Resource 3: Electronic Health Record Template for Nurse led Follow-Up Cardiovascular Health Visit

September 2021

The assigned provider leading the follow-up visit should document the below information provided by the patient to ensure a clear understanding of how the patient is monitoring and adhering to recommended treatment for their cardiovascular health, focused on hypertension (HTN), cholesterol and smoking. The below is an example template that could be adapted for use in your EHR.

Clinic Documentation Tool for Electronic Health Records

Cardiovascular Health Clinic: _____

Follow up visit number (up to 3 visits and then back to provider):_____

1. BP Readings from Last 4 Encounters:
   [BP readings automatically brought into note here]

2. BP Medication taken today: {YES/NO:400258}

3. BP Medication brought to visit: {YES/NO:400258}

4. Can name blood pressure medications: {YES/NO:400258}

5. Any recent BP medication changes: {YES/NO:400258}

6. What time is BP medication taken:
   A. Is this correct: {YES/NO:400258}

7. How many missed doses in the past week of BP meds:

8. If taking a cholesterol medication, how many missed doses in the past week?_____

9. [If adherence is identified as an issue, discuss barriers to taking medications (timing, side effects, social situations, etc.) and establish an action plan.]

10. Any side effects or new symptoms since last visit: (describe)

    _____

11. Any over the counter (OTC) cold, allergy, respiratory medications: {YES/NO:400258}

12. If you have sleep apnea are you using your Continuous Positive Airway Pressure (CPAP) nightly: {YES/NO:400258}

13. Do you have a home BP monitor to check your BP: {YES/NO:400258}
    [If no, pend order for home BP monitor for provider to sign]

14. If brought to clinic, was it checked to see if it is accurate: {YES/NO:400258}
    A. Was it accurate: {YES/NO:400258}

15. Do you drink beer, wine, or any other form of alcohol: YES/NO:400258}
    A. How many drinks in the last 24 hours: _____

Tobacco follow up questions – limit to current tobacco users

[Check back in even if they were not interested in quitting at the first session]

1. Since your last visit, has there been a change in your tobacco use?
   YES / NO

2. If yes, what changed?
   - Quit – congratulations; info on ongoing supports to prevent slips.
   - Cut down – congratulations;
   - Some other positive change (reduction, restricting when / where smoking)
   - Smoking more

SKIP to Q7 if you offered smoking cessation referral at the last visit

3. If still smoking, are you interested in quitting in the next month? {YES/NO:400258}
   [**If last time they did not want assistance, you might say something like: "Last time we talked, you were not interested in assistance with quitting. Would you like assistance now?]

4. If yes, would you like me to connect you with someone who can assist you in quitting? {YES/NO:400258}

5. If yes to Q4, was patient referred to smoking cessation resource? {YES/NO:400258}
   [Can refer to Ohio Quitline via web referral at https://ohio.quitlogix.org/en-US/Just-Looking/Health-Professional/How-to-Refer-Patients. The quit line will then reach out to the patient and provide counseling and nicotine replacement]

6. Tobacco cessation medications can increase your likelihood of quitting by 2-3 times. Are you interested in using medications to help quit? {YES/NO:400258}
   [Assist by pending order or note to provider to order nicotine patch and gum, chantix, or wellbutrin for clinician.]

If offered assistance/referral for smoking cessation at last visit

7. If still smoking, consider telling patient the following: “remember that it takes multiple attempts to quit for good. Each attempt is a learning experience in how to stick with it longer the next time. Getting past the first few days is the hardest, but counseling and medications can help with planning, strategies and reducing cravings.”

8. Last time we talked, you wanted to get referred to tobacco cessation counseling. Did you connect with the counselor? {YES/NO/NA:400258}
   If no – do you want me to place that referral again / get you the information to connect?
   If yes – was it helpful? {YES/NO/NA:400258}
   Offer additional resources if available – other counseling, web, texts,

9. If prescribed a medication at the last visit could say: Last time we talked, there was an order for X medication (nicotine patch and gum or varenicline or wellbutrin) Did you get and use those meds? {YES/NO/NA:400258}

10. Would it be helpful to talk with someone to answer your questions about starting those medications? {YES/NO/NA:400258}. If yes, refer back to provider to discuss medications.

Assessment:

1. Has the blood pressure goal been met: {YES/NO/NA:400258}

2. Has the smoking goal been met: {YES/NO/NA:400258}

Plan:

_____

Medication changes (if applicable):

_____

Education given (especially lifestyle change such as DASH and low salt diet):

_____

(Describe and print to After Visit Summary)

Referred to Dietitian: {YES/NO:400258}

Follow up appointment with_____in_____weeks.

Patient agrees with plan: {YES/NO:400258}

Basic metabolic panel today: {YES/NO:400258}
[If provider newly started or increased a medication which could change potassium or kidney function, remind patient to obtain lab or ask provider to order lab if not already done]

Consulted with Dr.: _____

Guidelines for follow-up:

- If BP is at goal: See PCP in 3 months
- If BP remains high: See RN in 4 weeks
- After third visit with RN, if BP is still high, follow up with PCP in 2-4 weeks
- If patient is a smoker and interested in being referred to smoking cessation help, then schedule phone follow-up in 1 month to check and see how patient is doing and re-refer if needed at that time.
- If medication adherence (or medication taking) is a concern, follow-up in one month to assess how action plan is going even if BP controlled