

TELEHEALTH AND HIGH-RISK PATIENT MANAGEMENT CHECKLIST



Due to the COVID-19 pandemic, primary care practices are facing unprecedented cancellations by patients who have scheduled follow up visits for chronic disease management. These cancellations can be detrimental to patient well-being and to the viability of primary care practices.

The scheduling and pre-planning telehealth (audio and visual) visits for the chronically ill, especially during this defined COVID-19 surge, provides patients with the additional benefit of enhanced management of their chronic illnesses. In addition, primary care clinicians may effectively use their availability to reduce the downstream complications of patients' chronic conditions. According to the CDC, people of any age who have serious underlying medical conditions are higher risk for severe illness from COVID-19 and certainly are at high risk of the sequelae of chronic illness if left uncontrolled.

Use the following checklist to systematically improve chronic disease management in this vulnerable group of patients.

IDENTIFY PATIENTS¹

Query your EHR for your patients who have not completed a visit with your practice in the last 3 months and who have one or more of the following:

- Uncontrolled hypertension
- Diabetes with Hgb A1C's > 7.9 percent
- LDL cholesterols > 130
- 10-year ASCVD risk score > 10%. If high ASCVD risk population cannot be automated, cross the lists above and designate those who appear on ≥ 2 lists as highest risk and those > age 50 as intermediate-high risk.
- Uncontrolled chronic lung disease and/or moderate to severe asthma.

Also, prioritize patients discharged from hospital (IP or ED) to home for visit as soon as possible to help the practice and patient ensure effective transitions of care.

Tip: Systematically schedule chronic disease patient visits from high-risk to low-risk until all population lists are exhausted. Prioritize follow up of uncontrolled high-risk patients over lower-risk patients but eventually work down to the lower-risk lists.

¹CDC complete list of People Who Are at Higher Risk for Severe Illness from COVID-19 cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

SCHEDULE THE VISIT

- A patient may not recognize the value of telehealth visits and wish to wait for the re-establishment of face to face visits. Emphasize the value of controlling dangerous illnesses now in the context of COVID infection as well as the uncertainty of when regular face-to-face visits will be available.
- Designate video or telephone (if video not possible) visit slots for high-risk patients prioritizing the highest-risk patients first.
- Ensure flexibility with technology and high-risk patients when scheduling the visit. While the practice may prefer a telehealth solution, the practice may have to work with what the patient is most comfortable with (i.e. Facebook, Facetime, Skype, telephone). Obtain patient consent per requirements.
- Verify insurance coverage and inform the patient about copayments (if applicable).
- Validate any need for translation service.
- Ask patient to have their medications (and DME if feasible) next to them during the visit for discussion.

Tip: Share telehealth FAQ document with patient. An example is listed at: ncahec.net/wp-content/uploads/2020/05/TelehealthPatientFAQ.pdf. Consider mailing this to all high-risk patients.

PREPARE FOR VISIT

- Check with insurance carrier to find out if there are any provisions (i.e. during COVID-19) for covering relevant DME (especially digital blood pressure cuffs and glucometers), medication renewals, or other important condition management supports.
- If this is the patient's first telehealth visit, allow extra time for visit "check-in," start-up, and orientation to telehealth technology.
- Conduct pre-visit huddles each day (or before each session) for all scheduled patients. Review patient history, reason for visit, vitals needed (and feasible if known), insurance coverage/opportunities for additional DME for condition management, any other patient concerns.

INTAKE

- Have nurse /CNA obtain weight (if patient has scale) and blood pressure (if patient has digital device).
- Screen for COVID-19 symptoms.
- If patient is diabetic and has glucometer, get glucometer readings during intake.
- If patient is hypertensive and does not have a digital device, use the pre-visit to advise the purchase of the digital monitor or designate an isolated, "clean" office area for blood pressure monitoring "drop in" (would probably reserve this for individuals with very high pressures at last visit, e.g. systolic > 160 or diastolic > 100).
- Consider behavioral health screening (e.g. depression, dangerous drinking).

PROVIDER VISIT

- Focus on aggressive risk reduction, e.g. intensification of diabetes meds, hypertension meds, addition of statins.
- Take a thorough history in terms of adherence to new meds or dose adjustments and ask about any relevant side effects. Continue to intensify care if indicated.
- With medication adjustments, arrange follow up telehealth visit at a short interval, e.g. 2 weeks, to ensure that improving trends and associated risk reduction is proceeding appropriately.

PATIENT CHECK-OUT

- Telehealth visits typically end when patient-provider communication ends. For this reason, it is important for the practice to promptly contact the patient to schedule the next appointment, ensure the patient knows their next steps if the provider ordered any labs or screening/diagnostic tests, and to collect feedback on the telehealth experience.

OTHER

- Provide a handout for all hypertensive patients and those in the ASCVD high risk-group who do not own a digital blood pressure cuff with potential solutions for obtaining a dependable digital monitor. Emphasize insurance coverage, if known. Note Medicaid is currently paying for these devices. Check with other carriers.
- Incorporate telehealth with annual wellness exams and a prioritization of high-risk patients.
- When 2020-2021 influenza vaccine is available, guide patients on how to obtain the vaccine.
- Engage with NC HealthConnex. It can help providers working either in the office or remotely in the following ways:
 - a. Provides access to secure, web-based patient's longitudinal record across healthcare settings.
 - b. Enables practices to view patient history, hospital and ER admissions/discharges, vaccinations, and lab test results (especially as they relate to COVID-19 and other respiratory or influenza diagnosis codes) as they become available via participant EHRs.
 - c. Enables direct (electronic) messaging between providers.
 - d. NC HealthConnex information is available at: hiea.nc.gov