

Provider Quality Learning Collaborative

July 1, 2026



Welcome to Sentara Health Plans

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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
- Health Coordination Network (HCN) Program Overview
- Dario Overview
- How Can Sentara Health Plans Help You?
- Q & A
- Closing Remarks

Health Coordination Network (HCN) Program

Sentara Provider Network

Marcus Divers

HCN Program Manager, Virginia Health Information (VHI)

Morgan Croft-Schornak,

Senior Solution Design Lead, PointClickCare



Health Coordination Network (HCN) Program Overview

Sentara Provider Network

Closing Care Gaps Requires Visibility Across the Entire Network



Patients move across multiple providers and care settings—and care gaps emerge when those encounters are not visible.

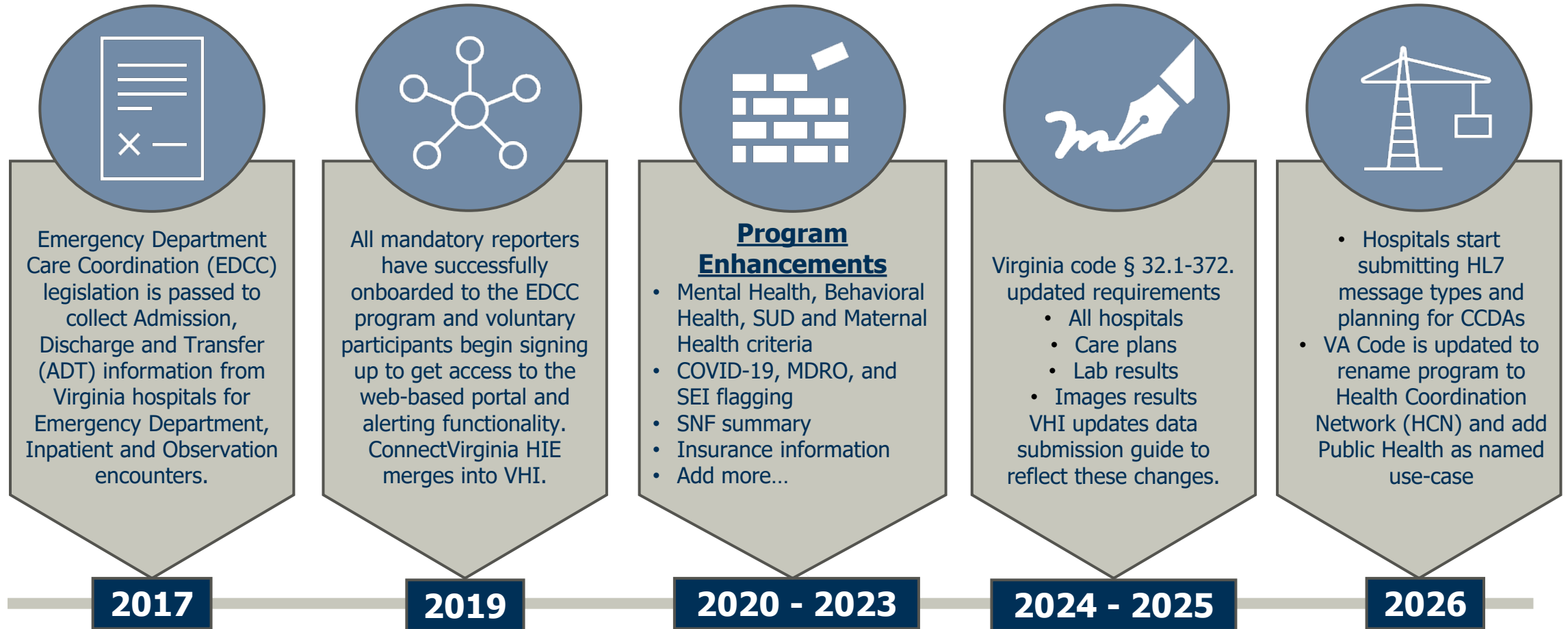
- Patients receive care across hospitals, independent providers, behavioral health, and post-acute settings
- Key information is often fragmented across organizations and systems
- This fragmentation leads to missed follow-up, duplicated services, and delays in care

Closing care gaps depends on having the right information at the right time—across the full care network.



Health Coordination Network (HCN) Background

Previously the Emergency Department Care Coordination (EDCC) Program



What the HCN Does for you & How you Can Use It



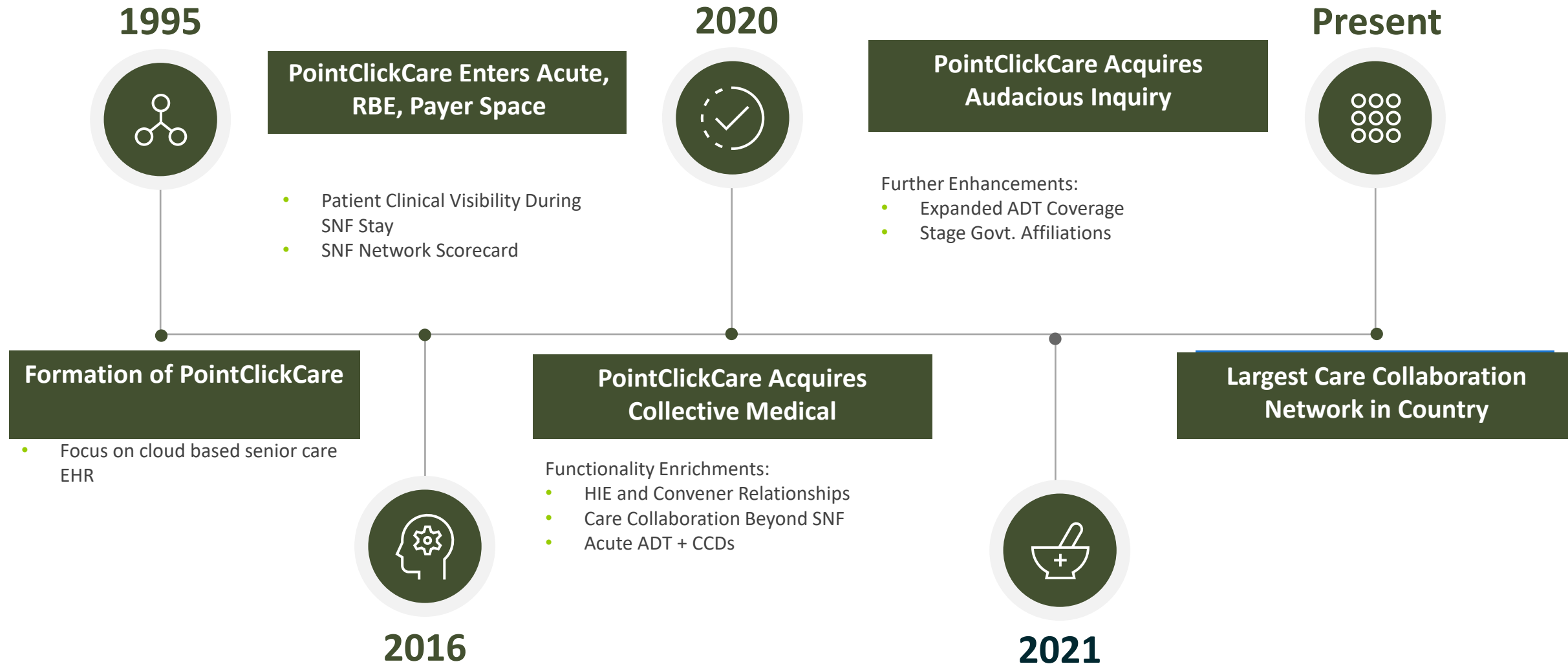
Immediate Value

- Receive real-time alerts when your patients access care (ED, inpatient, SNF)
- Understand where your patients are across the care continuum
- Prioritize high-risk patients based on utilization patterns
- Support timely follow-up after discharge to prevent missed care
- Reduce duplicate services and care delays with better visibility

How Providers Use the HCN in Daily Workflows

1. Get notified when your patient has a new encounter
2. Review context and recent utilization
3. Identify if follow-up or intervention is needed
4. Take timely action (outreach, appointment, care coordination)

PointClickCare's Timeline



How HCN Supports Providers Across the Continuum



Each provider type can benefit from the HCN

Hospital	Primary Care (PCP)	Specialist	Behavioral Health	Post Acute Care
Real-time alerts in ED track-board on high-risk patients	Visibility into hospital activity	Insight into patient utilization across settings	Awareness of BH/SUD-related acute events	Visibility into hospital encounter history
Access to patient history from outside encounters	Alerts that support timely follow-up and help close care gaps	Coordinate care with PCPs and hospital teams	Coordinate care across medical and behavioral health providers	Coordinate care with hospital teams and PCPs post-discharge
Improve care transitions and discharge planning	Identify high-risk patients and prioritize outreach	Identify specialty follow-up needs and close gaps in care	Support continuity of care and reduce missed follow-up after crisis	Reduce readmissions and support continuity of care after discharge

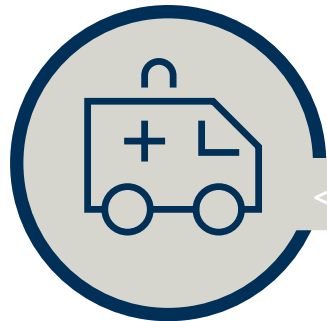
How Does the HCN Work?

**Patient Has a Hospital
Encounter**

**Care Team Notified if
Patient Meets Criteria**

**Real Time
Notification Sent**

**Care Team Member
Logs
into Portal**



< 1 min



< 2 min



**Point
Click
Care.®**

What Criteria Sends Notifications?

Select which criteria best suits your organization...

Core Criteria

High Utilizing Patients

5+ ED encounters within 12 months

Rising Risk

3+ ED encounters within 90 days

All ED Encounters

Any emergency department encounter

All Inpatient Encounters

Any inpatient encounter

All SNF Encounters

BH/ SUD Criteria: History Of...

ED Visit with Mental/Behavioral Health Dx

ED Visit with Suicidal Ideation, Suicide Attempt and/or Self Harm

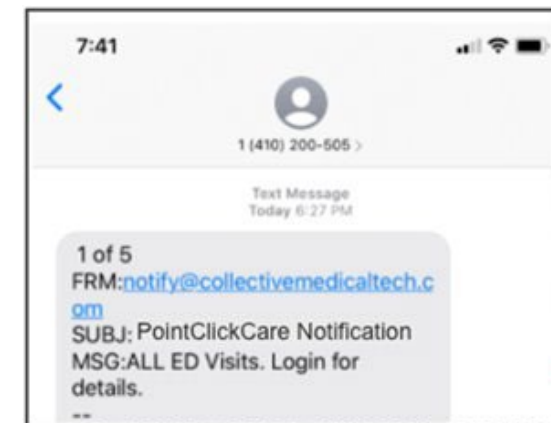
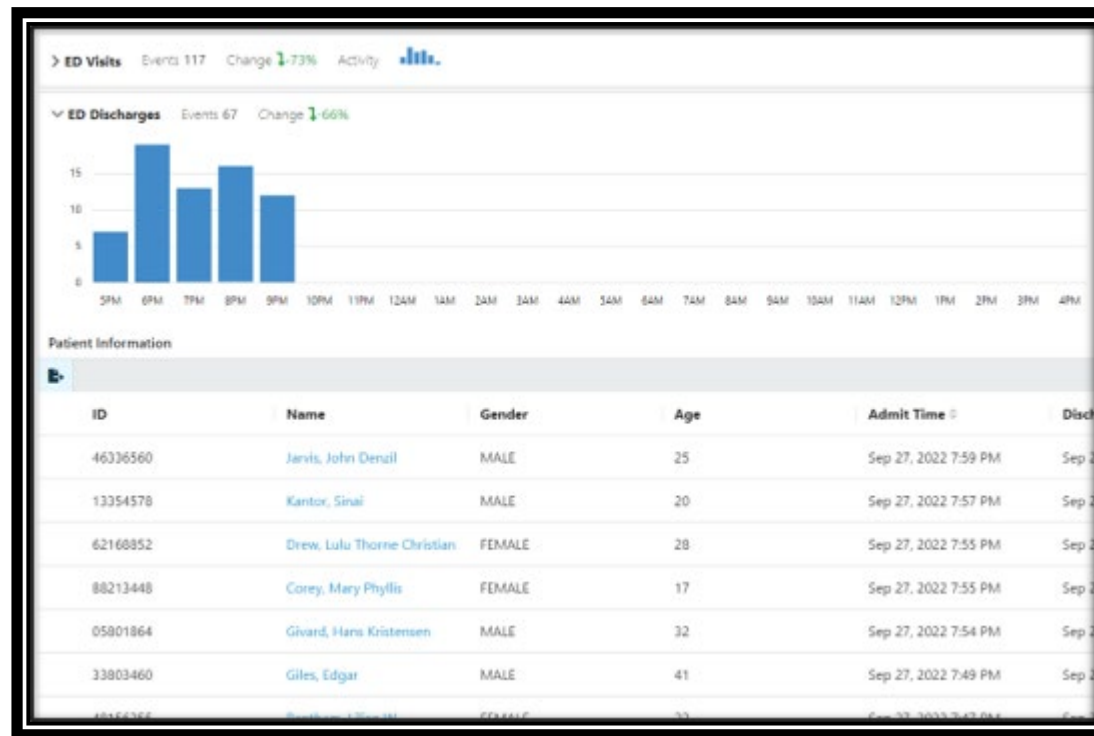
ED Visit with Opioid Overdose

ED Visit with Alcohol Abuse

ED Visit with Opioid Use Disorder

How can you receive notifications?

ED Track-board, Portal, Email and Text



Impacts:

- More informed decisions
- Improve the quality of care for the client

HCN Hospital Real-Time Alerts

- Patterns of High Utilization or Traveling
- SNF Transfer or Recent Discharge
- Care Insights, Safety/Security Events
- PMP Narx Score >500*, Advanced Directive
- ED/IP admission with confirmed MDRO
- History of BH/SUD, Maternal Health and SEI



Ruby Valley

Medical Center

Ruby Valley Medical Center

SAMPLE VIEW

 ED Notification

 AD POLST/AD

 Pain Agreement

 Recent Discharge

 Precautions

 Security Alert

EDIE Alert

Bed	Patient	Age	Gender	Complaint	Alerts	BP	Disposition	
ADULT B34	Young, Patricia	68	F	Fall	   	64	140/60	Room B34
ADULT A09	Croxton, Sally	30	F	Nausea	  	62	109/56	Room A09
ADULT A10	Patel, Ramesh	87	M	CHF	  	92	187/79	Room A10
ADULT A12	Singh, Ajai	19	M	Fever		120	70/30	Room A12
ADULT B20	Nolin, Jack	78	M	Chest Pain	     	62	110/78	Room B20

Enhanced Features Available



SNF Summary

Visibility into Skilled Nursing Facility (SNF) clinical data to make faster, more informed treatment decisions and accelerate care delivery

SUD Alerts

Alerts to identify patients with a history of substance use disorder (SUD) to ensure appropriate treatment and discharge planning

Maternal Health Alerts

Real time pregnancy, postpartum risk and substance exposed infant (SEI) alerts drive informed acute care and coordinated discharge

Mental & Behavioral Health

Real time identification to reduce hospitalization through shared care insights, expedited outpatient care and reduced ED length of stay

SMART on FHIR

Surfaces insights directly inside the EHR so clinicians easily access information without switching systems

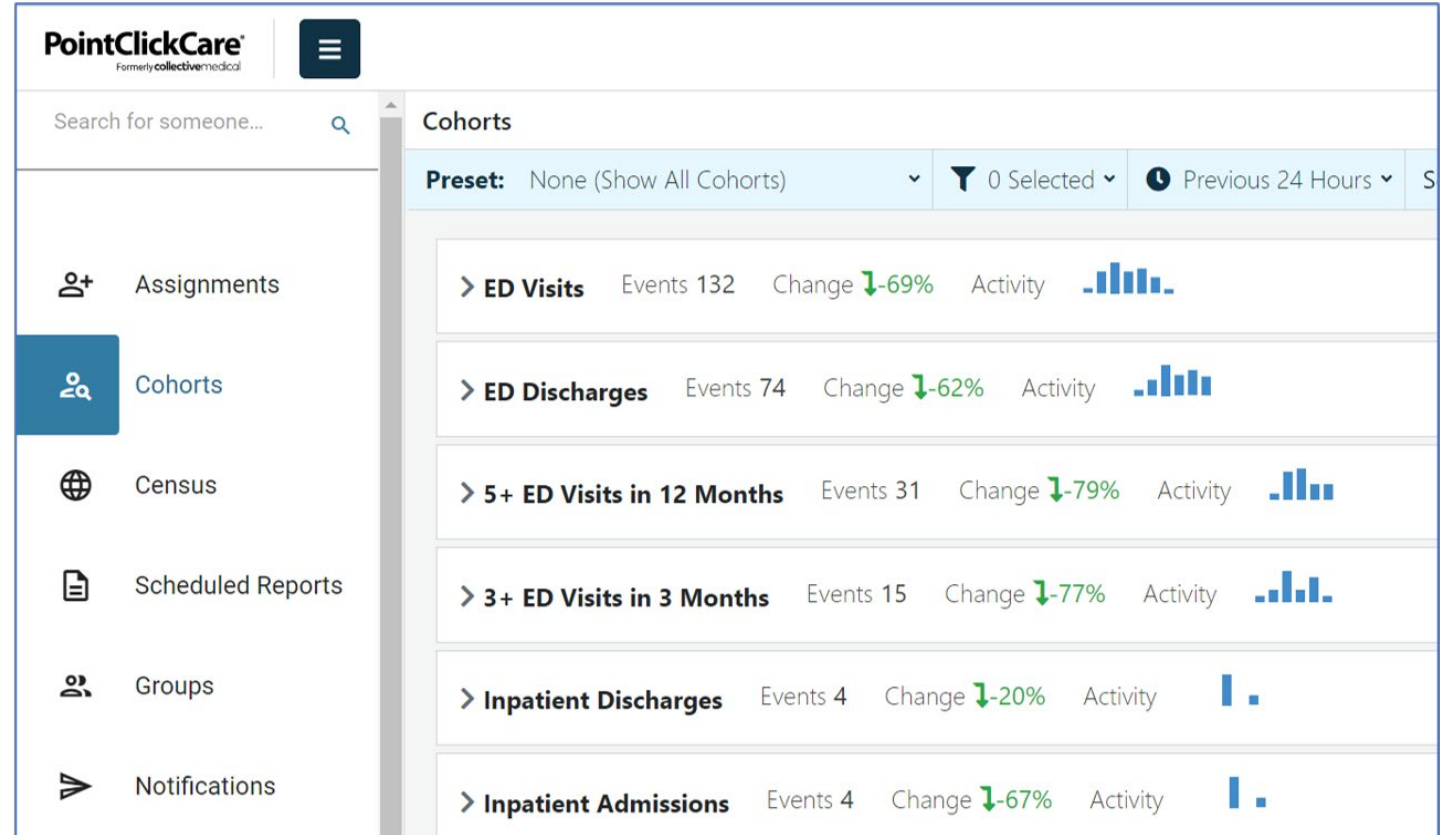
MDRO Flags

The EDCC flags multidrug-resistant organisms (MDRO) positive patients instantly to strengthen infection control and safer care transitions

Find the Patients Needing Outreach



- Real Time Notifications via text or email are powered when the criteria is met
- Notifications are leverages for real time actions/ interventions
- Web-based portal houses all encounter data



Utilization History with Encounter Details



PointClickCare
Formerly collective medical

My Account Logout

Recent Security Event This patient had a **security event** on Jan 1, 2023, 2:35:55 AM at John Barker

Nolin, Jack

View More

Address

4701 Cozy Forest
Lone Pine, VA 23244
View More

Phone

(703) 555-2776
View More

DOB

07/15/1939 (83)
View More

Gender

Male

Tags

+

ABC Program

XYZ Patients

Care Team

Care Team 4 showing all - 2 years

AARON, MAUREEN M, M.D.

Family Medicine

Practice

(276) 638-8692

(276) 638-3389

PointClickCare
Formerly collective medical

Encounter History

Encounter Trends

Individual Encounters

0 Selected Previous 12 Months Date & Time

ED Count 7

Date & Time	Location	Type	Major Type
06/11/2023 @ 7:00am	Ruby Valley Medical Center Galax, VA	Emergency	Emergency
05/18/2023 @ 11:59am	Madeline's Skilled Nursing Alexandria, VA	Skilled Nursing	Post Acute Care
05/11/2023 @ 5:13am	Innova Regional Hospital Alexandria, VA	Inpatient	Inpatient
05/07/2023 @ 7:00am	Innova Regional Hospital Alexandria, VA	Emergency	Emergency
02/17/2023 @ 1:23am	Virginia Hospital Arlington, VA	Inpatient	Inpatient

Encounter Details

Ruby Valley Medical Center Galax, Virginia

Admit Date: 11/14/2022 @ 12:57am Collective Visit ID: 7dc2d-25ed8-60b04

Source: HL7 - Ruby Valley Medical Center - Created On: 11/13/2022 @ 11:57am

Overview Medications Notifications

Attending Physician

Visit Account Number

Billing Account Number

Type

Insurance

Major Type

Chief Complaint

Diagnoses

Administered Medications

Prescribed Medications

Discharge Date and Time

Discharge Disposition

Discharge Diagnosis

Scheduled Report Examples

ED Census & Utilization Report

Patient ID	First	Last	DOB	Admit	Discharge	Visit Type	Facility Name	Chief Complaint	Diagnosis	Criteria Met
12345	David	Smith	1/1/1951	9/30/2020 8:43	9/30/2020 11:21	Emergency	Southwest Medical Center	Abdominal Pain	R1010; Upper abdominal pain, unspecified	5+ ED Visits in 12 Months Suicide or Self-Harm Related Visit - Current ED Encounter
23456	Juan	Martinez	2/2/1962	9/30/2020 9:15	9/30/2020 5:32	Emergency	Southwest Medical Center	SI	R45851; Suicidal ideations	
34567	Carol	Brown	3/3/1973	9/30/2020 10:35	9/30/2020 2:50	Emergency	Southwest Medical Center	fever, diarrhea, dehydration	T6291XA; Toxic effect of unspecified noxious substance eaten as food	History of Suicide or Self-Harm (12 mo.)
45678	John	Jackson	4/4/1984	9/30/2020 11:22	9/30/2020 9:46	Emergency	Southwest Medical Center	laceration on arm	X789XXA; Intentional self-harm by unspecified sharp object, initial encounter	
56789	Maria	Gonzalez	5/5/1995	9/30/2020 12:58	10/1/2020 2:35	Emergency	Southwest Medical Center	Wrist Pain	S52501A; Unspecified fracture of the lower end of right radius, initial encounter	

Behavioral Health 'Cohort' Report

Patient ID	First	Last	DOB	Admit	Discharge	Visit Type	Facility Name	Criteria Met
12345	David	Smith	1/1/1951	9/30/2020 8:43	9/30/2020 11:21	Emergency	Southwest Medical Center	History of Suicide or Self-Harm (12 mo.)
23456	Juan	Martinez	2/2/1962	9/30/2020 9:15	9/30/2020 5:32	Emergency	Southwest Medical Center	History of Suicide or Self-Harm (12 mo.)
34567	Carol	Brown	3/3/1973	9/30/2020 10:35	9/30/2020 2:50	Emergency	Southwest Medical Center	History of Suicide or Self-Harm (12 mo.)
45678	John	Jackson	4/4/1984	9/30/2020 11:22	9/30/2020 9:46	Emergency	Southwest Medical Center	History of Suicide or Self-Harm (12 mo.)
56789	Maria	Gonzalez	5/5/1995	9/30/2020 12:58	10/1/2020 2:35	Emergency	Southwest Medical Center	History of Suicide or Self-Harm (12 mo.)

Specific Cohort Report

Patient ID	First	Last	DOB	Admit	Discharge	Visit Type	Facility Name	Criteria Met
12345	David	Smith	1/1/1951	9/30/2020 8:43	9/30/2020 11:21	Emergency	Southwest Medical Center	History of Suicide or Self-Harm (12 mo.)
23456	Juan	Martinez	2/2/1962	9/30/2020 9:15	9/30/2020 5:32	Emergency	Southwest Medical Center	Suicide or Self-Harm Related Visit - Current ED Encounter
34567	Carol	Brown	3/3/1973	9/30/2020 10:35	9/30/2020 2:50	Emergency	Southwest Medical Center	Patient Tag Criteria
45678	John	Jackson	4/4/1984	9/30/2020 11:22	9/30/2020 9:46	Emergency	Southwest Medical Center	History of Suicide or Self-Harm (12 mo.), Patient Tag Criteria
56789	Maria	Gonzalez	5/5/1995	9/30/2020 12:58	10/1/2020 2:35	Emergency	Southwest Medical Center	MH/BH Related Visit - Current ED Encounter

Behavioral Health: Improving Follow-Up and Closing Care Gaps



Closing BH care gaps requires visibility across the full episode—from crisis to community follow-up.

ED / Crisis Event

- Real-time alerts for BH/SUD-related ED visits (e.g., SI, overdose)
- Immediate awareness of patients in crisis

IP Psych & Acute Care Visibility

- Expanded visibility as IP psych data is added through VHI
- Track patient movement across ED → inpatient psych → discharge

Community Follow-Up & Coordination

- Identify patients needing timely BH follow-up
- Coordinate across PCP, BH, and hospital teams
- Use cohorts/reports to track high-risk populations

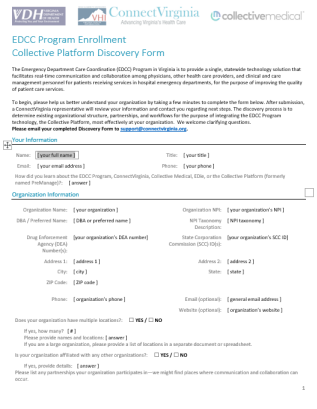
Post-Acute Transitions: Reducing Readmissions Through Improved Visibility



Better visibility into post-acute transitions helps reduce readmissions and close transition-related care gaps.

- Know when your patient is admitted to or discharged from a SNF/post-acute provider via access real-time alerts during key transition points (admission, discharge, transfer)
- Gain better context on recent SNF stays and treatment history
- Support timely PCP/specialist follow-up after post-acute discharge
- Identify opportunities to intervene earlier and prevent avoidable readmissions

The Onboarding Process



VDH | ConnectVirginia | collectivemedical

EDCC Program Enrollment Collective Platform Discovery Form

The Emergency Department Care Collaborative (EDCC) Program in Virginia is to provide a single, interoperable technology solution that facilitates real-time communication and collaboration among physicians, other health care providers, and clinical and care management personnel for patients receiving services in hospital emergency departments, for the purpose of enhancing the quality of patient care services.

To help, please help us better understand your organization by filling out the information below. After submission, a ConnectVirginia representative will review your information and contact you regarding next steps. The discovery process is to determine existing organizational structure, technology, and workflow for the purpose of integrating the EDCC Program technology. The Collective Platform, most effectively at your organization. We welcome clarifying questions. Please email your completed Discovery Form to connect@collectivemedical.com.

Your Information

Name: [text field] Title: [text field]
 Email: [text field] Phone: [text field]
 How did you learn about the EDCC Program, ConnectVirginia, Collective Platform, CPE, or the Collective Platform (if already known)? [text field]

Organization Information

Organization Name: [text field] Organization NPI: [text field]
 SBA / Preferred Name: [text field] NPI Taxonomy: [text field]
 Drug Enforcement Agency (DEA) Number(s): [text field] State Organization Committee (SOC) ID(s): [text field]
 Address 1: [text field] Address 2: [text field]
 City: [text field] State: [text field]
 ZIP Code: [text field]
 Phone: [text field] Email (optional): [text field]
 Website (optional): [text field]

Does your organization have multiple locations? ☐ YES ☐ NO

If yes, how many? [text field]
 Please provide names and locations: [text field]
 If you are a large organization, please provide a list of locations in a separate document or spreadsheet.
 Have you ever participated in a similar program? ☐ YES ☐ NO

If yes, provide details: [text field]
 Please list any partnerships your organization participates in—see right-hand page where communication and collaboration can occur.



Fill out a Discovery Form for your organization

Schedule a HCN demonstration

Review and sign the MSA and HCN addendum

IT Implementation with PointClickCare Team

Join the HCN Collaboratives

Thank you

Questions? Reach out to our HCN Support Team at
HCNSupport@vhi.org



Dario

Mark Jackson

Senior Director, Client Success





Sentara Provider Learning Collaborative

July 1, 2026



Dario Helps Sentara Members



Learn what affects their blood sugar and habits



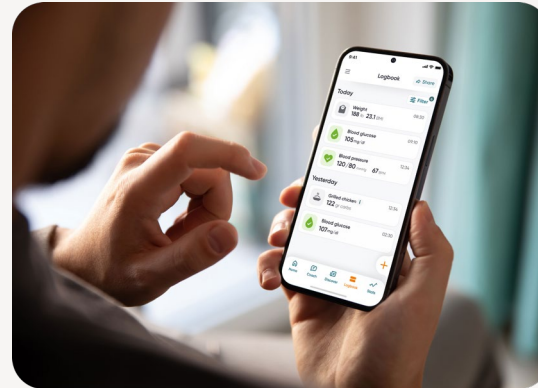
Get real-time feedback and coaching that fits their lifestyle



Set realistic goals to help them stay on track



Connected Blood Glucose Monitor



Easy-to-use App

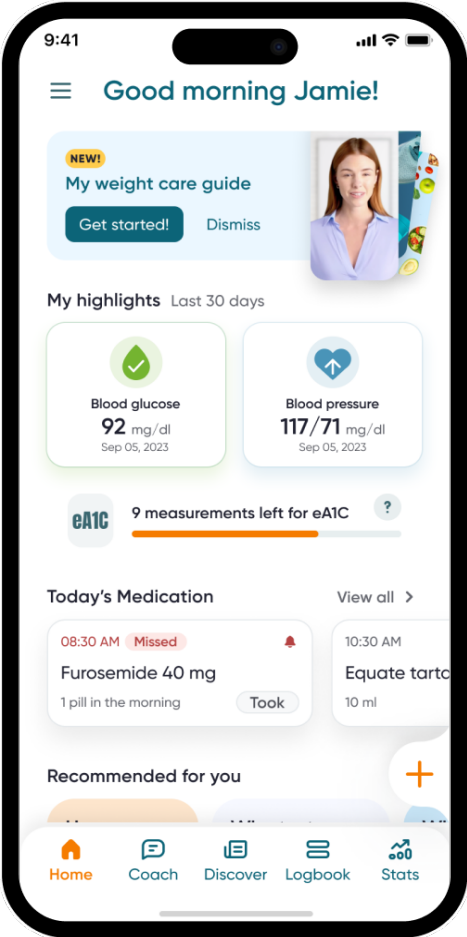
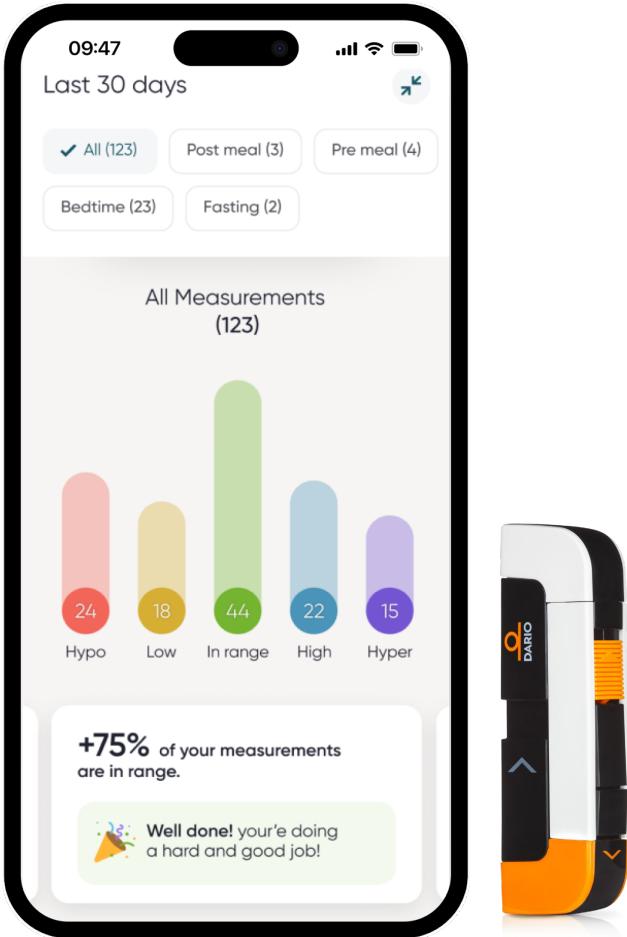


Coaching Support

Simplifying Diabetes Management

Dario is here to make tracking, understanding, and improving health easier every day

Diabetes tools and devices members receive for free through Dario

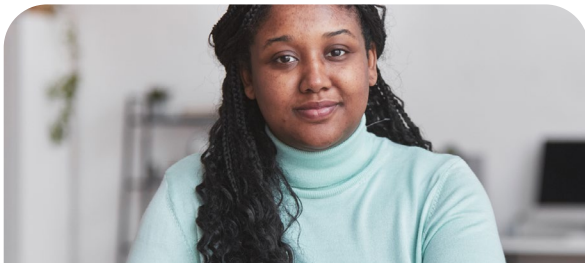


Care That Meets Your Patients Where They Are

From specialty coaching to self-guided digital tools, every patient is matched to the support level that's right for their stage of disease management



Samantha
High risk or recently diagnosed



Olivia
Challenges with managing condition



Mark
Long-term diagnosis fairly well managed

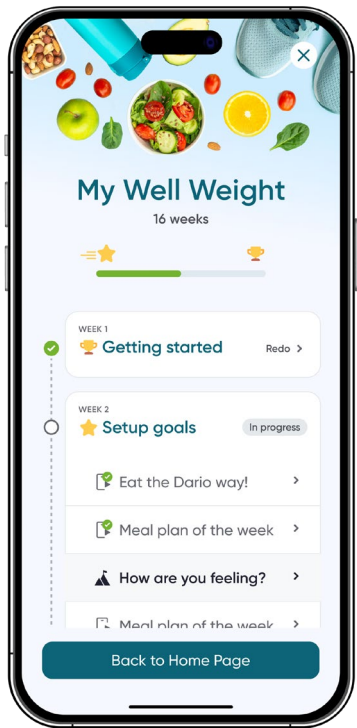
Enrollment Pathway	Enrollment Specialist	Digital or Telephonic Enrollment	Digital Enrollment
Recommended Member Supports	Diabetes-Specific Care Plan with Specialty Coach + App - Medical Knowledge - Medication Adherence - Condition Specific Lifestyle Modification - Ensure establish care provider - Advanced SDoH condition management - Condition Advocacy & external referrals Most utilized App Features: - Understanding impact of logbook - Relationship of food and physical activity tracking - Setting Reminders - Apple Health Kit - Grocery Scanner - Medication Cabinet for adherence	Care Plan with Health Coach + App - Identify motivation of change - Overall health improvement - Lifestyle changes - Sustain healthy habits - Address SDoH needs - Encourage follow up with PCP Most utilized App Features: - Chat with coach - Understanding features of logbook - Tracking food and physical activity - Setting Reminders aligned with habits - Apple Health Kit - Grocery Scanner - Medication Cabinet for awareness	Self-Guided Care Plan + App - Expand on existing motivation - Device and App feedback based on engagement - Light coaching intervention as requested Most utilized App Features: - Use of logbook - Tracking food and physical activity - Apple Health Kit - Grocery Scanner - Medication Cabinet

Creating engagement that lasts a lifetime

Dario fits into members' daily routines to build habits that stick

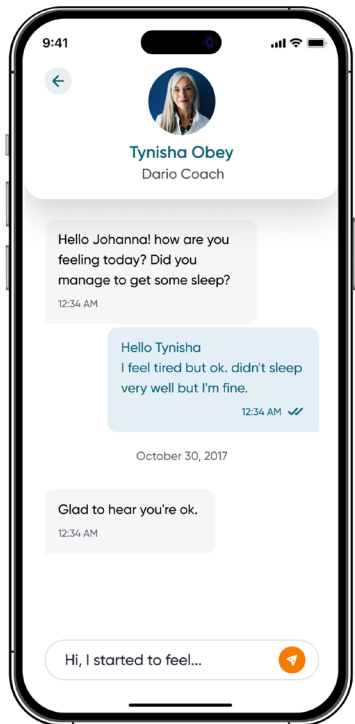
Self-Guided Programs

Evidence-based activities and tools that help make lasting changes.



Coaching

Personal support to guide, motivate, and keep members on track.



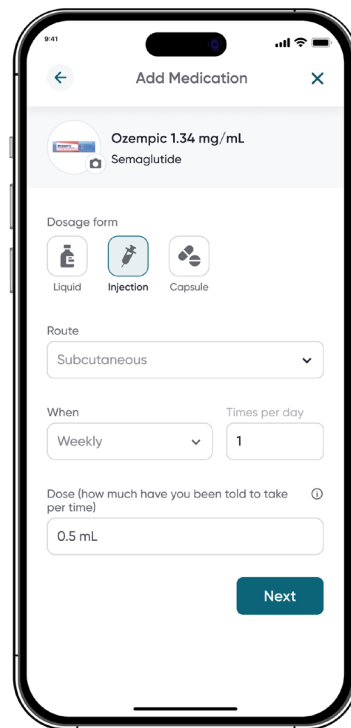
Health App & CGM Integration

All their health data in one easy-to-use app.



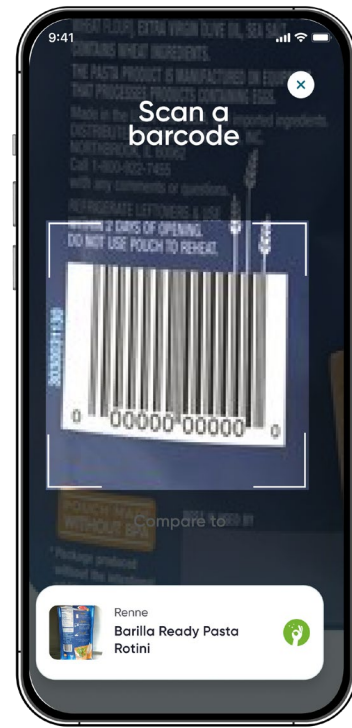
Medication Cabinet

Ability to track meds, set reminders, and stay organized.



Grocery Scanner & Care Kitchen

Food scanning and smart recipe ideas tailored to their needs.



Dario's Member Enrollment Process

*online enrollment available in English & Spanish

- 1 Sentara members enroll via Dario's landing page (URL/QR code)
- 2 Dario performs an eligibility check
- 3 Member inputs their phone and email
- 4 Member selects their diabetes program (+glucometer connector selection)
- 5 Member adds their shipping address
- 6 Program, device, and address confirmation, plus instructions to download the Dario app

Eligible users can also enroll over the phone!

Dario enrollment specialists are available M-F, 9am-9pm EST at 1-833-708-3061

Executive Summary: Engagement Drives Outcomes

Across all modalities—measurement, education, lifestyle, and coaching—engagement was strongly linked to significant blood glucose reductions

-1.0 pt A1c

High-risk members achieve significant A1c reduction. Members with A1c >8.0 lowered estimated A1c by 1 point within 3 months, sustained for 18 months — with 50% reaching at least that reduction.

p=0.028

Coaching significantly reduces blood glucose. Direct coaching sessions showed a statistically significant effect (98.6% model confidence); blended approaches combining digital tools, coaching, and measurement showed similar improvements.

50%

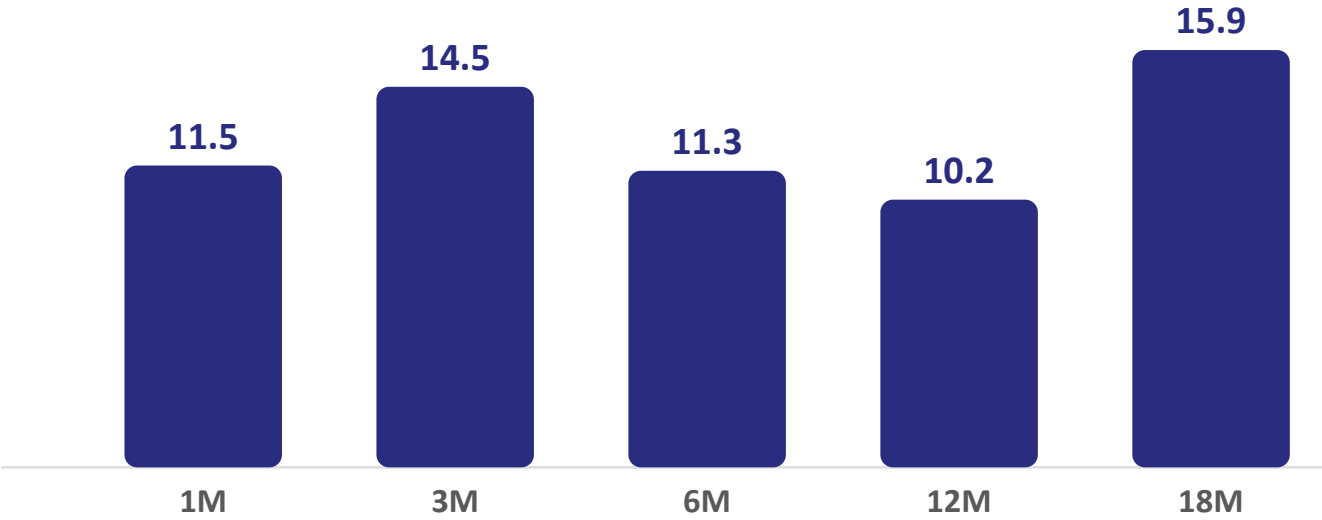
Sustained outcomes, population-wide. Half of high-risk members reached a healthier glucose range, supporting disease progression prevention across the total population.

14–15 /month

Strong glucose measurement engagement. Members logged measurements consistent with clinical recommendations, with strong early engagement in the first 1–3 months.

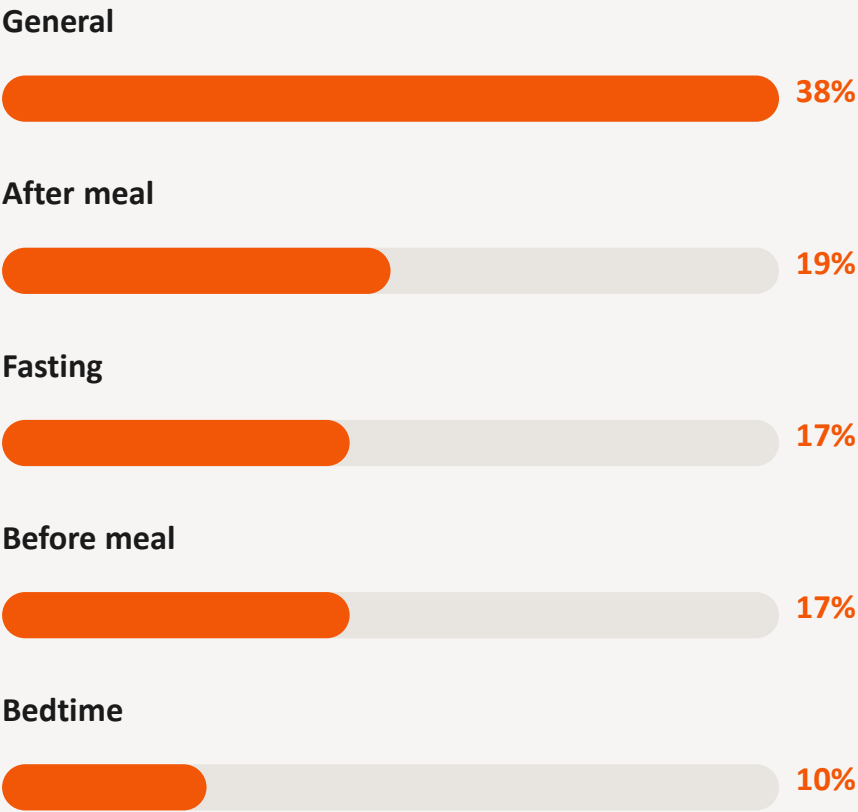
Blood Glucose Measurement Frequency

Average Monthly Blood Glucose Measurements



Monthly measurement frequency is consistent with recommended levels in the literature, given the heterogeneity of the diabetes population. Dario data shows a stronger blood glucose decrease among members with >12 average monthly measurements—a dose-response relationship between measurement frequency and outcomes.

Measurement Type Distribution



Dario 2026: News & Product Roadmap

What's happening at Dario?

- **Launched DarioIQ™:** conversational AI for personalized member support, testing in our D2C innovation lab
- **ADA Scientific Sessions (Jun 2026):** 44.8% of high-risk diabetes members achieved ≥ 1 pt eA1c reduction at 12 months; 6.4% weight loss alone, 14.3% combined with a GLP-1, and fewer hospitalizations among high-risk members
- **100+ peer-reviewed studies:** the most of any digital health company
- **New Care Guides** added to platform created by our clinical team and backed by research
- **Supporting oral GLP-1 therapy:** 79% of Dario members already engage in weight management; structured behavioral tools (medication tracking, food logging, coaching) help reinforce adherence as oral GLP-1s scale into primary care
- **New ML study (Frontiers in Digital Health, Mar 2026):** 22,414 adults with T2D showed sustained glucose improvements; 12+ measurements/month identified as the key engagement threshold

Everything you need to manage diabetes with confidence

Connect your device, track progress, and get real-time support.

- Easy-to-use Dario app
- Connected glucometer
- Personal coaching and guidance
- Healthy living tips you can use today

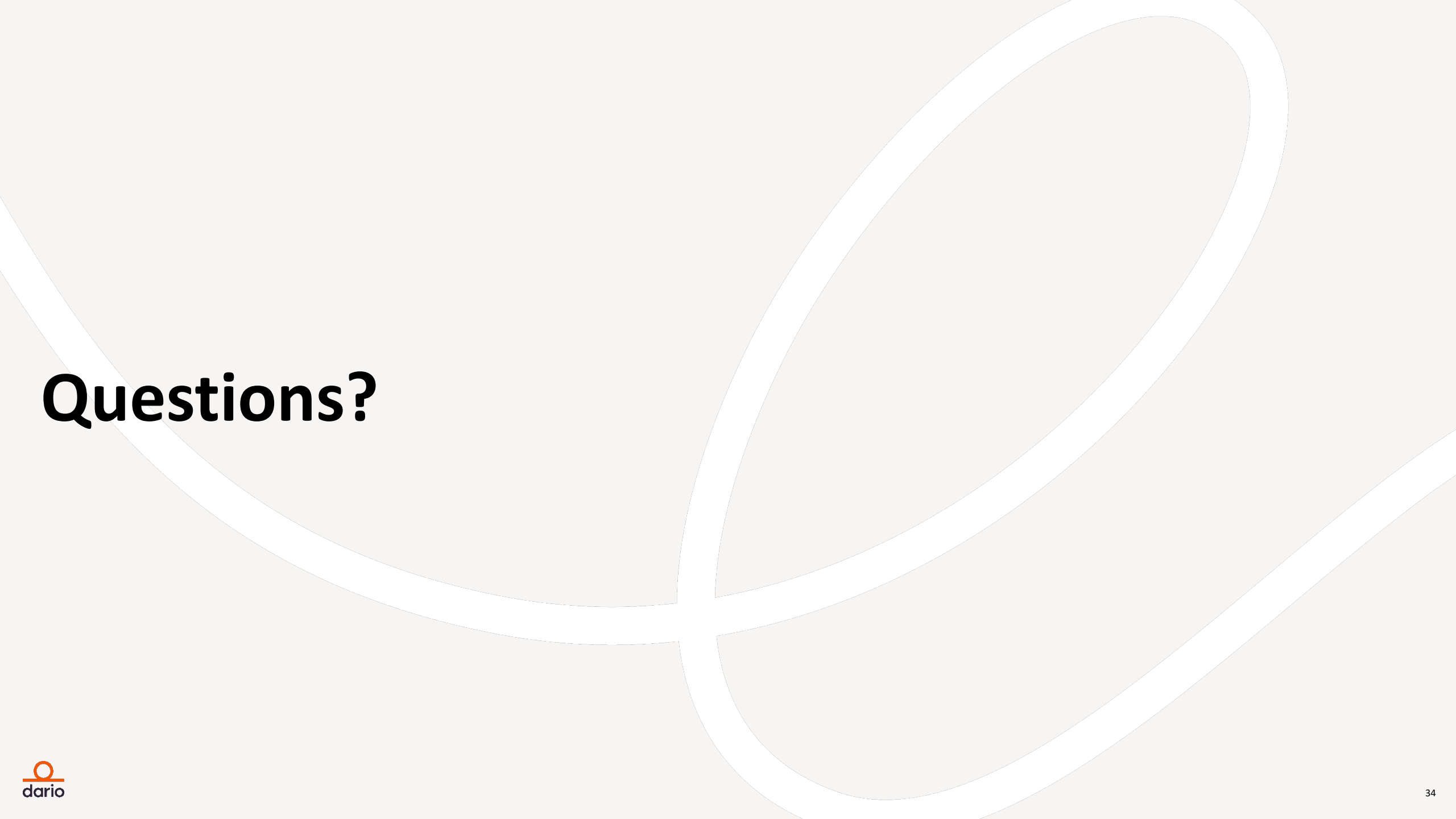


Scan the QR code to join today!

OR CALL:

1-833-708-3061

The Dario program is available at NO COST to Sentara members who qualify.



Questions?

Appendix

Introduction

The integration of digital health technologies and machine learning (ML) is transforming chronic disease management by enabling scalable, personalized, and data-driven care. In particular, ML models such as decision trees can stratify individuals based on key clinical and behavioral factors [1]. Among ML methods, decision trees are particularly valuable in real-world clinical settings due to their interpretability and ability to capture nonlinear relationships. They have demonstrated potential in predicting diabetes-related complications and identifying subgroups who may benefit from more intensive or specialized interventions [2,3]. Dario, a digital health platform for chronic condition management, combines connected monitoring devices, behavioral tools, and real-time data collection. By analyzing longitudinal data from the platform, machine learning techniques can be used to identify moderating factors that shape individual blood glucose (BG) trajectories. This approach supports the development of adaptive and personalized care strategies aimed at improving glycemic outcomes over time.

Objective

This study utilizes Dario's digital health platform data to gain insights into BG patterns influenced by clinical and engagement factors, for developing personalized interventions.

Methods

Retrospective data analysis was performed on high-risk T2D users (BG >180 mg/dL at month 1, equivalent to eA1c 8.0) who measured their BG on the Dario platform between 2020 and 2024 for a minimum of two separate months. A piecewise linear mixed-effects (LME) model defined time-related fluctuations in monthly average BG (AvgBG) with cutoff at 4 months based on a year data visualization. An ML approach was adopted using a piecewise LME decision tree to identify factors moderating BG trajectories such as no. of comorbidities, any insulin usage, self-reported BMI, year of diagnosis, and monthly number of BG measurements.

Results

- A group of 22414 users was evaluated (Age 57.5 SD ±12.1; 46% females). A significant decrease in the AvgBG was observed in the first 4 months (B=-6.8, p<.001) followed by a milder decrease in the next 8 months (B=-.3, p<.001).
- The decision tree first split based on insulin usage and then on the year since diagnosis, categorizing users into <5 and ≥5 years (before/after 2019). In the first 4 months, insulin users with less than 5 years since diagnosis (after 2019) had the strongest decrease in AvgBG (B=-14.3, p<.001) (Figure 1).

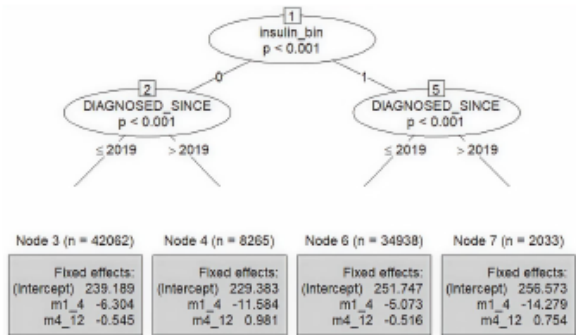


Figure 1: Piecewise mixed-effects model tree showing estimated coefficients in the terminal nodes for monthly average BG. The data were divided into four subgroups: the first split differentiates insulin users from non-insulin users, followed by a second split based on diabetes duration (≤2019 vs. >2019). m1_4 denotes estimates for the initial time segment (months 1–4), and m4_12 denotes estimates for the subsequent period (months 4–12).

- BG monitoring tree segmented into 2 subgroups: ≤12 and >12 average monthly measurements. There was a significant decrease in the AvgBG in the first 4 months for both groups (≤12: B=-6.4, p<.001; >12: B=-9.0, p<.001), with a stronger decrease for the >12 group. In the following 8 months, >12 group demonstrated an additional decrease in the AvgBG (B=-1.3, p<.001) yet the ≤12 experienced no change (p=.5) (Figure 2).

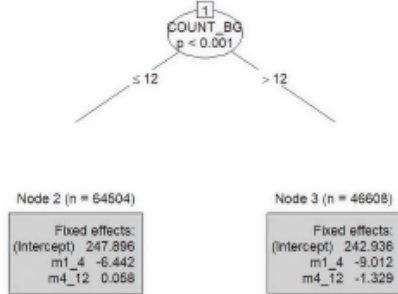


Figure 2: Piecewise mixed-effects model tree displaying estimated coefficients at the terminal nodes for monthly average BG. The data is split into two groups based on the number of BG measurements per month: individuals with ≤12 measurements and those with >12. m1_4 denotes the estimated change during months 1–4, and m4_12 denotes the change during months 4–12.

Discussion

This study demonstrates the utility of ML decision trees combined with piecewise linear mixed-effects modeling in uncovering patterns of glycemic change among high-risk individuals with type 2 diabetes using a digital health platform. By analyzing real-world data collected through the Dario platform, we identified clinical and engagement-related factors that significantly moderate BG trajectories over time. In the overall cohort, a substantial reduction in AvgBG was observed during the first four months of platform use, suggesting the initial engagement period plays a critical role in glycemic improvement. Beyond this window, a more modest decline was observed, indicating the need for sustained and tailored interventions to maintain momentum, supported by previous studies [4,5]. The decision tree stratified users first by insulin usage and then by diabetes duration. The strongest initial glycemic improvement was observed in insulin users diagnosed within the past five years, emphasizing the potential for greater responsiveness among those earlier in their disease course [6]. These findings support the hypothesis that intervention timing relative to disease progression is a key determinant of impact.

A second decision tree, based on BG monitoring frequency, revealed that users who measured BG more frequently (>12 times per month) experienced a significantly greater and more sustained reduction in AvgBG. This underscores the importance of self-monitoring behavior as a modifiable engagement factor that may drive better compliance and clinical outcomes [7]. Together, these results highlight the value of leveraging longitudinal digital health data to guide adaptive care strategies. ML-driven subgroup identification can inform more precise planning, such as intensified support for users late in their disease course or reinforcement of BG monitoring habits to sustain glycemic gains. Importantly, the interpretability of decision trees enhances their clinical utility, making them a promising tool for real-world implementation.

Conclusion

These findings highlight the importance of using ML to understand clinical and engagement factors enabling the development of personalized interventions on digital health platforms.

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Analysis design

Population: members measuring blood glucose assigned to cohort (active-in-month), can be in multiple months

Modeling: change in Average blood glucose and eA1c from baseline to the selected month over a year

N=397 Engaged Members (performed any engagement activity)

N=349 Members with baseline blood glucose measurement

Engagement variables:

- Coaching (calls and chat)
- Digital engagement (account set up/onboarding, profile, pairing activity)
- Blood glucose (BG) Measurements
- Digital + Coaching
- Coaching + BG Measurement
- Digital+ BG Measurement
- Education (articles, videos, tips, messaging, reports)
- Life-style Activities (physical activity, food and nutrition logging, medications, reminders)

Methodology

Data: 288 members (baseline eA1C > 7); average monthly blood glucose.

Model: Changes in blood glucose (BG) over time were modeled as a function of engagement behaviors. A mixed-effects model with member-specific intercepts was used where possible; otherwise, ordinary least squares regression was applied.

Scaling: Time was standardized (z-scored), and skewed engagement behaviors were log-transformed and standardized to allow comparability.

Read it: Negative effect = faster BG drop for $\sim +1$ SD engagement; Negative coefficients indicate faster reductions in blood glucose, which can be interpreted as approximate per-month changes (e.g., -9.1 translates to about -2.4 mg/dL per month).

Uncertainty: was assessed using 95% confidence intervals and Wald tests.

“Hit when $\uparrow$ ” = probability BG decreases as engagement increases.

The model is Associational; not causal/Bayesian/piecewise; no random slopes or multiple-testing adjust; sensitive to missingness and unmeasured factors.

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.**

- August – Provider Spotlight – Behavioral Health Walk-in Center vs. ER
- September – Provider Spotlight – Collaborating with SHP Provider Outreach

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

- August 11
- November 10

➤ **New Provider Orientation**

- July 2, 15 and 21
- August 6, 12 and 18

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

- September 23
- December 16

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

- July 16 and 28
- August 13 and 25

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

- July 8
- October 7

View Schedule/Register



Register Today 😊

[View Schedule/Register](#)



August 5th This session is designed for behavioral health and other providers and their staff interested in learning how a provider is achieving success in reducing avoidable emergency room (ER) admissions. You will hear how a provider has relieved ER strain by providing quicker access to care with a crisis walk in center.

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

Sentara Health Plans Medicare Healthy Rewards 2026

Providers may direct inquiries about these rewards to provider services at 757-552-7474 or 1-800-229-8822, option 2, 8 a.m. to 6 p.m., Monday through Friday.

Visit our website at
<sentaramedicare.com/rewards>
for more details about the
Healthy Rewards Program.

Preventive screening, exam or vaccine	Reward	Who is eligible?
Annual wellness visit	\$100	All members
Combined with annual physical exam	+\$20	
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 ¹	\$15	All members
Flu Vaccine	\$10	All members
In-home assessment ²	\$25	All members

¹Members complete an online Falls Risk Assessment to earn this reward.

²Contact Member Services to schedule an In Home Assessment.

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 2026](#)

[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](#)