are more frequently associated with cancer than chronic disease. Post meeting note: CVD was displayed at the highest level (i.e., “CVD”) as opposed to how it is represented in the logic (as the presence of “MI”, “Angina”, “IVD”, and several procedures such as CABG, PCI and Carotid Intervention), therefore the Clinical Status designations may need to be re-visited.

**CDS Connect Pilot Overview**

CAMH provided an overview of the plan for the CDS Connect Pilot project with AllianceChicago (AC). The pilot will start in July across three Federally Qualified Health Center (FQHC) sites in rural areas of the western United States. The goal of the pilot is to have the sites download, use, and provide feedback on the artifacts to evaluate the clinician experience with the artifacts. CAMH will also test the artifacts themselves to determine how they are operating in the EHR systems.

The workgroup offered comments and questions about the Pilot:

EHR System

* Given the challenges with lookback periods, we look forward to seeing how the artifacts operate in GE Centricity.

Evaluation of Patient Experience

* The [collaboRATE tool](http://www.collaboratescore.org/), developed [by a research group](http://preferencelaboratory.org/) at Dartmouth University evaluates shared decision making from a patient’s point of view through a short survey about a patient’s clinical encounter. Consider capturing the patient perspective in the pilot.
* Consider evaluating the pilot in numerous ways (e.g., if the artifact can be accessed and utilized via the repository, if changes to the CDS can make it better, what the patient’s point of view is after the encounter. A survey can be used to capture this).

**Statin CDS Demos: Options for Providing CDS Notifications**

The work group Chair and AC performed demonstrations of a clinical encounter in their respective EHR systems.

Demo #1:

* There are numerous ways for a provider to pull up a risk score in the system.
* Use as few words as possible for notifications or recommendations at the point of care to minimize impact to workflow.
* Shared decision making resources can be accessed via a link.
* CDS during lab review is very helpful.
* Adherence data is helpful to inform decisions.

Demo #2:

* Disease Management Advisor displays last observed values for risk and can calculate a new risk for ASCVD and Framingham on demand, along with the appropriate recommendation.
* Includes links to the guideline so the reference does not have to be updated in the system and the ability to order a statin on the same screen.
* Includes contextual information on lab values and the span of recommendations along with a tab that supports a discussion with the patient. Providers do not always use the shared discussion section, which is a challenge. They provide education materials that align with the decision.

**Close and Next Steps**

At next month’s meeting, CAMH will share more details about the pilot planning. CAMH will send out an email to the WG members about additional questions about value sets as they continue to build out the USPSTF artifacts.

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