CARDIOVASCULAR CLINIC (CC)

PATIENTS WHO SHOULD BE ENROLLED:

Patients with:

- Hypertension,
- Cardiovascular disease,
- Chronic anticoagulant therapy, and
- Isolated dyslipidemia, if the primary purpose of management is to prevent cardiovascular disease.

BASELINE HISTORY AND PROCEDURES:

Document data on the following forms:

- DC4-770DD, *Cardiovascular Baseline History and Procedures*
- DC4-701F, *Chronic Illness Clinic*
- DC4-770D, *Cardiovascular Clinic Flow Sheet*
- DC4-730, *Problem List*

Documentation shall include a diagnosis and statement as to the control of the disease (Good, Fair or Poor).

Baseline history will include an assessment of risk factors:

- Smoking
- Diet
- Over the counter medication use
- Illicit drug use
- Hypertension
- Diabetes (Type 1 or 2)
- Coronary heart disease
- Chronic Kidney disease
- Peripheral Vascular disease
- Family history
- Review DC4-710A, *Immunization Record,* for pneumococcal and influenza history (order if necessary)

*Additional resource for estimating risk:

- http://tools.cardiosource.org/ASCVD-Risk-Estimator/#/ASCVD-Risk-Estimator/

Physical examination will include evaluation and documentation of:

- Vital signs
- Heart,
- Lungs,
- Extremities (noting edema if present)
- Peripheral pulses
- Bruits (if present)
- Fundoscopic examination

Baseline Procedures will include:

- Electrocardiogram (EKG)
- Basic metabolic profile (BMP)
- Thyroid stimulating hormone (TSH)
- Urine dipstick

If clinically indicated:

- Chest x-ray (CXR)
- Lipid profile (patients with established cardiovascular disease or at high risk for developing it or with diabetes).
- Complete blood count with platelets
- PTT
- PT
- INR
- Albumin
- Creatinine
- Liver function tests

TREATMENT RECOMMENDATIONS:
Prescribe Low dose aspirin unless contraindicated.

Hypertension:

- Therapeutic lifestyle changes: Low Salt Diet, Cardiovascular Exercise, Weight Reduction if BMI is greater than 25
- Pharmacotherapy: According to current national guidelines

Hyperlipidemia:

- Therapeutic lifestyle changes (TLC) (diet, exercise, weight reduction if BMI is greater than 25)
    - If LDL is above goal, a 3 month trial of TLC is appropriate unless LDL is greater than 220
- Consider adding drug therapy if LDL exceeds goal for patient
- Identify metabolic syndrome and treat, if present, after 3 months of TLC
- Treat elevated triglycerides as clinically indicated

Anticoagulation:

- If high risk for thrombosis: (i.e. active thrombotic process i.e. DVT or pulmonary embolism or an underlying malignancy) start Low Molecular Weight Heparin (LMWH) and warfarin therapy.
- If lower thrombotic risk (e.g., Atrial fibrillation without recurrent thromboembolism) can be started on warfarin alone

EDUCATION:

Education will include:

- Disease process
- Diet
- Exercise
- Smoking cessation, if applicable
- Medication-name(s), side effects, foods or beverages to avoid, dosing times

FOLLOW-UP VISITS:

Schedule patients based on clinical need and/or as follows:

Hypertension:

- without end-organ damage at least annually

Hyperlipidemia:

- TLC after 3 months to repeat lipid panel until patient reaches target LDL
- Once goal is reached Lipids and LFT's should be monitored at 6-12 month intervals

Anticoagulation:

- If stable every 90 days

At each Chronic Clinic visit the clinician shall document:

- Review of the record (labs, treatment records, MARs, etc…)
- Evaluate the control of the disease (Good, Fair, or Poor)
- Current status of the patient compared with the previous Chronic Clinic visit (Improved, Unchanged, or Worsened).
- Provide education as outlined above

Document follow-up visits on forms:

- DC4-770D, *Cardiovascular Clinic Flow Sheet*
- DC4-701F, *Chronic Illness Clinic*
- DC4-730, *Problem List*, if there are changes or additional diagnoses

Physical examination at every Chronic Clinic Visit will include at a minimum an evaluation and documentation of:

- Vital signs
- Heart
- Lungs,
- Extremities (noting edema if present)
- Peripheral pulses
- Bruits (if present)
- Fundoscopic examination

Procedures as needed and at a minimum annually:

- BMP
- Urine dipstick

If clinically indicated:

- EKG
- Lipid Profile
- LFT's
- INR

GOALS:

Hypertension:

- Blood pressure <140/90
  - If diabetic <130/80

Hyperlipidemia

LDL Cholesterol	Low risk	<160
	Moderate risk	<130
	High risk	<100
HDL Cholesterol	Men	>40 mg/dl
	Women	>50 mg/dl
Triglycerides	<150 mg/dl	

Anticoagulation:

- Minimize number of clinicians prescribing/adjusting warfarin for patient
- Establish to review each patient at least monthly
- Achieve a therapeutic INR goal within 30 days of warfarin initiation
- Use singe target INR value as goal endpoint (i.e. target 2.5 range 2.0-3.0)
- Avoid major medication interactions

Reference:

American College of Cardiology and American Heart Association (2014). *ASCVD Risk Estimator*. Retrieved from http://tools.cardiosource.org/ASCVD-Risk-Estimator/#page_reference