Cholesterol/LDL Screening Measure Proposal

Cholesterol Screening in Children

Selective Screening	Medical History Risk Factors[c]	Risk Assessment[d]	Action if Risk Assessment Is Positive
Dyslipidemia (if not universally screened at this visit)	12 through 16 Year Visit • Parent, grandparent, aunt or uncle, or sibling with myocardial infarction, angina, stroke, coronary artery bypass graft/stent/ angioplasty, or sudden death at <55 years in males and <65 years in females. • Parent with total cholesterol level ≥240 mg/dL or known dyslipidemia. • Patient has diabetes, hypertension, or body mass index ≥85th percentile or smokes cigarettes. • Patient has a moderate- or high-risk medical condition.	*Not previously screened with normal results* ***At the 11 through 14 Year Visits,*** *ask the older child or young adolescent* • Do you smoke cigarettes or use e-cigarettes? *Ask the parent* • Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)? • Does your child have a parent with an elevated blood cholesterol level (≥240 mg/dL) or who is taking cholesterol medication? ***At the 15 and 16 Year Visits,*** *ask the adolescent* • Do you have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)? • Do you have a parent with an elevated blood cholesterol level (≥240 mg/dL) or who is taking cholesterol medication? • Do you smoke cigarettes or use e-cigarettes? ***At the 17 through 21 Year Visits,*** *if not universally screened, ask the adolescent or young adult* • Do you have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)? • Do you have a parent with an elevated blood cholesterol level (≥240 mg/dL) or who is taking cholesterol medication? • Do you smoke cigarettes or use e-cigarettes?	Lipid profile

Recommendation Summary

Population	Recommendation	Grade
Children and adolescents 20 years or younger	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for lipid disorders in children and adolescents 20 years or younger.	I

Clinician Summary

Expand All

Population	**Asymptomatic children and adolescents 20 years or younger**
Recommendation	**No recommendation.** **Grade: I (insufficient evidence)**

Cholesterol or LDL screening in Adults

Current USPSTF Recommendation for Adults

Recommendation Summary

Population	Recommendation	Grade
Adults aged 40 to 75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (ie, symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults aged 40 to 75 years. See the "Clinical Considerations" section for more information on lipids screening and the assessment of cardiovascular risk.	B
Adults aged 40 to 75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 7.5% to 10%	Although statin use may be beneficial for the primary prevention of CVD events in some adults with a 10-year CVD event risk of less than 10%, the likelihood of benefit is smaller, because of a lower probability of disease and uncertainty in individual risk prediction. Clinicians may choose to offer a low- to moderate-dose statin to certain adults without a history of CVD when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 7.5% to 10%.	C
Adults 76 years and older with no history of CVD	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of initiating statin use for the primary prevention of CVD events and mortality in adults 76 years and older without a history of heart attack or stroke.	I

Current USPSTF

Screening and Statin Use in Adults Aged 21 to 39 Years

- It found insufficient evidence that screening for dyslipidemia before age 40 years has an effect on either short- or longer-term cardiovascular outcomes.

Adults Aged 40 to 75 Years

- Periodic assessment of cardiovascular risk factors from ages 40 to 75 years, including measurement of total cholesterol, LDL-C, and HDL-C levels, is required to implement screening.
- The optimal intervals for cardiovascular risk assessment are uncertain.
- Based on other guidelines and expert opinion, reasonable options include annual assessment of blood pressure[17] and smoking status[18] and measurement of lipid levels every 5 years.[1]
- Shorter intervals may be useful for persons whose risk levels are close to those warranting therapy, and longer intervals are appropriate for persons who are not at increased risk and have repeatedly normal levels.

Proposed Screening Measure

Denominator = All active patients with UDS medical visit in the reporting period who are 40 – 75 years of age.

Numerator = All active patients with UDS medical visit in the reporting period who are 40 – 75 years of age and have had a lipid screening during the measurement period or fours years prior.

Exclusions = Patients on hospice

Remote Patient Monitoring Data

Discussion Only

Current Issues

- RPM vendors are often not able to integrate data feeds to EHRs
- EHR vendors may not be able to integrate data feeds from RPM vendors
- Built in EHR RPM systems may be difficult for patients to use
- There may be data quality issues in built-in RPM systems
- Monitoring of incoming data to EHR or other platforms may be challenging.

QUESTION for DSIC as experts:

What are reasonable strategies for managing RPM data?

- Human data entry with criteria
- Monthly report in patient documents, RN creates a TE where they enter the high, low and avg for the month. Not currently structured and there is an issue with the dates not being correct. If care escalation they are data entering but they are high.
- Reports in patient docs and data into Relevant
- Can avg be used for quality related reporting?
- Staffing challenges - can we think about how to do this with fewer human resources
- What about a feed into Relevant? Direct feed into E.H.R.? Leverage Healow?
- How do we track billing? CCM patients, how to get the correct dx codes in the E.H.R.
- Consideration for eCW RPM module