



The Annenberg Academy for Team-Based Care

Interprofessional Care of Patients with Hyperlipidemia

MANAGING PATIENTS WITH HYPERLIPIDEMIA: KEY CONCEPTS

Atherosclerotic cardiovascular disease (ASCVD) remains the most common cause of morbidity and mortality in the United States.¹ Low-density lipoprotein cholesterol (LDL-C) is a key modifiable risk factor for ASCVD and the primary lipid target for most patients with hyperlipidemia.² Beyond LDL-C, a variety of risk-enhancing factors contribute to a patient's risk of ASCVD.² A statin is the cornerstone of pharmacologic treatment, but the addition of nonstatin therapy is often required to reach a patient's individualized lipid goal. Key concepts to keep in mind when managing patients with hyperlipidemia are:

- Traditional ASCVD risk factors and the more recently proposed risk-enhancing factors are important to utilize for individual patient risk stratification and overall ASCVD risk assessment.^{2,3}
- ASCVD risk prediction has limitations and challenges, particularly in older adults.⁴ However, incorporating validated risk assessment tools, including the 10-year ASCVD risk calculator and common imaging modalities (e.g., coronary artery calcium), into risk stratification, can better inform shared decision-making between patients and clinicians.^{2,3}
- The 2018 ACC/AHA Multi-Society Guideline on the Management of Blood Cholesterol has categorized patients with clinical ASCVD as 'not at very high-risk' or 'very high-risk'.²
- Elevated lipoprotein a [Lp(a)] is the most common genetic dyslipidemia, affecting approximately 20% of the global population, and is considered an independent, linear, and causal risk factor for ASCVD and calcific aortic stenosis.^{2,3,5,6}
- The 2022 ACC Expert Consensus Decision Pathway on the Role of Nonstatin Therapies Guidelines recommended aggressive LDL-C reductions to optimal levels <55 mg/dL, with levels exceeding this considered a threshold to consider additional therapy.³
- Risk stratifying patients with clinical ASCVD as 'not at very high-risk' or 'very high-risk' is essential to determine lipid treatment/targets and improve outcomes.^{3,7}
- If patients with clinical ASCVD receiving maximally tolerated statin therapy and ezetimibe are not at treatment goals, consideration can be given to adding a PCSK9 monoclonal antibody, bempedoic acid, or inclisiran.³

- Clinical inertia and other barriers to initiating and maintaining nonstatins are common. Various clinical strategies can be implemented to navigate the prior authorization process to optimize prescribing and treatment access.^{8,9}

INTERPROFESSIONAL COLLABORATION: PRINCIPLES

For the evolution in treatment to be of optimal benefit to patients, comprehensive strategies for choosing, delivering, monitoring, and modifying therapy have become especially important. As a consequence, care is typically provided by an interprofessional, multidisciplinary care team that extends beyond physicians to include nurses, nurse practitioners, pharmacists, physician associates, social workers, and others, often involving collaboration between providers in community and academic settings.

To that end, the following reflects a conversation among 3 healthcare professionals about interprofessional care and how collaborative practices and teams can strengthen our health systems.

Christopher Flores, MD: In medical school, I was taught that the patient-doctor relationship was the most critical and important dynamic in healthcare. But after 30-plus years in clinical care, I can attest that healthcare is a team sport and we deliver care in teams of individuals with different training, different skills, different talents. And we teach each other, we learn from each other, we brainstorm and solve problems to meet the needs of the patient.

I want to make a point that interprofessional refers to clinicians in different professions, such as nurses, nurse practitioners, pharmacists, physicians, and physician associates. Multidisciplinary refers to clinicians in different specialties or sub-specialties, such as cardiology, dermatology, and oncology. LaTosha, do you want to talk about interprofessional collaboration?

LaTosha Mollette, DNP: The World Health Organization defines interprofessional collaboration as when multiple healthcare workers from various backgrounds work together with patients, families, and communities to provide the best healthcare possible.¹⁰ This is exactly what teamwork should look like, but it is important to remember that healthcare teams can vary from patient to patient.

I work in a rural setting, working together with various healthcare professionals to improve access to needed



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healthcare services, which helps to prevent unnecessary delays in care and treatment. Ultimately, working together as a team helps to meet the needs of others to improve health outcomes, patient care, and safety.

Christopher Flores, MD: I think all of us in healthcare are trying to figure out how to do things better, make life easier for ourselves, and make everybody happier, patients, our staff, and ourselves, to make things more sustainable. Interprofessional collaboration can accomplish this. There's a growing body of literature that shows that interprofessional collaboration can improve patient outcomes, acceptance of treatment, and satisfaction.¹¹⁻¹⁴ It can decrease costs, improve efficiency, reduce disparities, improve health equity, and make things more sustainable for providers.^{11,15-22}

The Interprofessional Education Collaborative has identified 4 behavioral competencies for effective interprofessional collaboration: 1) roles and responsibilities; 2) values and ethics; 3) communication; and 4) teams and teamwork.²³ Michael, do you want to talk a little bit about the roles and responsibilities?

Michael Smith, PharmD: Certainly, it's one of these things that we don't often think about, but it's important for 2 reasons. One, understanding our own responsibility and roles that we have within our team and what our teammates can expect from us in terms of what we can deliver to them and deliver to patients.²³ The other is understanding what your team can do for you as well, so that you understand their educational background and you can help them practice at the top of their license by utilizing their skillset to the fullest extent.

It is increasingly common for clinicians, even those within a profession, to take different educational and practice paths leading to clinical practice. As an example, there are various differences in training a pharmacist. Nowadays, all pharmacists graduate with a Doctor of Pharmacy degree (PharmD), but some of us have done 1 or 2 years of residency training or postdoc fellowships. So, getting to know your teammates and what you can expect from them and what they can expect from you can really help your team function at a high level.

Christopher Flores, MD: We talk about values and ethics as well.²³ In medicine, we're constantly required to make very difficult and complicated treatment decisions for our

patients. We really are missing a great opportunity if we don't involve the opinions of all the members of our team. What does the nurse think about this plan or what does the social worker who has talked to the family members think about this plan? Or what does the physical therapist think, who has been working with the patient for the last 3 days? LaTosha, what do you think about communication?

LaTosha Mollette, DNP: Communication is essential in everything we do, and it's how we're able to effectively achieve goals, as well as improve relationships and interactions with others.²³ The healthcare system is often described as being fragmented with little communication and collaboration, but when healthcare professionals communicate responsibly and respectfully, this allows them to overcome differences and work together to accomplish a shared goal, including learning from each other, to better improve patient outcomes and safety.^{16,24-26}

Christopher Flores, MD: We're talking a lot about teams and teamwork. Michael, do you have any other points you want to make about teamwork?

Michael Smith, PharmD: Most of us are members of various teams during the course of a typical day. Think about the team members that you work with to take care of patients, but also think about a team from a networking standpoint. Do you have a network of like colleagues? As an example, other pharmacists in our healthcare system may reach out to me for advice about a patient with pain, whether or not I'm actually seeing the patient. We can make our team small, we can make them big, but we should be making our teams in ways that everybody's functioning at a high level and putting the patient at the center of the team.

Christopher Flores, MD: Michael, LaTosha talked about the fragmented healthcare system and how interprofessional collaboration can help with that. Do you have any examples from your experience?

Michael Smith, PharmD: Think about the patient's experience through our healthcare system. Even if a patient receives all of their healthcare within 1 system, they often have to travel to many different places just to access care. From a primary care clinic to a hospital, to a specialty clinic, to a pharmacy. We can fill these gaps by using our interprofessional framework, our education, and allowing our collaborative practice teammates to step in and fill that.



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Christopher Flores, MD: In conclusion, I just want to summarize that medicine is a team sport and that there is a growing body of evidence that supports the various benefits of interprofessional collaboration. LaTosha, Michael, do you have any final thoughts?

LaTosha Mollette, DNP: I think just being willing to change is crucial. I think sometimes we have become complacent in clinical practice, but our healthcare system is ever evolving. So, learning how to be a team player always benefits everyone involved.

Michael Smith, PharmD: I've learned a great deal from my interprofessional colleagues, and I hope that I've helped them learn as well, with the ultimate goal of really improving patient care.

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For patients with hyperlipidemia, shared decision making is essential, so that an individualized treatment plan that addresses the varied and complex medical and psychosocial needs of the patient can be developed. This is especially important since patients with hyperlipidemia often have other cardiometabolic disorders such as ASCVD, type 2 diabetes, or obesity. Consequently, holistic patient care and ongoing support require that care is provided by a large interprofessional, multidisciplinary care team.^{27,28} The

benefits of such care have been described in patients with lipid disorders in the inpatient and outpatient settings.²⁹⁻³¹

In an expert clinical review, the National Lipid Association described the composition of the interprofessional, multidisciplinary care team and the roles of each member to optimize the management of patients with lipid disorders and promote cardiometabolic health (**Table**).³² Team members share a common responsibility to monitor treatment response, safety and tolerability, and adherence. The large care team typically needed for patients with hyperlipidemia and comorbid cardiometabolic disorders, especially when the care team is physically dispersed, necessitates utilizing effective communication techniques, such as regular team meetings, case conferences, electronic health record-linked messaging, and standardized protocols.^{27,33-35} Interprofessional, multidisciplinary team meetings are recommended as particularly important by the International Atherosclerosis Society in patients with severely elevated LDL-C.²⁷

Some specialists may be located through the following:

- Cardiovascular genetic counselor
 - [CardioGenomic Testing Alliance](#)
 - [National Society of Genetic Counselors](#)
- Exercise/Physical activity: [American College of Sports Medicine](#)
- Nutrition: [Academy of Nutrition and Dietetics](#)



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Table. Interprofessional, multidisciplinary lipid care team.³²

Profession/Specialty	Role
Lipid Specialist (physician, physician associate, nurse practitioner)	<ul style="list-style-type: none"> Assess and diagnose lipoprotein lipid disorders Provide overall medical supervision Engage in shared decision-making conversation with patient
Primary Care (physician, physician associate, nurse practitioner)	<ul style="list-style-type: none"> Conduct initial evaluation, screening for comorbidities Coordinate long-term management of cardiometabolic disorders Provide ongoing monitoring
Registered Dietitian Nutritionist	<ul style="list-style-type: none"> Member of cardiac rehabilitation team Individualize medical nutrition therapy Provide individualized nutritional counseling Provide overall support for lifestyle changes
Pharmacist	<ul style="list-style-type: none"> Assist in individualizing pharmacotherapy Assist with insurance authorization for medications Engage in shared decision-making conversation with patient to maximize treatment adherence Provide counseling on adverse effects Provide ongoing monitoring, medication titration/adjustment
Nurse	<ul style="list-style-type: none"> Provide clinical care support, including patient education Administer certain lipid-lowering therapies
Physical Activity Specialist	<ul style="list-style-type: none"> Member of cardiac rehabilitation team Provide individualized exercise program Provide overall support for lifestyle changes
Genetic Counselor	<ul style="list-style-type: none"> Discuss indications for genetic testing Interpret results of genetic tests Provide counseling based on results of genetic tests Recommend appropriate individuals for cascade screening
Mental Health/Behavioral Therapy Specialist	<ul style="list-style-type: none"> Member of cardiac rehabilitation team Provide individualized behavior support Assess support system Provide overall support for lifestyle changes
Case Manager	<ul style="list-style-type: none"> Serves as point of contact for patients to facilitate access to services

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