



HYPERTENSION MANAGEMENT PROGRAM

Patient Hypertension Encounter – Flowsheet/Custom Form Criteria

Standardizing the approach for clinical visits for hypertension through an encounter flowsheet or custom form is essential to aligning best practices for care. It also means that a larger portion of staff can support visits, as what needs to be done and documented is laid out, the information needed for a health care provider is really at the point of care.

When creating a flowsheet, consider your organization’s current documentation standards, EMR functionality and related clinical processes; as these can aid in a final flowsheet that pre-populates with chart information reducing documentation duplication, links to referral processes already in place for efficiency and communicates with others in the team in a way that is already familiar. Save completed flowsheets to the patient chart, so patient specific information is available in future, but also for reporting; this is especially helpful when information collected does not have a normal ‘home’ in the EMR. Whenever possible, use flags/coding or prompts to demonstrate a required action or guideline (e.g. overdue or missing items, values outside goals/target range(s)), and embed patient tools so they can be retrieved ‘on demand’ at the point of care.

Lastly, set up flowsheets so that different members of the organization can each support elements of the visit, such as a nurse providing BP measures, a clinician reviewing medication and a dietitian addressing diet goals and assessments. Allowing for this diversity is one step in expanding scope of practice and leveraging all the disciplines available to effect positive health outcomes for patients.

Category	Data	Notes
Patient Identification	Chart#	Record tracking
	Name	Record tracking
	Date of Birth	For age calculation
	Gender	Relates to waist measurement risk
	Ethnicity	Allows for sub-population analysis (e.g. languages to support, cultural sensitivity)
Visit Information	Date of Visit	Required for overdue reporting
	HCP/Rostering Provider	Can be used to categorize metrics and follow up plans

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Diagnosis and History	Diagnosis of either <ul style="list-style-type: none"> • first degree Hypertension OR • (history of) Elevated Blood Pressure 	Relates to guidelines for follow up and management
	Diagnosis of: <ul style="list-style-type: none"> • Dyslipidemia • Diabetes • Kidney Disease • Obesity • Coronary Heart Disease • Stroke or TIA • Depression 	Comorbidities related to management of hypertension and risks
	Family History of: <ul style="list-style-type: none"> • Dyslipidemia • Diabetes • Kidney Disease • Obesity • Coronary Heart Disease • Stroke or TIA • Depression 	Additional cardiovascular risks
	When was hypertension diagnosed: <ul style="list-style-type: none"> • >= 1yr ago • < 1 yr ago • Not yet (e.g. elevated BP) 	Program analysis for outcomes
Tools and Follow up	Patient Education/Self-Management tools provided? Y/N	Prompts and identifies self-management tool use
	BP Monitoring Plan: <ul style="list-style-type: none"> • Ambulatory • Home Monitoring 	Prompts and identifies expected follow up
	Referrals: <ul style="list-style-type: none"> • HCP (e.g. escalation, inter-professional team) • Community (e.g. external program/support) 	Prompts and identifies follow up actions For HCP referrals, consider linking to your organizations internal referral process (e.g. through your EMR)
	Next Hypertension Visit: X weeks or X months	Identifies expected follow up alternatively, this can be linked to booking system/function

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<p>Cardiovascular Risk Factors & Assessments</p>	<p>Cardiovascular Risk Factors (yes/no):</p> <ul style="list-style-type: none"> • Weight • Physical Activity (inactivity) • Diet/Nutrition • Smoking • Alcohol Intake • Stress 	<p>Personal risk factors, re-assess at each visit and adjust as needed (e.g. to reflect change)</p> <p>KPI on this data help identify needs by patient population</p>
	<p>Patient Selected Lifestyle Goal (health behavior change):</p> <ul style="list-style-type: none"> • Weight (reduction) • Physical Activity (increase) • Diet/Nutrition – Sodium Reduction • Diet/Nutrition – DASH diet • Smoking (cessation) • Alcohol Intake (reduction) • Stress (management) 	<p>Self-management of risk factor(s), assess at each visit (goals change over time), work with patient to identify goal based on highest confidence and importance and patient view of goals</p> <p>KPI on this data help identify resource needs by patient population and specific interest</p> <p>DASH = Dietary Approaches to Stop Hypertension</p>
	<p>Current Assessment of CV Risk Factors:</p> <ul style="list-style-type: none"> • Physical Activity – min/wk • Smoking – cigs/day • Alcohol – drinks/day • High Salt Foods – always/often/sometimes/never • DASH diet - always/often/sometimes/never • Stressed - always/often/sometimes/never 	<p>Assess at each visit, celebrate improvements with patient, use to frame discussions on lifestyle change/health behavior change/lifestyle goals</p>
	<p>Patient view of selected Lifestyle Goal (health behavior change)</p> <ul style="list-style-type: none"> • Uninterested • Thinking • Deciding • Taking Action • Maintaining • Relapsed 	<p>This assesses the patient’s readiness to change (see related resource “Patient’s Readiness to Change Assessment”) and follows the Transtheoretical Model of Change/Stages of Change</p>
	<p>Patient Assessment of Lifestyle Goal (health behavior change)</p> <ul style="list-style-type: none"> • How important is the lifestyle change to the patient (1-10, 10=most) • How confident is the patient in carrying out the lifestyle change (1-10, 10=most) 	<p>These assess patient motivation using the ‘importance/confidence’ ruler technique (see related resource “Assessing Motivation”)</p>

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Medications	<p>Currently Prescribed</p> <ul style="list-style-type: none"> • Diuretic • ACE Inhibitor • A-II receptor antagonist • Beta Blocker • Calcium Channel Blocker • Other Antihypertensive • Statin • Other lipid-lowering • Oral hypoglycemic • Insulin • ASA 	<p>Consider specific flagging for: Reconciliation done? Single pill combinations considered? ACE/ARB combination reviewed?</p>
	<p>Side Effects Reported</p> <ul style="list-style-type: none"> • Diuretic • ACE Inhibitor • A-II receptor antagonist • Beta Blocker • Calcium Channel Blocker • Other Antihypertensive • Statin • Other lipid-lowering • Oral hypoglycemic • Insulin • ASA 	<p>Consider your organizations practice for medication review, do side effect reports require an escalated review (e.g. by MD/NP, pharmacist)?</p>
	<p>Prescription Decision (today’s visit) per class:</p> <p>Same, Increase, Decrease, Stop, Start, In-Class Switch</p>	<p>Identifies change in pharmacological management Consider flagging for shortened follow up timeframe to assess BP following medication change</p>
	<p>Patient Adherence</p> <ul style="list-style-type: none"> • How often does patient miss taking his/her meds?- /wk • Does patient take herbal remedies/see traditional healer/naturopath? – Y/N • Does the patient have adequate drug coverage? – Y/N 	<p>Elicits information to inform medication choices, discussion on adherence, contraindications</p> <p>Consider adding ‘are you taking any over the counter medications’ (e.g. during cold and flu season) to further target possible contraindications</p>
Physical Exam	<ul style="list-style-type: none"> • Blood Pressure (SBP/DBP) • Was an Automated Office BP monitor (AOBP) used? – Y/N • Height – cm/in. • Weight – kg/lb. • Waist – cm/in. 	<p>Target BP values are reduced where AOBP is used</p> <p>Height/Weight needed for BMI calculation, Waist circumference relates to increased CV risk</p> <p>Consider flagging out of range values</p>

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Lab Work	Lipids LDL value/date (mmol/L goal <2.0) TC/HDL value/date (Ratio goal <4.0) HDL value/date (mmol/L goal >1.0) Triglycerides value/date (mmol/L goal <1.7)	Consider flag for re-order if dates greater than recommended intervals or no result available, this also pairs well with a Medical Directive to allow a broader group of staff to order routine labs
	A1C and FBS A1C value/date (goal <7.0%, or <0.07) FBS value/date (mmol/L goal 4-7)	
	eGFR and ACR eGFR value/date (mL/min) (normal range >90) ACR value/date (mg/mmol) (goal <2.0)	