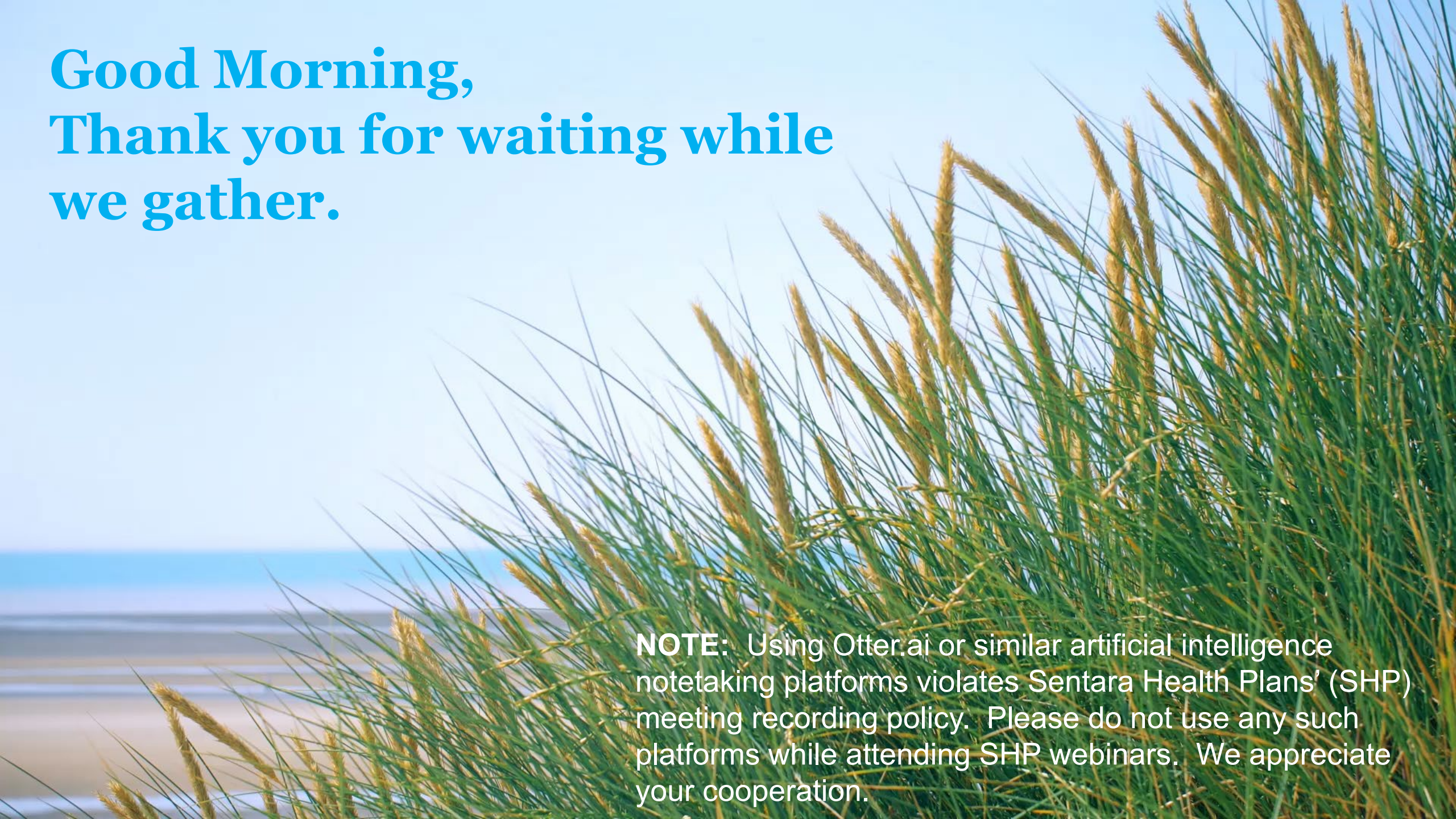




**Good Morning,
Thank you for waiting while
we gather.**

NOTE: Using Otter.ai or similar artificial intelligence notetaking platforms violates Sentara Health Plans' (SHP) meeting recording policy. Please do not use any such platforms while attending SHP webinars. We appreciate your cooperation.

Provider Quality Learning Collaborative

June 3, 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
- Medicare Health Outcomes Survey
- Medicaid Chronic Disease Management Programs Overview
- Documentation Tips
- How Can Sentara Health Plans Help You?
- Q & A
- Closing Remarks

Medicare Health Outcomes Survey

Why Everyday Conversations Matter for DSNP Patients

Lindsay Lopez

Medicare Stars Program Manager



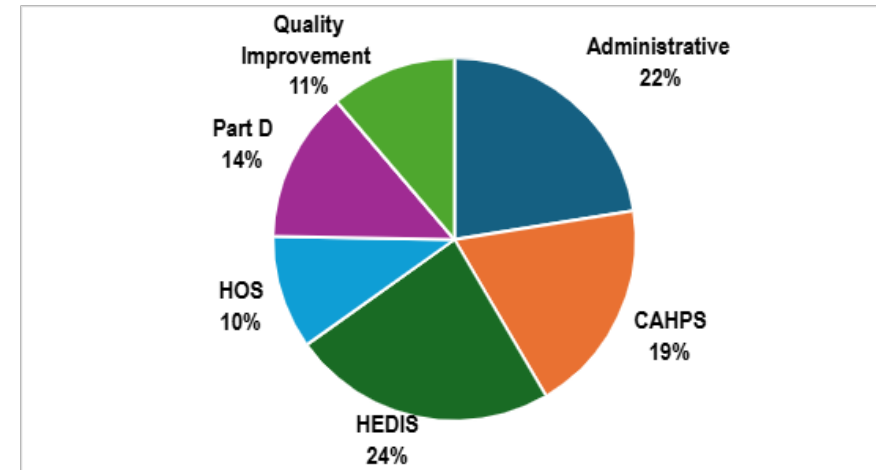
Health Outcomes Survey (HOS): Fast Facts

1. HOS is a Medicare Advantage-only survey.
2. Sentara Health Plans' Medicare Advantage membership consists of DSNP and Partial DSNP members.
3. DSNP members often live with multiple chronic conditions, functional limitations, and social risk factors.
4. HOS is not a satisfaction survey. HOS captures **patient-reported outcomes**, not claims or chart data.

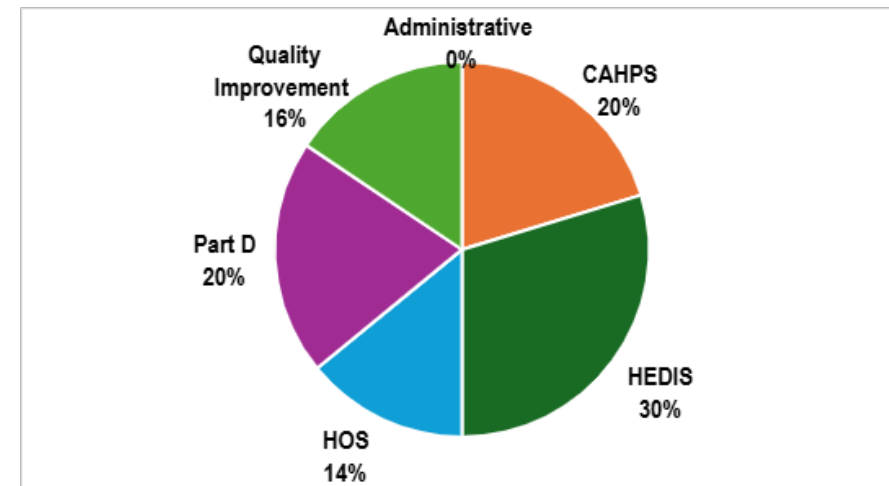
Why HOS Matters

- HOS measures affect Medicare Advantage Star Ratings
- Star Ratings influence:
 - ✓ Plan stability
 - ✓ Resources for care management
 - ✓ Supplemental benefits for your patients
- HOS focuses on outcomes that matter to members

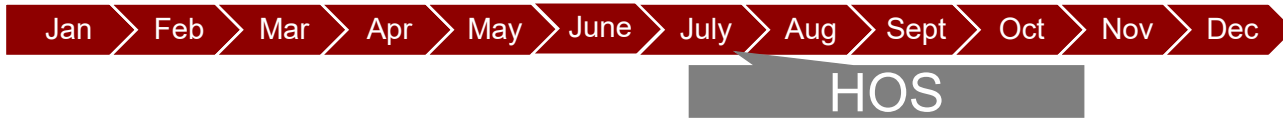
Star Year 2027



Final Rule - Star Year 2029



How HOS Works



Eligible patients are:

- Surveyed at a baseline
- Then surveyed again about two years later

How results are used:

- Some measures evaluate **change over time** (improved, maintained, or declined function)
- Other measures capture **current status**

For Star Ratings:

- Results are based on responses from members age **65 and older**



For many DSNP members, avoiding decline is success.

What HOS Measures

HOS focuses on:

- Physical functioning – walking, climbing stairs, staying active
- ADLs – bathing, dressing, toileting
- Falls and fall risk
- Bladder control
- Mental health and emotional well-being status
- Self-rated physical health status

HOS measures **function** and **patient-reported experiences of care** – not diagnoses or claims data.



What HOS Asks

HOS Measure	Measure Weight	Example Question (not verbatim)	Measure Type
Monitoring Physical Activity	1	<i>Did your provider talk with you about physical activity?</i> <i>Did your provider encourage you to be physically active or exercise?</i>	Doctor-Patient Discussion
Reducing the Risk of Falling	1	<i>Did you talk with your provider about falls or balance problems?</i> <i>Did your provider help with fall prevention or balance problems?</i>	Doctor-Patient Discussion
Improving Bladder Control	1	<i>Does urine leakage interfere with your daily activities?</i> <i>Did you talk with your provider about urine leakage?</i> <i>Did your provider talk to you about options to help this issue?</i>	Doctor-Patient Discussion
Improving or Maintaining Physical Health	3	<i>Does your health limit you in everyday activities like housework or climbing stairs?</i> <i>In the past month, have you accomplished less than you'd like?</i> <i>How much does pain affect your daily life?</i>	Health Outcome over Time
Improving or Maintaining Mental Health	3	<i>Have emotional problems made it harder to get daily activities done?</i> <i>Has physical health or emotional problems interfered with social activities?</i>	Health Outcome over Time

High Impact Focus Areas for DSNP Members

Top Drivers of HOS Outcomes

Depression	• Screen annually (PHQ-2/PHQ-9) • Ask how mood or stress affects daily life • Close the loop on treatment
Pain	• Ask about pain and its impact on activities • Adjust treatment plans • Prioritize even small improvements in pain
Mobility & Falls	• Ask about falls, balance, or fear of falling • Review medications and mobility needs • Refer to PT or OT early
ADLs	• Identify decline early • Coordinate supports • Recognize that functional decline affects reported health
Bladder Health	• Ask directly • Address or refer when symptoms affect daily life • Reduce bladder symptoms to preserve function and independence

Why Primary Care Matters Most

HOS reflects how patients function in daily life – and in some measures, whether patients recall receiving guidance from their provider, often during visits like the **Annual Wellness Visit**.

Primary care influences HOS outcomes by:

- Maintaining **stability of chronic conditions**
- Managing **pain and mobility** that affects daily activities
- Addressing **emotional health** that interferes with function
- Recognizing **early changes** in balance, walking, or self-care
- Identifying **bladder symptoms** that affect safety and independence
- Setting **clear goals and follow-up plans** patients understand



What Patients Remember When They Complete HOS

- Being asked about symptoms
- Feeling heard and taken seriously
- Understanding next steps
- Knowing help was available



The Shared Care Team's Role in HOS Outcomes

HOS reflects whether care translates into real-world function – and that happens through partnership.

Strong outcomes depend on:

- Addressing key issues: pain, mood, mobility, bladder concerns
- Ensuring follow-up plans and referrals move forward
- Making sure patients understand next steps
- Maintaining continuity and coordination over time
- Engaging caregivers to support care between visits

Bottom line:

PCPs lead clinical decisions; the broader care team sustains outcomes between visits.



Sentara Health Plans - Medicaid Chronic Disease Management Programs Overview

Tammy Forbes, MSN, RN

Director, Chronic Disease Management &
Transitions of Care



Program Goals

Program Conditions

1. Diabetes
2. Asthma
3. Chronic Obstructive Pulmonary Disease (COPD)
4. Cardiovascular conditions (Heart Failure, Hypertension, & Coronary Artery Disease)

- Engage enrollees and care partners in the enrollee's care through provision of education and interventions to engage enrollees and caregivers as partners in care
- Increase utilization of preventive services and Improve health outcomes by utilizing objective measurable methods
- Facilitate the scientific approach to improving health care services through the use of goals, specific interventions, reference populations, analysis plans, and quantifiable, measurable outcomes.
- Close the gaps on disparate access, utilization, or outcomes through assessment from SDOH and health/wellness questions on chronic disease assessment
- Implement best practices informed by ongoing program evaluation

Referral Criteria

- **Diabetes Mellitus (DM) Members must have one confirmed:** A1C >8, Blood Pressure (BP) 140/90; Abnormal Retinopathy Exam; documented impaired renal function; Non-Compliance with Statin Medication refills or documented hyperlipidemia
- **Hypertension (HTN) Members must have one confirmed:** BP 140/90; Noncompliance with Statin Medication refills or documented hyperlipidemia
- **Chronic Obstructive Pulmonary Disease (COPD) members must have one confirmed:** Spirometry results missing or abnormal result; 3 Emergency Department (ED) visits in 90 days related to COPD
- **Asthma members must have one confirmed:** Allergy test not completed or abnormal; 1 admission for asthma in last 6 month or 2 or more ED visits in last 6 months
- **Congestive Heart Failure (CHF) Members must have one confirmed:** 2 ED visits or 2 admissions for CHF in the last 6 months and Non-Compliance with CHF symptom treatment medication refills
- Members newly diagnosed with one of the above conditions

Diabetes Transition Program



Targeted Members: Members admitted/readmitted to the hospital with a **primary** diagnosis of any diabetes code.

Line of Business (LOB): Medicaid and Dual Special Needs Plan (DSNP)

Goal: Ensure/assist members with follow up appointments to providers and specialists, transportation, compliance and understanding of medications, self- management/sick day plans, equipment, and community resources to prevent further diabetic readmissions.

High Risk Maternity Co-management Program



Targeted Members: Members who are identified as high-risk pregnancy (Maternal Team) accompanied by one of the following chronic conditions – DM, Asthma, COPD, HIV/AIDs, CHF, CAD or HTN.

LOB: Medicaid

Goal: Provide support to improve the physician or practitioner/patient relationship and adherence to plan of Disease. Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies with individualized Disease planning. The program evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health throughout their pregnancy.



Omada Health Prediabetes Program

Sentara Health Plans partners with Omada® to offer a targeted group of Sentara Health Plans members a year-long diabetes and heart disease prevention program. As part of the program, eligible members will receive:

- an **interactive program** to guide their journey
- a **wireless smart scale** to monitor progress
- **weekly online lessons** to empower them
- a **professional health coach** for added support
- a **small group of peers** to keep them engaged in the program

The Omada program is modeled on the National Institutes of Health-sponsored Diabetes Prevention Program clinical trial, which showed that people with prediabetes who lost a modest amount of weight through lifestyle intervention sharply reduced their chances of developing diabetes. Research has shown that applying these same core principles of behavior change can reduce risk factors for heart disease as well.¹

Using specific clinical criteria and claims data, Sentara Health Plans has identified a targeted population for this **invite-only** program. Eligible Sentara Health Plans members may receive invitations via mail or email to visit a dedicated Omada web page and complete a brief health test to determine if Omada is right for them.

**All this at no
additional cost to you!**

**Find out if you're eligible:
omadahealth.com/sentara**

What is Dario Health?

Dario Health is an **invite-only** program that helps eligible Medicaid members with type 2 diabetes. The program helps members focus on healthy habits by using an app that includes digital tools and coaching. The app has information on how to eat better, move more, manage stress, and other ways to manage diabetes easier.

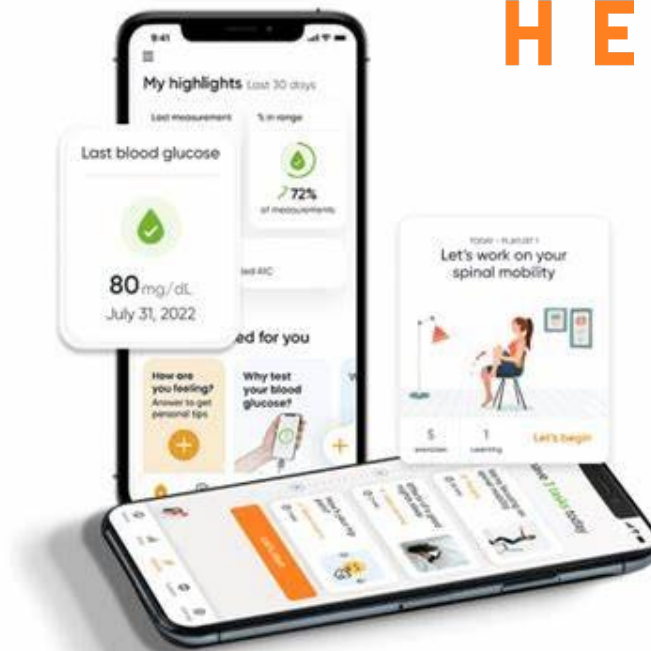
How do members qualify for Dario?

Members qualify if they have an A1C value of 8 or above, and are:

- A Sentara Community Plan member
- At least 18 years of age
- Diagnosed with type 2 diabetes

Members may not qualify if they are pregnant or have:

- Liver failure
- End-stage renal disease (ESRD)
- Had an organ or bone marrow transplant
- Cystic fibrosis
- Other exclusionary conditions (a list of these conditions is available)



Eligible members are sent a letter offering the program with instructions on how to enroll.

Members can enroll by phone or online by using the instructions in the letter.

Eligible members will receive:

- Glucometer
- Supplies, including lancets and strips
- Access to the Dario Health app including digital coaching, updates, activity log, and more
- Onboarding coaching and technical support
- Certified specialty coaching by diabetes educators, and other specialties that apply, to work with members on managing their conditions and help them meet their behavioral change goals
- Members already using Dario, call 1-833-914-3798 (TTY: 711), Monday through Friday, 9 a.m. to 9 p.m.
- Members who are interested in the Dario program, can call the same number.

[Dario Health | Medicaid | Sentara Health Plans](#)

Documentation Tips

Naidelys Rodriguez
Manager, Clinical Coding



Documentation Tips

Specificity: Documentation must be specific as possible to code to the highest level of specificity in ICD-10. Examples:

- Active
- Stable
- History of
- Controlled
- Uncontrolled
- Remission status (Partial/Full)
- Under surveillance
- Complications
- Exacerbation
- Cause and Effect
- Manifestations
- Late effects (sequela)
- Trimester of pregnancy
- Associated conditions

Key reminder: Avoid contradictions within the same encounter.

Provider Documentation Tips

- **Be Specific with Acuity and Type:**
 - **Diabetes:** Focuses on specificity (e.g., Type 1 or 2), short-term complications (ketoacidosis, hyperosmolarity), long-term complications, and uncontrolled status.

The **"With"** in ICD-10, implies a causal relationship. For example, "Diabetes with Kidney Disease" automatically links the two unless you state they are unrelated.
 - **COPD/CHF:** Document "Acute," "Chronic," or "Acute on Chronic" to accurately reflect the patient's status.
 - **Documentation Examples:**
 1. A patient is on Lasix for CHF – documentation should state “compensated CHF; stable on Lasix” instead of “History of CHF”.
 2. A patient is on Advair for COPD - documentation should state "COPD controlled with Advair".
 - **CKD:** Specify the current stage of the condition and avoid contradicting documentation within the same encounter.
 - **Asthma:** Specify type (intermittent vs. persistent), severity (mild, moderate, severe), and frequency. **Status Asthmaticus:** if a patient fails to respond to initial treatment, documentation must reflect "status asthmaticus" rather than just "exacerbation" to support higher severity.

Documentation Tips

Be Specific with Type:

- Acute
- Chronic
- Intermittent
- Persistent

Be Specific with Frequency:

- Single episode
- Recurrent episode

Be Specific with Severity:

- Mild
- Moderate
- Severe

Be Specific with Alcohol/Drug:

- Use
- Abuse
- Dependence

Be Specific with Stages:

- CKD:
 - Stage: 1, 2, 3, 4, 5 and ESRD (Avoid contradictions).

Be Specific with DM and Complications:

- Document the link when complication is due to diabetes.
- Ensure the note contains no contradicting information.

Provider Documentation Tips

Clinical Conditions Frequently Linked to Documentation Deficiency

Complicate conditions such as:

DM with or W/O complication
CKD with progression of Stages
CHF (Types-Classifications)

Support:

Malignant Neoplasm
Secondary Malignant Neoplasm (Sites)
Morbid Obesity

Acute conditions such as:

CVA (Sequalae)
Myocardia Infarction (MI) date of onset
Embolism (PE)

Specification:

Depression (severity)
DVT (Chronic/Acute)
Dementia (Type/Severity)

Key Takeaway: If it is not documented, it cannot be reported, managed, or accurately reflected in risk adjustment.

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.**

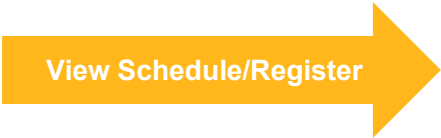
- July 1 - Vendor partners share how they help improve member health
- August – Provider Spotlight – Behavioral Health Walk-in Center vs. ER

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

- August 11
- November 10

➤ **New Provider Orientation**

- June 4, 10 and 16
- July 2, 15 and 21



➤ **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)**

- June 11 and 23
- July 16 and 28

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

- July 8
- October 7

Register Today 😊

[View Schedule/Register](#)



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

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 OBGYN • 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

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
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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](#)