Suggested Guidelines for Secondary Prevention and Risk Reduction Therapy
for Patients with Coronary and Other Atherosclerotic Vascular Disease*

Area for Intervention	*Recommendations*
Smoking	Goal: Complete cessation. No exposure to environmental tobacco smoke. Advise at every office visit.
Blood Pressure control	Goal: <140/90 mm Hg Patients with BP≥140/90 mm Hg should be treated, as tolerated, with BP medication; treating initially with B-blockers and/or ACE inhibitors, with addition of other drugs as needed to achieve goal BP.
Lipid management	Goal: Treatment with statin therapy; use statin therapy to achieve an LDL-C of <100 mg/dL; for very high risk patients an LDL-C <70 mg/dL is reasonable; if triglycerides are ≥200 mg/dL, non-HDL-C should be <130 mg/dL, whereas non-HDL-C <100 mg/dL for very high risk patients is reasonable.
Physical activity	Goal: at least 30 minutes, 7 days per week (minimum 5 days per week).
Weight Management	Goals: Body mass index: 18.5 to 24.9 kg/m^2; Waist circumference: women <35 inches, men <40 inches.
Type 2 diabetes mellitus management	Note: Recommendations below are for prevention of cardiovascular complications. • Care for DM should be coordinated with the patient's PCP and/or endocrinologist. • Lifestyle modifications including daily physical activity, weight management, BP control, and lipid management are recommended for all patients with diabetes.
Influenza vaccination	Annual influenza vaccination recommended.
Depression	For patients with recent CABG or MI, it is reasonable to screen for depression if patients have access to case management, in collaboration with their PCP and a mental health specialist.
Cardiac rehabilitation	All eligible patients with ACS or whose status is immediately post CABG or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit. All eligible outpatients with the diagnosis of ACS, CABG or PCI, chronic angina and/or PAD within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.

Area for Intervention	*Recommendations*
Antiplatelet agents/anticoagulants	Aspirin 75-162 mg daily is recommended in all patients with CAD unless contraindicated. • Clopidogrel 75 mg daily is recommended as an alternative for patients who are intolerant of or allergic to aspirin. A P2Y12 receptor antagonist (clopidogrel 75 mg daily, prasugrel 10 mg daily or ticagrelor 90 mg twice daily) in combination with aspirin is indicated for all patients after PTCA with placement of either a bare-metal or drug-eluting stent. A minimum of 12 months of treatment with a P2Y12 receptor antagonist is recommended after any stent placement for ACS. A P2Y12 receptor antagonist in combination with aspirin is also indicated for all patients after ACS with/without stent placement. For patients undergoing CABG, ASA dosing regimens ranging from 100 to 325 daily for 1 year appear to be efficacious.
Renin-angiotensin-aldosterone system blockers	ACE inhibitors should be started and continued indefinitely in all patients with left ventricular ejection fraction $\leq$40% and in those with HTN, diabetes or CKD, unless contraindicated. ARBS are recommended in patients who have HF or who have had an MI with left ventricular ejection fraction $\leq$40% and who are ACE-inhibitor intolerant. Aldosterone blockade in post-MI patients without significant renal dysfunction (estimated creatinine clearance should be >30 mL/min.) or hyperkalemia (potassium should be <5.0 mEq/L) is recommended in patients who are already receiving therapeutic doses of an ACE inhibitor and B-blocker, who have a left ventricular ejection fraction $\leq$40%, and who have either diabetes or HF.
B-Blockers	Should be started and continued for 3 years in all patients with normal left ventricular function who have had myocardial infarction or ACS. (Use should be limited to carvedilol, metoprolol succinate or bisoprolol, which have been shown to reduce mortality). Should be used in all patients with left ventricular systolic dysfunction (ejection fraction $\leq$40%), unless contraindicated.

Heartcare – CAD is a Health Management Program available to ConnectiCare members diagnosed with coronary artery disease. Enrolled members may receive educational materials and individualized health coaching and case management from a registered nurse. To enroll a member in Heartcare – CAD or ConnectiCare's program for smoking cessation, QuitCare, call **1-800-390-3522.** To learn more about ConnectiCare's Health Management Programs refer to ConnectiCare's Physician and Provider Manual or **www.connecticare.com**.

** Based on the AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2011 Update: A guideline from the AHA and ACCF*