From the National Cardiovascular Alliance:

Dyslipidemia Master Class Toolkit

MAKE well KNOWN FOUNDATION

National Minority Cardiovascular Alliance

MAKE well KNOWN FOUNDATION

The Make Well Known Foundation is a 501(c)(3) charitable organization focused on supporting the health of minority and underserved communities. We collaborate with a range of not-for-profit, government and commercial institutions to activate solution-oriented initiatives that reach into at-risk communities and empower people to cultivate better health.

National Minority Cardiovascular Alliance

An initiative of the MWKF, the National Minority Cardiovascular (NMC) Alliance, is an organization committed to eliminating minority cardiovascular health inequities. Our work considers the influence of culture, genetics, and social determinants on cardiovascular health.

Master Class on Dyslipidemia

Addressing communication barriers about dyslipidemia among clinicians and patients in minority communities

This Master Class was developed not to add to the ever increasing number of visit checklists, but as a method of effectively communicating with patients with dyslipidemia that results in increased patient understanding and medication adherence.

This communication framework was originally developed by the Camden Coalition of Healthcare Providers as a set of techniques and tools for care management. A foundation of this framework is the relationship between the clinician and the patient, enabling the dyad to effectively work together and attain behavior change towards long-term health management. Based on the successful implementation in intesnsive care management settings, the NMC Alliance has adapted to the dysipidemia space for this project.

This toolkit will provide care teams with tools to support minority patients with dyslipidemia. To best utilize this strategy, the whole care team - (receptionists, medical assistants, nursing staff, Nurse Practitioners, Physicians, and anyone else who touches patients during a visit) would benefit from viewing the x minute training module.

How to use the Master Class

- View the 33 minute video to hear the results of patient and clinician interviews and the resulting best practice recommendations: [link]
- Review this toolkit for additional resources
- Discuss implementation as a care team (see page 4)

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Considerations for Implementation

The research that supported this toolkit demonstrated that a better understanding of dyslipidemia is required by minority patients, including risks associated with the condition and the safety profile of drugs used to treat. Patients need information from their clinicians to fill the information gaps.

The Master Class program was developed to create a standardized conversation guide to increase patient understanding of dyslipidemia and encourage adherence to prescribed medications. It presents a communication model – COACH – to be used by clinicians and their staff in order to support patients in their journey for control of dyslipidemia. It is an easy to use roadmap that guides the information to be shared in an efficient, digestible, culturally appropriate way.

This communication model provides multiple benefits to clinicians and practice staff:

- It adheres to the tenet of shared decision making. CMS is mandating that shared decision making occur in several areas and utilizing this model ensures readiness as the mandate expands.
- It takes into account value-based care and a focus on outcomes. Patient understanding of their condition and adherence to their medication regimen are key contributors to good outcomes.
- It allows all individuals who are part of the practice staff to contribute. This ensures that the clinicians are not overwhelmed with additional tasks and that the essential information is distributed among those who can best deliver the message.
- As the use of telehealth increases, the model can effectively be applied in various settings to deliver the required information.

This proven communication model is one we believe can be effectively adaptable to almost any practice in any setting.

The COACH Model

C — CONNECT Tasks with Vision and Priorities

-Patient's health literacy -Patient's goal for intervention
-Patient's long-term vision for self

O — OBSERVE the Normal Routine

-Patient's strength, level of need, awareness of resources

A — ASSUME a Coaching Style

-"I do" "You do" "We do"

C — CREATE a Backwards Plan

-Begin with a discussion of ideal outcomes, and work backwards on steps to achieve

H — HIGHLIGHT Progress with Data

-Use appropriate language when praising patient on progress
-Focus on progress, not person

Connect tasks with priorities

I. Talk about patient's overall vision and goals for health

II. Explain where/how dyslipidemia fits in

III. Ensure patient understands connection between dyslipidemia and CV risks

Patient Focus Group Finding:

"If patients do not feel symptoms of high cholesterol, there is an aversion to taking medication; once providers explain the risks, patients are more adherent."

COACH

Tip: Use reflective, emphatic language and open-ended questions to understand what the patient's goals are. Reflect on the patient's short term and broader vision to motivate through the intervention.

Observe the normal routine

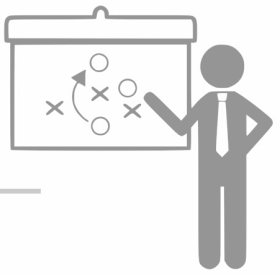
- Meet the patient where he/she is
- Observe the patient without intervention or judgement and ask open-ended questions to understand how the patient manages his/her health condition, as well as social issues and barriers
- Build on systems the patient already has in place, ensure the prescription/adaptations fit into current normal routine

COACH

Don't forget:

Make sure you understand the patient's level of health literacy, need, and awareness of resources

A Assume a coaching style



01 Understand how to best communicate with each patient

02 Choose a coaching style, for example, "I do," "we do," "you do"

03 Model behavior based on patient's health literacy and existing supports

04 This better equips patients with relevant skills to achieve long-term goals

COACH

I Do, We Do, or You Do

After observing the normal routine...

I Do: The clinician does this task because he/she has assessed the patient is not currently able to because he/she has never done it before, the task is complicated, or the patient is in a fragile state with limited/no support

We Do: The clinician and patient do this task together, the patient performs what he/she is comfortable doing, and the clinician fills in the gaps

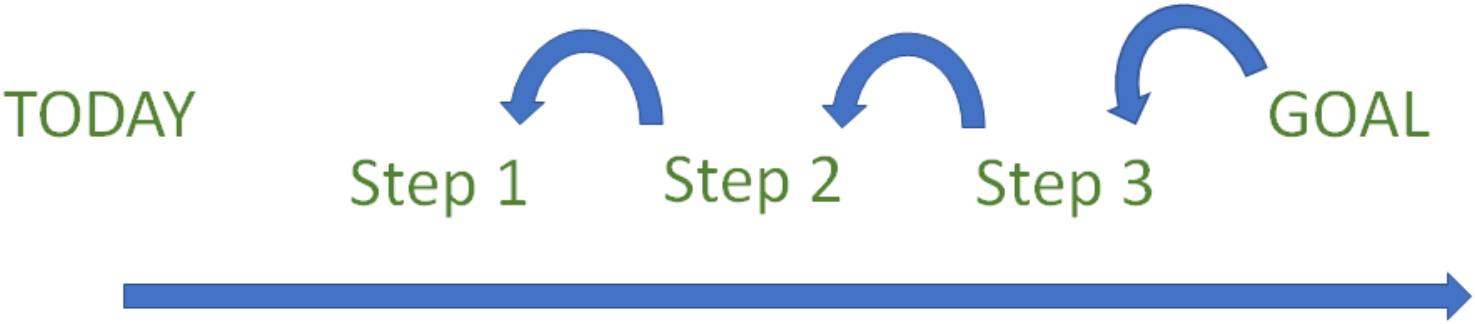
You Do: The patient does this task by his/herself because the dyad has concluded the patient is comfortable doing so. Reinforce patient's ability to do the task.

Create a backwards plan

- Use motivational interviewing to conduct an active conversation with the patient to develop a care plan based on the patient's priorities and identify the steps necessary to achieving long- and short-term goals.

- Develop a care plan based on the patient's priorities and work backwards to identify the steps necessary to achieving goals.

COACH



H Highlight progress with data

- Monitor the patient's progress and process with repeat test results and communicate progress over time

- Focus on efforts, as well as outcomes
- Consider appropriate language to use when praising patient on progress (focus on the process, not the person)

COACH

Utilize the backwards plan to assist patients in visualizing and tracking what they have accomplished over the course of the intervention

Dyslipidemia treatment options

Along with living a heart-healthy lifestyle, patients may be prescribed medication in order to manage blood cholesterol

Commonly used medications are listed below. Click on the medication name to view prescribing information.

Statins

atorvastatin

rosuvastatin

ACL inhibitors

bempedoic acid

bempedoic acid + ezetimibe

PCSK9 inhibitors

evolocumab

alirocumab

Treatment

Accessing helpful tools and resources

1. CardioSmart

CardioSmart is the patient education and empowerment initiative brought to you by the American College of Cardiology. The mission of CardioSmart is to help individuals prevent, treat and manage cardiovascular disease.

www.cardiosmart.org

2. Centers for Disease Control & Prevention's Cholesterol Resources for Health Professionals

Health professionals have many opportunities to educate others. To support that effort, CDC's Division for Heart Disease and Stroke Prevention has put together two sets of educational materials. One set is for patients, and another set is for professionals.

https://www.cdc.gov/cholesterol/materials_for_patients.htm

3. American Heart Association

Interactive cholesterol tools and treatments for patients and providers.

https://www.heart.org/en/health-topics/cholesterol/cholesterol-tools-and-resources

Acknowledgements

Master Class Faculty

Latha Palaniappan, MD, MS
Professor of Medicine (Primary Care, Population Health, and Health Research & Policy)
The Stanford University Medical Center

Fatima Rodriguez, MD, MPH
Assistant Professor of Medicine (Cardiovascular)
The Stanford University Medical Center

Kevin Lindsey Thomas, MD
Associate Professor of Medicine
Duke University School of Medicine

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