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:

- https://tools.acc.org/ldl/ascvd_risk_estimator/index.html#!/calulate/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)
- Comprehensive Metabolic Panel (CMP)
- 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

TREATMENT RECOMMENDATIONS:
Prescribe low dose aspirin for secondary prevention of ASCVD unless medically contraindicated in patients with known history of Stroke, MI, CABG, or coronary artery stenting. Low-dose aspirin might be considered for the primary prevention of ASCVD among select adults 40 to 70 years of age who are at higher ASCVD risk, but not at increased bleeding risk.The decision whether to use aspirin for primary prevention should be made only after a detailed discussion between the patient and health care provider, guided by personal patient preferences and estimated benefits and harms relative to the specific patient.

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 hypertriglyceridemia according to the current AHA/ACC guidelines. **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:

- CMP

- 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

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: https://tools.acc.org/ldl/ascvd_risk_estimator/index.html#!/calulate/estimator/

Current AHA/ACC Guidelines:
https://www.acc.org/latest-in-cardiology/articles/2019/01/11/07/39/hypertriglyceridemia-management-according-to-the-2018-aha-acc-guideline