Sentara® Health Plans

Care Management:

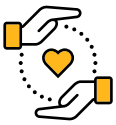
Your discharge partners for medical and behavioral health patients

Care Management Overview

Sentara Health Plans takes a comprehensive approach to healthcare that involves coordinating and managing the care of individuals with complex medical needs. Our care management teams seek to improve the quality of care, enhance patient outcomes, and optimize healthcare resources by providing personalized, coordinated, and cost-effective care for individuals with chronic or complex health conditions.

Care coordination enhances the U.S. healthcare system by boosting effectiveness, safety, and efficiency, along with a deep understanding of patient populations. This effort is geared toward improving survival rates, decreasing emergency room visits, lowering medication expenses, and closing care gaps.

The following departments provide care management services:



- Cardinal Care Management
- Welcoming Baby
- Addiction Recovery Treatment Services and Behavioral health (ARTS/BH)
- Transitions of Care (Medical and Behavioral Health)
- Chronic Disease Management

We support our members post-discharge by:

- Completing health risk assessments or condition specific assessments
- Creating an individualized care plan with interventions, goals, and timelines
- Providing education on disease state, health, and wellness recommendations for conditions, age, and gender
- Evaluating the need for durable medical equipment (DME) and assist with securing blood pressure cuff, blood glucose monitor, scales for members active in the Chronic Disease Management Program (CDM) tracking self-monitoring compliance and results
- Securing and assisting with referrals and other resources
- Assisting with closing gaps in care
- Participating in interdisciplinary care planning and interdisciplinary care team meetings with the primary care manager (PCM)
- Participating in care management rounds when invited by the PCM or the medical director

Communication with our provider partners is critical:
Care management wants to have an open, mutual collaboration with our providers to meet our members' healthcare needs. We are contacting you to support our members who need the greatest level of assistance connecting with these services to improve health outcomes and avoid being readmitted unnecessarily.

Care management helps members with the following and more:

- Avoiding Possible Preventable Emergency Department (PPED) visits, Possible Preventable Admissions (PPA), and Possible Preventable Re-admissions (PPR)
- Assistance with obtaining DME
- Connecting with local resources to address social determinants of health (SDOH)
- Assistance with pharmacy issues, such as delays in prior authorization, formulary sharing, incorrect scripts, or delays in medication renewals
- Connecting with specialty providers
- Prioritization of appointments for condition exacerbation
- Condition-specific interventions and education
- Understanding benefits

Transitions of Care supports members being discharged from a Medical Admission, ARTS/BH Inpatient Hospitalization to ensure members are:

1. Connected to clinically-sound aftercare services to include therapy, medication management, and/or community based behavioral health/ARTS services.
2. Connected to resources, the members have noted they need i.e., housing referrals, food referrals, peer support, and transportation.

Helpful Resources

PointClickCare®
PointClickCare is a platform designed to enhance communication among care teams and improve patient outcomes by integrating data across various care settings. By providing real-time information on patient location, reasons for visits, treating providers, and potential risks, it facilitates better coordination and more effective care. Contact **edccpsupport@vhi.org** to inquire about creating an account.

Best Healthcare Software - PointClickCare

How to reach Care Management:
Provider services:
1-800-229-8822 (TTY: 711)
Monday-Friday 8a.m.-5.pm.