St. Luke's Health Partners

Network News

Summer 2023

A quarterly newsletter for participating providers and clinic staff, with up-to-date information on network happenings and featuring timely articles and relevant educational content about value-based care, team members and current events.

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United Hero Award

Jennifer Preucil, MD

Please join us in congratulating Dr. Jennifer Preucil, a recipient of the United Hero Award, for her exceptional patient experience scores. The award recognizes excellence in achieving high patient-experience scores in getting needed care, care coordination and the doctor-patient experience.

While in our care, good patient experiences result in continued engagement, loyalty, satisfaction and improved health outcomes.

Leadership Spotlight

Dani Jones
Chief Operating Officer, Health Partners

It's hard to believe that a year has already passed since I joined St. Luke's Health Partners. As I commemorate my one-year anniversary, I have taken the opportunity to reflect on the many things I have learned from my St. Luke's colleagues, many notable health care experts and speakers, former coworkers, family, friends and even strangers. While there were some important personal life lessons packed in there too, I wanted to share some insights about the work-related stuff in the hope that they might resonate with some of you.

1. Never has there been a more critical time to be the change you want to see in the world. I was recently reminded of a quote from Dr. Martin Luther King, Jr.: "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." It is a stark reminder of how long we have overlooked the impacts of social determinants of health on one's overall personal well-being, and subsequently the influence they have on the collective health of our populations, and the critical work we have ahead to address health inequity in our communities.
2. It's vital to put the patient in the center of what we do, not in the middle. This is an important distinction because we talk about being patient centered, but amid a complex health care system that is very confusing to navigate, where provider shortages and access-to-care issues abound, we have not done a good job of making it easy for consumers to find or get care. (Let alone making that care a positive experience.) Patients are often triangulated between fragmented care delivery, billing and payment challenges with insurance companies, and clunky collections processes. I look forward to exploring some consumer-based strategies to improve care delivery and the overall patient experience.

3. Health care is still too expensive. Particularly for those who are underinsured, health care costs are unaffordable and can lead to avoided care and unnecessarily advanced illness or missed early diagnosis. We still function in a fee-for-service mentality and there is still waste and duplication in the system that we need to address.
4. Our workforce of doctors, nurses, pharmacists and other clinicians, as well as clinical and nonclinical support staff, are burned out. They are fragile and at a tipping point. We must find ways to remove burden, create efficiencies, reduce fatigue, find easy buttons and instill joy back in their work. We must act quickly.
5. A good organizational fit is of the utmost importance. I cannot overstate how imperative it is to align yourself with an organization that matches your own personal vision and values. Despite the constant changes in health care, the recent financial burdens on health systems, and the impacts of a volatile political climate on our providers and workforce, it's much easier to come to work every day and fight the good fight when you have like-minded and dedicated people alongside you.

Those are but a few of my more pressing observations from the past year, and the challenges we all face daily have only increased my passion for this work and fueled my fire to continue driving change for the better. I am so very grateful to be working with so many kind hearts and brilliant minds at Health Partners. I look forward to another year of progress and transformation and the exciting data strategy enhancements we have ahead, and it is my honor to serve the mission of this work alongside such a high-value network of providers who are committed to the same objectives of improving care and outcomes, and making care more affordable and accessible for those in our communities.

Medical Musings

Evaluating Social Determinants of Health Is Key in Getting to Know Your Patients

Alejandro Necochea, MD
Medical Director, Health Partners

At Health Partners, when we think about delivering care in a value-based model, we consider three pillars: know your population, close gaps in care and reduce unnecessary health care spending.

Getting to know your population entails a variety of activities—from knowing who constitutes your panel of patients, to understanding who's not coming to the clinic on a regular basis, to being able to identify patients with certain conditions so they can be managed proactively.

One important aspect of knowing your population is understanding the social and economic challenges they face. Estimates vary, but social determinants of health (e.g., income, level of educational attainment, employment status, food and housing insecurity, and social inclusion) may affect as much as 50% of health outcomes.[i] Genetics, behaviors and medical care account for the rest. Incorporating screening and documentation of these determinants into clinical practice can help you develop a fuller picture of your patients and their challenges. Identifying gaps in determinants can help clinical. Resources like findhelpidaho.org, a searchable clearinghouse of resources that is free and available in various languages, can help you and your team connect patients with resources to mitigate social determinants of health gaps.

Centers for Medicare and Medicaid Services and other payers are monitoring the impact of health disparities in our patients and are asking clinics, or will soon be asking clinics, to develop plans to address social determinants of health and health inequities. Fortunately, many clinics in our network (particularly Federally Qualified Health Centers) already have screening tools incorporated into their electronic medical records and have organized themselves so that members of their teams can support patients and refer them to services. If you would like to learn more about this topic, or want to know where you can start, please don't hesitate to contact Dr. Alejandro Necochea (necochea@slhs.org) or Kim Tilley (tilleyk@slhs.org) with our population health team.

[i] Hood CM, et al. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. American Journal of Preventive Medicine. February 2016; 50(2):129-135

Team Member Spotlights

Meet just a few of St. Luke's Health Partners newest staff members.

Rosie Harmon

Director, Health Partners

Rosie Harmon is the newest member of the care management leadership team, coming from a program manager role with St. Luke's Health Partners and with over 30 years' experience at St. Luke's. She has a curious nature and a background in exploring existing processes for optimization opportunities and system alignment. The team affectionately refers to her as "the mechanic" because she loves to dig in and learn how things work, and more importantly, how they can work better. She will support the strategic care management efforts to know our patient populations and align services to their needs by pushing innovative approaches to an integrated health care delivery system.

Marissa Murray

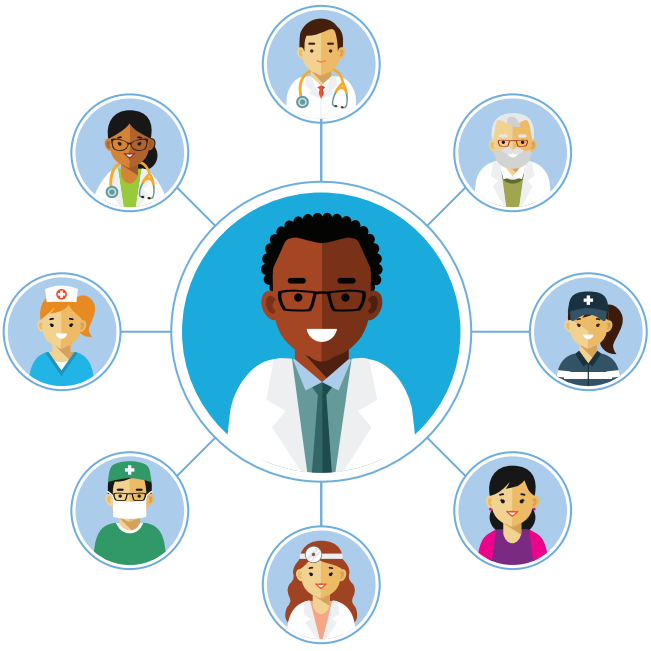
Network Performance Improvement Specialist, Health Partners

Marissa Murray has worked in the health care industry for more than 20 years, during which time she has had the opportunity to be involved in many aspects of ambulatory health care including front office, back office, billing, and for the past seven years, value-based health care. Her most recent roles include care coordination, HEDIS gap closure and spearheading many projects in quality improvement. She is excited to work with the population health team and help clinics achieve their goals.

Amanda Quintana

Network Performance Improvement Specialist, Health Partners

Amanda Quintana joined Health Partners in March 2023. She started out in health care eight years ago working in retail pharmacy. In 2020, she transitioned to quality improvement, gaining experience in HEDIS, Stars, Medicare reporting and compliance. Her prior role was at Molina Healthcare working in Las Vegas for the Nevada market. There, she was responsible for meeting with provider groups to support their efforts in quality gap closure. She now brings that experience to Heath Partners' population health team, meeting with the network's independent providers.



Coding Connection

Documentation and Coding Tips

Depressive Disorders

Documentation of depressive disorders is important to adequately describe the severity of the patient's illness and for accurate coding.

Specify When Documenting

Include the required specific information below for accurate coding of depressive disorders. In the absence of key documentation elements, our default codes are: F32.9-Major depressive disorder, single episode, unspecified or F32.A-Depression, unspecified (depression NOS, depressive disorder NOS).

- Episode: Single or recurrent.
  - o Single – A patient experiences only one single depressive episode during their lifetime.
  - o Recurrent – Considered recurrent when there is an interval of at least two consecutive months between separate episodes during which criteria are not met for a major depressive episode.
- Severity: Mild, moderate, severe, with or without psychotic features.
- Clinical Status: Partial or full remission.
  - o In remission – With appropriate treatment, the patient's depression symptoms may be controlled, in which case they are considered "in remission." They still carry the diagnosis of major depression.
  - o Partial – Occasional symptoms from a previous major depressive episode without meeting full criteria or a hiatus lasting less than two months without any significant symptoms.
  - o Full – No significant signs or symptoms of the disturbance present during the past two months.

Include the key elements below to provide additional specificity for coding and patient care.

- Underlying cause of depression, if known.
- Any comorbidities, if known.
- Treatment plan/results: Screening, testing, medication, counseling/therapy, referrals.

Documentation and Coding Examples

Non-specific documentation example:
65-year-old male seen today for depression. He is responding well to citalopram.

Assign Code: F32.A Depression, unspecified.

Specific documentation example:
72-year-old female with prior known episodes of major depressive disorder, severe without psychosis. Her symptoms are worsening with increased loss of interest in activities, sadness and she is tearful today. Denies self-harm. We will increase her Lexapro dosage to 20 mg and will see her for follow up appointment in 2 weeks.

Assign Code: F33.2 Major depressive disorder, recurrent, severe without psychotic features.

Documentation and Coding Tips

Substance Disorders: Use, Abuse, Dependence, Remission

Substance disorders are increasingly diagnosed and treated by the patient's primary care provider. These conditions are divided into four categories by severity: use, abuse, dependence and remission. It's the provider's responsibility to document whether the condition is mild, moderate or severe. DSM-5 provides further guidance regarding the criteria required for diagnosing the disorder and the patient's current severity.

Use: The irregular or low-frequency use of a substance that is not habitual. Not typically coded unless there is a documented medical concern linked to the use.

Abuse: The habitual use of a substance that negatively impacts a patient's health or social functioning but has not arrived at the point of physical and/or mental dependency. The patient has "mild" substance abuse disorder. Mild is the presence of 2-3 symptoms.

Dependence: A chronic mental and physical state in which the patient must use a substance to function normally. Patients generally experience signs of withdrawal upon cessation of the substance. The patient has "moderate or severe" substance use disorder. Moderate is presence of 4-5 symptoms. Severe is presence of 6 or more symptoms.

In Remission: Requires a provider's clinical judgement and documentation if the patient is in remission or not.

Document these key points for the accurate and specific assignment of the correct ICD.10 code(s) for alcohol, drug and substance disorders:

- Status – use, abuse or dependence.
- Substance type – alcohol, cannabis, opioids, etc.
- Severity – mild, moderate, or severe. (i.e., "Use disorder" is insufficient for proper code assignment).
- Substance-induced mood/psychotic symptoms – depression, hallucinations, anxiety, etc.
- Current complications/presentation – intoxicated, drunkenness, withdrawal, sleep disorder, etc.
- History/pattern of use – continuous use, in remission, relapsed, etc.
  - o Do not use the word "history" if the condition is still active.
- Treatment plan – counseling, rehabilitation, maintenance therapy (specify drug), Alcoholic Anonymous (AA), etc.

Documentation and Coding Examples

Nonspecific example: Patient is being admitted to the treatment center with a history of opioid dependence

Rationale: If the patient is being admitted, it seems unlikely this patient is in remission but, by stating "history of," this is what is documented. Patient has opioid dependence, not a history of opioid dependence.

Specific Example: Patient is being admitted to the treatment center for treatment of opioid dependence. She has been an IV heroin user for five years.

Rationale: Documentation quantifies the time the patient has been an opioid user without making the mistake of using "history of."

Per ICD.10, if the provider documents use, abuse or dependence of the same substance, only one code should be assigned to identify the pattern of use based on the below hierarchy.

Documented	Assign Only
Use and abuse	Abuse
Abuse and dependence	Dependence
Use, abuse and dependence	Dependence
Use and dependence	Dependence

Documentation and Coding Tips

CPT Category II codes

The What, Why and When for Using CPT Category II Codes

Supplemental tracking codes are used for performance measurements that describe clinical components, usually included in E&M or clinical services. Therefore, they do not have a relative value associated with them and are not reimbursable.

Use is optional and may not be used as a substitute for Category I codes.

Five-character alpha-numeric codes that always end with the character “F.”

When specific measuring criteria have been met, these codes identify opportunities for better clinical outcomes for your patient’s care and close gaps in care more accurately and quickly, which leads to enhanced performance on HEDIS measures for your practice.

They also help track member screenings to aid you in monitoring care and avoiding sending unnecessary reminders.

This efficient process reduces the need for chart reviews and medical record requests.

If clinical and documentation requirements are met, there is no limitation on how often these codes can be submitted.

Tips For Implementing CPT Category II Coding Into Your Practice

Work with your system vendor to add these codes into your EMR and practice management system.

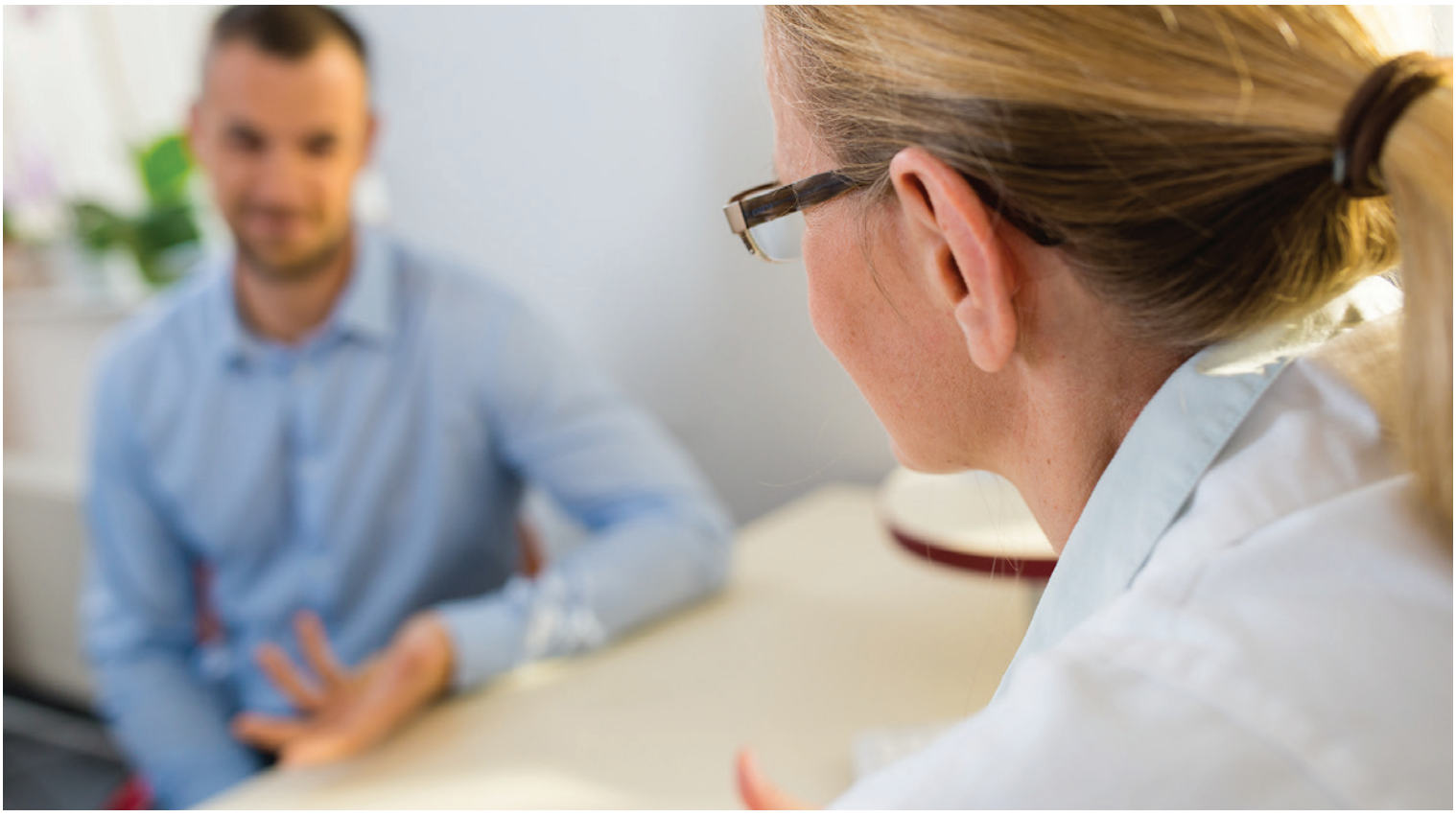
Inquire about automation. Some systems can automatically translate clinical data elements into the appropriate CPT II codes and ensure these codes are included on the claim.

Develop workflows for clinical office staff, billers and coders for proper code submission.

These codes may be submitted on claims with other applicable codes. They are entered in the procedure code field, just like your regular CPT codes are billed.

Check payer-specific guidelines for submitting Category II codes. Some payers may require a professional service is performed on the date the Category II services are reported.

Verify the charge amount criteria with your EMR/Practice Management and Clearinghouse vendors. These codes will be entered with either a .00 or .01 charge amount.



CPT Category II Codes

HEDIS Measure Name and Documentation Guidelines	CPT II code	CPT Category II Code Description	Charge Amount
Controlling High Blood Pressure (CBP) Medical record stating hypertension diagnosis and the following blood pressure screening documentation: • Date and most recent results of the blood pressure reading. • The blood pressure reading must occur on or after the date of the second diagnosis of hypertension. • Documentation must be from provider managing the condition. *Note: Two codes (one from 3074F-3077F and one from 3078F-3080F) must be reported to identify the lowest systolic and lowest diastolic reading to satisfy the CBP measure.*	3074F	Most recent systolic blood pressure <130 mm Hg	.00 or .01
	3075F	Most recent systolic blood pressure 130-139 mm Hg	.00 or .01
	3077F	Most recent systolic blood pressure >/=140 mm Hg	.00 or .01
	3078F	Most recent diastolic blood pressure <80 mm Hg	.00 or .01
	3079F	Most recent diastolic blood pressure 80-89 mm Hg	.00 or .01
	3080F	Most recent diastolic blood pressure >/=90 mm Hg	.00 or .01
Eye Exam for Patients with Diabetes (EED) Medical record stating a confirmed diagnosis of diabetes to include the following retinal eye exam documentation: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that a retinal or dilated eye exam was completed by an eye care professional (optometrist or ophthalmologist). • Evidence of bilateral or unilateral eye enucleation any time during the patient's history through 12/31 of the current calendar year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care specialist in the year prior. *Note: Any provider can report the appropriate CPT Category II code. Report 2022F-2033F with date of eye exam, not the date of service (DOS) when the report was reviewed. Report 3072F with the current year DOS. An eye exam result documented as "unknown" does not meet criteria.*	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed with evidence of retinopathy.	.00 or .01
	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed without evidence of retinopathy.	.00 or .01
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed with evidence of retinopathy.	.00 or .01
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed without evidence of retinopathy.	.00 or .01
	2026F	Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed with evidence of retinopathy.	.00 or .01
	2033F	Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed without evidence of retinopathy.	.00 or .01
	3072F	Low risk for retinopathy (no evidence of retinopathy in prior year).	.00 or .01
Hemoglobin A1c Control for Patients with Diabetes (HBD) Medical record stating a confirmed diagnosis of diabetes to include the following HbA1c screening documentation: • Document the date and result(s) or provide a copy of the lab report with the most recent HbA1c control indictor used regardless of data source. *Note: Report CPT Category II code with the date of the A1c test, not the date of the office visit when the test was reviewed.*	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%.	.00 or .01
	3046F	Most recent hemoglobin A1c level greater than 9.0%.	.00 or .01
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%.	.00 or .01
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%.	.00 or .01
Advanced Care Planning (ACP) Medical record should include the following discussions between a qualified health care professional and the patient: • Discuss the patient's health care wishes if they become unable to make decisions about their care with or without completing legal forms. This may include living wills, instruction directives, health care proxy, health care power of attorney.	1123F	Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record.	.00 or .01
	1124F	Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	.00 or .01
	1157F	Advance care plan or similar legal document present in the medical record.	.00 or .01
	1158F	Advance care planning discussion documented in the medical record.	.00 or .01

Care for Older Adults (COA) Functional Status • Notation that activities of daily living (bathing, dressing, eating, walking, etc.) or instrumental activities of daily living (grocery shopping, driving, meal preparation, laundry, taking medications, etc.) were assessed or documentation of result of assessment using a standardized functional status assessment.	1170F	Functional status assessed.	.00 or .01
Care for Older Adults (COA) Medication List	1159F	Medication list documented in medical record.	.00 or .01
Care for Older Adults (COA) Medication Review Medication list and evidence of medication review by prescribing practitioner or clinical pharmacist, including date when performed or notation that member in not taking any medication and date when noted, which may include transitional care management services during the same outpatient visit. *Note: Both 1159F and 1160F must be reported to satisfy the medication review component of COA measure.*	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record.	.00 or .01
Care for Older Adults (COA) Pain Assessment	1125F	Pain severity quantified; pain present.	.00 or .01
Medical record with documentation of pain assessment or result of assessment using a standardized pain assessment tool, which may include positive or negative findings for pain.	1126F	Pain severity quantified; no pain present.	.00 or .01
Prenatal and Postpartum Care (PPC) Stand Alone Prenatal Visits ***See details CPT Category II Code Description***	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]).	.00 or .01
	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit).	.00 or .01
	0502F	Subsequent prenatal care visit [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care)].	.00 or .01
Prenatal and Postpartum Care (PPC) Postpartum Visits	0503F	Postpartum care visit.	.00 or .01
Transitions of Care (TRC)-Medication Reconciliation Medical record should include a medication reconciliation by a qualified health care professional post-discharge in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. • The medication list may include medication names only or may include medication names, dosages, and frequency, over the counter (OTC) medications and herbal or supplemental therapies. *Notes:* • *The medication reconciliation must be documented on the date of discharge through 30 days after the discharge (31 days total).* • *1111F can be reported when the post-discharge medication reconciliation is done during a telephone call or during the transitional care management (TCM).*	1111F	Discharge medications reconciled with the current medication list in outpatient medical record.	.00 or .01

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Documentation and Coding Tips

Social Determinants of Health and Z Diagnosis Coding

The Journey to Better Patient-Centered Outcomes: Code It and Track Patient Needs

There are socioeconomic factors that can affect a person's health, including both environmental and societal conditions such as education and literacy, employment, health behaviors, housing, lack of adequate food or water, occupational exposure to risk factors, social support, transportation and violence.

Tracking the social needs that impact patients allows providers to identify trends to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor intervention effectiveness.

Because the social determinants of health (SDoH) Z diagnosis codes in these categories represent social information, rather than medical diagnoses, they can be assigned based on documentation by nonphysician clinicians involved in the care of these patients. Self-reported documentation from the patient, if the information is approved and incorporated into the medical record by a clinician or provider, can be reported as well.

SDoH data may be documented in the problem list, patient history, diagnosis list or provider notes. These SDoH Z diagnosis codes are supplemental diagnosis codes and should not be used as the admitting or principal diagnosis to indicate the medical reason for the visit. Always assign all relevant SDoH Z diagnosis codes to paint the true picture of the patient's needs and situation.

Identify workflows to minimize staff burden and define what roles each team member will play. For example, coders can easily assign these codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record, or pre-visit planning teams can capture this information prior to the patient's visit.

Or your team can implement standardized questions regarding housing stability, food security and access to transportation as part of your currently required health risk assessments. This is an additional reminder for providers to capture these codes during patient visits.

Work with your system vendor to add the SDoH Z diagnosis codes below into your EMR.

Z55-Problems related to Education and Literacy

ICD.10 Z Code Description	ICD.10 Z Code
Illiteracy and low-level literacy.	Z55.0
Schooling unavailable and unattainable.	Z55.1
Failed school examinations.	Z55.2
Underachievement in school.	Z55.3
Educational maladjustment and discord with teachers and classmates.	Z55.4
Less than a high school diploma: • No general equivalence degree (GED).	Z55.5
Other problems related to education and literacy: • Problems related to inadequate teaching.	Z55.8

Z56-Problems related to Employment and Unemployment

Unemployment, unspecified.	Z56.0
Change of job.	Z56.1
Threat of job loss.	Z56.2
Stressful work schedule.	Z56.3
Discord with boss and workmates.	Z56.4
Uncongenial work environment: • Difficult conditions at work.	Z56.5
Other physical and mental strain related to work.	Z56.6
Other problems related to employment.	**See five-digit codes below.**
Sexual harassment on the job.	Z56.81
Military deployment status: • Individual (civilian or military) currently deployed in theater or in support of military war, peacekeeping and humanitarian operations.	Z56.82
Other problems related to employment.	Z56.89
Unspecified problems related to employment: • Occupational problems NOS.	Z56.9

Z57-Occupational exposure to risk factors

Occupational exposure to noise.	Z57.0
Occupational exposure to radiation.	Z57.1
Occupational exposure to dust.	Z57.2
Occupational exposure to other air contaminants.	**See five-digit codes below.**
Occupational exposure to environmental tobacco smoke.	Z57.31
Occupational exposure to other air contaminants.	Z57.39
Occupational exposure to toxic agents in agriculture: • Occupational exposure to solids, liquids, gases or vapors in agriculture.	Z57.4
Occupational exposure to toxic agents in other industries: • Occupational exposure to solids, liquids, gases or vapors in other industries.	Z57.5
Occupational exposure to extreme temperature.	Z57.6
Occupational exposure to vibration.	Z57.7
Occupational exposure to other risk factors.	Z57.8
Occupational exposure to unspecified risk factor.	Z57.9

Z58-Problems related to physical environment

Inadequate drinking-water supply: • Lack of safe drinking water.	Z58.6

Z59-Problems related to housing and economic circumstances

Homelessness.	**See five-digit codes below.**
Homelessness unspecified.	Z59.00
Sheltered homelessness: • Doubled up. • Living in a shelter such as: motel, scattered site housing, temporary or transitional living situation.	Z59.01
Unsheltered homelessness: • Residing in place not meant for human habitation such as: abandoned buildings, cars, parks, sidewalk. • Residing on the street.	Z59.02
Inadequate housing: • Lack of heating. • Restriction of space. • Technical defects in home preventing adequate care. • Unsatisfactory surroundings.	Z59.1
Discord with neighbors, lodgers and landlord.	Z59.2
Problems related to living in residential institution: • Boarding-school resident.	Z59.3

Lack of adequate food.	**See five-digit codes below.**
Food insecurity.	Z59.41
Other specified lack of adequate food: • Inadequate food. • Lack of food.	Z59.48
Extreme poverty.	Z59.5
Low income.	Z59.6
Insufficient social insurance and welfare support.	Z59.7
Other problems related to housing and economic circumstances.	**See five- and six-digit codes below.**
Housing instability, housed: • Foreclosure on home loan. • Past due on rent or mortgage. • Unwanted multiple moves in the last 12 months.	Z59.81
○ Housing instability, housed, with risk of homelessness: • Imminent risk of homelessness.	Z59.811
○ Housing instability, housed, homelessness in past 12 months.	Z59.812
○ Housing instability, housed unspecified.	Z59.819
Transportation insecurity: • Excessive transportation time. • Inaccessible transportation. • Inadequate transportation. • Lack of transportation. • Unaffordable transportation. • Unreliable transportation. • Unsafe transportation.	Z59.82
Financial insecurity: • Bankruptcy. • Burdensome debt. • Economic strain. • Financial strain. • Money problems. • Running out of money. • Unable to make ends meet.	Z59.86
Material hardship: • Material deprivation. • Unable to obtain adequate childcare. • Unable to obtain adequate clothing. • Unable to obtain adequate utilities. • Unable to obtain basic needs.	Z59.87
Other problems related to housing and economic circumstances: • Foreclosure on home. • Isolated dwelling. • Problems with creditors.	Z59.89
Problems related to housing and economic circumstances, unspecified.	Z59.9

Z60-Problems related to social environment

Problems of adjustment to life cycle transitions: • Empty nest syndrome. • Phase of life problem. • Problem with adjustment to retirement [pension].	Z60.0
Problems related to living alone	Z60.2
Acculturation difficulty: • Problem with migration. • Problem with social transplantation. ○ DEF: Problem adapting to a different culture or environment not based on any coexisting medical disorder.	Z60.3
Social exclusion and rejection.	Z60.4
Target of (perceived) adverse discrimination and persecution.	Z60.5
Other problems related to social environment.	Z60.8
Problem related to social environment, unspecified.	Z60.9

Z62-Problems related to upbringing

Inadequate parental supervision and control.	Z62.0
Parental overprotection.	Z62.1
Upbringing away from parents.	**See five-digit codes below.**
Child in welfare custody: • Child in care on non-parental family member. • Child in foster care.	Z62.21
Institutional upbringing: • Child living in orphanage or group home.	Z62.22
Other upbringing away from parents.	Z62.29
Hostility towards and scapegoating of child.	Z62.3
Inappropriate (excessive) parental pressure.	Z62.6
Other specified problems related to upbringing.	**See five- and six-digit codes below.**
Personal history of physical and sexual abuse in childhood.	Z62.810
Personal history of psychological abuse in childhood.	Z62.811
Personal history of neglect in childhood.	Z62.812
Personal history of forced labor or sexual exploitation in childhood.	Z62.813
Personal history of unspecified abuse in childhood.	Z62.819
Parent-child conflict.	**See six-digit codes below.**
Parent-biological child conflict: • Parent-child problem NOS.	Z62.820
Parent-adopted child conflict.	Z62.821
Parent-foster child conflict.	Z62.822

Other specified problems related to upbringing.	**See six-digit codes below.**
Parent-child estrangement NEC.	Z62.890
Sibling rivalry.	Z62.891
Other specified problems related to upbringing.	Z62.898
Problems related to upbringing, unspecified.	Z62.9

Z63-Other problems related to primary support group, including family circumstances

Problems in relationship with spouse or partner: • Relationship distress with spouse or intimate partner.	Z63.0
Problems in relationship with in-laws.	Z63.1
Absence of family member.	**See five-digit codes below.**
Absence of family member due to military deployment: • Individual or family affected by other family member being on military deployment.	Z63.31
Other absence of family member.	Z63.32
Disappearance and death of family member: • Assumed death of family member. • Bereavement.	Z63.4
Disruption of family by separation and divorce: • Marital estrangement.	Z63.5
Dependent relative needing care at home.	Z63.6
Other stressful life events affecting family and household.	See five-digit codes below
Stress on family due to return of family member from military deployment: • Individual or family affected by family member having returned from military deployment (current or past conflict).	Z63.71
Alcoholism and drug addiction in family.	Z63.72
Other stressful life events affecting family and household: • Anxiety (normal) about sick person in family. • Health problems within family. • Ill or disturbed family member. • Isolated family.	Z63.79
Other specified problems related to primary support group: • Family discord NOS. • Family estrangement NOS. • High expressed emotional level within family. • Inadequate family support NOS. • Inadequate or distorted communication within family.	Z63.8
Problem related to primary support group, unspecified: • Relationship disorder NOS.	Z63.9

Z64-Problems related to certain psychosocial circumstances

Problems related to unwanted pregnancy.	Z64.0
Problems related to multiparity.	Z64.1
Discord with counselors. • Discord with probation officer. • Discord with social worker.	Z64.4

Z65-Problems related to other psychosocial circumstances

Conviction in civil and criminal proceedings without imprisonment.	Z65.0
Imprisonment and other incarceration.	Z65.1
Problems related to release from prison.	Z65.2
Problems related to other legal circumstances: • Arrest. • Child custody or support proceedings. • Litigation. • Prosecution.	Z65.3
Victim of crime and terrorism: • Victim of torture.	Z65.4
Exposure to disaster, war and other hostilities.	Z65.5
Other specified problems related to psychosocial circumstances: • Religious or spiritual problem.	Z65.8
Problem related to unspecified psychosocial circumstances.	Z65.9

Quality Care

Depression Awareness

Depression is a common and serious mental health disorder that is characterized by feelings of sadness, hopelessness, withdrawal and loss of interest in previously enjoyed activities. Symptoms of depression can vary between individuals and can also negatively impact physical health. If not acknowledged and treated, depression can lead to devastating consequences for the individual, their family and even society. Fortunately, depression is highly treatable, and many great organizations are working to lessen the stigma associated with mental illness.

There is never a better time to encourage people to put their mental health first. Here are a few tips and tricks to improve mental health and well-being.

1. **Practice self-care:** Take care of yourself, while reminding yourself that self-care is NOT selfish care.
2. **Connect to social supports:** reach out to friends, family, and loved ones. Setting aside time to maintain those positive healthy relationships in your life.
3. **Manage Stress:** utilize meditation apps, practice deep breathing, and/or asking for help.
4. **Get outside:** walk, hike, bike, or just enjoy being out in nature.
5. **Seek Professional Help:** consider seeing a counselor, psychiatrist, or other mental health professional to ensure you get a proper diagnosis and treatment.

Depression Screening

According to the U.S. Preventive Services Task Force, depression screening is recommended for adolescents 12-18 years of age as well as all adults. Major depressive disorder is a significant contributor to global disability, ranking as the second leading cause of disability, impacting approximately 120 million individuals. Studies suggest that the prevalence of major depressive disorder over a person's lifetime ranges from 10% to 15%. Additionally, 16% of individuals in the U.S. report receiving a diagnosis of depression from a health care provider at some point in their lives.

Older individuals are at higher risk of a major depressive disorder if they have had a disability, chronic illness, complicated grief, difficulty sleeping and/or loneliness. Social determinants contributing to depression are lack of education, divorce and unemployment. Females, young and middle-aged adults, and nonwhite individuals also have increased rates of depression.

Screening for depression requires systems in place that ensure an accurate diagnosis, treatment that is effective and timely follow-up.

Diabetes Measures

The Centers for Disease Control and Prevention (CDC) report that diabetes is the primary cause of kidney failure and new cases of adult blindness. Diabetes is also associated with an increased risk of cardiovascular disease, nonalcoholic liver disease and steatohepatitis. Screening for diabetes control (A1c), diabetic retinopathy, blood pressure control and kidney health evaluation are imperative to maintaining diabetes control and prevention of worsening disease.

HEDIS Measure Specifications
HEDIS® – The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Hemoglobin A1c Control (<8.0%): The percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year.

- HbA1c control (<8.0%)
- HbA1c poor control (>9.0%)

Blood Pressure Control in Persons With Diabetes
The percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Retinopathy Screening
The percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) who had a retinal eye exam (multi-year measure).

Kidney Health Evaluation for Patients With Diabetes (KED)
The percentage of members 18-85 years of age with diabetes (Type 1 and Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) *and* a urine albumin-creatinine ratio (uACR), during the measurement year.

Switching It Up

Metformin is a well-known first-line medication to treat Type 2 diabetes. It is available in two formulations: immediate release (IR) and extended release (ER). The IR formulation is typically administered two to three times daily, while the ER formulation is usually administered once daily. Studies have shown that the ER formulation is associated with better gastrointestinal (GI) tolerability and patient adherence than the IR formulation,[1,2] which in turn creates increased patient satisfaction and improved patient outcomes. Additionally, patients will pay the same copay for metformin ER as they do for metformin IR. Please consider making the switch to metformin ER to help with patient tolerability, medication adherence, patient satisfaction and improved patient outcomes.

Metformin Best Practices[3]

1. **Set the stage:** Tell patients about the side effects of metformin and explain that they are usually temporary.
2. **Start low and go slow:** To improve GI tolerability, start with metformin ER 500mg once daily and titrate slowly to target dose of ~2,000mg/day. Consider increasing the dose slowly by 500mg/day every one to two weeks.
    a. If a patient has a history of GI intolerance, starting at 250mg/day and titrating more slowly (i.e., by 250mg/day every one to two weeks) is a good option.
    b. If GI symptoms occur, reduce the dose to the last tolerated dose, and wait at least two weeks before attempting another titration.
3. Making the switch: Patients receiving metformin IR may be switched to metformin ER once daily at the same total daily dose, up to 2,000mg daily.[4]
4. Tell patients to take metformin with food (during or right after meals) to improve GI tolerability. For once daily dosing, recommend taking metformin with the largest meal of the day.[5]
5. Some generic metformin products have an unpleasant odor. If this occurs, switching to a different manufacturer may help.[6]

Other Tips and Tricks to Help Increase Medication Adherence

1. **Pill boxes:** Using a pill box helps a patient visualize medications and their associated time of day/day of the week to be taken. A good rule of thumb is to refill the pill box on the same day each week (e.g., always on Sundays).
2. **Alarms:** Have a patient set alarms on their phone or purchase timer caps for each pill bottle and set them to go off when the next dose is due (some pill boxes also have timers).
3. **Task association:** Associate taking medications with a task such as brushing teeth, eating lunch or going to bed.
4. **Bubble packing:** Some pharmacies offer bubble packing services to help patients keep track of doses and the time of day each medication should be taken.
5. **Communication:** The absolute best method to help patients with medication adherence is communication. Talk to your patients and ensure they know the names of their medications and what each medication is for. If you are prescribing something new, always tell them the name of the medication, why you are prescribing it (to help lower your blood pressure; to protect your kidneys since you have diabetes; etc.), how to take it, how long they will be taking it and what to expect from it (side effects, etc.).

[1] Depression (healthwise.net)

[2] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening

[3] Donnelly LA, Morris AD, Pearson ER. Adherence in patients transferred from immediate release metformin to a sustained release formulation: a population-based study. Diabetes Obes Metab. 2009;11:338–342.

[4] Gao H, Xiao W, Wang C, et al. The metabolic effects of once daily extended-release metformin in patients with type 2 diabetes: a multicentre study. Int J Clin Pract. 2008;62:695–700.

[5] Clinical Resource, Improving Metformin Tolerability. Pharmacist's Letter/Prescriber's Letter. February 2022. [380203]

[6] Lexi-Drugs/Metformin. Lexicomp app. UpToDate Inc. Accessed May 4, 2023.

Provider Network Updates

An up-to-date and accurate provider directory is an important resource maintained by Health Partners and utilized by our payer partners and value-based contract members. By having accurate information about our providers, patients can choose providers within their network who more closely align with their individual needs. It also helps them receive timely care.

Please assist us in this effort by promptly notifying Health Partners when provider changes occur. You can do so by utilizing the provider update form available on our website: stlukeshealthpartners.org/credentialing-and-contracting.

Use the provider update form to:

- Add a currently credentialed or facility-based provider to an existing group.
- Update demographic information for existing providers.
- Remove a provider from your group.

If you have questions about the participation status of a provider, please reach out to us at SLHealthPartners@slhs.org.

In addition, Health Partners has made important updates to the initial credentialing application and provider update form found on our website. These updates will allow our providers the option to provide more in-depth information about themselves related to diversity, equity and inclusion. Our aim in gathering this information is to further assist patients in accessing providers who more closely meet their needs.

We appreciate your collaboration and commitment to ensuring accurate directory information.

Network News Best Practices

Since 2021, the clinical discernment team at Health Partners has had the joy of working on clinical documentation feedback projects with 60 clinics. Our vision is to be a complementary resource to providers to help simplify/clarify documentation to reflect an accurate illness burden. We do this by reviewing annual wellness visits shortly after they occur and providing feedback on conditions that are supported by clinical indicators in the chart. We have reviewed more than 7,000 charts and have some rich data to share. The top five conditions that we give feedback on the most often are related to these hierarchical condition categories:

- Vascular disease.
- Diabetes with complications.
- Chronic kidney disease.
- Morbid obesity.
- Substance abuse.

The best part of our job is providing real-time feedback with real-time data. In the course of our work, we often identify high performing clinics and providers. We always ask them to share their best practices. St. Luke's Clinic – Family Medicine in Meridian shared these best practices:

- "During Medicare AWVs, I look at the full chart, including imaging and labs."
- "I search for atherosclerosis in imaging studies and always look at labs for trending GFRs."
- "I add chronic kidney disease to the problem list early (stage 2) to watch for trends as my patients come in."
- "I leverage the functionality in the electronic record. For example, do word searches for 'GFR >60' or search for 'atherosclerosis of aorta.'"
- "For my diabetic patients, I address all complications of diabetes."
- "For patient with a BMI >35, I check for co-morbidities."

We love to see providers so engaged in these projects. We are now enrolling new clinics in our feedback projects. Please reach out if we could be of assistance or if you are interested in participating in a feedback project for your group.