

**PUBLIC HEALTH RESOURCE GROUP (PHRG)
BEST PRACTICE IN CHRONIC CARE
CHART REVIEW FORM**

Patient ID number: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> </div>	DOB: _____ Gender: _____ Place of Residence: _____ Advanced Directive? Yes/No/Unknown
Name of reviewer:	
Name of healthcare site:	
Date:	/ /

Section A – Diagnosis

Please circle yes/no if a diagnosis of one or more of the conditions listed are recorded in the patient’s medical chart. If more than one description of a diagnosis appears (e.g. Diabetes: insulin dependent, insulin resistant, adult or youth onset), include the description in the comments area.

Diagnosis	Y	N	Comments:
(C1) High cholesterol	Y	N	
(C2) Hypertension	Y	N	
(C3) Congestive Heart Failure	Y	N	
Coronary Artery Disease	Y	N	
(C4) Diabetes	Y	N	Please note Type I or II, if indicated: _____
(C5) Obesity	Y	N	
(C6) COPD	Y	N	
(C7) Major Depression (diagnosed in past year only)	Y	N	

Section B – General Indicators

Indicate whether the following is recorded in the patient’s chart (past 12 months unless otherwise specified). For questions that may not be applicable or that the patient has refused, please circle NA or indicate “refused” in the comments section, respectively.

Indicator	No record	Record?	Comments:
Weight (first record in past year): _____	<input type="checkbox"/>		
Weight (most recent in past year): _____	<input type="checkbox"/>		
Height (most recent): _____	<input type="checkbox"/>		
BMI (first record in past year): _____	<input type="checkbox"/>		
BMI (most recent in past year): _____	<input type="checkbox"/>		
Blood pressure (most recent): ____ / ____ mmHg	<input type="checkbox"/>		
Fasting lipoprotein (most recent): LDL _____	<input type="checkbox"/>		
		Record?	
Weight recorded at the last visit?	Y	N	
Blood pressure recorded at the last visit?	Y	N	
Discussion of physical activity and/or diet regimen	Y	N	
Discussion of smoking status	Y	N	
If current smoker, evidence of smoking cessation efforts or counseling?	Y	N	NA
Influenza Vaccination (prior to last flu season)	Y	N	
Review of medications at last visit?	Y	N	
Discussion regarding end of life care	Y	N	

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Section C – Specific Indicators

Complete only those sections for which the patient has a diagnosis. For each Section, indicate whether the following is recorded in the patient's chart within the past 12 months unless otherwise specified. For questions that may not be applicable or that the patient has refused, please circle NA or indicate "refused" in the comments section, respectively.

(1) Management of Hyperlipidemia			
If LDL has been elevated in the past year:	Record?		Comments:
Plans and/or evidence of a follow up fasting lipoprotein?	Y	N	
Evidence of efforts to change diet?	Y	N	
Evidence of efforts at weight reduction?	Y	N	
Prescription of Statins?	Y	N	

(2) Management of Hypertension			
If blood pressure has been elevated in the past year:	Record?		Comments:
Plans and/or evidence of a follow up blood pressure?	Y	N	
Prescription of hypertensive medications?	Y	N	
If the patient was treated for hypertension, follow up blood pressure: ____ / ____ mmHg	No record <input type="checkbox"/>		NA

(3) Management of Congestive Heart Failure			
	Record?		Comments:
Clinical Characteristics/Etiology			
Record of etiology	Y	N	Etiology indicated: _____
Hospitalization (< 3 years) with a primary or secondary discharge diagnosis of CHF or other cardiac cause?	Y	N	Primary diagnosis: _____ Secondary diagnosis: _____
Clinical Management			
Left Ventricular Ejection Fraction (LVEF) (<2 yrs)	Y	N	LVEF results: _____
Discussion regarding daily monitoring of weight?	Y	N	
Physician inquiry regarding patient compliance with medical regimen and/or restricted sodium diet?	Y	N	
Evidence of communication among team members providing care to patient?	Y	N	
If the patient was diagnosed in the past year, is there a follow-up recorded within 3-4 months?	Y	N	NA
Medication Management			
Please <u>circle</u> the medications that the patient is currently taking. If any medications were declined, record "declined" next to the medication in the space provided.			
ACE Inhibitors	Angiotensin Receptor Blockers (ARBs)	Beta-blockers	
Digoxin or other Inotropes	Diuretics	Statins	
Daily aspirin (unless contraindication noted)	Other anti-hypertensives		

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(4) Management of Diabetes			
	Record?		Comments:
Clinical Characteristics			
Hospitalization (<3 yrs) with a primary or secondary discharge diagnosis of Diabetes and/or its complications?	Y	N	Primary discharge diagnosis: _____ Secondary discharge diagnosis: _____
Clinical Management			
Is there a recorded office visit in the past three months?	Y	N	
Is there evidence of weight loss or management?	Y	N	
Foot exam at last visit?	Y	N	
Evidence of a dilated eye exam/discussion/referral	Y	N	
Fasting blood sugar test within the past 3-6 months?	Y	N	
If elevated HgbA1c in past year, follow up < 4 months?	Y	N	
Physician inquiry regarding patient compliance with medical and/or diet regimen?	Y	N	
	No record		
Fasting blood sugars (most recent): _____	<input type="checkbox"/>		
HgbA1c (most recent): _____	<input type="checkbox"/>		
Microalbumin (most recent): _____	<input type="checkbox"/>		
Serum creatinine (most recent): _____	<input type="checkbox"/>		
Medication Management			
Please circle the medications that the patient is currently taking. If any medications were declined, record "declined" next to the medication in the space provided.			
<i>Hypoglycemic medications:</i>	Oral agents		Insulin

(5) Management of Obesity			
	Record?		Comments:
Clinical Management			
Waist circumference: _____	Y	N	
Pulse measured at the last visit?	Y	N	
Discussion of behavioral risk factors (smoking status, physical activity, diet)?	Y	N	
Assessment of the patient's readiness to lose weight?	Y	N	
Evidence that a managed food and activity diary and/or goals were discussed?	Y	N	
Is there evidence of weight loss or maintenance?	Y	N	
Therapy			
Is there evidence that the following was recommended and/or administered (past year)?			
Dietary therapy	Y	N	
Physical activity therapy	Y	N	
Behavioral therapy	Y	N	
Follow Up			
If the patient was diagnosed in the past year, has their been a follow up at one month after diagnosis?	Y	N	NA

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(6) Management of Chronic Obstructive Pulmonary Disease (COPD)			
	Record?		Comments:
Clinical Characteristics			
Hospitalization (<3 yrs.) for pulmonary disease as the primary or secondary discharge diagnosis?	Y	N	Primary discharge diagnosis: _____ Secondary discharge diagnosis: _____
How many times has the patient been hospitalized (<3 yrs.) for pulmonary disease?	---	---	NA # of Hospitalizations: _____
Spirometry test within the past year?	Y	N	FEV ₁ /FVC (%): _____ FEV1: _____
Physical activity tolerance assessed?	Y	N	
If the patients physical activity tolerance has been assessed, has there been an increase in tolerance?	Y	N	NA
Clinical Management			
Record of at least 2 office visits in the past year?	Y	N	
Discussion of a physical activity regimen?	Y	N	
Environmental and/or occupational exposure assessed, and steps suggested or taken to minimize exposure?	Y	N	
Evidence that the patient has received COPD education?	Y	N	
Evidence of communication among team members providing care to patient?	Y	N	
Medication Management			
Is the patient using home oxygen?	Y	N	
Please circle the medications that the patient is currently taking. If any medications were declined, record "declined" next to the medication in the space provided.			
Short-acting β_2 -agonists	Long-acting β_2 -agonists	Short-acting Anticholinergics	
Long-acting Anticholinergics	Combination short-acting β_2 -agonists plus anticholinergic in one inhaler	Methylxanthines	
Inhaled Glucocorticosteroids	Combination long-acting β_2 -agonists plus glucocorticosteroids in one inhaler	Systemic Glucocorticosteroids	

(7) Management of Major Depression			
	Record?		Comments:
Diagnosis of Major Depression			
Documentation noting specific use of the DSM-IV TR criteria	Y	N	
<i>Has the patient had the following symptoms over the same 2-week period:</i>			
Disinterest/displeasure in most/all activities most of the day, nearly every day	Y	N	
Depressed mood (e.g. feels sad or empty) most of the day, nearly every day	Y	N	
Significant (5% change) weight gain or loss, or change in appetite	Y	N	
Fatigue or loss of energy nearly every day	Y	N	
Sleep disturbances or insomnia nearly every day	Y	N	
Psychomotor agitation or retardation nearly every day (observable symptoms)	Y	N	
Feelings of worthlessness or inappropriate guilt nearly every day	Y	N	
A diminished ability to think/concentrate or indecisiveness nearly every day	Y	N	
Recurrent thoughts of death, suicide ideation or suicide attempt	Y	N	

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(7) Management of Major Depression (continued)			
	Record?		Comments:
Clinical Characteristics			
Discussion regarding the onset and severity of symptoms	Y	N	
Discussion regarding the degree of functional impairment in social and/or occupational settings	Y	N	
Discussion about psychosocial stressors	Y	N	
Does the patient have any of the following comorbid medical conditions: Diabetes, Cardiac Disease, Cancer, and/or Stroke?	Y	N	
Discussion regarding current drug or alcohol use	Y	N	
Previous psychological episodes or concurrent conditions assessed?	Y	N	
Management and Education			
Evidence that information about major depression been discussed and/or provided?	Y	N	
Psychotherapy referral discussed	Y	N	
Is there evidence of follow up visit within three months after diagnosis date?	Y	N	
Evidence of a discussion regarding suicidal ideation?	Y	N	
Medication Management			
If the patient is taking medication for Major Depression, is there a record that the patient has been educated on side effects and compliance issues?	Y	N	NA
If the patient is taking medication for Major Depression, evidence that the patient has been on the same treatment for at least 6 months?	Y	N	NA

Section D – Referral/Consultation

Indicate whether there is a record that the patient has been referred or has had a consultation with a specialist or other health care provider outside of the healthcare site. If there is an indication of a referral or consultation, please check the box under “outcome” if there is documentation regarding the referral/consultation outcome (e.g. letter to primary care site, phone conversation). If the patient has consulted with a provider not listed below, indicate the provider type under “other.”

Specialist/Health care provider type	Record?		Outcome	Comments:
Ambulatory Diabetes Education & Follow-up (ADEF) or Diabetes Self-Management Training (DSMT) Program	Y	N	<input type="checkbox"/>	
Dietician or Nutritionist	Y	N	<input type="checkbox"/>	
Palliative Care Consultation and/or Hospice Program	Y	N	<input type="checkbox"/>	
Psychiatrist	Y	N	<input type="checkbox"/>	
Psychologist	Y	N	<input type="checkbox"/>	
Rehabilitation	Y	N	<input type="checkbox"/>	Please indicate rehabilitation type.
Ophthalmologist	Y	N	<input type="checkbox"/>	
Other: _____	Y	N	<input type="checkbox"/>	
Other: _____	Y	N	<input type="checkbox"/>	