



Provider Quality Learning Collaborative

May 6, 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
- Depression Screening and Follow-Up Plan (18 years and older)
- Behavioral Health Special Programs
- How Can Sentara Health Plans Help You?
- Q & A
- Closing Remarks

Depression Screening and Follow-Up Plan (18 years and older)

Sarah Anzick, MBA, BSN, RN, CSSBB
Manager, Quality Improvement



Depression Screening and Follow-Up Plan

Depression screening must occur on the date of the encounter (wellness or outpatient visits) or within 14 days prior to the encounter using an age-appropriate standardized depression screening tool. If the screening is positive, a follow-up plan must be documented on the date of the qualifying encounter.

Key Points for Compliance

- CMS Core Set Measure
- Approved Depression Screening Tool:

ADULT-	Patient Health Questionnaire (PHQ-9)	Beck Depression Inventory (BD-1 or BD-II)	Center for Epidemiologic Studies Depression Scale (CES-D)	Depression Scale (DEPS)	Geriatric Depression Scale (GDS)
ADULT-	Cornell Scale for Depression in Dementia (CSDD)	PRIME MD- PHQ@, Hamilton Rating scale for Depression (HAM-D)	Quick Inventory of Depressive Symptomatology Self Report (QID-SR)	Computerized Adaptive Testing Depression Inventory (CAT-DI)	Computerized Adaptive Diagnostic Screener (CAD-MDD)
PRENATAL-	Edinburgh Postnatal Depression Scale	Postpartum Depression Screening Scale	Patient Health Questionnaire 9 (PHQ-9)	Beck Depression Inventory, Beck Depression Inventory II	Center for Epidemiologic Studies Depression Scale
PRENATAL-	Zung Self-rating Depression Scale				

- Required HCPCS Level II Codes:
 - **G8431**- Positive screen for depression on the date of an outpatient visit or up to 14 days prior using a standardized tool with a follow-up plan documented.
 - **G8510**- Negative screen for depression on the date of an outpatient visit or up to 14 days prior using a standardized tool.

- Couple HCPCS Level II codes with an assessment-specific LOINC code to identify depression screening measurement and observations. LOINC codes:

LOINC: 44264-6

LOINC: 89205-9

LOINC: 90853-3

LOINC: 48545-8

LOINC: 55758-7

LOINC: 71777-7

LOINC: 89209-1

LOINC: 48544-1

LOINC: 89208-3

LOINC: 71965-8

LOINC: 99046-5

LOINC: 89206-7

LOINC: 89209-1

LOINC: 90221-3

LOINC: 73832-8

LOINC: 77861-3

- Document a Follow-up Plan(s) if screening results yield a positive result
 - Referral to a provider for additional evaluation (ex. Referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression)
 - Pharmacological interventions
 - Other interventions or follow-up for the diagnosis or treatment of depression (ex. Behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options)

Key Takeaways

- Screening must be age-appropriate and standardized
- Document a follow-up plan for a positive screen
- Use correct G-codes coupled with LOINC codes
- Screening can occur up to 14 days prior to the encounter
- The documented follow-up plan must be related to positive depression screening (ex. “Patient referred for psychiatric evaluation due to positive depression screening.”)

Sentara Health Plans Behavioral Health Special Programs

Erin Martin, LCSW

Manager, Behavioral Health



Behavioral Health Case Management

Behavioral Health Special Programs



Peer Support

BH Crisis

BH/SUD Pregnant and Parenting

FUM/FUA/APM Hedis Support

Tribal Care Coordination

Justice Care Coordination

Denial Team

Telephonic Transition of Care Team

Non Sentara Navigator Team

Whole Person Care

Large Provider Onsite Team

Peer Support Services

What?

Telephonic and virtual video peer support services.

Who?

All Sentara Health Plan members who have behavioral health, substance abuse or co-occurring needs.

How?

Worklist: Cardinal Peer Recovery

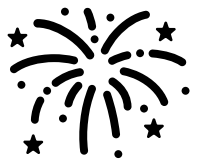
Outside Provider: SHP_BH_Programs@sentara.com

Peer support services are non-clinical, evidence-based programs where people with lived experience of mental health or substance use challenges provide support and guidance to help others on their recovery journey.

Highlights



Peer support is evidence based; national studies show that peer support is associated with a 14% reduction in relative risk of psychiatric hospital admission.

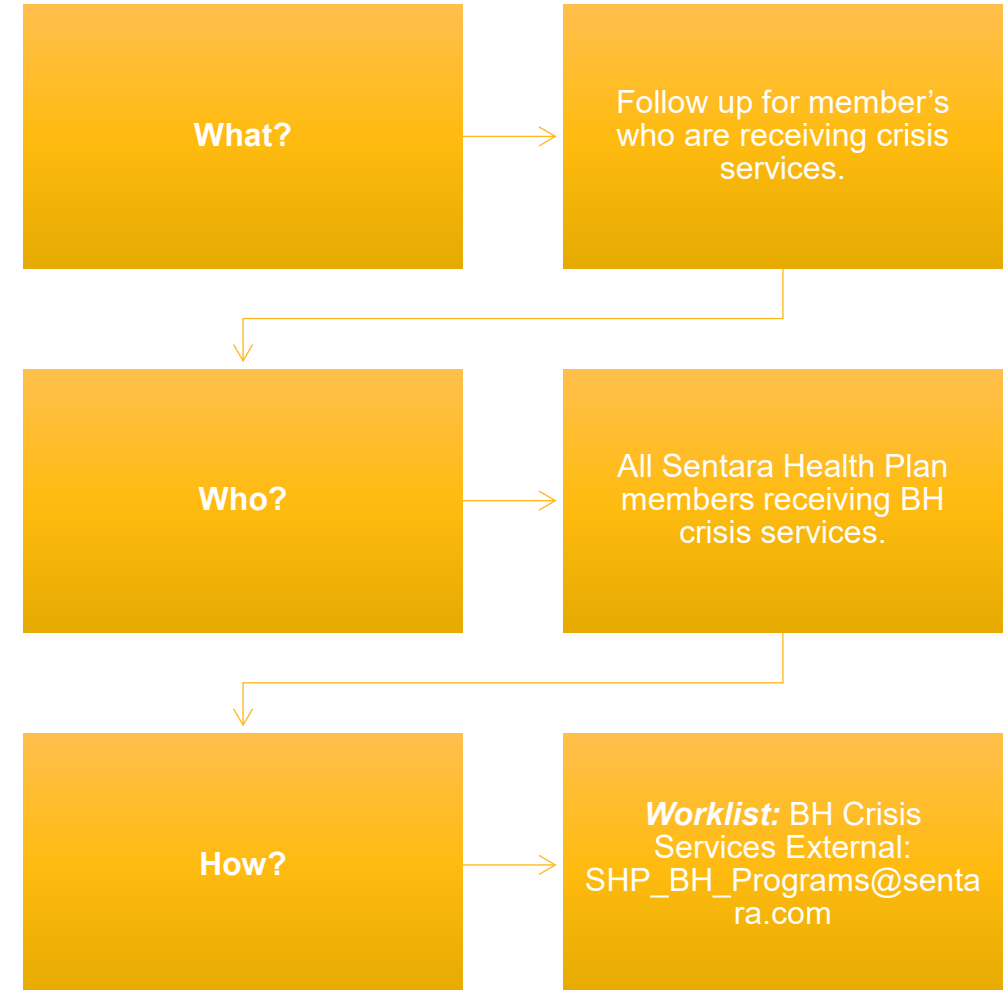


BH Crisis Services

Mobile Crisis Response

23 Hour Crisis

Crisis Stabilization Unit



Behavioral Health Maternity/SUD Pregnant and Parenting

SUD Pregnant and Parenting:

Members can be held up to one year postpartum, coordination with an ARTS staff for escalated SUD needs.

Monthly cooperative trainings and meetings.

Weekly leadership huddles with maternity CM leadership.

Baby shower engagement, in person and virtual.

Weekly case staffing with the maternity CM team and medical directors.

Workflow changes ongoing to coordinate with maternity team.

What?

Sentara Health Plan's Substance Use Disorder (SUD) Pregnant and Parenting initiative strives to ensure that pregnant women with substance use, and co-existing mental disorders are supported and receive intervention to prevent relapse during their pregnancy and after childbirth.

Who?

Pregnant and up to 1 year postpartum members who categorize as "high risk" (SUD or SMI)

How?

Worklist: Cardinal BH Maternal

External: SHP_BH_Programs@sentara.com

BH HEDIS Team (FUM/FUA/APM)

What?

Works to close behavioral health gaps for HEDIS Measures:

Who?

Sentara Health plan Members who trigger for the below HEDIS measure follow up:

FUM (follow up after ED visits for mental health- 7 and 30 days measure)

FUA (follow up after ED visits for substance use- 7 and 30 day measure)

APM (Metabolic Monitoring for children and adolescents on antipsychotics-blood glucose testing, cholesterol testing)

How?

Point Click Care Reports



Tribal Case Management

What?

Care Coordination

Responsible to ensure Tribal members are provided opportunity to seek care with Tribal providers regardless of network status.

Who?

SHP members who identify as of Native American or Alaskan Native descent.

How?

Worklist: Cardinal Tribal

SHP_BH_Programs@sentara.com

Vincent Jones has been featured in multiple SHP podcasts, interviews and articles.

[Tribal Care Coordinator helps Native American community members access care](#)



Tribal Care Coordination:

Assistance with Denial Follow Up

Outreach and coordination with Tribal leadership

Engagement in Statewide Powwows

Daily monitoring of PCC

Member hospital/NF visits as needed

HRA completion

Justice Care Coordination

What?

Care Coordination for the justice involved population

Who?

SHP members who are active on probation/parole or have been released from jail within the past 6 months

How?

Worklist: Cardinal Justice

SHP_BH_Programs@sentara.com

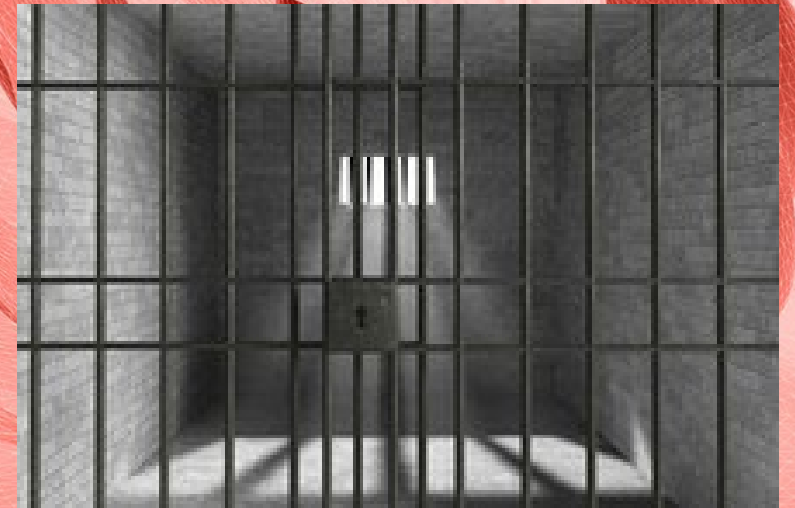
The Sentara Justice program was initiated during early release in 2020.

Patient Services Coordinator

- Research, outreach, monitoring: Currently 3,200 members
- Quarterly outreach to juvenile facilities to build relationships

Care Coordinator -Ongoing outreach/coordination with active members

- Assignment of PCM when needed
- HRA completion
- Justice assessment completion
- Coordination with probation/parole
- Engagement in re-entry counsels
- Engagement in probation/parole health fairs
- Presentations to and engagement with jails



Transition of Care

What?

Telephonic transition of care outreach

Who?

SHP members who receive inpatient hospitalization

How?

Worklist: Cardinal BH-IP TOC

Outside Provider: SHP_BH_Services@sentara.com

Onsite Navigators

What?

Onsite Navigator program at Non-Sentara hospitals

Who?

Members who are BH IP in the below hospitals

- *Poplar Springs*
- *Cumberland*
- *Virginia Beach Psych*
- *Kempsville*
- *Williamsburg Pavilion*
- *Life Center of Galax*

How?

Worklist: Cardinal BH-IP TOC

Outside Provider:

SHP_BH_Services@sentara.com

Behavioral Health Onsite Navigators and Large Provider Support

- **Onsite support**, including the option to embed care management staff within CSB locations when needed.
- **Enhanced Care Coordination:** Henrico CSB, Region 10, RBHA, Norfolk CSB
- **Onsite behavioral health and care management assessments** for SHP members, with a focus on reviewing historical service utilization to determine the most appropriate behavioral health or substance use level of care.
- **Assistance with utilization management needs**, including resolving issues or prioritizing requests proactively.
- **Linkage to in-network providers** when services are not available within the CSB.
- **Support during FAPT meetings**, including care coordination and resource recommendations.
- **Assistance with residential or therapeutic group home searches** for SHP members.
- **Review and coordination of comorbid medical needs**, including scheduling medical appointments as needed.
- **Care transition support** from hospital to community, including arranging follow-up appointments when they are not available through the CSB.
- **Scheduling Medicaid transportation** for members.
- **Linkage to SHP internal support programs**, including housing supports, high-risk pregnancy programs, and ARTS services.
- **Assistance resolving pharmacy-related issues**, including prior authorizations and medication access barriers.
- **Connection to SHP expanded benefits** ([Added Benefits](#) | [Medicaid](#) | [Sentara Health Plans](#)).
- **Linkage to Nations Meals** and other community-based benefit programs.
- **Care coordination for justice-involved individuals**, including discharge planning and navigation support

Whole Person Care (WPC)

What?

Whole person care is a comprehensive approach to healthcare that supports a person's physical, emotional, behavioral, social, spiritual, financial, and system navigation needs—connecting these elements so they work together to improve overall well-being and care outcomes.

Whole-person care is critical for improving health outcomes because:

- Human wellness depends on multi-dimensional, multisystemic care coordination
- Social, emotional, economic, and environmental conditions affects health
- Target populations often struggle with overlapping physical and behavioral health issues that stem from psychosocial determinants of health

WPC Care Coordination Includes:

- Face to face visits with members
- Hospital visits to members
- Intensive coordination medically and behaviorally
- Active assistance closing medical and BH gaps in care

Who?

- SHP Internal referrals and DMAS escalations
- Sentara Referrals (OPT BH, SMG, Hospitals, BHUs, Community Care Centers, Ambulatory, EDs)
- High Cost / High Utilization Reports
- CSBs and Provider Partners

How? SHP_BH_Programs@sentara.com



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.**

- June 3 - Medicaid Chronic Disease Management Programs Overview
- July 1 - Vendor partners share how they help improve member health

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

- May 12
- August 11

➤ **New Provider Orientation**

- May 17, 13 and 19
- June 4, 10 and 16

View Schedule/Register



➤ **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)**

- May 7 and 19
- June 11 and 23

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

- July 8
- October 7

Register Today 😊

[View Schedule/Register](#)



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.

July 1st Hear directly from our vendor partners to learn what services they provide to improve the health of Sentara Health Plan members with chronic conditions, require additional resources and more. The partnerships serve as a bridge between visits to close health care gaps.

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

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](#)