



Provider Quality Learning Collaborative

September 2, 2026



Welcome to Sentara Health Plans

Sunil Sinha, MD

Medical Director, Value Based Care/
Provider Network

Purpose

1. Provide a platform to build strong relationships with our practice partners.
2. Share resources and best practices to improve health care outcomes, increase HEDIS measure compliance, close care gaps and increase quality scores.
3. Decrease interruptions caused by multiple outreaches to provider offices from the health plan.

You are welcome to post your questions in the chat.

Agenda

- Welcome
- HealthMap - Improving Quality and Lowering Costs
- Rewarding Better Health for Medicaid and Medicare Members
- Provider Spotlight – New River Valley Pediatrics and Medical Assistant Outreach
- How Can Sentara Health Plans Help You?
- Q & A
- Closing Remarks

HealthMap

Marigot “Maggi” Vreeland

Regional Director
HealthMap Solutions



IMPROVING QUALITY AND LOWERING COSTS

Kidney Population Health Management

**Healthmap Solutions Overview for
Provider Team**



AGENDA

1

Healthmap Solutions Overview

2

Kidney Health Management Program

3

Tools for Providers

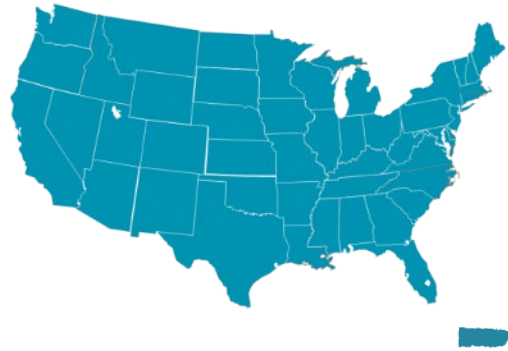
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Questions

Healthmap Solutions Today

FOUNDED IN
2013

as the first Kidney
Population Health
Management Company



FOOTPRINT ACROSS ALL
50 STATES

plus Puerto Rico with
all lines of business

CONTRACTED FOR
200K+

kidney lives with
~\$4.5B in medical spend: 60% Medicare
25% Medicaid
15% Commercial

ENGAGED
**OVER
75%**

of all program eligible members
through our client's existing provider
network and our multidisciplinary
Care Navigation team

CONSISTENTLY GENERATED

7-13%

gross savings on total
cost of care in PY2+

Active Health Plan Clients

Florida Blue 
Your Health Solutions Partner

MEDICARE

TRIPLE-S

cigna
healthcare

HIGHMARK
HEALTH

CENTENE
Corporation



 **Health New England**

 **MOLINA**
HEALTHCARE

 **Blue Cross
Blue Shield
Blue Care Network
of Michigan**



HITRUST

Our Kidney Health Management (KHM) Program

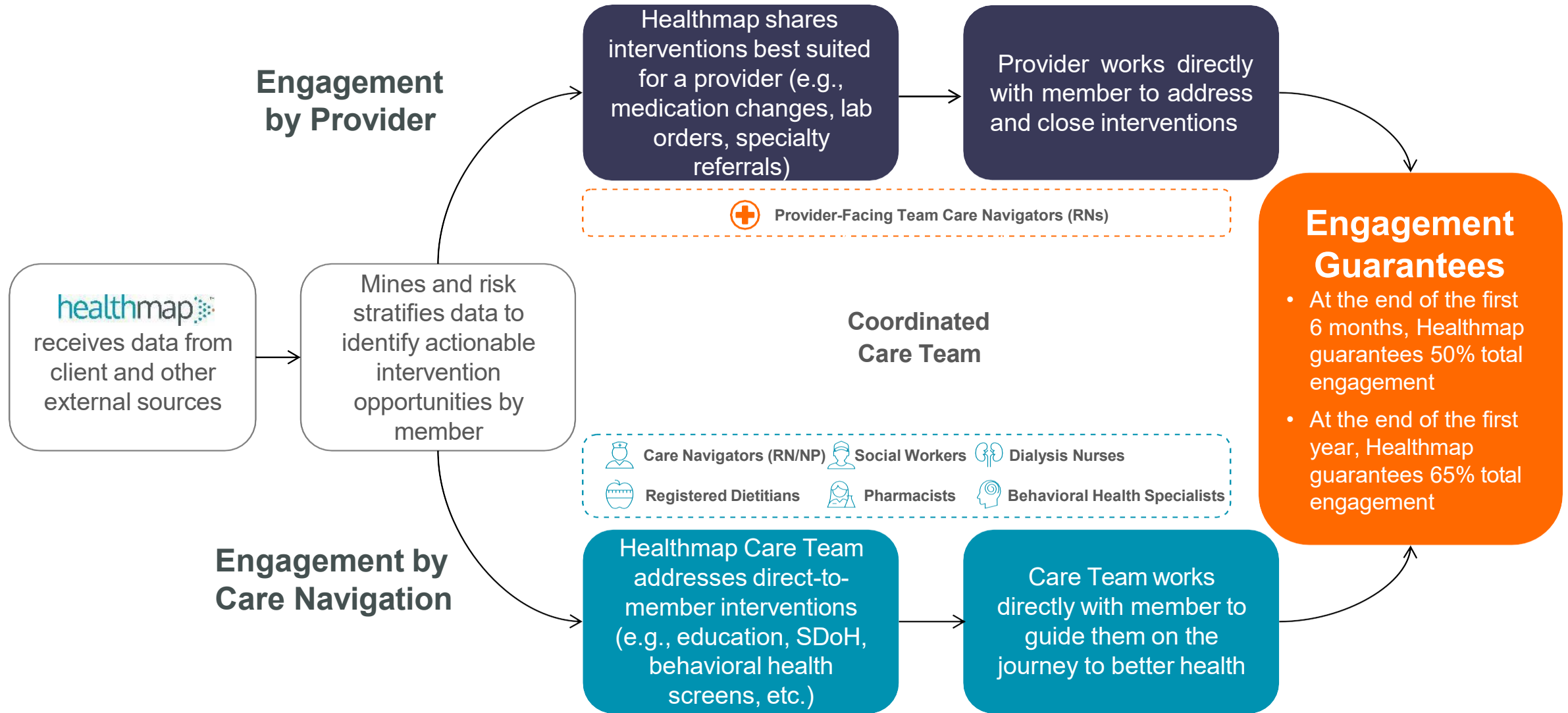


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Member and Provider Engagement

ILLUSTRATIVE JOURNEY





Healthmap delivers personalized care factoring in various member attributes (including stage/risk of disease) and leverages analytics to identify “next best action” for each member

Member Approach	
Segment	Activities (Not Exhaustive)
Preventative Care	Personal Health Assessment (PHA), Healthy Action Plan (HAP), address quality measures, review diagnostic lab testing, medication review and medication management
Comorbidity Management	Ensure adherence to medications and deliver comprehensive member education program on lifestyle management and caregiver support
CKD Stage	
Social Barriers to Care	Behavioral health screening, nutrition assistance, transportation assistance, financial assistance, investment in social workers and community resources

Example Stage-Specific CKD Activities	
Stage	Focus / Activities
Stage Unspecified	- Facilitate labs for CKD staging - Educate on kidney health (avoid NSAIDs, medication adherence, etc.), comorbidities, and preventive care
Stage 3	- Slow progression through comorbidity management that includes lifestyle modification - Identify members who would benefit from early nephrologist support - Coordinate care across providers for complex members
Stage 4	- Ensure proper utilization of nephrology services - Educate on Renal Replacement Therapy (RRT): transplant evaluation, dialysis site of service, vascular access
Stage 5	- Ensure proper cadence of nephrology services - Critical focus on RRT readiness with smooth ESRD transition - Educate on anemia and bone disease management
ESRD	- Ensure adherence with dialysis therapy and diet - Evaluate opportunities for home dialysis conversion, fistula/graft access, and transplant evaluation

Healthmap identifies and addresses social barriers to care

25%

OF MEMBERS

in Care Navigation have identified social barriers to care

Of those members,

95%

have been historically addressed by Healthmap's multidisciplinary Care Navigation team through community-based resources and/or the health plan's supplemental benefits



Economic Stability

- Income / financial barriers
- Job opportunities
- Food insecurity



Health Care Access and Quality

- Preferred language / need for interpreter
- Transportation
- Disability



Education Access and Quality

- Health literacy
- Educational attainment



Neighborhood and Environment

- Geographic location
- Polluted air and water
- Housing insecurity and safety



Social and Community Context

- Social isolation / community support
- Racism, discrimination, and violence
- Cultural / religious preferences

Providers working with Healthmap receive comprehensive support for their patients

Support provided by Healthmap's Clinical Ops team

- Care gap intervention identification and notification**
 - Healthmap nurses share list of care gaps detected for members attributed to the onboarded provider
- Member engagement, education, and support**
 - Healthmap engages directly with members to provide ongoing education and support (e.g., SDoH)
- Urgent alerts (e.g., renal-related medications to avoid, transitions of care)**
 - Healthmap provides alerts and helps coordinate visits based on key events (e.g., Rx, ADTs)
- Historical HCC risk code opportunity and education**
 - Healthmap analyzes and shares attributed members' historical HCC codes for provider review based on attributed members' 36-month lookback period

Level of support provided to providers caring for Client #1's KHM¹ members

~4

Average interventions presented per member per year

36%

Provider-engaged members directly engaged by Healthmap Care Navigation nurses²

> 6,500

Renal-related med avoid & IP ADT alerts shared with providers

> 100,000

HCC risk coding opportunities tracked / identified in 2024

1. KHM: Healthmap Kidney Health Management (KHM) program
2. Represents percent of overall provider engaged members engaged in Care Navigation.



Member SDOH Case Study: Amanda's Story

[Click Here to Hear from Amanda](#)



Amanda
Healthmap KHM Member
Living with ESRD, high blood pressure, congestive heart failure, and depression

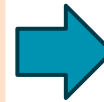
Barriers to care: Experiencing homelessness, struggling to access food, having difficulty establishing care with providers and dialysis clinic, being unable to receive dialysis due to her child's school schedule, all while battling depression and chronic health conditions.



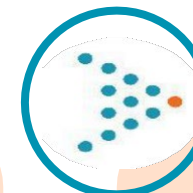
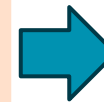
Amanda was receiving emergency dialysis regularly at her local hospital. **Healthmap identified Amanda as a high utilizer of the Emergency Department.**



Healthmap's Quality Practice Advisor Samiah traveled to the hospital where Amanda had been receiving dialysis treatments to meet her, introduce her to the Healthmap KHM program, and **help her establish care at a local dialysis clinic.**



Healthmap's Care Navigator Felicia helped Amanda find **resources for accessing housing and food**. She coordinated appointments for Amanda to see a **PCP, Nephrologist, and Cardiologist**. She also helped schedule her **dialysis appointments**.



Healthmap continues to support Amanda with her SDOH needs while coordinating care with her providers to keep her health on track.

***"Felicia and Samiah are my angels and my biggest help. I can't thank them enough for what they have done."** – Amanda*



Tools for Providers

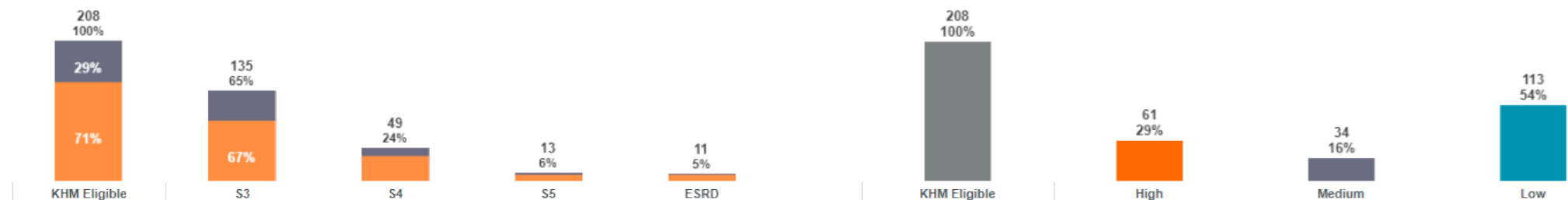
Kidney Impact Dashboard

Provider Summary

Population Summary

■ CKD Only
■ Cardiac and CKD

Risk Level



Opportunity Summary

Opportunity Description	# of Patients	% of Patients	Definition
1. Promote Care Navigation for Higher Risk Members	68	33%	Patients identified as high priority for Care Navigation engagement – we would seek provider assistance if appropriate
2. Address High Inpatient and/or ED Utilization	11	5%	Patients with greater than or equal to 3 inpatient/ED visits in prior year or 2 in prior quarter
3. Promote HCC Recapture Rate	102	49%	Patients with open chronic HCC coding opportunities based on year-to-date claims data
4. Increase Nephrologist Visit Utilization	23	11%	Patients with potential need for a nephrologist visit (CKD Stage 4/5 with a 3 month lapse)
5. Increase Cardiologist or Endocrinologist Visit Utilization	50	24%	Patients with a potential need for a Cardiologist or Endocrinologist visit
6. Address Lab Opportunities	57	27%	Patients with open lab opportunities as identified by claims data and evidence-based guidelines
7. Address Medication Opportunities	110	53%	Patients with open medication opportunities as identified by claims data and evidence-based guidelines
8. Increase Hypertension or Cardiac Medication Utilization	69	33%	Patients who could potentially benefit from a Hypertension or Cardiac Medication
9. Medication Adherence: RAS Antagonist	19	9%	Patients with a proportion of days covered (PDC) ratio <80% for an RAS Antagonist prescription
10. Increase Statin Utilization	28	13%	Patients with CKD who could potentially benefit from a statin
11. Medication Adherence: Statin	23	11%	Patients with a proportion of days covered (PDC) ratio <80% for a statin
12. Medication Adherence: Diabetes Medications	12	6%	Patients with a proportion of days covered (PDC) ratio <80% for specific classes of diabetes medications (excluding insulin)

Utilization Summary

Last Twelve Month Admit Count								
CKD Stage	0 Admit	1 Admits	2 Admits	3 Admits	> 3 Admits	Total	0 Admit	80%
S3	111	13	8	3	-	135	1 Admit	12%
S4	41	4	3	1	-	49	2 Admits	6%
S5	10	2	1	-	-	13	3 Admits	2%
ES	4	6	1	-	-	11	>3 Admits	0%
Total	166	25	13	4	-	208		

Patient 360: Single-Page View of Member Care Needs

Attributed Provider: Dr. Smith		Health Plan: Customer ABC		Date of Birth: XX/XX/XXXX	
Specialty: PCP		Line of Business: MA		Care Navigation Status: Engaged	
Company: Main Street Health		CKD Stage: CKD Stage 5			
Practice:		Healthmap Risk Level: High			

Patient Care Team		Utilization Summary		Care Opportunity Summary	
Name:	Dr. Smith	Most Recent Attributed Provider Visit:	XX/XX/XXXX	Open Care Opportunities	
Practice:	Main Street Health	Most Recent Nephrology Visit:	XX/XX/XXXX	Lab	8
Specialty:	Nephrology	Most Recent Annual Wellness Visit (AWV):	XX/XX/XXXX	Medication	4
Name:	Dr. Smith	Most Recent Hospital Discharge:	XX/XX/XXXX	Referral	1
Practice:	Main Street Health	Most Recent ED Visit:	XX/XX/XXXX		
Specialty:	PCP				

Medication Opportunities				Lab Opportunities			
Category	Drug Name	Alternative Drug	Date Identified	Category			Date Identified
DUPLICATE	Adrenergic alpha-Antagonists [MoA], Adrenergic beta1-Antagonists [MoA], Adrenergic beta2-Antagonists [MoA], alpha-Adrenergic Blockers...	carvedilol 12.5 MG Oral Tablet	3/21/2023	CBC			7/9/2023
	Arteriolar Vasodilation [PE], Arteriolar Vasodilator [EPC] - Hydralazine Hydrochloride 50 MG Oral Tablet	Hydralazine Hydrochloride 25 MG Oral Tablet	3/21/2023	Fasting lipid panel			3/21/2023
	Increased Diuresis at Loop of Henle [PE], Loop Diuretic [EPC] - torsemide 20 MG Oral Tablet	Furosemide 40 MG Oral Tablet	3/21/2023	PTH			5/28/2023
INTERACTION	Beta Blocker	Insulin	3/21/2023	Renal Function Panel			6/4/2023
				Serum Albumin or Prealbumin			6/4/2023
				Serum phosphorous (phosphate)			4/23/2023
				Urinalysis with microscopic analysis			6/13/2023
				Urine albumin/creat ratio or protein/creat ratio			3/21/2023

Hierarchical Condition Categories Opportunities				Referral Opportunities			
HCC Category	Diagnosis Code	Description	Last Coded	Category			Date Identified
Chronic Obstructive Pulmonary Disease	J432	Centrilobular emphysema		Nephrologist			3/21/2023
Coagulation Defects and Other Specified Hematological Disorders	D696	Thrombocytopenia unspecified					
Congestive Heart Failure	I5043	Acute on chronic combined systolic (congestive) and diastolic (congestive) ...					
Diabetes with Chronic Complications	E1140	Type 2 diabetes mellitus with diabetic neuropathy unspecified		Utilization Detail			
Dialysis Status	Z992	Dependence on renal dialysis		Inpatient			
Lung and Other Severe Cancers	C9000	Multiple myeloma not having achieved remission		DRG	Hospital	LOS	7 Day F/U
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic ...	G620	Drug-induced polyneuropathy		Heart Failure And Shock With Moc			XX/XX/XXXX
Other Significant Endocrine and Metabolic Disorders	E8581	Light chain (AL) amyloidosis		Emergency			
Unstable Angina and Other Acute Ischemic Heart Disease	I249	Acute ischemic heart disease unspecified		Dx	ER Name		Discharge Date
Vascular Disease	I700	Atherosclerosis of aorta		Shortness of breath			XX/XX/XXXX

- **P360 is a one-page member summary.**
 - Demographics
 - Care Team
 - Utilization
 - Interventions
 - HCCs
 - Assessments – coming soon
- **Future Enhancements**
 - Automation of P360 through direct secure messaging to all members with an upcoming Annual Wellness Visit or recurring visits
 - Provider leave-behind for Tiers 4 and 5, high-utilization members

Overview of Highest Impact Opportunities

High impact opportunities are primarily concentrated on ~30% of KHM membership expected to account for ~80% of future medical expense in a CKD population

	Prioritized Count	Clinical Rationale
Medication Avoid	[x]	NSAIDs: Stage 4/5 with ≥1 NSAID Rx with supply totaling ≥14d Stage 3 with ≥2 NSAID Rx's with supply totaling ≥28d
	[x]	Other medications: Nephrotoxic Rx or Rx's with risk of harmful accumulation requiring avoidance in CKD or Rx's with risk of harm in certain conditions
Statin Adherence	[x]	Priority 1: Refill >7 days overdue Admission for ASCVD, CHF, PAD, and/or stroke in last 12m
	[x]	Priority 2: Refill >7 days overdue Missed 15+ days of statin therapy during CY Does not have 90-day Rx
	[x]	Priority 3: Refill >7 days overdue Missed 15+ days of statin therapy during CY Has 90-day or more Rx
ACE/ARB Adherence	[x]	Priority 1: Refill >7 days overdue AKI admission in last 12m
	[x]	Priority 2: Refill >7 days overdue Missed 15+ days of ACE/ARB therapy during CY Does not have 90-day Rx
	[x]	Priority 3: Refill >7 days overdue Missed 15+ days of ACE/ARB therapy during CY Has 90-day or more Rx
Diabetes Adherence	[x]	Priority 1: Refill >7 days overdue Diabetes-related admission in last 12m
	[x]	Priority 2: Refill >7 days overdue Missed 15+ days of diabetes medication therapy during CY Does not have 90-day Rx
	[x]	Priority 3: Refill >7 days overdue Missed 15+ days of diabetes medication therapy during CY Has 90-day or more Rx

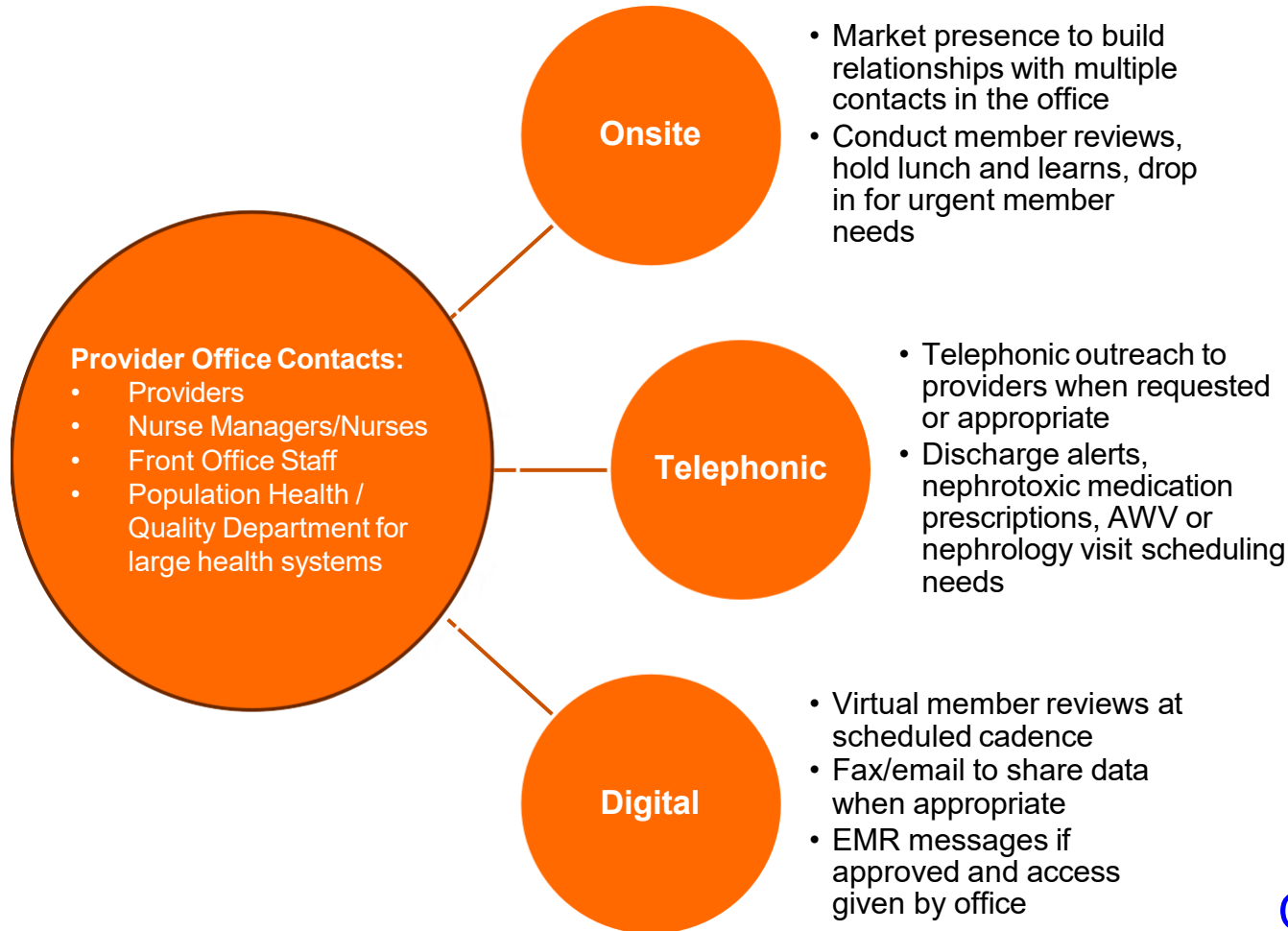
Overview of Highest Impact Opportunities

High impact opportunities are primarily concentrated on ~30% of KHM membership expected to account for ~80% of future medical expense in a CKD population

	Prioritized Count	Clinical Rationale
Annual Wellness Visit	[x]	Priority 1: No AWV in the calendar year and 5 or more HCC's outstanding from last year
	[x]	Priority 2: No AWV in the calendar year, 3 or more HCC's outstanding and high likelihood of missing an AWV this year
	[x]	Priority 3: No AWV in the calendar year and high likelihood of missing AWV this year
Nephrology Referral	[x]	Priority 1: Stage 5 with no visit in 6m CKD Stage 4 with no visit in 12m Stage 3 with no visit in 12m AND eGFR decline $\geq$ 5mL/min, UACR > 300mg/g, glomerular disease, OR age <50 years
	[x]	Priority 2: Stage 5 with no visit in 3m CKD Stage 4 with no visit in 6m
	[x]	Priority 3: CKD Stage 3 with no visit in 12m AND prior high-risk renal dx (e.g., polycystic kidney, hepatic or cardio renal syndrome, interstitial nephritis, nephrolithiasis, sickle cell disease, pregnancy, etc. in last 12m)
Cardiology Referral	[x]	Priority NA: No cardiology visit in last 12m Admission in last 12m for coronary or peripheral revascularization, MI, or CHF Clustered HFrEF probability $\geq$ 25% Medication addition opportunity for statin, antiplatelet or GDMT
Statin Medication Utilization	[x]	Priority 1: Admission in last 12m for ASCVD (coronary or peripheral revascularization), CHF, or stroke Medication addition opportunity for statin age < 90y
	[x]	Priority 2: Medication addition opportunity for statin age < 90y
ACE/ARB/ARNi Medication Utilization	[x]	Priority 1: Stage 3-4 with DM or HTN with AKI admission in last 12m no ACE/ARB in past 12m age <90y
	[x]	Priority 2: Stage 3-4 with DM or HTN and no ACE/ARB in past 12m Stage 3-5 with HF and no ACE/ARB/ARNi in past 12m age <90y
Antiplatelet Medication Utilization	[x]	Priority NA: MI in the last 12m or PCI in the last 6m Medication addition opportunity for antiplatelet

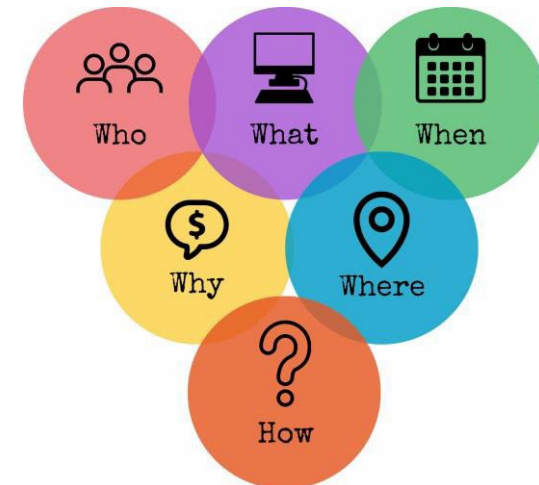
QUESTIONS?

Provider Engagement



Providers Choice

We will meet you when, where, and how you need it most



Christina Schweizer
Clinical Care Manager

Christina.Schweizer@healthmapsolutions.com



**THANK
YOU**

Rewarding Better Health for Medicaid and Medicare Members

Rosalind W. Jenkins

Manager, Provider Education & Training



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Sentara Health Plans Medicaid Member Incentives 2026

Call provider services at
757-552-7474 or 1-800-229-8822
Option 2
8 a.m. to 6 p.m.
Monday through Friday

Sentara Health Plans Medicaid incentives	Value	Description
Adolescent immunizations	\$15	Children turning 13
Child and adolescent well visit	\$25	Ages 3-21
Childhood immunizations	\$15	Children turning 2
Diabetic HbA1c test	\$10	Members with diabetes, ages 18-75
Diabetic eye exam	\$25	Members with diabetes, ages 18-75
Adult wellness exam	\$50	Ages 19-64
Colorectal cancer screening	\$15	Ages 45-75
Controlling high blood pressure	\$10	Members with hypertension, ages 18-85
Covid-19 vaccine	\$25	Ages 18+
Flu vaccine	\$10	Ages 18+
Pneumonia vaccine	\$10	Ages 50+
Breast cancer screening (mammogram)	\$15	Females, ages 40-74
Cervical cancer screening (pap test)	\$15	Females, ages 21-64
Prenatal care	\$150	Females, visit within first trimester, or within 42 days of enrollment
Postpartum care	\$150	Females, visit within 7-84 days after delivery
Welcoming Baby program incentives	Value	Description
Welcoming Baby - Initial screening	\$20	Welcoming Baby is an incentive-based program that provides guidance, support, and education to members who are pregnant and who have just given birth.
Welcoming Baby - Complete program	\$20	
Welcoming Baby - Follow-up prenatal or postpartum screening	\$10	

Members can earn one reward per service per plan year. Services must be completed in 2026 using in-network providers and facilities.

Sentara Health Plans Medicare Healthy Rewards 2026

Call provider services at
757-552-7474 or 1-800-229-8822
Option 2
8 a.m. to 6 p.m.
Monday through Friday

Preventive screening, exam or vaccine	Reward	Who is eligible?
Annual wellness visit	\$100	All members
Combined with annual physical exam	+\$20	
Breast cancer screening	\$20	All members
Colorectal cancer screening	\$20	All members
COVID-19 vaccine	\$10	All members
Diabetic A1c test	\$15	All members with diabetes
Diabetic eye exam	\$20	All members with diabetes
Diabetic kidney test	\$10	All members with diabetes
Fall risk assessment ¹	\$15	All members
Flu Vaccine	\$10	All members
In-home assessment ²	\$25	All members

Learn More

Medicaid and Medicare Incentive Programs

Scroll down to the Member Benefit Education Aids heading

<https://www.sentarahealthplans.com/en/providers/provider-support/close-care-gaps>

Medicaid Added Benefits

<https://www.sentarahealthplans.com/en/members/medicaid/medicaid-benefits-programs-and-services>

Medicare Extra Benefits

<https://www.sentarahealthplans.com/en/members/medicare/using-your-extra-benefits>

Provider Spotlight – New River Valley Pediatrics

Lee Cox, MSN, RN

Practice Manager, New River Valley Pediatrics

Dawn Gunn

Manager, Marketing Development Outreach



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New River Valley Pediatrics

- Located in New River Valley – Offices in Radford and Blacksburg
- Founded in 1952
- Currently have 9 physicians
- Service 10 surrounding counties
- Open 7 days a week

Project Information

- Challenge was to reduce the number of no-show appointments. This enhances care for our patients and closes care gaps.
- Focus was on preventative care and medication management visits.
- Over a 6-month period, we sent information on 45 patients to Sentara and 22 of those patients were rescheduled and seen in our office.

Process

- No-shows reviewed daily from previous day.
- Demographics with patient information, including insurance, appointment type and date/time collected.
- Took less than 2 minutes per patient to gather and print needed information.
- Information sent to Sentara on a weekly basis.
- Benefit in patients/families hearing from health plan as opposed to provider office regarding importance of preventative visits and disease management appointments.

Medical Assistant Member Outreach



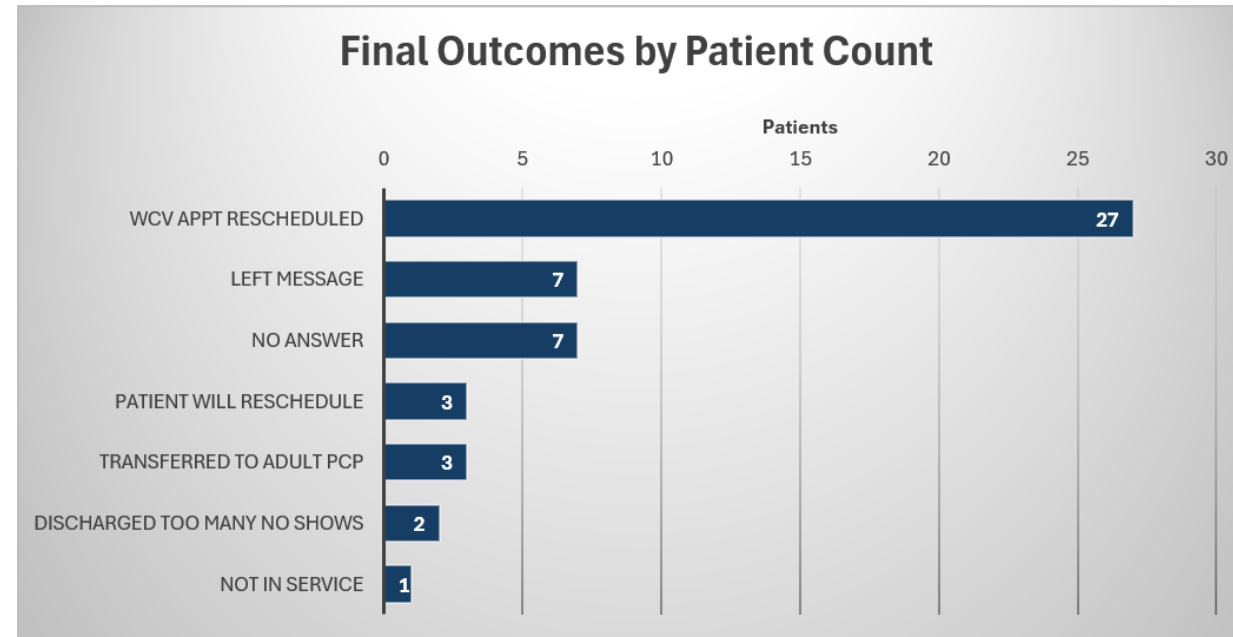
Member Support Approach

- Build trust through attentive, responsive support
- Listen to concerns and identify gaps in care
- Connect members to resources
- Remain available for follow-up

Key Responsibilities

- Welcome new members and review plan benefits
- Show members how to use their benefits
- Confirm each member has a Primary Care Provider
- Help schedule the Annual Wellness Visit
- Introduce members to their Case Manager
- Complete the Health Risk Assessment

Medical Assistant Member Outreach



Member Outcomes

- Patients responded favorably to the outreach
- Help with rescheduling was welcomed by patients
- Guidance covered attending appointments and calling the facility right away when one is missed
- The education provided was recognized by members
- A direct facility contact was secured, easing collaboration between the Health Plan and the facility for patient care.

Medical Assistant Member Outreach



Contact Information



Phone: 833-673-2169
Monday-Friday 8am-
4:30pm

How Can Sentara Health Plans Help You?

Ebony Franklin
Network Relations Manager

1. Sharing Care Gap Reports frequently
2. Financial Incentives available for members
3. Scheduling Member Appointments
4. Providing Educational Resources and Documents
5. Support Visits



Care Gap Closure Best Practices



1

Use appropriate documentation and correct coding

2

Maintain appointment availability for patients with recent emergency department visits

3

Amplify multiple HEDIS measures by educating on the importance of effective and consistent healthcare

4

Provide personalized messages for appointment reminders and follow-up appointments

5

Encourage follow-up visits via telehealth when appropriate to the principal diagnosis

6

Submit claims and encounter data timely

Join the Provider Quality Learning Collaborative Monthly

February – November
12-1 p.m.

Visit the Care Gaps page for related resources

<https://www.sentarahealthplans.com/en/providers/value-based-care>

Support Visits



- Outreach will be made to coordinate a site visit or virtual visit within the coming months
- Review EMR access options
- Medical record review
- Identify and address questions/barriers

*To request a support visit sooner,
please contact us at
emfrankl@sentara.com*

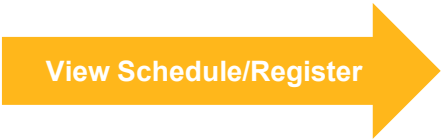
Provider Education - 2026

Provider Newsletter Schedule

Edition
Winter (January)
Spring (April)
Summer (July)
Fall (October)

- **Provider Quality Care Learning Collaborative: 12 - 1 p.m.**
 - October 7 – Congestive Heart Failure, Asthmas and Diabetes management and prevention plans
 - November 4 – HEDIS measure updates and outreaching DSNP members to close gaps in care
- **Let’s Talk Behavioral Health: 1 - 2 p.m.**
 - November 10

- **New Provider Orientation**
 - September 16, 24
 - October 8, 14 and 20



- **Claims Brush Up Clinics: 1 – 1:30 p.m.**
 - September 23
 - December 16
- **Appeals, Reconsiderations and Contestment Process: 1 – 1:30 p.m.**
 - October 7

Register Today 😊

[View Schedule/Register](#)



October 7th This session equips providers and clinical staff with evidence-based approaches to managing congestive heart failure, diabetes and asthma. Led by our integrated care management team, it reviews risk stratification and preventive care planning for patients with these chronic conditions. Documentation and coding requirements will also be reviewed.

November 4th This session provides an update on current HEDIS quality measures and their documentation and coding requirements. Participants will also learn how the health plan engages members to support your practice in identifying and closing potential gaps in care.

As value-based care and care gap closure practices increasingly influence healthcare, we encourage your participation in these educational sessions to build your knowledge and confidence with the related terminology and best practices.

Let's Talk

Any questions you want to ask?

Any challenges you would like to discuss?

Any successes you would like to share?



Appendix

Helpful Resources



CAHPS Resources

CAHPS Resources

Patient Experience Matters

Patients who are satisfied are more likely to adhere to treatment plans.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3262489/>

Patients who feel heard and respected are empowered.

<https://www.wolterskluwer.com/en/expert-insights/why-patient-empowerment-matters>

Patients who have a strong provider relationship are loyal.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4732308/>

Patients who are treated with dignity have a greater sense of well-being.

<https://www.aafp.org/pubs/fpm/issues/2007/0100/p33.html>

Centers for Medicare & Medicaid Services (CMS) Patient Experience Surveys

Consumer Assessment of Healthcare Providers & Systems (CAHPS)

<https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems>

Medicare Advantage and Prescription Drug Plan CAHPS

<https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/medicare-advantage-and-prescription-drug-plan-cahps>

CAHPS Scripts for Improved Patient Experience

"If you ever need a sooner appointment, call us — we'll get you in as quickly as possible."

"We hold same-week spots. Just ask and we'll help you get in."

"You can also see one of our nurse practitioners or do a telehealth visit to be seen sooner."

"If the online schedule looks full, call us — we can often fit you in."

"Let me make sure I understand... [reflect back what patient said]."

"Thank you for sharing that — it's important."

"I hear what you're saying. Let's work through this together."

"Your perspective matters. Let's make a plan that fits what's important to you."

"You'll get your results in __ days. If you don't hear from us, please reach out — we always follow up."

"Your results will be posted in the portal with notes from me."

"We'll contact you by phone/portal as soon as everything is back."

"Here's how we'll communicate your results so you know what to expect."

"What questions or concerns haven't we covered yet?"

"Before we finish, is there anything else important to you today?"

"What else can I answer while we're together?"

"I want to be sure you leave with everything you need — what else can I clarify?"

"Let me look at your recent tests and visits so we stay aligned."

"I see you saw a specialist — here's how that fits into your plan."

"Here's the plan and who will follow up with you next."

"Tell me in your own words what our plan is — I want to be sure I explained it clearly."

"I want to make sure we're on the same page."

"That makes sense — thanks for telling me."

"I can see why that would be concerning. Let's talk through it."

"I'm here with you, and we'll take this one step at a time."

"I want to be sure I fully understand your concerns."

HEDIS/Quality Resources

Year End Measurement Year 2025

- HEDIS Department Processed > **20,000** Medical Records in an effort to close the Gaps In Care for our members

Time to Prepare for HEDIS® Medical Record Review

- For HEDIS MY2025, we will begin requesting medical records in February 2026
- No special authorization is required to share member medical record information with us, as HEDIS is a Quality Improvement (QI) initiative and a routine part of healthcare operations
- If you have any questions, please contact Sentara Health Plans Quality Improvement Office at 757-252-8400 or 844-620-1015

What's New for HEDIS MY2026

New Measures

Risk Adjusted Utilization Measures:

- Acute Hospitalizations Following Outpatient Orthopedic Surgery (HFO)
- Acute Hospitalizations Following Outpatient General Surgery (HFG)
- Acute Hospitalizations Following Outpatient Colonoscopy (HFC)
- Acute Hospitalizations Following Outpatient Urologic Surgery (HFU)

Intent: *To ensure Health plans provide proper care coordination during the critical post-surgical period.*

Changes to Existing HEDIS Measures:

*NCQA retired the Administrative and Hybrid reporting methods for following measures. **Only the ECDS reporting method will be used.***

- Lead Screening in Children (LSC-E)
- Statin Therapy for Patients With Cardiovascular Disease (SPC-E)
- Statin Therapy for Patients With Diabetes (SPD-E)

Retired Measures:

- Asthma Medication Ratio (AMR)
- Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

Annual Wellness Visit (AWV)

The purpose of the Annual Wellness Visit is for providers to develop or update a member's personalized prevention plan based on their current health and risk factors.

HCPCS Codes for AWV:

- **IPPE “Welcome to Medicare” visit:** G0402
- **Initial Annual Wellness visit:** G0438
- **Subsequent Annual Wellness Visit:** G0439

Care for Older Adults (COA)

The percentage of persons 66 years of age and older who had both of the following during the measurement period:

- Medication Review
- Functional Status Assessment

CPT /CPT Cat II Codes for COA:

Medication review: 1160F, 90863, 99483, 99605, 99606

Medication list: 1159F

Transition care management: 99495, 99496

Functional Status Assessment: 1170F, 99483

HEDIS Hybrid Measure Issues and Actions for Compliancy-Adult

Measure	Issues Impacting Compliance	Actions to take
ALL MEASURES	- Medical records do not have a name and DOB or MRN on every page, so oftentimes unable to verify that the medical record belongs to the same member - Hand-written documentation in medical records is often difficult to interpret	- Need name and DOB or MRN clearly documented on every page - Switch from hand-written documentation to an electronic (typed) version
BPD/CBP - Blood Pressure-Diabetes - Controlling High BP	- Lack of documentation for BP re-takes when BP elevated - Lack of documentation of BP value or "average" value during a telehealth or telephone visit	- Recheck BP if > 140 and/or >90, document original and retake - During telehealth visits document BP taken by member with a digital device or average BP (no ranges)
COA Care of Older Adults	- Functional status assessment not including enough ADLs/IADLs - Medication Review – Only including the code for the presence of a medication list	- Need to document at least 5 ADLs and/or 4 IADLs - Need to include the second code that indicates a medication review took place
EED Eye Exam - Diabetes	No documentation of details on last diabetic eye exam	Need documentation of retinal/dilated eye exam by an eye care professional (who the professional was), the date and the results
PPC Prenatal/Postpartum Care	Lack of pregnancy diagnosis for confirmation of pregnancy visit with PCP	Need positive pregnancy test, as well as diagnosis of pregnancy
TRC Transitions of Care	- No documentation of when provider is notified of member's hospital admission and/or when provider receives member's DC summary - Follow up after inpatient admission - lack of documentation stating admission or inpatient stay along with hospitalization dates	- Need documentation of the date when provider is notified of member's inpatient admission and when DC summary is received along with provider signature or initials - Include documentation that references visit for "hospital follow-up", "admission", "inpatient stay" along with dates of admission

Childhood Measures - Issues and Actions for Compliancy

Measure	Issues Impacting Compliance	Actions to Take
CIS-E - Childhood Immunization Status	• Immunizations given after 2nd birthday • Missing documentation of complete series of immunizations given	• Monitor for when the 2nd birthday will occur and coordinate visits so that all vaccines will occur by 2 years of age • Inquire where immunization occurred if not within your records
WCV - Child and Adolescent Well-Care Visits	• Use of appropriate codes • Appropriate provider/visit type	• Recommended CPT Codes: 99381–99385, 99391–99395, 99461 • Recommended ICD-10 Codes: Z00.00–Z00.01, Z00.110–Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1–Z76.2 • PCP or OB/GYN • Telehealth visits no longer allowed

EMR Access

Do you struggle with HEDIS season?

Our HEDIS team can pull the records for you by granting us EMR access.



Useful Contacts

Frequent Sentara Health Plans Contacts – Members

Department	Contact
Care Management	DL_SHP_MCM_MGR@sentara.com 757-552-8360 or 1-888-512-3171 Monday – Friday; 8 a.m. – 5 p.m.
Behavioral Health	757-552-7174 or 1-800-946-1168
Welcoming Baby	<u>welcomingbaby@sentara.com</u> 1-844-671-2108 (TTY: 711) Monday – Friday; 8 a.m. – 5 p.m.
24/7 Nurse Advice Line	Medicaid: 1-833-933-0487
Behavioral Health Crisis Line	1-833-686-1595 (TTY: 711) 24 hours per day; 7 days per week
Member Services	<u>members@sentara.com</u> 757-552-7401 or 1-877-552-7401 Monday – Friday; 8 a.m. – 5 p.m.

Frequent Sentara Health Plans Contacts – Quality

Team Member	Contact Information
Shanshan Hu, Ph.D., SSBBP Director, HEDIS, Data Management & Quality Analytics	(804)613-5755 sxhu@sentara.com
Anita Grant, BSN, RN Manager, Quality HEDIS	804-613-5512 asgrant@sentara.com
Jacqueline Chamberland, M.Ed., RN Supervisor, Quality HEDIS	804-613-5811 jlchamb1@sentara.com
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Jennifer J. Williams, BSN, RN Senior Quality Improvement Coordinator	757-252-8418 jjwillia@sentara.com

Things to Consider to Improve Quality Gap Closure

Early Visits

Staff calls all patients on gap files without AWW or wellness visits to avoid last minute access issues.

Pre-visit Planning

Include orders in chart in advance

Make note of labs, etc. needed to keep at provider's fingertips

<https://edhub.ama-assn.org/steps-forward/module/2702514>

Daily Huddle

5-minute touch point to run through the patients and point out any gaps

Pre-identify challenging patients to plan time accordingly

Boosts productivity and teamwork

<https://edhub.ama-assn.org/steps-forward/module/2702506>

Templates

Creating EMR templates and rooming protocol

Ask about all quality components and record dates of completion

Record where things were done so you can retrieve records

EMR

Use to highest capacity, ex. alerts, auto order labs, result notifications, standing orders for care team

Grant EMR access to health plan

Billing & Member Incentives

Use NCQA recommended billing codes

Encourage patients to learn their plan's incentive programs

Resources

Care Gap Closure Resources [Value-Based Care](#) | [Providers](#) | [Sentara Health Plans](#)

[Annual Wellness visit and Annual Routine Physical Exam](#)

[Comprehensive Care Gap Documentation Guide 2026](#)

[SHP-HEDIS Measures for 2025](#)

Provider News <https://www.sentarahealthplans.com/providers/updates/newsletters> *most recent provider alerts and Newsletter*

Sentara Mobile Care [Get the Sentara Health Plans Mobile App](#) | [Members](#) | [Sentara Health Plans](#) *members access to health plan information*

Provider Tool Kit [Provider Toolkit](#) | [Providers](#) | [Sentara Health Plans](#)

Provider Manuals [Provider Manuals and Directories](#) | [Providers](#) | [Sentara Health Plans](#)

Medical Policies [Medical Policies](#) | [Providers](#) | [Sentara Health Plans](#) | [Sentara Health Plans](#)

Prior Authorization Tool to review if authorization is required [Search PAL List: Sentara Health Plans](#)

Jiva Tutorial / Demo [JIVA Resources](#) | [Providers](#) | [Sentara Health Plans](#) | [Sentara Health Plans](#)

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