

HYPERTENSION MANAGEMENT PROGRAM Follow up Protocol for Patients with Hypertension

Identifying Patients who are Overdue	 Use reminders, missed appointment lists, EMR queries or other reporting to identify patients. See companion resource "Hypertension Management Program - Key Performance Indicators" for additional criteria suggestions. Hypertension patients actively modifying health behaviors should be followed-up at 3 to 6 month intervals. Shorter intervals (every 1 or 2 months) are needed for patients with higher BPs (2018 Hypertension Canada). Patients on antihypertensive drug treatment should be seen monthly or every 2 months, depending on the level of BP, until readings on 2 consecutive visits are below target. Shorter intervals between visits will be needed for symptomatic patients and those with severe hypertension, intolerance to antihypertensive drugs, or target organ damage. When the target BP has been reached, patients should be seen at 3 to 6 month intervals (2018 Hypertension Canada). 		
Most	Controlled BP <135/85 (AOBP) or	Uncor BP >= 135/85 (AOBP) or	>=180/110
recent BP	<140/90 (Non-AOBP) or BP <130/80 in patients with Diabetes	>= 140/90 (Non-AOBP) or BP >= 130/80 in patients with Diabetes	
Best Practice Follow up	3 to 6 month intervals	1-2 month intervals	Immediately
e done during follow-up?	Assess: 1. BP, Waist Circumference, Weight 2. Cardiovascular Risk Factors 3. Lifestyle Goal (selecting a goal, or discuss progress on selected goal) 4. Medication (side effects, adherence, improving adherence) 5. Review lab work 6. Refer to MD/NP as needed Discuss and book next visit		Needs urgent medical treatment: send to hospital emergency department. If not, have NP/MD see patient immediately
What needs to be d	MD/NP: 1. Order lab work as indicated 2. Review medications *Refill/adjust medication as needed*		 MD/NP: 1. Assess treatment plan and medications (side effects, adherence) 2. Modify medications as necessary Discuss and book next visit