BRITISH COLUMBIA
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Ministry of Health

HYPERTENSION CARE FLOW SHEET

This Flow Sheet is based on the Hypertension Guideline
Web site: http://www.bcguidelines.ca

BRITISH COLUMBIA MEDICAL ASSOCIATION

Guidelines & Protocols Advisory Committee

NAME OF PATIENT	SEX ☐ M ☐ F	DATE OF BIRTH	AGE AT DIAGNOSIS

CARE OBJECTIVES

RISK FACTORS AND CO-MORBID CONDITIONS (NOTE: if patient also has DM and/or CHF, use respective flowsheet instead)

☐ Obesity

HEIGHT (cm)

DATE	BMI (kg/m²)	TARGET
		Normal: 18.5-24.9
		Overwt: 25-30
		Obese: ≥30

DATE	WAIST CIRC.	TARGET
		Male (cm) Caucasian ≤ 102 Asian ≤ 90
		Female (cm) Caucasian ≤ 88 Asian ≤ 80

☐ CVD _____
☐ Dyslipidemia
☐ Kidney
☐ Review BP:
  ☐ <140/90 no co-morbid condtions
  ☐ 130/80 DM, renal disease or end organ damage

☐ Smoker
☐ Alcohol (assess/discuss)
☐ Gout
☐ Asthma
☐ Allergy: (e.g. ASA)

☐ Other: _____

SELF MANAGEMENT (Discuss with patient)

☐ Explain the consequences of hypertension
☐ Review meds & adverse effects
☐ Smoking cessation: *Quit Now*
Phone toll free in BC: 1 877 455-2233
☐ Refer to guideline & patient guide
☐ Set goals with patient (See reverse):
- Promote weight loss & exercise
- Avoid excessive alcohol
- Reduce salt intake & improve diet

☐ Copy of Flow Sheet to patient if appropriate
☐ Other: _____

VISITS (3 TO 6 MONTHS)

DATE	BP	WEIGHT Lbs | Kg	NOTES (REVIEW RISK FACTORS, GOALS, & CLINICAL STATUS.)	BP MEDICATION NOTES
				BASELINE (Note allergies, side effects & contraindications) *Consider low dose ASA if age 50-70 & ≥ 20% CHD risk
				☐ NO CHANGE
				☐ NO CHANGE
				☐ NO CHANGE
				☐ NO CHANGE
				☐ NO CHANGE
				☐ NO CHANGE
				☐ NO CHANGE
				☐ NO CHANGE
				☐ NO CHANGE
				☐ NO CHANGE

REMINDERS: **1) CONSIDER END ORGAN DAMAGE: EYES, HEART, CIRCULATION, KIDNEYS**
2) SEE REVERSE FOR LIFESTYLE MANAGEMENT & TREATMENT RECOMMENDATIONS

ANNUALLY (UNLESS NOT CLINICALLY INDICATED)

LIPIDS				FRAMINGHAM 10-YR RISK
DATE	TC	LDL	TC/HDL	%
TARGETS		< 3.5	<5.0	MOD < 20%
		< 2.5	<4.0	HIGH ≥ 20%

KIDNEY		
DATE	ACR	eGFR
TARGETS	M: < 2.0 F: < 2.8	> 60

CONSIDER TESTING EVERY SECOND YEAR IF LESS THAN 10% CHD RISK

VACCINATIONS (If ≥ age 65 or has other risk factors)

Annual Flu: DATE _____ DATE _____

Pneumovax: DATE _____

HLTH/BCMA (REV 06/07)

BILLING CODE: 14052 DIAGNOSTIC CODE: 401 BILLING: DATE _____ DATE _____

Lifestyle Management for Patients with Hypertension

Suggestions for the following lifestyle changes should be offered and reviewed at each visit:

Smoking cessation
Recommend complete cessation of smoking and exposure to second hand smoke.
BC Smokers Helpline: 1-877 455-2233 (toll-free in B.C.) 10 AM-6 PM, and www.quitnow.ca.

Physical activity
Prescribe 30-60 minutes of moderate intensity dynamic activity (such as walking 2 miles in 30 minutes once per day, or 1 mile in 15 minutes two times per day, jogging, cycling or swimming) 4-7 days per week. Recommend getting a pedometer for immediate positive feedback.

Weight reduction
All overweight patients with hypertension should be advised to lose weight. Weight loss strategies should be long-term and employ a multidisciplinary approach that includes dietary education, increased physical activity, and behavioural intervention. Target: body mass index (BMI) 18.5-24.9 kg/m^2, waist circumference <102 cm for men and <88 cm for women.

Dietary recommendations
Advise a diet high in fruits, vegetables, low-fat dairy products, dietary and soluble fibre, whole grains and protein sources reduced in saturated fats and cholesterol (Dietary Approaches to Stop Hypertension (DASH) diet). Reduce consumption of trans-fats and increase intake of fish that is high in omega 3 fatty acids.

Reduce salt intake
Recommend reduced dietary sodium intake of ≤ 1,500 milligrams per day (approximately 1 tsp of table salt).

Alcohol consumption
Limit to two drinks or less per day, and consumption should not exceed 14 standard drinks per week for men and 9 standard drinks per week for women.

Potassium, calcium and magnesium intake
Supplementation of potassium, calcium and magnesium is not recommended for the prevention or treatment of hypertension.

Pharmacologic Treatment without Co-morbid Conditions

The benefits of pharmacologic treatment in people with mild hypertension (average BP between 140/90 and 160/100), and a 10-year coronary heart disease risk of less than 20%, are unclear. Use clinical judgment when recommending therapy for this patient group.

Pharmacologic treatment, in addition to lifestyle modification is recommended for patients with an average BP ≥ 160/100, even in the absence of other major cardiovascular risk factors.

Consider monotherapy with a low-dose thiazide diuretic as first-line treatment.

If BP is not controlled, use combination therapy by adding 1 or more of:
- ACEI or ARB if ACEI intolerant
- Long-acting dihydropyridine calcium channel blockers (CCB (DHP))

Note:
- Long-acting CCB (DHP) are preferred 2nd line treatment for patients at risk for, or with a history of, stroke
- Beta blockers may no longer be a first line treatment option, with some exceptions (guideline under revision)
- Alpha blockers are not a 1st line treatment option

Consider addition of low-dose ASA therapy if Framingham risk score is ≥ 20% and patient is between 50 to 70 years-of-age. Avoid using ASA in patients with a history of hemorrhagic stroke. Exercise extreme caution if blood pressure is not controlled.

See hypertension guideline for pharmacologic management if co-morbid conditions exist.