The Center for Preventive Cardiology and Rehabilitation at Cleveland Clinic provides patients with a comprehensive assessment to identify traditional and emerging nontraditional cardiovascular risk factors. We collaborate with referring physicians to create individualized treatment plans. Patients typically have a limited number of visits in the center and return to their primary care or referring physician for care.

**LDL Levels Among Statin-Tolerant Adults**

Patients taking statins for both primary and secondary prevention experienced reductions in low-density lipoprotein (LDL) cholesterol levels. Patients were seen at baseline and had at least two follow-up visits within one year. The time between visits varied from patient to patient.

**Primary Prevention, Statin-Tolerant Adults (N = 715)**

**2006 – 2011**

<table>
<thead>
<tr>
<th>LDL Value</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>111.5 mg/dL</td>
<td>81 mg/dL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Follow-up</td>
<td>82 mg/dL</td>
<td>62 mg/dL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Secondary Prevention, Statin-Tolerant Adults (N = 301)**

**2006 – 2011**

<table>
<thead>
<tr>
<th>LDL Value</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>82 mg/dL</td>
<td>62 mg/dL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Follow-up</td>
<td>62 mg/dL</td>
<td>50 mg/dL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**LDL Levels Among Statin-Intolerant Adults**

Patients referred to the prevention clinic who could not tolerate statins still experienced reductions in LDL levels. Patients had at least two follow-up visits within a year.

**Primary Prevention, Statin-Intolerant Adults (N = 152)**

2006 – 2011

**LDL Value**

- **Baseline**: 148 mg/dL
- **2nd Follow-up**: 99 mg/dL

**Secondary Prevention, Statin-Intolerant Adults (N = 96)**

2006 – 2011

**LDL Value**

- **Baseline**: 129.5 mg/dL
- **2nd Follow-up**: 82 mg/dL
Blood Pressure Among Primary and Secondary Prevention Patients (N = 834)

2011

Patients who were seen in the prevention clinic for both primary and secondary prevention experienced reductions in blood pressure. All patients had at least two follow-up visits within a year.

<table>
<thead>
<tr>
<th>Value (mg/dL)</th>
<th>Baseline</th>
<th>2nd Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic</td>
<td>124</td>
<td>122</td>
</tr>
<tr>
<td>Diastolic</td>
<td></td>
<td>72</td>
</tr>
</tbody>
</table>

Shared Medical Appointments

include groups of six to eight patients with similar health concerns. The group meets with a dietitian and nurse practitioner during one appointment. The visit addresses multiple needs, and patients receive personalized dietary counseling and group interaction and support.

The Weigh to a Healthy Heart

The Weigh to a Healthy Heart is a comprehensive 11-week weight loss program designed to help prevent cardiovascular disease. The program includes a team of dietitians, physicians, exercise physiologists and behavioral counselors. Patients receive an exercise prescription and participate in private nutrition sessions, group exercise classes, lipid and fasting sugar testing, and weekly group support sessions. They also get help creating a grocery list.

In 2011, patients who attended more than 75 percent of the classes lost an average of 7.1 pounds. Those who attended fewer than 75 percent of the classes lost an average of 4 pounds.

<table>
<thead>
<tr>
<th>Year</th>
<th>Median Weight Loss over 11 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8.2 pounds</td>
</tr>
<tr>
<td>2011</td>
<td>5 pounds</td>
</tr>
</tbody>
</table>
HbA₁c Levels Among Patients with Diabetes (N = 239)

2011

Patients seen in the prevention clinic who had diabetes reduced HbA₁c levels during the course of their treatment. All patients were seen at baseline and had at least two follow-up visits within a year.

Exercise Prescriptions

2005 – 2011

Cleveland Clinic's exercise prescriptions are designed to help patients start an exercise program. The prescription is written after the patient's fitness level is determined. It provides the information about the recommended frequency, intensity, type and length of exercise sessions.
Cardiac Rehabilitation

Outcomes measured in the Cardiac Rehabilitation Program include those related to functional capacity, quality of life, blood pressure and weight.

Improvement in Exercise Capacity by Exercise Stress Test (N = 278)

2011

The metabolic equivalent of task (MET) is the ratio of the working metabolic rate to the resting metabolic rate. Each 1-MET increase in functional capacity reduces the risk of mortality by 8 to 12 percent. The average predicted reduction in mortality for patients in the program based on improvement in functional capacity (METs) was approximately 15 percent.

Data represent all cardiac rehab patients with both entry and exit visits in 2011.

Improvement in Quality of Life Assessment (N = 278)

2011

Quality of life (QOL) is measured using the 36-item short-form health survey (SF-36®) Health Status Survey. This is a validated QOL measure to track overall wellness of patients in cardiac rehabilitation. Patients who completed the program experienced improved physical and emotional QOL.
Cardiac Rehabilitation
Improvement in Systolic Blood Pressure (SBP) (N = 278)
2011

Among patients who completed the Cardiac Rehabilitation Program, 86 percent achieved normal blood pressure (< 140/< 90 mm Hg). The average improvement was -10 mm Hg.

Data represent all cardiac rehab patients with both entry and exit visits in 2011.

Cardiac Rehabilitation
Improvement in Weight (N = 278)
2011

Patients who completed the Cardiac Rehabilitation Program lost an average of 4.5 pounds.

Data represent all cardiac rehab patients with both entry and exit visits in 2011.