Category Prose Descriptions

**Aspirin**

*Aspirin for people at risk.* Individuals with coronary artery disease, symptomatic carotid or vertebral artery atherosclerosis, or symptomatic atherosclerotic peripheral artery disease of the lower extremity should be prescribed aspirin to be taken on a daily basis. In patients who are intolerant of or allergic to aspirin, clopidogrel is recommended as an alternative. This includes those who have undergone therapeutic intervention to treat atherosclerotic disease in one or more of the above vascular territories. These individuals will have a current or previous diagnosis of an ICD-9 code(s) comprising the single-level diagnoses categories 100, 101, 108, 109, 112, 113, 114, 115, or 116 for ICD-9-CM databases developed by the Agency for Healthcare Research and Quality in the Healthcare Cost and Utilization Project.

**Blood Pressure**

*Blood pressure control.* A core measure of the CMS EHR Meaningful Use program is the recording of patient vital signs. The vital signs of all patients should be assessed at every office visit. The vital signs of patients with hypertension or atherosclerosis should be documented at least once every six months. The goal of blood pressure control is to achieve a systolic blood pressure of <140 mm Hg and a diastolic blood pressure of <90 in patients without diabetes or chronic kidney disease. In patients with either diabetes or chronic kidney disease, the goal is to achieve a systolic blood pressure of <130 and a diastolic blood pressure of <80. Blood pressure management is a key component of secondary prevention in individuals with coronary artery disease, symptomatic carotid or vertebral artery atherosclerosis, an abdominal aortic aneurysm, or atherosclerotic peripheral arterial disease. This includes those who have undergone therapeutic intervention to treat atherosclerotic disease in one or more of the above vascular territories. These individuals will have a current or previous diagnosis of an ICD-9 code(s) comprising the single-level diagnoses categories 98, 99, 100, 101, 108, 109, 112, 113, 114, 115, or 116 of the Clinical Classifications Software (CCS) for ICD-9-CM databases developed by the Agency for Healthcare Research and Quality in the Healthcare Cost and Utilization Project. For the purposes of this CDS, the diagnosis of hypertension is established by an ICD-9 code(s) contained in the diagnosis categories 401, 402, 403, 404, and 405; the diagnosis of diabetes is established by an ICD-9 code(s) contained in the single-level CCS diagnosis categories 49 and 50; and the diagnosis of chronic kidney disease by an ICD-9 code(s) contained in the diagnosis categories 156, 157, and 158.

**Cholesterol**

*Cholesterol regulation.* Cholesterol management is a key component of both primary and secondary prevention. The first step in cholesterol management is risk assessment. Individuals with atherosclerosis (coronary artery disease, symptomatic carotid or vertebral artery atherosclerosis, an abdominal aortic aneurysm, atherosclerotic peripheral arterial disease) or diabetes, including those who have undergone therapeutic intervention to treat atherosclerotic disease in one or more of the above vascular territories, are considered high risk. These individuals will have a current or previous diagnosis of an ICD-9 code(s)
comprising the single-level diagnoses categories 49, 50, 100, 101, 108, 109, 112, 113, 114, 115, or 116 from the Clinical Classifications Software (CCS) for ICD-9-CM, databases developed by the Agency for Healthcare Research and Quality as part of the Healthcare Cost and Utilization Project. These individuals should have a periodic (yearly) lipid profile assessment and (regardless of LDL level) be treated with statin therapy (absent intolerance or other contraindication). An adequate dose of a statin should be used that reduces the LDL to <100 mg/dL. If higher dose and/or higher potency statin therapy does not achieve the desired LDL goal, the intensification of therapy with the addition of a bile acid sequestrant, niacin, ezetimibe, and/or fish oil should be considered. Individuals at moderate risk include those who are not otherwise classified as high risk and who have 2 or more of the following risk factors: tobacco use, age >=45 if male or >=55 if female, hypertension, LDL <40 mg/dL, family history of premature coronary artery disease. These individuals should have a yearly lipid profile assessment, and be treated with statin therapy and/or other cholesterol-lowering agents if the LDL is >=100 to reduce the LDL to <100 mg/dL. All other individuals are considered low risk. These individuals should have a fasting lipid panel checked every 5 years to identify those with an LDL of >=190 as an indication for statin or other cholesterol-lowering agents. Therapeutic lifestyle changes, including daily physical activity, weight management, and dietary therapy to reduce saturated fat and trans fatty acid intake, should be recommended for all individuals regardless of risk.

**Smoking**

*Smoking cessation.* There are numerous health risks associated with tobacco smoking and ample evidence to support reduction of these risks with smoking cessation. The ability to electronically record, modify and retrieve the smoking status of a patient is a requirement for ONC-ATCB electronic health record certification. All patients are to be asked about tobacco use status at every office visit. Smoking cessation counseling should be advised at every visit for those who are considered active smokers, which comprises the categories of: current every day smoker, current some day smoker, and smoker – current status unknown. In addition, individuals are to be included if either of the ICD-9 codes 305.1 or V15.82 are listed.