To the Editor:

Schwalm et al \(^1\) called for resource-efficient strategies to reduce the identified evidence-practice gaps of primary and secondary prevention of cardiovascular disease, rightly stressing the need for the improvement of systems of care and ranking first effective measures for tobacco control. Like the Journal, they deserve to be commended because this article may be the best comprehensive framework provided yet, but some comments are needed about secondary prevention.

First, in terms of the need for developing and deploying systems of care that address barriers of systems of care, the failure is obvious. In the United States, Pearson and Peters raised concerns as early as 1999 about the treatment gaps in the chain (inpatient/hospital programs, specialist/generalist communication, ambulatory care, patient compliance).\(^2\) In 2012, The Joint Commission aimed to move forward for quality measures with a full Cessation Performance Measure-Set (TOB) and proposed that hospitals document the following: (1) the tobacco-use status of all admitted patients (TOB-1), (2) the cessation counseling and medication during hospitalization (TOB-2), (3) the referral at discharge for evidence-based cessation counseling and a prescription for cessation medication (TOB-3), and (4) the tobacco-use status approximately 30 days after discharge (TOB-4).\(^3\) The first available results just recently appeared in 2014 (the 2015 Joint Commission’s Annual Report). Only 68 US hospitals chose to report data on TOB, the score being 36.4\% for TOB-3 (see Table 14 of the report at http://www.jointcommission.org/annualreport.aspx).\(^4\) For 2015, there will be 671 hospitals reporting TOB compared with an average of 3254 hospitals reporting data for other measure sets. As in 2014, there will be no TOB-4 data for 2015. In fact, data collection was suspended for TOB-4 as a result of the inability of hospitals to document follow-up information obtained in the medical record after patients have left the hospitals.

Second, claims that “the prevention is suboptimal” and “gaps are much more pronounced in low- and middle-income countries” are understatements.\(^1\) In Europe the first EUROASPIRE survey among patients with coronary disease was performed in 1995 to 1996. The fourth round, recently available, includes 78 centers from 24 countries measuring quality of care from hospital records (n=16426) and patient interviews and examinations ≥6 months later (n=7998).\(^5\) Conclusions are alarming: “Risk factor control is inadequate despite high reported use of medications and there are large variations in secondary prevention practice between centres.”\(^5\)

Why can the systems of care not organize monitoring of treatments to adapt them or to improve compliance? Is the spreading or the cost of new information technology tools the barrier?

**DISCLOSURES**

None.

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\(^1\) Schwalm et al

\(^2\) Pearson and Peters

\(^3\) The Joint Commission

\(^4\) Joint Commission’s Annual Report

\(^5\) EUROASPIRE
REFERENCES
Letter by Braillon Regarding Article, "Resource Effective Strategies to Prevent and Treat Cardiovascular Disease"
Alain Braillon

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