From Dr. Daniel Dickinson, Internal Medicine, Sentara Healthcare, Medical Director at SQCN

Welcome to the April SQCN/SACO newsletter, *Inside Population Health* . This issue of the newsletter describes some important tools to help practices be successful in managing patients, including resources to address social determinants of health, end of life conversations, and medication adherence. Please note the tips on accurate coding and documentation, which ensures appropriate payments from health plans to us for the care of our patients.

I am excited to be able to support this Population Health team and the many practices providing world-class care to our SQCN and SACO patients. Recently, I visited a number of our practices in Harrisonburg, Charlottesville, and Norfolk. I'm so impressed with the quality of care and dedication by the providers at the practices of Dr. Christian Iudica, Dr. Mark Neuhaus, Dr. Tim Williams, and Dr. James Newby. I look forward to meeting many more.

Thanks for all you do!

SQCN April 2023 Primary Care Meetings*

- The Pediatric PCPC meeting will be held on 4/18 from 6-7:30 p.m. Speaker and topic are TBD. Meeting link **here**.
- The Adult PCPC will be held on 4/20 from 6-7:30 p.m. Dr. James Newby will present on National Minority Health Month education. Meeting link **here**.

SQCN April 2023 Practice Managers Meeting*

- The meeting will be held on 4/26 from 12:15-1 p.m. Meeting link **here**.

SACO April 2023 Primary Care Leadership Meeting

- The monthly meeting will be held on 4/21 at 7 a.m. Discussion will include quality measure on depression screening and palliative care updates.

*No preregistration is necessary, simply join the links above. Click on the button below to access the 2023 meeting schedule and information.

2023 SQCN Primary Care Engagement Bonus Meetings

Social Determinants of Health (SDOH): How to Help Your Patients

At times, SDOH needs may be a barrier to patients in managing chronic, acute, or even preventive issues. Determining what SDOH needs your patient may have and connecting them to local resources can improve healthcare outcomes. **Here are some open conversations about SDOH needs to ask:**

- Who offers you care when you aren't feeling well?
- What is your primary mode of transportation?
- What do you find difficult about managing your diabetes, heart disease?

There is a tool in Epic that helps us improve SDOH needs. The information comes from interviews during office visits, outreach from the Population Health staff, and self-reporting through MyChart.

Office staff can utilize the SDOH assessment tool to gather data relating to social support, financial strain, housing and food insecurity, concerns surrounding transportation, and stress concerns.

Tracking this data with Z-codes will allow Sentara Healthcare to continue to improve quality measures throughout our healthcare system.

Problems Related To...	Z-Code
Education and literacy	Z55
Employment and unemployment	Z56
Occupational exposure to risk factors	Z57
Physical environment	Z58
Housing and economic circumstances	Z59
Social environment	Z60
Upbringing	Z62
Primary support group, including family circumstances	Z63
Certain psychosocial circumstances	Z64
Other psychosocial circumstances	Z65

Social Work Services

Our Population Health team includes members who are specially trained to offer social work services, including:

- Local transportation programs or ride share benefits through their health plan.
- Food benefits through SNAP or Meals on Wheels.
- Behavioral health resources for mental health counseling and social isolation.
- Financial resources for healthcare and medication costs.
- Caregiver support resources.
- Transitions in care and housing needs.
- Connection with community resources.

If you have a patient who might benefit from social work services, please contact SQCN at 757-455-7330 or email **SQCN@sentara.com**, or SACO at 757-455-7040 or email **SACO@sentara.com**.

Program Update: Unite Us

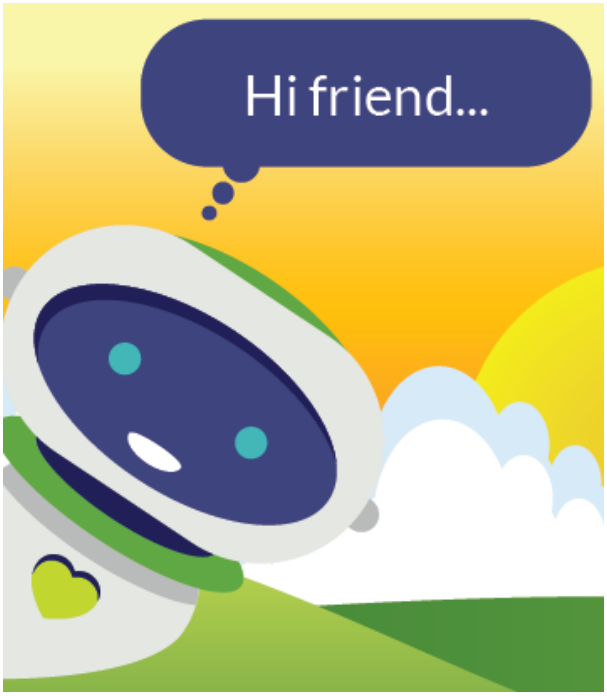
Do you have patients with SDOH needs? SQCN has partnered with **Unite Us Virginia** to offer this tool to practices, streamlining the process of identifying the resources their patients need most.

SQCN has a limited amount of Unite Us Virginia licenses available for independent PCP practices. There is no cost to the practice to participate. If

you are interested in learning more, please contact **Lisa Helms**.

Pyx Health

This app addresses loneliness and social isolation, the root cause of many health problems. Pyx Health delivers the following:



- User support 24/7, outside the care setting
- Access to resources, screenings, and SDOH assistance
- Daily engagement with Pyxir, a virtual chatbot
- Free and easy sign-up

Let your patients know about this free service with this customizable **tip sheet**.

CipherHealth: ED Discharge Outreach

Both SQCN-attributed commercial patients and SACO patients who are discharged from a Sentara Healthcare facility ED will receive a CipherHealth robo call within 48-hours post discharge. This call will check on the following:

- General health status (feeling better, same, or worse since ED visit).
- After-visit instructions received and understood.
- Follow-up appointment(s) scheduled.
- Medications obtained and patient understands how to take them.

If the patient selects any response that indicates additional assistance is needed, they will be contacted by a member of our care management team.

Epic Healthy Planet

Healthy Planet will become available to SQCN primary care providers in April 2023. Healthy Planet is a set of Epic tools focused on Population Health Management and:

- Allows employed and independent practices to review and contribute clinical information to a patient's record.
- Provides quality dashboards and care gap lists.
- Gives providers access to aggregated patient data and risk segmentation tools.

Together, it helps prioritize patient-centered care. **Live training sessions for advanced users will begin later this month.** Look for an invitation in your email. Additional training materials for all users will be posted to the SQCN SharePoint site as well.

Innovative Initiatives from Our Practices

Advance Care Planning (ACP): Glennan Center for Geriatrics and Gerontology at Eastern Virginia Medical School (EVMS)

Talking with patients and their families about ACP can be difficult and uncomfortable. Dr. Marissa Galicia-Castillo, Director of the Glennan Center for Geriatrics and Gerontology at EVMS, shared that primary care physicians and family physicians are ideally situated to facilitate this very necessary conversation. As Dr. Galicia-Castillo explains, there are opportunities over the course of a patient's journey to get in front of ACP so they can make decisions about care they would (or would not) want to receive if they became unable to speak for themselves. And, maybe even more importantly, identifying a trusted person to serve as a Medical Power of Attorney and become the patient's voice when decisions need to be made and the patient is not able.

"ACP is not just for our patients, but also for ourselves," says Dr. Galicia-Castillo. "April is ACP month—if you have not had ACP discussions or completed an ACP, get it done this month!"

ACP is not a "one-size-fits-all" approach. The American Academy of Family Physicians **has materials from CMS** on topics such as billing, planning for end-of-life decisions, and handouts to support patient conversations.

For Medicare beneficiaries, she recommends having conversations about ACP during their scheduled annual wellness visit since it is more for routine care

and there is no out-of-pocket cost for them if done during that appointment. Another opportunity is at the onset of a medical status change and throughout the patient's condition. This allows patients and their families to adjust course with symptom management and end-of-life plans as the disease progresses.

Palliative Care Medicine Opportunity: "Keys to Skillful Communication"

This virtual session is the first of a 4-part series inspired by the letters of Dr. Thomas Pellegrino, Associate Dean for Education at EVMS, and a beloved teacher and mentor. In 2011, Dr. Pellegrino was diagnosed with a terminal illness and shared a series of letters to help his students understand illness from the patient's perspective.

The event will on **Tuesday, April 18, from 12-1:30 p.m.**, and is moderated by Dr. Galicia-Castillo. **Register via Zoom.**

Panelists include:

- Nichole Baer, RN, CHFM, CSCM, Vice President, Hospice and Palliative Care, Interim Healthcare of Southeast Virginia
- Jason Callahan, MDiv, MS, BCC, Chaplain, Thomas Palliative Care Unit, VCU Massey Cancer Center
- Brenda Cobb, MSW, ACSW, Director of Psycho-social Team, Interim Hospice
- Justin Van Klein, MD, Palliative Medicine & Comprehensive Care, INOVA Fairfax & 2021 Graduate of the Glennan Center Hospice and Palliative Medicine Fellowship

EVMS is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

EVMS designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Pharmacy Highlights: Medication Adherence

Medication adherence is a complex and costly priority for our healthcare team. Many factors contribute to our patient's ability to take their medications. These factors include patient related barriers such as: health literacy, cognitive

impairment, lack of motivation, denial, and belief systems. Additionally, treatment related barriers may include complexity of treatment, side effects, inconvenience, and cost.

A CDC study determined that understanding root causes of medication nonadherence and developing cost-effective approaches that are applicable in diverse patient populations is essential to increasing adherence and improving long-term health impact.

Recommended strategies from this study include:

- Implementing team-based care.
- Educating and empowering patients to understand the treatment regimen and its benefits.
- Reducing barriers to obtaining medication (including cost reduction), keep medication regimens as simple as possible, and efforts to retain or re-engage patients in care.

Improving medication adherence is a public health priority. Together, we can reduce the economic and health burdens associated with many chronic conditions and support the best possible outcome for our patients.

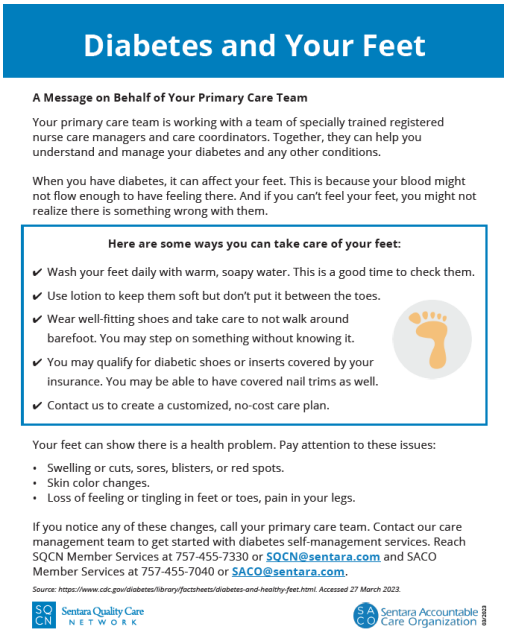
[Source: Neiman AB, Ruppar T, Ho M, et al. *CDC Grand Rounds: Improving Medication Adherence for Chronic Disease Management—Innovations and Opportunities*. MMWR Morb Mortal Wkly Rep 2017;66. DOI: https://www.cdc.gov/mmwr/volumes/66/wr/mm6645a2.htm.]

Care Corner: Diabetes and Foot Care

Diabetes and foot care are connected. Help your patients with diabetes understand how to take care of their feet and get help when needed.

If you have a patient who might benefit from diabetes education, you can download and share this tip sheet.

Contact SQCN at 757-455-7330 or email SQCN@sentara.com. Contact SACO at 757-455-7040 or email SACO@sentara.com for diabetes self-management services.



Diabetes and Your Feet

A Message on Behalf of Your Primary Care Team

Your primary care team is working with a team of specially trained registered nurse care managers and care coordinators. Together, they can help you understand and manage your diabetes and any other conditions.

When you have diabetes, it can affect your feet. This is because your blood might not flow enough to have feeling there. And if you can't feel your feet, you might not realize there is something wrong with them.

Here are some ways you can take care of your feet:

- ✔ Wash your feet daily with warm, soapy water. This is a good time to check them.
- ✔ Use lotion to keep them soft but don't put it between the toes.
- ✔ Wear well-fitting shoes and take care to not walk around barefoot. You may step on something without knowing it.
- ✔ You may qualify for diabetic shoes or inserts covered by your insurance. You may be able to have covered nail trims as well.
- ✔ Contact us to create a customized, no-cost care plan.

Your feet can show there is a health problem. Pay attention to these issues:

- Swelling or cuts, sores, blisters, or red spots.
- Skin color changes.
- Loss of feeling or tingling in feet or toes, pain in your legs.

If you notice any of these changes, call your primary care team. Contact our care management team to get started with diabetes self-management services. Reach SQCN Member Services at 757-455-7330 or SQCN@sentara.com and SACO Member Services at 757-455-7040 or SACO@sentara.com.

Source: https://www.cdc.gov/diabetes/library/factsheets/diabetes-and-healthy-feet.html. Accessed 27 March 2023.

SQCN Sentara Quality Care NETWORK

SACO Sentara Accountable Care Organization

HCC/Coding Tip: Foot Ulcers

Good foot care can help avoid these ulcers and other issues. Only one "Diabetes with Complications" diagnoses is required to satisfy the Diabetes HCC coding. However, this complication holds its own HCC weight and should be coded if it exists.

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 (RAF 2.028)
  - Category 158 (RAF 1.069)
  - Category 159 (RAF 0.656)
- Non-pressure chronic ulcers (L97.101-L98.499)
  - Category 161 (RAF 0/515

Questions About SQCN or SACO?

For Independent Practices, please contact the Population Health Team:

757-455-7330 | **SQCN@sentara.com**

757-455-7040 | **SACO@sentara.com**

For SASD and SMG practices, please contact your Director of Business Operations and Director of Medical Operations, respectively.

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