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From Niall D. Crowley, MD, Critical Care Medicine, Pulmonary Medicine, Sentara Pulmonary Critical Care and Sleep Specialists

Welcome to the November edition of the SQCN/SACO newsletter, *Inside Population Health*. We are focusing on lung and COPD awareness month, smoking cessation, and antibiotics information for adults and children. For our care management services, we are looking at caregiver resources and support, advanced care planning, childhood grief, and our diabetes self-management program.

Our measures include the flu shot, tobacco screen, comprehensive diabetes care (including the diabetic eye exam), and avoidance of antibiotic treatment in adults with acute bronchitis.

Lung cancer is the third most commonly diagnosed cancer and the leading cause of cancer deaths in the United States. New treatment options combined with the lung cancer screening program have led to improved mortality. See more about the lung cancer screening program below. **We still have a lot of work to do in Virginia, as only 8% of eligible patients are being screened and approximately 15% of adults are still smoking cigarettes.**

It is important to discuss smoking cessation at every visit with your patients. You can make a difference. Guidelines recommend varenicline and nicotine replacement therapy together to increase the rate of successful smoking cessation. There are many effective, no-cost smoking cessation tools available at **Quit Now Virginia** and American Cancer Society's **Great American Smokeout**

campaign.

Guidelines continue to evolve for patients with COPD. Initial inhaler treatment is now LAMA/LABA for those newly diagnosed. ICS is recommended for patients with COPD exacerbations requiring emergency department visits or hospital admission and can be considered in COPD patients with elevated eosinophils. Pulmonary rehabilitation can improve your patient's respiratory symptoms and quality of life. See our HCC coding tips for COPD below. We will be releasing ambulatory protocols for asthma treatment to follow up our COPD treatment guidelines in 2024.

Continue to read for an update on our "**What Matters Most**" Palliative Care Medicine Services pilot that is now live, along with a **shareable tip sheet explaining advanced care planning, hospice care, and palliative care medicine for patients** . There is content on the effective use of antibiotics, the Population Health diabetes self-management program and A1C maintenance, and caregiver support resources. **Finally, this is a great time of year to get your Annual Wellness Visits completed.**

Thank you for all that you do to keep our patients healthy.

How Are We Doing?

Please provide your feedback as we plan newsletter content for 2024. This quick, 10-question survey should take less than two minutes. Tell us what you like, areas of improvement, and topics that will help your practice.

2024 Inside Population Health Survey

SQCN November 2023 Primary Care Meetings*

- The Adult PCPC meeting is on November 16 from 7-8 a.m. Dr. Kara Hawkins and Dr. Christian Iudica will be the presenting on Diabetes Best Practice Protocol. Meeting link **here.**
- The Pediatric PCPC is on November 21 from 6-7:30 p.m. Dr. William Obermeyer is presenting on physiological and psychological effects of pectus excavatum. Meeting link **here**.

SQCN November 2023 Practice Managers Meeting*

- The meeting is on November 22 from 12:15-1 p.m. Meeting link **here**.

SACO November 2023 Primary Care Leadership Meeting

- The monthly meeting is cancelled on November 17 at 7 a.m. We will use that time for an independent provider focus group session on quality reporting.

*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

SQCN Impact Scorecards

This link will take you to your monthly 2023 Adult and Pediatric Practice Impact Scorecard. Please be sure to check back monthly for your practice performance.

Avoidable ED visits (rate per 1,000) remain as our utilization metric and there are several 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 will be updated monthly so that you can track your practice's performance.

See the button below for more information about the Impact Scorecard and the SQCN distribution plan.

Please contact **SQCN@sentara.com** if you have any questions.

Impact Scorecards SBAR

HCC/Coding Tip : Chronic Obstructive Pulmonary Disease (COPD)

COPD Cat. 280, RAF 0.319

COPD in coding is defined as having both chronic bronchitis and emphysema. Both conditions hold RAF individually and are in the same HCC category. Be sure to save the chronic diagnosis to the patient's problem list, so that it is coded

correctly in the future.

If the patient has respiratory failure along with the following diagnoses or requires supplemental oxygen, you should code these as well.

HCC CAT 280

- COPD with (acute) lower respiratory infection J44.0
- COPD with (acute) exacerbation J44.1
- COPD with unspecified J44.9

Identify if:

- Acute exacerbation
- Acute lower respiratory infection
- Specify infection as secondary diagnosis (extra RAF potential if certain pneumonias)

But don't forget to revert back to non-acute, non-infectious state once acute condition has been resolved.

- J42 Chronic bronchitis NOS
- J43 Emphysema

Chronic bronchitis:

- Simple
- Mucopurulent
- Mixed
- Unspecified

Emphysema:

- Unilateral (MacLeod's syndrome)
- Panlobular
- Centrilobular
- Other
- Unspecified

Lung Cancer Screening

Consider the lung cancer screening program for your patients at high risk. Patients are eligible if they are currently smoking cigarettes or quit smoking in the last 15 years AND have at least a 20-pack year smoking history AND are between 50-80 years old. The screening uses lower radiation dose chest CT scans to detect lung cancer at earlier stages, leading to earlier diagnosis and treatment and, hopefully, a reduction in mortality. These CT scans can be ordered in the primary care setting.

Source: American Thoracic Society

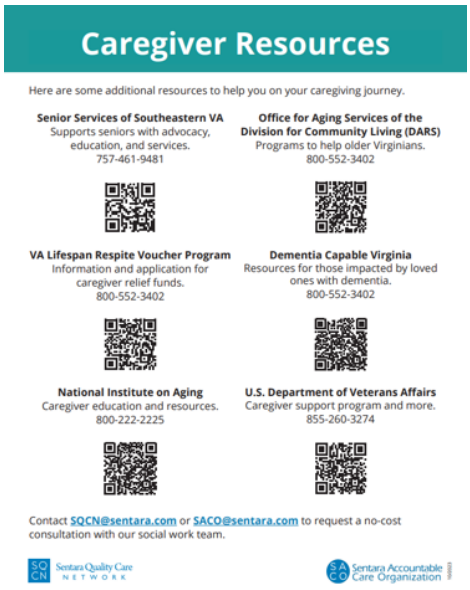
Caregiver Support Resources

November is National Caregiver Appreciation Month. Caring for a loved one can be a hard yet rewarding task.

Our Population Health team has specially trained social workers that can help your patients through the caregiving journey.

Read more about our no-cost social work services and other resources that can help in this two-page, **downloadable tip sheet**.

Contact **SQCN@sentara.com** or **SACO@sentara.com** for more information on care management services, including social work.



National Hospice and Palliative Care Month: Understanding Grief in Children

Children and teens grieve differently than adults, for both deaths and major changes. This includes the loss of a loved one or pet, parents going through a divorce, or even a good friend moving. Parents or caregivers should speak with their children in clear terms appropriate for their age. Kids need to know what has happened so they can process what the change means to them.

The following are more serious signs of grief:

- A long period of depression.
- Trouble with sleep, eating, or being alone.
- Staying away from friends or activities once enjoyed.
- Decline in school performance or attendance.
- Acting like they are the person that passed or talking with them/seeing them.
- Suicidal ideations so they can be with the passed person.

If your patients have children experiencing any of the above, there are many resources to help. Our community offers grief camps like the **Sentara Health Camp Lighthouse** program for both children and caregivers. There are also several **Virginia bereavement support groups available here**.

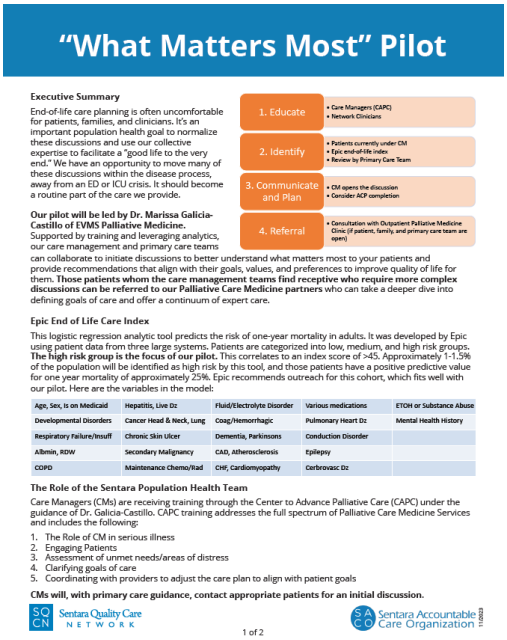
Source: American Academy of Child and Adolescent Psychiatry

Program Update: What Matters Most

Our What Matters Most Palliative Care Medicine Services program is now live. Led by Dr. Marissa Galicia-Castillo of EVMS Palliative Medicine, this program aims to normalize life transition planning and use our collective expertise to facilitate a "good life to the very end."

Providers have an opportunity to move these discussions to within the disease process, instead of waiting for an ED or ICU crisis. Read more about the pilot program below. The tip sheet on the left is for providers, and on the right, to share with your patients.

If you have any additional questions or would like to participate in the pilot, please contact **SQCN@sentara.com** or **SACO@sentara.com**.



"What Matters Most" Pilot

Executive Summary

End-of-life care planning is often uncomfortable for patients, families, and clinicians. It's an important population health goal to normalize these discussions and use our collective expertise to facilitate a "good life to the very end." We have an opportunity to move many of these discussions within the disease process, away from an ED or ICU crisis. It should become a routine part of the care we provide.

1. Educate
   - Care Managers (CAPC)
   - Network Clinicians
2. Identify
   - Patients currently under CM
   - Epic end-of-life index
   - Review by Primary Care Team
3. Communicate and Plan
   - CM opens the discussion
   - Consider ACP completion
4. Referral
   - Consultation with Outpatient Palliative Medicine Clinic (if patient, family, and primary care team are open)

Our pilot will be led by Dr. Marissa Galicia-Castillo of EVMS Palliative Medicine. Supported by training and leveraging analytics, our care management and primary care teams can collaborate to initiate discussions to better understand what matters most to your patients and provide recommendations that align with their goals, values, and preferences to improve quality of life for them. **Those patients whom the care management teams find receptive who require more complex discussions can be referred to our Palliative Care Medicine partners** who can take a deeper dive into defining goals of care and offer a continuum of expert care.

Epic End of Life Care Index

This logistic regression analytic tool predicts the risk of one-year mortality in adults. It was developed by Epic using patient data from three large systems. Patients are categorized into low, medium, and high risk groups. **The high risk group is the focus of our pilot.** This correlates to an index score of >45. Approximately 1-1.5% of the population will be identified as high risk by this tool, and those patients have a positive predictive value for one year mortality of approximately 25%. Epic recommends outreach for this cohort, which fits well with our pilot. Here are the variables in the model:

Age, Sex, is on Medicaid	Hepatitis, Live Dz	Fluid/Electrolyte Disorder	Various medications	ETOH or Substance Abuse
Developmental Disorders	Cancer Head & Neck, Lung	Coag/Hemorrhagic	Pulmonary Heart Dz	Mental Health History
Respiratory Failure/Insuff	Chronic Skin Ulcer	Dementia, Parkinsons	Conduction Disorder	
Albmin, RDW	Secondary Malignancy	CAD, Atherosclerosis	Epilepsy	
COPD	Maintenance Chemo/Rad	CHF, Cardiomyopathy	Carbrovasc Dz	

The Role of the Sentara Population Health Team

Care Managers (CMs) are receiving training through the Center to Advance Palliative Care (CAPC) under the guidance of Dr. Galicia-Castillo. CAPC training addresses the full spectrum of Palliative Care Medicine Services and includes the following:

1. The Role of CM in serious illness
2. Engaging Patients
3. Assessment of unmet needs/areas of distress
4. Clarifying goals of care
5. Coordinating with providers to adjust the care plan to align with patient goals

CMs will, with primary care guidance, contact appropriate patients for an initial discussion.

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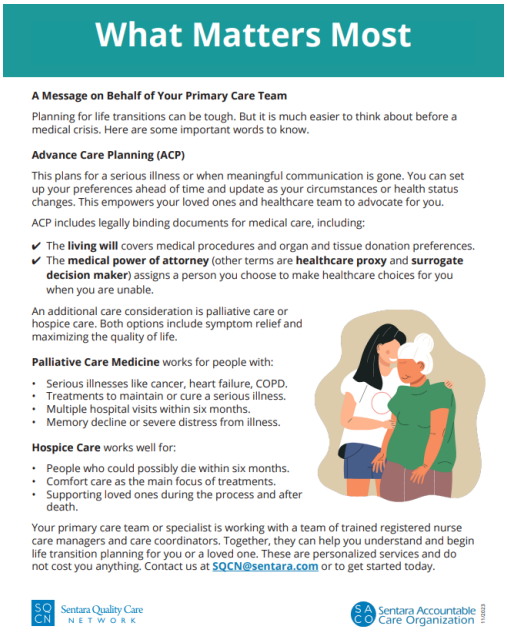

What Matters Most

A Message on Behalf of Your Primary Care Team

Planning for life transitions can be tough. But it is much easier to think about before a medical crisis. Here are some important words to know.

Advance Care Planning (ACP)

This plans for a serious illness or when meaningful communication is gone. You can set up your preferences ahead of time and update as your circumstances or health status changes. This empowers your loved ones and healthcare team to advocate for you.

ACP includes legally binding documents for medical care, including:

✔ The **living will** covers medical procedures and organ and tissue donation preferences.
✔ The **medical power of attorney** (other terms are **healthcare proxy** and **surrogate decision maker**) assigns a person you choose to make healthcare choices for you when you are unable.

An additional care consideration is palliative care or hospice care. Both options include symptom relief and maximizing the quality of life.

Palliative Care Medicine works for people with:

- Serious illnesses like cancer, heart failure, COPD.
- Treatments to maintain or cure a serious illness.
- Multiple hospital visits within six months.
- Memory decline or severe distress from illness.

Hospice Care works well for:

- People who could possibly die within six months.
- Comfort care as the main focus of treatments.
- Supporting loved ones during the process and after death.

Your primary care team or specialist is working with a team of trained registered nurse care managers and care coordinators. Together, they can help you understand and begin life transition planning for you or a loved one. These are personalized services and do not cost you anything. Contact us at SQCN@sentara.com or to get started today.

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Program Update: The Pyx Health Program and National Caregiver Appreciation Month

According to AARP's "**Valuing the Invaluable**" series, care provided by the millions of unpaid family caregivers across the United States was valued at $600 billion in 2021. Many of your patients may be living with a caregiver or be a caregiver themselves. It takes an incredible amount of love, patience, and energy to care for a loved one, and caregiving can feel isolating, stressful, and ultimately, lonely.

Pyx Health is available free of charge to SQCN and SACO patients as extra support to anyone who might benefit from the 24/7 companionship, resource navigation and wellness tips provided by the program via the mobile app and phone outreach program.

Check out **this two-minute video** for a refresher on how the Pyx Health program works. With Pyx Health, no one has to feel alone.

If you're interested in promoting this service to your patients, please access the attached **customizable tip sheet**.

Contact **SQCN@sentara.com** or **SACO@sentara.com** with any questions.

Innovative Office: Population Health Diabetes Collaboration Program

The Population Health Diabetes Collaboration Program helps you and your patients with diabetes education, diabetes medical management, and diabetes self-management services.

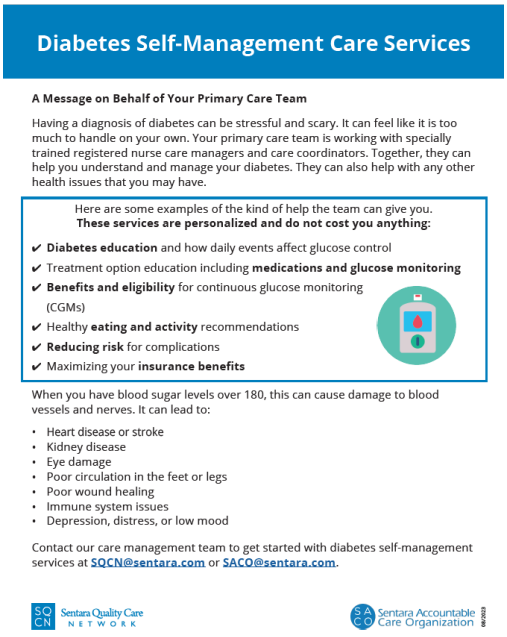
Diabetes education is giving specific information or instruction on how to manage diabetes. A Population Health Certified Diabetes Care and Education Specialist (CDCES) can work with individuals to provide diabetes education and self-management skills and/or can work with care managers to identify diabetes education resources locally.

Diabetes medical management is the diagnosis of diabetes, assessing a variety of measures (labs, home glucoses), evaluating potential complications, and prescribing or adjusting appropriate medications. The Population Health interdisciplinary team—made up of CDCES, clinical pharmacy specialists, and an endocrinologist—collaborate on a regular basis to review patient history, clinical data, and social context to develop recommendations for their primary care team. This team works with the larger care management team and can connect patients with support for both medical and social needs.

And finally, our **Population Health diabetes self-management services** help your patient with the ongoing management of diabetes.

This includes:

- Working diabetes care into their lifestyle and giving support needed to make those lifestyle changes.
- Building self-care skills through informed decision making, problem solving, and healthcare team collaboration.
- Improving clinical outcomes, health status, and overall quality of life.



Diabetes Self-Management Care Services

A Message on Behalf of Your Primary Care Team

Having a diagnosis of diabetes can be stressful and scary. It can feel like it is too much to handle on your own. Your primary care team is working with specially trained registered nurse care managers and care coordinators. Together, they can help you understand and manage your diabetes. They can also help with any other health issues that you may have.

Here are some examples of the kind of help the team can give you.
These services are personalized and do not cost you anything:

- ✔ **Diabetes education** and how daily events affect glucose control
- ✔ Treatment option education including **medications and glucose monitoring**
- ✔ **Benefits and eligibility** for continuous glucose monitoring (CGMs)
- ✔ Healthy **eating and activity** recommendations
- ✔ **Reducing risk** for complications
- ✔ Maximizing your **insurance benefits**

When you have blood sugar levels over 180, this can cause damage to blood vessels and nerves. It can lead to:

- Heart disease or stroke
- Kidney disease
- Eye damage
- Poor circulation in the feet or legs
- Poor wound healing
- Immune system issues
- Depression, distress, or low mood

Contact our care management team to get started with diabetes self-management services at SQCN@sentara.com or SACO@sentara.com.

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For more information, share this **downloadable tip sheet** with your patients. Your patients can contact **SQCN@sentara.com** or **SACO@sentara.com** to get

started with the diabetes self-management program today.

Pharmacy Highlights: Medications to Help Maintain A1C

Your patients with type 2 diabetes may benefit from one or more medications to help control blood sugar levels. Each glucose-lowering medication has different health risks, side effects, and costs. The chart below shows several different medications along with the following:

- Ability to lower glucose
- Risk of hypoglycemia
- Weight change
- Effect on ASCVD, CHF, and renal disease

Drugs	Ability to Lower Glucose	Risk of Hypoglycemia	Weight Change	Effect on ASCVD	Effect on CHF	Effect on Renal Disease
2nd Generation SU	High	Yes	Increase	Neutral	Neutral	Neutral
Metformin	High	No	Neutral-modest weight loss	Potential Benefit	Neutral	Neutral
TZDs	High	No	Increase	Potential Benefit (Pioglitazone)	Increased	Neutral
DPP-4 inhibitors	Intermediate	No	Neutral	Neutral	Potential Increase (saxagliptin and alogliptin)	Neutral
SGLT2 inhibitors	Immediate	No	Decrease	Potential Benefit	Benefit	Benefit-Reduced progression of renal failure
GLP-1 receptor agonists	High	No	Decrease	Benefit	Neutral-Potential Benefit	Benefit-Decreased proteinuria

This table shows the expected decrease of A1C levels. The numbers are based on drug-native patients with an A1C of 8% and weight of 90 kg after 26 weeks of treatment.

Drug	A1c % Decrease	Drug	A1c % Decrease
Metformin 2000mg	1.01	Dulaglutide 0.75	1.18
Metformin 2550mg	1.09	Dulaglutide 1.5mg	1.36
Glipizide 5-20mg	0.86	Exenatide 10ug BID	0.86
Glyburide 1.25-20mg	1.17	Exenatide 2mg QW	1.16
Glimepiride 1-8mg	0.97	Exenatide 2mg QWS	1.14
Pioglitazone 15mg	0.62	Liraglutide 0.6mg	0.88
Pioglitazone 30mg	0.85	Liraglutide 1.2mg	1.13
Pioglitazone 45mg	0.98	Liraglutide 1.8mg	1.25
Rosiglitazone 4mg	0.67	Lixisenatide 10ug	0.44
Rosiglitazone 8mg	0.91	Lixisenatide 20ug	0.66
Canagliflozin 100mg	0.84	Semaglutide 0.5mg	1.43
Canagliflozin 300mg	1.01	Semaglutide 1.0mg	1.77
Dapagliflozin 5mg	0.65	Alogliptin 12.5mg	0.58
Dapagliflozin 10mg	0.73	Alogliptin 25mg	0.66
Empagliflozin 10mg	0.69	Linagliptin 5mg	0.59
Empagliflozin 25mg	0.77	Saxagliptin 2.5mg	0.59
Ertugliflozin 5mg	0.73	Saxagliptin 5mg	0.67
Ertugliflozin 15mg	0.81	Sitagliptin 100mg	0.72
The decreases in A1c are modeled for drug naïve patients with an A1c of 8% and a weight of 90kg after 26 weeks of treatment.			

Many of the newer medications are effective in their ability to lower glucose and show a beneficial effect on ASCVD, CHF, and/or renal disease. However, they may also be cost prohibitive. There may be additional resources to support our patients with the costs of these medications. Feel free to reach out to the pharmacy team for more information at **SQCN@sentara.com**.

Sources: National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

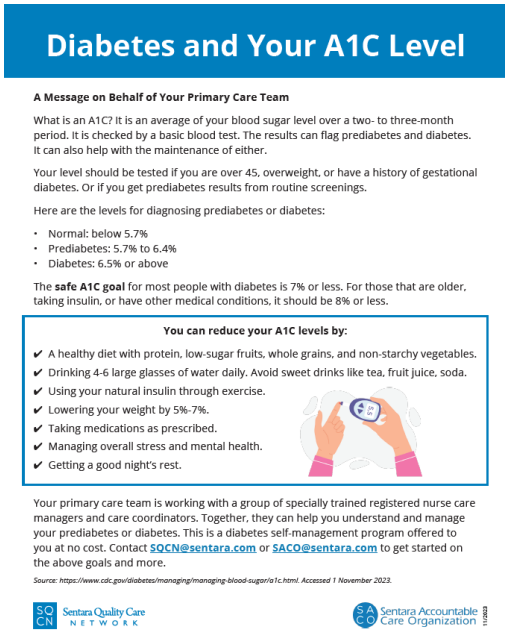
Feingold KR, Anawalt B, Blackman MR, et al., editors. Endotext [Internet]. South Dartmouth (MA): MDText.com, Inc.; 2000-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK279141/

Care Corner: Diabetes and A1C

It's important for patients with prediabetes and other diabetes risk factors to learn more about A1C levels and overall health.

This **downloadable tip sheet** includes information on what the A1C measures, what the levels indicate, and how to reduce it, if needed.

If you have a patient who can benefit from diabetes self-management services, have them contact **SQCN@sentara.com** or **SACO@sentara.com** to get started.



Diabetes and Your A1C Level

A Message on Behalf of Your Primary Care Team

What is an A1C? It is an average of your blood sugar level over a two- to three-month period. It is checked by a basic blood test. The results can flag prediabetes and diabetes. It can also help with the maintenance of either.

Your level should be tested if you are over 45, overweight, or have a history of gestational diabetes. Or if you get prediabetes results from routine screenings.

Here are the levels for diagnosing prediabetes or diabetes:

- Normal: below 5.7%
- Prediabetes: 5.7% to 6.4%
- Diabetes: 6.5% or above

The **safe A1C goal** for most people with diabetes is 7% or less. For those that are older, taking insulin, or have other medical conditions, it should be 8% or less.

You can reduce your A1C levels by:

- ✔ A healthy diet with protein, low-sugar fruits, whole grains, and non-starchy vegetables.
- ✔ Drinking 4-6 large glasses of water daily. Avoid sweet drinks like tea, fruit juice, soda.
- ✔ Using your natural insulin through exercise.
- ✔ Lowering your weight by 5%-7%.
- ✔ Taking medications as prescribed.
- ✔ Managing overall stress and mental health.
- ✔ Getting a good night's rest.

Your primary care team is working with a group of specially trained registered nurse care managers and care coordinators. Together, they can help you understand and manage your prediabetes or diabetes. This is a diabetes self-management program offered to you at no cost. Contact SQCN@sentara.com or SACO@sentara.com to get started on the above goals and more.

Source: https://www.cdc.gov/diabetes/managing/managing-blood-sugar/a1c.html. Accessed 1 November 2023.

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Be Antibiotics Aware: Protect Your Patient

The Centers for Disease Control and Prevention (CDC) is urging healthcare professionals to prescribe antibiotics only when necessary to help fight antimicrobial resistance and the spread of superbugs and to protect their patients from antibiotic-related adverse drug events. During U.S. Antibiotic Awareness Week and throughout the year, CDC promotes Be Antibiotics Aware, an educational effort to raise awareness about the importance of safe antibiotic prescribing and use.

This is a great time to talk with your patients about when antibiotics are and are not needed, and discuss possible side effects such as C. diff, allergic reactions, and antimicrobial-resistant infections. CDC has **patient education resources** to help.

Source: Centers for Disease Control and Prevention Antibiotic Use

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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.
