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Welcome to the April newsletter. We are highlighting health disparities, stress management, advanced healthcare planning, and mental health and kids. **The measure of the month is avoidable emergency department (ED) visits.** See “Meet the Measures” below for practice info and support on avoidable ED visits. We also feature Hampton Family Practice as an "Innovative Office" on how they help patients avoid the ED.

As a Sentara employee for more than 30 years, I have served as a Family Practice physician and as a SQCN medical director. My new clinical focus benefits those in need of medical attention and education within underserved areas. The **Sentara Community Care Medical Program** was created from lessons learned during the COVID-19 community vaccination and educational outreach efforts. Namely, the need for many other

healthcare services in these communities.

Today, the Community Care and Health Equity teams work together with faith-based and other trusted community organizations to help marginalized groups with housing insecurity, transportation issues, food insecurity, and financial struggles while also building trust. **We strive to reduce ED readmissions, as well as bring preventive services** for high blood pressure, diabetes management, prostate cancer screening, and mammography screenings to the members of our communities.

What can you do to help your community as a provider? If you are interested in volunteering a few hours of time, the Community Care team is always looking for physicians or APPs to assist at community events for screening, education, health counseling, and additional support. Most of these opportunities provide "free" care or services to patients and therefore credentialing by site is not needed. **Contact Suzanne Nadal for more information.**

What can you do to help your patients? Make it a priority to address challenges that may be getting in the way of care. Screen for transportation, financial, food, and/or housing needs. Taking care of a patient's blood pressure and cholesterol is about 20% of their health picture. The other 80% is addressing their physical environment, healthy behaviors, and social issues. **Contact the Population Health team** for care management services, social work resources, pharmacy support, and more.

Be sure to join me at the Adult PCPC meeting on Thursday, April 18, from 7-8 a.m. I will go into the Community Care program and volunteer opportunities in greater detail. **Link here.**

Thanks for all you do!

Meet the Measures: Avoidable ED Visits

Care in the ED can be limb and lifesaving, but many ED visits are for conditions that are far less acute. The avoidable ED metric aims to steer patients toward primary or urgent care for non-limb or life-threatening issues. For both our SQCN and SACO network partners, implementing a strategy to reduce avoidable ED visits can generate cost savings for both

medical groups and patients without compromising the quality of care.

If your office has access to patients released from the ED, the best practice would be to ensure each patient receives a follow-up appointment either in-person or via telehealth within 7 days, if possible, or within 30 days, if necessary. (There are separate metrics for each, but you get credit for both if you hit the 7-day mark).

Other ways to help your patients while improving your quality score:

- **Encourage patients to always schedule a follow-up** and bring their discharge paperwork to their appointment.
- **Emphasize the importance of follow-up and adherence to treatment recommendations.**
- **Use the same diagnosis for substance use and/or mental health based on ED diagnosis** at each follow-up visit (a non-substance diagnosis code will not fulfill this measure).
- **Coordinate care between behavioral health and primary care physicians by:**
    - Sharing progress notes and updates.
    - Including the diagnosis for substance use.
    - Reaching out to members who cancel appointments and assisting them with rescheduling as soon as possible.

Your practice and our network have roles in this strategy and can work in concert to provide the right care, at the right time, in the right place.

Please **contact us** for help with patient education, SDOH resources, or developing a telehealth strategy. See our Innovative Office feature below on Hampton Family Practice for more tips.

Upcoming Meetings

- The **Pediatric PCPC** meeting is April 16 from 6-7 p.m. **Link.**

Impact Scorecards

Avoidable ED visits (rate per 1,000) remain as our utilization metric and there are several

- The **Adult PCPC meeting** is April 18 from 7-8 a.m. **Link.**
- The **SACO Primary Care Leadership** meeting is on April 19 from 7-8 a.m.
- The **Practice Managers** meeting is April 24 from 12:15-1 p.m. **Link.**

2024 SCHEDULE

quality metrics for adult and pediatric populations. These metrics are scored for each practice and the total score is expressed as a percentage from 30-100%. That performance score will be combined with attribution to determine distributions. The report is updated monthly so that you can track your practice's performance.

LINK TO SCORECARD

Innovative Office: Hampton Family Practice (HFP) and Avoidable ED

When it comes to keeping patients out of the ED, Hampton Family Practice is one of the top scoring independent offices in our network. Here are some best practices that work well:

- **A large portion of Annual Wellness Visits/AWVs (also known as Medicare Wellness Exams) are performed by wellness nurse(s) on staff.** These nurses explain the purpose of the exam and assist with fulfilling certain standing orders for preventive care. Quality goals pertaining to preventive care measures are periodically distributed to the staff to encourage closing those care gaps at all patient visit types.
- **The physicians instill a culture of compassionate, flexible accessibility to meet patient needs.** HFP creates policies that do not present roadblocks to care, but instead a pathway of access for the patient. This includes same day nurse triage for incoming phone calls, a process to monitor daily appointment capacity, and communication to the providers for additional capacity. Providing prompt, immediate reassurance with the patient over the phone can often avert a non-emergent ED visit.
- **HFP implemented the "Open Access" scheduling model which always provides same-day accessibility to their patients.** They offer

extended hours until 6:30 p.m. for acute care, Monday-Thursday, as well as Saturday office hours. There is telehealth flexibility for various acute visits and TCMs.

- **Clinical teams are responsible for providing timely follow-up phone touches with patients after an ED or urgent care visit.** FHP provides education and guidance even if the patient was not referred by our office to the ED. A care manager periodically addresses frequent ED utilizers with their PCP to create a new care plan and shorter follow-up visits.
- **The practice identified that a substantial percentage of ED visits were coupled with a behavioral health diagnosis.** In October, HFP implemented a collaborative behavioral health model to address more timely access to counseling services for their patients and will track the outcomes over time.
- **FHP aligns practice workflows to try and meet a parent's treatment expectation for their child.** In addition to NPPs to extend care, the physicians have a few "CHILD" work-in slots embedded in their schedule that may only be used for pediatric same-day appointments with their own provider. This establishes trust with the parents and good continuity of care for a developing child. FHP provides a direct physician phone number for mothers of newborns to help with their questions or concerns.

VISIT HAMPTON FAMILY PRACTICE HERE

HCC Coding Tips: Foot Ulcers and Diabetes

There are two types of foot ulcer codes: vascular/non-vascular and secondary code to classify further.

- DMII with foot ulcer (category 18 & 161; E11.621)
- DMII with other skin ulcer (category 18 & 161; E11.622)
- Pressure ulcers, stages 2-4 (L89.000-L89.95)
    - Category 157
    - Category 158
    - Category 159

- Non-pressure chronic ulcers (L97.101-L98.499)
    - Category 161

If you have patients that may benefit from our no-cost diabetes self-management program, please **contact us** today.

National Healthcare Decisions Day

April 16 is a day to empower your patients (and you!) to plan ahead. It is never too early to put healthcare wishes down. They can be updated annually or as often as needed. Here is an advanced care planning guide for **Virginia** and **North Carolina** .

Pharmacy Highlights: Fentanyl

Fentanyl is a synthetic opioid medically used for chronic pain, cancer pain, critically ill patients in the ICU, and more. However, if misused, a few sand-like grains can be deadly. **Learn more about fentanyl misuse** and how you can best help your patients.

Kids and Mental Health

The top mental health disorders in children are ADHD, anxiety, behavioral problems, and depression. These can occur together as well. Access Centers for Disease Control and Prevention (CDC) patient resources **here**.

Pyx Health for Stress Management

It's not news that chronic stress can damage our bodies and our minds with lasting negative impact to immune, digestive, cardiovascular, and reproductive systems. While we can't always avoid the things that worry us, we can learn to cope better. Our partners at Pyx Health, not only provide companionship for lonely patients, but they also offer tips and activities to help manage stress and anxiety via the Pyx Health app and their compassionate outreach staff.

Here's something we can all try right now:

- Calmly breathe in for 5 seconds, hold for 5 seconds, and exhale slowly for 5 seconds.
- Then, look around you.
- Using the senses can help you feel 'grounded' in the present moment when you start to feel stressed or overwhelmed.

To learn more about how the Pyx Health program can support your patients, click the button below.

LEARN MORE ABOUT PYX HEALTH

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