



Provider Quality Learning Collaborative

April 1, 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
- Developmental Screening in the First Three Years of Life
- How Can Sentara Health Plans Help You?
- Provider Spotlight: Riverside
- Q & A
- Closing Remarks

Developmental Screening in the First Three Years of Life

Sarah Anzick, MBA, BSN, RN, CSSBB

Manager, Quality Improvement



Developmental Screening in the First Three Years of Life

Developmental screenings must occur during the well-child visit (WCV) using an age-appropriate standardized developmental screening tool used to screen for the risk of developmental, behavioral, and social delays. If the screening is positive, a follow-up plan must be documented on the date of the well-child visit.

Key Points for Compliance

- CMS Core Set Measure
- Administer a Generalized Developmental Screening using an approved Standardized Screening Tool
 - On or before the first birthday (9-month WCV)
 - On or before the second birthday (18-month WCV)
 - On or before the third birthday (30-month WCV)
- Use a Domain-specific Developmental Standard Screening Tool if the above screening is positive, such as: M-CHAT or ASQ-SE
- Administer an Autism Spectrum Disorder Standardized Screening tool at each of the following ages:
 - 18-month WCV
 - 24-month WCV
- Standardized Screening Tool Required Billing CPT code: 96110
And
ICD-10 Diagnosis Codes indicating reason for Standardized Screenings: Z13.41 or Z13.42, or Z13.49, or Z13.40

- Document a Follow-up Plan(s) if screening results yield a positive result
 - Referral to a specialist for additional evaluation
 - Referral to PT,OT, and/or SLP for evaluation/intervention
 - Other interventions for the treatment of developmental delays

Key Takeaways

- Screening tools must be age-appropriate and standardized
- Use the correct CPT code coupled with the ICD-10 Code
- Adhere to the minimum requirements for age-based administration
- Children with Medicaid, under the age of 3, identified with developmental delays should be referred to the Infant and Toddler Connection (early intervention) program. Visit [Infant & Toddler Connection of Virginia - ITCVA](#) to submit a referral

Example Developmental Screening Tools that meet criteria for the Core Set Measure:

(Note: The examples provided are not specific recommendations but are examples of tools cited in Bright Futures that meet the above criteria.)

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC)

The 2020 AAP Statement describes the screening tool properties that may be useful for states to consider in designing their policies.

Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they often are not used by primary care providers in the context of routine well-child care) include the following:

- Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months

Tools that do NOT meet the criteria

It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.

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.**

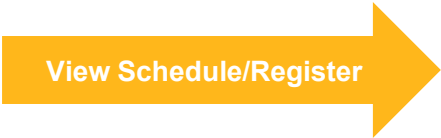
- May 6 - Behavioral Health & Depression Screening
- June 3 - Medicaid Chronic Disease Management Programs Overview

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

- May 12
- August 11

➤ **New Provider Orientation**

- April 9, 15 and 21
- May 17, 13 and 19



➤ **Claims Brush Up Clinics: 1 – 1:30 p.m.**

- June 17
- September 23

➤ **Lunch & Learn - Provider Website Tours: 12 – 12:30 p.m. (New Provider Orientation Part 2 & Refresher)**

- April 7 and 23
- May 7 and 19

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

- April 8
- July 8

Register Today 😊

[View Schedule/Register](#)



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.

June 3rd This session is designed for primary care and other practitioners and their staff interested in learning how Sentara Health Plans engages members through education and interventions to increase utilization of preventive services and improve health outcomes for members with chronic conditions such as diabetes. We will also review the Medicare Health Outcomes Survey (HOS), a CMS-required measure of patient-reported changes in physical and mental health, and how evidence-based primary care interventions directly influence DSNP quality outcomes. 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.

Provider Spotlight: Riverside Health

Anne M. Mercer
Quality & Value Base Performance Director
Riverside Medical Group





Riverside
Health

Ticket to Schedule in Primary Care

Efficient appointment management for better patient care

April 2026

Understanding Ticket to Schedule

Automated Scheduling Process

- ❖ Ticket to Schedule automates appointment management to reduce administrative workload and improve efficiency
- ❖ Allow focus on more complex patient care activities

Patient Self-Scheduling

- ❖ Allows patients to self-book appointments via platforms like EPIC and MyChart, increasing convenience and access
- ❖ Automating scheduling tasks decreases staff burden,

Supports Value-Based Care

- ❖ Enhances timely follow-ups and preventive care, supporting improved patient outcomes and population health metrics

Efficiency in Primary Care

- ❖ Frees up staff resources, reduces wait times, and prioritizes patient-centered, technology-enabled scheduling

Origin Story:

During COVID, Riverside rapidly implemented a centralized vaccination clinic to expand access for both established patients and the surrounding community.

This effort introduced a ticket-based scheduling model within the EMR, enabling existing Riverside patients to self-schedule appointments through MyChart and provide public-facing links for community members in of COVID vaccinations.

What began as a high-volume access solution became the foundation for today's Ticket to Schedule workflows, demonstrating how scalable, patient-driven scheduling can improve access while reducing administrative burden.

Roles & Responsibilities in Ticket to Schedule

Key Stakeholders

Directors' Responsibilities

- ❖ Enable ticket scheduling and request access for authorizing bulk scheduling
- ❖ Oversee compliance with scheduling policies/template management
- ❖ Resource books for scheduling must be “open” for patient self-scheduling

Managers' Role

- ❖ Prepare EPIC templates, configure workflows, manage appointment slots
- ❖ Create standardized smartphrases for patient communication
- ❖ Educate/train the Care Team on workflows
- ❖ Monitor feedback from team members & patients, make improvements/changes as needed

Care Team Engagement

- ❖ Use ticketing systems to engage patients, communicate options, and support self-scheduling
- ❖ Respond to patient questions about tickets & encourage real-time action

Workflow Design

Getting Started

Phased Implementation

- ❖ Start with high-impact appointments Annual Wellness Visits
- ❖ Summer 2024 pilot with 3 PCP practices w/ lower than expected performance

Standardized Communication

- ❖ Use SmartPhrases and patient portals to ensure clear and consistent messaging during initial rollout

Staff Training and Support

- ❖ Train staff to handle patient inquiries and develop FAQs to improve patient experience

Continuous Monitoring and Feedback

- ❖ Monitor outcomes and scheduling data regularly to refine processes and improve system adoption

Dear @NAME@

Our records indicate you are overdue for an appointment with your Primary Care Provider (PCP). To make this process as convenient as possible, we have attached a scheduling ticket that will allow you to select an available appointment time at your convenience.

If you need any assistance or have questions, please do not hesitate to contact our office at @PracticePhone@.

*Thank you,
@PracticeName@*

Workflow Example: Annual Wellness Visit

Identifying Eligible Patients

- ❖ The process starts by running an AWW Due report to find patients eligible for the Annual Wellness Visit, excluding new Medicare enrollees

Order Placement and Communication

- ❖ Orders are entered into the electronic health record and patients receive MyChart messages to self-schedule their wellness appointments

Benefits of the Workflow

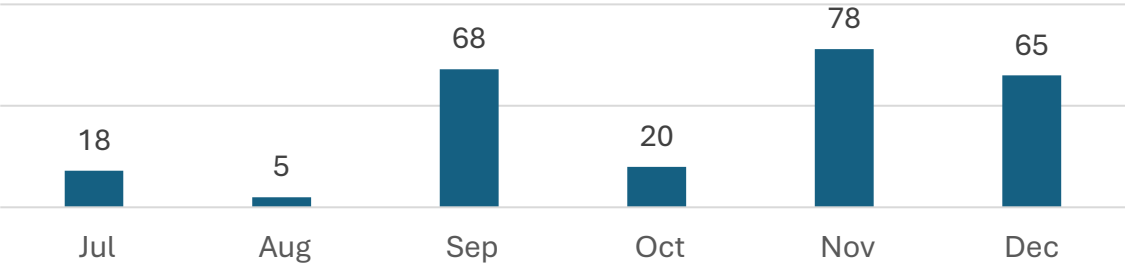
- ❖ This workflow streamlines scheduling, reduces administrative work, and empowers patients to manage their healthcare proactively
- ❖ Customized for other healthcare services & requires ongoing monitoring for efficiency & responsiveness

The screenshot shows the 'Place Orders' window in a medical software interface. At the top, there are fields for 'Authorizing Provider' and 'PCP Type' (set to 'General'). Below this, there are tabs for 'Preference Lists' and 'Bulk Orders'. Under 'Bulk Orders', there are sections for 'COVID Vaccines' and 'Appointment Requests'. In the 'Appointment Requests' section, 'MEDICARE WELLNESS VISIT' is selected. To the right, there is a 'Procedures' list with 'MEDICARE WELLNESS VISIT' selected. At the bottom, there are buttons for 'Add Communication', 'Sign Orders', and 'Cancel'. A yellow banner at the bottom states: 'After the action has been processed, check In Basket to verify that the orders were placed for all selected patients.'

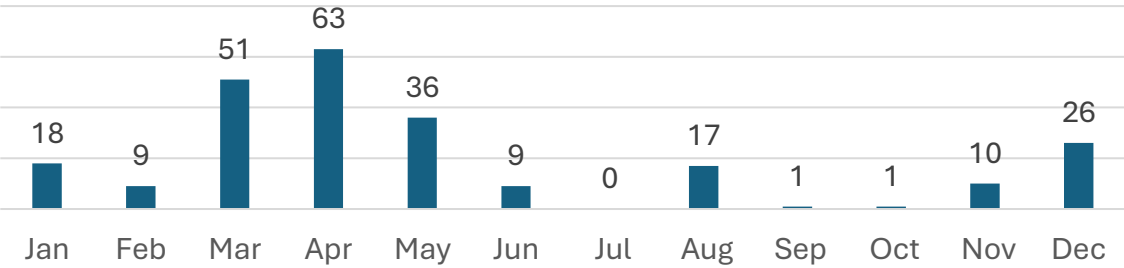
The screenshot shows the 'Place Orders' window with the 'Outreach Details' tab selected. It displays a 'Template Selection' for 'MEDICARE WELLNESS'. Below this, there is a 'Riverside MyChart View' section with a 'Show preview for: Hart, Peggy A' dropdown. The preview text reads: 'Thank you for selecting Riverside Medical Group for your healthcare. After reviewing your records, we have identified that it is time for your Annual Wellness Exam. This appointment is essential for keeping up with preventive healthcare services, and it will be provided to you free of charge. We kindly ask you to use the attached appointment ticket to schedule an appointment with the Family Medicine Health Coach. To make it easy to schedule your appointment, we are sending you a scheduling "ticket" to your MyChart account. Once you receive your scheduling ticket notification, you can click on the "Schedule Now" button, or at anytime: • Click the green "Schedule Now" button on your home page alert. • Go to Visits>>Schedule an Appointment, you should see a ticket to schedule. Again thank you for trusting Riverside with your care and we look forward to serving you in the future.' At the bottom, there is an 'Outreach Tracking' section with a 'Contacted about' field and a 'Next contact' dropdown set to '1 Week'. Buttons for 'Sign Orders With Communication' and 'Cancel' are at the bottom right.

Results – AWW Tickets & Results

2024 - Total # of AWWs Scheduled from Tickets



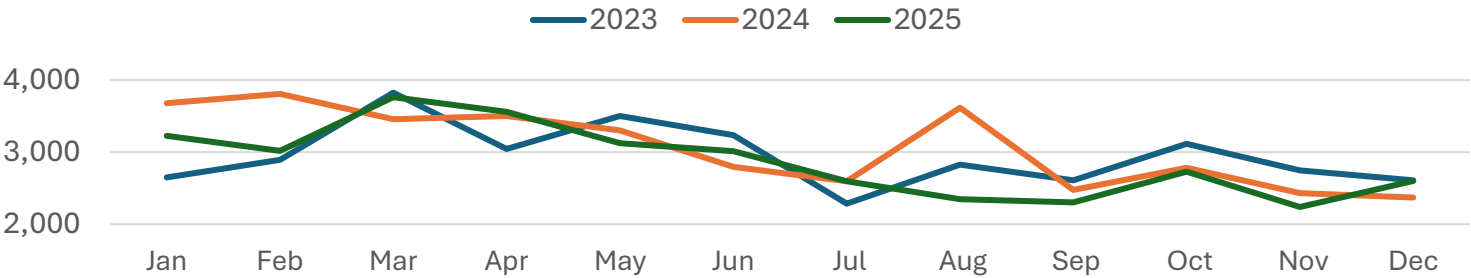
2025 - Total # of AWWs Scheduled from Tickets



AWV Pilot Jul. 2024 – Dec. 2024

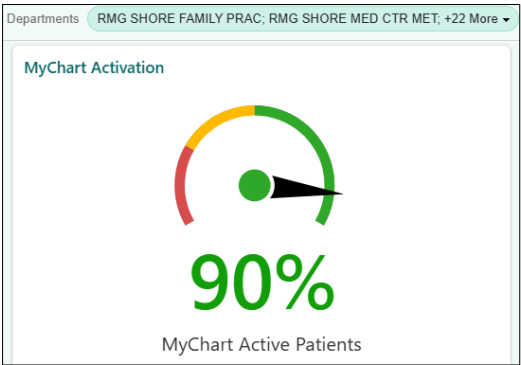
- 254 AWWs scheduled via Tickets to the Health Coach Schedule
- 100 Completed (39%); 131 Cancelled (51%), 23 No Show (9%)
- Cancellation Reasons - #1 Office Conflict & #2 Patient Reason
- 1 of 3 pilot locations did not meet annual AWW goals

Completed AWW's Comparison By Month



Launched to all Primary Care Locations in 2025

- No material impact on scheduling AWWs
- 241 AWW's scheduled via Tickets
- 120 Completed (49%); 113 Cancelled (46%); 8 No Show (3%)
- Cancellation Reason - #1 Patient Reason & #2 Office Conflict
- 19 of 26 locations meet/exceed AWW goals



Expanding & Evaluating Ticket to Schedule

Other Common Tickets & Service Expansion

Expanded Ticket Scheduling

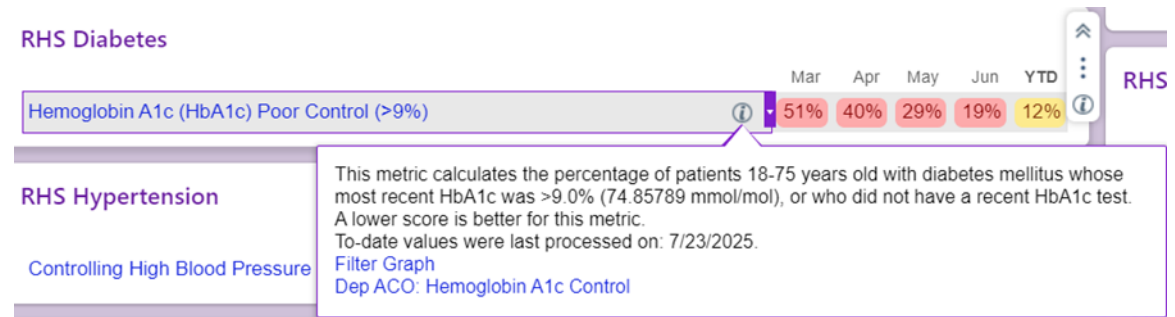
- ❖ Extends beyond wellness visits to include labs, blood pressure checks, & Provider appointments
- ❖ Smithfield - Used tickets to schedule GI Nurse Prep Appts
- ❖ Future - Diabetic Eye Exams with launch of new pilot

Customized Templates

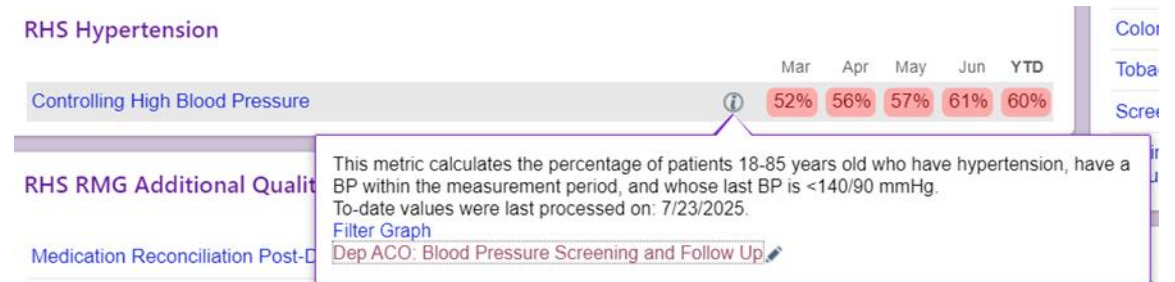
- ❖ Each service requires tailored templates and communication strategies for efficient patient management

Ongoing Evaluation

- ❖ Regular review of scheduling data and patient feedback supports continuous improvement & goal alignment



Hemoglobin A1C = LAB Resource Template

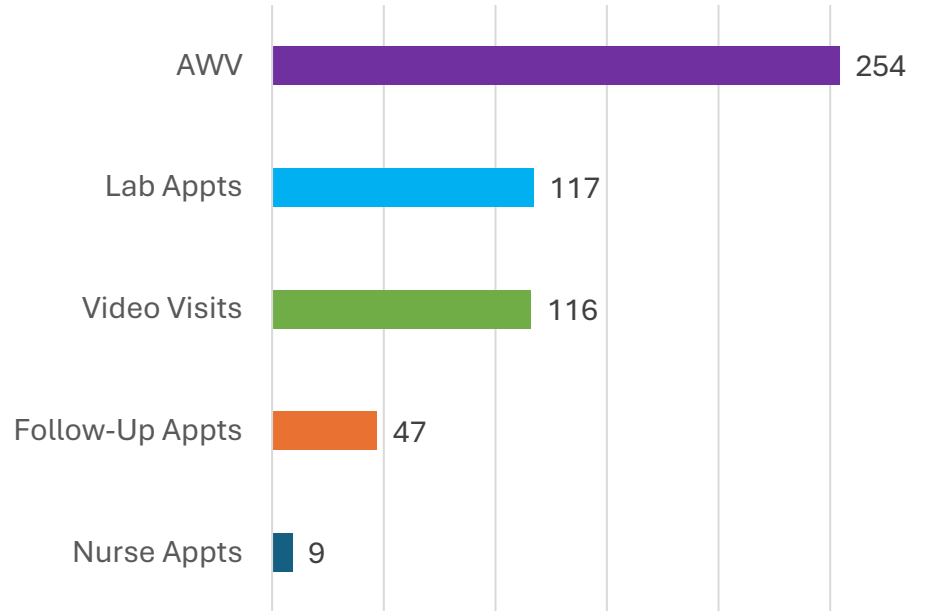


Blood Pressure Checks = Nurse Resource Template

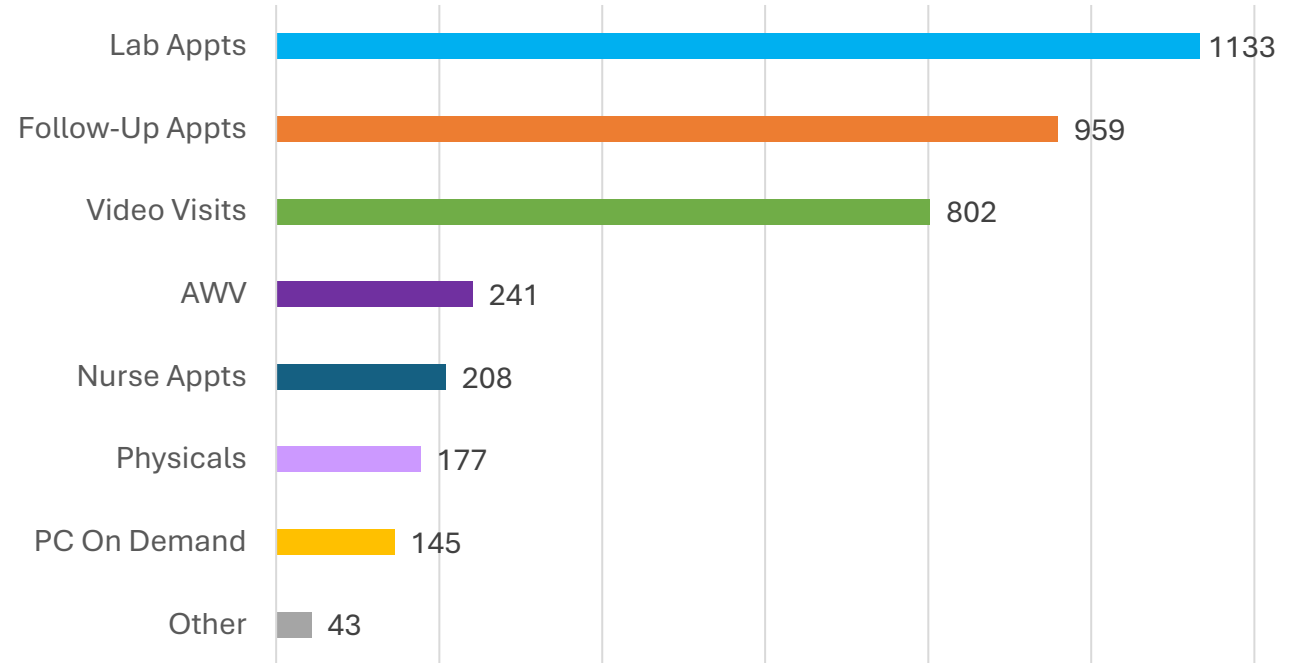
*Patients without an appointment in last year receive PCP scheduling ticket

Impact of Ticket Scheduling

of Visits Scheduled from Tickets
Jul 24 – Dec 24



of Visits Scheduled from Tickets
Jan 25 – Dec 25

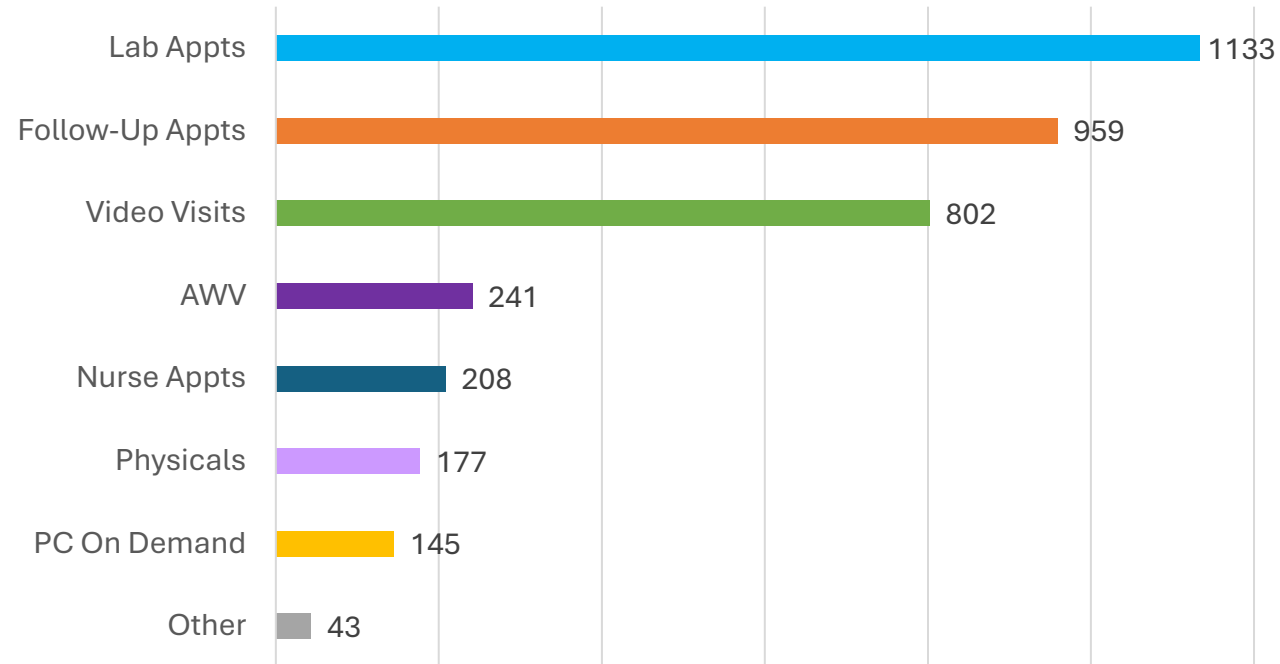


2025 Manager Goal: Increase # of Tickets Scheduled per PCP Location

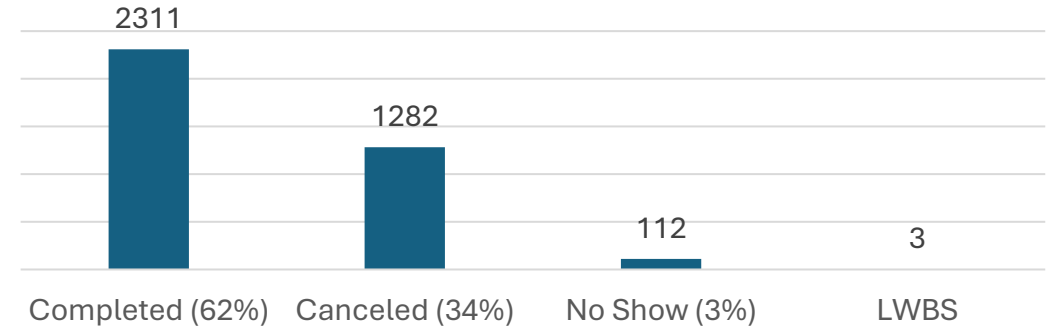
- Threshold – 50 Tickets; Target – 100 Tickets; Stretch – 150 Tickets
- Actual Total Visits Scheduled = 3,708 (~148 per location)

Impact of Ticket Scheduling

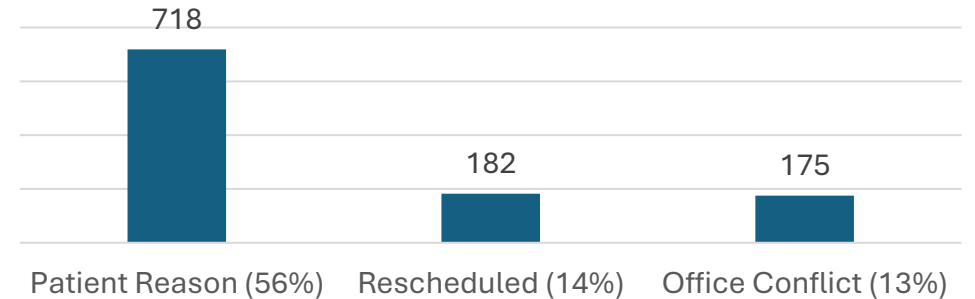
of Visits Scheduled from Tickets
Jan 25 – Dec 25



Ticket Scheduling Visit Appointment Status
Jan 25 – Dec 25



Top 3 Cancellation Reasons
Jan 25 – Dec 25



- Patients w/ Lab Appts = 77% CHF Registry; 53% HTN Registry; 27% Diabetes Registry
- Patients w/ Nurse Appts = 81% CHF Registry; 75% HTN Registry; 22% Diabetes Registry

Final Thoughts

Lessons Learned

- ❖ Each ticket pathway needed a separate schedule/resource book to match the appropriate appointment type
- ❖ Schedule/resource books must be “open” to allow patients self-scheduling, including individual Provider schedules
- ❖ Monitoring changes in Lab/Nurse schedule for EIB, PTO
- ❖ Ensuring clinical consensus with Providers – example – protocols for A1C orders
- ❖ Practice Operations/Access project; did include tracking quality outcomes tied to patients accepting/completing tickets vs. no tickets or cancellations
- ❖ After new Data Analyst onboards, will compare operations efficiency measures and impact on patient outcomes, search for optimization tactics based on population



QUESTIONS

Anne M. Mercer, CPHQ

Director of Quality & Value Based Performance, Riverside Medical Group

anne.mercer@rivhs.com www.riversideonline.com

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
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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 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](#)