IMPROVING USE OF STATIN THERAPY FOR HIGH RISK PATIENTS ROADMAP

INSTRUCTIONS

PURPOSE: This **Improving Use of Statin Therapy for High-Risk Patients Roadmap** is a tool to help organizations achieve ≥80% on the use of statin therapy to prevent and treat cardiovascular disease in high-risk patients.

OVERVIEW: This tool organizes groups of interventions and activities to help organizations develop a deliberate strategy or approach to their cholesterol management efforts. Interventions are outlined across three categories: **Core, Elective, and Capstone**. Each category has a list of **current activities** and **planned activities** to help organizations identify and achieve their statin therapy goals. Organizations can start by focusing on core evidence-based strategies that provide a strong foundation for success. Once in place, organizations can build on their **core strategies** by implementing additional interventions and activities in the **electives** category and, when ready, in the **capstone** category.

STEP-BY-STEP INSTRUCTIONS FOR EACH HEALTH CENTER:

1. **Determine** your organization's current statin therapy performance rates for patients at high risk for cardiovascular events. Rates should include individual risk group performance (ASCVD diagnosis, LDL-C ≥190 mg/dL, and Diabetes + LDL-C 70-189 mg/dL) and overall/aggregate performance.

2. **Identify** the **statin therapy rate range** in the table in which your organization's current performance rate falls across the **Core, Elective, and Capstone** categories. Review which set of intervention strategies and activities are aligned with your performance range.

3. **For selecting Current Activities:**
   - Identify the strategies your organization has in place or has completed.

4. **For selecting Planned Activities:**
   - Prioritize implementing the intervention strategies and activities that correspond to your current performance range.
   - Use your selected **Current Activities** as a reference to guide your selection of **Planned Activities**.
   - Create a plan to implement interventions/activities selected in the **Planned Activities** category to continue improving use of statin therapy for high-risk patients.

     NOTE: This tool is not designed to be used linearly. Consider planning for activities across all categories even if your performance is in a more advanced category.

5. **Add the health center name** into the text box provided below ***or*** go to **File>Save As** to change the file name to include the health center name.

6. **Repeat** these steps for each participating health center.

HEALTH CENTER NAME _____

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CORE STRATEGIES

STATIN RANGE: **< 65%** Statin Therapy aggregate measure (CMS347v3) OR any risk group < 65%
GOAL: **≥15% improvement** in Statin Therapy

1. Identify the **Current Activities** your organization has in place or completed.
2. Select **Planned Activities** that are not in place or completed to improve use of statin therapy for high-risk patients.
3. Create plan to complete **Planned Activities**.

	CURRENT	PLANNED
ASSESS/PREPARE PEOPLE, POLICIES, AND PROTOCOLS	☐ Assess clinician knowledge, attitudes, and beliefs (KAB) on statin therapy use ☐ Provide clinician education on 2018 ACC/AHA Guideline on the Management of Blood Cholesterol tailored to assessed KAB (ensure buy-in) ☐ Update practice protocols to reflect 2018 Cholesterol Guideline ☐ Provide care team education on medication adherence ☐ Audit medical records of high-risk patients without statin therapy to understand driving factors	☐ Assess clinician knowledge, attitudes, and beliefs (KAB) on statin therapy use ☐ Provide clinician education on 2018 ACC/AHA Guideline on the Management of Blood Cholesterol tailored to assessed KAB (ensure buy-in) ☐ Update practice protocols to reflect 2018 Cholesterol Guideline ☐ Provide care team education on medication adherence ☐ Audit medical records of high-risk patients without statin therapy to understand driving factors
INITIATE STATIN THERAPY	☐ Embed guideline criteria into care processes ☐ Develop care gap reports to address therapeutic inertia ☐ Initiate statin therapy for high-risk patients not on statin therapy, including leveraging available telemedicine modalities to schedule encounters ☐ Schedule 3 month follow-up to assess response to therapy (including labs)	☐ Embed guideline criteria into care processes ☐ Develop care gap reports to address therapeutic inertia ☐ Initiate statin therapy for high-risk patients not on statin therapy, including leveraging available telemedicine modalities to schedule encounters ☐ Schedule 3 month follow-up to assess response to therapy (including labs)
IMPROVE MEDICATION ADHERENCE	☐ Assess for non-adherence (e.g., 3-month lab results, questionnaires, pill counts, contextual flags, missed appointments, infrequent refills) ☐ Offer solutions: ☐ Prescribe low-cost generics ☐ Align prescription refills ☐ Approaches to address "forgetfulness" ☐ Blister packaging or pill boxes	☐ Assess for non-adherence (e.g., 3-month lab results, questionnaires, pill counts, contextual flags, missed appointments, infrequent refills) ☐ Offer solutions: ☐ Prescribe low-cost generics ☐ Align prescription refills ☐ Approaches to address "forgetfulness" ☐ Blister packaging or pill boxes
IMPROVE CLINICAL DECISION SUPPORT AND DATA-DRIVEN CARE PROCESSES	☐ Assess current clinical decision support (CDS) using CDS 5 Rights Framework ☐ Implement/optimize point-of-care CDS to identify: ☐ Patients without a lipid panel in the past 3 years ☐ High-risk patients not on statin therapy ☐ Develop population health registries to identify: ☐ Patients without a lipid panel in the past 3 years and no appointment ☐ High-risk patients not on statin therapy and no appointment ☐ Shore up workflows with external providers: ☐ Diagnoses of qualifying high-risk conditions ☐ Statin therapy prescriptions ☐ Ensuring structured EHR documentation	☐ Assess current clinical decision support (CDS) using CDS 5 Rights Framework ☐ Implement/optimize point-of-care CDS to identify: ☐ Patients without a lipid panel in the past 3 years ☐ High-risk patients not on statin therapy ☐ Develop population health registries to identify: ☐ Patients without a lipid panel in the past 3 years and no appointment ☐ High-risk patients not on statin therapy and no appointment ☐ Shore up workflows with external providers: ☐ Diagnoses of qualifying high-risk conditions ☐ Statin therapy prescriptions ☐ Ensuring structured EHR documentation
INCREASE PATIENT ENGAGEMENT	☐ Apply shared-decision making at initiation of treatment plan and throughout ☐ Use collaborative communication skills in conversations (e.g., non-judgmental, ask about cost) ☐ Use visuals/other tools to help patients understand their reduced risk of heart attack and stroke with statin therapy	☐ Apply shared-decision making at initiation of treatment plan and throughout ☐ Use collaborative communication skills in conversations (e.g., non-judgmental, ask about cost) ☐ Use visuals/other tools to help patients understand their reduced risk of heart attack and stroke with statin therapy

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ELECTIVE STRATEGIES

STATIN RANGE: 65 - 79% Statin Therapy aggregate measure (CMS347v3)
GOAL: ≥10% improvement OR **≥80% in Statin Therapy**

1. Identify the **Current Activities** your organization has in place or completed.
2. Select **Planned Activities** that are not in place or completed to improve use of statin therapy for high-risk patients.
3. Create plan to complete **Planned Activities**.

	CURRENT	PLANNED
ASSESS/ PREPARE PEOPLE, POLICIES, AND PROTOCOLS	☐ Develop collaborative practice agreements for pharmacists: ☐ Refill authorization ☐ Medication titration ☐ Formulary management ☐ Provide refresher clinical education on 2018 Cholesterol Guideline and medication adherence	☐ Develop collaborative practice agreements for pharmacists: ☐ Refill authorization ☐ Medication titration ☐ Formulary management ☐ Provide refresher clinical education on 2018 Cholesterol Guideline and medication adherence
INITIATE STATIN THERAPY	☐ Outreach to set up encounters for: ☐ Patients without a lipid panel in the past 3 years ☐ High-risk patients not on statin therapy who are not scheduled for an appointment	☐ Outreach to set up encounters for: ☐ Patients without a lipid panel in the past 3 years ☐ High-risk patients not on statin therapy who are not scheduled for an appointment
IMPROVE MEDICATION ADHERENCE	☐ Regular expanded care team encounters that include medication education and adherence coaching ☐ Outreach to patients after initiating statin therapy to: ☐ Ensure prescription filled Address barriers to adherence ☐ Titrate medication, if needed ☐ Reinforce medication benefits	☐ Regular expanded care team encounters that include medication education and adherence coaching ☐ Outreach to patients after initiating statin therapy to: ☐ Ensure prescription filled Address barriers to adherence ☐ Titrate medication, if needed ☐ Reinforce medication benefits
	☐ Develop population health registries to: ☐ Identify missed opportunities (high-risk patients who had an encounter and did not receive a statin prescription) ☐ Develop targeted interventions by risk group, demographics, and other patients factors ☐ Implement/optimize point-of-care CDS to identify high-risk patients who: ☐ Refused statin therapy ☐ Discontinued statin therapy ☐ May have barriers to medication adherence	☐ Develop population health registries to: ☐ Identify missed opportunities (high-risk patients who had an encounter and did not receive a statin prescription) ☐ Develop targeted interventions by risk group, demographics, and other patients factors ☐ Implement/optimize point-of-care CDS to identify high-risk patients who: ☐ Refused statin therapy ☐ Discontinued statin therapy ☐ May have barriers to medication adherence
INCREASE PATIENT ENGAGEMENT	☐ Empower patients to set goals	☐ Empower patients to set goals

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CAPSTONE STRATEGIES

STATIN RANGE: **≥80%** Statin Therapy aggregate measure (CMS347v3)
GOAL: 1+ emerging best practice

1. Identify the **Current Activities** your organization has in place or completed.
2. Select **Planned Activities** that are not in place or completed to improve use of statin therapy for high-risk patients.
3. Create plan to complete **Planned Activities**.

	CURRENT	PLANNED
ASSESS/ PREPARE PEOPLE, POLICIES, AND PROTOCOLS	☐ Develop other innovative strategies to increase care delivery capacity (e.g., community partnerships)	☐ Develop other innovative strategies to increase care delivery capacity (e.g., community partnerships)
INITIATE STATIN THERAPY	☐ Focus on hard to reach patients, patients who discontinued or refused statin therapy, and missed opportunities	☐ Focus on hard to reach patients, patients who discontinued or refused statin therapy, and missed opportunities
IMPROVE MEDICATION ADHERENCE	☐ Partner with payers or pharmacies to obtain prescription fill data ☐ Measure medication adherence: ☐ Proportion of days covered ☐ Medication possession ratio	☐ Partner with payers or pharmacies to obtain prescription fill data ☐ Measure medication adherence: ☐ Proportion of days covered ☐ Medication possession ratio
IMPROVE CLINICAL DECISION SUPPORT AND DATA-DRIVEN CARE PROCESSES	☐ Develop other innovative strategies to improve CDS and data-driven care processes	☐ Develop other innovative strategies to improve CDS and data-driven care processes
INCREASE PATIENT ENGAGEMENT	☐ Develop other innovative strategies to increase patient engagement	☐ Develop other innovative strategies to increase patient engagement

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