I have no conflicts of interest to disclose
Learning Objectives

- Identify and address opportunities to streamline clinical recommendations across related guidelines.
- Avoid inconsistency in recommendations across related guidelines.

Kaiser Permanente: Largest Non-Profit Health Care Program in the United States

- Founded in 1945
- 8 regions in 9 states and District of Columbia
- 8.7 million members
- 14,000 physicians
- 160,000 employees
- KP Care Management Institute (CMI)
- KP National Guideline Program (NGP)
Integrated Cardiovascular Health (ICVH)

- Program started by CMI in 2008
- Integrate primary prevention, secondary prevention, & treatment
- Medication management
- Lifestyle modification
- Reduction of global CV risk

KP CVD-related Guidelines

- CAD, DM, HTN, Dyslipidemia
- Increased scope of individual guidelines
- Problems:
  1. Inefficiencies
  2. Inconsistencies
  3. Gaps
  4. Out-of-scope issues
KP CVD-related Guidelines

Inefficient to maintain 4 guidelines

- Literature review by > 1 GDT (several recommendations & problem formulations occur in > 1 guideline)
- Considerable rework as GDTs attempt to resolve recommendation differences across guidelines
- No single source of all relevant recommendations focused on CVD reduction (must access > 1 guideline)
Inconsistencies between guidelines

- **CAD**
  - *Increase intake of n-3 (omega-3) polyunsaturated fatty acids to a level of ~ 1 g/day from a variety of sources (flaxseed, canola, and soybean oils, nuts, fish, and fish oil supplements).*

- **Dyslipidemia**
  - *Fish oil supplements (~1 g/day of eicosapentaenoic acid/docosahexaenoic acid [EPA/DHA]) are optional for post-myocardial infarction patients for the purpose of reducing CAD events.*

Gaps needing to be addressed

- No comprehensive risk reduction guideline for CVD
- Co-morbidities not fully addressed
- Definitions of CAD, DM, and dyslipidemia not explicitly stated
Out-of-scope issues

- ASA [HTN, Dyslipidemia]
- Omega 3 Fatty Acids [CAD, Dyslipidemia]
- Alcohol [CAD, Dyslipidemia]
- Hormone Therapy [CAD]
- Depression [CAD, HTN]
- hsCRP [Dyslipidemia]
- Therapeutic Lifestyle Changes [Dyslipidemia]

Solution: ICVD Risk Reduction Guideline

- A recommendation on a given topic will be addressed only once.
- Will ensure that all relevant GDT members review the same literature at the same time.
- This guideline will be the comprehensive primary and secondary prevention guideline for CVD.
- Disease-specific guidelines will be reconstituted from the relevant problem formulations (ICVD Guideline + disease-specific topics).
ICVD Risk Reduction GL

Scope

Patient Population

Guideline Development Teams

Clinical Recommendations

ICVD RR

Guideline

ICVD Evidence Grid

### ICVD Evidence Grid

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Established CAD</th>
<th>Outcomes: CAD, CVA/TIA, PAD, AAA, EKD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td></td>
<td></td>
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<tr>
<td>6. Use of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Aspirin</td>
<td>YP</td>
<td>DPTCB</td>
</tr>
<tr>
<td>b. Other antiplatelet agents</td>
<td>YP</td>
<td>PC</td>
</tr>
<tr>
<td>7. Use of ACE inhibitors in those not of childbearing age</td>
<td>YP</td>
<td>YP</td>
</tr>
<tr>
<td>8. Use of ARBs in those not of childbearing age</td>
<td>YP</td>
<td>YP</td>
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<tr>
<td>9. Beta Blockers</td>
<td>YP</td>
<td>YP</td>
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<tr>
<td>10. Use of Statins in those not of childbearing age</td>
<td>YP</td>
<td>YP</td>
</tr>
<tr>
<td>11. Third-line treatment (statins)</td>
<td>YP</td>
<td>YP</td>
</tr>
<tr>
<td>12. Second-line therapy (Niacin)</td>
<td>YP</td>
<td>YP</td>
</tr>
</tbody>
</table>
A work in progress…

- Incorporating GRADE methodology
- External producers of systematic reviews
- Systematic review data repository
- Prioritization and updating of problem formulations/clinical recommendations

Discussion

- Do you have any experience working on this type of cross-guideline integration that you would like to share?
- Questions?

craig.w.robbins@kp.org