



Provider Quality Learning Collaborative

March 4, 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
- CAHPS
- Clinical Documentation Tips
- Connecting Our Members to Sentara Health Plans Resources
- HEDIS/Quality: Medical Records Best Practices
- How Can Sentara Health Plans Help You?
- Q & A
- Closing Remarks

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Lindsay Lopez

Medicare Stars Program Manager



CAHPS Patient Experience Survey

Each year, the Centers for Medicare & Medicaid Services (CMS) conducts the CAHPS survey to gather feedback from a random sample of adult and pediatric health plan members. This survey focuses on your **patients' experiences with their healthcare providers** and their access to care.



✓ Improving patient experience has many benefits.

- Increase patient retention and loyalty.
- Increase engagement and compliance with treatment recommendations.
- Improve health outcomes.

<https://pubmed.ncbi.nlm.nih.gov/9752374/>

CAHPS Questions and Provider Tips

Care Coordination	Doctors who Communicate Well	Getting Appointments and Care Quickly	Rating of Personal Doctor
In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?	In the last 6 months, how often did your personal doctor show respect for what you had to say?	In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?
Provider Tip	Provider Tip	Provider Tip	Provider Tip
Tell every patient exactly how and when you will deliver their test results <u>before they leave the visit.</u>	Use the "Respect Loop" - Listen Fully, Reflect Back, and Validate the patient's perspective.	Clearly tell every patient exactly how to get a sooner appointment <u>before they leave the visit.</u>	End every visit with a clear, personal "Closing Loop" statement. <i>Before we finish, is there anything else you were worried about or wanted to make sure we covered today?</i>

Clinical Documentation Tips

Naidelys Rodriguez

Manager, Clinical Coding



Documentation Tips

Specificity: Documentation must be specific as possible to code to the highest level of specificity in ICD-10. Examples:

- Active
- Stable
- History of
- Controlled
- Uncontrolled
- Remission status (Partial/Full)
- Under surveillance
- Complications
- Exacerbation
- Cause and Effect
- Manifestations
- Late effects (sequela)
- Trimester of pregnancy
- Associated conditions

Key reminder: Avoid contradictions within the same encounter.

Provider Documentation Tips

- **Be Specific with Acuity and Type:**

- **Diabetes:** Focuses on specificity (e.g., Type 1 or 2), short-term complications (ketoacidosis, hyperosmolarity), long-term complications, and uncontrolled status.

The "**With**" in ICD-10, implies a causal relationship. For example, "Diabetes with Kidney Disease" automatically links the two unless you state they are unrelated.

- **Asthma:** Specify type (intermittent vs. persistent), severity (mild, moderate, severe), and frequency. **Status Asthmaticus:** if a patient fails to respond to initial treatment, documentation must reflect "status asthmaticus" rather than just "exacerbation" to support higher severity.
- **COPD/CHF:** Document "Acute," "Chronic," or "Acute on Chronic" to accurately reflect the patient's status.
 - **Documentation Examples:**
 1. A patient is on Lasix for CHF – documentation should state "compensated CHF; stable on Lasix" instead of "History of CHF".
 2. A patient is on Advair for COPD - documentation should state "COPD controlled with Advair".

Documentation Tips

Be Specific with Type:

- Acute
- Chronic
- Intermittent
- Persistent

Be Specific with Frequency:

- Single episode
- Recurrent episode

Be Specific with Severity:

- Mild
- Moderate
- Severe

Be Specific with Alcohol/Drug:

- Use
- Abuse
- Dependence

Be Specific with Stages:

- CKD:
 - Stage: 1, 2, 3, 4, 5 and ESRD (Avoid contradictions).

Be Specific with type of Ulcer & Stages:

- Pressure/Non-Pressure
- Stage 1, 2, 3, 4 and Unstageable or Deep tissue pressure injury. (Avoid contradictions).

Key Takeaway:

If it is not documented, it cannot be reported, managed, or accurately reflected in risk adjustment.

Provider Documentation Tips

Clinical Conditions Frequently Linked to Documentation Deficiency

Complicate conditions such as:

DM with or W/O complication
CKD with progression of Stages
CHF (Types-Classifications)

Support:

Malignant Neoplasm
Secondary Malignant Neoplasm (Sites)
Morbid Obesity

Acute conditions such as:

CVA (Sequalae)
Myocardia Infarction (MI) date of onset
Embolism (PE)

Specification:

Depression (severity)
DVT (Chronic/Acute)
Dementia (Type/Severity)

Connecting Our Members to Sentara Health Plans Resources

Allison L. Raines, DO MBA MPH FACEP

Senior Medical Director
Chief Medical Officer Medicaid

Valerie Hicks, MD FAAP

Lead Pediatric Medical Director

- Sentara's Mission
- Collaborative Partnerships
- Improving Health Outcomes
- Clinical Efficiency Measures
- Case Management Program Overview
- Disease Management Resources



Our Mission

We improve health every day



Our Purpose

Sentara exists to be the trusted partner to individuals and the community in their journey to health and well-being

Our Values

People, Quality, Patient Safety, Service and Integrity

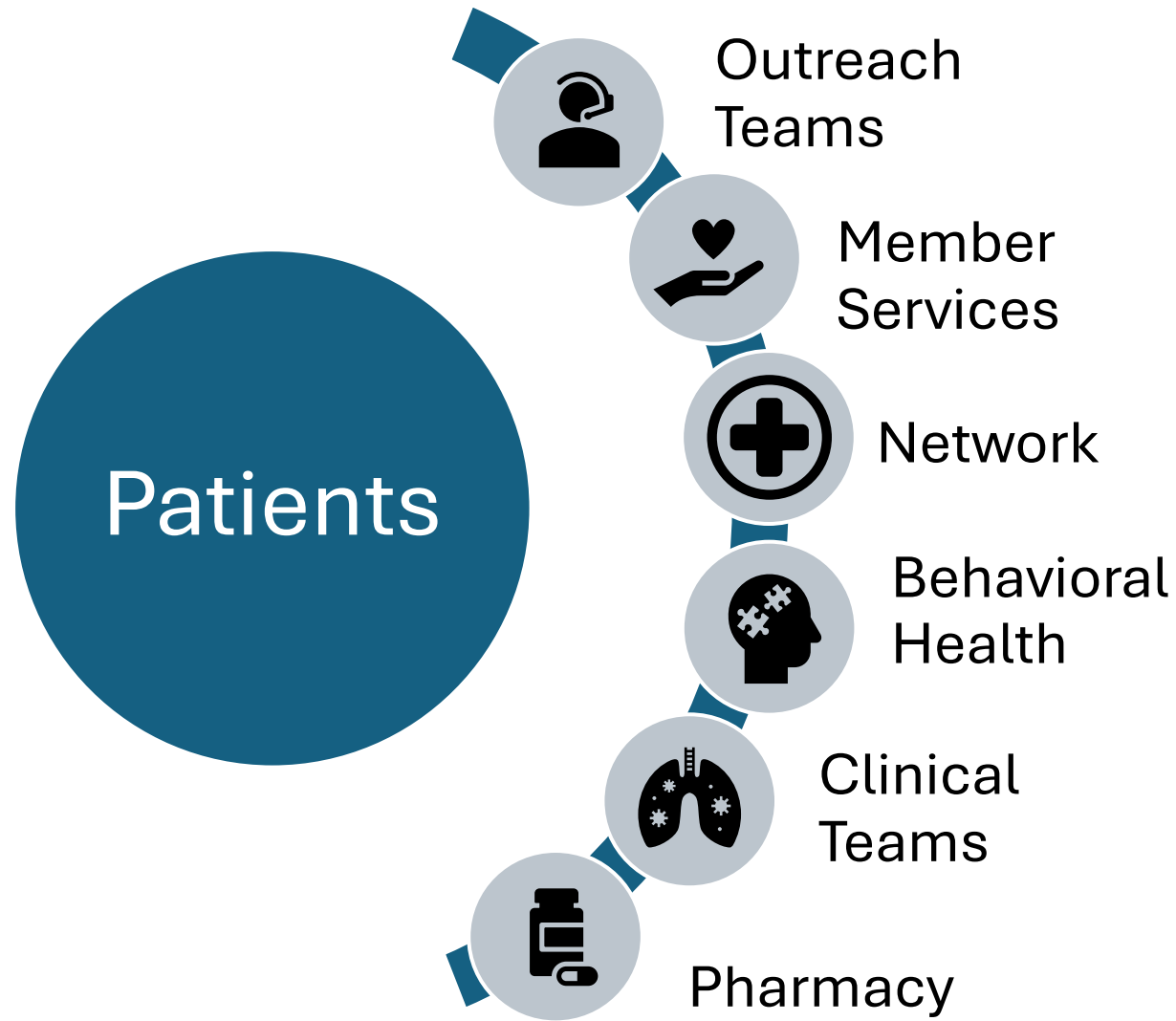
Sentara Commitments

At Sentara, we are committed to:

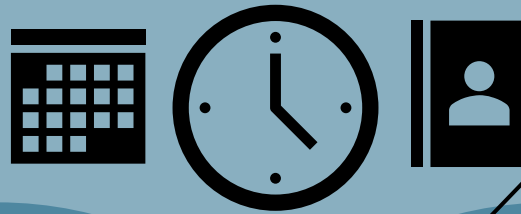
- ALWAYS keep you safe
- ALWAYS treat you with dignity, respect, and compassion
- ALWAYS listen and respond to you
- ALWAYS keep you informed and involved
- ALWAYS work together as a team to provide you quality healthcare

Quintuple Aim





Access



Clinical Efficiency Programs

Low Acuity Non-Emergent ER Visits
Preventable Readmissions
Avoidable Admissions

Improved Health Outcomes

HEDIS Gaps & Quality Measures

Diabetes, HTN, Asthma, COPD, CHF
Prenatal & Postpartum Care
Behavioral Health Services
Annual Well Child Visits



Engagement



Quality

Clinical Efficiency Programs

Department of Medical
Assistance Services



“Reducing preventable, avoidable, and unnecessary utilization through better care management.”

Potentially Preventable
Emergency Department
Visits

Potentially Preventable
Admissions

Potentially Preventable
Readmissions

Proactive case management
and disease education.

High quality outpatient
treatment and disease
management.

Coordination between
settings and support for
patient self-management.



1. Intake & Assessment

Member intake and eligibility screening
Comprehensive needs assessment
Risk and safety assessment

2. Care Planning

Development of individualized care plans
Prioritization of needs and interventions

3. Coordination & Referral

Interdisciplinary team meetings
Referral to appropriate services and programs
Coordination with providers and community resources
Scheduling appointments and services

4. Advocacy

Patient advocacy within systems and services
Assistance with benefits and accommodations
Support during transitions

5. Implementation

Facilitation of service delivery
Patient education and health coaching
Skill-building and self-management support

6. Monitoring & Follow-Up

Ongoing disease monitoring
Outcome measurement and reassessment
Adjustments and updates to care plans
Regular patient check-ins

7. Advanced Care Planning

Goals of Care
Crisis and contingency planning

8. Transition & Discharge

Transition planning
Continuity-of-care coordination
Discharge planning and follow-up

Case Management Programs Overview



Community Health Social Workers

Our Community Health Social Workers promote health and improve access to services. They engage in a variety of activities ranging from health education and advocacy to outreach. This includes providing information about disease prevention, helping individuals navigate healthcare options, linking residents to needed services, while conducting screenings and basic health assessments.



Case Management

Case management is a collaborative, patient-centered process that assesses, plans, and coordinates care to improve health, social, and functional outcomes. This team is designed to help individuals achieve optimal wellness and functional capability while navigating the healthcare and social service systems.





Complex Case Management

Focus on High-Risk Members

This program focuses on high-risk individuals facing conditions like COPD, CHF, diabetes, and asthma. With personalized assessment and care planning, registered nurses provide continuous support to enhance patients' health outcomes.



High Risk Pediatrics

This team supports our high-risk pediatric members. Care managers coordinate with providers, schools, and social services to ensure preventive care, address social needs, support development, and help caregivers navigate complex systems for better long-term outcomes.



Maternal & Infant Care

Welcoming Baby

Supporting mothers and their infants, this program provides essential resources including prenatal and postpartum care, substance use treatments, and access to community services to ensure healthy outcomes for both baby and mother.

NICU Program

Care managers guide families through their baby's condition, coordinate care, and ensure follow-up with specialists. Partnering with Progeny, they assess the baby's health, family needs, and home setup to create a personalized care plan, supporting a smooth transition home and healthy development.

Long Term Care Programs

Long Term Services & Supports

Supports LTSS members with PDN, ventilator care, and personal care services. Case managers promote independence, coordinate care, connect to resources, monitor health, track service effectiveness, and support care transitions to improve quality of life.

Nursing Facility Program

Collaborate with providers and families to create personalized care plans, monitor health, prevent hospital visits, and support care transitions. Connect members to behavioral health, therapy, and community resources to enhance well-being.



Transitional Care Coordinators

Transitional Care Coordinators support patients and families as they transition from hospitals or rehabilitation facilities to home or other care settings. They coordinate care among multiple providers to ensure that patients move safely and effectively between care settings, reducing hospital readmissions and improving overall patient outcomes.





Behavioral Health Navigators

Our Behavioral Health Navigators are trained to help connect members to mental health resources. They identify local services which best fit individual needs, coordinate appointments, and collaborate with treatment teams.

Healthy Habits, Healthy You



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Healthy Habits, Healthy You

Healthy Habits, Healthy You is a diabetes and heart disease prevention program.

Take steps to prevent diabetes and heart disease by making healthy food choices, losing a small amount of weight and moving more every day. Find ways to keep calm during your day to lower your stress.

Interact with "[Healthy Habits, Healthy You: A Diabetes and Heart Disease Prevention Program](#)" to learn more about this program.

Make Healthy Food Choices

- Make half of your plate vegetables and fruits.
- Choose 100% whole grains like whole wheat bread, oats and brown rice.
- Cut back on high-fat foods like whole milk, cheeses, and fried foods.
- Try grilled chicken or salads at fast food restaurants instead of a cheeseburger or pizza.
- [Select from a collection of healthy recipes](#).
- [Learn more about healthy eating from the "Eating for Life" program.](#)

Manage Your Weight

- Put less food on your plate.
- Try not to skip meals.
- Use a smaller plate, bowl, and glass.

Manage Your Weight

- Put less food on your plate.
- Try not to skip meals.
- Use a smaller plate, bowl, and glass.
- Read the food labels on packages.
- [Visit \[www.ChooseMyPlate.gov\]\(http://www.ChooseMyPlate.gov\) to create a daily meal plan.](#)

Be Active

- Try to be active for at least 30 minutes, 5 days a week. Up to 60 to 90 minutes daily may be needed for weight loss.
- Walk in a safe place like the mall or at community centers.
- Dance and turn up the music when doing household chores.
- March in place while you watch TV.
- [Learn more about the MoveAbout program and exercise DVDs.](#)

Cut Back on Foods High in Sugar, Fat, and Salt

- Drink water instead of juice, sweet tea or regular soda.
- Cut back on candy, pastries, and desserts.
- Keep a healthy snack with you, like fresh fruit, a handful of nuts, or whole grain crackers.
- Choose lean meats and poultry without skin, and cook by grilling, baking or broiling.
- Reduce daily sodium intake to less than 2,300 milligrams (mg).
- Use oils to replace shortening and butter.
- Season with onion, garlic, peppers, fresh herbs instead of salt, bacon or cured meats.

Find Ways to Relax and Get More Sleep

- Try deep breathing, taking a walk, or listening to your favorite music.
- Aim for 7 to 9 hours of sleep daily. Avoid caffeine, nicotine or alcohol several hours before going to sleep.
- Think before you eat. Try not to snack when you are bored, upset, or unhappy.
- Avoid tobacco use.
- Learn more about [Guided Meditation](#) and [Tobacco Cessation programs](#).

This information is intended for individuals who are 18 years and older only and those living in the Sentara service areas.

Mental Health & Well-being



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Home > Members > Health and Well-being > Mental Health Services

Mental Health Services

Contact us at [757-552-7174](tel:757-552-7174) or [1-800-648-8420](tel:1-800-648-8420) – or your primary care physician – for help finding a mental health provider.



Mental Health

Mental health is an essential part of your complete health experience. You can positively affect your mental health by focusing on your emotional wellbeing and personal growth, as well as building resilience and understanding the impact of viruses on your overall health.



Proprietary and Confidential



Emotional Well-being

There are many resources to strengthen your emotional well-being. Learn how to manage depression, anxiety, stress, and more.

[Improve Your Well-being](#)

Find tools to help you achieve your best health.

[Becoming Mindful Not Mind Full](#)

Webinar on the importance of mindfulness.

[How Music Affects Our Health](#)

How to use healthy sound in your daily routine.

[Diabetes and Depression](#)

A 9-hour program to help with diabetes management.



Personal Growth

Your physical, legal, and financial health can impact one another. When you work on a family budget, understand legal issues, and grow your savings, you can create health in all areas of your life.

[Planting Your Money Tree](#)

Webinar with tools for a better financial wellbeing.

[Budgeting for Healthcare](#)

Video to help you choose the most affordable options.

[Explaining Deductibles, Copayments and Coinsurance](#)

This video makes understanding healthcare jargon easier.

[Health Insurance ABCs](#)

A video on the basics of health insurance.



Building Resilience

Resilience is a skill you can keep improving. Work on yours with the following resources.

[MoveAbout Program](#)

Designed to help you become more active and stay healthy.

[Healthy Habits, Healthy You](#)

Take steps to take care of yourself.

[Tai Chi](#)

These 18 movements teach you to relax mentally and physically.

[Blue Zone Workouts](#)

The world's healthiest populations skip the gym, using daily movement.

[Preventive Health Guidelines](#)

What you can do to protect your health.



Viruses and Your Health

Viruses can affect us mentally, as well as physically. Here are some resources to help you cope with your emotional health before, during, or after an illness.

[COVID-19 Vaccination and Testing Information](#)

Learn about vaccination and testing options.

[Flu and Cold Prevention](#)

The latest information on staying healthy.

[Immunization Schedules](#)

Easily access immunization tables for adults and kids.

[Access Virtual Care](#)

Get care from anywhere, at any time.

Nutritional Support & Eating for Life



Home > Members > Health and Well-being > Prevention and Well-being > Eating for Life

Eating for Life

Eating for Life is a program designed by a registered dietitian nutritionist that gives you the knowledge and skills to eat the right amount and right variety of foods to promote good health.

This program offers a variety of resources to help keep you informed on how to stay healthy.

Watch the videos for helpful tips that will teach you to eat for life.

Meal Planning Activity

Meal planning supports our well-being, both physically and financially.

[Learn how to plan healthy meals.](#)



Eating For Life Program - Introduction



Eating For Life Program - Getting Started



Eating For Life Program - Reduce Sodium
1:18

A video about the importance of reducing your sodium intake.



Eating For Life Program - Nutrition Facts
1:17

A video that informs how to look at nutrition facts and food labels while shopping for healthy food options.



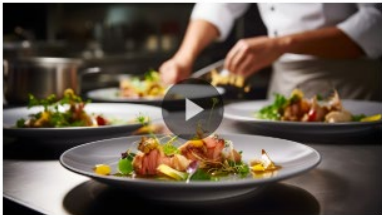
Eating For Life Program - Limit Calories
1:25

A video about the importance of limiting caloric intake as part of a healthy eating regimen.



Eating For Life Program - Physical Activity
0:59

A video that informs about the importance of physical activity in addition to healthy eating.



Eating For Life Program - Healthy Restaurant Choices
47

A video about how to select healthy eating choices while dining out at restaurants.



Eating For Life Program - Grocery Shopping
1:16

A video that informs how to shop for healthy eating at the grocery store.

Asthma Program

Sentara Health Plans Members Providers Employers Brokers



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The Sentara Health Plans Asthma Program

Asthma is a disease of the airways in the lungs that can make it difficult to perform daily activities. The good news is that asthma can be controlled and we're here to help you.

Our program helps our members keep asthma under control. All members with asthma are welcome to participate.

We reach out to members, but you don't need to wait for us to contact you. If you want to participate, please call member services using the number on your member ID card and ask to be connected to a case manager.

The Asthma Management Team is made up of registered nurses, respiratory therapists, and patient service coordinators. The team promotes healthy behaviors, provides education, makes suggestions for optimal treatment, serves as a support system, and answers questions about asthma.

A home health nurse can even visit members at home if they've made repeat hospital visits for asthma. A nurse can help them identify possible triggers in their home and make suggestions to reduce them.

Program Information

Who is part of the Asthma Management Team?

The Asthma Management Team is made up of registered nurses, respiratory therapists, and patient service coordinators. This team will work with you to promote healthy behaviors, provide education about asthma and suggestions for optimal treatment, serve as a support system, and help answer any questions you may have about asthma.

What type of support does the program provide?

The Asthma Management Team will mail members with asthma educational materials and booklets about asthma. When a member has additional needs identified by their doctor or through Emergency Room or inpatient hospital visits for asthma, they will be contacted by a member of the Asthma Management Team on the phone to provide additional education and answer any questions or concerns the member might have. Members who have been to the hospital several times for their asthma will be eligible to have a home health nurse come and visit them in their home to talk about the possible causes for their asthma and make suggestions for changing the home environment to reduce these triggers.



Asthma Information

What You Can Do to Take Control

- Take the [Asthma Control Test™](#).
- Develop an asthma action plan for treating your asthma with your doctor.
- Take your medications and bring them with you when you go to the doctor.
- Get a [flu shot](#) (if recommended by your doctor).
- Learn about the Sentara ["Stay Smokeless for Life"](#) program.
- For children at school:
 - Have an asthma action plan signed by your doctor on file at school.
 - Have an inhaler at school for your child's use, as needed.

Asthma Triggers

An asthma attack can occur when you are exposed to certain things in the environment. Some of the most important asthma triggers and actions you can take to counteract them are listed below.

- Environmental Tobacco Smoke – minimize your exposure to secondhand smoke; smokers should never smoke around persons with asthma or places they inhabit
- Dust Mites and Dust – keep your home clean and clutter-free, use mattress and pillow case covers, and don't use down-filled pillows, quilts or comforters
- Outdoor Air Pollution and Irritants – monitor air quality forecasts and plan activities accordingly; avoid irritants such as perfume, cosmetics, paints, cleaning products, etc
- Cockroach Allergen – keep roach populations under control in your house
- Pets – minimize your exposure to pets, bathe them regularly and keep floors clean
- Mold – keep your home humidity levels low with an air conditioner and/or dehumidifier and fix water leaks
- Emotions – minimize stress and anxiety by using relaxation techniques that work for you
- Exercise – consult your doctor, take your prescribed medications, start gradually and take an active role in controlling your asthma
- Cold and Flu – wash your hands, avoid sick people and get a flu shot, if recommended by your doctor.
- Foods and Additives – avoid foods that trigger attacks and consult your doctor about your diet

Proprietary and Confidential

< Could I Have Severe Asthma?

Take the Asthma Control Test™

The Asthma Control Test™ can help you and your doctor determine whether your asthma is being properly controlled. Share the score with your healthcare provider as a starting point for a conversation about your asthma management goals.

The Childhood Asthma Control Test® is a way to help your child's healthcare provider determine if your child's asthma symptoms are well controlled. Share the results with your child's healthcare provider.

Asthma Control Test is a trademark of QualityMetric Incorporated.
*The Childhood Asthma Control Test was developed by GSK.

Meeting Your Asthma Goals

Though there isn't a cure for asthma, controlling it is possible with the right plan and the help of your asthma support system. It is important to develop your personalized asthma management goals to help control your asthma.

Examples of goals that may be achieved with well-controlled asthma:



Reduced asthma symptoms during the day or night



Reduced limitations in activity or play



Fewer days absent from school or work



Fewer attacks or flare-ups



Reduced emergency room or hospital visits for asthma



Decreased need for quick-relief medicine

Chronic Obstructive Pulmonary Disease



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Chronic Obstructive Pulmonary Disease (COPD)

Facts About Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a serious lung disease that, over time, makes it hard to breathe.

It is the 4th leading cause of death in the United States and causes serious, long-term disability.¹

The number of people with COPD is increasing. More than 12 million people are currently diagnosed with COPD and an additional 12 million likely have the disease and don't even know it.²

What Does Sentara Health Plans Have to Offer?

[Learn about the Sentara Health "Stay Smokeless for Life" program.](#) >

[Get a flu shot \(if recommended by your doctor\)](#) [↗](#)



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Understanding Your COPD Medications

Learn the types of COPD medicines and how they work.



What you need to know about COPD

Find out how COPD affects the airways, what causes it and different types of COPD.



What to do after a COPD diagnosis

Learn important treatment information such as how to use your COPD medicines and develop a COPD action plan.



How to manage COPD in daily life

Understand how to prevent COPD flare ups/exacerbations and manage your daily activities to maintain a good quality of life.



Early Warning Signs of COPD

Don't delay talking to your healthcare provider about respiratory symptoms—early detection may improve your quality of life.

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Congestive Heart Failure

Sentara Health Plans Members Providers Employers Brokers



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Congestive Heart Failure

More than six million adults in the U.S. have heart failure¹, and is the leading cause of hospital admissions for persons over age 65².

Congestive heart failure happens when the heart is not able to pump blood effectively, which can cause your organs to receive inadequate blood, oxygen, and nutrients. Fluid builds up in your body's tissue and can cause increased pressure on your heart.

Congestive heart failure is a [progressive condition](#) that can worsen over time. It's important to work with your physician

Sentara Health Plans can help.

Management and Treatment

Prevent your condition from getting worse:

- keep your blood pressure in a healthy range
- quit smoking, chewing tobacco, or vaping
- monitor your symptoms
- contact your physician if you experience rapid weight changes or swelling
- maintain fluid balance
- limit salt intake
- manage your weight
- take your medications as prescribed
- schedule regular appointments with your physician

My Heart Failure Action Plan

If you notice changes in your heart failure symptoms follow your heart failure action plan. Acting quickly will help you to feel better and stay out of hospital.

A doctor or nurse specialist will develop your heart failure action plan with you. Ask at action plan at each visit.

I feel well

My symptoms:

- Weight on target. Target range _____ kg
- Little or no swelling
- Breathing is easy

What to do:

- Keep taking m
- Keep doing m
- Keep eatin
- Keep mak
- health

I do not feel well

Weight up by _____ kg over 1-2 days

- Swelling in ankles, legs or abdomen.
- Hard to breathe when active or at night
- Need to use more pillows at night
- Constant cough or wheeze
- Very tired

Weight down by _____ kg over 1-2 days

- Dry mouth/skin
- Dizziness

I need to get help now. call 111

My symptoms:

- Sudden, severe shortness of breath
- Angina not relieved after following angina action plan
- Develop new chest pain/tightness/heaviness
- Sweating, weakness or fainting

Heart Foundation

Daily checks

Heart failure symptoms mainly happen because fluid builds up in your body. Do these checks every day to identify when you have extra fluid in your body.

1 Any changes in your weight?

Weigh yourself

- In the morning
- After going to the toilet
- Before breakfast
- Digital scales are best

Compare daily weight to your target weight. Target weight is your weight with no extra fluid, when your heart works best. Your target weight should be written on your action plan.



2 Any swelling?

Check for swelling

Do your rings on your fingers, your waistband or your socks and shoes feel tighter?

Check one leg for swelling

- **Press firmly into the skin** of your ankle, shin and knee with your finger
- If your finger makes a dent in your skin, you have swelling

3 Any changes in your breathing?



More short of breath than usual?



Constant cough or wheeze?



Having difficulty carrying on a conversation?



Using more pillows at night to avoid being short of breath or having to sleep upright?



Note down your daily check information. You may like to use the sheets on the next few pages to get you into the habit of recording this important information.

If you have any changes in your weight, any swelling or changes in your breathing then act quickly and follow your heart failure action plan.

Hypertension

Quick Facts

The blood pumping through your circulatory system is under pressure. Hypertension occurs when the force of the pressure is abnormally high. Your blood pressure normally increases with age, and you are more likely at risk for hypertension once you reach age 45, although it can develop in younger people.

Blood pressure is measured using an arm cuff that is inflated and sensors read the pressure of your blood beating against the arteries, in the form of two numbers. Your systolic pressure is the force in the arteries when the heart beats, and is the higher of the two. The second, diastolic, is the pressure in the arteries when the heart rests between beats. A normal blood pressure reading is about 120/80 for an adult; and it's normal for blood pressure to fluctuate depending on physical activity or emotional state at time of reading.

Elevated blood pressure can cause a lot of problems, including:

- heart failure
- [kidney failure](#) 
- stroke
- vision problems and blindness
- damage to blood vessels
- damage to brain

Risk Factors

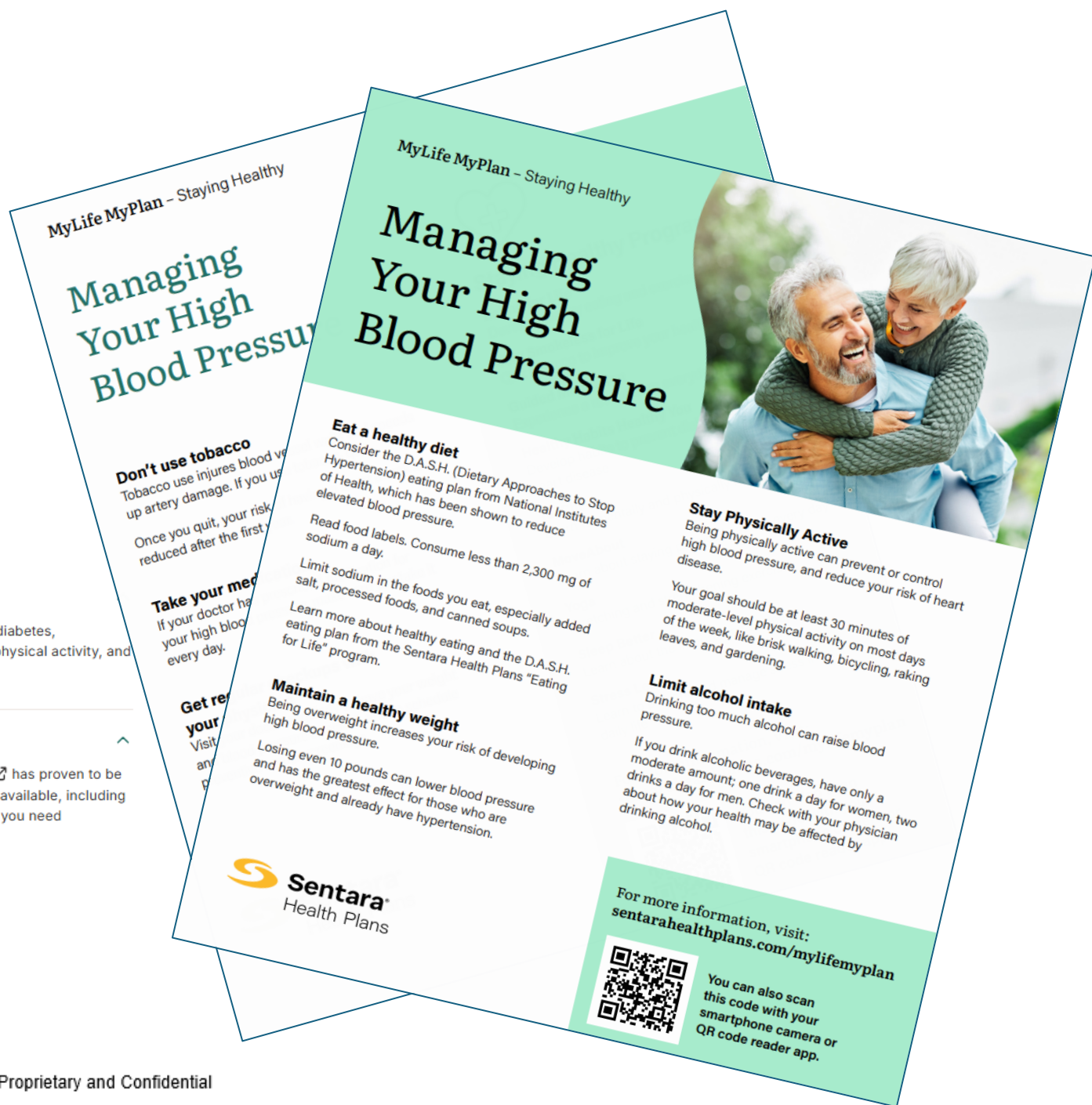
Hypertension can be related to family history, genetics, health conditions like diabetes, medications, or your lifestyle. Excess sodium in your diet, stress, not enough physical activity, and obesity are common risk factors.

Prevention and Treatment

Despite the statistics, hypertension is preventable and treatable. [Medication](#)  has proven to be an effective treatment. There are several types of blood pressure medications available, including diuretics, beta blockers, calcium channel blockers, ACE inhibitors and more. If you need medication, speak with your physician to learn which will work best for you.

You can help prevent hypertension by:

- eating healthy
- getting plenty of exercise
- losing weight
- quitting smoking
- quitting or reducing alcohol intake



MyLife MyPlan – Staying Healthy

Managing Your High Blood Pressure

Don't use tobacco
Tobacco use injures blood vessels and speeds up artery damage. If you use tobacco, quit today. Once you quit, your risk of heart disease is reduced after the first year.

Take your medication
If your doctor has prescribed medication for your high blood pressure, take it every day.

Get regular checkups
Visit your doctor regularly to check your blood pressure.

Eat a healthy diet
Consider the D.A.S.H. (Dietary Approaches to Stop Hypertension) eating plan from National Institutes of Health, which has been shown to reduce elevated blood pressure.

Stay physically active
Being physically active can prevent or control high blood pressure, and reduce your risk of heart disease.

Limit alcohol intake
Drinking too much alcohol can raise blood pressure.

Maintain a healthy weight
Being overweight increases your risk of developing high blood pressure.

Read food labels. Consume less than 2,300 mg of sodium a day.

Limit sodium in the foods you eat, especially added salt, processed foods, and canned soups.

Learn more about healthy eating and the D.A.S.H. eating plan from the Sentara Health Plans "Eating for Life" program.

Losing even 10 pounds can lower blood pressure and has the greatest effect for those who are overweight and already have hypertension.

For more information, visit:
sentarahealthplans.com/mylifemyplan

You can also scan this code with your smartphone camera or QR code reader app.

 **Sentara**
Health Plans

Diabetes Management



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Home > Members > Health and Well-being > Health Conditions > Sentara Health Plans Diabetes Disease Management Programs

Sentara Health Plans Diabetes Disease Management Programs

Diabetes is a serious disease that can lead to potentially life-threatening complications such as heart disease, stroke, kidney disease, blindness, and amputation. Diabetes-related complications may be prevented, but only if long-term lifestyle changes are made.

We have programs and trained healthcare professionals ready to help you make healthy lifestyle changes to manage your diabetes. All members with diabetes are welcome to participate.

How to Access

We reach out to members, but you don't need to wait – if you want to participate, please call member services using the number on your member ID card and ask to be connected to a case manager.

Help from Qualified Professionals

The Diabetes Management Team is made up of registered nurses, licensed practical nurses and patient service coordinators.

This team serves as a member support system and promotes healthy behaviors, provides education and offers solutions to your questions.

Diabetes Supplies

Strips, lancets, meters, control solutions and insulin pump supplies are covered under most Sentara Health Plans policies.

Most members have a copay for diabetes supplies. Just take your prescription to your retail pharmacy.

Dilated Eye Exams

One dilated eye exam is covered per year for persons with diabetes.

Copayments may apply.

See your plan documents for more information. Members may also call the Sentara Health Plans Vision Care Services Center at 1-888-610-2268.

Hospital Education Classes

Education programs hosted by facilities that participate with Sentara Health Plans are covered by most Sentara Health Plans policies.

You do not need an authorization for attending diabetes classes, but some facilities require a doctor's referral.

Diabetes Basics

Diabetes is a disease in which the body cannot use food for energy causing high blood sugar levels. Diabetes management is possible and can be controlled.

Your body gets the energy it needs from food. After you eat, food breaks down into sugar and the blood vessels carry the sugar to all the cells in the body. Your body changes most foods into sugar, so you can get high blood sugar even without eating sweets. Insulin acts as a key and unlocks the door of the cell so the sugar can enter. With diabetes, you either do not make enough insulin or do not use the insulin you make. Without insulin, sugar cannot enter the cells and it builds up in the blood causing high blood sugar levels.

Signs and Symptoms

When sugar builds up in the blood, your body starts to give you signals including a need to urinate often, extreme thirst, hunger, sudden weight loss, blurred vision, dry, itchy skin, weakness, numbness or tingling in hands and feet, and slow healing cuts or sores. You may have some, all or none of these symptoms.

Types of Diabetes

Type 1 Diabetes — the body makes no insulin so the sugar can't enter cells.

If you have Type 1 Diabetes you may need to take daily insulin injections as recommended by your doctor. You also need to eat healthily, get regular exercise and check your blood sugar.

Type 2 Diabetes — the body makes insulin but it is not enough or it does not work right.

Some people with Type 2 Diabetes can control it with a meal plan and exercise. If these don't work alone, then you need medication. At some point, you may need to take insulin. Just like people with Type 1 Diabetes, you also need to check your blood sugar.

Dilated Eye Exams

Even if you can see fine, a regular dilated eye exam is an important part of vision care. You should have a dilated eye examination once per year.



What is Diabetes

4:08

Diabetes is an illness that effects the way food is turned into energy by your body. This video will cover the basics facts about diabetes.



Diabetes Prevention

6:55

Small changes in lifestyle now, can lower your risk of developing diabetes in the future. Learn more about how you can prevent diabetes.



Achieving and Maintaining Blood Sugar Control

4:24

Keeping your blood sugar under control is key to successfully managing diabetes and living well with diabetes

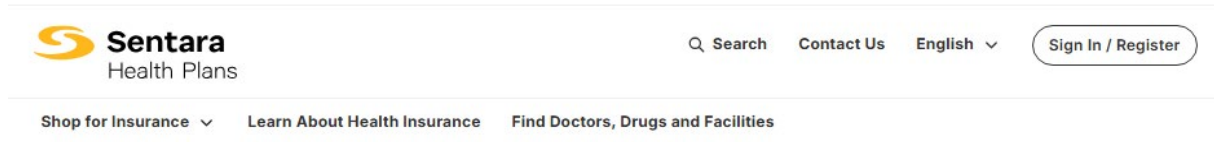


The Omada Program - Diabetes Prevention

1:04

Sentara Health Plans has partnered with Omada® to offer a targeted group of members a year-long diabetes and heart disease prevention program.

How to get your patients connected to SHP Resources?



With Us, You're
More than a
Number

Personal is part of the plan.



Contact Information for Members and Partners



Members

Contact information for members.



Providers

Contact information for providers.



Employers

Contact information for employers.



Brokers

Contact information for brokers.

Member Services

For the fastest service, please call member services at the number on your member ID card.

You can also call our main number at [757-552-7401](tel:757-552-7401) or toll-free at [1-877-552-7401](tel:1-877-552-7401).

If you are hearing impaired, please call our TTY VA Relay Service at [1-800-828-1140](tel:1-800-828-1140) or [711](tel:711).

Phone lines are open 8 a.m. to 6 p.m. EST Monday – Friday.

members@sentara.com

Need Nurse Advice?

Call the 24/7 Nurse Advice Line at 757-552-7250 or 1-800-394-2237 — available 24 hours a day, 7 days a week.

Provider Services

[1-800-881-2166](tel:1-800-881-2166)

Medical Provider Service Representatives

[757-552-7474](tel:757-552-7474) or [1-800-229-8822](tel:1-800-229-8822)

8 a.m. to 5 p.m. Monday through Friday

Fax: 757-552-7316

ProviderRelations@sentara.com

Medicaid Provider Services

[757-552-7474](tel:757-552-7474) or [1-800-229-8822](tel:1-800-229-8822)

8 a.m. to 6 p.m. Monday through Friday

ProviderRelations@sentara.com

Behavioral Health Provider Service Representatives

[757-552-7174](tel:757-552-7174) or [1-800-648-8420](tel:1-800-648-8420)

8 a.m. to 5 p.m. Monday through Friday

8 a.m. to 6 p.m. Monday through Friday (Medicaid only)

Fax: 757-552-7499

ProviderRelations@sentara.com

HEDIS/QUALITY: Medical Records Best Practices

Jennifer J. Williams, BSN, RN

Senior Quality Improvement Coordinator HEDIS



Measurement Year 2025

- **Time to Prepare for HEDIS® Medical Record Review**
- HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
- For HEDIS MY2025, we have begun requesting medical records from providers for the 2026 Annual Project
- For the Hybrid Project we are looking for medical record visits from CY2025
- 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

HEDIS Data Collection Methods



Best Practice HEDIS®

Controlling High Blood Pressure (CBP)

Measure Overview

Evaluates members ages 18–85 with diagnosed hypertension whose most recent blood pressure during the measurement year is controlled (<140/90 mm Hg).

HEDIS BP Control Threshold

Controlled: systolic <140 AND diastolic <90

Not controlled: systolic ≥140 OR diastolic ≥90

Documentation Best Practices

- Confirm hypertension diagnosis
- Document BP at every visit
- Recheck BP ≥140/90
- Record exact values (do not round)

Follow-Up for Uncontrolled BP

Schedule nurse or telehealth BP recheck within 2 weeks and encourage proper home blood pressure monitoring.

Systolic CPT® II Codes

3074F: <130

3075F: 130–139

3077F: ≥140 (not controlled)

Diastolic CPT® II Codes

3078F: <80

3079F: 80–89

3080F: ≥90 (not controlled)

Best Practice HEDIS®

Glycemic Status Assessment for Patients With Diabetes (GSD)

The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement period (January 1 -December 31):

- Glycemic Status <8.0%
- Glycemic Status >9.0%

Documentation Tips:

Document Accurately and Completely: Ensure all documentation includes the patient's name, date of birth, date of service, and the provider's name/credentials.

Incorporate CGM Data: If using Glycemic Status from Continuous Glucose Monitoring (GMI), document the GMI value, the date range of the CGM data used, and the device type (if electronic).

**CPT HbA1c lab test
8036, 8037**

CPT II Codes:

3044F HbA1c level < 7.0%

3046F HbA1c level > 9.0%

3051F HbA1c level ≥7.0% and <8.0%

3052F HbA1c level ≥8.0% and ≤9.0%

Best Practice HEDIS®

Child and Adolescent Well-care Visits (WCV)

The percentage of persons 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period

Documentation Tips:

- At least one (1) comprehensive well-care visit with a PCP or OB/GYN during the measurement year
- The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member
- Clearly state the visit is a well-child or preventive visit
- Document a comprehensive history and physical exam
- Document developmental assessment addressing age appropriate physical, cognitive, emotional and social milestones
- Provide and document anticipatory guidance or preventive counseling
- Ensure documentation supports use of a preventive CPT code

CPT Codes To Identify Well-child Visits:

99381, 99382, 99383, 99384, 99385,
99391, 99392, 99393, 99394, 99395, 99461

ICD-10 Codes: Z00.0, Z00.01, Z00.110,
Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, ,
Z76.1, Z76.2, Z01.411, Z01.419, Z02.5,
Z02.8

❖ WCV is a claims-based measure. Accurate preventive coding supported by clear documentation is required to meet HEDIS compliance.

Reminder: Do not include Telehealth visits

How You Can Assist in Closing Gaps in Care

- What is the best process for retrieving records to close gaps in care for HEDIS 2026
 - EMR Access
 - Email/Fax
 - Portal
- **Using NCQA Recommended Billing Codes**
- **Make appointments available for members who may be calling you**
- Members will be incentivized for closing gaps in care
- HEDIS Fax # to send medical records at 844-518-0706

Questions?

- Please call a member of the HEDIS team at 757-252-7571



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.**

- April 1 – Provider Spotlight – Blood pressure checks and elevated A1C
- May 6 - Behavioral Health & Depression Screening

➤ **Let’s Talk Behavioral Health: 1 - 2 p.m.**

- May 12
- August 11

➤ **New Provider Orientation**

- March 11 and 19
- April 9, 15 and 21

View Schedule/Register



➤ **Claims Brush Up Clinics: 1 - 2 p.m.**

- March 11
- June 17

➤ **Lunch & Learn - Provider Website Tours: 12 – 1 p.m. (New Provider Orientation Part 2 & Refresher)**

- March 10 and 26
- April 7 and 23

➤ **Appeals, Reconsiderations and Contestment Process: 1 – 1:30 p.m.**

- April 8
- July 8

Register Today 😊

[View Schedule/Register](#)



April 1st designed for all providers and their staff interested in discovering new workflow ideas to improve care gap performance. You will hear a provider's journey to utilize their EMR "ticketing" system to electronically schedule nurse visits for blood pressure rechecks and lab visits for elevated A1c results. Our quality team will introduce a new provider resource which will soon be available that outlines developmental screening best practices.

May 6th This session is designed for behavioral health providers, PCPs and their staff interested in reducing preventable behavioral health admissions and readmissions. Our behavioral health team will provide an overview of our programs and resources available at Sentara Health Plans. Additionally, our quality will review depression screening tips and best practices. We will reserve time for an open forum so participants can discuss their successes and barriers in these areas as well as ask questions.

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.



Member Incentives that Close Gaps in Care

Sentara Health Plans Medicaid Member Incentives 2026

Please contact **Asha Tillery**

QHC Team Coordinator with any
questions axhudson@sentara.com
or call **804-613-6547**

The maximum in gift cards is \$50 per member in a calendar year. Once you earn a total of \$50, you will not be able to get more gift cards. The visit, exam, or vaccination must be completed by December 31 to earn a gift card for that same calendar year.

Sentara Health Plan MEDICAID Incentives	Reward Amount	Qualifying Members
Breast Cancer Screening	\$15	Women 40 – 74 years of age
Cervical Cancer Screening	\$15	Females 21 – 64 years of age
Child and Adolescent Well Care	\$15	Children turning 3 through 21 in the measurement year
Childhood Immunizations	\$15	Children turning 2 in the measurement year
Chlamydia Screening in Women	\$10	Females 16 – 24 years of age
Colorectal Cancer Screening	\$15	Members 45 – 75 years of age
Comprehensive Diabetes: ▪ Eye Exam- Retinal or Dilated ▪ Kidney Health Evaluation ▪ Hemoglobin A1C Control ▪ BP Control	\$15 \$10 \$15 \$10	Members 18 – 75 years of age with diabetes (Type 1 and Type 2)
Controlling High Blood Pressure	\$10	Members 18 – 85 years of age with Diagnosis of Hypertension
Flu Vaccination	\$10	Members 18 – 64 years of age
Immunizations for Adolescents	\$15	Children turning 13 in the measurement year
Lead Screening	\$10	Children turning 2 in the measurement year
Prenatal and Postpartum Care ▪ Initial Assessment ▪ Physician Visit ▪ Postpartum Visit ▪ Postpartum Assessment	\$15 \$20 \$15 \$15	Pregnant Members who deliver a live birth between October 8, 2025 and October 7, 2026
Weight Assessment and Counseling for Nutrition and Physical Activity	\$10	Children turning 3 through 17 in the measurement year
Well Care First 30 Months	\$15	Children turning 30 months in the measurement year

Sentara Health Plans Medicare Healthy Rewards 2026

Please contact **Nicole Myers**
Manager Quality Performance and
Outreach with any questions
namyers@sentara.com
757-373-9779

Preventive screening, exam or vaccine	Reward	Who is eligible?
Annual wellness visit Combined with annual physical exam	\$100 +20	All members
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	\$15	All members
Flu vaccine	\$10	All members
In-home assessment	\$25	All members
RSV vaccine	\$10	All members

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
Asha Tillery Supervisor, Quality HEDIS	804-613-6547 axhudson@sentara.com
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 2025](#)

[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](#)

Billing and Claims [Billing and Claims](#) | [Providers](#) | [Sentara Health Plans](#)