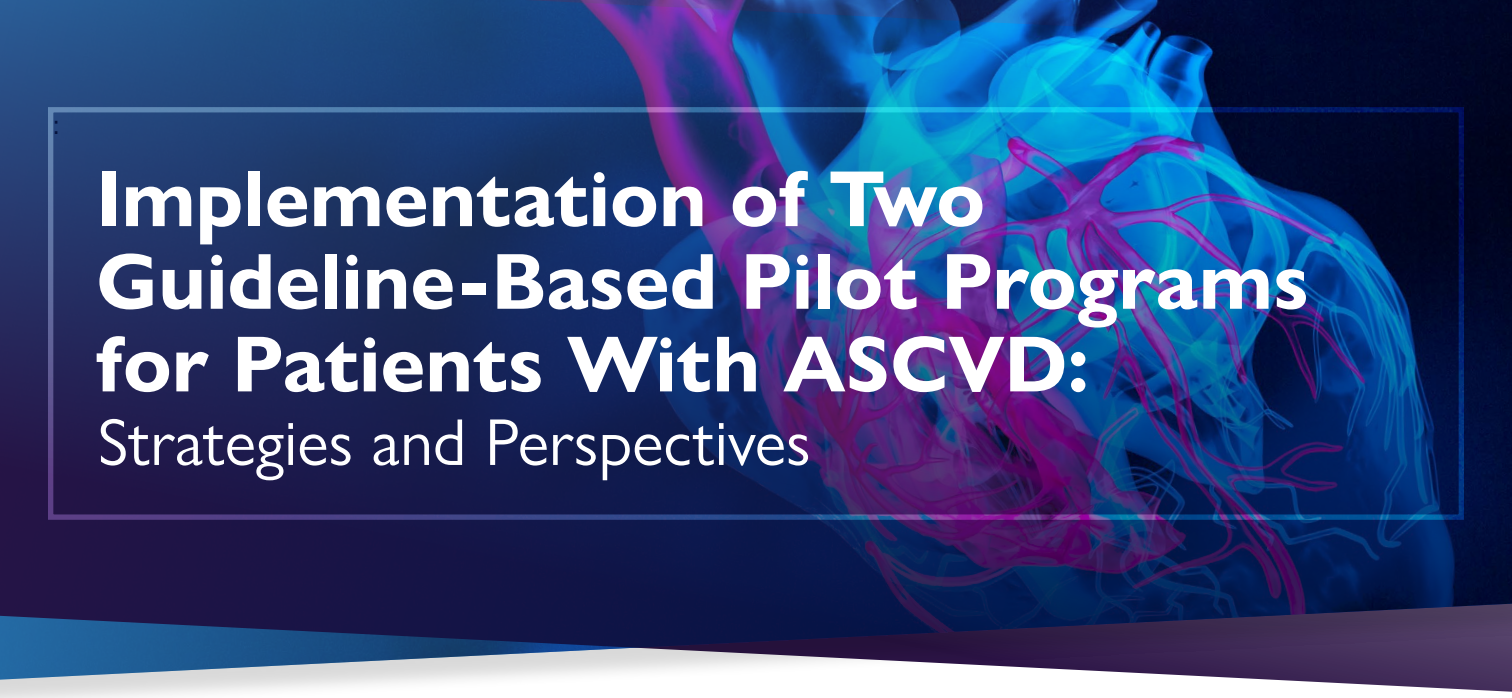


Implementation of Two Guideline-Based Pilot Programs for Patients With ASCVD:
Strategies and Perspectives

Sponsored by: UPMC LIFE CHANGING MEDICINE AMGEN

Key Strategies

The University of Pittsburgh Medical Center introduced two guideline-based pilot programs to improve quality of care for very high–risk patients with ASCVD. Based on their experience, key strategies for successful implementation include:

- working with a multidisciplinary team to develop documentation, training materials, and processes/workflows for the pilot program;
- identifying a physician peer-to-peer champion to educate providers and help ensure that clinicians (eg, cardiologists, APPs) are on board with the goals of the pilot program;
- securing buy-in from leadership at the health system level and having a physician peer-to-peer champion communicate directly with peers to educate participants and gain their buy-in;
- working with a multidisciplinary team that includes a data manager, a clinical pharmacist, and an administrator;
- having infrastructure in place to analyze and use data;
- analyzing data for individual providers and delivering a *report card* with feedback to providers showing their own gaps in care to help foster buy-in;
- developing and implementing a guideline-based checklist for APPs to standardize care during telehealth visits;
- supplying providers with customized guideline-based documented notes and care plan recommendations based on patient history at the point of care to move patients toward a recommended LDL-C level;
- ensuring that the pilot program leadership team is in alignment and meeting regularly to discuss pilot program logistics; and
- integrating aspects of the pilot program into existing communication channels such as the EHR system. Use of the EHR system provides benefits in terms of visibility and timing, as the guideline-based documented notes are available to the provider at the point of care immediately before patient visits.

Background

The 2018 clinical guidelines developed by the ACC/AHA Task Force on Clinical Practice Guidelines recommend that clinicians consider adding nonstatins to statin therapy for those patients with ASCVD who are at very high risk of a CV event* and who have an LDL-C level of 70 mg/dL or more.[1] In 2022, the ACC issued an ECDP that recommended a lower threshold (< 55 mg/dL) for patients with clinical ASCVD who are at very high risk based on clinical data showing that patients with LDL-C levels below 55 mg/dL experienced fewer CV events.[2] Despite the availability of statin and nonstatin drugs to lower LDL-C levels and the release of updated clinical practice guidelines on managing elevated levels, many patients at risk of a CV event consistently fall short of reaching an LDL-C level below the threshold set forth in guidelines and ECDPs.[3] There remains room to improve delivery of guideline-based care to patients with ASCVD.

To help address this gap and improve quality of care, UPMC and Amgen developed and implemented 2 pilot programs for patients with ASCVD. These programs were implemented at select UPMC locations. Pilot program 1 (telehealth visits for post-event patients) was implemented at Presbyterian Hospital and Passavant Hospital, and pilot program 2 (care plan recommendations for patients with chronic ASCVD at very high risk) was implemented at Presbyterian Hospital, Passavant Hospital, and Shadyside Hospital.

In this white paper, the following topics will be discussed:

- **the rationale behind the development and implementation of the pilot programs;**
- **the designs of the pilot programs;**
- **best practices and key learnings for other health systems looking to operationalize such initiatives, including workflow integration and provider engagement; and**
- **stakeholder perspectives and keys to successful implementation of these types of programs.**

About UPMC

Based in Pittsburgh, Pennsylvania, UPMC is a vertically integrated health care provider and insurer that is committed to delivering accountable, cost-effective, patient-centered care. With more than 5000 doctors and 100,000 employees, UPMC operates more than 40 academic, community, and specialty hospitals and has 800 doctors' offices and outpatient sites. UPMC, a recognized innovator in information technology, adopted EHR systems and interoperability solutions to connect these systems early on. UPMC has achieved the highest levels of EHR adoption at its outpatient locations and at more than a dozen of its hospitals.[4]

The UPMC leadership team for the pilot programs included:

- **Aryan Aiyer, MD,** medical director of the UPMC Heart and Vascular Institute Lipid Clinic;
- **Suresh Mulukutla, MD,** vice president and chief data and analytics officer at UPMC;
- **Floyd Thoma,** research data manager at the UPMC Center for Cardiovascular Outcomes and Innovation;
- **Deanne Hall, PharmD, BCACP,** clinical pharmacist at the UPMC HVI Lipid Clinic; and
- **Lisa Henry, DNP, CRNP,** director of heart and vascular services at the UPMC HVI.

Rationale for the Pilot Programs

Consistent with national data,[3] Dr Aiyer and Dr Mulukutla from the UPMC HVI observed that a large proportion of patients with established CV disease were not treated to guideline-recommended LDL-C levels and that available pharmacologic options to reach LDL-C goal were not recommended or implemented. To better understand the scope of the issue across the HVI, Dr Aiyer and Dr Mulukutla evaluated EHR data and found that goal attainment fell short at the population level—a substantial proportion of patients were not at a guideline-recommended LDL-C level.

*Patients with ASCVD at very high risk of a CV event were defined as patients with a history of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions (eg, hypertension, diabetes, chronic kidney disease).[1]

Guideline LDL-C levels were suboptimal across academic and community hospitals, urban/surburban/rural settings, race/ethnicity, and diverse cardiology practitioners. Dr Aiyer and Dr Mulukutla sought to evaluate the reasons why patients do not achieve LDL-C goal and then determine whether intervening and recommending guideline-based care to change physician behavior and improve care standardization would lead to better patient outcomes (ie, attainment of LDL-C goal).

To execute this design, the UPMC pilot program leadership team worked with Amgen in a value-based partnership. There was clear mutual alignment on the goal of improving patient care by developing and implementing a guideline-based intervention.

"There's a lot of support for these initiatives where you can focus on a specific gap in [a] directed way. When you do so, I think people can see the benefit of addressing the deficiency [related to] the clinical care of a patient.

We've done this work for a long time now in other disease areas—identifying gaps in care where we could improve patient treatment and provide care that follows guidelines more closely. We have seen success in implementing guideline-based care in other disease areas. So that formed the basis of our interest in partnering with Amgen in this endeavor. We realized there is an opportunity. What made it even more valuable and exciting was that this isn't something that's particularly unique to our health care institution at UPMC. It's just a snapshot of what really is a national and a global issue—care gaps. We hope the information we can derive through this analysis informs [staff at] other institutions about how they can get the right care to the right patients."

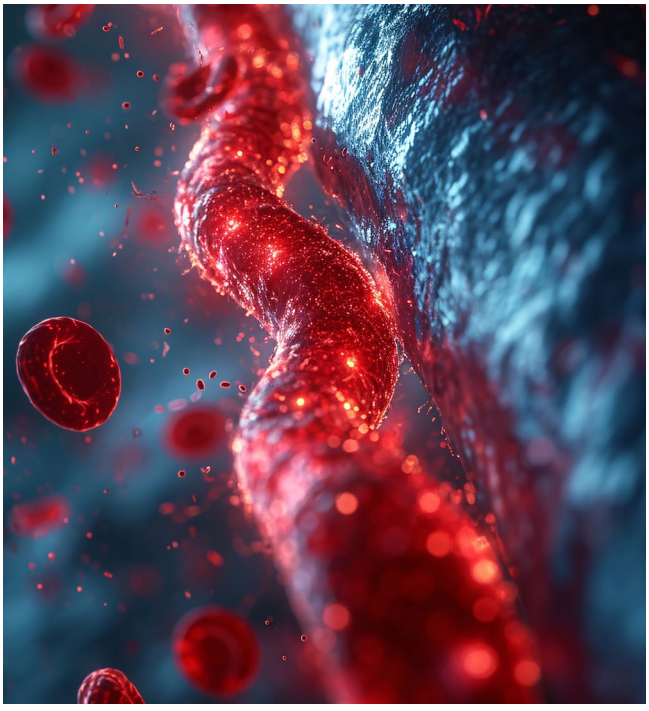
—Suresh Mulukutla, MD, vice president and chief data and analytics officer at UPMC

"Guidelines have been vetted by experts, and [they] take into account clinical trial data. We are really trying to deliver what we think is quality care based on evidence and supported by national institutions. We recognize that there are always going to be exceptions and nuances to care, but it's really important to be able to deliver standardized care. These efforts are really [designed to get providers] to standardize care."

—Aryan Aiyer, MD, medical director of the UPMC HVI Lipid Clinic

"Optimizing patient outcomes is paramount to the mission of the UPMC Heart and Vascular Institute. Collaborating with both internal and external stakeholders is important for achieving our goals."

—Lisa Henry, DNP, CRNP, director of heart and vascular services at the UPMC HVI



Design of the Pilot Programs

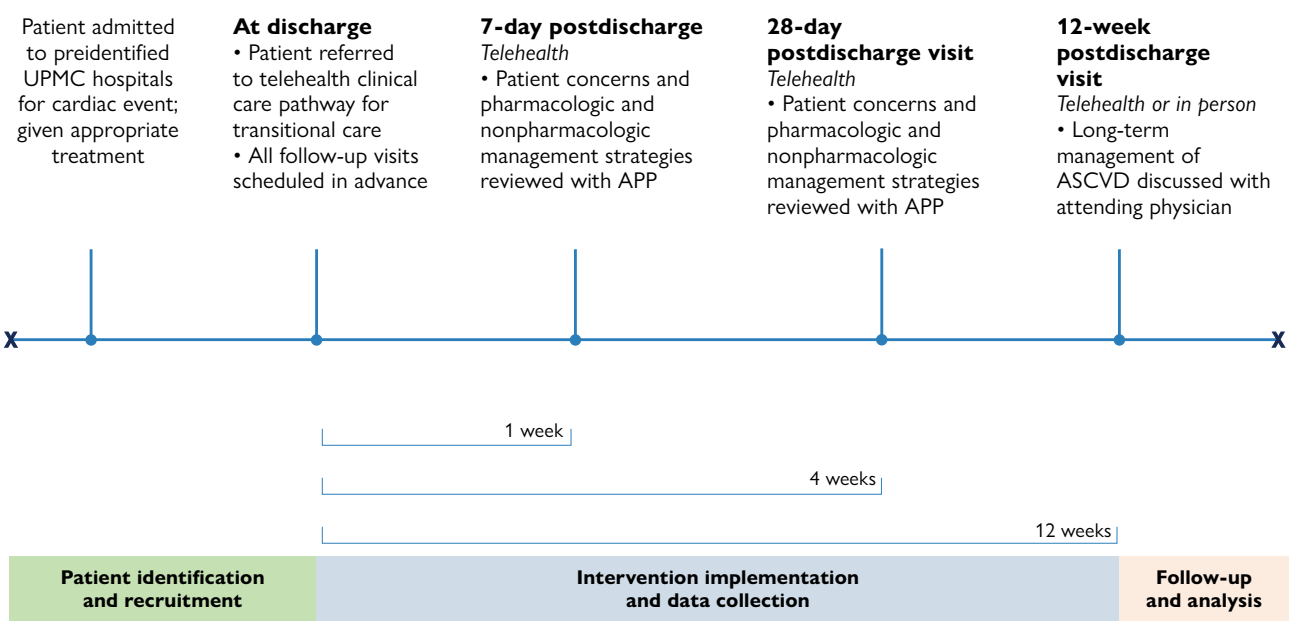
Two pilot programs were developed to address the needs of different groups: (1) patients who experienced a CV event, underwent PCI, and needed follow-up care; and (2) patients with chronic ASCVD who were at very high risk. In pilot program 1, an APP worked directly with post-event patients; in pilot program 2, a clinical pharmacist provided recommendations to a health care provider to help move a very high–risk patient with chronic ASCVD toward a guideline-recommended LDL-C level below 70 mg/dL.*

Pilot Program 1: Telehealth Visits for Post-Event Patients

Pilot program 1 focused on patients who received treatment for a myocardial infarction, unstable angina, or stable angina and underwent PCI (ie, stent placement, revascularization). In this program, an APP worked directly with post-event patients and implemented strategies to achieve a guideline-recommended LDL-C level during telehealth visits. An overview of pilot program 1 is shown in **Figure 1**.

Eligible patients were identified by inpatient providers (eg, cardiologists, fellows, residents, APPs). Before discharge, eligible patients were asked whether they were willing and capable of participating in follow-up visits via telemedicine. Patients who agreed to participate were scheduled for follow-up telehealth visits with an APP at 7 days and 28 days after discharge. These visits were conducted using existing telehealth infrastructure implemented at UPMC at the beginning of the COVID-19 pandemic in 2020.

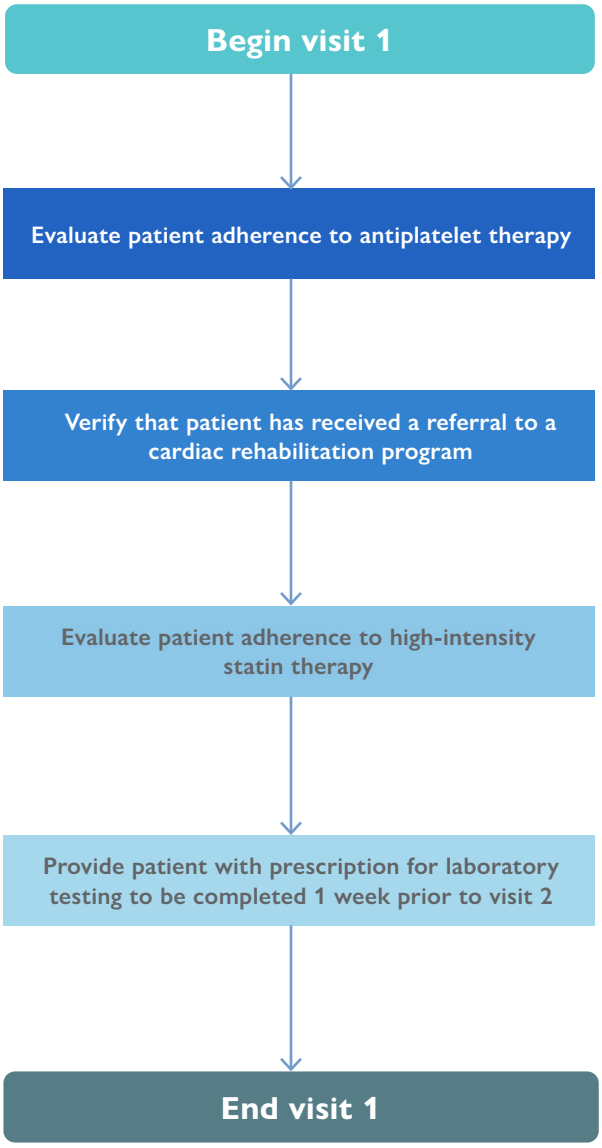
Figure 1. Overview of Pilot Program 1: Telehealth Visits for Post-Event Patients



*An LDL-C threshold below 70 mg/dL was selected for the pilot programs based on clinical guidelines issued in 2018 by the ACC/AHA.[1] In 2022, the ACC issued an ECDP and recommended a lower LDL-C threshold of less than 55 mg/dL for those with clinical ASCVD who were at very high risk.[2] As the pilot programs were already in progress when the ACC ECDP was issued, the decision was made to use an LDL-C threshold below 70 mg/dL for the duration of the pilot programs.

During each telehealth visit, the APP followed a lipid management checklist developed for the pilot program (see **Figure 2** and **Figure 3**). The protocol involved intensifying the dose of statin therapy as tolerated by the patient and then adding nonstatin therapy if needed; the target LDL-C level was below 70 mg/dL. The APP provided patient education, reviewed pharmacologic and nonpharmacologic lipid management strategies with the patient, and addressed any concerns. The APP also could prescribe medications and order laboratory testing during the telehealth visit.

Figure 2. Pilot Program 1: Telehealth Visits for Post-Event Patients—Flowchart for APP Use During Telehealth Visit 1 (Day 7)

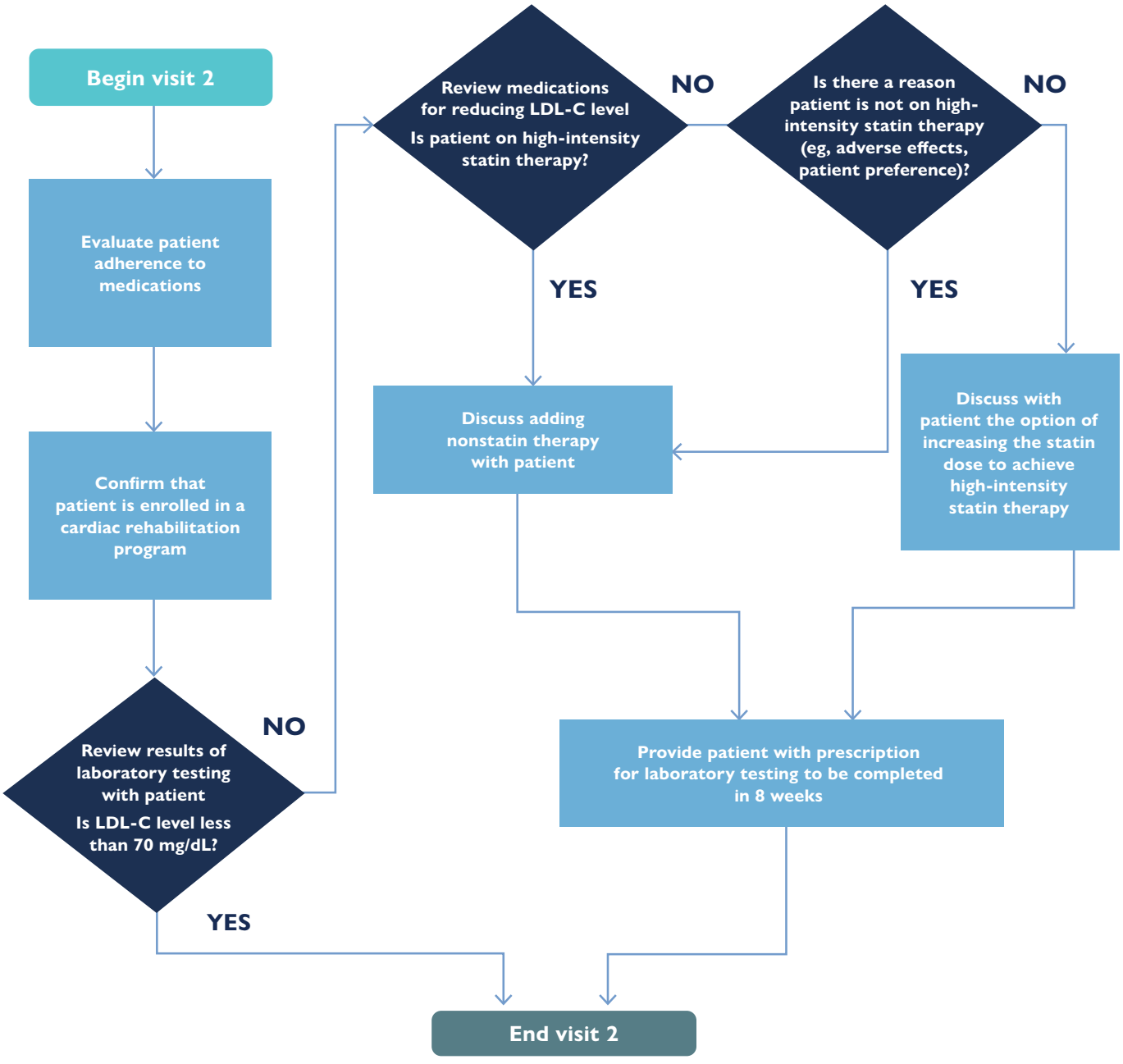


At the first telehealth visit on day 7, the APP reviewed all of the patient's medications and assessed adherence to statin therapy. Patients were asked to complete laboratory testing 1 week before the 28-day visit so that results could be reviewed with the APP. At the second telehealth visit on day 28, if the patient's LDL-C level was not at target, the APP would increase the statin dose or add a second agent if the statin was already being given at the highest dose. Selection of a second agent was made by the patient and APP through shared decision-making after discussing the benefits and adverse events associated with each option. The recommendation was partially guided and influenced by the degree of additional LDL-C reduction needed to attain a goal level below 70 mg/dL.

As the telehealth visits were taking place, the APP collaborated with the patient's primary cardiologist regarding the patient's care. At the 12-week postdischarge visit, which was not part of pilot program 1, the patient would see their primary cardiologist and discuss long-term management of ASCVD. Patient education provided by APPs during the telehealth visits helped to facilitate productive discussions between patients and cardiologists during the 12-week postdischarge visits.

> "We're using advanced practice providers to try to make more optimal use of our workflow and decompress our attending physicians so that they can see other patients rather than deal with issues that could be easily adjudicated by an advanced practice provider within their scope of practice."
>
> *—Aryan Aiyer, MD, medical director of the UPMC HVI Lipid Clinic*

Figure 3. Pilot Program 1: Telehealth Visits for Post-Event Patients—Flowchart for APP Use During Telehealth Visit 2 (Day 28)



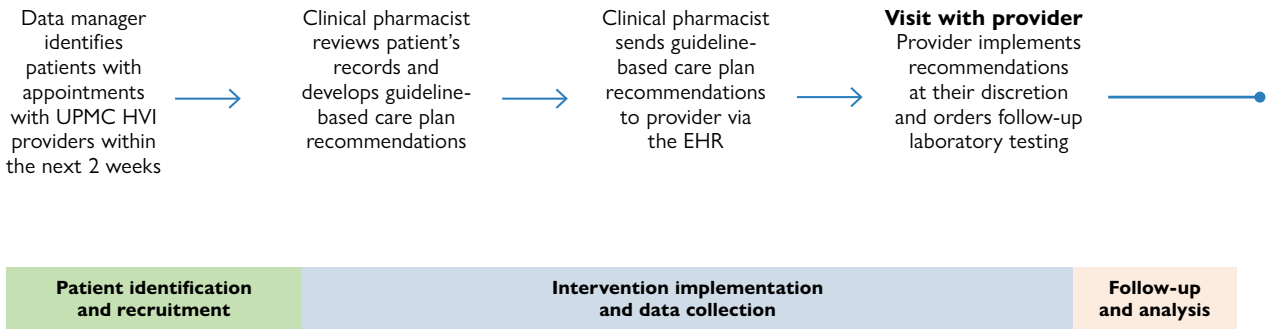
Pilot Program 2: Care Plan Recommendations for Very High–Risk Patients With Chronic ASCVD

Pilot program 2 involved delivering recommendations to providers who cared for very high–risk patients with chronic ASCVD (ie, history of PCI, myocardial infarction, or coronary artery bypass graft surgery) who had not recently experienced a CV-related event; this intervention was intended to help patients achieve a guideline-recommended LDL-C level below 70 mg/dL.* In this pilot program, a clinical pharmacist reviewed a patient's records and provided care plan recommendations to the patient's cardiologist via a documented note in the EHR system. The cardiologist could then implement the recommendations at their discretion. Use of the EHR system provided benefits in terms of visibility and timing, as the guideline-based documented notes would be available to providers at the point of care immediately before patient visits. An overview of pilot program 2 is shown in **Figure 4**.

For pilot program 2, on an ongoing basis, the data manager (Mr Thoma) identified patients who had appointments with UPMC HVI providers within the following 2 weeks and notified the clinical pharmacist (Dr Hall) about very high–risk patients with chronic ASCVD who had an LDL-C level that was not below 70 mg/dL.

Dr Hall then reviewed the patient records and provided guideline-based care plan recommendations to the cardiologist. These care plan recommendations involved intensifying the dose of statin therapy as tolerated by the patient and then adding nonstatin therapy if needed to ultimately reach a target

Figure 4. Overview of Pilot Program 2: Care Plan Recommendations for Providers Treating Very High–Risk Patients With Chronic ASCVD

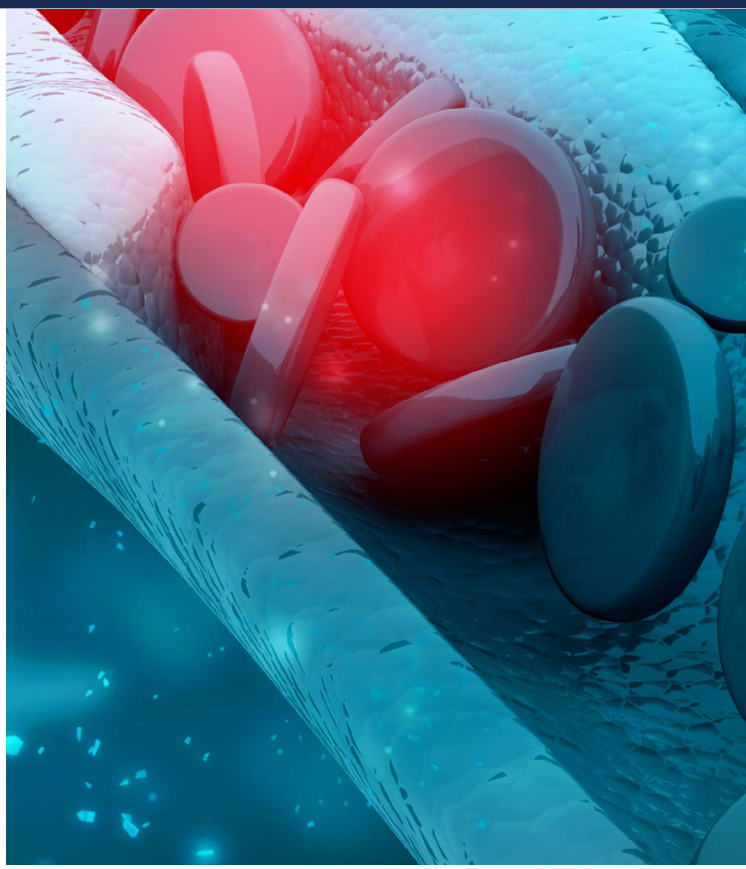


*An LDL-C threshold below 70 mg/dL was selected for the pilot programs based on clinical guidelines issued in 2018 by the ACC/AHA.[1] In 2022, the ACC issued an ECDP and recommended a lower LDL-C threshold of less than 55 mg/dL for those with clinical ASCVD who were at very high risk.[2] As the pilot programs were already in progress when the ACC ECDP was issued, the decision was made to use an LDL-C threshold below 70 mg/dL for the duration of the pilot programs.

LDL-C level below 70 mg/dL. If the patient was not on a statin, Dr Hall would check the chart for a documented reason. If the patient was on a moderate-intensity statin, she would recommend high-intensity statin therapy. If the patient was already on high-intensity statin therapy, she would recommend a nonstatin therapy. Dr Hall's suggestions about which nonstatin therapy to use were influenced by the patient's last known LDL-C level, the amount of further reduction needed to get the level below 70 mg/dL, and the previous medication history. A standard template was developed for providing recommendations to clinicians; Dr Hall used the template as a starting point but customized the messaging to be patient specific.

These recommendations were sent to the provider via the EHR; the provider then could implement the recommendations at their discretion. Dr Hall typically provided clinical recommendations 5 to 7 days before a patient's appointment, which ensured that the information would not get lost in the system and that there was enough time for the provider to consider and act upon the information.

> "[For pilot program 2,] what we were looking at for the existing very high–risk, secondary prevention patients was, if they [were] not at goal, what were the reasons that their therapy couldn't be optimized? And then we offered suggestions, perhaps recommend[ed] pushing the statin dose to high intensity. If they're on a max[imum]-dose statin, are we going to add on another drug at this point? If they're on a statin, can we utilize nonstatin therapies?"
>
> *—Deanne Hall, PharmD, BCACP, clinical pharmacist at the UPMC HVI Lipid Clinic*



Key Strategies

- **Customized guideline-based documented notes with care plan recommendations were provided to providers by the UPMC clinical pharmacist via the EHR system within a few days of a patient's visit. This time frame was not too far in advance that the information might get lost, yet there was enough lead time for the patient's provider to consider and act upon the information at their discretion.**

- **Have documented notes available at the point of care. Aspects of the pilot program were integrated into existing communication channels such as the EHR system. Use of the EHR system provides benefits in terms of visibility and timing, as the guideline-based documented notes are available to providers at the point of care and immediately before patient visits.**

Considerations for Implementation of the Pilot Programs

There were several critical components to the success of the pilot program, including:

- **gaining buy-in at the institution level and from participating providers;**
- **developing clinical materials for providers;**
- **educating clinicians about the pilot programs;**
- **considering administrative planning/logistics; and**
- **analyzing data and involving clinical analytics.**

Gaining Buy-In

The support of UPMC leadership and buy-in from providers were critical to the success of the pilot programs. Dr Aiyer served as the physician peer-to-peer champion and worked with a multidisciplinary team that included a data manager, a clinical pharmacist, and an administrator to gain buy-in and implement the pilot programs.

Dr Mulukutla noted that there was a great deal of support from the UPMC HVI leaders for this type of initiative. At the institution level, there was support that enabled Dr Aiyer and Dr Mulukutla to access all the data needed for the program. The proposal for the program was also reviewed and approved by the UPMC quality review committee. Clinical leaders at the HVI intend to publish the results of the pilot programs in a peer-reviewed journal.

Another key driver of the success of the pilot programs was gaining buy-in from the participating clinical providers. Dr Aiyer and Dr Mulukutla worked together to inform physicians about the pilot program during grand rounds and division meetings. As the physician peer-to-peer champion, Dr Aiyer regularly met with other providers involved in the pilot programs during one-on-one informal meetings and in group settings to ensure that all providers understood the value of the endeavor. Dr Aiyer also provided materials via email; these documents included background reading material and guidelines, a slide deck, and updated reports on the proportion of their patients who had an LDL-C level below 70 mg/dL. Overall, there was considerable support from physicians involved in the pilot programs, which helped the pilot programs run relatively smoothly. This support was gained through the efforts of Dr Aiyer and Dr Mulukutla as they educated their peers throughout the course of the pilot programs.

Key Strategies

- **Ensuring that there is a physician peer-to-peer champion invested in educating peers to gain buy-in.**
- **Sending a *report card* with feedback to providers showing their own gaps in care to foster buy-in.**
- **Collaboration among the physician peer-to-peer champion and a multidisciplinary team that included a data manager, a clinical pharmacist, and an administrator.**
- **The physician peer-to-peer champion also gained buy-in from health system leadership.**

Developing Clinical Materials

Another critical component of the pilot programs was the development of documentation and templates. The physicians (Dr Aiyer, Dr Mulukutla), clinical pharmacist (Dr Hall), and nurse practitioner/administrator (Dr Henry) held several meetings to develop clinical materials and workflows that would provide a framework for assigning roles and responsibilities to various team members and create transparency for providers and patients.

For pilot program 1 (telehealth visits for post-event patients), the guidelines-based checklist was developed and distributed to APPs via email. Dot phrases (ie, short phrases recognized by the EHR

system that expand into longer text [eg, *.ruq* could expand to *right upper quadrant*]) were created and entered into templates in the EHR to help ensure that key points were not missed by clinicians during telehealth visits with patients.

For pilot program 2 (care plan recommendations for very high–risk patients with ASCVD), a standard template was developed for providing recommendations to clinicians. The clinical pharmacist (Dr Hall) reviewed the patient's EHR and provided recommendations to the provider using the template as a starting point but customized the messaging to be patient-specific, so the provider would recognize that this was being handled at the level of the individual patient and that this was not just a *one-size-fits-all* mass mailing.

Key Strategies

- **Documentation, training materials, and processes/workflows for the pilot programs were developed by a multidisciplinary team.**
- **A guidelines-based checklist was developed for APPs to help standardize care during telehealth visits.**
- **A standard template for providing recommendations to clinicians was developed and used; however, documented notes were customized to be patient specific.**

Educating Clinicians

Providing participating clinicians with information and education regarding the pilot programs was key to successful implementation of the pilot programs. Dr Aiyer, the physician peer-to-peer champion, educated clinicians involved in the pilot programs by setting up meetings with individual practices and teams and giving presentations and educational sessions that provided information about the programs' goals, protocols, and workflow. In addition, clinical staff involved in the program received an email with a copy of the 2018 AHA/ACC/Multisociety Guideline on the Management of Blood Cholesterol and reports on the proportion of their patients who had an LDL-C level below 70 mg/dL.

Key Strategy

- **The physician peer-to-peer champion educated providers and helped ensure that everyone (eg, cardiologists, nurses) was on board with the goals of the pilot programs.**

Administrative Planning/Logistics

From an administrative standpoint, planning was needed to ensure that resources were in place to run the pilot programs. Each step of the workflow was assigned to the appropriate team members or providers. No additional HVI providers were added as part of the pilot programs; thus, work had to be redistributed among existing providers. Schedulers and inpatient teams were involved, because time on clinical providers' schedules needed to be blocked out for telehealth visits with patients.

> "Practices need to ensure they have adequate power in terms of workforce to be able to deliver these [pilot programs]."
>
> *—Aryan Aiyer, MD, medical director of the UPMC HVI Lipid Clinic*

> "I think that [pilot program 1] improved the work-life balance of the health care providers, because the advanced practice providers were able to lead telemedicine visits. They were able to do [the visits] remotely, and [they did] not have to be in the clinic."
>
> *—Lisa Henry, DNP, CRNP, director of heart and vascular services at the UPMC HVI*

> "[When implementing a pilot program such as this one], I think it needs to be team based and have a physician champion. When we were doing the planning as part of the team, our input was important to each [member]. So, for example, I was able to help provide the drug algorithm for pilot program 1. For pilot program 2, Lisa [Henry] helped me work out the best way to communicate with the physicians. So, being team based is important for success from, first, the buy-in level, and then also figuring out the processes, because no 1 person on the team knows how all the different parts work within a practice."
>
> *—Deanne Hall, PharmD, BCACP, clinical pharmacist at the UPMC HVI Lipid Clinic*

Key Strategy

- **The leadership team met regularly to ensure alignment, discuss planning and logistics for the pilot programs, and address any concerns or challenges.**

Data and Clinical Analytics

Involving a data manager early in the process and having the infrastructure in place to quickly analyze data were essential to the success of the pilot programs. Historically, Dr Mulukutla noted, a clinician might see an individual patient in the clinic and note that the patient has not achieved the guideline-directed LDL-C level. However, there was no means of quickly identifying all patients within the entire patient population who were not at goal. Current technology allows this type of analysis to be performed very quickly.

Dr Aiyer and Dr Mulukutla described the importance of working with a multidisciplinary team that includes a data manager (in this case, Mr Thoma). Dr Aiyer and Dr Mulukutla collaborated to define patient populations, comorbidities, medications prescribed, and outcomes of interest (eg, blood cholesterol levels). After the parameters were defined, Mr Thoma determined a way to extract the requested variables out of the UPMC clinical data warehouse. This enabled Dr Aiyer and Dr Mulukutla to define the patient population and follow the patient population throughout the course of the pilot program.

The pilot program was conducted using the existing EHR system; no customization or changes to the existing function of the EHR system were required. Data analysis was performed by a statistician within the UPMC HVI under the direction of Dr Aiyer and Dr Mulukutla. Members of the clinical team and the data analytics team worked closely throughout the pilot program and joined biweekly all-team calls to ensure alignment.

For pilot program 1 (telehealth visits), post-event patients were followed during the pilot program, and data from the telehealth visits were recorded in the EHR. For pilot program 2 (care plan

recommendations), a database was created that included the participating very high–risk patients with ASCVD. Data will be pulled from the EHR system after a period of time has elapsed to allow patients to complete follow-up blood testing. These data will be analyzed to determine whether the pilot program interventions helped more patients to achieve the guideline-recommended LDL-C goal.

At the time of this writing, data from the pilot programs are being analyzed. The initial results are quite promising, and key stakeholders are very happy with the results of the 2 pilot programs from both the clinical and process standpoints. They are excited to share the results in an upcoming publication.

"The support of the clinical analytics team was vital to the success of not just this project but to the research efforts of [the departments of] Cardiology and Cardiothoracic Surgery and other departments as well."

—Floyd Thoma, research data manager at the UPMC Center for Cardiovascular Outcomes and Innovation

"The ability to analyze and use data is critical to these [pilot programs]. It's impossible to really conduct these [pilot programs] effectively unless you have really good control of the data, you are able to extract it, and you are able to analyze it and look at it. It's no simple task, and every health care organization needs to spend the time and the resources and [put forth] the effort to build that infrastructure. At UPMC, this was an infrastructure that was 10 years in the making. Only with that [infrastructure] were we able to do this. If someone asked me to do this 10 years ago, I don't think we would have been able to do it."

—Suresh Mulukutla, MD, vice president and chief data and analytics officer at UPMC

Key Strategies

- **Having the infrastructure in place to analyze and use data is extremely important.**
- **A data manager is an essential member of the interdisciplinary team involved in the implementation of these types of pilot programs.**

Stakeholder Perspectives on the Pilot Programs and Key Wins

Members of the clinical team expressed a high degree of satisfaction regarding their involvement with the pilot programs—they enjoyed participating, and they found it to be a very positive experience. Clinical leadership expressed satisfaction in being able both to address an unmet clinical need and to engage with their colleagues as part of pilot programs designed to bring about meaningful change in patient outcomes.

This model of collaboration was successful within the UPMC system. Data currently are being analyzed, and patient outcome results will be available in the near future. From the operational perspective, key wins from the pilot program include driving standardization and addressing a specific gap in care by:

- **using data in a powerful way to clearly identify the needs of patients with CV disease;**
- **designing an actionable plan to drive standardization and address a specific gap in care;**
- **collaborating and communicating with peers across the practice to gain buy-in; and**
- **providing customized outreach to providers at the point of care.**

"This program has several wins. One, we were able to show that we can do telemedicine—it does provide an option to help patients transition postdischarge. We get patients coming in, we have them able to quickly see people and adjudicate a lot of medication compliance/adherence. That, to me, is a huge win, because it is a new tool to address these challenges. The second win, personally, was [that this was] my first real value-based partnership project with industry. I've been involved in regular clinical trials. Patient recruitment has always been challenging and tough in these regular clinical trials. I didn't get as much personal satisfaction [from being involved in regular clinical trials]. This [pilot program] was much more fun. That personal satisfaction piece—I'll take that as a win, as well.

The third win is [that] we were able to really connect with our colleagues in a meaningful way—not just at division meetings or collaborating on individual patients but really engaging them to be a part of a bigger project to try to move our health system in the right direction without hopefully overburdening them….In some cases, [we may have relieved some of the burden] especially with follow-up taken care of by our advanced practice providers. I think the challenge is just trying to get people to move from an accepted workflow to a different workflow and having a team-based approach to vascular disease or ASCVD. I think that just requires a little bit of a change. So that I'll take that as a half win, because I don't think we were completely successful at moving people away from their usual practice. But we engaged them in thinking about things in a different way. So that's always fun to do."

—Aryan Aiyer, MD, medical director of the UPMC HVI Lipid Clinic

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ACC, American College of Cardiology; AHA, American Heart Association; APP, advanced practice provider; ASCVD, atherosclerotic cardiovascular disease; CV, cardiovascular; ECDP, Expert Consensus Decision Pathway; EHR, electronic health record; HVI, Heart and Vascular Institute, LDL-C, low-density lipoprotein cholesterol; PCI, percutaneous coronary intervention; UPMC, University of Pittsburgh Medical Center.

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