IMPROVING CARDIOVASCULAR OUTCOMES IN PRIMARY CARE

EvidenceNow SOUTHWEST
Advancing Heart Health in Primary Care
208 practices in Colorado, 52 in New Mexico
Evidence based information for CVD prevention

CMEs & MOC Part IV

Data Health IT Services

Health Extension (HEROs)

Facilitation Services

ACADEMIC DETAILING
Evidence-based, non-product-driven research & communication about real-world clinical decisions.

(2016 NaRCAD Training)
Drug Industry: Great Communicators

Academia: Trusted source of clinical information

ACADEMIC DETAILING
At the core:

What’s the point of evidence-based medicine?

- Identify effective and safe treatments...
- Increase their use
- Avoid causing harm

Benefit to One-on-One Interaction

The academic detailer can accomplish several key goals:

• Understand the clinician’s current practices, attitudes, and beliefs;

• Tailor a message specifically targeted to that person’s educational needs, and where he or she is coming from;

• Keep the learner engaged. *(It’s harder to read e-mails, or doze off if you’re in the middle of a conversation.)*
Why is Academic Detailing a preferred method to Sharing Evidence Based Medicine?

• Traditional methods for disseminating EB information does not guide/change clinical behavior (direct mail, journal publications, electronic dissemination, etc.)

• Up to 17 years for proven info to change clinical behaviors
Academic detailing is not:

A brochure sent by mail or dropped off at the clinic
PowerPoint lecture
Primarily about cost reduction

MICHAEL A. FISCHER, M.D., M.S., “Evidence-based Medicine and Academic Detailing in the 21st Century” from 2016 NaRCAD Training
IMPROVING CARDIOVASCULAR OUTCOMES IN PRIMARY CARE

EvidenceNow SouthWest
The sources for the guidelines and recommendations shared through this academic detailing process are:

- Aspirin when appropriate
- Blood pressure control
- Cholesterol management
- Smoking cessation

JNC-8
Eighth Joint National Committee on Prevention, Detection, Evaluation, and Treatment of Hypertension

U.S. Preventive Services Task Force

American College of Cardiology

American Heart Association
The State of Health in Colorado

- **Heart disease** is the No. 2 killer in Colorado
  
  = 6,177 people in CO died of heart disease in 2014

- **Stroke** is the No. 5 killer in Colorado
  
  = 1606 people in CO died of stroke in 2014

- Colorado’s **strength**: 49th highest death rate from cardiovascular disease in the country.
**Primary prevention** is designed to prevent a disease or condition, from occurring in the first place.

*Example:* Regular physical activity to reduce the risk of developing cardiovascular disease is a classic example of primary prevention measures.

**Secondary prevention** attempts to identify a disease at its earliest stage so that prompt and appropriate management can be initiated. Successful secondary prevention reduces the impact of the disease.

*Example:* A person gets lab work done to detect high blood pressure or high cholesterol. If diagnosed, this allows treatment to begin at an early stage of the disease.
Primary prevention is designed to prevent a disease or condition, from occurring in the first place.

Example: Regular physical activity to reduce the risk of developing cardiovascular disease is a classic example of primary prevention measures.

Secondary prevention attempts to identify a disease at its earliest stage so that prompt and appropriate management can be initiated. Successful secondary prevention reduces the impact of the disease.

Example: A person gets lab work done to detect high blood pressure or high cholesterol. If diagnosed, this allows treatment to begin at an early stage of the disease.
How to Use this Guide

**At-A-Glance Decision Tree**
Each page begins with an at-a-glance decision tree that distills the latest evidence-based guidelines, focusing specifically on any new elements in the recommendations.

**Additional Tools/Info**
Any additional information or tools relevant to the new guideline are included in summarized form.
Clinical Guidelines
The full clinical guideline language from the relevant source.

References
Listing of any sources, academic journal articles, national white papers, etc.

Additional Tips

How to Use this Guide

EVIDENCE BASE: BLOOD PRESSURE CONTROL

Current JNC 8 guidelines are based on multiple studies.

Recommendation 1: In the general population aged 60 years or older, initiate pharmacologic treatment to lower blood pressure (BP) at systolic blood pressure (SBP) of 150 mm Hg higher or diastolic blood pressure (DBP) of 90 mm Hg or higher and treat to a goal SBP <150 mm Hg and goal DBP <90 mm Hg. (Strong Recommendation – Grade A)

Recommendation 2: In the general population < 60 years, initiate pharmacologic treatment to lower BP at DBP ≥ 90 mm Hg and treat to a goal DBP < 90 mm Hg. (For ages 30-59 years, Strong Recommendation – Grade A; For ages 18-29 years, Expert Opinion – Grade E)

Recommendation 3: In the general population < 60 years, initiate pharmacologic treatment to lower BP at SBP ≥ 140 mmHg and treat to a goal SBP <140 mmHg. (Expert Opinion – Grade E)

Recommendation 4: In the population aged ≥ 18 years with chronic kidney disease, initiate pharmacologic treatment to lower BP at SBP ≥ 140 mm Hg or DBP ≥ 90 mm Hg. (Expert Opinion – Grade E)

Recommendation 5: In the population aged ≥ 18 years with diabetes, initiate pharmacologic treatment to lower BP at SBP ≥ 140 mm Hg or DBP ≥ 90 mm Hg. (Expert Opinion – Grade E)

References:
1. Askjdflsdkjflkfdj
2. Sdfkjalsdflkjaslkdj
3. Asldkfjaskldklajsf
4. Asldkfjaskldkasldj

Choosing an antihypertensive drug class based on patient characteristics

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Best Suited For:</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiazide-type diuretics</td>
<td>A first-line treatment in most patients</td>
<td>Monitor kidney function &amp; potassium (↓)</td>
</tr>
<tr>
<td>ACE-I or ARB</td>
<td>Diabetes -Chronic kidney disease -Congestive heart failure -Ischemic heart disease</td>
<td>Monitor kidney function &amp; potassium (↑) (if ACE-I, monitor cough; switch to ARB)</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>Coronary artery disease -Congestive heart failure</td>
<td>No longer first choice for uncomplicated hypertension - Use with caution in obstructive pulmonary disease</td>
</tr>
<tr>
<td>Calcium Channel Blockers (CCB)</td>
<td>Coronary artery disease (if beta-blocker intolerant)</td>
<td>Lower extremity edema - Constipation</td>
</tr>
</tbody>
</table>
Throughout this guide, we will reference several tools you can use to make informed choices as a primary care provider, based on the latest cardiovascular guidelines. The following icons are used as a quick reference:

**ASCVD Calculator**

A key tool necessary to implement many of the new guidelines related to cardiovascular disease prevention is the “ASCVD calculator”. This calculator enables health care providers and patients to estimate 10-year and lifetime risks for atherosclerotic cardiovascular disease (ASCVD), defined as coronary death or nonfatal myocardial infarction, or fatal or nonfatal stroke, based on the Pooled Cohort Equations and lifetime risk prediction tools.

Use this calculator to assess long term CVD risk. The information required to estimate ASCVD risk includes age, sex, race, total cholesterol, HDL cholesterol, systolic blood pressure, blood pressure lowering medication use, diabetes status and smoking status. It is available as both a free smartphone app and an online tool.

For use on a computer:
http://tools.acc.org/ASCVD-Risk-Estimator/

For use on a smartphone or tablet:
* Download free app
* Search for “ASCVD calculator” and look for this icon:
DAILY LOW-DOSE ASPIRIN REDUCES TOTAL CARDIOVASCULAR EVENTS BUT NOT REDUCTION IN ALL-CAUSE MORTALITY OR CARDIOVASCULAR MORTALITY AND INCREASED RISK OF BLEEDING, ESPECIALLY GASTROINTESTINAL (GI) BLEEDING
Does the patient have established cardiovascular disease?
Does the patient have established cardiovascular disease? YES
Does the patient have established cardiovascular disease?

YES

THE CLEAR CHOICE:
Treat all patients with established CVD with low-dose aspirin.
(patients with history/diagnosis of heart attack, angina, stroke, heart failure, irregular heart beat)
Does the patient have established cardiovascular disease?

THE CLEAR CHOICE:
Treat all patients with established CVD with low-dose aspirin.
(patients with history/diagnosis of heart attack, angina, stroke, heart failure, irregular heart beat)
Does the patient have established cardiovascular disease?

**NO**

RISK vs BENEFIT: Evidence for aspirin as primary prevention is mixed.

**YES**

THE CLEAR CHOICE: Treat all patients with established CVD with low-dose aspirin. (patients with history/diagnosis of heart attack, angina, stroke, heart failure, irregular heart beat)
Does the patient have established cardiovascular disease?

**NO**

**RISK vs BENEFIT:** Evidence for aspirin as primary prevention is mixed.

1. Calculate ASCVD risk
2. Consider bleeding risk
3. Estimate net potential benefit for patient

**YES**

**THE CLEAR CHOICE:** Treat all patients with established CVD with low-dose aspirin.
(patients with history/diagnosis of heart attack, angina, stroke, heart failure, irregular heart beat)
Does the patient have established cardiovascular disease?

**YES**

THE CLEAR CHOICE:
Treat all patients with established CVD with low-dose aspirin.
(patients with history/diagnosis of heart attack, angina, stroke, heart failure, irregular heart beat)

**NO**

RISK vs BENEFIT:
Evidence for aspirin as primary prevention is mixed.

LOW-DOSE ASPIRIN RECOMMENDED AS PRIMARY PREVENTION:
- Age 50-59
- 10-year ASCVD risk ≥ 10%
- 10+ year life expectancy
- Willing to take daily dose for at least 10 years
Does the patient have established cardiovascular disease?

NO

RISK vs BENEFIT: Evidence for aspirin as primary prevention is mixed.

LOW-DOSE ASPIRIN RECOMMENDED AS PRIMARY PREVENTION:
- Age 50-59
- 10-year ASCVD risk ≥ 10%
- 10+ year life expectancy
- Willing to take daily dose for at least 10 years

YES

THE CLEAR CHOICE: Treat all patients with established CVD with low-dose aspirin.
(patients with history/diagnosis of heart attack, angina, stroke, heart failure, irregular heart beat)

Daily low-dose aspirin not recommended for patients under age 50 or over age 70. Decision to recommend for patients age 60-69 should be an individual one, based on the value of potential benefits vs known risks.
Recommendation: For patients with established coronary artery disease (CAD), (including patients after the first year post-ACS and/or with prior coronary artery bypass graft [CABG] surgery): long-term single antiplatelet therapy with **aspirin 75 to 100 mg daily** OR clopidogrel 75 mg daily over no antiplatelet therapy.

Recommendation: For adults aged 50 to 59 years with a ≥10% 10-year CVD risk, the USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. [Grade B]

Recommendation: Adults aged 60 to 69 years with a ≥10% 10-year CVD risk, the decision to initiate low-dose aspirin use for the primary prevention of CVD and CRC in adults aged 60 to 69 years who have a 10% or greater 10-year CVD risk should be an individual one. Persons who are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years are more likely to benefit. Persons who place a higher value on the potential benefits than the potential harms may choose to initiate low-dose aspirin.

References:
Blood pressure control
Screening for and treating hypertension can improve the health of patients and the population.

1 in 3 adults suffer from hypertension

1 in 3 adults with hypertension do not know they have this disease

1 in 3 adults treating their hypertension cannot adequately control it

EFFECTIVE TREATMENT FOR HYPERTENSION CAN REDUCE

Heart Failure  50%
Stroke        35-40%
MI            20-25%
How old is the patient?
How old is the patient?

Over 60 years old
How old is the patient?

Over 60 years old

Blood pressure control

150

90 or under
How old is the patient?

- Under 60 years old
- Over 60 years old

Blood pressure control

150
90
or under
How old is the patient?

- **Under 60 years old**:
  - Blood pressure: 140/90 or under

- **Over 60 years old**:
  - Blood pressure: 150/90 or under

Blood pressure control
How old is the patient?

Under 60 years old

140
90 or under

Over 60 years old

150
90 or under
How old is the patient?

Under 60 years old:
- BP ≤ 140/90

Over 60 years old:
- BP ≤ 150/90

Regardless of age, patients with diabetes or chronic kidney disease should aim for BP of ≤ 140/90.
Lifestyle modification remains a critical component of health promotion and ASCVD risk reduction, both prior to and in addition to the use of antihypertensive medications.

Choosing an antihypertensive drug class based on patient characteristics

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Best Suited For:</th>
<th>Risks/Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiazide-type diuretics</td>
<td>A first-line treatment in most patients</td>
<td>- Monitor kidney function &amp; potassium (↓)</td>
</tr>
<tr>
<td>ACE-I or ARB</td>
<td>-Diabetes</td>
<td>- Monitor kidney function &amp; potassium (↑)</td>
</tr>
<tr>
<td></td>
<td>-Chronic kidney disease</td>
<td>(if ACE-I, monitor cough; switch to ARB)</td>
</tr>
<tr>
<td></td>
<td>-Congestive heart failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Ischemic heart disease</td>
<td></td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>-Coronary artery disease</td>
<td>- No longer first choice for uncomplicated hypertension</td>
</tr>
<tr>
<td></td>
<td>-Congestive heart failure</td>
<td>- Use with caution in obstructive pulmonary disease</td>
</tr>
<tr>
<td>Calcium Channel Blockers (CCB)</td>
<td>Coronary artery disease (if beta-blocker intolerant)</td>
<td>- Lower extremity edema</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Constipation</td>
</tr>
</tbody>
</table>
**Recommendation 1:** In the general population aged 60 years or older, initiate pharmacologic treatment to lower blood pressure (BP) at systolic blood pressure (SBP) of 150 mm Hg higher or diastolic blood pressure (DBP) of 90 mmHg or higher and treat to a goal SBP <150 mm Hg and goal DBP <90 mm Hg. (Strong Recommendation – Grade A)

**Recommendation 2:** In the general population < 60 years, initiate pharmacologic treatment to lower BP at DBP ≥ 90 mm Hg and treat to a goal DBP < 90 mm Hg. (For ages 30-59 years, Strong Recommendation – Grade A; For ages 18-29 years, Expert Opinion – Grade E)

**Recommendation 3:** In the general population < 60 years, initiate pharmacologic treatment to lower BP at SBP ≥ 140 mmHg and treat to a goal SBP <140 mmHg. (Expert Opinion – Grade E)

**Recommendation 4:** In the population aged ≥ 18 years with chronic kidney disease, initiate pharmacologic treatment to lower BP at SBP ≥ 140 mm Hg or DBP ≥ 90 mm Hg. (Expert Opinion – Grade E)

**Recommendation 5:** In the population aged ≥ 18 years with diabetes, initiate pharmacologic treatment to lower BP at SBP ≥ 140 mm Hg or DBP ≥ 90 mm Hg. (Expert Opinion – Grade E)

**References:**
To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.
To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.

- **Encourage healthy lifestyle**
- **Calculate ASCVD risk every 4-6 years**

**AGE:** Any

**ASCVD RISK:** 0-5%

**DIABETES:** No

**LDL-C:** 70-189 mg/dL
To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.

**AGE:** Any

**ASCVD RISK:** 0-5%

**DIABETES:** No

**LDL-C:** 70-189 mg/dL

* Encourage healthy lifestyle
* Calculate ASCVD risk every 4-6 years

**AGE:** 18-40 OR 75+

**ASCVD RISK:** 5-7.5%

**DIABETES:** No

**LDL-C:** 70-189 mg/dL

* Clinician-patient discussion
* Re-evaluate status periodically
To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.

**Cholesterol management**

To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.

**To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.**

**AGE:**
- **Any**
- **18-40 OR 75+**
- **40-75**

**ASCVD RISK:**
- **0-5%**
- **5-7.5%**
- **5-7.5%**

**DIABETES:**
- **No**
- **No**
- **Yes**

**LDL-C:**
- **70-189 mg/dL**
- **70-189 mg/dL**
- **70-189 mg/dL**

**Treatment Options:***
- **Encourage healthy lifestyle**
- **Calculate ASCVD risk every 4-6 years**
- **Clinician-patient discussion**
- **Re-evaluate status periodically**
- **MEDIUM intensity statin**
- **Reinforce lifestyle**
- **Monitor adherence**
To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.

**AGE:**
- Any
- 18-40 OR 75+
- 40-75

**ASCVD RISK:**
- 0-5%
- 5-7.5%
- ≥ 7.5%

**DIABETES:**
- No
- Yes
- Yes/No

**LDL-C:**
- 70-189 mg/dL
- ≥ 190 mg/dL

- Encourage healthy lifestyle
- Calculate ASCVD risk every 4-6 years
- Clinician-patient discussion
- Re-evaluate status periodically
- MODERATE intensity statin
- Reinforce lifestyle
- Monitor adherence
- HIGH intensity statin
- Reinforce lifestyle
- Monitor adherence
To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.

**Cholesterol management**

To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.

**C**

**Encourage healthy lifestyle**

* Calculate ASCVD risk every 4-6 years

**AGE:** Any

**ASCVD RISK:** 0-5%

**DIABETES:** No

**LDL-C:** 70-189 mg/dL

---

**AGE:** 18-40 or 75+

**ASCVD RISK:** 5-7.5%

**DIABETES:** No

**LDL-C:** 70-189 mg/dL

---

**AGE:** 40-75

**ASCVD RISK:** 5-7.5%

**DIABETES:** Yes

**LDL-C:** 70-189 mg/dL

---

**AGE:** 40-75

**ASCVD RISK:** ≥ 7.5%

**DIABETES:** Yes/No

**LDL-C:** ≥ 190 mg/dL

---

**AGE:** 40-75

**ASCVD DIAGNOSIS**

* Encourage healthy lifestyle
* Calculate ASCVD risk every 4-6 years

* Clinician-patient discussion
* Re-evaluate status periodically

* MODERATE intensity statin
* Reinforce lifestyle
* Monitor adherence

* HIGH intensity statin
* Reinforce lifestyle
* Monitor adherence

AGE: 40-75

ASCVD DIAGNOSIS
To determine treatment options for cholesterol management, you will need to use the ASCVD calculator as well as have recent lab work measuring cholesterol levels.

**Cholesterol management**

- **Encourage healthy lifestyle**
- **Calculate ASCVD risk every 4-6 years**

**AGE:** Any  
**ASCVD RISK:** 0-5%  
**DIABETES:** No  
**LDL-C:** 70-189 mg/dL

**AGE:** 18-40 OR 75+  
**ASCVD RISK:** 5-7.5%  
**DIABETES:** No  
**LDL-C:** 70-189 mg/dL

**AGE:** 40-75  
**ASCVD RISK:** 5-7.5%  
**DIABETES:** Yes  
**LDL-C:** 70-189 mg/dL

**AGE:** 40-75  
**ASCVD RISK:** ≥ 7.5%  
**DIABETES:** Yes/No  
**LDL-C:** ≥ 190 mg/dL

- **MODERATE intensity statin**  
- **Reinforce lifestyle**  
- **Monitor adherence**

- **HIGH intensity statin**  
- **Reinforce lifestyle**  
- **Monitor adherence**

**AGE:** 75+  
**ASCVD DIAGNOSIS**

**AGE:** 40-75  
**ASCVD DIAGNOSIS**
Lifestyle modification remains a critical component of health promotion and ASCVD risk reduction, both prior to and in addition to the use of antihypertensive medications.

**STATIN BENEFITS FOR PATIENTS WITH KNOWN CORONARY ARTERY DISEASE**

- **16% reduction in absolute risk of death**
- **20% reduction in all major CVD events**

**MODERATE INTENSITY STATINS**
* Lower LDL by 30-50%*
- Atorvastatin 10-20 mg
- Rosuvastatin 5-10 mg
- Simvastatin 20-40 mg
- Pravastatin 40-80 mg

**HIGH INTENSITY STATINS**
* Lower LDL by 50+%*
- Atorvastatin 40-80 mg
- Rosuvastatin 20-40 mg
**Recommendation:** 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.

Presence of established CVD plus (1) multiple major risk factor (especially diabetes), (2) severe and poorly controlled risk factors (especially continued cigarette smoking), (3) multiple risk factors of the metabolic syndrome (especially high triglycerides ≥ 200 mg/dl plus non-HDL-C ≥ 130mg/dl with low HDL – C < 40 mg/dl, and (4) patients with acute coronary syndromes.

**Non-statins for Cholesterol Treatment:**

Ezetimibe lowers LDL, but has limited hard endpoint data. Reserve its use for patients unable to take a statin.

PCSK9 inhibitors are injectable agents that reduce LDL dramatically, but their role is not yet clear. Statins should remain the first choice.

**References:**

Smoking cessation
FOCUSED COUNSELING SESSIONS BETWEEN PROVIDER & PATIENT CAN INCREASE SUCCESSFUL TOBACCO CESSATION BY UP TO 20%
E-cigarettes are NOT associated with successful quitting in general population-based samples of smokers.

For patients ready to commit to quit, use both BEHAVIORAL INTERVENTIONS and PHARMACOLOGICAL THERAPY.

- Placebo: 14%
- Varenicline: 33%
- Nicotine gum (>14 weeks): 26%
- Bupropion SR: 24%
In New Mexico, insurance may not approve a prescription for pharmacotherapies unless the person has called the quit line.
Recommendation: The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration–approved pharmacotherapy for cessation to adults who use tobacco. (A recommendation)

References:
## Summary of EvidenceNOW Southwest Clinical Quality Measures

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>NQF</th>
<th>CMS ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Aspirin</td>
<td>Patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period and who had documentation of use of aspirin or another antithrombotic during the measurement period</td>
<td>0068</td>
<td>164v5.2</td>
</tr>
<tr>
<td>B: Blood Pressure Management</td>
<td>Patients aged 18 through 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year.</td>
<td>0018</td>
<td>165v3</td>
</tr>
<tr>
<td>C: Cholesterol Management</td>
<td>Statin use in at least one of the following populations: 1. Patients previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) 2. Patients aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL 3. Adult patients with a fasting or direct Low-Density Lipoprotein Cholesterol (LDL-C) level ≥ 190 mg/dL</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>S: Smoking Cessation Support</td>
<td>Patients aged 18 years or older who were screened about tobacco use one or more times within 24 months AND who received cessation counseling intervention, if identified as a tobacco user.</td>
<td>0028</td>
<td>138v5</td>
</tr>
</tbody>
</table>

These are the clinical quality measures determined by the EvidenceNOW initiative at the national level for tracking and measuring the ABCS. For the most part, they relate directly to measures already being tracked within electronic health records.