CARE TEAM
CHART REVIEW CHECKLIST

1 Review Chart for Recent Hospitalizations or ED Visits

- Review reason for hospitalization or ED visit. Use this ED EMR tex snippet for this outreach.
- Frequent ED Utilizer? Discuss the plan with the patient's provider. Follow up with the patient at least once per week until stable
- Chronic Disease Exacerbation or Serious Medical Event:
    - *Phone call within 48 hours to see how patient is doing and schedule follow-up visit*
    - *Send message to provider*
- Fall, Broken Bone, Laceration, etc:
    - *Phone call within 48 hours to see if patient needs anything*
- Cold, rash, ran out of medication, etc (ED not neccessary):
    - *Phone call within 48 hours to offer patient office resources to avoid ED in the future*
        - *Same Day/Next Day Sick Visits*
        - *Telehealth Visit*
        - *Portal Message*
        - *24 Hour On-Call Provider*

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CARE TEAM
CHART REVIEW CHECKLIST

2 Review Preventative Health Screenings

- Has the patient had an Annual Wellness Visit or Physical in the last 365 days? Verify the next one is scheduled; if not, assist the patient with getting it scheduled.
- Is the patient in active cancer treatment? Are they totally homebound or living long-term in a facility or on palliative or hospice care? If yes, discuss the plan for more medical coordination of care with the provider.

General Population:

- Cancer Screenings
  - *Colorectal: Patients 45-74, per clinical guidelines or provider recommendation*
  - *Cervical: Women 21-64, per clinical guidelines or provider recommendation*
  - *Mammogram: Women 40+, per clinical guidelines or provider recommendation*
- Vaccinations
  - *Flu*
  - *Pneumococcal*
  - *Tdap*
  - *Shingles*
  - *Covid-19 & Booster(s)*
- Tobacco Use, Interested in cessation?
  - Offer referal to Health Coach, Smoking Cessation Counselor or DE Quitline

CARE TEAM
CHART REVIEW CHECKLIST

Hypertension:

- Is the patient checking BP at home? Review the proper way to take a BP. Suggest submitting a BP log weekly or monthly.
- Is the patient currently taking all prescribed medications, including a statin? Any issues or concerns?
- If BP is over 130/80 mmHg, offer to partner with the patient on a BP Action Plan.
  - *Refer to Poplar HTN Pathway. Use this snippet and walk through with the patient*
  - *Identify if they would like to focus on Nutrition or Exercise*
    - *Click Here for the Nutrition EMR Snippet and Pathway*
    - *Click Here for the Exercise EMR Snippet and Pathway*
    - *Ask the patient if they would like to be referred to the Health Coach for more support*
  - *If BP is regularly over 150/90 mmHg, send message to provider for evaluation.*

Diabetes:

- A1c on file: 7.0 or greater: in the last 90 days or Under 7.0: in the last 6 months
- Is the patient checking blood sugar at home? Review the proper way to test BS. Suggest submitting BS log weekly or monthly.
- Is the patient currently taking all prescribed medications? Any issues or concerns?
- If A1c is over 7.0%, offer to partner with the patient on an Action Plan.
  - *Identify if they would like to focus on nutrition. Click Here for the Nutrition EMR Snippet and Pathway*
  - *Identify if they would like to focus on exercise. Click Here for the Exercise EMR Snippet and Pathway*
  - *Ask the patient if they would like to be referred to the Health Coach for more support*
- If BS is regularly over 180 or under 80, send message to provider for evaluation.
- Is the annual DM eye exam on file or scheduled?
- DM Nephropathy Screening (microalbuminuria) done in the last 6 months?

CARE TEAM
CHART REVIEW CHECKLIST

CHF:

- Any changes or concerns with recent symptoms?
- Tracking weight at home?
- Refer to Poplar CHF Pathway and EMR Snippet
- If applicable, ask the patient if they would like to be referred to the Health Coach for more support

CAD:

- Any changes or concerns with recent symptoms, including chest pain or SOB?
- Any changes to medications or treatment plan with Cardiologist we should be aware of?
- Refer to Cardiovascular Protocol and CAD Action Plan
- If applicable, ask the patient if they would like to be referred to the Health Coach for more support

COPD/Asthma:

- Any changes or concerns with recent symptoms, including any trouble breathing?
- How often are you using your rescue inhaler (Albuterol)?
- Do you check Peak Flows at home? If so, what are you getting?
- Some monitors have a green, yellow, or red zone. Red zone would be worrisome. Yellow zone means we might need to change or add meds.
  - *Green Zone: 80 to 100 percent of the usual or normal peak flow readings are clear.*
  - *Yellow Zone: 50 to 79 percent of the usual or normal peak flow readings*
  - *Red Zone: Less than 50 percent of the usual or normal peak flow readings*
- Refer to Poplar COPD Pathway

CARE TEAM
CHART REVIEW CHECKLIST

3 Review and Enroll in CCM if appropriate

- Is the patient scheduled for a follow up visit in the right time frame?
- Contact patient and conduct check-in call, enroll in CCM if appropriate, and obtain reports or assist with scheduling any needed preventative health services or overdue testing
- Schedule appropriate visits, if needed
- If the patient identifies they want more support, conduct a Lifestyle Opportunity Assessment and choose appropriate Action Plans
    - *Identify if they would like to focus on Nutrition or Exercise*
        - *Click Here for the Nutrition EMR Snippet and Pathway*
        - *Click Here for the Exercise EMR Snippet and Pathway*
        - *Ask the patient if they would like to be referred to the Health Coach for more support*
- Refer to Health Coach for more Action Plan support
    - *Complex clinical needs, reach out to RN to discuss escalation*
        - *Frequent Hospitalization/ED Use*
        - *Multiple Chronic Conditions, unstable, seeing many specialists*
        - *Polypharmacy (5 or more meds, especially if they need help managing or aren't taking as prescribed)*
        - *Patients that are having trouble with Activities of Daily Living*
- Document all information in EMR

CARE TEAM
CHART REVIEW CHECKLIST

How to Enroll in Patients in CCM: This can be done by any staff at any office visit.

Who is eligible? Medicare, some MA. Must have 2+ chronic, life-threatening diseases.

Your job: Encourage each patient to participate and get verbal agreement that they agree to participate in CCM and document.

Read this script to eligible patients:
We encourage our patients to participate in Medicare's Chronic Care Management Program. This allows Medicare to pay us to provide more services in between office visits and can save you from having to come into the office and pay a copay.
Your insurance covers most or all of the costs. Sometimes, there is a small cost to patients, depending on insurance. This is voluntary; you can cancel it at any time.
Only one medical office may provide Chronic Care Management to you per month.
Is it OK if we set you up for CCM?

If they agree:
Document it in the chart (anywhere) that you discussed, and they agreed to CCM. Tag/sticky note them in the chart "CCM Agreed" and send a note to your CCM Team/CCM Lead to add them to their list.

How to Create a CCM Care Plan

A CCM Care Plan must be created once for each CCM enrollee. This can be done by a trained Medical Assistant.

1. Create a note titled "CCM Care Plan".
2. Copy the Assessment/Plan section from the most recent encounter.
3. Add any other key chronic diseases not mentioned.
4. Remove any acute problems like sinus infection.
5. For each problem listed, look at the verbage after it. Look for things that need to be followed up and add these.
6. Send the CCM Care Plan to the provider to sign off on.
7. Once signed by the provider, bill G0506. You must add 2 or more chronic conditions to the claim. Your practice can only bill this code once in a patient's lifetime.

One-Time Ever Code
G0506 Creation of Initial Care Plan

CARE TEAM
CHART REVIEW CHECKLIST

How to Log CCM Time

Any staff member who addresses something relevant to a CCM patient's chronic diseases should log the time spent.

Examples of activities that may be billed as CCM

- Communicating in any way with anyone regarding anything chronic health-related (i.e., most things that come up)

What about acute situations?

If the patient's chronic conditions make them at risk for complications, then the time is countable. Example: time spent addressing any infection should be counted in a diabetic since they are at risk.

How to log CCM time

- Write the note or message in the chart as you normally would.
- At the end of the note, add "CCM X min" where X is a number.
- Use CCM time tracking feature in your EMR

CARE TEAM
CHART REVIEW CHECKLIST

Check In Call

- Introduce yourself and the purpose of your call. If this is a new patient to Care Management, explain what you can help them with and ask what their needs are.
- "The purpose of you and I working together is to meet your health goals. We want to assist you with providing knowledge about your _____ (chronic disease diagnosis), identifying your health goals, and working toward meeting these goals."
    - *Review any overdue or recommended screenings or vaccines*
    - *Review medications*
    - *Any changes/concerns with _____ (chronic disease)?*
    - *Any resources needed to obtain medication and/or supplies?*
    - *Offer appropriate Poplar Pathway or Action Plan and start intervention, as needed/requested by the patient*
    - *Assist with making appointments or referrals to internal (RN, Health Coach, or Provider) or external resources (specialists, testing, lab work)*
    - *Ask if they have a family member or friend that can help support their goals*
    - *Send a message to provider with any medical updates or questions*
    - *Make a plan to connect again, based on patient risk level or patient requent*
    - *Thank the patient and wish them well!*

Reminders you could review:

- Utilize mental and physical health or immune system screeners (below)
- Invite the patient to use the portal if they aren't already
- How to make same-day appointments
- What to do for after-hours needs or urgent care
- Review warning signs of heart attack, stroke, and other serious conditions for which they may be at risk
- When to call for help and whom to call
- When to use emergency care

Additional Screenings/ Future Opportunities

- Behavioral Health Screening & Referral
- Alcohol/Substance Use Screening & Referral
- SDOH Screening & Referral

Are there other Poplar Care Network Pathways that could be offered?

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CARE TEAM
CHART REVIEW CHECKLIST

- **Daily Check-in questions for measuring mental & physical health**

Question	Care Manager Response
How connected do you feel with any support network (e.g., community, spiritual, friends/family, nature, yoga, or meditation)?	If not connected, explore ways of finding a connection. Virtual social groups? Memberships? Old friends? More frequent calls with family?
Do you feel... • Anxious? • Depressed? • Sad? • Lonely? • Scared? • In pain? • Tired? • Sick?	Explore the source of the ill feelings. Recommend telehealth visit with the provider to address.
Do you feel... • Calm? • Happy? • Loved? • At peace? • Loved? • Confident? • Pain free? • Energetic? • Healthy?	Explore the positive things going on in their life. Can any of these be built upon? Repeat the behaviors that elicited the positive feelings?
On a scale of 0 to 10, where 10 is the healthiest you can be, how healthy do you feel now?	If the number has declined or is below 5, explore further.
Do you have any medical concerns that your provider should know about? If so, what are they?	Pass concerning problems on to the provider.

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CARE TEAM
CHART REVIEW CHECKLIST

- **Daily Check-in questions for measuring mental & physical health**

Question	Care Manager Response
How many hours did you sleep last night?	The goal is 7-8. If less than 6, do a sleep hygiene assessment and counseling.
How many alcohol-containing beverages did you consume in the last day?	If > 0, recommend abstaining from alcohol to maximize immune function.
Do you smoke?	If yes, counsel to quit.
How many fruits and vegetables servings do you consume per day?	Goal is 10 or more.
How many minutes of moderate intensity exercise (where you can talk but not sing) did you get in the last day?	The goal is 25+ minutes per day to get to 150 minutes per week.

POPLAR CARE
NETWORK SNIPPETS

- **ED Visit Follow-up Snippet & Protocol:**

- ER Follow-up:
- Diagnosis:
- Spoke with pt:
- Symptoms:
- New Medications:
- Changed Medications:
- Stopped Medications:
- Discuss each medication: Pt is taking medication as ordered. Education on Medication side effects given to Pt.
- Medication List updated
- Education on Clinic hours and availability given to pt.
- Complete review of systems
- Specialist f/u appt made for date
- All hospital records uploaded to chart
- f/u appt scheduled for Date

POPLAR CARE
NETWORK EMR SNIPPETS

- **Lifestyle Medicine Opportunity Assessment:**

Which of these do you want to do the most?

1. Eat healthier Food
2. Build Exercise habits
3. Get better Sleep
4. Strengthen the Relationships in my life
5. Develop a Positive mindset
6. Reduce the Alcohol, Tobacco, or Substances I use
7. Get more Mental Health Counseling
8. Improve my Home and Financial Situation
9. I am not ready to make a change in any of these areas

POPLAR CARE NETWORK
HTN PATHWAY EMR SNIPPET

Hypertension EMR Snippet & Pathway:

1. What is your average home BP? __ Measure BP at home daily, following AMA 7 Simple Tips to Get an Accurate Blood Pressure Reading

2. Which BP medicines and doses are you on? __ How often do you forget? __ How can we help you remember to take your BP medicines more regularly? __

3. Salt is VERY important for blood pressure. How many high-sodium meals do you consume each day? __ Packaged foods, processed foods, and restaurant foods are VERY high in sodium. How can you identify high-salt foods? __ Look at labels: should have less sodium per serving than calories. Restaurant food is ALWAYS high in salt.

4. Whole Plant Foods can be powerful medicine for blood pressure. How many servings of fruit and vegetables are you eating per day? __ How many whole foods plant-based meals are you eating per day? __

5. These blood pressure superfoods can help * Dark green leafy vegetables like arugula and spinach (high in potassium, magnesium, and nitrites) * Flax seed – 2 tbsps daily * Soy products * Garlic * colorful fruit (berries, pomegranate, purple grapes) * green tea - regular or decaf * colorful veggies Which of these are you consuming now? __

6. Regular aerobic exercise for 3+ months lowers blood pressure. How many minutes per week are you doing moderate-intensity exercise? __

7. Stress. Could stress be contributing to your blood pressure? __ What form of stress reduction are you willing to do? (Daily exercise, mindfulness, therapy, ...) __ (once a year)

8. More than 2 drinks of alcohol per day can raise blood pressure. How many drinks per day on average? __ (once a year)

9. Some people are sensitive to excessive caffeine. How much caffeine? __ When should we reconnect? __ How should we reach you? __

POPLAR CARE NETWORK

NUTRITION PATHWAY EMR SNIPPET

Nutrition EMR Snippet & Pathway:

- Our practice recommends a whole food plant-based diet for optimal health, including fruits, vegetables, whole grains, beans, and nuts and seeds.
- To what extent do you now eat this whole foods, plant-based diet? __ %
- What do you eat in a typical day?
  - *Breakfast* __
  - *Lunch* __
  - *Dinner* __
  - *Snacks* __
- How would your life be different if you were eating a healthier diet? __
- What is 1 meaningful action you can take now to improve your nutrition? __
- Here are some meaningful actions you could take:
  1. Eat a meal that consists of just whole plant foods
  2. Eat 5+ fruits and vegetables
  3. Go dairy-free for the day
  4. Drink only water or unsweetened beverages
  5. Eat a large salad daily with a low-calorie dressing
  6. Avoid all high-calorie snacks. Enjoy unlimited fruit
- You are pursuing:
  Option #__ How many days per week do you do this now? __

POPLAR CARE NETWORK
PATHWAY EMR SNIPPET

- **Nutrition EMR Snippet & Pathway Continued:**

- When will you start doing that? __
- How many times per week? __
- What might get in the way? __
- What can you do to overcome that? __
- On a scale of 1 to 10, how confident are you that you could do this? __
  [if less than 7, revise the plan]
- When should we reconnect?
  __ weeks (ideally 1-2 weeks)
- How should we reach you?
  _____

POPLAR CARE NETWORK

EXERCISE PATHWAY EMR SNIPPET

Exercise EMR Snippet and Pathway:

- Our practice recommends 150 minutes per week of moderate-intensity exercise, where you are winded. We also recommend 2 strength training sessions per week. We also recommend avoiding prolonged sitting.
- To what extent do you now get all the aerobic exercise and strength training your body needs? __ %
- How would your life be different if you were exercising more? __
- What is 1 simple exercise you could start doing to add more movement to your week? ___
    - *When will you start doing that? __*
    - *How many minutes? __*
    - *How often? __*
    - *What might get in the way? __*
    - *What can you do to overcome that? __*
    - *On a scale of 1 to 10, how confident are you that you could do this? __*
      [if less than 7, revise the plan]
- What are some ways that you could avoid prolonged sitting? __
- When should we reconnect? __ weeks (ideally 1-2 weeks)
- How should we reach you? __

→

POPLAR CARE NETWORK
CHF PATHWAY EMR SNIPPET

CHF EMR Snippet and Pathway

1. Any symptoms of CHF like :
   - shortness of breath?
   - wheezing or coughing?
   - weight gain?
   - fatigue or weakness?

2. More than a pound a day is alarming for fluid gain.
If weight gain, how much? __

3. BLOOD PRESSURE
Uncontrolled blood pressure can cause heart failure. What is your average blood pressure? __

4. PCP: MEDICATION OPTIMIZATION
Beta-blocker if class 2 or eplerenone if class 3 +
ACEI or ARB or ARB+ARNI (Entresto) or hydralazine plus nitrate or SGLT-2i
diuretic if volume overloaded
A 2022 Meta-Analysis found that optimal therapy was a combination of: Beta Blocker + Mineralocorticoid (eplerenone) + ARNI (Entresto) + SGLT-2i

5. PCP: TOXIC DRUGS
Consider stopping toxic drugs, including nonsteroidal anti-inflammatory drugs, antiarrhythmic drugs, calcium channel blockers, and thiazolidinediones (Actos). See list here:
https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000000426