Survey of Policies and Practices Related to Cardiovascular Health for Georgia's Health Plans

GEORGIA DEPARTMENT OF HUMAN RESOURCES

Cardiovascular disease (CVD) includes a wide array of conditions affecting the heart and blood vessels. This survey focuses on coronary artery, cerebrovascular and peripheral vascular diseases because they are the most common forms of CVD and because they share preventable pathways to disease.

We would like to begin by asking you about some characteristics of your particular health plan.

A. Health Plan Information

1. Currently, how many **physicians** are under contract with your health plan? _____

2. Which of the following **types of providers** are available through your health plan?

   1. ☐ Cardiologists → How many (total)? _____
   2. ☐ Registered Dieticians → How many (total)? _____
   3. ☐ Tobacco Control Specialists → How many (total)? _____
   4. ☐ Exercise Specialists → How many (total)? _____
   5. ☐ Family Medicine/Internal Medicine/Primary Care Physicians
   6. ☐ Pediatricians
   7. ☐ Obstetricians/Gynecologists
   8. ☐ Nurse Practitioners
   9. ☐ Physician Assistants
   10. ☐ Registered Nurses
   11. ☐ Health Educators
   12. ☐ Other providers (Specify: _____)

3. What **service area**(s) does your health plan cover in Georgia? (Please use the attached list of counties to provide this information or state "All of Georgia")
   _____
   _____

GEORGIA COUNTIES LIST							
Appling		Dooly		Long		Telfair	
Atkinson		Dougherty		Lowndes		Terrell	
Bacon		Douglas		Lumpkin		Thomas	
Baker		Early		Macon		Telfair	
Baldwin		Echols		Madison		Terrell	
Banks		Effingham		Marion		Thomas	
Barrow		Elbert		McDuffie		Tift	
Bartow		Emanuel		McIntosh		Toombs	
Ben Hill		Evans		Meriwether		Towns	
Berrien		Fannin		Miller		Treutlen	
Bibb		Fayette		Milton		Troup	
Bleckley		Floyd		Mitchell		Turner	
Brantley		Forsyth		Monroe		Twiggs	
Brooks		Franklin		Montgomery		Union	
Bryan		Fulton		Morgan		Upson	
Bulloch		Gilmer		Murray		Walker	
Burke		Glascock		Muscogee		Walton	
Butts		Glynn		Newton		Ware	
Calhoun		Grady		Oconee		Warren	
Camden		Greene		Oglethorpe		Washington	
Campbell		Gwinnett		Old Walton		Wayne	
Candler		Habersham		Paulding		Webster	
Carroll		Hall		Peach		Wheeler	
Catoosa		Hancock		Pickens		White	
Charlton		Haralson		Pierce		Whitfield	
Chatham		Harris		Pike		Wilcox	
Chattahoochee		Hart		Polk		Wilkes	
Chattooga		Heard		Pulaski		Wilkinson	
Cherokee		Henry		Putnam		Worth	
Clarke		Houston		Quitman			
Clay		Irwin		Rabun			
Clayton		Jackson		Randolph			
Clinch		Jasper		Richmond			
Cobb		Jeff Davis		Rockdale			
Coffee		Jefferson		Schley			
Colquitt		Jenkins		Screven			
Columbia		Johnson		Seminole			
Cook		Jones		Spalding			
Coweta		Lamar		Stephens			
Crawford		Lanier		Stewart			
Crisp		Laurens		Sumter			
Dade		Lee		Talbot			
Dawson		Liberty		Taliaferro			
Decatur		Lincoln		Tattnall			
DeKalb				Taylor			
Dodge							

4. In what **year** was your health plan first licensed in Georgia? _____

5. Is your health plan **accredited** by NCQA? 1. Yes ___ 2. No ___ 3. ___ Not Sure/DK

6. How many **total members** were enrolled in your health plan on July 1st for the following years?

   1. Year 2000 _____
   2. Year 2001 _____
   3. Year 2002 _____
   4. Year 2003 _____

With your permission, now we would like to ask some specific questions related to your plan's polices and guidelines for Primary Prevention of CVD.

B. Policies and Guidelines for Primary Prevention of Cardiovascular Disease

A **policy** is a position statement. It is a written statement of generally recommended procedures and goals acceptable to your health plan. A **guideline** refers to an explicit indication or outline of how your policy on CVD Health should be put into action.

7. Does your health plan have a **written position statement or guideline related to the primary prevention of CVD**? (**Primary Prevention** is a measure that can be undertaken to prevent the development of disease. As an example, preventing young adults from smoking cigarettes is a primary prevention measure for CVD.

Check all that apply:

1. ☐ Health plan has a policy statement
2. ☐ Health plan has a written guideline

   ... *If you have a written guideline, how was it established?*

   a. ☐ Established our own

   b. ☐ Used American Heart Association's (AHA) *Guide to Primary Prevention of CVD* – **see Attachment 1**

   c. ☐ Used some other source

   May we have a copy of your policy/guidelines? ___ Yes ___ No

3. ☐ No (***Go to Question 12***)
4. ☐ Don't Know/Not Sure

8. Has that policy or guideline been **distributed** to your network of participating providers?

   1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

9. Does your health plan **promote** the AHA's *Guide to Primary Prevention of Cardiovascular Disease* for your members and participating providers?

   1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

10. Does your health plan **provide** the AHA's *Guide to Primary Prevention of Cardiovascular Disease* to participating providers?

    1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

11. How many **patient charts are reviewed** per year to assess compliance with your plan's policy/guidelines?

    1. ☐ _____ patient charts per year
       (number)
    2. ☐ We have not reviewed patient charts to assess compliance with the plan's policy/guidelines.
    3. ☐ Don't Know/Not Sure

    May we have a copy of your chart review protocol? ___ Yes
    ___ No

We would like to ask some specific questions related to your plan's policies and guidelines for secondary prevention of CV Health.

C. Policies and Guidelines for Secondary Prevention of Cardiovascular Disease

Secondary Prevention are measures that are undertaken when disease has been documented. These measures prevent the development of progressive cardiovascular disease. As an example, individuals with elevated low density lipoproteins unresponsive to diet and exercise may need statin drugs to prevent the further development of cardiovascular disease

12. Does your health plan have a **written policy statement or guideline related to secondary prevention** of cardiovascular disease? ***Check all that apply:***

1. ☐ Health plan has a policy statement
2. ☐ Health plan has a written guideline

… If you have a written guideline, how was it established?

a. ☐ Established our own

b. ☐ Uses AHA's *Guide to Comprehensive Risk Reduction for Patients with Coronary and Other Vascular Diseases* – **See Attachment 2**

c. ☐ Used some other source

May we have a copy of your policy/guideline? ___ Yes ___ No

3. ☐ No (***Go to Question 17***)
4. ☐ Don't Know/Not Sure (***Go to Question 17***)

13. Has that policy or guideline been **distributed** to your network of participating providers?

1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

14. Does your health plan **promote** the AHA's *Guide to Comprehensive Risk Reduction for Patients with Coronary and Other Vascular Diseases* for your members and participating providers?

1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

15. Does your health plan **provide** the AHA's *Guide to Comprehensive Risk Reduction for Patients with Coronary and Other Vascular Diseases* to participating providers?

1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

16. How many **patient charts are reviewed** per year to assess compliance with your plan's policy/guidelines?

1. ☐ _____ patient charts per year
   (number)
2. ☐ We have not reviewed patient charts to assess compliance with the plan's policy/guidelines.
3. ☐ Don't Know/Not Sure

May we have a copy of your chart review protocol? ___ Yes ___ No

We would now like to discuss measures you may be utilizing to address risk factors for cardiovascular disease.

D. Counseling: CVD, Smoking Cessation, Physical Activity, Nutrition

17. Does your health plan promote and/or encourage participating providers to **assess and counsel members on:**

	a. **All Members**	b. **Only Selected Members (e.g. only persons with or at high risk for CVD)**	c. **No One**
1. **Tobacco**	☐	☐	☐
2. **Physical activity** (exercise)	☐	☐	☐
3. **Nutrition**	☐	☐	☐

18. Does your health plan promote and/or encourage participating providers to **refer smokers to the Georgia Tobacco Quit Line?**

	a. **All Members who Smoke**	b. **Only Selected Members who Smoke (e.g. only persons with or at high risk for CVD)**	c. **No One (If Checked see 18a)**
Georgia Tobacco Quit Line	☐	☐	☐

18a. Did you know that there is a **Quit Line** for **Georgians** who want to quit smoking?

1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

19. Does your health plan provide a **benefit that allows discounts or fee reductions** to members who join specified programs to help start and maintain:

	a. **Yes**	b. **No**	c. **Not Sure / Don't Know**
1. **Tobacco** (e.g. Cessation Program)	☐	☐	☐
2. **Physical activity** (e.g. Exercise; Fitness Clubs)	☐	☐	☐
3. **Nutrition** (e.g. Weight Watchers)	☐	☐	☐

20. Does your health plan **reimburse providers and pay members** who receive the following assessment and counseling from specialists?

	a. **Yes**	b. **No**	c. **Not Sure / DK**
1. **Tobacco Cessation Counseling (Tobacco Control Specialists)**	☐	☐	☐
2. **Physical Activity or Exercise Assessment / Counseling from Exercise Physiologist**	☐	☐	☐
3. **Nutrition Assessment / Counseling (Medical Nutrition Therapy)**	☐	☐	☐

21. How many **patient charts are reviewed** per year to assess whether providers are conducting assessments and counseling for:

	a. **Tobacco**	b. **Physical Activity**	c. **Nutrition**
1. ☐ Patient charts per year	_____ (number)	_____ (number)	_____ (number)

2. ☐ We have not reviewed patient charts to assess compliance with counseling/assessment.
3. ☐ Don't Know/Not Sure

May we have a copy of your chart review protocol? ___ Yes ___ No

We would now like to discuss measures you may be utilizing to address risk factors for cardiovascular disease through health education.

E. Health Education: CVD, Smoking Cessation, Physical Activity, Nutrition

22. Does your health plan **provide financial support** for education programs regarding the signs and symptoms of heart attack and stroke?

1 ☐ Yes ----------> What type of education is provided? **(Check all that apply:)**

2 ☐ No

3 ☐ Don't Know/ Not Sure

- a) ☐ Community health messages
- b) ☐ Worksite health messages
- c) ☐ CPR training to public
- c) ☐ Discounts on CPR training for members
- e) ☐ Other (Please specify:) _____
- f) ☐ Don't Know/Not Sure

23. Does your health plan routinely provide the following health education to your members (i.e. classes, newsletters, media campaigns, lectures, etc.)?

	a. **Yes**	b. **No**	c. **Don't Know / Not Sure**
1. **Tobacco Use Education**	☐	☐	☐
2. **Physical Activity Education**	☐	☐	☐
3. **Nutrition Education**	☐	☐	☐

24. What types of educational materials are provided to all plan members? **(Check all that apply:)**

	a. **Tobacco Use Education**	b. **Physical Activity Education**	c. **Nutrition Education**
1. **Classes**	☐	☐	☐
2. **Newsletters**	☐	☐	☐
3 **Media Campaigns**	☐	☐	☐
4. **Posters**	☐	☐	☐

5. **Brochures**	☐	☐	☐
6. **Videos**	☐	☐	☐
7. **Other**	☐	☐	☐
(Please Specify:)	_____	_____	_____
8. **Don't Know / Not Sure**	☐	☐	☐

The following questions relate to assessment and counseling regarding high blood pressure and cholesterol levels.

F. Assessment and Counseling for High Blood Pressure and High Cholesterol Levels

25. Does your **health plan reimburse providers or pay for members to have their lipid levels checked**?

    1. ☐ Yes → If yes, which of the following are routinely checked?
        a. ☐ Total serum cholesterol
        b. ☐ High and low density lipoproteins
        c. ☐ Trigylcerides
    2. ☐ No (**Go to Question 27**)
    3. ☐ Don't Know/Not Sure (**Go to Question 27**)

26. Under your health plan's coverage, **how often can members have their lipid levels checked**?

    1. _____ times per ☐ year → If so, what lipid levels are checked?
       Check all that apply:
    2. ☐ Don't Know/Not Sure
        a. ☐ Total cholesterol
        b. ☐ High & low density lipoproteins
        c. ☐ Trigylcerides

27. Does your health plan **reimburse providers** for therapeutic lifestyle change counseling for patients with **hyperlipidemia**?

    1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

28. Does your health plan **reimburse physicians** for therapeutic lifestyle change counseling for patients with **hypertension**?

    1. ☐ Yes 2. ☐ No 3. ☐ Don't Know/Not Sure

29. Does your health plan **assist physicians in achieving blood pressure control** in hypertensive patients?

1 ☐ Yes ----------> If yes, what type of assistance is provided?

2 ☐ No (**Check all that apply**)

3 ☐ Don't Know/ Not Sure

a. ☐ Protocols or algorithms specifying visit/ monitoring schedule

b. ☐ Feedback on rates of BP control using claims data

c. ☐ Feedback on rates of BP control using medical records audit data

d. ☐ Free CME sessions on blood pressure control

e. ☐ Other (please specify:) _____

f. ☐ Don't Know/Not Sure

30. Does your health plan **assist physicians in achieving cholesterol control in patients with hyperlipidemia**?

1 ☐ Yes ----------> If yes, what type of assistance is provided?

2 ☐ No (**Check all that apply**)

3 ☐ Don't Know/Not Sure

a. ☐ Protocols or algorithms specifying visit/ monitoring schedule

b. ☐ Feedback on cholesterol levels using claims data

c. ☐ Feedback on cholesterol levels using medical records audit data

d. ☐ Diet and exercise measures

e. ☐ Other (please specify:) _____

f. ☐ Don't Know/Not Sure

Our final question concerns whether your health plan has a Heart Disease Quality Initiative (QI).

G. Quality Initiative for Heart Disease

31. Do you have a **Quality Initiative** (QI) related to heart disease?

1. ☐ Yes ----------→ If yes, what **type of initiative** is this?
2. ☐ No
3. ☐ Don't Know/Not Sure

a. ☐ A QI study or QI studies
b. ☐ A disease management program
c. ☐ Other (please specify: _____)
d. ☐ Don't Know/Not Sure

32. **Any additional comments?**

Thank you for taking the time to respond to this survey!

33. **Person responding to these questions:** _____

Title: _____

Date: _____

01/20/04

ATTACHMENT 1 – PRIMARY PREVENTION GUIDELINES

Risk Intervention and Goals	Recommendations
Smoking Goal: Complete cessation. No exposure to environmental tobacco smoke.	Ask about tobacco use status at every visit. In a clear, strong, and personalized manner, advise every tobacco user to quit. Assess the tobacco user's willingness to quit. Assist by counseling and developing a plan for quitting. Arrange follow-up, referral to special programs, or pharmacotherapy. Urge avoidance of exposure to *secondhand* smoke at work or home.
BP control Goal: <140/90 mm Hg; <130/85 mm Hg if renal insufficiency or heart failure is present; or <130/80 mm Hg if diabetes is present.	Promote healthy lifestyle modification. Advocate weight reduction; reduction of sodium intake; consumption of fruits, vegetables, and low-fat dairy products; moderation of alcohol intake; and physical activity in persons with BP of ≥130 mm Hg *systolic* or 80 mm Hg diastolic. For persons with renal insufficiency or heart failure, initiate drug therapy if BP is ≥130 mm Hg *systolic* or 85 mm Hg diastolic (≥80 mm Hg diastolic for patients with diabetes). Initiate drug therapy for those with BP ≥140/90 mm Hg if 6 to 12 months of lifestyle modification is not effective, depending on the number of risk factors present. Add BP medications, individualized to other patient requirements and characteristics (eg, age, race, need for drugs with specific benefits).
Dietary intake Goal: An overall healthy eating pattern.	Advocate consumption of a variety of fruits, vegetables, grains, low-fat or nonfat dairy products, fish, legumes, poultry, and lean meats. Match energy intake with energy needs and make appropriate changes to achieve weight loss when indicated. Modify food choices to reduce *saturated* fats (<10% of calories), cholesterol (<300 mg/d), and *trans*-fatty acids by substituting grains and unsaturated fatty acids from fish, vegetables, legumes, and nuts. Limit salt intake to <6 g/d. Limit alcohol intake (≤2 drinks/d in men, ≤1 drink/d in women) among those who drink.
Aspirin Goal: Low-dose aspirin in persons at higher CHD risk (especially those with 10-y risk of CHD ≥10%).	Do not recommend for patients with aspirin intolerance. Low-dose aspirin increases risk for gastrointestinal bleeding and hemorrhagic stroke. Do not use in persons at increased risk for these diseases. Benefits of cardiovascular risk reduction outweigh these risks in most patients at higher coronary risk.[25–27] Doses of 75–160 mg/d are as effective as higher doses. Therefore, consider 75–160 mg aspirin per day for persons at higher risk (especially those with 10-y risk of CHD of ≥10%).
Blood lipid management Primary goal: LDL-C <160 mg/dL if ≤1 risk factor is present; LDL-C <130 mg/dL if ≥2 risk factors are present and 10-y CHD risk is <20%; or LDL-C <100 mg/dL if ≥2 risk factors are present and 10-y CHD risk is ≥20% or if patient has diabetes. Secondary goals (if LDL-C is at goal range): If triglycerides are >200 mg/dL, then use non-HDL-C as a secondary goal: non-HDL-C <190 mg/dL for ≤1 risk factor; non-HDL-C <160 mg/dL for ≥2 risk factors and 10-y CHD risk ≤20%; non-HDL-C <130 mg/dL for diabetics or for ≥2 risk factors and 10-y CHD risk >20%. Other targets for therapy: triglycerides >150 mg/dL; HDL-C <40 mg/dL in men and <50 mg/dL in women.	If LDL-C is above goal range, initiate additional therapeutic lifestyle changes consisting of dietary modifications to lower LDL-C: <7% of calories from saturated fat, cholesterol <200 mg/d, and, if further LDL-C lowering is required, dietary options (plant stanols/sterols not to exceed 2 g/d and/or increased viscous [soluble] fiber [10–25 g/d]), and additional emphasis on weight reduction and physical activity. If LDL-C is above goal range, rule out secondary causes (liver function test, thyroid-stimulating hormone level, urinalysis). After 12 weeks of therapeutic lifestyle change, consider LDL-lowering drug therapy if: ≥2 risk factors are present, 10-y risk is >10%, and LDL-C is ≥130 mg/dL; ≥2 risk factors are present, 10-y risk is <10%, and LDL-C is ≥160 mg/dL; or ≤1 risk factor is present and LDL-C is ≥190 mg/dL. Start drugs and advance dose to bring LDL-C to goal range, usually a statin but also consider bile acid–binding resin or niacin. If LDL-C goal not achieved, consider combination therapy (statin+resin, statin+niacin). After LDL-C goal has been reached, consider triglyceride level: If 150–199 mg/dL, treat with therapeutic lifestyle changes. If 200–499 mg/dL, treat elevated non-HDL-C with therapeutic lifestyle changes and, if necessary, consider higher doses of statin or adding niacin or fibrate. If >500 mg/dL, treat with fibrate or niacin to reduce risk of pancreatitis. If HDL-C is <40 mg/dL in men and <50 mg/dL in women, initiate or intensify therapeutic lifestyle changes. For higher-risk patients, consider drugs that raise HDL-C (eg, niacin, fibrates, statins).
Physical activity Goal: At least 30 min of moderate-intensity physical activity on most (and preferably all) days of the week.	If cardiovascular, respiratory, metabolic, orthopedic, or neurological disorders are suspected, or if patient is middle-aged or older and is sedentary, consult physician before initiating vigorous exercise program. Moderate-intensity activities (40% to 60% of maximum capacity) are equivalent to a brisk walk (15–20 min per mile). Additional benefits are gained from vigorous-intensity activity (>60% of maximum capacity) for 20–40 min on 3–5 d/wk. Recommend resistance training with 8–10 different exercises, 1–2 *sets* per exercise, and 10–15 repetitions at moderate intensity ≥2 d/wk. Flexibility training and an increase in daily lifestyle activities should complement this regimen.
Weight management Goal: Achieve and maintain desirable weight (body mass index 18.5–24.9 kg/m^2). When body mass index is ≥25 kg/m^2, waist circumference at iliac crest level ≤40 inches in men, ≤35 inches in women.	Initiate weight-management program through caloric restriction and increased caloric expenditure as appropriate. For overweight/obese persons, reduce body weight by 10% in first year of therapy.
Diabetes management Goals: Normal fasting plasma glucose (<110 mg/dL) and near normal HbA1c (<7%).	Initiate appropriate hypoglycemic therapy to achieve near-normal fasting plasma glucose or as indicated by near-normal HbA1c. First step is diet and exercise. Second-step therapy is usually oral hypoglycemic drugs: sulfonylureas and/or metformin with ancillary use of acarbose and thiazolidinediones. Third-step therapy is insulin. Treat other risk factors more aggressively (eg, change BP goal to <130/80 mm Hg and LDL-C goal to <100 mg/dL).
Chronic atrial fibrillation Goals: Normal sinus rhythm or, if chronic atrial fibrillation is present, anticoagulation with INR 2.0–3.0 (target 2.5).	Irregular pulse should be verified by an electrocardiogram. Conversion of appropriate individuals to normal sinus rhythm. For patients in chronic or intermittent atrial fibrillation, use warfarin anticoagulants to INR 2.0–3.0 (target 2.5). Aspirin (325 mg/d) can be used as an alternative in those with certain contraindications to oral anticoagulation. Patients <65 y of age without high risk may be treated with aspirin.

BP indicates blood pressure; CHD, coronary heart disease; LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; and INR, international normalized ratio.

Circulation. **July 16, 2002;106:388-391.**

ATTACHMENT 2 – SECONDARY PREVENTION GUIDELINES

<table>
<tr><th>Goals</th><th colspan="3">Intervention Recommendations</th></tr>
<tr><td>Smoking:
<u>Goal</u>
complete cessation</td><td colspan="3">Assess tobacco use. Strongly encourage patient and family to stop smoking and to avoid secondhand smoke. Provide counseling, pharmacological therapy, including nicotine replacement and buproprion, and formal smoking cessation programs as appropriate.</td></tr>
<tr><td>BP control:
<u>Goal</u>
<140/90 mm Hg or
<130/85 mm Hg if heart failure or renal insufficiency
<130/80 mm Hg if diabetes</td><td colspan="3">Initiate lifestyle modification (weight control, physical activity, alcohol moderation, moderate sodium restriction, and emphasis on fruits, vegetables, and low-fat dairy products) in all patients with blood pressure ≥130 mm Hg systolic or 80 mm Hg diastolic.
Add blood pressure medication, individualized to other patient requirements and characteristics (ie, age, race, need for drugs with specific benefits) if blood pressure is not <140 mm Hg systolic or 90 mm Hg diastolic or if blood pressure is not <130 mm Hg systolic or 85 mm Hg diastolic for individuals with heart failure or renal insufficiency (<80 mm Hg diastolic for individuals with diabetes).</td></tr>
<tr><td rowspan="2">Lipid management:
<u>Primary goal</u>
LDL <100 mg/dL</td><td colspan="3">Start dietary therapy in all patients (<7% saturated fat and <200 mg/d cholesterol) and promote physical activity and weight management. Encourage increased consumption of omega-3 fatty acids. Assess fasting lipid profile in all patients, and within 24 hr of hospitalization for those with an acute event. If patients are hospitalized, consider adding drug therapy on discharge. Add drug therapy according to the following guide:</td></tr>
<tr><td>LDL <100 mg/dL
(baseline or on-treatment)
Further LDL-lowering therapy not required
Consider fibrate or niacin (if low HDL or high TG)</td><td>LDL 100–129 mg/dL
(baseline or on-treatment)
Therapeutic options:
Intensify LDL-lowering therapy (statin or resin*)
Fibrate or niacin (if low HDL or high TG)
Consider combined drug therapy (statin+fibrate or niacin) (if low HDL or high TG)</td><td>LDL ≥130 mg/dL
(baseline or on-treatment)
Intensify LDL-lowering therapy (statin or resin*)
Add or increase drug therapy with lifestyle therapies</td></tr>
<tr><td>Lipid management:
<u>Secondary goal</u>
If TG ≥200 mg/dL, then non-HDL† should be <130 mg/dL</td><td colspan="3">If TG ≥150 mg/dL or HDL <40 mg/dL: Emphasize weight management and physical activity. Advise smoking cessation.
If TG 200–499 mg/dL: Consider fibrate or niacin after LDL-lowering therapy*
If TG ≥500 mg/dL: Consider fibrate or niacin before LDL-lowering therapy*
Consider omega-3 fatty acids as adjunct for high TG</td></tr>
<tr><td>Physical activity:
<u>Minimum goal</u>
30 minutes 3 to 4 days per week
<u>Optimal</u> daily</td><td colspan="3">Assess risk, preferably with exercise test, to guide prescription.
Encourage minimum of 30 to 60 minutes of activity, preferably daily, or at least 3 or 4 times weekly (walking, jogging, cycling, or other aerobic activity) supplemented by an increase in daily lifestyle activities (eg, walking breaks at work, gardening, household work). Advise medically supervised programs for moderate- to high-risk patients.</td></tr>
<tr><td>Weight management:
<u>Goal</u>
BMI 18.5–24.9 kg/m^2</td><td colspan="3">Calculate BMI and measure waist circumference as part of evaluation. Monitor response of BMI and waist circumference to therapy.
Start weight management and physical activity as appropriate. Desirable BMI range is 18.5–24.9 kg/m^2.
When BMI ≥25 kg/m^2, goal for waist circumference is ≤40 inches in men and ≤35 inches in women.</td></tr>
<tr><td>Diabetes management:
<u>Goal</u>
HbA1$_c$ <7%</td><td colspan="3">Appropriate hypoglycemic therapy to achieve near-normal fasting plasma glucose, as indicated by HbA1$_c$.
Treatment of other risks (eg, physical activity, weight management, blood pressure, and cholesterol management).</td></tr>
<tr><td>Antiplatelet agents/ anticoagulants:</td><td colspan="3">Start and continue indefinitely aspirin 75 to 325 mg/d if not contraindicated. Consider clopidogrel 75 mg/d or warfarin if aspirin contraindicated. Manage warfarin to international normalized ratio=2.0 to 3.0 in post-MI patients when clinically indicated or for those not able to take aspirin or clopidogrel.</td></tr>
<tr><td>ACE inhibitors:</td><td colspan="3">Treat all patients indefinitely post MI; start early in stable high-risk patients (anterior MI, previous MI, Killip class II [S$_3$ gallop, rales, radiographic CHF]). Consider chronic therapy for all other patients with coronary or other vascular disease unless contraindicated.</td></tr>
<tr><td>β-Blockers:</td><td colspan="3">Start in all post-MI and acute ischemic syndrome patients. Continue indefinitely. Observe usual contraindications. Use as needed to manage angina, rhythm, or blood pressure in all other patients.</td></tr>
</table>

BP indicates blood pressure; TG, triglycerides; BMI, body mass index; HbA1$_c$, major fraction of adult hemoglobin; MI, myocardial infarction; and CHF, congestive heart failure.

*The use of resin is relatively contraindicated when TG >200 mg/dL.

†Non-HDL cholesterol=total cholesterol minus HDL cholesterol.

***Circulation*. September 25, 2001;104:1577-1579.**