Clinical Snapshot - Coronary Artery Disease

What is coronary artery disease?
Coronary artery disease (CAD) is also called coronary heart disease (CHD), heart disease, or ischemic heart disease and occurs when plaque builds up on the inner surface of arteries supplying blood to the heart muscle. Plaque is composed of cholesterol, fat, calcium, and other substances. This plaque, or atherosclerosis, reduces the flow of blood and oxygen to the heart muscle. Plaque also may completely block coronary arteries or form blood clots that can block the arteries.1 A myocardial infarction (MI), or heart attack, occurs when a blood clot cuts off the blood and oxygen supply to the heart muscle.

Unfortunately, only 18% of heart attacks are preceded by longstanding angina.3 The first sign of CAD may be a heart attack.1

The diagnosis of CAD is based on:1
• Symptoms
• Medical history
• Family history
• Risk factors
• Physical exam
• Lab tests (i.e., fasting lipid profile)
• Diagnostic tests (i.e., EKG, echocardiogram, exercise stress test, etc.)

Risk factors for coronary artery disease
Approximately 90% of individuals with CAD have prior exposure to at least one of these major risk factors, which include: high total blood cholesterol levels or current medication with cholesterol-lowering drugs, hypertension or current medication with BP-lowering drugs, current cigarette use, and clinical report of diabetes mellitus.3 The chance for developing heart disease is related to the number of risk factors.3

Risk factors are divided into two groups – factors that are beyond an individual’s control and factors that are within an individual’s control. It is estimated that approximately 90% of the risk related to an initial acute heart attack (MI) are associated with factors within an individual’s control.3

Uncontrollable Risk Factors 1
• Age
  o Risk increases after age 45 for men
  o Risk increases after age 55 for women
• Family history of early heart disease
  o Diagnosed before age 55 in father or brother
  o Diagnosed before age 65 in mother or sister

Controllable Risk Factors 3
• Cigarette smoking
• Abnormal blood lipid levels
• Hypertension
• Diabetes mellitus
• Abdominal obesity
• Lack of physical activity
• Low daily fruit and vegetable consumption
• Alcohol overconsumption
• Psychosocial index

Over time, CAD can result in heart failure, or the inability of the heart muscle to adequately pump blood to the rest of the body, and arrhythmias, or changes in the normal rhythm of the heartbeat.1

Chest pain, or angina pectoris, develops when the heart muscle does not receive enough blood or oxygen and is caused by the narrowing of coronary arteries.1 It is a clinical syndrome characterized by chest, jaw, shoulder, back, or arm pain.2 Pain usually increases with exertion or emotional stress and is relieved by nitroglycerin.2 Unstable angina is chest pain that is unexpected and usually occurs at rest and may be more severe or lasts longer than typical stable angina.2

Signs and symptoms of coronary artery disease
The most common signs of CAD are:1
• Chest pain or discomfort (angina)
• Pain in either arm, the left shoulder, neck, jaw, or back
• Chest pain or discomfort (angina)
• Shortness of breath
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Prevalence of Coronary Artery Disease in the United States
The prevalence of CAD among those 65 and older is 20.3%. Prevalence varies greatly by region with the highest prevalence in the south and the lowest in the west.\(^6\)

The prevalence of CAD varies by race and culture and in 2009 was highest among whites:\(^3\)

<table>
<thead>
<tr>
<th>Incidence per 1,000</th>
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<tbody>
<tr>
<td>Black women</td>
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<tr>
<td>Black men</td>
</tr>
</tbody>
</table>

The incidence of CAD per 1,000 people also varies by race and gender and was highest for white men:\(^3\)

<table>
<thead>
<tr>
<th>Incidence per 1,000</th>
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</thead>
<tbody>
<tr>
<td>Black women</td>
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<tr>
<td>Black men</td>
</tr>
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</table>

CAD also varies by age and gender:\(^3\)
- The rate of MI is higher for men than women
- The rate of angina pectoris is higher for women than men
- The average age of a first heart attack is 64.5 years for men and 70.3 years for women
- The lifetime risk of developing CAD after age 40 is 49% for men and 32% for women
- CAD usually occurs 10 years earlier in men than women
- Major CAD events (MI and sudden death) usually occur 20 years earlier in men than women

Costs of Coronary Artery Disease
The American Heart Association estimates that the annual national expenditures in 2007 for coronary heart disease were $177.5 billion. This includes costs for acute myocardial infarction, other acute ischemic (coronary) heart disease, angina pectoris, atherosclerotic cardiovascular disease and all other forms of coronary heart disease. Of this amount, $82.2 billion is due to expenditures for hospital, nursing home, physicians/other professional services, drugs/other medical durables, and home health care. Prescription drug costs alone were $8.5 billion. The remaining $95.3 billion results from indirect costs associated with lost productivity due to morbidity and mortality.\(^3\)

Complications of Coronary Artery Disease
CAD is the number one killer of American men and women and is the leading cause of premature, permanent disability in the United States labor force.\(^8\) Over 13 million people have CAD and over 500,000 die each year from this disease.\(^1\) Of those with CAD, 7.9 million have had heart attacks and 9 million suffer from chest pain (angina pectoris).\(^3\)

The incidence of heart attacks (MI), per 1,000 population, varies by race and age:\(^3\)

<table>
<thead>
<tr>
<th>Incidence per 1,000</th>
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</thead>
<tbody>
<tr>
<td>Black women</td>
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<td>Black men</td>
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</table>

The incidence of heart attacks among American Indian men ages 65 to 74 was 7.6 per 1,000 compared with 4.9 per 1,000 for American Indian women.\(^3\)

Data suggest that within five years of a first MI:\(^3\)
- 22% of men and women ≥ 65 years of age will have another MI
- 46% of white men, 53% of white women, 54% of black men and 58% of black women ≥ 65 years of age will die
- 20% of men and 23% of women ≥ 65 years of age will develop heart failure
- 5% of men and 8% of women ≥ 65 years of age will have a stroke

The death rate from heart attacks also varies by gender and race. Approximately 30% of women will die within one year after a heart attack compared with 25% of men.\(^3\)

Although the death rate from CAD declined 27.8% from 1997 to 2007, the number of deaths declined only 14.2%.\(^3\)
**Prevention of Coronary Artery Disease**

Coronary artery disease may be prevented by following a healthy lifestyle including:

- Following a diet low in saturated fat and cholesterol
- Remaining physically active
- Maintaining a healthy weight
- Not smoking

For example, a Nurses Health Study of 84,129 women indicates that women who follow all five of the identified healthy lifestyle factors maintain a healthy body weight, eat a healthy diet, exercise regularly (a half hour or more a day of at moderate or vigorous exercise, do not smoke, and consume alcohol moderately (<1 drink/day) will have an 83% reduction in cardiovascular risk compared with other women. When 3 of the 5 factors were present the relative risk over a 14-year period was 57% lower.

However, data from NHANES 1999-2002 showed that only about one-third of adults complied with 6 or more of recommended heart-healthy behaviors. Dietary recommendations, in general, and daily fruit intake were the least likely to be followed.

Low risk for CAD is defined by:

- Untreated blood pressure 120/80 mm Hg
- Serum cholesterol level under 200 mg/dL
- Absence of current smoking
- Absence of diabetes mellitus
- Absence of major electrocardiographic abnormalities

**Treat Coronary Artery Disease**

The purpose of treating CAD is to:

- Relieve symptoms;
- Slow or stop atherosclerosis;
- Lower the risk for blood clots;
- Widen or bypass clogged arteries; and
- Reduce cardiac events (MI)

Treatments include lifestyle changes, medications, and invasive procedures.

**Lifestyle changes:**

All individuals with CAD should make the following lifestyle changes:

- Eat a healthy diet to:
  - Prevent or reduce high blood pressure
  - Prevent or reduce high blood cholesterol
  - Maintain a healthy weight
- Stop smoking
- Exercise regularly
- Lose weight if overweight or obese
- Reduce stress

**Medications:**

In addition to lifestyle changes, individuals may need to take some or all of the following medications to relieve symptoms, to reduce the chance of having a heart attack or sudden death, or to prevent or delay the need for invasive procedures (i.e., bypass surgery or angioplasty):

- Cholesterol-lowering medications
- Anticoagulants/anti-platelet medications, including aspirin, to prevent clots from forming within arteries
- ACE Inhibitors to lower blood pressure and reduce the strain on the heart
- Beta-blockers to slow the heart rate and lower blood pressure
- Calcium channel blockers to relax blood vessels and lower blood pressure
- Nitroglycerin to prevent or relieve chest pain symptoms by relaxing blood vessels to the heart and increasing nitrogen supply
- Long-acting nitrates to open the arteries and increase blood flow

**Invasive procedures:**

Invasive procedures are used to increase blood flow to the heart muscle when lifestyle changes and medications do not control CAD symptoms and include:

- Angioplasty to open blocked or narrowed coronary arteries
- Coronary artery bypass surgery to bypass diseased coronary arteries

**Clinical Guidelines**

The American Heart Association (AHA) and the American College of Cardiology (ACC) developed joint guidelines for health care professionals to monitor and treat patients with CAD. The guidelines include aggressive risk reduction therapies for patients with CAD to improve patient survival, reduce recurrent events, and improve patients’ quality of life.

The guidelines recommend that all medical care settings that manage patients with CAD:

- Organize a plan to identify appropriate patients;
- Develop reminder systems for providers based on national guidelines; and
- Continuously assess efforts to provide appropriate therapies to all patients who could benefit from them
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An outline of these detailed guidelines for aggressive risk-reduction therapies for patients with established coronary and other atherosclerotic vascular disease, covering various behaviors and medication management, have been listed on the following three pages. These guidelines are presented with the class of recommendations and level of evidence behind each intervention. These guidelines are recognized by the American College of Physicians as a scientifically valid review of the evidence.

The guidelines can also apply to individuals with stable angina, or chest pain due to coronary artery disease. The purpose of treating individuals with angina is to prevent MI and death and to reduce symptoms of angina and the occurrence of ischemia which is a restriction in the blood supply.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Goal</th>
<th>Intervention Recommendation With Class of Recommendation and Level of Evidence</th>
</tr>
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</table>
| Smoking | Complete cessation. No exposure to environmental tobacco smoke. | • Ask about tobacco use at every visit. I (B)  
• Advise every tobacco user to quit. I (B)  
• Assess the tobacco user’s willingness to quit. I (B)  
• Assist by counseling and developing a plan for quitting. I (B)  
• Arrange follow-up, referral to special programs, or pharmacotherapy (including nicotine replacement and bupropion). I (B)  
• Urge avoidance of exposure to environmental tobacco smoke at work and home. I (B) |
| BP Control | <140/90 mm Hg or <130/80 mm Hg if patient has diabetes or chronic kidney disease | • For all patients, assess risk with a physical activity history and/or an exercise test, to guide prescription. I (B)  
• For all patients, encourage 30 to 60 minutes of moderate-intensity aerobic activity, such as brisk walking, on most, preferably all, days of the week, supplemented by an increase in daily lifestyle activities (e.g., walking breaks at work, gardening, household work). I (B)  
• Encourage resistance training 2 days per week. IIb (C)  
• Advise medically supervised programs for high-risk patients (e.g., recent acute coronary syndrome, revascularization, heart failure). I (B) |
| Lipid Management | LDL <100 mg/dL  
If triglycerides are ≥200 mg/dL, non-HDL-C should be <130 mg/dL† | For all patients:  
• Start dietary therapy. Reduce intake of saturated fats (to <7% of total calories), trans-fatty acids, and cholesterol (to <200 mg/d). I (B)  
• Adding plant stanols/sterols (2 g/d) and viscous fiber (>10 g/d) will further lower LDL-C. I (B)  
• Promote daily physical activity and weight management. I (B)  
• Encourage increased consumption of omega-3 fatty acids in the form of fish† or in capsule form (1 g/d) for risk reduction. For treatment of elevated triglycerides, higher doses are usually necessary for risk reduction. IIb (B)  

For lipid management: Assess fasting lipid profile in all patients, and within 24 hours of hospitalization for those with an acute cardiovascular or coronary event. For hospitalized patients, initiate lipid-lowering medication as recommended below before discharge according to the following schedule:  
• LDL-C should be <100 mg/dL I (A), and  
• Further reduction of LDL-C to <70 mg/dL is reasonable. IIa (A)  
• If baseline LDL-C is ≥100 mg/dL, initiate LDL-lowering drug therapy.§ I (A)  
• If on-treatment LDL-C is ≥100 mg/dL, intensify LDL-lowering drug therapy (may require LDL-lowering drug combination). I (A)  
• If baseline LDL-C is 70 to 100 mg/dL, it is reasonable to treat to LDL-C <70 mg/dL. IIa (B)  
• If triglycerides are 200 to 499 mg/dL, non-HDL-C should be <130 mg/dL. I (B), and  
• Further reduction of non-HDL-C to <100 mg/dL is reasonable. IIa (B)  
• Therapeutic options to reduce non-HDL-C are:  
  ⇒ More intense LDL-C-lowering therapy I (B), or  
  ⇒ Niacin¶ (after LDL-C-lowering therapy) IIa (B), or  
  ⇒ Fibrate therapy# (after LDL-C-lowering therapy) IIa (B)  
• If triglycerides are ≥500 mg/dL#, therapeutic options to prevent pancreatitis are fibrates¶ or niacin¶ before LDL-lowering therapy; and treat LDL-C to goal after triglyceride-lowering therapy. Achieve non-HDL-C <130 mg/dL if possible. I (C) |
AHA/ACC Guidelines for Preventing Heart Attack and Death in Patients with Atherosclerotic Cardiovascular Disease: 2006 Update

<table>
<thead>
<tr>
<th>Topic</th>
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</tr>
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</table>
| Physical Activity | 30 minutes, 7 days per week (minimum 5 days per week) | • For all patients, assess risk with a physical activity history and/or an exercise test, to guide prescription. I (B)  
• For all patients, encourage 30 to 60 minutes of moderate-intensity aerobic activity, such as brisk walking, on most, preferably all, days of the week, supplemented by an increase in daily lifestyle activities (eg, walking breaks at work, gardening, household work). I(B)  
• Encourage resistance training 2 days per week. IIb (C)  
• Advise medically supervised programs for high-risk patients (eg, recent acute coronary syndrome or revascularization, heart failure). I (B) |
| Weight Management | Body mass index: 18.5 to 24.9 kg/m²  
Waist circumference: men <40 inches, women <35 inches | • Assess body mass index and/or waist circumference on each visit and consistently encourage weight maintenance/reduction through an appropriate balance of physical activity, caloric intake, and formal behavioral programs when indicated to maintain/achieve a body mass index between 18.5 and 24.9 kg/m². I (B)  
• If waist circumference (measured horizontally at the iliac crest) is ≥35 inches in women and ≥40 inches in men, initiate lifestyle changes and consider treatment strategies for metabolic syndrome as indicated. I (B)  
• The initial goal of weight loss therapy should be to reduce body weight by approximately 10% from baseline.  
• With success, further weight loss can be attempted if indicated through further assessment. I (B) |
| Diabetes Management | HbA1c <7% | • Initiate lifestyle and pharmacotherapy to achieve near-normal HbA1c. I (B)  
• Begin vigorous modification of other risk factors (eg, physical activity, weight management, blood pressure control, and cholesterol management as recommended above). I (B)  
• Coordinate diabetic care with patient’s primary care physician or endocrinologist. I (C) |
| Antiplatelet Agents/ Anticoagulants |  | • Start aspirin 75 to 162 mg/d and continue indefinitely in all patients unless contraindicated. I (A)  
⇒ For patients undergoing coronary artery bypass grafting, aspirin should be started within 48 hours after surgery to reduce saphenous vein graft closure. Dosing regimens ranging from 100 to 325 mg/d appear to be efficacious. Doses higher than 162 mg/d can be continued for up to 1 year. I (B)  
• Start and continue clopidogrel 75 mg/d in combination with aspirin for up to 12 months in patients after acute coronary syndrome or percutaneous coronary intervention with stent placement (>1 month for bare metal stent, >3 months for sirolimus-eluting stent, and >6 months for paclitaxel-eluting stent). I (B)  
⇒ Patients who have undergone percutaneous coronary intervention with stent placement should initially receive higher-dose aspirin at 325 mg/d for 1 month for bare metal stent, 3 months for sirolimus-eluting stent, and 6 months for paclitaxel-eluting stent. I (B)  
• Manage warfarin to international normalized ratio=2.0 to 3.0 for paroxysmal or chronic atrial fibrillation or flutter, and in post–myocardial infarction patients when clinically indicated (eg, atrial fibrillation, left ventricular thrombus). I (A)  
• Use of warfarin in conjunction with aspirin and/or clopidogrel is associated with increased risk of bleeding and should be monitored closely. I (B) |
<table>
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<th>Goal</th>
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</tr>
</thead>
</table>
| Renin-Angiotensin-Aldosterone System Blockers | ACE inhibitors: | • Start and continue indefinitely in all patients with left ventricular ejection fraction ≤40% and in those with hypertension, diabetes, or chronic kidney disease, unless contraindicated. **I (A)**  
• Consider for all other patients. **I (B)**  
• Among lower-risk patients with normal left ventricular ejection fraction in whom cardiovascular risk factors are well controlled and revascularization has been performed, use of ACE inhibitors may be considered optional. **IIa (B)** |
| | Angiotensin receptor blockers: | • Use in patients who are intolerant of ACE inhibitors and have heart failure or have had a myocardial infarction with left ventricular ejection fraction <40%. **I (A)**  
• Consider in other patients who are ACE inhibitor intolerant. **I (B)**  
• Consider use in combination with ACE inhibitors in systolic-dysfunction heart failure. **IIb (B)** |
| | Aldosterone blockade: | • Use in post–myocardial infarction patients, without significant renal dysfunction** or hyperkalemia††, who are already receiving therapeutic doses of an ACE inhibitor and beta-blocker, have a left ventricular ejection fraction ≤40%, and have either diabetes or heart failure. **I (A)** |
| Beta-Blockers | | • Start and continue indefinitely in all patients who have had myocardial infarction, acute coronary syndrome, or left ventricular dysfunction with or without heart failure symptoms, unless contraindicated. **I (A)**  
• Consider chronic therapy for all other patients with coronary or other vascular disease or diabetes unless contraindicated. **IIa (C)** |
| Influenza Vaccination | | • Patients with cardiovascular disease should have an influenza vaccination. **I (B)** |

**Classification of Recommendations and Level of Evidence**

| Class I: | Conditions where there is evidence and/or general agreement that a given procedure or treatment is beneficial, useful, and effective. |
| Class II: | Conditions where there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment. |
| Class IIa: | Weight of evidence/opinion is in favor of usefulness/efficacy. |
| Class IIb: | Usefulness/efficacy is less well established by evidence/opinion. |
| Level of Evidence A: | Data derived from multiple randomized clinical trials or meta-analyses. |
| Level of Evidence B: | Data derived from a single randomized trial or nonrandomized studies. |
| Level of Evidence C: | Only consensus opinion of experts, case studies, or standard-of-care. |

*Patients covered by these guidelines include those with established coronary and other atherosclerotic vascular disease, including peripheral arterial disease, atherosclerotic aortic disease, and carotid artery disease. Patients whose only manifestation of cardiovascular risk is diabetes are not covered here. ACE indicates angiotensin-converting enzyme.  
†Non-HDL-C = total cholesterol minus HDL-C.  
‡Pregnant and lactating women should limit their intake of fish to minimize exposure to methylmercury.  
§When LDL-lowering medications are used, obtain at least a 30% to 40% reduction in LDL-C levels. If LDL-C <70 mg/dL is the chosen target, consider drug titration to achieve this level to minimize side effects and cost. When LDL-C <70 mg/dL is not achievable because of high baseline LDL-C levels, it generally is possible to achieve reductions of >50% in LDL-C levels by either statins or LDL-C-lowering drug combinations.  
¶Standard dose of statin with ezetimibe, bile acid sequestrant, or niacin.  
‖The combination of high-dose statin + fibrate can increase risk for severe myopathy. Statin doses should be kept relatively low with this combination. Dietary supplement niacin must not be used as a substitute for prescription niacin.  
#Patients with very high triglycerides should not consume alcohol. The use of bile acid sequestrant is relatively contraindicated when triglycerides are >200 mg/dL.  
**Creatinine should be <2.5 mg/dL in men and <2.0 mg/dL in women.  
††Potassium should be <5.0 mEq/L.
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CMS Clinical Performance Measurement
Cardiac Population Health

The purpose of the Cardiac Population Health Project is to achieve transformational change in selected physician offices through a series of Learning Networks and individual interventions. The goal of this transformational change is to improve the effective management of patients with coronary artery disease or peripheral vascular disease in blood pressure control, cholesterol control, aspirin therapy and smoking cessation.

In addition to the AHA/ACC guidelines reported above, other guidelines exist for each of the four measurement areas which can be used to aid physicians. Only one of these guidelines, the Joint National Committee (JNC) on Prevention, Detection, Evaluation and Treatment of High Blood Pressure, was specifically mentioned by CMS for the 10th SOW. The JNC guidelines discuss the types of therapy needed to keep blood pressure under control, depending upon the patient’s condition.6,7

LDL cholesterol (LDL-C) is called the “bad” cholesterol as elevated levels of LDL-C are associated with an increased risk of CAD. A cholesterol plaque can be formed which causes a thickening of the artery walls and a narrowing of the arteries which can restrict blood flow and oxygen. The National Institute of Health (NIH), AHA and ACC have published the National Cholesterol Education Program (NCEP) guidelines for cholesterol treatment which is due to be updated the end of 2010. These guidelines describe the various levels of risk of a cardiac event and the desired cholesterol level and treatment for each risk category.8

In 2009, Federal advisors scaled back their recommendations about which people should be taking aspirin in hopes of lowering the risk of a heart attack or stroke and targeted a narrower group due to concerns about intestinal bleeding, including bleeding ulcers. The U.S. Preventive Service Task Force (USPSTF) now provides different recommendations relating to age and gender.9

Tobacco is the single greatest cause of disease and premature death in America today – yet use is the single most preventable cause of death and disease. The Public Health Service guideline for clinical practices offers practical advice for physicians. A separate clinical snapshot on Tobacco Use and Cessation is available which covers smoking cessation counseling in some detail.

All physician offices must be able to provide information on the measurement areas and to address the potential focus areas listed in the table below. The adoption of care management and patient self-management processes include assessing, planning, implementing, coordinating, monitoring, and evaluating treatment options and services to meet an individual’s health needs.

While some physician offices with an established EHR system will be asked to participate in PQRS for tobacco use and blood pressure measurement, all practices do not have to have an EHR to participate in any of the learning network sessions.
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<table>
<thead>
<tr>
<th>Measurement Area</th>
<th>Potential Focus Areas</th>
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</table>
| **Blood Pressure Control:** Percentage of Medicare patients with CAD or peripheral vascular disease whose most recent blood pressure during the measurement year is <140/90 mm Hg | 1. Conduct treatment consistent with the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC) practice  
  2. Address behavioral and lifestyle risk factors as well as medication adherence  
  3. Ability to provide measurement data to QIO                                                                 |
| **Lipids Management:** Percentage of patients with Medicare with ischemic vascular disease whose most recent LDL-C screening had a result of <100. | 1. Adoption of care management process for prescribing a lipid-lowering therapy  
  2. Check the National Cholesterol Education Program (NCEP) guidelines for treatment based on risk levels  
  3. Ability to provide measurement data to QIO                                                                 |
| **Aspirin Therapy:** Percentage of patients with Medicare with ischemic vascular disease who have documentation of use of aspirin or other antithrombotic during the 12-month measurement period | 1. Adoption of care management process for low aspirin therapy  
  2. Check the U.S. Preventive Service Task Force (USPSTF) for recommendations based on age and gender  
  3. Ability to provide measurement data to QIO                                                                 |
| **Smoking Cessation:** Percentage of patients with Medicare who receive smoking cessation counseling | 1. Adoption of care management process for smoking cessation interventions including screening for smokers  
  2. Check the U.S. Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update with its “5A” model for interventions  
  3. Ability to provide measurement data to QIO                                                                 |
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Current Performance Level
The current quality of care for Medicare beneficiaries within physician offices provides significant room for improvement.

Controlling weight and quitting smoking can have a profound influence on whether people will develop serious, life-threatening conditions like diabetes and CAD. Yet, despite the well-known benefits of these interventions, findings from the 2010 Healthcare Effectiveness Data and Information Set (HEDIS) measures suggest much needed improvement. For example, physicians may advise patients to quite smoking, but are less likely to discuss cessation strategies.

According to the National Committee for Quality Assurance, using HEDIS survey information, performance for selected managed care organizations in 2009 was as follows:\textsuperscript{11}

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Percent of HMO Medicare Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received beta blocker after MI</td>
<td>82.6%</td>
</tr>
<tr>
<td>Screened for LDL cholesterol after hospital discharge for CAD</td>
<td>88.4%</td>
</tr>
<tr>
<td>LDL cholesterol treatment goal (&lt;130 mg/dL) achieved after discharge for CAD</td>
<td>55.7%</td>
</tr>
<tr>
<td>Blood pressure at goal (&lt;140/90)</td>
<td>60.5%</td>
</tr>
<tr>
<td>Diabetes poorly controlled (HbA1c&gt;9.0)</td>
<td>28.0%</td>
</tr>
<tr>
<td>Advised smokers to quit</td>
<td>77.9%</td>
</tr>
<tr>
<td>Discussed smoking cessation strategies</td>
<td>N/A</td>
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</table>

For Additional Information, Please Contact:
(Insert your QIO contact information here)

References


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