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**Cholesterol Management Work Group**

**Meeting Summary**

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| **Date** | 06/21/2017 |
| **Time** | 1:30 – 2:45 PM EST |

**AGENDA**

* **Welcome and Review of Agenda**
* **Gather Feedback on Additional Details Required to Support Development of the eCQM Artifact**
* **Next Steps and Closing**

**SUMMARY**

**Welcome**

CAMH welcomed the WG Members to the June Cholesterol Management Meeting and provided an overview of the agenda.

**Gather Feedback on Additional Details Required to Support Development of the eCQM Artifact**

CAMH provided an update on the current stage of development for the eCQM artifact since the previous work group meeting, and requested feedback on the following topics:

* Should an upper age limit be added to the logic for Populations 1 and 2 to address patient safety concerns?
  + One organization has added 75 years of age as a threshold. From age >=76, the strength of the recommendation lessens and shared decision making is emphasized. Another organization did not include age limitations.
  + In part, it depends if the artifact is trying to support the eCQM metric, provide CDS or both. **The emphasis is on CDS, while aligning with the eCQM when able.**
  + Population 1: can do either way (with or without age threshold). Will need different messages (and possibly logic) for individuals 76 and older to encourage shared decision making and consider a lower intensity statin. This aligns with the ACC/AHA guidelines.
  + Population 2:
    - By the time they are 75, do patients truly have hypercholesterolemia versus a provoked one time bump? Setting this threshold seems advisable. **A message will be needed to consider age before determining the intensity of medication that is ordered.**
    - Pure Cholesterolemia is not used correctly and may cause misfiring of CDS if used.
* How is pregnancy (and breastfeeding) captured in various EHRs (i.e., ICD code, flag) to support evaluation as an exclusion?
  + Pregnancy and breastfeeding will likely not be captured as an ICD10 code, except by an OB/GYN doctor.
  + Members were unsure how these concepts are captured on the back end of their systems.
  + They can be mentioned in recommendation notifications as an exclusion, if implementers do not feel strongly that this data is captured as a diagnosis code.
* Lookback period for Population 2
  + Consider adding a lookback period for this population also to support processing efficiency
* Lookback period for Population 3
  + It is reasonable to translate ‘LDL result <= 2 years starts before end of Measurement Period’ in to a lookback period of 3 years.
    - Feasibility concerns informed the eCQM lookback specifications
    - Due to potential delays in processing time to support a longer lookback, work group members voiced consent to keeping the lookback at 3 years (as opposed to 6 years for an earlier artifact).
  + One work group member voiced concern that the specifications for this population do not take in to account scenarios where patients who are well controlled on statins fall out of the denominator for the eCQM. Note: This does not affect our CDS.
  + If LDL > 70, you want to alert for a statin. If LDL < 70 you don’t want to take them out of the denominator for quality performance and run chart evaluations. This is where CDS and eCQMs diverge.
    - Will need to handle point of care CDS as a distinct use case.
    - Often, it is more relevant to consider the highest LDL *before* treatment, rather than looking at LDL <70 *while on* treatment.

Value Set Discussion

* Familial and Pure Hypercholesterolemia
  + To correctly represent the above, remove Primary, Polygenic, History of, Hypercholesterolemia, and Secondary to align.
  + All work group members in attendance voiced concern about effective use of codes that correspond to pure hypercholesterolemia due to poor definitions and understanding of the condition. They feel that this data element will likely be revised during the annual update based on provider feedback.
* Rhabdomyolysis as an exclusion
  + All codes in this value set are valid as exceptions.
    - Ensure they are not hospitalized and the condition is classified as ACTIVE. A lookback period should not be used. Resolved conditions do not need to be excluded.
    - Leave nuances of milder forms of myalgias (e.g., myositis, myalgia within past year) to providers on the front line.
  + Concerning the accuracy of using conditions deemed as Active on the problem list: this provides transparency on why the CDS is or is not firing. It is an easy place for providers to double check and rectify if anything needs to be cleaned up. Problem lists can be neglected at times and some items may need to be resolved and moved to the Past Medical History section of the chart. Utilizing the problem list to determine the presence of a condition is a manageable constraint when creating CDS rules.
  + **After further discussion, it was determined that Rhabdomyolysis should be added to the USPSTF artifact as an exclusion also.**
* Hepatitis A
  + It is episodic. If active, then all codes in the value set should be excluded.
  + If past/resolved, then no need to exclude.
  + Alternately, one organization does not list specific liver conditions. Instead, they specify cirrhosis or an ALT > 3x’s the upper limit or normal.
  + You can argue that Active Hep C should be excluded also.
* Hepatitis B
  + One member thought that Active or Remitted Hep B should be excluded, another thought Hep B as a blanket statement should not be excluded because some variations qualify and others don’t. It is very hard to train clinicians on the CDS when you have so many caveats. It is better to provide a more succinct statement that is reasonable to implement and understand (i.e., cirrhosis or ALT > 3 x’s the normal limit)
  + Some studies have shown that patients with Hep B do fine on statins.
* Liver Disease
  + Liver disease is very complicated. There are lots of variations, coinfections and severities. There is a large opportunity to over or under capture appropriate contraindications when trying to select distinct codes for each variation.
    - Another member advocated for the approach mentioned earlier – evaluating for Cirrhosis or an ALT > 3x/s the upper limit of normal.

Notification to Providers

* ‘Should be on a statin’ may be too strong of a statement. One organization uses the verb ‘Consider’ so the provider is not led to believe that the computer knows better than him/her or knows something that they don’t know. Shared decision making should always be included.
  + Another organization uses different verbs for different strength recommendations. Some recommendations can be represented as ‘start’, others as ‘consider’ or ‘discuss’.
* Providers make clinical decisions based on patient condition and the guidelines. They are not/should not be prompted by meeting a metric, so would not include the metric in the recommendation statement. Would not include ‘according to available data either’.
* Include the rationale in the message (i.e., consider statin based on ASCVD, consider statin based on high LDL, etc.)
* Information on guidelines are available as a link in the EHR or Infobuttons on the alert; not usually as a link in the recommendation statement.

**Next Steps and Closing**

CAMH will provide an update on the pilot and discuss clinical domain areas under consideration for Option Year work at the July WG Meeting.

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