

The VA/DoD Cardiovascular Clinical Practice Guidelines for the Management of Hypertension, Ischemic Heart Disease, and the Pharmacologic Management of Chronic Heart Failure

Pilot Tool Kit

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September 2004**



Why Cardiovascular Guidelines?

- **Leading cause of death in men and women**
- **Leading cause of premature or permanent disability**
- **Top 5 causes of death in active duty population**

The Supporting Cardiovascular Toolkit

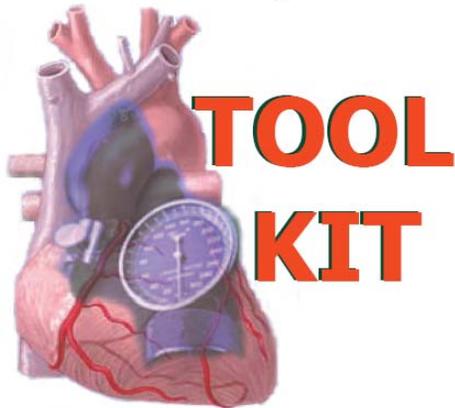
- **Group of multidisciplinary providers from VA, Army, Navy and AF met in Washington D.C in January, 2002**
- **Cardiovascular Guidelines presented by the VA and DoD Champions**
- **Broke up in provider, patient, system support groups to review tools**
- **Tools selected, work began on adapting them to the CVD CPGs**
- **Had teleconferences and email in refining tools**
- **Work was stopped with the delay of the cardiovascular guidelines**

The Cardiovascular Toolkit

VA/DoD

CardioVascular Disease

Clinical Practice Guidelines



Pilot Implementation
September, 2004



- Provider Support Tools
- Patient Self-Management Tools
- System Support Tools

Provider Support Tools

- **Guidelines and Summaries**
- **Champion's Implementation Manual**
- **Implementation Worksheets**
- **Documentation Forms**
- **Provider Reference and Pocket cards**

Provider Support Tools (cont)

- **VA Chronic Heart Failure Self-Management Health Tips**
- **Champion Briefs**
- **Pharmacotherapy for Cardiovascular Diseases in Primary Care Cards**
- **“Time is Life” Provider Fact Sheet**

Cardiovascular Guidelines

VA/DoD CLINICAL PRACTICE GUIDELINE FOR
THE MANAGEMENT OF ISCHEMIC HEART DISEASE
CORE MODULE SUMMARY

VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE
MANAGEMENT OF ISCHEMIC HEART DISEASE
MODULE A SUMMARY

VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE
MANAGEMENT OF ISCHEMIC HEART DISEASE
MODULE B SUMMARY

VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE
MANAGEMENT OF ISCHEMIC HEART DISEASE
MODULE C SUMMARY

VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE
MANAGEMENT OF ISCHEMIC HEART DISEASE
MODULE G SUMMARY

MEDICAL FOLLOW-UP AND SECONDARY PREVENTION

Patients who have a history of ischemic heart disease (IHD) are candidates for secondary prevention of further coronary events. These include patients with prior myocardial infarction (MI), ischemic cardiomyopathy, silent ischemia, segmental wall motion abnormality by left ventricular (LV) angiography or cardiac ultrasound, positive stress test, prior coronary revascularization, pathologic Q-waves on the resting electrocardiogram (ECG), and males older than age 50 with typical angina.

This module provides guidelines for clinical predictors for progression of IHD and identifies areas for which there are effective interventions. It also emphasizes that all patients are on optimal doses of pharmacological therapies with proven morbidity and mortality benefits, and that patients are assessed for possible benefits from a revascularization procedure.

This module also emphasizes the assessment for coronary artery disease (CAD) risk factors, where interventions are known to reduce the likelihood of future coronary events (particularly smoking, diabetes mellitus [DM], dyslipidemia, and hypertension). Although the evidence of benefit is less strong, the diagnosis and treatment of depression and promotion of cardiac rehabilitation are also discussed.

KEY ELEMENTS

Management of Medical Follow-Up

- Identify and triage IHD patients with a possible acute coronary syndrome (i.e., ST-elevation myocardial infarction (STEMI), non-ST-elevation myocardial infarction (NSTEMI), or unstable angina).
- Assess if stable symptoms are due to noncardiac conditions.
- Identify and treat other medical conditions that may exacerbate IHD symptoms.
- Ensure all patients receive aspirin (or other antiplatelet therapy, as appropriate).
- Titrate pharmacological therapy for ischemia, angina, and congestive heart failure (CHF) to physiologic end-points, therapeutic doses, or patient tolerance.
- Administer a cardiac stress test to assess the risk of future cardiac events, if not previously performed, or if there has been worsening of ischemic symptoms.
- Initiate angiotension-converting-enzyme (ACE) inhibitor therapy for patients with significant DM and/or left ventricular (LV) dysfunction (ejection fraction [EF] <0.40). Consider in patients without LV dysfunction.
- Identify and provide therapy for patients with heart failure.
- Identify patients at high risk for sudden cardiac death or complications for whom a cardiology referral is appropriate.

Secondary Prevention

- Assure appropriate treatment with beta-adrenergic blocking agents (beta-blockers) in patients with prior MI.
- Identify and treat patients with high low-density-lipoprotein cholesterol (LDL-C).
- Assess and treat high blood pressure.
- Reduce cardiac risk with smoking cessation.
- Promote cardiac rehabilitation as secondary prevention.
- Achieve tight glycemic control in diabetic

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Web version available online
at:

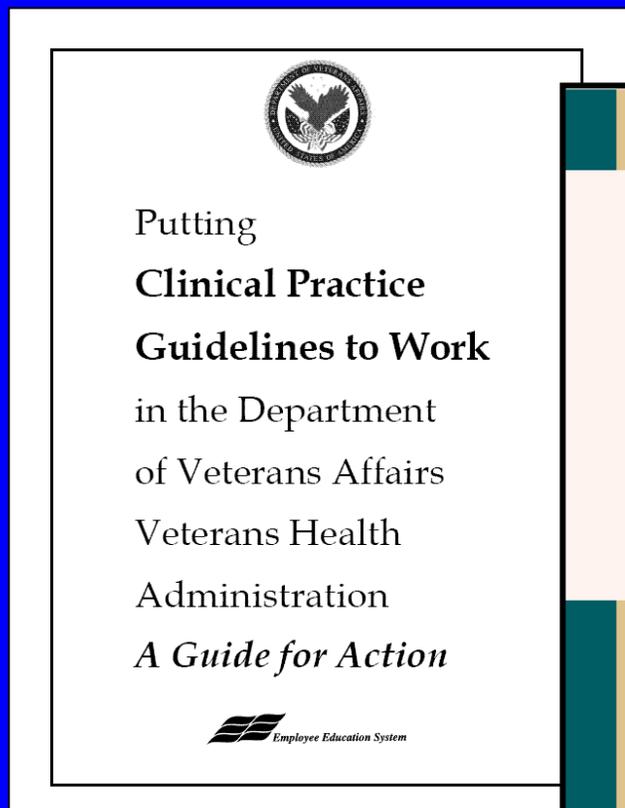
<http://www.oqp.med.va.gov/cpg/cpg.htm>

Also available online at:

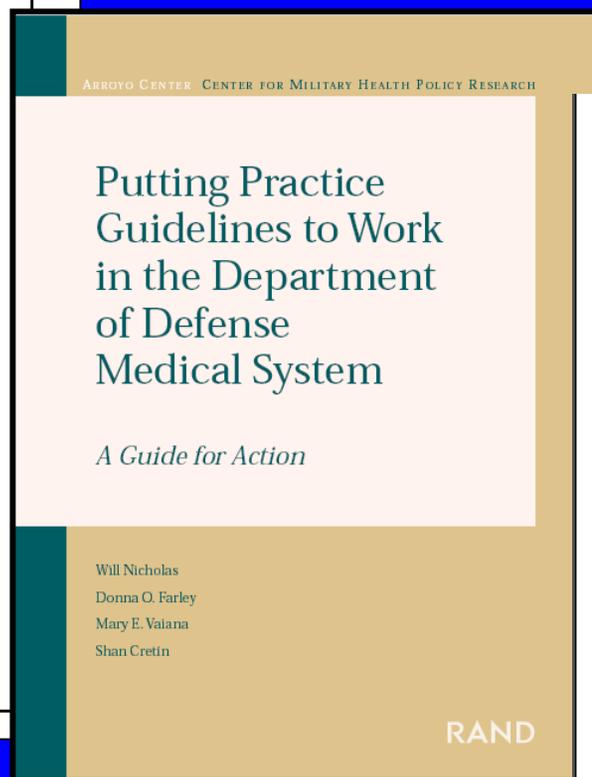
<http://www.QMO.amedd.army.mil>

Cardiovascular Guideline
Summaries available in the
CVD Binder

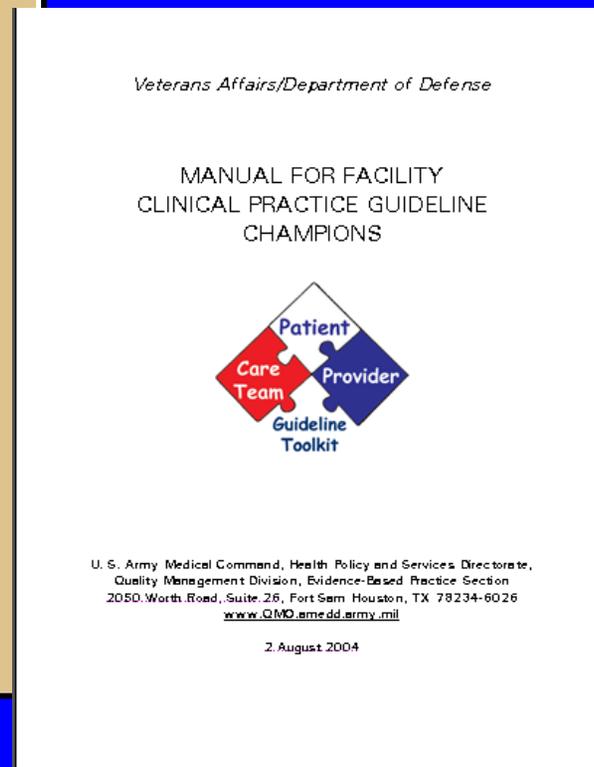
Manuals for Facility Clinical Practice Guideline Champions



VA Implementation Manual



RAND Implementation Manual



DoD Implementation Manual

Implementation Worksheets

Worksheet 1. IMPLEMENTATION STRATEGY
 Guideline: Management of Hypertension, Update 2004

Overall Implementation Strategy/Focus:

Key Guideline Element	Gaps in Current Practices (Planning Step 1)	Action Strategy (Planning Step 3)

Worksheet 2A. ACTION PLAN FOR GUIDELINE INTRODUCTION AND STAFF EDUCATION
 Guideline: Management of Hypertension, Update, 2004

Identify actions for guideline introduction and education. (IN)	Designate someone to serve as lead for the action and other staff to be involved.		Identify the tools and resources for the action.	Specify the action timeline.
Action #IN_ _	Lead:	Other Staff		Start Complete

Worksheet 3. GANTT CHART OF TIMELINE FOR GUIDELINE IMPLEMENTATION
 Guideline: Management of Hypertension, Update, 2004

Actions	MONTH OF WORK											
	1	2	3	4	5	6	7	8	9	10	11	12
<i>Introduction & Education</i>												
#IN_ _												
#IN_ _												
#IN_ _												
#IN_ _												
<i>Practice Changes</i>												
#_ _												
#_ _												
#_ _												
#_ _												
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5

Provider Documentation Form MEDCOM Test Form 744-R Front

Draft Documentation
Form developed by past
working group with CVD
key elements.

<input type="checkbox"/> Initial visit <input type="checkbox"/> Follow up visit		MEDICAL RECORD - CARDIOVASCULAR DISEASE OUTPATIENT DOCUMENTATION For use of this form see MEDCOM Cir 40-15				DATE:		
DRAFT FORM						TIME:		
SECTION I - SUBJECTIVE DATA: PATIENT HISTORY (To be completed by Patient, reviewed by Health Care Provider)								
Please check a Yes or No. If Yes, explain in the Remarks Section					YES	NO	Remarks:	
1. Do you have chest pain or shortness of breath?								
2. Any significant weight changes?								
3. Any emergency room visits or hospitalizations?								
4. Medication problems or changes?								
5. Do you use any herbal, supplement or over the counter products?								
6. Are you on a special diet (Diabetes, low salt, low cholesterol, DASH (Dietary Approaches to Stop Hypertension))?								
7. Do you exercise? What kind and how often?								
8. Do you have diabetes?								
9. Do you have any allergies?								
10. Are you on any over the counter medications? (please list below)								
Medications:								
SECTION II - VITAL SIGNS/SCREENING ASSESSMENT (To be completed by Ancillary Support Staff)								
BP: _____ PULSE: _____ RESP: _____ TEMP: _____ HT: _____ WT: _____ BMI: _____								
Age: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F								
Do you have pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____ Intensity: ____ /10 (0 = no pain -10 = worst pain)								
Deployment related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe								
During the past two weeks, have you been bothered by: Feeling down, depressed or hopeless? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Want to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Tobacco cessation material offered? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount per week _____ (Screener's Signature)								
SECTION III - SUBJECTIVE, OBJECTIVE, ASSESSMENT and PLAN (To be completed by Health Care Provider)								
Subjective:								
Review of Systems:								
	Yes	No		Yes	No		Yes	No
Chest pain			Weight Change			Syncope		
Shortness Of Breath			Edema			Fatigue		
Orthopnea			Claudication			Depressed		
Paroxysmal Nocturnal			Palpitations			Other:		
Objective:	Normal	Abnormal	Remarks	Studies/Lab Results				
General								
Neck								
Heart								
Lungs								
Abdomen								
Extremities								
Other:								
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)								

**Provider
Documentation
Form
MEDCOM Test Form
744-R
Back**

SECTION III - SUBJECTIVE, OBJECTIVE, ASSESSMENT and PLAN (Continued)			
Assessment: Check all that apply			
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Adequate Control - No change in treatment	<input type="checkbox"/> Uncontrolled	
<input type="checkbox"/> Dyslipidemia	LDL goal _____ <input type="checkbox"/> Met <input type="checkbox"/> Not met		
	HDL goal > _____ <input type="checkbox"/> Met <input type="checkbox"/> Not met		
	TG goal < _____ <input type="checkbox"/> Met <input type="checkbox"/> Not met		
<input type="checkbox"/> Ischemic Heart Disease	<input type="checkbox"/> Acute Disease (Immediate Urgent Care)	<input type="checkbox"/> Stable Post-MI	
	<input type="checkbox"/> Stable Post Revascularization	<input type="checkbox"/> Stent	<input type="checkbox"/> CABG
<input type="checkbox"/> Angina (Canadian Cardiovascular Society Classification of Angina = CCS)	<input type="checkbox"/> I (Angina only with strenuous exercise) <input type="checkbox"/> II (Angina with moderate exercise) <input type="checkbox"/> III (Angina with minimal exercise or ordinary activity) <input type="checkbox"/> IV (Angina at rest or with any physical activity)		
<input type="checkbox"/> Chronic Heart Failure	Ejection Fraction = _____ Date: _____	<input type="checkbox"/> < 40% <input type="checkbox"/> > 40%	
	(New York Heart Association Functional Classification = NYHA)	<input type="checkbox"/> Class I (No limitation of physical activity) <input type="checkbox"/> Class II (Slight limitation of physical activity) <input type="checkbox"/> Class III (Marked limitation of physical activity) <input type="checkbox"/> Class IV (Unable to carry on any activity without physical discomfort)	
Plan:			
Comments:			
New	Continue	Change	Ordered Studies/Labs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Aspirin/Anticoagulant: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Antilipidemic: _____ (up to 40 mg QD)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> B-Blocker: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ACEI: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ARB: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diuretic: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nitrates: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CCB: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Digoxin: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____
Other Medication Considerations:			
Referrals/Other:		Education:	
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Medical Nutrition Therapy	<input type="checkbox"/> Medication	<input type="checkbox"/> Diet
<input type="checkbox"/> Cardiac Rehab/Physical Therapy	<input type="checkbox"/> Tobacco Cessation	<input type="checkbox"/> Exercise	<input type="checkbox"/> Tobacco Cessation
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____	
Follow-Up Appointments:			
<input type="checkbox"/> 1 Month	<input type="checkbox"/> 3 Months	<input type="checkbox"/> 6 Months	
<input type="checkbox"/> CVD Group Visit	<input type="checkbox"/> Other: _____		
			_____ (Provider's Signature)

**Provider
Documentation
Cardiovascular Flow
Sheet
MEDCOM Test Form
744-1-R**

MEDICAL RECORD - CARDIOVASCULAR DISEASE FLOW SHEET								
DRAFT FORM		For use of this form see MEDCOM Cir 40-15						
Diagnosis: <input type="checkbox"/> HTN <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> CAD/IHD <input type="checkbox"/> CHF <input type="checkbox"/> DM								
Parameters:	Patient Goal	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Blood Pressure								
Tobacco Use (Y/N)								
BMI/Weight								
Exercise (# minutes/frequency per week)								
Lipids: TC								
HDL								
TG								
LDL								
HbA1c								
Microalbumin								
Serum Creatinine								
Eye Exam								
Foot Exam								
Electrocardiogram								
ECHO (EF%)								
Functional Assess (Exercise Stress Test etc)								
Yearly Influenza Vaccine								
Pneumonia Vaccine (> 65 yo; all with diabetes)								
Aspirin/Anticoagulant								
Beta Blocker (all with h/o MI)								
ACEI (all with diabetes and proteinuria; consider for CHF)								
Diuretic								
Nitroglycerin								
Antilipidemic Agent ()								
Patient Education	Diabetes	Medication	Nutrition Therapy	Tobacco Use Cessation				
Dates:								
Dates:								
<small>PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)</small>								

Pharmacotherapy for Cardiovascular Diseases in Primary Care Med Cards

Pharmacotherapy for Cardiovascular Diseases in Primary Care

VA/DoD Medications Used in the Management of Cardiovascular Diseases in Primary Care			
DRUG*	ORAL DOSE	POTENTIAL SIDE EFFECTS	PRECAUTIONS/CONTRAINDICATIONS/COMMENTS
ANTIPLATELET/ANTICOAGULANT			
Aspirin [†]	UAMI 160 mg-325 mg (1* dose) Chronic 81 mg-325 mg qd	<ul style="list-style-type: none"> GI intolerance: dyspepsia, nausea, GI bleeding, heartburn Bronchospasm: prominent in patients with a history of asthma and nasal polyps Tinnitus Thrombocytopenia 	<ul style="list-style-type: none"> ASA hypersensitivity: bronchospasm, angioedema, and anaphylaxis Active, severe bleeding Clopidogrel should be used in patients who are unable to take ASA
Clopidogrel ^{†,‡,§}	NSTE-ACS 300 mg oral load then 75 mg qd for at least 1 month & up to 9 months with elective PCI Post stent 300 mg oral load then 75 mg qd at least 1 month & up to 12 months Non acute conditions 75 mg qd May be given with aspirin (81-325 mg) unless aspirin is contraindicated or not tolerated	<ul style="list-style-type: none"> Thrombotic thrombocytopenic purpura rarely reported (sometimes after less than 2 weeks exposure) Bleeding GI intolerance: diarrhea Clopidogrel increases risk of major bleeding (i.e., requiring transfusion of ≥ 2 units) when combined with ASA 	<ul style="list-style-type: none"> History of bleeding diathesis Chest pain without ECG changes in whom etiology of chest pain is unlikely to be ischemic in origin Known hypersensitivity to ticlopidine, due to cross reactivity or any component of the product Known hypersensitivity to clopidogrel or any component of the product Active pathological bleeding (GI bleeding and intracranial hemorrhage) Withhold clopidogrel for 5-7 days prior to elective CABG or other major surgical intervention
Warfarin ^{†*}	Prevent systemic embolization: INR 2-3 Prevent recurrent MI within first 3 months: INR 2.5-3.5	<ul style="list-style-type: none"> Bleeding (e.g., GU/GI) Skin necrosis 	<ul style="list-style-type: none"> Pregnancy Hemophilia Cerebrovascular hemorrhage History of warfarin induced skin necrosis Vitamin K may decrease anticoagulant response; patient should be instructed on importance of consistent dietary intake of vitamin K
CARDIOVASCULAR			
ACE Inhibitors			
Captopril ^{†*}	12.5-150 mg/day (divided bid-tid)	<ul style="list-style-type: none"> Hypotension, hyperkalemia, acute renal impairment, angioedema, cough 	<ul style="list-style-type: none"> Avoid in 2nd and 3rd trimesters of pregnancy due to possible fetal and neonatal morbidity and death Hypersensitivity Bilateral renal artery stenosis Renal failure; use ACEI with caution in patients sCr >3.0 mg/dL Take captopril 1 hr prior to food ingestion Concomitant therapy with K⁺-sparing diuretics and/or K⁺ supplements may result in hyperkalemia
Enalapril ^{†*}	2.5-20 mg/day (divided qd-bid)	<ul style="list-style-type: none"> Monitor K⁺ and renal function 	
Fosinopril ^{†*}	5-40 mg qd		
Lisinopril ^{†*}	2.5-40 mg qd		
Ramipril ^{†,‡,§}	2.5-10 mg/day (divided qd-bid; qd for prevention of cardiovascular events)		

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VA access to full guideline: <http://www.oqp.med.va.gov/cpg/cpg.htm>

DoD access to full guideline: <http://www.QMO.amedd.army.mil>

Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services, Pharmacy Benefits Management Strategic Health Care Group (PBM), Medical Advisory Panel (MAP), and the Department of Defense.

December 2003



Primary Care	Primary Care	Primary Care
DIS/COMMENTS	COMMENTS	COMMENTS
<p>incy due to and death</p> <p>ot tolerate ACEIs uretics and/or emia</p> <p>roxin levels by igh digoxin</p> <p>esther</p> <p>armacologic effects of uction y disease</p> <p>atients with HF art rate, cause n A/V node k), systolic HF</p> <p>rith liver with caution in</p> <p>armacologic effects conduction ue to its potential otension</p> <p>ed hypokalemia ay cause ↑ K+ t require ey stones hough these</p> <p>roption; ↓ lithium</p> <p>e useful in e patch may not rst placed</p>	<p>nes</p> <p>tiated in</p> <p>hypertrophy rs to reduce</p> <p>for HF</p> <p>ven at</p> <p>prevent)</p> <p>intracranial</p> <p>athy as -70% levels by digoxin y ↑ risk of</p> <p>manufacturers se, and</p> <p>est dose in</p> <p>y is y). The risk ovastatin or 4 (azole ppressives, juice, rone).</p>	<p>se 8-10 gm/d rfer resin</p> <p>licated in</p> <p>contraindicated</p> <p>dosage to</p> <p>ts art or dosage after</p> <p>tablished or tion with gout if <10 ml/min</p> <p>et</p> <p>otransferase; (P :stinal; :osorbide mber SLE=systemic use</p>

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Page 3 of 4

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Provider Exam Room Cards

VA/DoD Cardiovascular Clinical Practice
Guidelines

PROVIDER REFERENCE CARDS

Hypertension
Ischemic Heart Disease
Chronic Heart Failure

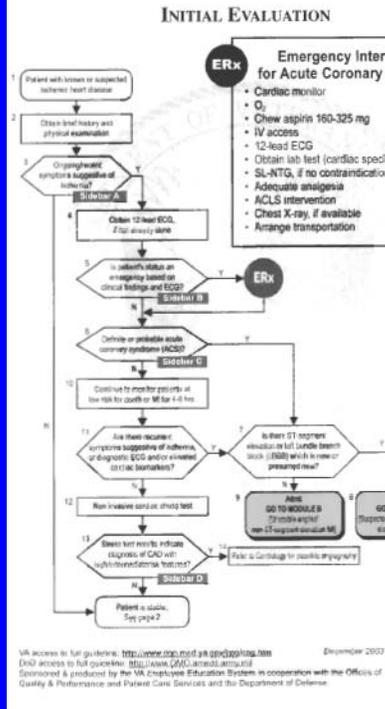


Clinical Practice Guideline Web Sites
www.QMO.amedd.army.mil

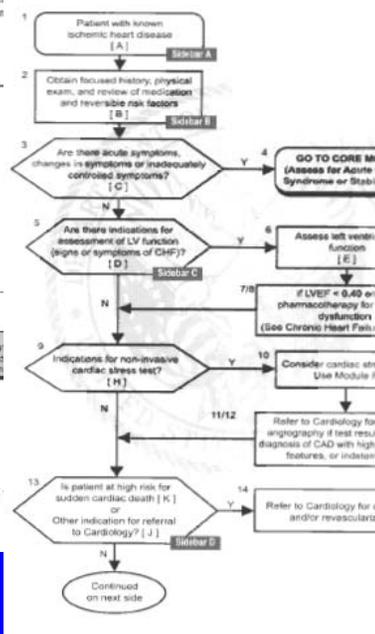
- **Guideline Key Elements**
- **Algorithms**
- **Population Level Metrics**
- **ICD-9-CM Codes**

Cardiovascular Provider Pocket Cards

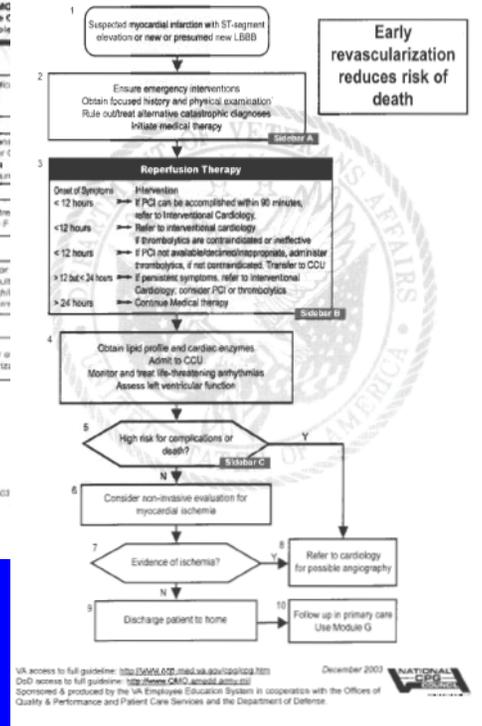
VA/DoD Clinical Practice Guideline Management of Ischemic Heart Disease (IHD) – Core Module Pocket Guide



VA/DoD Clinical Practice Guideline Management of Ischemic Heart Disease (IHD) Module G Pocket Guide Follow-Up & Secondary Prevention



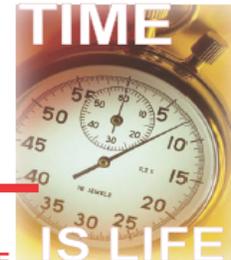
VA/DoD Clinical Practice Guideline Management of Ischemic Heart Disease (IHD) Module A Pocket Guide



Provider Fact Sheet “Time is Life”

Act in Time to Heart Attack Signs

Use the **T.I.M.E.** Method to Help Your Patients Make a Heart Attack Survival Plan



Why Your Patients Need to Act in Time to Heart Attack Signs

Coronary heart disease is the leading killer of both men and women in the United States. Each year, about 1.1 million Americans suffer a heart attack. About 460,000 of those heart attacks are fatal. Disability and death from heart attack can be reduced with prompt thrombolytic and other artery-opening-therapies ideally given within the first hour after symptom onset. Patient delay is the largest barrier to receiving therapy quickly.

Heart Attack Warning Signs

- ▶ Chest discomfort (pressure, squeezing, fullness, or pain in the center of the chest)
- ▶ Discomfort in one or both arms, back, neck, jaw, or stomach
- ▶ Shortness of breath (often comes with or before chest discomfort)
- ▶ Breaking out in a cold sweat, nausea, or light-headedness

Women May Experience:

- ♀ Shortness of breath without chest pain
- ♀ Pain in lower part of chest
- ♀ Fatigue

Uncertainty Is Normal

Most people think a heart attack is sudden and intense, like a “movie heart attack.” The fact is many heart attacks start slowly as mild pain or discomfort. People who feel such symptoms may not be sure what is wrong.

Delay Can Be Deadly

Most heart attack victims wait 2 or more hours after symptoms begin before they seek medical help. People often take a wait-and-see approach or deny that their symptoms are serious. Every minute that passes without treatment means more heart muscle dies. Calling 9-1-1 saves lives.

Use the T.I.M.E. is Life Method:

Talk with your patients about -

- ▶ Risk of a heart attack.
- ▶ Recognition of symptoms.
- ▶ Right action steps to take/rationale for rapid action.
- ▶ Rx-give instructions for when symptoms occur (based on patient history).
- ▶ Remembering to call 9-1-1 quickly within 5 minutes.

Investigate -

- ▶ Feelings about heart attack.
- ▶ Barriers to symptom evaluation and response.
- ▶ Personal and family experience with AMI and emergency medical treatment.

Make A Plan -

- ▶ Help patients and their family members to make a plan for exactly what to do in case of heart attack symptoms.
- ▶ Encourage patients and their family members to rehearse the plan.

Evaluate -

- ▶ The patient's understanding of risk in delaying.
- ▶ The patient's understanding of your recommendations.
- ▶ The family's understanding of risk and their plan for action.



Web Sites:
www.OMO.amedd.army.mil
www.OOP.med.va.gov

VA and DoD Champion Briefs

Patient Self-Management Tools

- **Educational Booklet and Brochures**
 - “Do Your Part: Care for Your Heart”
 - “Time is Life: Know the Warning Signs of a Heart Attack”
- **NIH “Facts About the DASH Diet”**
- **“Time is Life” action plan**
- **CEMM CD ROMS**
 - “Cardioconnection: Hypertension”
 - “Cardioconnection: Dyslipidemia”
- **Patient Wallet Cards**
- **Patient Video**
 - “Time is Life: Combat Heart Attack and Survive”

Cardiovascular Care Patient Information

DO YOUR PART



CARE FOR YOUR HEART



This patient guide will provide you with information related to the care of your heart. It is only the beginning of the educational process to become an active and effective partner in managing your cardiovascular health.

August 2003

Did You Know . . .

Heart attack victims do best when they are taken to the hospital withing the **first hour of the first** symptom?

Remember:

The longer you wait, the less likely medications will work and the higher your risk of death.

CALL 911:

Call **911** right away if you think it may be a heart attack. Do Not drive to the hospital. Emergency medical staff will take you to the hospital.





KNOW THE WARNING SIGNS OF A HEART ATTACK

Signs

Driving to the hospital yourself an delay care! It's too dangerous or you and other drivers.

Make a Plan:

Learn heart attack warning signs

Talk to your health care provider about reducing heart attack risks and completing a survival plan and wallet card

Share your survival plan with family and friends



TIME IS LIFE



DO NOT WAIT CALL 911 IMMEDIATELY!

Heart Disease is the leading cause of death in women

Besides symptoms common to men, women may have other symptoms such as:

- ✓ Shortness of breath without chest in pain
- ✓ Pain in the lower part of the chest
- ✓ Fatigue

- ✓ Chest discomfort with a feeling of doom or imminent death.
- ✓ Take 1 regular aspirin unless you are allergic to aspirin
- ✓ Tell the ambulance driver you are having chest pain

Don't delay because you are afraid of causing a scene or finding out it was a false alarm.

Web Sites:
www.QMO.amedd.army.mil
www.OQPmed.va.gov

Time is Life: Know the Warning Signs of a Heart Attack

DASH Diet

NIH

Waiting for copyright approval



FACTS ABOUT

The *DASH* Eating Plan



Research has found that diet affects the development of high blood pressure, or hypertension (the medical term). Recently, two studies showed that blood pressure can be lowered by following a particular eating plan—called the Dietary Approaches to Stop Hypertension (DASH) eating plan—and reducing the amount of sodium consumed.

While each step alone lowers blood pressure, the combination of the eating plan and a reduced sodium intake gives the biggest benefit and may help prevent the development of high blood pressure.

This fact sheet, based on the DASH research findings, tells about high blood pressure, and how to follow the DASH eating plan and reduce the amount of sodium you consume. It offers tips on how to start and stay on the eating plan, as well as a week of menus and some recipes. The menus and recipes are given for two levels of daily sodium consumption—2,400 milligrams (the upper limit of current recommendations by the Federal Government's National High Blood Pressure Education Program (NHBPEP) and the amount used to figure food labels' Nutrition Facts Daily Value) and 1,500 milligrams.

Those with high blood pressure may especially benefit from following the eating plan and reducing their sodium intake. But the combination is a heart healthy recipe that all adults can follow.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
National Heart, Lung, and Blood Institute

TO CONTROL BLOOD PRESSURE

DASH* TO THE DIET

FOLLOWING THE DASH EATING PLAN

**Dietary Approach to Stop Hypertension*

New research shows that a diet low in fat and rich in lowfat dairy foods, fruits and vegetables, substantially lowers blood pressure in people with or without high blood pressure without sodium restriction or the use of drugs. A great complement to other current lifestyle recommendations.

(Appel, et al., NEJM, 336(16), 1117-24, 1997)

NCE

blood pressure. The study
the diet and contained the
each of the food groups
For many people, following
in be an important and easy
aging high blood pressure.

1

corn flakes (with 1 tsp sugar)
lowfat milk
banana
whole wheat toast
jelly
grapefruit

sliced turkey
pita bread
lowfat mayonnaise
Raw vegetable medley with:
sticks each carrot and celery
radishes
loose leaf lettuce leaves
fruit cocktail in light syrup

dried apricots
mini pretzels
mixed nuts
flavored lowfat yogurt

grilled lean beef
scallion rice
steamed broccoli
spinach salad with
raw spinach
cherry tomatoes
cucumber slices
light Italian dressing
lowfat chocolate milk

reate a Baked Potato Bar—
erve baked potatoes with
variety of toppings like
fat cheese, chili, refried
beans, salsa or broccoli.
Add them up—one
meal could contain
three to four
vegetable servings!

ourage Big Dippers!
ake a fruit dip by sprinkling
marmoset into vanilla lowfat
yurt. For a quick vegetable
dip, add ranch seasoning or
enchilada onion soup mix to
plain lowfat yogurt.

Say Cheese!
Melt shredded lowfat cheese
over steamed vegetables.

Time is Life Action Plan



Patient Name: _____ Provider Name: _____ Date: _____

Know Heart Attack Warning Signs

- ✓ Uncomfortable pressure, fullness, squeezing or pain anywhere in the chest lasting more than a few minutes.
- ✓ Pain spreading to the shoulder, neck, in one or both arms, stomach or back
- ✓ Chest discomfort with lightheadedness, fainting, sweating, nausea, vomiting, or shortness of breath
- ✓ Chest discomfort with a feeling of doom or imminent death

Heart Disease Is The Leading Cause Of Death In Women

Beside symptoms common to men, women may have other symptoms such as:

- ✓ Shortness of breath without chest pain
- ✓ Pain in lower part of chest
- ✓ Fatigue

Call 911

If you have any of these warning signs of a heart attack:

- ✓ Don't delay
 - ✓ Call 911 Immediately
 - ✓ Take 1 regular aspirin unless you're allergic to aspirin
 - ✓ Tell the ambulance driver that you are having chest pain
- Driving yourself can delay care!
It's too dangerous for you and other drivers.*
- Don't delay because you may be afraid of causing a scene, or finding it was false alarm.*

Make A Plan

- ✓ Learn heart attack warning signs
- ✓ Share your plan with family and friends
- ✓ Talk to your health care provider about reducing heart attack risks and completing a survival plan wallet card.

My Medications & Specific Instructions From My Health Care Provider


 Web Sites:
www.CMOamedd.army.mil
www.OGP.med.va.gov

How To Reduce Your Risk of Heart Attack

- To find your risk for heart attack, check the boxes that apply to you:
- Family history of early heart disease (father or brother diagnosed before age 55 or mother or sister diagnosed before age 65)
 - Age (Men 45 years or older; Women 55 or older)
 - High blood cholesterol
 - High blood pressure
 - One or more previous heart attacks, angina, bypass surgery, or angioplasty, stroke, or blockages in neck or leg arteries
 - Overweight
 - Physically inactive
 - Cigarette smoker
 - Diabetes

The more risk factors you have, the greater your risk of heart attack.

Reduce Your Risk of Heart Attack by Taking Steps to Prevent or Control Risk Factors

High Blood Pressure

- ✓ Have your blood pressure checked
- ✓ Aim for a healthy weight
- ✓ Follow a healthy eating plan, including food lower in salt and sodium
- ✓ Limit alcoholic beverages
- ✓ Take medication as prescribed

High Blood Cholesterol

- ✓ Have blood cholesterol checked every 5 years, or more often if needed
- ✓ Learn what your cholesterol numbers mean
- ✓ Follow a low-saturated fat, low cholesterol eating plan
- ✓ Become physically active
- ✓ Aim for a healthy weight
- ✓ Take medication as prescribed

Cigarette Smoking

- ✓ Stop smoking or cut back gradually
- ✓ Attend a smoking cessation class
- ✓ Keep trying if you can't quit the first time

Overweight

- ✓ Maintain a healthy weight, try not to gain extra
- ✓ If you are overweight, try to lose slowly (1/2-1 pound a week)

Diabetes

- ✓ Find out if you have diabetes
- ✓ Have your blood sugar level checked by your health care provider
- ✓ Control your blood sugar levels

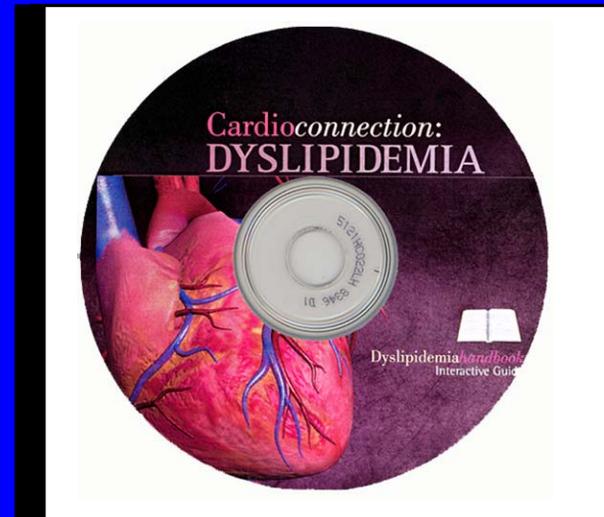
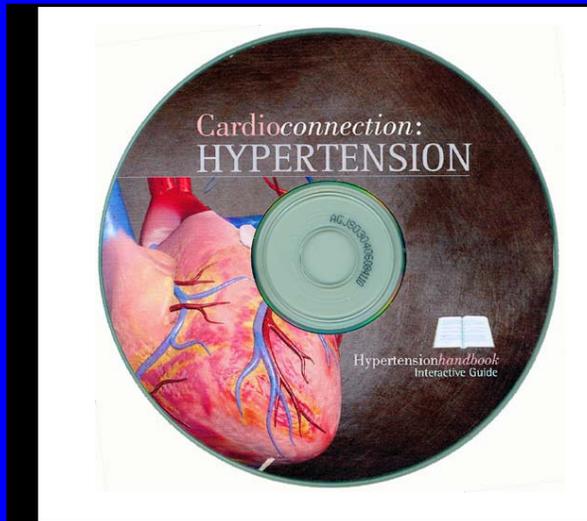
Physical Inactivity

- ✓ If you have a chronic condition or have been physically inactive, check with your provider before beginning exercise
- ✓ Do 30 minutes of moderate exercise, such as brisk walking, on most days of the week
- ✓ If needed, break the 30 minutes into periods of 10 minutes each

Call 911 right away if you think it may be a heart attack. Do not drive to the hospital. Emergency medical staff will take you to the hospital.

Have patient complete the action plan and sign with the provider

CEMM CD ROMS



Patient Wallet Cards

My Blood Pressure

It Is Important To Take Prescribed Blood Pressure Drugs !

Ask your health care provider to help you fill out the information below:

Blood Pressure Medicine:

Special Instructions:

Questions To Ask Your Provider If You Have High Blood Pressure ?

- What is my blood pressure reading in numbers?
- What is my goal blood pressure?
- Is there a healthy eating plan that I should follow to help lower my blood pressure and lose weight?
- Is it safe for me to do regular physical activity?
- What is the name of my medication? What is the generic name?
- What are the possible side effects of my medication?
- What time of day should I take my blood pressure medicine?
- Should I take it with or without food?
- What should I do if I forget to take my blood pressure medicine at the recommended time?



My Blood Pressure Wallet Card



Web Sites:
www.QMO.amedd.army.mil
www.OQP.med.va.gov

Time is Life: Heart Attack Warning Signs

Heart Attack Survival Plan !

Information for ambulance and hospital staff: My medicines & specific instructions from my health care Provider:

Medicines I'm allergic to:

Important Contact Information !

Health care provider phone number during office hours:

Phone number after office hours:

Person to contact if I go to the hospital:

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

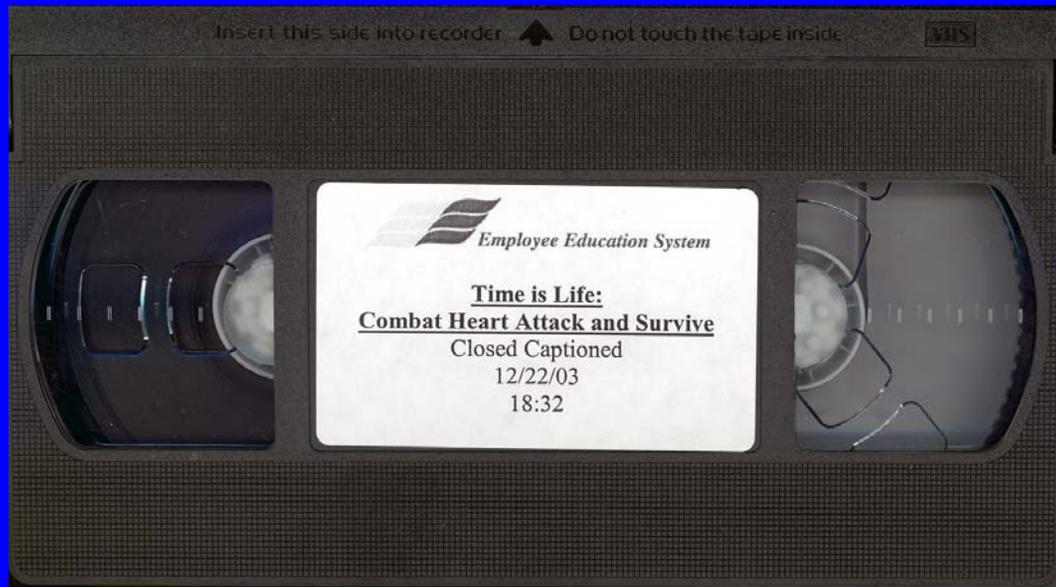


Heart Attack Warning Signs Wallet Card



Web Sites:
www.QMO.amedd.army.mil
www.OQP.med.va.gov

Patient Video “Time is Life: Combat Heart Attack and Survive”



Time is Life Poster



Know Heart Attack Warning Signs

- ✓ Uncomfortable pressure, fullness, squeezing or pain anywhere in the chest lasting more than a few minutes.
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♀ Heart Disease Is The Leading Cause Of Death In Women ♀

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*Driving yourself can delay care!
It's too dangerous for you and other drivers.*

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causing a scene, or finding it was false alarm.*

Make A Plan

- ✓ Learn heart attack warning signs
- ✓ Share your plan with family and friends
- ✓ Talk to your health care provider about reducing heart attack risks and completing a survival plan wallet card.



Web Sites:
www.CMO.amedd.army.mil
www.OOP.med.va.gov

Improving Chronic Illness Care Tools

Group Visit Starter Kit Improving Chronic Illness Care

Congestive Heart Failures Zones for Management

<p style="text-align: center;">Green Zone: All Clear</p> <p>Your Goal Weight: _____</p> <ul style="list-style-type: none"> ● No Shortness of breath ● No swelling ● No weight gain ● No chest pain ● No decrease in your ability to maintain your activity level 	<p style="text-align: center;">Green Zone Means:</p> <ul style="list-style-type: none"> ● Your symptoms are under control ● Continue taking your medications as ordered ● Continue daily weights ● Follow low-salt diet ● Keep all clinic appointments
<p style="text-align: center;">Yellow Zone: Caution</p> <p>If you have any of the following signs and symptoms:</p> <ul style="list-style-type: none"> ● Weight gain of 3 or more pounds ● Increased cough ● Increased swelling ● Increase in shortness of breath with activity ● Increase in the number of pillows needed ● Anything else unusual that bothers you <p style="text-align: center;">Call your health care provider if you are going into the YELLOW zone</p>	<p style="text-align: center;">Yellow Zone Means:</p> <ul style="list-style-type: none"> ● Your symptoms may indicate that you need an adjustment of your medications <p style="text-align: center;">Call your health care provider, nurse coordinator, or home health nurse.</p> <p>Name: _____</p> <p>Number: _____</p> <p>Instructions: _____</p>
<p style="text-align: center;">Red Zone: Medical Alert</p> <ul style="list-style-type: none"> ● Unrelieved shortness of breath: shortness of breath at rest ● Unrelieved chest pain ● Wheezing or chest tightness at rest ● Need to sit in chair to sleep ● Weight gain or loss of more than 5 pounds ● Confusion <p style="text-align: center;">Call your health care provider immediately if you are going into the RED zone</p>	<p style="text-align: center;">Red Zone Means:</p> <ul style="list-style-type: none"> ● This indicates that you need to be evaluated by a health care provider right away <p style="text-align: center;">Call your health care provider right away</p> <p>Name: _____</p> <p>Number: _____</p> <p>Instructions: _____</p>

Used with permission. Improving Chronic Illness Care (ICIC) is a national program supported by The Robert Wood Johnson Foundation with direction and technical assistance provided by Group Health Cooperative's MacColl Institute for Healthcare Innovation.

Used with permission. Improving Chronic Illness Care (ICIC) is a national program supported by The Robert Wood Johnson Foundation with direction and technical assistance provided by Group Health Cooperative's MacColl Institute for Healthcare Innovation.

Body Mass Index Chart Poster*

		BODY MASS INDEX CHART																																			
		Normal					Overweight					Obese								Extreme Obesity																	
BMI		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (Inches)		Body Weight (pounds)																																			
58		91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59		94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60		97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61		100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	385
62		104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63		107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64		110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65		114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	40	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66		118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67		121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68		125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69		128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70		132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71		136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72		140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73		144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74		148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75		152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76		156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	432	443

Source: Adapted from Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults: The Evidence Report National Heart Lung Blood Institute, National Institutes of Health, US Department of Health and Human Services. Web Site: www.nhlbi.nih.gov/guidelines/obesity/bmi_30.pdf

*Available in the Diabetes tool kit and on the CPG shopping cart

Cardiovascular ICD-9-CM Cards

VA/DoD Cardiovascular Clinical Practice Guidelines

Provider Reference Card

HYPERTENSION	ICD-9-CODES
Malignant Hypertension	401.0
Essential or Benign Hypertension	401.1
Unspecified Hypertension	401.9
Hypertensive Heart Disease w/o CHF*	402.00 / .10/ .90
Hypertensive Heart Disease w CHF*	402.01 / .11/ .91
Hypertensive Renal Disease*	403
Hypertensive Heart and Renal Disease	404

* Hypertension ICD-9-CM Codes:
 *4th digit ... 0 = Malignant; 1 = Benign; 9 = Unspecified

403 Hypertensive Renal Disease	404 Hypertensive Heart and Renal
*5 th digit	*5 th digit
0- without mention of renal failure	0- without mention of heart or renal failure
1 ...with renal failure	1- with heart failure
	2- with renal failure
	3- with heart failure and renal failure

DYSLIPIDEMIA	ICD-9-CODES
Hyperlipidemia	272.4
Hyperlipdemia Carbohydrate Induced	272.1
Hyperlipdemia Combined	272.4
Hyperlipdemia Endogenous	272.1
Hyperlipdemia Exogenous	272.3
Mixed	272.2

CODES TO IDENTIFY AMI, PTCA AND CABG			
Description	CPT Codes	ICD-9-Codes	DRGs
AMI (inpatient)		410.x1	121, 122
PTCA	92980-92982, 92984,92995, 92996	36.01, 36.02, 36.05, 36.09	112*
CABG (inpatient)	33510-33514, 33516-33519, 33521-33523, 33533-33536	36.1, 36.2	106, 107, 109

5th digit: 1 = initial episode of care; 0 = unspecified episode of care; 2 = subsequent episode of care

References:

Physician ICD9 CM, 1999-2000, Volumes 1&2, 1999-2000, Medicode, Salt Lake City, UT
 Current Procedural Terminology CPT 2000, American Medical Association, Chicago, IL
 HEDIS 2003, Health Plan Employer Data and Information Set, NCQA, Washington, DC
 VA CPG website: <http://www.oop.med.va.gov/cpg/ogp.htm>

ISCHEMIC HEART DISEASE	ICD-9-CODES
Ischemic Heart Disease	414.9
Acute Myocardial Infarct	410
Of Anterolateral wall	410.01*
Other anterolateral wall	410.11*
Inferolateral wall	410.21*
Inferoposterior wall	410.31*
Other inferior wall	410.41*
True posterior wall	410.61*
Subendocardial infarction	410.71*
Of other unspecified site	410.81*
Unspecified site	410.91*
History of PTCA	V45.82
History of CABG	V45.81
History of MI	412

CODES TO IDENTIFY ACUTE MI AND B-BLOCKER TREATMENT		
Description	ICD-9-Code	DRG
Acute MI	410.X1*	121, 122, 516

CHRONIC HEART FAILURE	ICD-9-CODES
Systolic Heart Failure, Chronic	428.22
Diastolic Heart Failure, Chronic	428.32
Combined Systolic and Diastolic Heart Failure, Chronic	428.42

**Under CABG of ICD-9-CM Codes

- 36.1 Bypass anastomosis for heart revascularization
- 4th digit
- 36.10 - Aortoocoronary bypass for heart revascularization, not otherwise specified
- 36.11 - Aortoocoronary bypass of one coronary artery
- 36.12 - Aortoocoronary bypass of two coronary arteries
- 36.13 - Aortoocoronary bypass of three coronary arteries
- 36.14 - Aortoocoronary bypass of four coronary arteries
- 36.15 - Single internal mammary-coronary artery bypass
- 36.16 - Double internal mammary-coronary artery bypass
- 36.17 - Abdominal-coronary artery bypass
- 36.19 - Other bypass anastomosis for heart revascularization

PEC Update Newsletter

The Department of Defense Pharmacoeconomic Center

PEC UPDATE

March 2004, Vol. 04, Issue 2, www.pec.ha.osd.mil
PEC Update Home: www.pec.ha.osd.mil/ac03000.htm

SPECIAL EDITION

Cost Containment Tips

The DoD Pharmacoeconomic Center offers these cost-saving ideas to help MTFs deal with their tight FY04 pharmacy budgets while continuing to provide clinically effective patient care. We highlight drugs that will meet the clinical needs of most patients at significantly lower cost than other drugs in the therapeutic class. We also provide tips for purchasing drugs at lower prices. Please note that prices may vary depending on formulary status at your facility.

Purchasing / Logistics Tips

Prescribing the most cost-effective agent is only half the battle—your facility has to buy the correct product to actually realize the savings. [Page 4](#)

Statins

Nearly 70% of MTF atorvastatin (Lipitor) use is with the lower strengths (10-20 mg). Equivalent LDL-lowering can be achieved with 20-40 mg of simvastatin (Zocor) at a much lower cost (contract prices).

- Prescribe simvastatin 20 mg instead of atorvastatin 10 mg and save 59% per dose.
- Prescribe simvastatin 40 mg instead of atorvastatin 20 mg and save 64% per dose.

[Page 5 - 7](#)

Second-Generation Antihistamines

Use loratadine (Claritin or generics) instead of fexofenadine (Allegra), cetirizine (Zyrtec), or desloratadine (Clarinex) and save up to 87%. Loratadine costs from \$0.12 to \$0.38/tab compared to \$0.85/tab for Allegra, \$0.96/tab for Zyrtec, and \$0.89/tab for Clarinex. [Page 8 - 11](#)

Proton Pump Inhibitors

Rabeprazole (Acipex) and lansoprazole (Prevacid) cost only \$0.65/dose—75% less than either esomeprazole (Nexium) at \$2.55/dose or the Prilosec brand of omeprazole at \$2.64/dose. [Page 12 - 13](#)

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Use traditional NSAIDs (e.g., ibuprofen, naproxen, diclofenac) instead of COX-2 inhibitors — celecoxib (Celebrex), rofecoxib (Vioxx), or valdecoxib (Bextra)—for patients at low risk for NSAID-related GI adverse effects. COX-2 inhibitors cost ten times more per day than traditional NSAIDs.

Consider meloxicam (Mobic) for patients at increased risk. Meloxicam is on the Basic Core Formulary (BCF) and the weighted average cost per day is 43% less than COX-2 inhibitors. [Page 14 - 15](#)

Selective Serotonin Reuptake Inhibitors (SSRIs)

Generic fluoxetine costs only \$0.035 per dose (contract price). Other SSRIs cost at least 25 times more. [Page 17 - 18](#)

MEDCOM Clinical Practice Guideline Website Information

Address <http://www.qmo.amedd.army.mil>

OM / UM
Practice Guidelines >
Patient Safety
Customer Satisfaction
JCAHO
Risk Management >
CCQAS >
Credentialing
Policies
Case Management
Corporate Quality >
Resources
FAQ
Contact Us
QMO Home

U.S. Army MEDCOM
Quality Management Office

Wednesday, March 10, 2004

This site is brought to you by the Quality Management Office, MEDCOM, Headquarters.

We are continually assembling information which can be accessed from the menu bar on the left side of the page.

We have large quantities of information to publish, and desire to make this site your source for the latest information from our office.

On-Line Ordering System for Clinical Practice Guideline Tool Kit Supplies  **Shop For CPG Items Now**

Clinical Practice Guidelines

Visit our new on-line shopping system available to Army and Air Force facilities to replenish supplies of the Clinical Practice Guideline Tool Kits. Order refill items for multiple CPGs at one time. Receive an email confirmation of your order with your order number and summary. Once your order is shipped you can track it right on our web site.



Army & Air Force Order On-Line

[Click Here to Check It Out . . .](#)

Web Links Disclaimer

Links to non-federal organizations are provided solely as a service to our users. Links do not constitute an endorsement of any organization by the Army Medical Department (AMEDD) or the Department of Defense and none should be inferred. The AMEDD is not responsible for the content of the individual organization's web pages found via these links.

What's New

New 40-68 Army Regulation

The new Army Regulation 40-68, Clinical Quality Management, has been signed and is now available on-line. Check back here for link to forms which will soon be posted on the USAPA web site.

[View Army Regulation 40-68](#)

CPG Update

The Post Traumatic Stress Disorder Clinical Practice Guideline is now on-line.

[View Guideline](#)

Credentialing Update

The Credentialing section of this web site was just updated on 24 February 2004. Policies, Regulations and more have been added.

[Go To Credentialing Home Page](#)

Northwest Limb Preservation Conference - March 15-17, 2004

Click Below for:

Conference Information	Contact Information
--	-------------------------------------

Patient Safety Update

Significant revisions have been made to the Patient Safety portion of this web site. New and important information has been added and it is continually updated.

[Go To Patient Safety Home Page](#)

Resource Section Recently Added to Web Site

[Go To Resources Home Page](#)

Done

VA Clinical Practice Guideline Website Information

Address: <http://www.oqp.med.va.gov/cpg/cpg.htm>

Clinical Practice Guidelines

Office of Quality and Performance

OPP < CPG

- CPG Home
- FAQ
- Policy
- Presentations

CARDIOVASCULAR

- [Chronic Heart Failure \(CHF\)](#)
- [Hypertension \(HTN\)](#)
- [Ischemic Heart Disease \(IHD\)](#)
- [Dyslipidemia \(LIPIDS\)](#)

ENDOCRINE

- [Diabetes Mellitus \(DM\)](#)

EYE

- [Glaucoma](#)

GENITOURINARY TRACT

- [Benign Prostate Hyperplasia \(BPH\)](#)
- [Dysuria](#)
- [Erectile Dysfunction \(ED\)](#)
- [Pre-End-Stage Renal Disease \(ESRD\)](#)

MENTAL HEALTH

- [Major Depressive Disorder \(MDD\)](#)
- [Post Traumatic Stress Disorder \(PTSD\)](#)
- [Psychoses \(PSYCH\)](#)
- [Substance Use Disorder \(SUD\)](#)

MUSCULOSKELETAL

- [Low Back Pain \(LBP\)](#)

OB/GYN

- [Uncomplicated Pregnancy \(UP\)](#)

PULMONARY

- [Asthma](#)
- [Tobacco Use Cessation \(TUC\)](#)
- [Chronic Obstructive Pulmonary Disease \(COPD\)](#)

REHABILITATION

- [Stroke Rehabilitation](#)

OTHER

- [Post-Exposure to NBC Hazards & Management](#)

What's New!

- [Post Traumatic Stress Disorder \(PTSD\)](#)
- [Stroke Rehabilitation \(STR\)](#)
- [Uncomplicated Pregnancy \(UP\)](#)
- [OPIOID Therapy for Chronic Pain](#)
- [Terrorism Pocket Guide - Non VA Ordering Information](#)
- [SUD: Self Help Organizations for alcohol and drug problems](#) (See Guideline Community - Related Resources within Substance Use Disorder)
- [Biological, Chemical, and Radiation Induced Illnesses: Centers for Disease Control and Prevention \(CDC\) guidelines for:](#)
 - performing single-platform absolute CD4+ T-Cell determinations with CD4 Gating for persons infected with human immunodeficiency virus.
 - Smallpox vaccination and adverse reactions. Guidance for clinicians.
- [Biological, Chemical, and Radiation Induced Illnesses: Center for Civilian Biodefense Strategies, School of Medicine, Johns Hopkins University guidelines for:](#)
 - Botulinum toxin as a biological weapon: medical and public health management and (2) Botulinum toxin as a biological weapon. (Addendum).
 - Smallpox as a biological weapon: medical and public health management. (2) Smallpox as a biological weapon. (Addendum).
- [Protect Yourself: Prepare for emergencies and disasters: protect yourself by learning about chemical, biological weapons...](#)

Clinical Practice Guidelines

Implementation of evidence-based clinical practice guidelines is one strategy VHA has embraced to improve care by reducing variation in practice and systematizing "best practices". Guidelines, as generic tools to improve the processes of care for patient cohorts, serve to reduce errors, and provide consistent quality of care and utilization of resources throughout the system. Guidelines also are cornerstones for accountability and facilitate learning and the conduct of research. The guidelines on this site are those endorsed by VHA's National Clinical Practice Guidelines Council.

Clinical practice guidelines initially evolved in response to studies demonstrating significant variations in risk-adjusted rates across medical care. Discussion highlighted the

www.oqp.med.va.gov/cpg/cpg.htm

Cardiovascular Population Level Metrics

VA/DoD Clinical Practice Guidelines for the Management of Cardiovascular Diseases Population Level Metrics

Hypertension

- Percent of eligible patients with an active diagnosis of hypertension whose most recent blood pressure recording was:
 - Less than 140/90
 - Equal to or greater than 160/100 or NO BP recorded in the past year

Chronic Heart Failure

- Percent of patients discharged with a principal diagnosis discharge instructions in the medical record to include:
 - Activity level after discharge
 - Diet and fluid intake after discharge
 - All discharge medications
 - Follow-up appointment
 - Weight monitoring
 - What to do if heart failure symptoms worsen

VA/DoD Clinical Practice Guidelines for the Management of Cardiovascular Diseases Population Level Metrics

Ischemic Heart Disease

- ❖ % patients hospitalized with acute coronary syndrome (ACS) who had in-hospital EKG performed within 10 minutes of arrival
 - ❖ % of patients hospitalized with ACS found to be ST-segment elevation myocardial infarction (STEMI) patients who met criteria for reperfusion and received reperfusion
 - ❖ % of patients hospitalized with ACS found to be STEMI patients who met criteria for reperfusion and received PTCA/Primary Percutaneous Coronary Intervention (PCI) within 120 minutes (STEMI) of arrival or ECG if acute myocardial infarction (AMI) as inpatient
 - ❖ % of patients hospitalized with ACS found to be STEMI patients who met criteria for reperfusion and received thrombolytic therapy within 30 minutes of arrival or ECG if AMI as inpatient
 - ❖ % of patients hospitalized with ACS found to be STEMI or moderate-high risk non-ST segment elevation myocardial infarction (NSTEMI) (troponin positive) patients with cardiology involvement in care within 24 hours of arrival or ECG if AMI as inpatient
 - ❖ % of patients with result of troponin measurement returned in 60 minutes of initial draw
 - ❖ % of patients with previous MI, full lipid panel in the past two years, and LDL-C < 100 on most recent test in past 2 years
 - ❖ % of patients with previous AMI and LDL-C > = 120 on most recent test in past two years on lipid lowering medication
 - ❖ % of patients hospitalized with ACS found to be low risk ACS patients who had a plan prior to discharge that includes further outpatient stress testing and possible catheterization
 - ❖ % of patients hospitalized with ACS found to be low-moderate risk ACS patients who received non-invasive stress test prior to discharge
 - ❖ % of patients hospitalized with ACS found to be STEMI or moderate-risk NSTEMI patients who receive a diagnostic catheterization prior to discharge
 - ❖ % of patients previously hospitalized with ACS found to be STEMI or moderate-high risk NSTEMI patients while hospitalized who are seen, by a Cardiologist in 30 days after discharge
 - ❖ % of patients receiving aspirin within 24 hours before or after hospital arrival
 - ❖ % of patients with AMI who are prescribed aspirin at hospital discharge
 - ❖ % of AMI patients with left ventricular systolic dysfunction (LVSD) prescribed angiotensin converting enzyme inhibitor (ACEI) at hospital discharge
 - ❖ % of AMI patients without beta-blocker contraindications who are prescribed a beta-blocker at hospital discharge
 - ❖ % of patients receiving beta-blockers within 24 hours after arrival
 - ❖ % of patients with AMI screened for tobacco use cessation during the year prior to hospital arrival
 - ❖ % of patients with AMI given tobacco use cessation advice/counseling
 - ❖ Median time from arrival to administration of thrombolytic agents to patients with ST-segment elevation or left bundle branch block (LBBB) on the ECG performed closest to hospital arrival time
 - ❖ Time in minutes from hospital arrival to PTCA in patients with ST segment elevations or LBBB on the ECG performed closest to hospital arrival
 - ❖ Acute myocardial infarction patients who expire during hospital stay
 - ❖ % of patients with LV systolic function assess prior to discharge
- #### OUTPATIENTS
- ❖ % of patients on aspirin at most recent visit or contraindication documented
 - ❖ % of patients on Beta Blocker at most recent visit or contraindication documented
 - ❖ % of patients with LVEF <40 on ACEI at most recent visit
 - ❖ % of patients screened for tobacco use in past twelve months
 - ❖ % of patients with full lipid profile done within past two years
 - ❖ % of patients within past 2 years were advised of any lifestyle changes

Aggregate Army Metrics, Trended Diabetes Mellitus Portal, NQMP and HEDIS Data

The screenshot shows the U.S. Army MEDCOM Quality Management Office website. The main heading is "CLINICAL PRACTICE GUIDELINES". Below this, there are several sections:

- On-Line Ordering System for Clinical Practice Guideline Tool Kit Supplies:** A section for ordering supplies, with a "Shop For CPG Items Now" button.
- Clinical Practice Guidelines:** A section with a "Patient Care Team" logo and a "Guideline Toolkit" for Army and Air Force.
- VA / DoD Guidelines and Tool Kits Available and Anticipated:** A section with a "Click here to view dates" link.
- CPG Metrics and Benchmarks:** A section with links for "FY04 Performance Plan between Deputy Secretary of Defense and Asst Secretary Defense (H4)", "Entire Performance Plan", "Summary Table", "2002 Health-Related Behavior Survey among Military Personnel", and "Healthy People 2010".
- Military Healthcare System Population Health Portal (MHS Portal):** A section with links for "Military Health System Portal", "Aggregated Army Data", "Trended Asthma Portal Data", and "Trended Diabetes Mellitus Portal Data".
- CPG Update:** A section with a "NEW" tag and a link for "The Post Traumatic Stress Disorder Clinical Practice Guidelines - On-Line".
- Guideline Champion Information:** A section with links for "Manual for Facility Clinical Practice Guideline Champions", "Responsibilities of the National Clinical Practice Guideline Champion & Team Members", "Rand Manual - 'Putting Practice Guidelines to Work in the Department of Defense Medical System' (2001)", and "Guideline for Guidelines".

Red arrows point from the text labels on the right to the corresponding sections in the screenshot.

Aggregated Army Metrics

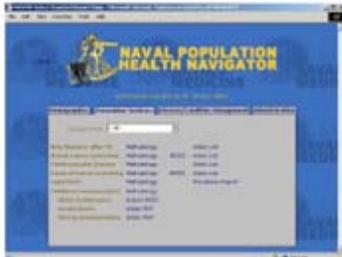
Trended CVD and DM Portal

NQMP and HEDIS Data

Military Healthcare System Population Health Portal

MHS Population Health Portal




Improve the Health Status of your Population with the . . .
 Air Force Population Health Portal
 Naval Population Health Navigator
 Army Population Health Information Connection
 . . . the one tool for all Services, known as the MHS Portal.

A Tri-Service web-based tool which generates detailed "Action Lists" for Clinical Preventive Services, Disease and Condition Management at the Provider and Clinic level for your enrolled beneficiaries:

- Click through "Index Card" design
- Standardized tabular reports with Excel® spreadsheet options
- Detailed methodological guidelines with national benchmarks
- Service level headquarters accounts with aggregate reports available

Demographics Tab:
 Population data stratified by preventive service, age, and gender

Preventive Services Tab:
 Proactively monitor six preventive services through action lists
 Track your success with national HEDIS® benchmarks
 Childhood immunizations currently limited to Air Force MTF and one Navy demonstration site

Disease Condition Management:
 Aggressively manage 10 diseases or conditions with action lists, prevalence reports and aggregate counts
 Track your success with national HEDIS® benchmarks

Request an account today at <https://pophealth.afms.mil/tsphp>

The MHS Portal was developed to meet the Services' request for actionable information for Population Health and Medical Management. Chartered by the Population Health and Medical Management (PHMM) Division at TRICARE Management Activity in collaboration with the Population Health Support Division in San Antonio and our Service partners.

PHMM Mission:
 Provides policies, instructions, programs, forums, and resources to measure, improve, and sustain the health status of the population.

PHMM Vision:
 We are the definitive source for population health information to facilitate the transformation of the MHS from a reactive to proactive healthcare system.

Population Health and Medical Management Division
 Office of the Chief Medical Officer, TRICARE Management Activity,
 5111 Leesburg Pike, Suite 810, Falls Church, VA 22041
 703.681.0064, DSN 761.0064, FAX 703.681.1242

SERVICE RESOURCES

<p><i>Air Force Population Health Portal</i> Lt Col Phillips, USAF, MC AF Population Health Support Division 210.332.4265 or DSN 240.4265 clm.phillips@brooks.af.mil</p>	<p><i>Naval Population Health Navigator</i> Mrs. Betty Rauschmeier BUMED-MEM2 202.762.3139 or DSN 762.3139 bettyrauschmeier@navy.mil</p>	<p><i>Army Population Health Information Connection</i> LTC(P) Margaret A. Hawthorne MEDCOM-MC-HO-Q 210.221.8297 or DSN 471.8297 margaret.hawthorne@medd.army.mil</p>
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<https://pophealth.afms.mil/tsphp/login/login.cfm>

Cardiovascular Clinical Practice Guideline Website Information

Directory of Cardiovascular Organizations and Related Websites



This directory is an expanded list of government agencies, voluntary associations, and private organizations that provide cardiovascular information and resources.

These organizations and related websites offer educational materials and support to people with cardiovascular disease and the general public. Other sites are specific to health care professionals.

Links to non-federal organizations are provided solely as a service to our users. Links do not constitute an endorsement of any organization by the Army Medical Department (AMEDD) or the Department of Defense (DoD) and none should be inferred. The AMEDD and the DoD is not responsible for the content of the individual organization's web page found via these web sites or their links.

Updated and current as of July 2004.

Websites for Additional Information on Cardiovascular Disease and Related Topics