For each member, the occurrence of any 2014 statin claim was determined. Of the 204,560 members: 55,099 (26.9 percent) were statin adherent (PDC ≥ 80 percent), and 147,054 (73.1 percent) were not statin adherent (PDC < 80 percent). Note: Columns do not sum due to some members having a CV event in more than one CV event category. The ‘any of above CV events’ category counts an individual once regardless of how many CV events they had.

### Results

- **Out of an average of about 13.8 million members per month, there were 5.5 million continuously enrolled members less than 65 years of age.** Among these members, all who had, in 2014 – 2015, either: 1) any ASCVD 2014 claim(s) or Age < 21; or 2) no ASCVD 2014 claim(s) and Age, (years) on Dec. /three.tf/one.tf/two.tf/zero.tf/four.tf; or 3) any 2015 cardiovascular (CV) event were categorized as members with or without a 2014 statin claim grouped together as either members with or without a 2014 statin claim associated with a diagnosis code for an acute coronary syndrome or ischemic cerebral infarction.

- **Claims indicating a diagnosis of ASCVD were defined as those for a CV event or with a diagnosis code for an acute coronary syndrome, stable or unstable angina, anger of peripheral arteries, or transient ischemic attack.** Individuals were counted only once in each of the unique CV event categories and may have had a CV event in more than one CV category. A member is counted only once for any of the CV event rate assessment.

- For each month, the occurrence of any 2014 statin claim was determined along with the static proportion of data captured (PDC). The methodology specified by the Pharmacy Quality Alliance (PQA) is widely used in commercial claims data to measure adherence to chronic medications.

- **By assigning individuals to risk categories recommended by the USPSTF requires clinical information not available from administrative claims data, e.g., laboratory values, smoking history or race. It therefore is not possible to assess compliance with evidence-based prevention with statin therapy for most individuals age 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD).** 

### Limitations

- **Assigning individuals to risk categories recommended by the USPSTF requires clinical information not available from administrative claims data, e.g., laboratory values, smoking history or race. It therefore is not possible to assess compliance with evidence-based prevention with statin therapy for most individuals age 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD).**

- **Use of any one year of claims data is limited if which members have a diagnosis of ASCVD is likely to have biased the percentage with a history of ASCVD.**

### Conclusions

- Current practice in this commonly insured population appears to be selective use of statin for primary prevention in members with diabetes age ≥ 40 as is consistent with the recommendation in the USPSTF guideline that needs most of these members should be treated. In 2014, only 15 percent had a statin claim and only 12 percent were adherence to statin therapy.

- In 2014, 18 percent of these members who had any cardiovascular event were under 65 years of age and not adherent to a statin.

- The adherence to statin therapy had a 25 percent lower incidence of any cardiovascular event. There is a large opportunity to improve the quality of care through increasing statin primary prevention use among individuals with diabetes 65 to 64 years of age. This event enrolment data provides a basis for estimated program clinical event rate ascertainment in calculation.

### References

1. The 2015 updated cholesterol guidelines from the American College of Cardiology (ACC) and American Heart Association (AHA) recommend statin therapy for most middle-aged individuals age ≥ 40 or with ASCVD. The ACC/AHA guidelines defined a 20 percent or more increase in cardiovascular risk to designate elevated risk for treatment with statin therapy. The ACC/AHA guidelines defined a 20 percent or more increase in cardiovascular risk to designate elevated risk for treatment with statin therapy.

2. For each member, the occurrence of any 2014 statin claim was determined. Of the 204,560 members: 55,099 (26.9 percent) were statin adherent (PDC ≥ 80 percent), and 147,054 (73.1 percent) were not statin adherent (PDC < 80 percent). Note: Columns do not sum due to some members having a CV event in more than one CV event category. The ‘any of above CV events’ category counts an individual once regardless of how many CV events they had.

3. Among individuals with diabetes age ≥ 40, current practice in this commonly insured population appears to be selective use of statin for primary prevention in members with diabetes age ≥ 40 as is consistent with the recommendation in the USPSTF guideline that needs most of these members should be treated. In 2014, only 15 percent had a statin claim and only 12 percent were adherence to statin therapy.

4. In 2014, 18 percent of these members who had any cardiovascular event were under 65 years of age and not adherent to a statin.

5. The adherence to statin therapy had a 25 percent lower incidence of any cardiovascular event. There is a large opportunity to improve the quality of care through increasing statin primary prevention use among individuals with diabetes 65 to 64 years of age. This event enrolment data provides a basis for estimated program clinical event rate ascertainment in calculation.

6. Assigning individuals to risk categories recommended by the USPSTF requires clinical information not available from administrative claims data, e.g., laboratory values, smoking history or race. It therefore is not possible to assess compliance with evidence-based prevention with statin therapy for most individuals age 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD). Use of any one year of claims data is limited if which members have a diagnosis of ASCVD is likely to have biased the percentage with a history of ASCVD.

7. The method for measuring statin adherence is also based on a small claims history and is likely to have overestimated the adherence to statin therapy. The method for measuring statin adherence is also based on a small claims history and is likely to have overestimated the adherence to statin therapy.