BMC2 Best Practice Protocol

Best Practice Protocol for the Blue Cross Blue Shield of Michigan Cardiovascular Consortium

Post-Discharge Management

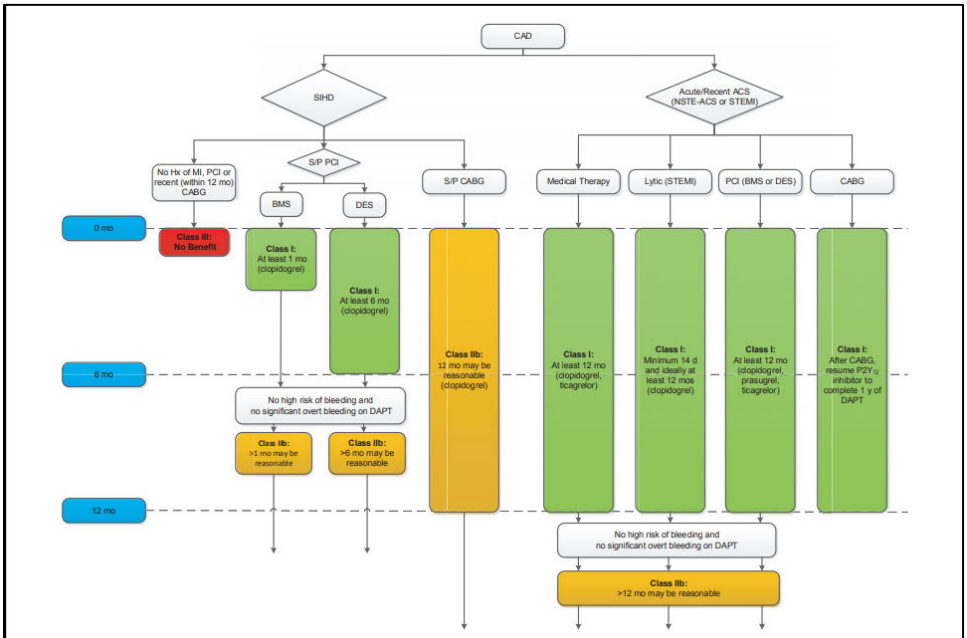
Contents

I. Antiplatelet and Anticoagulant Therapy

- For patients not taking an oral anticoagulant

  - Aspirin 81 mg daily PLUS ONE OF THE FOLLOWING P2Y12 inhibitors:
    - Clopidogrel (Plavix) 75 mg orally daily or,
    - Prasugrel (Effient) 10 mg orally daily or,
    - Ticagrelor (Brilinta) 90 mg orally twice a day

  - The duration of DAPT to be determined by presentation (SIHD vs ACS) as well as a discussion around bleeding/ischemic risk.
    - Interventional MD should make and document an initial minimum duration of antithrombotic therapy (i.e. specify DAPT plan).



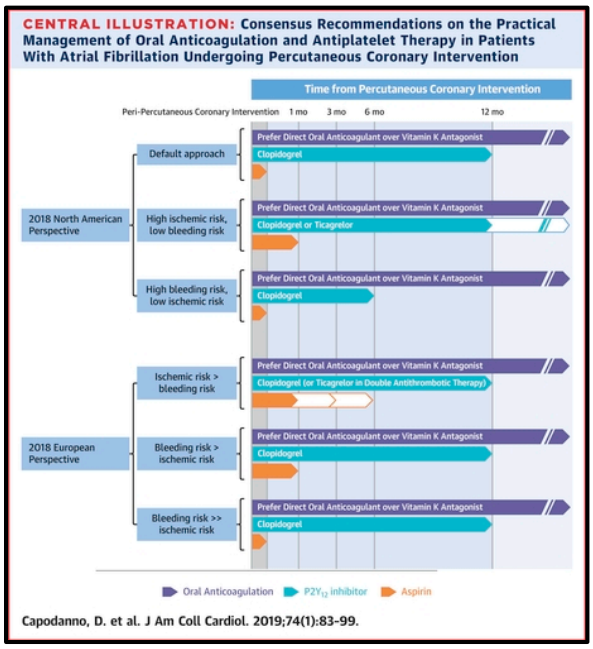
Colors correspond to Class of Recommendation in Table 1. Clopidogrel is the only currently used $P2Y_{12}$ inhibitor studied in patients with SIHD undergoing PCI. Aspirin therapy is almost always continued indefinitely in patients with CAD. Patients with a history of ACS >1 year prior who have since remained free of recurrent ACS are considered to have transitioned to SIHD. In patients treated with DAPT after DES implantation who develop a high risk of bleeding (e.g., treatment with oral anticoagulant therapy), are at high risk of severe bleeding complication (e.g., major intracranial surgery), or develop significant overt bleeding, discontinuation of $P2Y_{12}$ inhibitor therapy after 3 months for SIHD or after 6 months for ACS may be reasonable. Arrows at the bottom of the figure denote that the optimal duration of prolonged DAPT is not established. ACS indicates acute coronary syndrome; BMS, bare metal stent; CABG, coronary artery bypass graft surgery; CAD, coronary artery disease; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; Hx, history; lytic, fibrinolytic therapy; NSTE-ACS, non-ST-elevation acute coronary syndrome; PCI, percutaneous coronary intervention; SIHD, stable ischemic heart disease; S/P, status post; and STEMI, ST-elevation myocardial infarction.

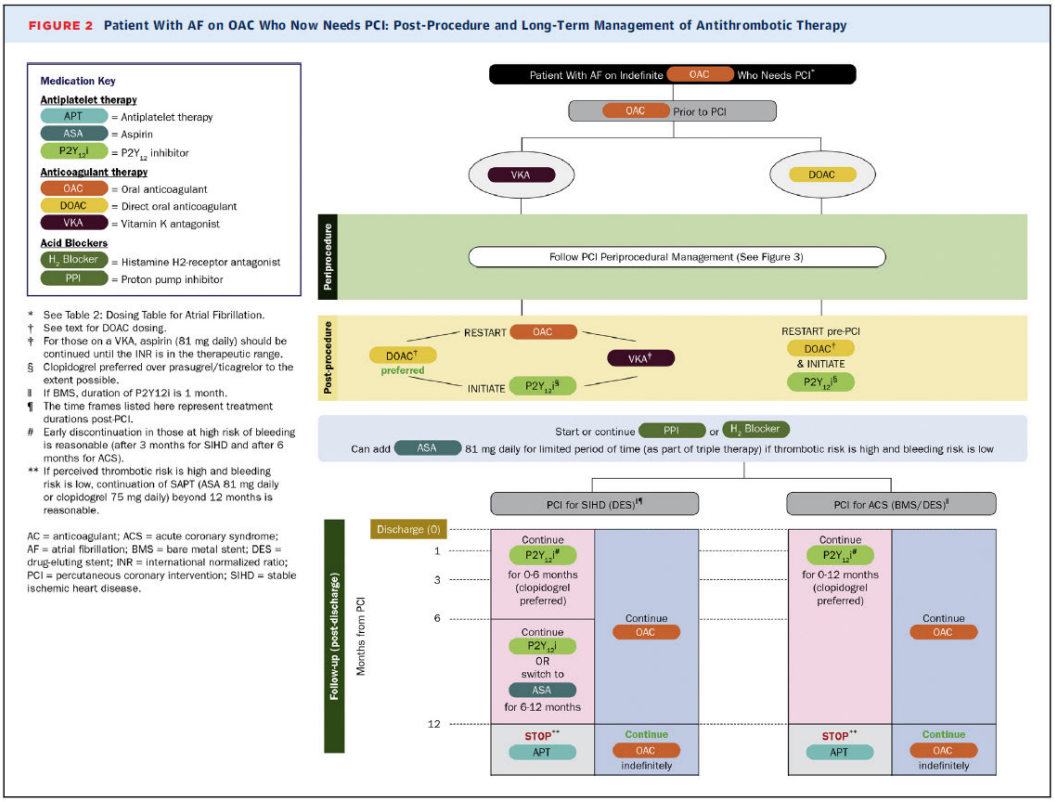
Master treatment algorithm for duration of $P2Y_{12}$ inhibitor therapy in patients with CAD treated with DAPT. Reprinted from "2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients With Coronary Artery Disease" by G.N. Levine, 2016, *Circulation,134*(10):e123-e155. (1)

- For patients taking an oral anticoagulant (trials were performed among patients taking an oral anticoagulant for atrial fibrillation).

  - General consensus is to minimize the duration of triple antithrombotic therapy (TAT) (2)
    - Recommend aspirin 81 mg daily use in the peri-PCI or in-hospital period; early discontinuation of aspirin 1-7 days post-PCI.

- Continue P2Y12 inhibitor for 12 months (shorter or longer duration can be considered based on thrombotic and bleeding risks) and oral anticoagulant (DOAC or VKA) indefinitely for atrial fibrillation stroke prophylaxis. (3)





Patient with AF on OAC Who Now Needs PCI: Post-Procedure and Long-Term Management of Antithrombotic Therapy. Reprinted from "2020 ACC Expert Consensus Decision Pathway for Anticoagulant and Antiplatelet Therapy in Patients With Atrial Fibrillation or Venous Thromboembolism Undergoing Percutaneous Coronary Intervention or With Atherosclerotic Cardiovascular Disease" by D.J. Kumbhani, 2020, *J Am Coll Cardiol*, *S0735-1097*(20), 36615-8.

- Additional strategies to mitigate bleeding risk
    - PPIs should be used in patients with a history of prior GI bleeding who require DAPT.
    - Use of PPIs is reasonable in patients with an increased risk of GI bleeding (eg, advanced age, concomitant use of warfarin, steroids, NSAIDs, Helicobacter pylori infection) who require DAPT. (4)
    - For patients on ≥2 antithrombotic agents, recommend starting PPI (or H2-receptor antagonists in selected cases) along with avoidance of NSAIDs to reduce the risk of GIB. These medications should be discontinued when the regimen returns to OAC alone, unless there are other indications for continued use. (3)

II. Lipid Management

- Statin
  - All patients <75 years old or those at very high-risk ASCVD (see table 4 below) should receive high-intensity or maximal statin therapy. (5)
  - If on maximally-tolerated statin and LDL-C ≥70 mg/dL, adding ezetimibe (Zetia) is reasonable.
  - If on maximal LDL-C lowering therapy (statin and ezetimibe) and LDL-C ≥70 mg/dL or non-HDL-C ≥100 mg/dL, adding a PCSK9-inhibitor is reasonable. (6)
  - Goal LDL <70 mg/dL; goal non-HDL <100 mg/dL.
- Icosapent ethyl (Vascepa)
  - Approved in patients with a known history of established cardiovascular disease or diabetes plus ≥2 more additional cardiovascular risk factors who have triglycerides >150 mg/dL on statin therapy.
  - 25% lower risk of the primary end point of CV death, nonfatal MI, nonfatal stroke, coronary revascularization, or unstable angina. (7)

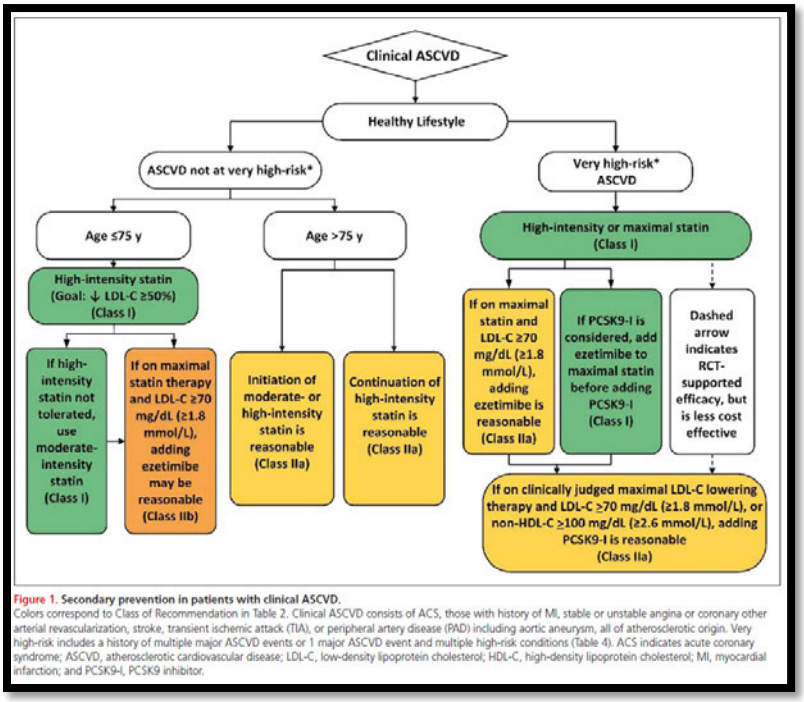


Figure 1. Secondary prevention in patients with clinical ASCVD.
Colors correspond to Class of Recommendation in Table 2. Clinical ASCVD consists of ACS, those with history of MI, stable or unstable angina or coronary other arterial revascularization, stroke, transient ischemic attack (TIA), or peripheral artery disease (PAD) including aortic aneurysm, all of atherosclerotic origin. Very high-risk includes a history of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions (Table 4). ACS indicates acute coronary syndrome; ASCVD, atherosclerotic cardiovascular disease; LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; MI, myocardial infarction; and PCSK9-I, PCSK9 inhibitor.

Table 4. Very High-Risk* of Future ASCVD Events

Major ASCVD Events
Recent ACS (within the past 12 mo)
History of MI (other than recent ACS event listed above)
History of ischemic stroke
Symptomatic peripheral arterial disease (history of claudication with ABI <0.85, or previous revascularization or amputation[54.1-40])
High-Risk Conditions
Age ≥65 y
Heterozygous familial hypercholesterolemia
History of prior coronary artery bypass surgery or percutaneous coronary intervention outside of the major ASCVD event(s)
Diabetes mellitus
Hypertension
CKD (eGFR 15-59 mL/min/1.73 m²)[54.1-15,54.1-17]
Current smoking
Persistently elevated LDL-C (LDL-C ≥100 mg/dL [≥2.6 mmol/L]) despite maximally tolerated statin therapy and ezetimibe
History of congestive HF

*Very high-risk includes a history of multiple major ASCVD events or one major ASCVD event and multiple high-risk conditions.
ABI indicates ankle-brachial index; ACS, acute coronary syndrome; ASCVD, atherosclerotic cardiovascular disease; CKD, chronic kidney disease; eGFR, estimated glomerular filtration rate; HF, heart failure; LDL, low-density lipoprotein cholesterol; and MI, myocardial infarction.

Secondary prevention in patients with clinical ASCVD. Reprinted from "AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: Executive Summary" by S.M. Grundy, 2018, *J Am Coll Cardiol*, *73*(24):3168-3209.

III. Hypertension Management

o Categorize HTN (8)

Table 6. Categories of BP in Adults* (Table view)

BP Category	SBP		DBP
Normal	<120 mm Hg	and	<80 mm Hg
Elevated	120–129 mm Hg	and	<80 mm Hg
Hypertension			
Stage 1	130–139 mm Hg	or	80–89 mm Hg
Stage 2	≥140 mm Hg	or	≥90 mm Hg

* Individuals with SBP and DBP in 2 categories should be designated to the higher BP category.
BP indicates blood pressure (based on an average of ≥2 careful readings obtained on ≥2 occasions, as detailed in Section 4); DBP, diastolic blood pressure; and SBP, systolic blood pressure.

Reprinted from "ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: Executive Summary", P.K. Whelton, 2018, *Hypertension, 71*(6), 1269-1324.

- Discuss the importance of non-pharmacologic interventions including weight loss, heart-healthy diet (DASH diet), sodium reduction, aerobic exercise, and advisement around alcohol consumption. Consider referral to behavior modification services after a discussion with the patient.

- Treat to a goal <130/80 with the selection of beta-blockers, ACE-I, ARB, aldosterone antagonists, diuretics, and dihydropyridine calcium channel blockers based on patient comorbid conditions (i.e. HF, CKD with proteinuria, stable ischemic heart disease).

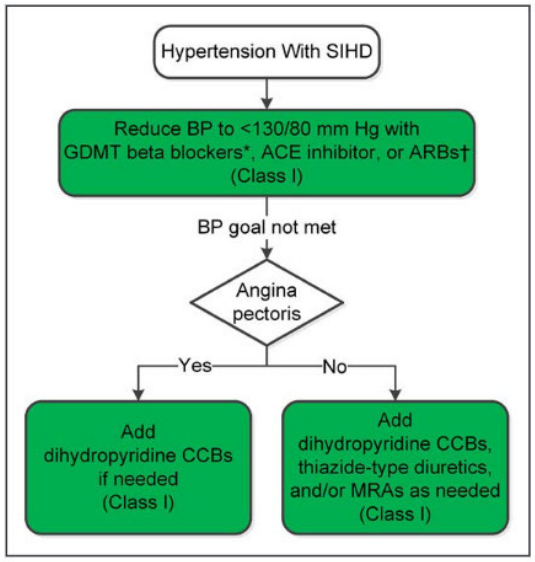


Figure 5. Management of hypertension in patients with SIHD. Colors correspond to Class of Recommendation in Table 1. *GDMT beta blockers for BP control or relief of angina include carvedilol, metoprolol tartrate, metoprolol succinate, nadolol, bisoprolol, propranolol, and timolol. Avoid beta blockers with intrinsic sympathomimetic activity. The beta blocker atenolol should not be used because it is less effective than placebo in reducing cardiovascular events. †If needed for BP control. ACE indicates angiotensin-converting enzyme; ARB, angiotensin receptor blocker; BP, blood pressure; CCB, calcium channel blocker; GDMT, guideline-directed management and therapy; and SIHD, stable ischemic heart disease.

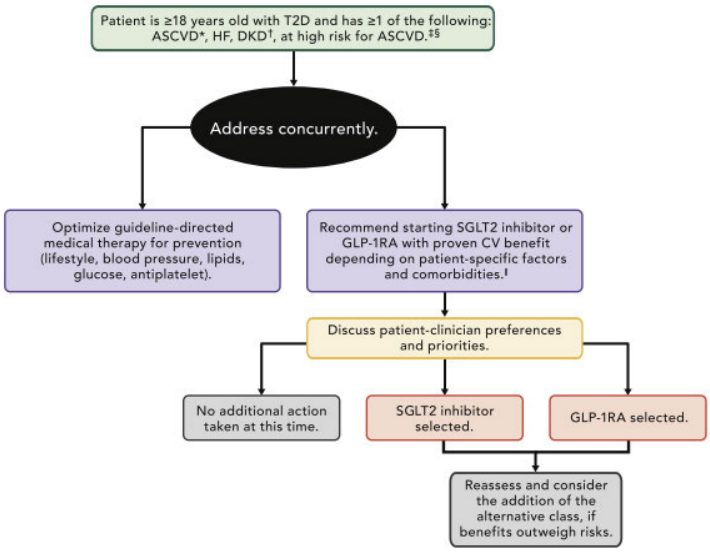
IV. Heart Failure management

- Randomized controlled trials have primarily enrolled patients with HFrEF (EF≤40%). (9,10)
- Patients should be on ACE-I/ARB and evidence-based beta-blockers (metoprolol succinate, carvedilol, or bisoprolol), and diuretics as needed.
- If they have NYHA class II-IV symptoms and CrCl >30 ml/min and K+ < 5.0 mEq/L, they should be on an aldosterone antagonist (spironolactone or eplerenone).
- If they have NYHA class II-III HF with adequate BP on ACEI or ARB and no contraindication to ARB or sacubitril, consider transition from ACE-I/ARB to ARNI (Entresto).

V. Diabetes management in patients with Atherosclerotic Cardiovascular Disease - Novel medications for CAD

GLP-1 agonists and SGLT-2 inhibitors (11)

- Recently, newer antidiabetic agents have demonstrated significant cardiovascular benefit among patients with cardiovascular disease. **As such, we believe it is imperative that these medications be considered among our patients with CAD and T2DM so that a discussion with the patient and their outpatient providers may occur in the peri-PCI setting.** Patients should already be taking metformin.
- These drugs should be administered in patients with T2DM already on metformin with A1C >7.0%. Increased vigilance for hypoglycemia is required in patients on insulin, sulfonylurea, or glinide therapy.
- At a minimum, consider communicating with outpatient providers the following: *"Recommend consideration of SGLT2 inhibitor or GLP-1 agonist if felt to be appropriate. Recent data has demonstrated improved cardiovascular outcomes in patients with diabetes mellitus and concomitant established or at a high risk for developing ASCVD."*



Summary of the Expert Consensus Decision Pathway. Reprinted from "2020 Expert Consensus Decision Pathway on Novel Therapies for Cardiovascular Risk Reduction in Patients With Type 2 Diabetes: A Report of the American College of Cardiology Solution Set Oversight Committee", S.R. Das, 2020, *J Am Coll Cardiol, 76*(9), 111-1145.

- SGLT-2 inhibitors (11)

TABLE 2 Doses, Indications, Dose Modifications, Contraindications, Cautions, and Adverse Effects of SGLT2 Inhibitors With Demonstrated CV Benefit

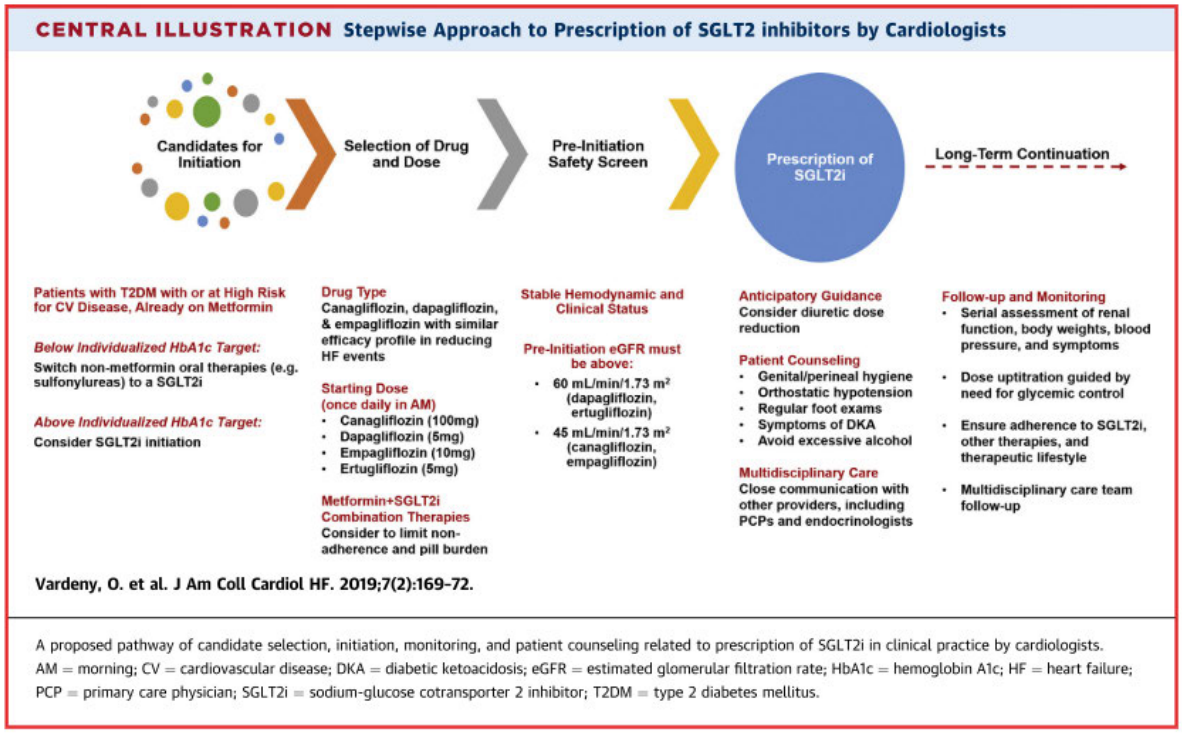
	Canagliflozin	Dapagliflozin	Empagliflozin
Recommended doses for CV benefit*	■ 100 mg PO daily	■ 10 mg PO daily	■ 10 mg PO daily
Indications	■ Improve glycemic control in adults with T2D as an adjunct to diet and exercise ■ Reduce risk of MI, stroke, or CV death in adults with T2D and CV disease ■ Reduce the risk of end-stage kidney disease, doubling of serum creatinine, CV death, and hospitalization for HF in patients with T2D and diabetic nephropathy with albuminuria	■ Improve glycemic control in adults with T2D as an adjunct to diet and exercise ■ Reduce the risk of hospitalization for HF in adults with T2D and established CV disease or multiple CV risk factors ■ Reduce the risk of CV death and hospitalization for HF in adults with HFrEF	■ Improve glycemic control in adults with T2D as an adjunct to diet and exercise ■ Reduce risk of CV death in adults with T2D and established CV disease
Dose modifications	■ eGFR 30 to 59 ml/min/1.73 m^2: max dose 100 mg daily ■ eGFR <30 ml/min/1.73 m^2: use is not recommended for glycemic control	■ eGFR <45 ml/min/1.73 m^2: use is not recommended for glycemic control ■ eGFR <30 mL/min/1.73 m^2: use is contraindicated.	■ eGFR <45 mL/min/1.73 m^2: use is not recommended.
Contraindications	■ History of serious hypersensitivity reaction to drug ■ Pregnancy or breastfeeding ■ On dialysis ■ eGFR <30 mL/min/1.73 m^2 (dapagliflozin) ■ ESRD (dapagliflozin and empagliflozin) ■ Severe renal impairment (empagliflozin)		
Cautions	■ Discontinue at least 3 days before a planned surgery to prevent postoperative ketoacidosis. ■ If HbA1c well-controlled at baseline, or known history of frequent hypoglycemic events, wean or stop sulfonylurea or glinide and consider reducing total daily insulin dose by ~20% when starting therapy. ■ May contribute to intravascular volume contraction; consider stopping or reducing diuretic dose if applicable. ■ Use with caution in patients with prior amputation, severe peripheral neuropathy, severe peripheral vascular disease, or active diabetic foot ulcers or soft tissue infections. ■ Possible increased risk of bone fractures (canagliflozin)		
Adverse effects to monitor	■ Genital fungal infections ■ Urinary tract infections ■ Euglycemic diabetic ketoacidosis ■ Lower limb ulcerations and soft tissue infections		

*Because there is no evidence of a graded dose response regarding CV and renal effects, SGLT2 inhibitors with CV benefit should be initiated at the lowest dose tested in CV and renal outcomes trials. Those doses are listed here. No further dose titration is needed for CV or renal risk reduction. However, dose increases may provide further glucose reduction benefits if indicated.

CV = cardiovascular; eGFR = estimated glomerular filtration rate; ESRD = end-stage renal disease; HbA1c = hemoglobin A1c; HF= heart failure; PO = "per os," by mouth; SGLT2 = sodium-glucose cotransporter-2; T2D = type 2 diabetes.

Doses, Indications, Dose Modifications, Contraindications, Cautions, and Adverse Effects of SGLT2 Inhibitors With Demonstrated CV Benefit. Reprinted from "2020 Expert Consensus Decision Pathway on Novel Therapies for Cardiovascular Risk Reduction in Patients

With Type 2 Diabetes: A Report of the American College of Cardiology Solution Set Oversight Committee", S.R. Das, 2020, *J Am Coll Cardiol, 76*(9), 111-1145.



Stepwise Approach to Prescription of SGLT2 Inhibitors by Cardiologists. Reprinted from "Practical Guide to Prescribing Sodium-Glucose Cotransporter 2 Inhibitors for Cardiologists", O. Vardeny, 2019, *JACC Heart Fail, 7*(2),169-172. (12)

- GLP-1 agonists (11)

TABLE 4 Doses, Indications, Dose Modifications, Contraindications, Cautions, and Adverse Effects of GLP-1RAs With Demonstrated CV Benefit

	Dulaglutide	Exenatide QW	Liraglutide	Lixisenatide	Semaglutide SC	Semaglutide PO
Recommended doses for CV benefit	■ Initiate 0.75 mg SC per week ■ Titrate slowly to 1.5 mg or maximally tolerated dose based on prescribing information.	■ 2 mg SC per week	■ Initiate 0.6 mg SC daily. ■ Titrate slowly to 1.8 mg or maximally tolerated dose based on prescribing information.	■ 10 mcg SC daily ■ Titrate as tolerated to 20 mcg daily based on prescribing information.	■ Initiate 0.25 mg SC per week. ■ Titrate slowly to 1 mg once weekly or maximally tolerated dose based on prescribing information.	■ Initiate 3 mg PO per day for the first 30 days. ■ Titrate slowly to 14 mg daily or maximally tolerated dose based on prescribing information.
Indications	■ Improve glycemic control in adults with T2D. ■ Reduce MACE for people with T2D with and without established CV disease.	■ Improve glycemic control in adults with T2D.	■ Improve glycemic control in adults with T2D. ■ Reduce risk of MI, CVA, or CV death in adults with T2D and CV disease.	■ Improve glycemic control in adults with T2D.	■ Improve glycemic control in adults with T2D. ■ Reduce risk of MI, CVA, or CV death in adults with T2D and CV disease.	■ Improve glycemic control in adults with T2D.
Dose modifications	■ Up-titrate slowly to reduce nausea and vomiting. ■ Discontinue if pancreatitis is suspected and do not restart if pancreatitis is confirmed. ■ No dose adjustment necessary with renal or hepatic impairment; data in end-stage renal disease are limited.	■ Discontinue if pancreatitis is suspected and do not restart if pancreatitis is confirmed. ■ eGFR <45 mL/min/1.73 m^2: Use is not recommended.	■ Up-titrate slowly to reduce nausea and vomiting. ■ Discontinue if pancreatitis is suspected and do not restart if pancreatitis is confirmed. ■ No dose adjustment is necessary with renal or hepatic impairment.	■ Up-titrate slowly to reduce nausea and vomiting. ■ Discontinue if pancreatitis is suspected, and do not restart if pancreatitis is confirmed . ■ eGFR ≥30 mL/min/1.73 m^2: No dosage adjustment is required. ■ eGFR 15 to 29 mL/min/1.73 m^2: Use caution and monitor renal function. ■ eGFR <15 mL/min/1.73 m^2: Use is not recommended.	■ Up-titrate slowly to reduce nausea and vomiting. ■ Discontinue if pancreatitis is suspected and do not restart if pancreatitis is confirmed. ■ No dose adjustment is necessary with renal or hepatic impairment.	■ Up-titrate slowly to reduce nausea and vomiting. ■ Discontinue if pancreatitis is suspected and do not restart if pancreatitis is confirmed. ■ No dose adjustment is necessary with renal or hepatic impairment.
Contraindications	■ History of serious hypersensitivity reaction to drug ■ Pregnancy or breast feeding ■ Severe renal impairment or end-stage renal failure (exenatide, lixisenatide) ■ Personal or family history of medullary thyroid cancer ■ Personal or family history of MEN2					
Cautions	■ Hypoglycemia risk increased with insulin, sulfonylureas, or glinides. ■ May delay gastric emptying; not recommended in patients with clinically meaningful gastroparesis. This effect is usually transient with longer-acting GLP-1Ras. ■ Care should be taken in patients with prior gastric surgery, including bariatric surgery. ■ Diabetic retinopathy complications were reported with semaglutide (injectable), although it is unclear if this is a direct effect of the drug or due to other factors such as rapid improvement in blood glucose control.					
Adverse effects to monitor	■ Nausea, vomiting, diarrhea, headache, weakness, or dizziness ■ Hypoglycemia when given with insulin, sulfonylureas, or glinides. ■ Weight loss ■ Injection site reactions					

Doses, Indications, Dose Modifications, Contraindications, Cautions, and Adverse Effects of GLP-1RAs With Demonstrated CV Benefit. Reprinted from "2020 Expert Consensus Decision Pathway on Novel Therapies for Cardiovascular Risk Reduction in Patients With Type 2 Diabetes: A Report of the American College of Cardiology Solution Set Oversight Committee", S.R. Das, 2020, *J Am Coll Cardiol, 76*(9), 111-1145.

TABLE 5 Opportunities to Initiate an SGLT2 inhibitor or a GLP-1RA With Demonstrated CV or Renal Benefit in Patients With T2D*

- In a patient with T2D and ASCVD (SGLT2 inhibitor or GLP-1RA)
- At the time of diagnosis of clinical ASCVD (SGLT2 inhibitor or GLP-1RA), DKD, and/or HF (SGLT2 inhibitor)† in a patient with T2D on a drug regimen that does not include an SGLT2 inhibitor or GLP-1RA with CV benefit
- At the time of diagnosis of T2D in a patient with clinical ASCVD (SGLT2 inhibitor or GLP-1RA), DKD, and/or HF (SGLT2 inhibitor)†‡
- At hospital discharge (with close outpatient follow-up) after admission for an ASCVD (SGLT2 inhibitor or GLP-1RA) or HF (SGLT2 inhibitor) event§
- In a patient with T2D and diabetic kidney disease (SGLT2 inhibitor, alternatively GLP-1RA for eGFR <30 ml/min/1.73 m^2)‡
- In patients determined to be at high risk of ASCVD‖ (SGLT2 inhibitor or GLP-1RA) or HF (SGLT2 inhibitor)†‡

Opportunities to Initiate an SGLT2 Inhibitor or a GLP-1RA With Demonstrated CV Benefit or Renal Impairment in Patients With T2D. Reprinted from "2020 Expert Consensus Decision Pathway on Novel Therapies for Cardiovascular Risk Reduction in Patients With Type 2 Diabetes: A Report of the American College of Cardiology Solution Set Oversight Committee", S.R. Das, 2020, *J Am Coll Cardiol, 76*(9), 111-1145.

TABLE 6 Patient and Clinician Preferences and Priorities for Considering SGLT2 Inhibitors With Demonstrated CV Benefit Versus GLP-1RAs With Demonstrated CV Benefit

Preference or Priority	Consider Using an SGLT2 Inhibitor First When Patient and Clinician Priorities Include:	Consider Using a GLP-1RA First When Patient and Clinician Priorities Include:
MACE prevention	+++	+++
HF prevention	+++	
Weight loss	+	+++
Renal disease progression prevention	+++	+
Mode of administration	Oral	Subcutaneous
Considerations that may prompt use of an alternative class	■ Severely reduced kidney function*,† ■ History of prior amputation, severe peripheral arterial disease, or active diabetic foot ulcers (caution with canagliflozin) ■ History of recurrent genital candidiasis ■ History of diabetic ketoacidosis ■ History of fracture (caution with canagliflozin) ■ The patient is considering pregnancy ■ The patient is breast feeding	■ Persistent nausea, despite appropriate dietary education and low doses ■ History of gastroparesis ■ Active gallbladder disease ■ History of MEN2 or medullary thyroid cancer ■ History of proliferative retinopathy (caution with semaglutide or dulaglutide) ■ The patient is considering pregnancy ■ The patient is breast feeding

*eGFR <45 ml/min/1.73 m^2 is currently a caution due to a decrease in glycemic efficacy (not due to safety), but ongoing studies are testing whether SGLT2 inhibitors offer renal benefits in these patients. The FDA label for canagliflozin allows use of canagliflozin to an eGFR of 30 ml/min/1.73m^2 specifically for patients with DKD.
†Use clinical judgement when initiating an SGLT2 inhibitor in a patient who will be starting or up-titrating an ACE inhibitor or ARB if the patient's renal function is impaired

ACE = angiotensin-converting enzyme; ARB = angiotensin reception blocker; CV = cardiovascular; DKD = diabetic kidney disease; eGFR = estimated glomerular filtration rate; FDA = Food and Drug Administration; GLP-1RA = glucagon-like peptide-1 receptor agonist; HF = heart failure; MACE = major adverse cardiovascular event; MEN2 = multiple endocrine neoplasia type 2; SGLT2 = sodium-glucose cotransporter-2.

Patient and Clinician Preferences and Priorities for Considering SGLT2 Inhibitors With Demonstrated CV Benefit Versus GLP-1RAs With Demonstrated CV Benefit. Reprinted from "2020 Expert Consensus Decision Pathway on Novel Therapies for Cardiovascular Risk Reduction in Patients With Type 2 Diabetes: A Report of the American College of Cardiology Solution Set Oversight Committee", S.R. Das, 2020, *J Am Coll Cardiol, 76*(9), 111-1145.

VI. Smoking cessation

- Discussion around the importance of smoking cessation
- Referral to smoking cessation program
- Nicotine replacement therapy discussed.
- Can also discuss smoking cessation treatments such as varenicline or bupropion with appropriate counseling, follow-up, and monitoring if these medications are prescribed.

VII. Cardiac rehabilitation

- Referral to cardiac rehabilitation. If not placed, indicate reason why. Attempt to schedule the patient for the first cardiac rehabilitation visit prior to discharge.

- Cardiac rehabilitation is associated with reductions in readmissions and mortality and improvements in exercise capacity and symptoms. (4)

- Research has demonstrated that clear physician endorsement of the benefits of cardiac rehabilitation significant increase patient participation in CR.

- **Face-to-face discussion, recommendation, and prescription that documents the following:**
  - Endorsement of cardiac rehabilitation noting that cardiac rehabilitation is an important next step in the patient's care.
  - An overview of what cardiac rehabilitation is and its associated benefits was discussed.
  - The patient's questions were answered.

VIII. REFERENCES

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