

CARDIAC CARE GUIDE

SUGGESTED GUIDELINES	PROCESS	IMPORTANT FINDINGS, MEASUREMENTS AND VALUES	INTERVENTIONS	FOLLOW-UP
Blood Pressure Management 1,2,3,4	<ul style="list-style-type: none"> Measure blood pressure (BP) at every encounter Use Therapeutic Lifestyle Change (TLC) Use diet, exercise and medications to achieve target BP, tobacco cessation and weight loss Adjust treatment as necessary, at each visit until target values achieved 	Blood pressure goal: <ul style="list-style-type: none"> <140/90 mm Hg <130/80 mm Hg if tolerated for patients with CHD, HF, diabetes, or chronic kidney disease <120/80 mm Hg is optimal 	If BP elevated above goal: <ul style="list-style-type: none"> Lifestyle modification: diet and exercise; educate about DASH diet Inform patient of BP goals Encourage home BP monitoring Pharmacology: <ul style="list-style-type: none"> Stage I (140-159/90-99): <ul style="list-style-type: none"> ACE-I and/or Beta Blocker for patients with CAD/HF Stage II (\geq160/100): <ul style="list-style-type: none"> Two-drug combination preferred 	<ul style="list-style-type: none"> Measure BP and evaluate management at each visit Assess compliance with lifestyle modification Assess for medication side-effects Review home BP record Encourage and assist, providing compliance tools and suggestions
Lipid Management 2,5	<ul style="list-style-type: none"> Measure fasting lipid (lipoprotein) profile within 24 hours of hospitalization for patient with an acute coronary event, and at least annually for all patients with CVD Use diet, exercise and medications to achieve target lipid levels Adjust treatment as necessary, at each visit until target is achieved 	<ul style="list-style-type: none"> Target goals for all patients with CVD <ul style="list-style-type: none"> LDL-C <100 mg/dL If Triglycerides >200 mg/dL, non-HDL-C should be <130 mg/dL LDL-C <70 mg/dL is reasonable for highest risk patients 	<ul style="list-style-type: none"> Initiate TLC for all patients <ul style="list-style-type: none"> Reduce saturated fats and cholesterol Reduce/eliminate trans fats Increase fiber intake Increase omega-3 fatty acids Daily physical activity Weight management Drug therapy if LDL-C \geq 100 mg/dL <ul style="list-style-type: none"> High-dose statin if LDL-C \geq70 mg/dL in high risk patients If triglycerides >500 mg/dL, treat with fibrate or niacin first 	<ul style="list-style-type: none"> Measure fasting LDL-C at 6 weeks following the start or the adjustment of therapy until goal is achieved If goal not achieved, and if on treatment and LDL-C \geq 100 mg/dL, therapy can be intensified, including use of drug-combination therapy. If goal is achieved, measure LDL-C at 12 weeks and every 4 to 6 months to assess response to therapy Monitor liver function tests before treatment with statins and periodically thereafter to assess for drug toxicity Monitor CPK in patients with muscle discomfort If baseline LDL-C is 70-100 mg/dL, it is reasonable to treat to < 70 mg/dL
Screening for Abnormal Glucose Metabolism 2,3	<ul style="list-style-type: none"> Screen with a fasting glucose every 3 years in patients with no risk factors starting at age 45. Consider testing all overweight adults (BMI \geq25 kg/m) with one of the following risk factors: <ul style="list-style-type: none"> Physical inactivity First-degree relative with diabetes Members of a high-risk ethnic population (e.g. African American, Latino, Native American, Asian American, Pacific Islander) 	Abnormal Glucose is: <ul style="list-style-type: none"> Impaired Fasting Glucose (IFG) is a FPG of 100 mg/dL to 125 mg/dL Impaired Glucose Tolerance (IGT) is a 2 – hour OGTT plasma glucose of 140 mg/dL to 199 mg/dL. Criteria for Diabetes: <ul style="list-style-type: none"> FPG > 126 mg/dL Symptoms of hyperglycemia and a random glucose \geq 200 mg/dL Two-hour PG \geq 140 mg/dL during a 75 mg anhydrous glucose OGTT. 	If abnormal: <ul style="list-style-type: none"> Follow diabetes treatment guidelines Reinforce TLC 	<ul style="list-style-type: none"> If normal, repeat at least every three years For high-risk patients, repeat annually

	<ul style="list-style-type: none"> ➤ Women who delivered a baby weighing >9 lb or were diagnosed with GDM ➤ Hypertension (>140/90 mmHg or on therapy for hypertension) ➤ HDL cholesterol level < 35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L) ➤ Women with polycystic ovarian syndrome (PCOS) ❖ IGT or IFG on previous testing ❖ Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans) ❖ History of CVD 	In the absence of unequivocal hyperglycemia with acute metabolic decompensation, these criteria should be confirmed by repeat testing on a different day		
Ischemic Heart Disease ^{2,6}	<ul style="list-style-type: none"> • Evaluate and treat all patients with known coronary artery disease, stable angina, unstable angina, post-coronary intervention (PCI) or history or evidence of prior MI based on current guidelines 	<ul style="list-style-type: none"> • Document medical history, physical exam • Document laboratory results <ul style="list-style-type: none"> ➤ CBC ➤ Fasting lipid profile ➤ Fasting glucose ➤ Others as appropriate • Document initial ECG, CXR • Document medication usage including <ul style="list-style-type: none"> ➤ Aspirin/anti-platelet agent ➤ Beta Blocker ➤ ACE-I or Angiotensin Receptor Blocker (ARB) ➤ Statins ➤ Nitrates/Calcium Channel Blocker • Document ejection fraction (EF) in post-MI patients 	<ul style="list-style-type: none"> • Aspirin therapy-at least 75-162 mg/d unless contraindicated • Clopidogrel for patient with aspirin contraindication • Aspirin (162-325 mg)/clopidogrel combination for 12 months in patients post Acute Coronary syndrome (ACS), or PTCA with drug eluting stents • Beta Blocker-in all patients post-MI/ACS or with LV dysfunction; consider in all CAD patients • ACE inhibitor-all patients with LVEF <40%, Diabetes, CKD, or hypertension; ARB if ACE-I intolerant • Statin-in all patients with LDL-C >=100 mg/dL; consider in all CAD patients with initial LDL 70-100 mg/dL • Nitrates/Calcium Channel Blockers and/or Beta Blockers for patient with continued angina symptoms 	<ul style="list-style-type: none"> • Exercise testing based on risk and symptoms • Assess medication compliance and smoking cessation at each visit • Teaches patient when to seek immediate emergency care for symptoms • Teaches patient about adverse reactions and when to seek immediate emergency care for adverse signs or symptoms
SUGGESTED GUIDELINES	PROCESS	IMPORTANT FINDINGS, MEASUREMENTS AND VALUES	INTERVENTIONS	FOLLOW-UP
Systolic Heart Failure ^{6,7,17,18}	<ul style="list-style-type: none"> • Identify patients in symptomatic stages of HF • Evaluate and treat all patients with heart failure in accordance with current guidelines 	<ul style="list-style-type: none"> • Document medical history, physical exam and assess clinical severity of HF • Determine and document severity of clinical disease and functional limitation. Determine and document ability to perform typical activities of daily living <ul style="list-style-type: none"> ➤ NYHA functional class ➤ 6-minute walk test • Document laboratory results <ul style="list-style-type: none"> ➤ CBC ➤ Electrolytes 	<ul style="list-style-type: none"> • ACE-I in all HF patients without contraindication; ARB if ACE-I intolerant, titrate to maximum tolerated doses • Beta Blockers in all HF patient without contraindication <ul style="list-style-type: none"> ➤ Initiate at low dose once patient is clinically stable and euolemic and up-titrate slowly • Consider adding ARB in patients with HF due to reduced LVEF with persistent symptoms or progressive 	<ul style="list-style-type: none"> • Measure K+ and serum creatinine levels at 7 and 30 days after starting or modifying aldosterone antagonist therapy and monthly thereafter • Check renal function and serum K+ levels one to two weeks after starting ACE inhibitors and periodically thereafter • Measure K+ after change in dose of any drug that may affect potassium balance • Consider serum digoxin

		<ul style="list-style-type: none"> ➤ BUN/Creatinine ➤ Calcium/Magnesium ➤ Serum Albumin ➤ BNP or NT-proBNP ➤ Urinalysis ➤ Liver Function Tests ➤ Thyroid function tests ➤ Fasting lipid panel (LDL, HDL, triglycerides) ➤ Fasting glucose ➤ ABGs may be considered • Document initial ECG, and PA and lateral CXR • Document medication usage including <ul style="list-style-type: none"> ➤ Aspirin/anti-platelet agent ➤ Beta Blocker-all patient with stable NYHA Class I to IV should receive a Beta Blocker unless contraindicated ➤ ACE-I or Angiotensin Receptor Blocker (ARB) • Determine volume status <ul style="list-style-type: none"> ➤ Presence of PND or orthopnea ➤ Presence of dyspnea of exertion ➤ Daily weights and vital signs with assessment of orthostatic changes ➤ Presence and degree of rales, S3 gallop, JVD, liver enlargement and tenderness, positive hepatjugular reflux, edema ana ascites. • • Evaluate cardiac structure and function: Measure EF in all patients with HF with echocardiogram or radionuclide ventriculography • Identify exacerbating factors • Determine etiology of HF • Evaluate risk of life-threatening arrhythmia • Evaluate for coronary disease and myocardial ischemia in new-onset Left Ventricular systolic dysfunction, especially if MI suspected or if symptoms worsening in pre-existing CAD. • Consider coronary angiography if high pre-test probability of ischemic cardiomyopathy and invasive coronary intervention may be 	<p>worsening while on optimized therapy with ACE-I and Beta Blocker.</p> <ul style="list-style-type: none"> • Consider Hydralazine/Nitrate combination if ACE-I and ARB intolerant due to hypotension or renal insufficiency, or in addition to ACE-I or ARB in African American patients <ul style="list-style-type: none"> ➤ Sildenafil is absolutely contraindicated in patients undergoing any long-acting nitrate drug therapy or using short-acting nitrates because of the risk of developing potentially life-threatening hypotension • Diuretics for symptomatic patients with fluid retention • Aldosterone antagonist for patients with NYHA class IV HF consider in class III). Review diet, supplements and other over-the-counter medications to avoid those containing high levels of K+. Contraindicated if K+ >5.0 mmol/L and serum creatinine > 2.0 mg/dL in women and > 2.5 mg/dL in men. • Consider Digoxin as part of the initial treatment in patients with severe symptoms, in addition to diuretics, ACE-I and beta blockers, or add it later if symptomatic on optimized regimen above (class II to IV) • Consider n-3 polyunsaturated fatty acids (PUFA) in HF patients with NYHA class II to IV symptoms and reduced LVEF. • Routine use of amiodarone is not recommended for asymptomatic arrhythmias not felt to contribute to HF or ventricular dysfunction. • Daily weights/dietary instruction • Manage co-morbid conditions (obesity, diabetes, ischemia) • Consider cardiology referral for patients who have EF <35%; consider defibrillator +/-or pacemaker placement or revascularization • Consider referral to a cardiac 	<p>measurement in two to three weeks after starting new drug in elderly or in those with impaired renal function</p> <ul style="list-style-type: none"> • All patients taking organic nitrates, should be informed about a possible life-threatening hypotensive reaction, and how to avoid and manage it.
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		<p>considered.</p> <ul style="list-style-type: none"> • Perform exercise testing to determine suitability for exercise training • Identify co-morbidities that influence therapy • Identify barriers to adherence and compliance 	<p>rehabilitation program for patients with CAD and/or CHF where available</p>	
SUGGESTED GUIDELINES	PROCESS	IMPORTANT FINDINGS, MEASUREMENTS AND VALUES	INTERVENTIONS	FOLLOW-UP
Diastolic Heart Failure^{6,7} (Preserved Systolic Function)	<ul style="list-style-type: none"> • Identify diastolic dysfunction inpatients with preserved EF and clinical findings consistent with heart failure 	<ul style="list-style-type: none"> • Diagnosis of diastolic dysfunction suggested by <ul style="list-style-type: none"> ➢ Clinical findings consistent with HF ➢ Framingham HF Criteria ➢ Boston HF Criteria ➢ Preserved EF on cardiac imaging studies ➢ Evidence of elevated filling pressures with normal volume and contractility 	<ul style="list-style-type: none"> • Control BP to < 130/80 • Restore sinus rhythm in afib/flutter • Treat volume overload cautiously with diuretics • Consider ACE-I, ARB, Beta Blocker, and nondihydropyridine Calcium Channel Blocker • Consider Digoxin if symptomatic on optimized above regimen • Manage comorbid conditions (obesity, diabetes, ischemia) <p>Consider referral to cardiology specialist</p>	<ul style="list-style-type: none"> • Based on pharmacologic agents being utilized
Atrial Fibrillation/Flutter Management^{8,17}	<ul style="list-style-type: none"> • Control rate • Anti-coagulate based on risk factors for embolic stroke <ul style="list-style-type: none"> ➢ Moderate risk factors: ≥75 yrs, hypertension, heart failure, LV Ejection Fraction (LVEF) ≤ 35%, Diabetes Mellitus ➢ High risk factors: history of stroke, TIA, or embolism; prosthetic heart valve; mitral stenosis • Consider restoration of sinus rhythm (restoration of sinus rhythm does not result in predictable clinical benefits) 	<ul style="list-style-type: none"> • Determine and document risk factors for ischemic stroke 	<p>Rate Control: (80 – 90 bpm at rest and < 110 – 130 bpm in moderate exercise)</p> <ul style="list-style-type: none"> • Digoxin (more effective at rest), Beta Blockers (more effective in exercise), Digoxin + Beta Blocker (more effective than BB alone), or non-dihydropyridine Calcium Channel Blockers <p>Anticoagulation:</p> <ul style="list-style-type: none"> • Anticoagulation with a vitamin K antagonist (warfarin) is recommended in all patients with afib and high risk factors for stroke, unless contraindicated • Anticoagulation with a vitamin K antagonist (warfarin) is recommended in all patients with afib and more than 1 moderate risk factor for stroke, unless contraindicated • For patients at low risk for stroke, aspirin 81-325 mg is appropriate <p>Restoration of Sinus Rhythm:</p> <ul style="list-style-type: none"> • Antiarrhythmic drugs and/or cardioversion • Evidence suggests that rate control is as effective as restoring sinus rhythm 	<ul style="list-style-type: none"> • For patients anticoagulated with Vitamin K antagonists: <ul style="list-style-type: none"> ➢ Target INR 2.5 (range 2.0-3.0) ➢ INR at least weekly until stable then monthly ➢ Extensive warfarin education ➢ Follow HR and maintain in normal range ➢ Consider referral to cardiac interventionist for evaluation for ICD/pacemaker/re-synchronization therapy when maximal therapy ≥ 9 months

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Tobacco Use ^{9, 10, 11, 12, 13}	<ul style="list-style-type: none"> Smoking cessation 	<ul style="list-style-type: none"> Tobacco use patterns Prior attempts to quit Readiness assessment 	<p>Think: 5 As</p> <ul style="list-style-type: none"> Ask about smoking Advise to quit Assess willingness to quit Assist user to quit (i.e.: refer to smoking cessation program and consider pharmacotherapy) Arrange follow-up <p>Pharmacotherapy adjuvants</p> <ul style="list-style-type: none"> Nicotine replacement Anti-depressants Varenicline 	<ul style="list-style-type: none"> Call on quit date or within 72 hours to boost self-efficacy Assess each visit: smoking status, weight gain, nicotine withdrawal symptoms
Weight Management ²	<ul style="list-style-type: none"> Calculate BMI and measure waist circumference 	<ul style="list-style-type: none"> BMI Target: 18.5-24.9 kg/m² Waist Target: 35 inches for females, 40 inches for males (varies by ethnicity) 	<ul style="list-style-type: none"> Prescribe weight management and physical activity programs as indicated 	
Physical Activity ²	<ul style="list-style-type: none"> Assess physical activity levels and opportunities for exercise 	<ul style="list-style-type: none"> Goal is 30 minutes per day of moderate intensity exercise for all or most days of the week 	<ul style="list-style-type: none"> Encourage 30 minutes of exercise 5-7 days per week Advise medically supervised programs for moderate to high-risk patients 	
SUGGESTED GUIDELINES	PROCESS	IMPORTANT FINDINGS, MEASUREMENTS AND VALUES	INTERVENTIONS	FOLLOW-UP
Immunizations ¹⁵	<ul style="list-style-type: none"> Immunization record/history 		<ul style="list-style-type: none"> Influenza vaccine to all patients yearly Pneumonia vaccine to all patients over age 65 or all patients with HF, diabetes, or other chronic illness as appropriate 	
Alcohol Avoidance ^{1,2,6}	<ul style="list-style-type: none"> Assesses alcohol intake at each visit 	<ul style="list-style-type: none"> No more than: <ul style="list-style-type: none"> 2 drinks per day for men; 1 drink per day for women Those with LV dysfunction should have no more than 1 drink per day 	<ul style="list-style-type: none"> Patients with alcohol-induced cardiomyopathy should abstain completely from alcohol 	<ul style="list-style-type: none"> Avoids excessive alcohol or abstains completely
Drug Use Screening ^{1,2,6}	<ul style="list-style-type: none"> Screen for illicit drug use 	<ul style="list-style-type: none"> Obtain history of current and past use of illicit drugs, current or past standard or “alternative therapies” and chemotherapy drugs 	<ul style="list-style-type: none"> Screens at initial and follow up visits 	<ul style="list-style-type: none"> Encourage the understanding of the relationship between drug use and CV disease and agrees to eliminate illicit drug use
Depression Screening ^{7,14, 16}	<ul style="list-style-type: none"> Screen for presence of depression 	<ul style="list-style-type: none"> Validated depression screening tool such as PHQ2/9 Mental health history/treatment 	<ul style="list-style-type: none"> Administer treatment and/or refer patients who meet criteria for depression to a mental health specialist 	<ul style="list-style-type: none"> Screening is suggested at subsequent visits Evaluate response to depression treatment with three follow-up contacts in 12 weeks and adjust medication as indicated and/or confer with appropriate treating mental health specialist
End of Life Issues ^{7, 16}	<ul style="list-style-type: none"> Set appointment specifically to discuss end of life issues 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Discuss patient’s prognosis, end of life, palliative care, life supportive care, hospice, and advance directives while they are stable 	<ul style="list-style-type: none"> Update end of life conversations yearly or more frequently as appropriate

			<ul style="list-style-type: none"> Develop an end-of-life care plan for sudden decompensation, death or progressive decline, including the inactivation of an implantable defibrillator to allow a natural death. 	
<p>*Cardiovascular disorders (CVD) included in this guide relate to hypertension, coronary heart disease (CHD), heart failure (HF) and atrial fibrillation. **There are some reports of angioedema with ARBs.</p>				

ACTIONS	FREQUENCY
ASSESSMENT FOR HYPERTENSION	At each visit
FASTING LIPID PROFILE	At least annually
SCREENING FOR ABNORMAL GLUCOSE METABOLISM	At least every three years
FLU AND PNEUMONIA VACCINE	Annually/initially
SMOKING CESSATION COUNSELING	Each provider visit
LIFESTYLE ASSESSMENT/COUNSELING	Each provider visit
DEPRESSION SCREENING	At least annually
MEMBER EDUCATION Low Sodium Diet in HF and Hypertension Cholesterol Management Weight Management Exercise Counseling	Initially/Ongoing
PHARMACOLOGIC THERAPY FOR HF ACE Inhibitors/ARB Hydralazine/Nitrates when unable to take ACE/ARBs Beta-Blockers for systolic dysfunction Aldosterone antagonist for advanced heart failure Diuretics Digoxin if systolic heart failure and continued symptoms despite optimal therapy	Initially/Ongoing
PHARMACOLOGIC THERAPY FOR CAD ACE Inhibitors/ARB Beta-Blockers Aspirin/Anti-platelet Therapy Statin Nitroglycerine for patients with continued angina episodes Nitrates/Calcium Channel Blockers	Initially/Ongoing
EJECTION FRACTION	Baseline and with change in symptoms

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