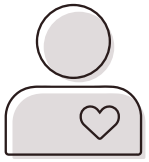
Cardiovascular Disease Management Program

The Sentara Health Plans Cardiovascular Disease Management Program provides members with the support they need to manage this very complex condition. Coronary Artery Disease (CAD) is a disorder that causes the major blood vessels surrounding the heart to become damaged or diseased. Congestive Heart Failure (CHF) occurs when the heart muscle doesn't pump blood as well as it should. Our overall program goal is to help members establish good self-management practices that improve outcomes, prevent complications, and reduce acute hospital admissions.

Members are eligible for the program if they are in active treatment for CAD.

Key aspects of the program:

- Case managers reach out to eligible members to invite them to participate and perform an initial risk assessment.
- Case managers complete a comprehensive health assessment of the participant, including screening for social determinants of health.
- Case managers work together with members and their providers to develop an individualized care plan, which includes measurable goals such as:
  - annual visits with their primary care physician (or more frequently as needed)
  - annual testing for LDL cholesterol levels and blood pressure
  - nutrition and activity plan
- Members and their providers can access the care plan 24/7 through the secure portals on **sentarahealthplans.com**.
- Case managers engage members as frequently as every two weeks but no less than every three months to review and update the care plan.
- Case managers reach out to members at least annually or more frequently based on changes in the member's condition or needs.



Diabetes Management Program

The Sentara Health Plans Diabetes Disease Management Program provides care coordination and ongoing education for members with diabetes and those at risk of developing diabetes. Diabetes is a disease in which the body cannot use food for energy. Diabetes does not go away with treatment but can be controlled.

Our overall program goal is to help members build skills to maintain optimal health habits over the course of a lifetime by providing members:

- access to nationally recognized diabetes education classes through Sentara Healthcare and other facilities
- low-cost to no-cost diabetes self-testing blood glucose meters and affordable blood glucose testing supplies
- access to a strong network of dietitians and appropriate benefit design to ensure access to individualized nutrition counseling
- a network of exercise facilities at reduced pricing

Key aspects of the program:

- Case managers reach out to eligible members to invite them to participate and perform an initial risk assessment.
- Case managers follow up with members and their providers to develop an individualized care plan, which includes measurable goals such as:
  - annual visit with their primary care physician (or more frequently as needed)
  - twice yearly A1c testing
  - annual urine microalbumin and LDL cholesterol testing, a dilated eye exam, and regular foot exams
- Members and their providers can access the care plan 24/7 through the secure portals on **sentarahealthplans.com**.
- Case managers engage members as frequently as every two weeks but no less than every three months to review and update the care plan.
- Case managers reach out to members at least annually or more frequently based on changes in the member's condition or needs.

Elements of our enhanced diabetes management program:

- Access to the Diabetes Prevention Program through Sentara and other locations for members at risk of developing diabetes
- Automated phone messaging to members identified with diabetes gaps in care to include medication adherence reminders, annual lab testing, foot and eye exams, and additional electronic reminders to providers alerting them to patient gaps in care related to diabetes

Members are eligible for the program if they are in active treatment for diabetes.

Partners in Pregnancy Program

The Sentara Health Plans Partners in Pregnancy Program provides members with information and support in making good choices throughout their pregnancy. We are dedicated to providing guidance, support, and education to all expectant members.

Partners in Pregnancy provides access to experienced pregnancy and childbirth nurses, clinical case managers, licensed social workers, and service coordinators to help members:

- maintain good health throughout their pregnancy
- develop a healthy nutrition and activity plan
- maximize their benefits and resources
- locate important resources, classes, and services on pregnancy and parenting
- coordinate prenatal care and appropriate risk screenings
- understand timely health tips, which are mailed directly to their home

Key aspects of the program:

- Partners in Pregnancy case managers reach out to eligible members to develop a pregnancy management plan within the first three months of pregnancy (by 14 weeks).
- Case managers follow up with members to develop an individualized care plan, which includes measurable goals such as:
  - visit with their obstetrician within the first three months of pregnancy, or by 14 weeks
  - visit their doctor for a postpartum checkup within six weeks after delivery
  - nutrition and activity plan
- Case managers re-engage members at least once a month to review and update the pregnancy care plan.
- Members and their providers can access the care plan 24/7 through the secure portals on **sentarahealthplans.com**.

Members are eligible for the program beginning in their first trimester of pregnancy.

Respiratory Disease Management Program

The Sentara Health Plans Respiratory Disease Management Program provides members with the support they need to keep their asthma and/or Chronic Obstructive Pulmonary Disease (COPD) under the best possible control. Asthma and COPD are ongoing diseases of the airways in the lungs. They cannot be cured but can be controlled. Our program goal is to help members establish lifestyle management practices that prevent damage to the lungs.

Key aspects of the program:

- Case managers reach out to eligible members to invite them to participate and perform an initial risk assessment.
- Case managers follow up with members and their providers to develop an individualized care plan, which includes measurable goals such as:
  - annual visit with their primary care physician (or more frequently as needed)
  - nutrition and activity plan
  - annual influenza vaccination, as appropriate
- Members and their providers can access the care plan 24/7 through the secure portals on **sentarahealthplan.com**.
- Case managers engage members every two weeks if needed, but no less than every three months to review and update the care plan, while assessing for any changes in the member's condition or needs.

Members are eligible for the program if they are in active treatment for asthma and/or COPD.