



HIGH CHOLESTEROL CLINICAL PANEL

RECOMMENDATIONS FOR HIGH CHOLESTEROL MANAGEMENT IN WISCONSIN
JUNE 2020

This WNA panel developed recommendations designed to identify and treat persons with undiagnosed or uncontrolled high cholesterol through the use of **patient-centered team-based care**.

The experts emphasize the **importance of sustainable linkages between health systems and the community**.

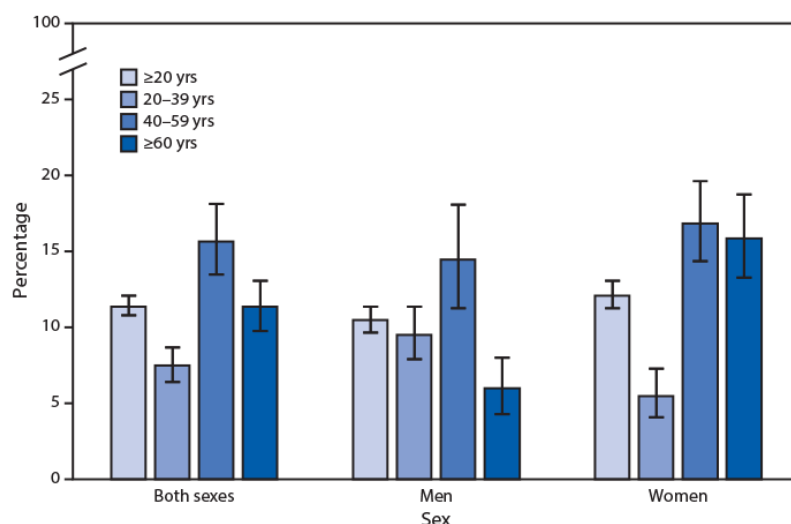


Wisconsin Nurses Association Concepts and Recommendations to Practical Action

Heart disease is the leading cause of death in Wisconsin and the United States (Wisconsin Department of Health Services, 2016). The World Health Organization notes that “Globally, a third of ischemic heart disease is attributable to high cholesterol.”

High Cholesterol in the United States notes that in 2015–2016, more than 12% of adults age 20 and older had total cholesterol higher than 240 mg/dL, and more than 18% had high-density lipoprotein (HDL, or “good”) cholesterol levels less than 40 mg/dL. Slightly more than half of the U.S. adults (55%, or 43 million) who could benefit from cholesterol medicine are currently taking it. 95 million U.S. adults age 20 or older have total cholesterol levels higher than 200 mg/dL. Nearly 29 million adult Americans have total cholesterol levels higher than 240 mg/dL 7% of U.S. children and adolescents ages 6 to 19 have high total cholesterol. High cholesterol has no symptoms, so many people don’t know that their cholesterol is too high. A simple blood test can check cholesterol levels.

Having high blood cholesterol raises the risk for heart disease, the leading cause of death, and for stroke, the fifth leading cause of death. Raised cholesterol increases the risks of heart disease and stroke. The chart below demonstrates the prevalence of high total cholesterol.



Prevalence of High Total Cholesterol* Among Adults Aged ≥20 Years,† by Age Group and Sex —U.S. National Health and Nutrition Examination Survey, 2015–2018 * Defined as serum total cholesterol ≥240 mg/dL.

Addressing high cholesterol in Wisconsin is important for the following reasons:

1. Having high blood cholesterol raises the **risk for heart disease**, the leading cause of death, and for stroke, the fifth leading cause of death. With treatment, this can be prevented.
2. **High cholesterol has no symptoms**, so many people do not know that their cholesterol is too high. A simple blood test can check cholesterol levels
3. Cholesterol travels through the blood on proteins called “lipoproteins.” Two types of lipoproteins carry cholesterol throughout the body: **LDL (low-density lipoprotein), sometimes called**

“bad” cholesterol and HDL (high-density lipoprotein), or “good” cholesterol, absorbs cholesterol and carries it back to the liver. The liver then flushes it from the body.

4. **95 million U.S. adults age 20 or older have total cholesterol levels higher than 200 mg/dL.** Nearly 29 million adult Americans have **total cholesterol levels higher than 240 mg/dL.**³
5. The age-standardized prevalence of self-reported high total cholesterol in WI is 29.9-31.7%
<https://www.cdc.gov/cholesterol/facts.htm>
6. Health care providers have an opportunity to improve upon the identification, treatment and management through patient education and engagement.

In 2017, revised national Cholesterol guidelines were issued by the American College of Cardiology and the American Heart Association, among others. The 2018 guideline is a comprehensive guideline incorporating new information from studies regarding high cholesterol related to the risk of cardiovascular disease. The Wisconsin Nurses Association (WNA) documents provided in this release are consistent with the new national guidelines.

Approach

Starting in 2018 and continuing to the present, WNA has worked with the Wisconsin Department of Health Service’s Division of Public Health, Chronic Disease Prevention Program (CDPP) under funding opportunity No. CDC-RFA-DP-1815 for chronic disease prevention from the CDC, U.S. Department of Health and Human Services. This statewide grant focuses on chronic disease prevention, with an emphasis on the prevention and control of hypertension, high cholesterol, diabetes, and obesity. WNA’s efforts specifically focus on:

- Hypertension prevention, detection, treatment, and control.
- Increased control among adults with high blood cholesterol.
- Improving systems of chronic disease prevention, including community linkages.
- Advancing a Wisconsin-centric model of patient-centered team-based care.

In 2018, the following short-term outcomes of the cooperative agreement were as follows:

- Increased reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of patients with high blood pressure and high blood cholesterol
- Increased use of and adherence to evidence-based guidelines and policies related to team-based care for patients with high blood pressure and high blood cholesterol.
- Increased community clinical links that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol

INTRODUCTION

WNA established two foundational concepts for clinical and community settings to use to improve prevention, detection, and management of hypertension published in 2017:

- 1) [Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model](#)
- 2) [Interprofessional Clinical Hypertension Expert Panel Recommendations](#)

These two concepts were designed to address hypertension but can be applied to other conditions and even preventive initiatives. It was determined that the concepts and model would be applied to

increased control among adults with high blood cholesterol. A clinical panel for high cholesterol was convened on June 5, 2019 utilizing the same methodology that was developed for the clinical hypertension expert panel to determine recommendations. The model was successfully applied.

The concepts also represent a ***call to practical action*** by health systems (herein known as parent organizations) and interprofessional patient health care teams, as well as state and local health departments, institutions of higher education, professional organizations/societies, and others. We strive for systemwide collaboration and partnerships between health systems and communities to accelerate improvements in the prevention, detection, and management of high cholesterol throughout Wisconsin.

CONCEPTS

Concept 1: Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model (WNA, 2016)

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model builds upon the existing and emerging work of many partners in Wisconsin and the nation to foster health care transformation that advances patient-centered team-based care and to move toward value-based care, improved patient health and safety, and improved health of the population. WNA, in collaboration with a community of partners and reviewers, developed the model. The model relies on the dynamic interplay of an engaged patient, three core elements, three influencing factors, and durable linkages and connections to communities.

The Engaged Patient:

- Empowered by the team and parent organization to be active, informed, and engaged
- The central focus of the model
- Aspires to achieve *care by me* and not just *care to me* (Okun et al., 2014)

Core Elements of the Model:

- The parent organization
- The interprofessional health care team
- A diverse workforce

Influencing Factors:

- Core principles and shared values
- Hallmarks of Wisconsin Practice
- Triple (quadruple) Aim of Health Care™

Community Linkages and Connections:

- Mutual investment in durable linkages and connections between health systems and communities is critical. Patients (caregivers, family, and support systems) live, grow, work, learn, and play in communities. Investing in durable connections by health systems contributes to healthy people in healthy communities.

The Interprofessional Clinical High Cholesterol Panel Recommendations focused on two of the core elements: parent organizations and patient-centered health care teams.

Concept 2: Interprofessional Clinical High Cholesterol Expert Panel Recommendations

On June 5, 2019, WNA convened a diverse clinical panel representing health care provider groups with extensive experience in providing frontline care (physicians, advanced practice registered nurses, pharmacists, and registered nurses). Their work was supported by key collaborating organizations, including Wisconsin Department of Health Services-Division of Public Health, Rural Wisconsin Health Cooperative, Preventative Cardiovascular Nurses Association, MetaStar Inc., Pharmacy Society of Wisconsin, University of Wisconsin-Milwaukee - School of Nursing, Sixteenth Street Community Health Centers (FQHC) in Milwaukee, WI, American Medical Society, Million Hearts, University of WI Health, American Heart Association and the WI Community Health Fund (Attachment 1).

As experienced frontline clinicians, the panel possesses expert understanding of both health care systems and patient care. These clinicians work together as interprofessional teams that include other health care team members. The expert panel was charged to develop recommendations to improve systems of care for the prevention, detection, and management of high cholesterol, focusing on the three priority target populations described earlier.

The specific charge to the group was as follows:

- Make recommendations to ultimately inform improvement in the quality and care outcomes for patients with elevated serum lipid levels in Wisconsin as an adjunct to the recommendations of the Hypertension Expert Clinical Panel in November 2017.
- These and subsequent recommendations will be developed into a document that will be shared on the Mighty Networks, social media platform for the Wisconsin Heart Health Community of Practice https://wisconsin-heart-health-cop.mn.co/sign_in, and the Wisconsin Nurses Association, Wisconsin NursesCONNECT, <https://wisconsin-nurses-connect.mn.co/feed> as well as be widely disseminated in Wisconsin and beyond.
- Apply the team-based care model (publication 2016) to the disease process of elevated serum lipid levels.
- Focus on two of the four central elements of the model: team and parent organization.
- Propose recommendations that will foster durable linkages between health systems, public health departments, and community agencies, now and into the future.

The meeting began with a review of the of the 2017 Hypertension Expert Clinical Panel on Recommendations for Management in Wisconsin Using a Team Based Care Approach followed by a presentation of the clinical experience of Pam Myhre, RN, APNP, CDE, Palliative Care Nurse Practitioner, Crossing Rivers Health - Prairie du Chien and co-author, Wisconsin Nurses Association Hypertension Expert Panel Recommendations

Lynne T. Braun, PhD, CNP, FAHA, FPCNA, FNLA Member of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines Writing Committee provided a presentation which reviewed the 2017 changes made for high cholesterol.

The panel was unanimous in its belief that patient-centered teams cannot move toward value-based care and achieve quality metric payment without the leadership and dynamic engagement of parent

organizations and interprofessional patient health care teams.

The resulting work of the panel was the identification of recommendations for identifying, treating, managing and promoting of patient self-care to improve cholesterol outcomes. The panel referred to the recommendations that were identified in the previous WNA PCTBC Hypertension Panel

OVERVIEW OF RECOMMENDATIONS* [**Refer to the Recommendations section for the complete set of recommendations*]

Recommendation 1: Establish a culture of Patient Centered Team Based Care (PCTBC) for the screening and treatment of patients for elevated serum lipid levels to achieve quality outcomes, long term cost reductions to health care systems, and improved population health in Wisconsin.

Utilize the ten 2017 American College of Cardiology/American Heart Association /multiple Medical Societies Clinical Practice Guidelines:

- 1) Emphasize a heart-healthy lifestyle across the life course of individuals.
- 2) In patients with ASCVD, reduce low-density lipoprotein cholesterol (LDL-C) levels with high-intensity statin therapy or maximally tolerated statin therapy.
- 3) In individuals with very high risk ASCVD, use an LDL-C threshold of 70/mg/dL to consider the addition of nonstatins to statin therapy.
- 4) In patients with severe primary hypercholesterolemia (LDL-C level \geq 190 mg/dl, without calculating the 10-year ASCVD risk, begin high intensity statin therapy.
- 5) In patients 40 to 75 years of age with DM and LDL-C level of \geq 70 mg/dl: Start moderate-intensity statin therapy without calculating their 10 ASCVD risk.
- 6) In patients 40 to 75 years of age with evaluate for primary ASCVD prevention: have a clinician-patient risk discussion before starting statin therapy.
- 7) In nondiabetic patients aged 40 to 75 years with LDL-C level of \geq 70 mg/dl, at a 10-year ASCVD risk of \geq 7.5%: Start a moderate-intensity statin therapy if s discussion of treatment options favors statin therapy.
- 8) In nondiabetic patients aged 40 to 75 years with a 10-year ASCVD risk of 7.5 – 19.9% (intermediate risk): Risk-enhancing factors favor initiation of statin therapy.
- 9) In nondiabetic patients aged 40 to 75 years with LDL-C level of \geq 70 -189 mg/dl, at a 10-year ASCVD risk of \geq 7.5 – 19.9%: If a decision about statin therapy is uncertain, consider measuring coronary artery calcium (CAC) levels.
- 10) Assess patient adherence and the percentage response to LDL-C lowering medications and lifestyle changes with a repeat lipid measurement 4-12 weeks after initiation of statin therapy or dose adjustment; repeat every 3-12 months as needed.

Recommendation 2: Allow all team members to practice to the top of license or top of education for non-licensed team members.

Recommendation 3: Establish a system wide principle: All health providers are involved in the prevention, diagnosis, and treatment of elevated serum lipid levels.

Recommendation 4: Improve information technology and the electronic health record DASHBOARD to support efficiencies in care delivery and patient safety.

Recommendation 8: Collaborate with the parent organization and informational technology services to develop registries, dashboards, and other system improvements that work for teams.

Recommendation 9: Acknowledge, disseminate, and celebrate team successes shown to improve efficiencies and effectiveness of operations and patient care.

Recommendation 10: Provide leadership that results in the creation of durable linkages between health systems and communities to improve outcomes related to elevated serum lipid levels that benefit the health of Wisconsin's population through effective partnerships.

CALL TO PRACTICAL ACTION

The foundational concepts have been developed and are ready for practical action.

- **Adopt the Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model**
- **Apply Concepts Beyond Hypertension to High Cholesterol**

These recommendations have the potential to be applied beyond the condition of hypertension to high cholesterol. The electronic health record is the central tool to target population groups within health systems regardless of condition/disease. Team care management can then develop structured systems to improve management and subsequent outcomes of chronic medical conditions. Successful improvement in health system performance and population health outcomes calls for explicit collaboration and shared leadership between parent organizations and interprofessional health care teams. Systems-oriented shared leadership can move us beyond treatment and cure to creating health for patients, populations, and communities.

- **Develop and Sustain Durable Community Linkages**

The recommendations stress the importance of leadership from Wisconsin's health systems to mutually develop and sustain durable linkages with communities and the community organizations that serve those communities. Patients simply do not live in clinics and hospitals; as such, it is critical that the resources of health systems and communities work together. Durable linkages can improve patient access to preventive and chronic care services; enhance health care delivery, public health, and community-based activities to promote healthy behaviors; engage patients to get help to change unhealthy behaviors; and support clinicians to get help for services they cannot provide themselves (Agency for Healthcare Research and Quality, 2016).

Next Steps

On June 29, 2020 WNA will begin statewide dissemination of these recommendations. Our intent is to stimulate dialogue, clarification, and improvement of the recommendations using patient-centered team-based care approaches. We believe this will accelerate implementation and improvement within Wisconsin health systems and our public health system to benefit the people of Wisconsin and the

communities where we live, grow, work, learn, and play.

Acknowledgement and Recognition

WNA expresses its gratitude to the Wisconsin Division of Public Health's Chronic Disease Prevention Program for funding and participating in the development of these recommendations. WNA also expresses its deep gratitude to the members of the Interprofessional High Cholesterol Clinical Panel, collaborating partner organizations, and WNA grant leadership (Appendix 1).

This publication was financially supported by Cooperative Agreement No. CDC-RFA-DP-1815 for chronic disease prevention from the CDC, U.S. Department of Health and Human Services, received by the Wisconsin Department of Health Services, Division of Public Health. Its contents are solely the responsibility of WNA and contributors and do not necessarily reflect the official views of the Centers for Disease Control and Prevention or the Wisconsin Department of Health Services.

The remainder of this document is the demonstration WNA's model that use patient centered team based care in the identification, treatment, management of patients with high cholesterol.

RECOMMENDATIONS

Interprofessional Clinical High Cholesterol Panel

Definitions:

(1) Parent organization:

The parent organization provides leadership and infrastructure, which is a crucial element to accomplishing system transformation that results in organizational culture change. This leadership promotes team and workforce success and positive patient outcomes. In addition, the parent organization is active in connecting health system services to communities to promote health and to build healthy communities. The parent organization has a critical leadership role in creating health for the patients it serves (WNA, 2016).

(2) Interprofessional patient health care team:

The team is prepared, proactive, and strives to achieve a high functionality through knowledge, skills, and attitudes. The team owns and exemplifies a set of adopted team-based principles, processes, and actions. Each patient (family & support system) has a relationship with a team prepared to provide first contact, continuous, and comprehensive care (WNA, 2016).

Recommendation 1. Establish a culture of patient-centered team-based care for high cholesterol prevention, detection, and control - to achieve quality outcomes, long-term cost reductions to health care systems, and improved population health in Wisconsin.

	Parent Organization	Interprofessional Teams
I. Invest in patient-centered team-based care as the delivery standard.		
<ul style="list-style-type: none"> Primary care settings that adopt patient-centered team-based care offer powerful benefits to patients, team members, population groups, and health systems because of the investment in prevention and health promotion. Provide inter-professional education and training with clear definition* of patient-centered team-based care and how team-based care can/will be implemented. 	X	
<p>*“Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated high-quality care” (Mitchell et al., 2012, p. 5).</p>		

	Parent Organization	Interprofessional Teams
<ul style="list-style-type: none"> Work with health care teams and key administrative champions to create buy-in on the benefits of patient-centered team-based care. 	X	
II. Develop and support a culture that holds teams accountable to accurately measure blood cholesterol to provide interventions to patients at every appointment/contact.	X	
III. Create and allow adequate time for educational programs to support continuous learning by all team members. This must include initial training and retraining when there is turnover.	X	
IV. Develop clear expectations for all team members. Measure evaluation of cholesterol for accuracy.	X	
<ul style="list-style-type: none"> Provide leadership to assure licensed professionals and team members practice at the <i>top of license</i> or <i>top of education</i>. Provide consistent patient care at each visit (from check-in to check-out), regardless of available care providers. Follow guidelines for testing frequencies. 	X	X
<ul style="list-style-type: none"> Use protocols for reporting and acting upon elevated cholesterol readings as part of each visit to prevent clinical inertia. Allow sufficient time for staff to educate, coordinate, and engage patient (caregivers/supports). 	X	X
<ul style="list-style-type: none"> Distribute after-visit summaries and patient education materials that are consistent with the patient's culture, health literacy, language, and other accommodating needs. 		X
V. Recognize and disseminate best practices and apply innovations systemwide (including specialty clinics).	X	
VI. Allocate time for regular team meetings to grow, nurture, and develop high functioning teams.	X	
VII. Allocate time for health promotion and disease prevention in support of the Triple (Quadruple) Aim of Healthcare™.	X	

	Parent Organization	Interprofessional Team
VIII. Develop, support, and educate staff in lifestyle and health promotion interventions beyond medication, which includes non-clinical staff. Information must be readily available. Examples include: <ul style="list-style-type: none"> • Food choices • Activity levels • Stress management • Rest/sleep 	X	

Recommendation 2. Allow all team members to practice to their *top of license* or *top of education* for non-licensed team members.

	Parent Organization	Interprofessional Teams
I. Encourage innovation by effectively using all team members. For example: <ul style="list-style-type: none"> • Pharmacist management of first-line medication for cholesterol protocol. • RN assessment of cholesterol lab results at subsequent visits. • Diagnostic (lab) ordering by protocol dependent on medication ordered and patient co-conditions. • Nutritional/Dietary Consultant 		X
II. Allow data entry into the medical record by all team members.		X
III. Refer for patient education and support programs (Self-Management Resource Center, 2017; Wisconsin Institute for Healthy Aging, 2013a, 2013b).		X
IV. Follow-up with patient (caregivers/supports) regarding understanding of educational offerings, including self-management of blood pressure.		X

	Parent Organization	Interprofessional Teams
V. Solicit patient (caregivers/supports) understanding of instructions (after-visit summary):		
<ul style="list-style-type: none"> • Provide information that is health literate. • Provide information by clinical staff. 		X
VI. Incorporate community health workers (CHW) into the team-based care approach. Note. CHWs are important members of the team. They have expertise in home visits, patient teaching, and addressing the determinants of health in the context of the family (e.g., housing, employment, literacy, environment, transportation follow-up appointments, access to nutritious foods).		X

Recommendation 3. Establish a systemwide principle: All health providers are involved in the prevention, diagnosis, and treatment of high cholesterol.

	Parent Organization	Interprofessional Teams
I. Create a time-sensitive system for addressing high cholesterol lab results.	X	X
<ul style="list-style-type: none"> • Patients identified from uncontrolled high cholesterol registry. • Patients referred from specialty providers. • Patients presenting for care unrelated to high cholesterol. 		
II. Develop improvements to:		
<ul style="list-style-type: none"> • Schedule appointments and make referrals. • Facilitate the next step of high cholesterol management promptly, such as modify medication(s); revisit nonpharmacological interventions. 	X	

Recommendation 4. Improve information technology and the electronic health record *DASHBOARD* to support efficiencies in care delivery and patient safety.

	Parent Organization	Interprofessional Teams
I. Create/utilize <i>dashboard</i> alerts for all providers and team members, systemwide.	X	
II. Assure that <i>dashboard</i> alerts allow easy access to: <ul style="list-style-type: none"> • Informational sources. • Guidelines for treatment. • Goals for cholesterol control. • Appropriate medications for treatment. 	X	
III. Establish and provide real-time high cholesterol registries and data flows. <ul style="list-style-type: none"> • Generated by system information technology services for local teams to outreach patients at risk and in need of follow up. 	X	
IV. Assure patients (caregivers/supports) have a plan and method to communicate to their provider.	X	
V. Establish a policy and procedure to incorporate high cholesterol readings into the electronic health record (EHR).	X	

Recommendation 5. Establish systemwide goals to manage high cholesterol using state and national quality metrics.

	Parent Organization	Interprofessional Teams
I. Educate and disseminate evidence-based materials/information beyond medication: <ul style="list-style-type: none"> • Motivational interviewing. • Teach-back processes and protocols. • Nutritional guidance • Physical activity level. • Stress management. • Rest and sleep hygiene. • Avoidance/limiting tobacco use. • Evaluation for other reasons for high cholesterol 	X	X

	Parent Organization	Interprofessional Teams
II. Determine if patient understands the desired goal and range of cholesterol labs.		X
III. Assure every patient (caregivers/supports) can: <ul style="list-style-type: none"> Identify individual goals for results. Recognize out-of-range results. 		X
IV. Refer patients (caregivers/supports) to community education programs and support groups on self-management of cholesterol.		X

Recommendation 6. Establish high cholesterol management teams (at both the health system and community levels) to champion excellence in the prevention and control of cholesterol for patients who are undiagnosed (*hiding in plain sight*) and patients who have uncontrolled hypertension.

	Parent Organization	Interprofessional Teams
I. Actively and regularly manage patient population registries to identify and outreach patients.		X
II. Promote and allow appropriate scheduling time for all team members.		X
III. Schedule appointments and/or labs.		X
IV. Provide advice and counseling.		X
V. Follow up with patients to determine medication changes, as needed.		X
VI. Follow up with patients (caregivers/supports) to provide further education and medication adjustment, as needed.		X
VII. Provide automatic referral through clinical decision support.		X
VIII. Refer patients for self-management education (see Wisconsin Institute for Healthy Aging, 013b).		X

Recommendation 7. Improve communication within and among team members.

	Parent Organization	Interprofessional Teams
I. Hold regular team meetings to discuss strategies for improving patient compliance.		X
II. Consider physical proximity of team members to day-to-day care.		X

	Parent Organization	Interprofessional Teams
III. Incorporate evidence-based and best practices into team-based care.		X
VI. Establish EHR alerts, prompts, and updates to allow rapid interactions within the team and with patients.		X
V. Support and encourage quick changes in therapy by all appropriate team members.		X
VI. Identify patients' health literacy level to support improved adherence.		X
VII. Assess and address issues that may impact the patient's adherence with their treatment plan. <ul style="list-style-type: none"> Use interpreters when English is a second language and for those who are deaf or hard of hearing. Evaluate social, emotional, economic, spiritual, and cultural barriers. 		X
VIII. Review and update registries on a regular basis.	X	X

Recommendation 8. Collaborate with the parent organization and informational technology services to develop registries, dashboards, and other system improvements that work for teams.

	Parent Organization	Interprofessional Teams
I. Apply quality improvement processes to enhance team-based care and patient outcomes. <ul style="list-style-type: none"> Capture metrics at all levels to measure the results of team-based care. Evaluate and assess metrics. Survey staff and patients. Share results of satisfaction surveys with all team members 	X	X

Recommendation 9. Acknowledge, disseminate, and celebrate team successes shown to improve efficiencies and effectiveness of operations and patient care.

	Parent Organization	Interprofessional Teams
I. Schedule time to share results of team efforts <ul style="list-style-type: none"> Report metrics Discuss outcomes and identify strengths and barriers Formulate plans for continued improvement 		X

II. Share results with system leaders and community stakeholders

X

Recommendation 10. Provide leadership that results in the creation of durable linkages between health systems and communities to improve cholesterol outcomes that benefit the health of Wisconsin’s population through effective partnerships. The following listing of practices and processes are examples for Wisconsin health systems to develop and/or enhance community-based linkages and partnerships to prevent and control high cholesterol.

	Parent Organization	Interprofessional Teams
I. Establish clear roles for all team members to assure care coordination with linkages to community resources.		X
II. Explore successes and barriers of existing linkages and partnerships.		X
III. Establish relationships with community-based providers and organizations to support identification and reporting of patients with undiagnosed and uncontrolled high cholesterol.	X	X
IV. Collaborate with and convene health care and community partners to identify potential actions that may include:		
• Partner with local health departments to develop community health improvement plans.	X	
• Collaboratively assess barriers and strengths, including the determinants of health, in support of community health improvement planning.	X	
• Engage discussion groups with community leaders and members to identify barriers to keep communities involved and motivated.	X	
• Recognize and replicate innovations carried out by other organizations and teams.		X
• Offer free on-site blood cholesterol testing within health systems for patients, caregivers, significant others, support persons and visitors.	X	X
• Refer to community educational and support groups on self-management of high cholesterol.		X

- Explore the HUB model for highest risk patients (see HUB Model for High Risk Patients).
- Work with partners to improve care coordination and management systems linked to the community.
- Encourage local employers and businesses to use the Wisconsin Worksite Wellness Assessment (see Resources).
- Demonstrate that the present and future *cost of care* can be reduced with appropriate prevention and control of cholesterol at worksites.
 - *Exercise and physical activity at work.*
 - *Nutrition interventions and education (e.g., eliminating soda dispensers, providing healthy food choices).*
 - *Stress reduction programs at work.* X X
- Involve community agencies, faith communities, health clubs, schools, and other organizations.
- Disseminate evidence-based health literature in regionally appropriate/specific languages.
- Engage key community personnel who can increase access to care coordination for at-risk or high-risk patients and families.
 - Parish and public health nurses.
 - Pharmacists.
 - Behavioral health providers.
 - Community health workers.
- Assure quick, easy, and bi-directional access for referrals (health system to community, community to health system).

V. Expand EHR capability.

- Extend community health care provider access to EHR platforms (e.g., Epic Care Link), thereby improving continuity of care. X X

	Parent Organization	Interprofessional Teams
VI. Assure EHR provides:		
<ul style="list-style-type: none"> • Quick data access. • Rapid appointment scheduling. • Community provider access to shared EHR. 	X	X
VII. Advocate and champion evidence-based educational programs for persons with chronic disease (see Resources for the following).		
<ul style="list-style-type: none"> • Living Well with Chronic Conditions • Diabetes Self-Management Programs • Diabetes Empowerment Education Program • See Resources for additional programs 	X	X

Resources

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model.

<http://wisconsinnurses.org/wp-content/uploads/2016/11/WNA-Publication-TeamBasedCare.pdf>

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model builds upon the existing and emerging work of many partners in Wisconsin and the nation to foster health care redesign that advances patient-centered team-based care and moves toward value-based care, improved patient health and safety, and improved health of the population.

Behavioral Health and Motivational Interviewing:

- Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. **A meta-analysis of motivational interviewing: Twenty-five years of empirical studies.** *Research on Social Work Practice, 20*(2), 137-160. doi:10.1177/1049731509347850
- Michie, S., Ashford, S., Sniehotta, F. F., Dombrowski, S. U., Bishop, A., & French, D. P. (2011). **A refined taxonomy of behaviour change techniques to help people change their physical activity and healthy eating behaviours: The CALO-RE taxonomy.** *Psychology & Health, 26*(11), 1479-1498. doi:10.1080/08870446.2010.540664
- VanBuskirk, K. A., & Loebach Wetherell, J. (2013). **Motivational interviewing with primary care populations: A systematic review and meta-analysis.** *Journal of Behavioral Medicine, 37*(4), 768-780. doi:10.1007/s10865-013-9527-4

Resources (including evidence-based) to Improve Cholesterol Levels and Prevent Clinical Inertia:

For Clinicians

- **2018 ACC/AHA/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol.**
These updated guidelines provide additional specificity to the 2013 recommendations, reinforce the need for appropriate-intensity statin therapy among people at risk of having an ASCVD event and emphasize the importance of patient–clinician shared decision making.
- **ASCVD Risk Estimator**
This risk estimator calculates the estimated 10-year and lifetime ASCVD risk among patients without ASCVD.
- **FH Foundation Familial Hypercholesterolemia Diagnosis, Management, and Family Screening**
This clinical resource provides information about the diagnosis and management of familial hypercholesterolemia.
- **CDC Cholesterol Communications Kit**
These social media messages and graphics can help your patients understand what cholesterol is and why managing cholesterol is important for reducing the risk of cardiovascular disease

- **HUB Model for High Risk Patients:** <http://www.cjaonline.net/pathways-community-hub-model-of-care-coordination/>
Note: The Pathways Community HUB Model is a care coordination system that aids community health workers (CHWs) and care coordinators to find those at risk, treat the whole person with evidence-based care, and measure the progress and outcomes of individuals and communities. In Milwaukee, Dane, Rock, and La Crosse counties, communities have begun use or are exploring use. The Pathways Model utilizes best practices, a payment-for-outcomes process, and services that successfully identify, provide services coordination, and measure for families in at-risk neighborhoods. The process and software are unparalleled in the community health industry. Learn more about the Pathways Community HUB Model at: <http://carecoordinationsystems.com/> or <https://pchcp.rockvilleinstitute.org/>

For Patients

- **The Scoop on Statins: What Do You Need to Know?**
 This Q&A helps people with high cholesterol understand not only the importance of taking a statin for heart attack and stroke prevention but also the facts about side effects.
- **Cholesterol**
 CDC's cholesterol web section contains plain language information for patients, including what cholesterol numbers mean and healthy lifestyle changes that can help lower cholesterol.
<https://www.cdc.gov/cholesterol/index.htm>
- **Mayo Clinic Statin Choice Decision Aide**
 This resource helps patients and their doctors discuss how they might want to reduce risk for heart attacks.
<https://statindecisionaid.mayoclinic.org/index.php/site/index>
- **Cholesterol and Statins**
 This infographic from the Food and Drug Administration helps explain cholesterol basics.
<https://www.fda.gov/drugs/drug-safety-and-availability/cholesterol-and-statins-infographic>
- **Familial Hypercholesterolemia**
 This infographic from the FH Foundation helps explain more about this condition.
https://thefhfoundation.org/media/FamilialHypercholesterolemia_Infographic_8.5x11_2016.pdf
- **Cholesterol Patient Tools and Handouts.**
 The Preventive Cardiovascular Nurses Association has developed these Cholesterol handouts for nurses and other health care providers to use with patients. <https://pcna.net/clinical-resources/patient-handouts/cholesterol-patient-tools-and-handouts-3/>

Other Resources

- **Million Hearts:** <https://millionhearts.hhs.gov>
- **Wisconsin Institute for Healthy Aging,** <https://wihealthyaging.org/living-well>
- **Chronic Disease Self-Management Programs (Stanford)**
<https://www.ncoa.org/healthy-aging/chronic-disease/chronic-disease-self-management-programs/#intraPageNav0>

- **The Lake Superior Quality Innovation Network – Representing Michigan, Minnesota and Wisconsin – Diabetes Empowerment Education Program.**
http://www.whcawical.org/files/2016/07/LSQIN_B2_DEEP_flier.pdf
- **Wisconsin Worksite Wellness Assessment,** <https://www.dhs.wisconsin.gov/physical-activity/worksite/kit.htm>

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