Implementing Hypertension Guidelines Through Shared Decision Making with Older Adults

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Objectives

- Discuss conflicting recommendations for treatment of high blood pressure in older adults
- Describe the use of shared decision making related to management of high blood pressure in the primary care setting.
- Explore the recommendations and evidence supporting the 2017 ACC/AHA High Blood Pressure Guidelines

Why Hypertension?

- May be as high as 75-85% in older adults
- Leading cause of death and disability worldwide
- Second only to smoking as a preventable cause of death
- Can be successfully treated with lifestyle modifications and/or medications
- Hypertension increases the risk for CV complications especially in those with diabetes or renal disease
- Usually a silent condition
Guidelines

• With the focus on EBP we all are expected to follow guidelines
• The challenge for the Primary Care Provider (PCP) is which guideline?
• To determine this the PCP needs to evaluate the guidelines and the evidence on which the recommendations are based
• Guidelines are recommendations and we still need to tailor these to the individual and make decisions using shared decision making with the patient.

Shared Decision Making

• Patient centered approach
• Involves listening to the patient and selecting the best treatment based on the evidence, patient preferences and values.
• Without shared decision making patients may not follow through with recommendations.
• Does require a little more time up front but increases compliance with plan of care.

Why Shared Decision Making

• More than half of the medications prescribed are either not taken or not taken accurately
• Patients preferences, values and knowledge impact decisions to take medications
• If we don’t explain what medications are for, what side effects might occur and how to take medications many patients will stop medications
• Also need to consider cost of medications when prescribing
SHARE Approach

- Seek your patient’s participation
- Help your patient explore and compare treatment options
- Assess your patient’s values and preferences
- Reach a decision with your patient
- Evaluate your patient’s decision


Blood Pressure Categories from JNC7 to the 2017 American College of Cardiology (ACC) and the American Heart Association (AHA) Guidelines

<table>
<thead>
<tr>
<th>SBP, mmHg</th>
<th>DBP, mmHg</th>
<th>JNC7 (2003)</th>
<th>JNC8 (2014)</th>
<th>2017 ACC/AHA</th>
<th>2018 ESC/ESC</th>
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<tr>
<td>&lt;120</td>
<td>&lt;80</td>
<td>Normal BP</td>
<td>Normal BP</td>
<td>Normal BP</td>
<td>Optimal</td>
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<td>&lt;80</td>
<td>Prehypertension</td>
<td>Normal BP</td>
<td>High BP</td>
<td>Normal</td>
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<tr>
<td>130-139</td>
<td>80-89</td>
<td>Prehypertension</td>
<td>Hypertension if under 60</td>
<td>Stage 1 hypertension</td>
<td>High Normal</td>
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<tr>
<td>140-149</td>
<td>90-99</td>
<td>Stage 1 hypertension</td>
<td>Hypertension if over 60</td>
<td>Stage 2 hypertension</td>
<td>Grade 1</td>
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<td>Hypertension</td>
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</table>

ACP/AAPA Guidelines for Older Adults

- More recommendations about pharmacological initiation
  - In patients over 60 providers should initiate treatment in those with SBP of 150 with target of less than 150
  - In patients over 60 with history of cardiac events initiate therapy at SBP of 140
  - Consider intensifying therapy for those with high risk of stroke and cardiac events to achieve an SBP of less than 140
2017 Guideline for the Prevention, Detection, Evaluation and Management of Hypertension

American College of Cardiology (ACC) and American Heart Association (AHA)

- Focused on prevention and diagnosis as well as management
- Emphasizes importance of accurate measurement of blood pressure
  - Blood pressure should be based on at least two blood pressures averaged within 2-3 minutes
  - Discusses White Coat and Masked Hypertension
  - Consider ambulatory BP monitoring or home monitoring

Recommendations

- High level of evidence for secondary prevention of high blood pressure
- Primary prevention is based on limited data
- The 2017 Guidelines had a heavy reliance on two RCT clinical trials (SPRINT and ACCORD)

CVD Risk Assessment

- Initiation of medication in the 2017 guideline is based on level of blood pressure and patients risk for CVD
- Most common risk assessment tool is the 10-year risk for preventable ASCVD events
- ASCVD events are coronary death, nonfatal MI and fatal or nonfatal stroke
- Patients age, gender, cholesterol levels blood pressure levels and history of diabetes, smoking or hypertension are used to determine the 10 year ASCVD risk.
- App available from the American College of Cardiology
Life Style Interventions

- Weight loss
- Exercise
- Smoking Cessation
- DASH diet – 2,300 mg of sodium
- Increase Potassium
- Stress reduction
- Screening for recreational drugs and alcohol

Initiation of Pharmacological Treatment

- Stage I (130-139/80-89 mm Hg) and ASCVD risk of > or equal to 10% and was not able to get to goal in one month
- Stage 2 (140/90 or higher) regardless of ASCVD risk start medications and reassess in one month
- ACP/AAFP are recommending in older adults to consider higher goals (150/90) for initiation of medication.
Shared Decision Making and Older Adults

- Evaluate for fall risk and other comorbidities
- Discuss recommendations with patient
- Educate the patient about risks related to CVD, diabetes and kidney disease
- Agree upon individualized goals for the patient
- Reassess in 1 month
- Repeat the process

Recommendations for Medication Therapy

- Several possible first line medications – Thiazides, ACE and ARB
- If African American start with thiazide or Calcium Channel Blocker
- Beta Blockers no longer considered first line
- Consider co-morbidities when making decisions
- Majority of patients with Stage 2 will need combination of medications.
- Monitor closely and consider labs if using thiazide for potassium level.
- Also need to monitor renal function

Adverse Effects

- Hypokalemia
- Hyponatremia
- Edema
- Erectile dysfunction
- Multiple medications and timing
- Isolated diastolic hypotension is associated with adverse cardiac outcomes (keep diastolic at > 60)
Considerations in Older Adults

- Depending on comorbidities may need to alter goals
- Some patients with risk for hypotension or falls may need to relax goals to 140/90 or 150/90
- Need to be aware of diastolic numbers these may be low even with high systolic
- Consider deprescribing if lightheadedness or blood pressure levels change

Summary

- Review evidence and identify recommendations that you will follow
- Share with patient different recommendations with risk/benefit
- Determine a plan of care
- Reevaluate on a regular basis
- Before adding or increasing medications make sure patient is following plan of care

Case Study

- 72 year old African American female comes into clinic for annual exam and blood pressure was found to be 158/90. Pt. has well controlled diabetes no other health problems. BMI is 35
  - What is your next step
- Recheck of blood pressure remained elevated at 152/88
- Discussed options for treatment – lifestyle versus medication
Case Study

- Pt. is back after a month of trying lifestyle blood pressure at home was 148/88-156/90 today blood pressure average was 152/90.
- What pharmacological treatment would be best?
- What labs or studies do you need to do prior to starting the medication?
- When should you have her in for follow up?

Questions

Reference List