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The Reply

Though we thank Braillon for his commentary, we do not find shame in the Get with the Guidelines-Coronary Artery Disease (GWTG-CAD) quality improvement initiative. To the contrary, we would congratulate the hospitals that participated in the GWTG-CAD registry and were able to achieve greater than 90% adherence for each of 6 core performance measures.[1] This is not shameful. GWTG-CAD is a *hospital*-based initiative. The analysis from Kumbhani et al suggests that GWTG-CAD is *almost* meeting its objectives of promoting adherence to guideline and evidence-based care during hospitalization for acute myocardial infarction. We also would emphasize that we are not satisfied, contrary to what Braillon has suggested. As the title of our commentary implies, we are only *almost* there.[2] While we would not disagree with "intensive" smoking cessation interventions, we cannot find shame in smoking cessation counseling as the groundwork.

We agree that programs like GWTG-CAD are only part of the solution. Braillon has recommended "looking forward." We would not disagree. But, the issues are complex. In a recent meta-analysis of nearly 400,000 patients from 20 studies assessing adherence to cardiovascular medications used for primary and secondary prevention using prescription refill frequency, Naderi et al demonstrated that the summary estimate for adherence across all studies was 57% after a median of 24 months.[3] In an evaluation of data from 3 federally funded trials, Farkouh et al demonstrated that only 18% of the Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE) diabetes subgroup, 23% of the Bypass Angioplasty Revascularization Investigation 2 Diabetes (BARI 2D) patients, and 8% of Comparison of Two Treatments for Multivessel Coronary Artery Disease in Individuals with Diabetes (FREEDOM) patients met all 4 prespecified treatment targets at 1 year of follow-up.[4] Farkouh et al concluded that "fundamentally new thinking is needed to explore approaches to achieve optimal secondary prevention treatment goals."[4] "Quality of care" needs such forward and new thinking.

Hospital-based interventions have a distinct purpose. As demonstrated by Kumbhani et al, hospitals participating in the GWTG-CAD registry demonstrate adherence to performance measures. Long-term adherence to and achievement of optimal secondary prevention treatment goals are processes of care that are distinct from hospital-based care. To look forward, as Braillon has suggested, we should embrace our achievements and recognize that these are distinct challenges and processes that characterize successful implementation of best practices during and following hospitalization.

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