COMMONWEALTH of VIRGINIA

Department of Health

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January 16th, 2026

MEMORANDUM

TO: The Honorable L. Louise Lucas
Chair, Senate Finance Committee

The Honorable Vivian E. Watts
Chair, House Appropriations Committee

The Honorable Richard C. Sullivan
Vice Chair, House Appropriations Committee

FROM: Karen Shelton, MD
State Health Commissioner, Virginia Department of Health

SUBJECT: Smartchart Network Program, Provided by Virginia Health Information (VHI)

This report is submitted in compliance with Item 283 B.3 of Chapter 2 (HB6001) of the 2024 Acts of Assembly, Special Session I, which states:

> *The department, in coordination with the ED Council, shall report annually to the Secretary of Health and Human Resources and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees on progress, including, but not limited to: (i) the participation rate of hospitals and health systems, providers and subscribing health plans; (ii) strategies for sustaining the program and methods to continue to improve care coordination; and (iii) the impact on health care utilization and quality goals such as reducing the frequency of visits by high-volume Emergency Department utilizers and avoiding duplication of health care services.*

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

KS/KB
Enclosure

Pc: The Honorable Janet Kelly, Secretary of Health and Human Resources

VDH—ITEM 283 B.3. (SPECIAL SESSION I, 2024)—SMARTCHART NETWORK PROGRAM ANNUAL

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

2025

VIRGINIA DEPARTMENT OF HEALTH

PREFACE

In accordance with § 32.1-372 of the Code of Virginia, the Commissioner shall enter into a contract with Virginia Health Information (VHI) to create, operate, maintain or administer the Smartchart Network Program (Program) created to provide a single, statewide technology solution that connects all health care providers, insurance carriers and other organizations with a treatment, payment or operations relationship with a patient in the Commonwealth to facilitate real-time communication and collaboration and improve the quality of patient care services. The Advisory Council shall consist of representatives of the:

- Department of Health
- Department of Medical Assistance Services
- Department of Health Professions
- Virginia Hospital and Healthcare Association
- Virginia Association of Health Plans
- Medical Society of Virginia
- Virginia College of Emergency Physicians
- Virginia Chapter of the American Academy of Pediatricians and
- Virginia Academy of Family Physicians

to advise the Commissioner and VHI regarding the establishment and operation, changes and outcome measures for the Program.

The Advisory Council shall continue to ensure that information is shared among emergency departments throughout the Commonwealth and all hospitals operating emergency departments in the Commonwealth, all Medicaid managed care contracted health plans, the state employee health insurance plan, all Medicare plans operating in the Commonwealth and all commercial plans operating in the Commonwealth, excluding ERISA plans, and shall participate in the emergency department information exchange program to continue to improve care coordination in hospital emergency departments and reduce the frequency of visits by high-volume emergency department utilizers.

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EXECUTIVE SUMMARY

The 2017 Virginia General Assembly established the Emergency Department Care Coordination (EDCC) program (§ 32.1-372) and in 2023 the General Assembly changed the EDCC program to the Smartchart Network Program (Program) effective January 2024. The following annual progress report on the Program includes the participation rate of hospitals and health systems, providers and subscribing health plans; strategies for sustaining the Program and methods to continue to improve care coordination; and the impact on health care utilization and quality goals such as reducing the frequency of visits by high-volume emergency department utilizers and avoiding duplication of health care services.

INTRODUCTION

ADVISORY COUNCIL MANDATE

Subsection C of § 32.1-372 states that the Commissioner shall enter into a contract with a third party to create, operate, maintain or administer the Program in accordance with this section, which shall include provisions for the protection of patient privacy and data security pursuant to state and federal law and regulations including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.). The Smartchart Network Program Advisory Council shall consist of representatives of the Department, the Department of Medical Assistance Services, the Department of Health Professions, the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Chapter of the American Academy of Pediatricians and the Virginia Academy of Family Physicians to advise the Commissioner and VHI regarding the establishment and operation, changes and outcome measures for the Program.

The Advisory Council shall continue to ensure that information is shared among emergency departments throughout the Commonwealth and all hospitals operating emergency departments in the Commonwealth, all Medicaid managed care contracted health plans, the state employee health insurance plan, all Medicare plans operating in the Commonwealth and all commercial plans operating in the Commonwealth, excluding ERISA plans. The Advisory Council shall also participate in the emergency department information exchange program to continue to improve care coordination in hospital emergency departments and reduce the frequency of visits by high-volume emergency department utilizers.

REPORT OUTLINE

The remainder of this report will review how the Program is complying with statutory requirements, provide updates on Program accomplishments and discuss the status of various projects established under program guidance from the Advisory Council.

LEGISLATION REQUIREMENTS AND COMPLIANCE

Specifically, § 32.1-372 defines the Program to have the capabilities which are listed below in **bold**. The *italicized* text that follows is a description of how the Program complies with the legislative requirement during the report period of October 1, 2024, through September 30, 2025:

- **Receives real-time patient visit information from and shares such information with every hospital emergency department (ED) in the Commonwealth through integrations that enable receiving information from and delivering information into electronic health records systems utilized by such hospital EDs.** *As of September 2025, 16 out of 19 health systems in the Commonwealth integrated the Program technology solution into their Electronic Health Record (EHR) and receive the alerts electronically. The remaining hospitals receive informational alerts via fax or printer. All hospitals share information on their patients to receive alerts, and data quality is regularly reviewed. Optionally, all hospitals can enable access to the Collective Platform portal and integrate additional notifications.*

- **Requires that all participants in the Program have fully executed healthcare data exchange contracts that ensure that the secure and reliable exchange of patient information fully complies with patient privacy and security requirements of applicable state and federal laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA).** *To participate, every organization signs the ConnectVirginia EXCHANGE Trust Agreement (ETA) to join VHI's existing legal and trust framework. In 2023, VHI began the process of evaluating and updating our legal framework for participation in the Program. The legal review continued through 2025 and a new Master Services Agreement, Business Associate Agreement and Program Addenda have been released for use in onboarding new participants. Outreach planning has taken place to align transition of current mandatory participants from the ETA to MSA and corresponding addendums with the updated data submission requirement rollout.*

- **Allows hospital EDs in the Commonwealth to receive real-time alerts triggered by analytics to identify patient-specific risks, to create and share care coordination plans and other care recommendations and to access other clinically beneficial information related to patients receiving services in hospital EDs in the Commonwealth.** *The Program combines historical patient data with real-time clinical data, including automated feeds and manually created and shared care recommendations, to identify at-risk patients. As the Program has been live since June 2018, there are now more than seven years of historical Admit, Discharge and Transfer (ADT) feed data submitted by participating hospitals on their previous patients. There is also historical data from facilities in other states and the initial four-million historical ED encounters provided by Virginia hospitals.*

- **Provides a patient's designated managed care organization (MCO), primary care physician (PCP) and supporting clinical and care management personnel with treatment and care coordination information about a patient receiving services in a**

hospital ED in the Commonwealth including care plans and hospital admissions, transfers and discharges. *All six Medicaid MCOs receive information on their members via the PointClickCare Platform and had an average number of covered lives of approximately 1.6 million in 2025. The Program has about 6.7 million lives covered by a Virginia health plan or risk bearing entity. If these participants present at the ED, the health plan can opt to receive a real-time update as well as view historical encounter data. The Program continues to encourage PCPs and other downstream providers to onboard, which would allow them to receive information and collaborate with hospitals and health plans on shared patients.*

- **Integrates with the Prescription Monitoring Program (PMP) and the Virginia Advance Health Care Planning Registry (ACPR) to enable automated query and automatic delivery of relevant information from such sources into the existing workflow of healthcare providers in the ED.** *The Advisory Council and the Department of Health Professions (DHP) continue to collaborate on mechanisms to integrate data from the PMP as required by the mandate. The NarxScore, an indicator from the PMP of a patient's narcotics utilization, is available for the majority of organizations and complements the PMP access available with these systems' integrated EHRs.*

  Subsection D of § 32.1-276.6 was enacted by the 2025 General Assembly session to require reporting admission, transfer and discharge data elements for patients experiencing nonfatal opioid overdoses to the Virginia Department of Health Professions for use in the Prescription Monitoring Program. VHI and DHP began work on this project in July 2025 with an anticipated completion date in 2026.

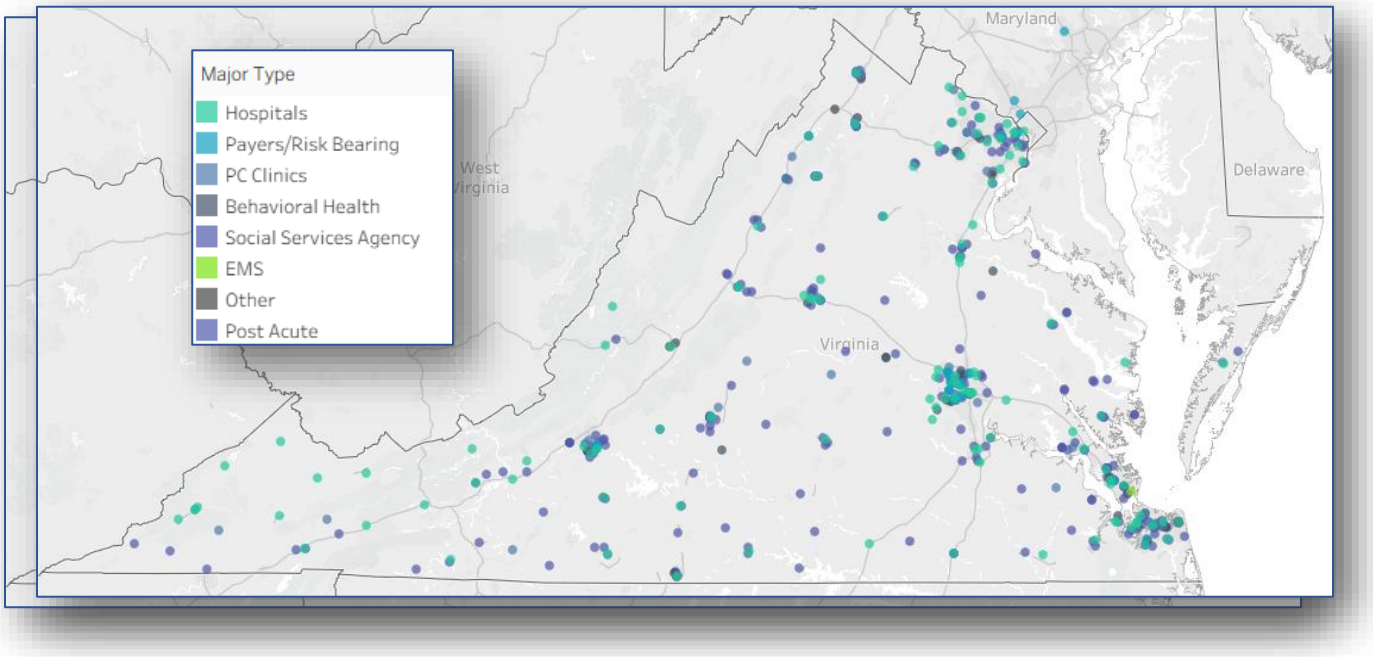
  When an advance care planning document is available in the ACPR and a patient visits an ED, an ED Notification—a single page informational document including historical encounters and care recommendations that an ED provider can review within 60-90 seconds—is sent including a link to the advance directive document(s) as required by the mandate. As of July 2025, there were over 13,000 individual active registrants with documents in the ACPR.

PROGRAM ACCOMPLISHMENTS

- **Interoperability and collaboration among all key stakeholders.** The Advisory Council advises the Commissioner and VHI regarding the establishment and operation, changes and outcome measures for the Program. The Advisory Council met quarterly during the report period to discuss major initiatives including Program branding, technology access options for participants, and the new data submission requirements. The Collaborative, comprised of program users and others directly involved in patient care, met quarterly as well to support initiatives of the Advisory Council. The team also facilitated four Collaborative meetings in the Tidewater region, several subcommittee meetings focusing on specific topics and three Central Virginia region Collaboratives. As part of the Collaborative workgroups and subcommittees, care managers, social workers and other

representatives are encouraged to collaborate and write short, actionable insights, or guidelines, about shared, high-utilizing patients. The Collaborative meetings facilitate discussions among clinicians and care teams across the Commonwealth.

Figure 1 - Participating Facilities In The Program as of September 2025



- **Expanded participation throughout the Commonwealth among a variety of care providers.** Figure 1 maps the location of all hospital emergency departments, health plans, and over 1,000 primary care clinics, behavioral health providers and post-acute care facilities participating in the Program as of September 2025. Within the Program participants, the total number of users has grown from 6,488 users in October 2024 to 7,966 users in September 2025 with a total of 3,259 active users.

- **Technology and functionality that adapts and works for all stakeholders with emphasis on enabling integration with hospitals' EHR systems.** Several health systems and health plans use single sign on (SSO) to gain access to the web-based portal. Health systems on Epic or Cerner can use SMART on FHIR technology that seamlessly integrates with the Program platform to give their users access within their own EHR. As of September 2025, five health systems have implemented SMART on FHIR technology.

- **User engagement with Smartchart tools has grown steadily with providers leveraging access to view patient information, receive real-time notifications and create or update care insights.** Care insights are an abbreviated care plan and/or guideline that can be authored and shared within the Program. From August 2024 to September 2025 over 10,000 care insights were created or updated to help assist care teams with complex patients. During that same period patient records grew by 23% and 2.3 million notifications were delivered to users based on Smartchart criteria.

- **Focus on identified patients with patterns of high utilization**. As highlighted in Figure 2, between August 2024 and September 2025 the Program found 23,028 patients that visited an ED more than 10 times. These patients equated to 378,149 ED visits and 67,948 inpatient admissions. Of those patients 60.3% had a behavioral health diagnosis but only 6.4 % had a care insight. The team works with providers to encourage the use of care insights and other strategies to reduce overutilization of the emergency for non-acute services.

Figure 2 - Patients With 10 or More ED Visits Within 12 Months From August 2024 Through September 2025

ED Utilization Category	ED Visits in 12 Months	# Patients	# ED Visits	Avg ED Visits per Person	# IP Admits	Avg IP Admits per Person	Avg IP Bed Days per Stay
Rising Risk	10 - 14	14,967	170,790	11.4	37,058	2.5	5.2
	15 - 19	4,023	66,736	16.6	12,827	3.2	4.9
High Utilization	20 - 29	2,422	56,989	23.5	9,645	4.0	4.7
	30 - 49	1,078	39,711	36.8	5,276	4.9	4.1
Super Utilization	50 - 74	321	18,966	59.1	1,743	5.4	4.4
	75 - 99	106	8,875	83.7	665	6.3	3.7
Extreme Utilization	100+	111	16,082	144.9	734	6.6	3.5

ED Utilization Category	ED Visits in 12 Months	% Visits BH	% Visits SUD	% Visits Suspected Homeless	% Visits Active Care Insight
Rising Risk	10 - 14	8.6%	3.0%	6.8%	4.6%
	15 - 19	11.8%	4.0%	12.8%	7.9%
High Utilization	20 - 29	14.4%	5.3%	19.9%	10.6%
	30 - 49	17.2%	6.4%	30.0%	14.3%
Super Utilization	50 - 74	18.5%	6.0%	40.6%	20.0%
	75 - 99	17.5%	4.9%	38.9%	24.3%
Extreme Utilization	100+	16.4%	3.3%	46.4%	23.6%

PROJECT STATUS UPDATES

The statute requires the following project status updates:

1. **The participation rate of hospitals and health systems, physicians and subscribing health plans operating in the Commonwealth:**

- In 2025 there were 19 health systems and 117 facilities sending ADT feeds to the Program which encompasses all but one emergency department. There was one recently reopened ED identified in 2023 still going through implementation.

- There are 9 health plans with 26 lines of business participating in the Program. As of September 2025, approximately 6.7million commercial, Medicare and other non-Medicaid covered lives submitted to the Program by participating health plans, accountable care organizations (ACOs) and risk bearing entities.

- In addition, as of September 2025, there were an estimated 21,150 Virginia physicians with a current, active license who are affiliated with at least one Virginia hospital which enables access to the Program.

2. Strategies for sustaining the Program and methods to continue to improve care coordination:

- Advisory Council representatives and VHI staff worked with stakeholders to secure appropriation of General Fund match dollars that allow the Department of Medical Assistance Services (DMAS) to obtain Medicaid Enterprise Systems (MES) funds from the Centers for Medicare & Medicaid Services (CMS) to sustain the technology costs for hospital Emergency Departments (EDs) and Medicaid MCOs. These funds also allowed for continued improvements to care coordination including functionality to support maternal and behavioral health. Specific enhancements include:

    - Collaboration and Coordination of Mental/Behavioral Health (MH/BH)—criteria were developed to surface patients who have a MH/BH related diagnosis, self-harm and suicidal ideation related diagnosis and a new mental health collaborative care insight was developed with the ability to attach a crisis plan.

    - Management of Substance Use Disorders (SUD)—criteria were developed to surface patients with a current visit pertaining to SUD, history of SUD over a 12 month look back, and expanded ontology to include Opioid Use Disorder, opioid overdose and Alcohol Use Disorder; and establish a new Medication Assisted Treatment (MAT) automated warm handoff.

    - Maternal Health—criteria were developed to surface substance exposed infants/neonatal abstinence syndrome (SEI/NAS) as well as pregnant women at risk for complications with a history of SUD, including alcohol and nicotine, sepsis or other complex conditions.

  Whereas no new funds were appropriated to support the legislative expansion of data collection for the Program, VHI continues to work with the Virginia Department of Health (VDH), DMAS and the General Assembly to allow general funds to be used as a match for additional CMS funding.

- Costs for commercial and Medicare lives are not paid with general funds or CMS MES funds but rather are paid by the participating insurers. ACOs and other risk-bearing entities pay for participation and receive access to an enhanced portal. Downstream providers get access to base functionality at no cost but can also pay for upgraded features and enhanced customizability.

3. The impact on healthcare utilization and quality goals such as reducing the frequency of visits by high-volume ED utilizers and avoiding duplication of prescriptions, imaging, testing or other healthcare services.

- Potential indicators that the frequency of visits by patients with high-volume ED utilization is decreasing include:

    - **Anecdotal success stories.** Upon onboarding to the Smartchart Program, Prince William Community Services Board has been able to roll out the tool to over 60 users by following a phased approach. They worked with each of their departments to accommodate different workflows, by either having administrative staff pull reports or giving case managers direct access. Shakeisha Sterling had this experience to share: "We had a client beginning to experience cognitive and physical decline at an alarming rate while living in an independent senior community. Her housing was in jeopardy after repeated falls caught on security cameras led to an APS report. Although she had a valid Uniform Assessment Instrument (UAI) on file, documentation was needed to support a reassessment. Using [Smartchart] reports and inpatient documentation, I was able to track hospital stays, diagnosis codes and discharge recommendations. This allowed me to work with the PWC health department to rescreen her immediately. The client was approved for in-home care and received services until she passed away at home as she desired. [Smartchart] has greatly enhanced my ability to advocate for clients, coordinate care and help them achieve their health goals."

- The Program team finalized an updated Data Submission Guide following a series of feedback sessions with health systems of varying sizes and EHR platforms. To support statewide implementation of expanded data submission requirements for the Program, the team engaged additional experts with extensive experience in Health Information Exchange (HIE) data collection. In collaboration with the Virginia Hospital & Healthcare Association (VHHA), the team also distributed notices to member organizations, current Program account managers and the Advisory Council. The guide was completed in September 2025, and implementation notices were issued in October to allow hospitals and health systems adequate time to prepare for the February 2026 project launch. Submission Guides and Data Specification Manuals may be found at https://www.vhi.org/ConnectVirginia/edcc.asp.

CONCLUSION

Since the 2024 annual report, the Program has continued success as noted below:

- The team hosted a training webinar for Program users to highlight new features, detail how to optimize their use of the program and share best practices with over 90 attendees, and also worked with the DMAS ED utilization workgroup to share strategies about available tools, which can be used between hospitals and post-acute care facilities to assist with the transition of care between care settings. The Program team also presented to the Combatting multidrug-resistant organisms (MDROs) in Virginia workgroup, hosted by VHHA and VDH, to highlight the growth of infectious disease teams that have onboarded to the program to utilize the MDRO flagging functionality.

- Executed ETAs and MSAs onboarding 20 new participants including many with multiple locations. This includes onboarding Humana Healthy Horizons as a new Managed Care Organizations for Cardinal Care. Figure 3 illustrates the growth of added facilities participating in the Program.

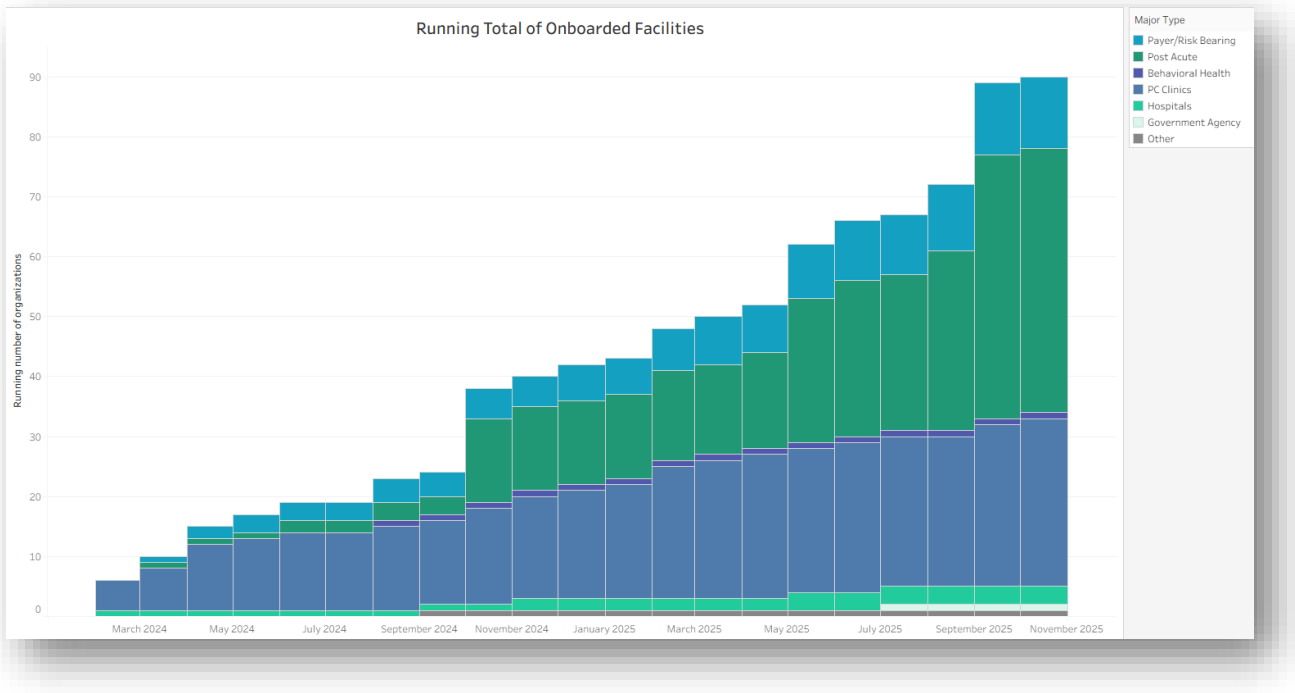


Figure 3 – Running Total of Onboarded Facilities Since March 2024

- Supported statewide and regional collaborative meetings and initiatives as described in **Interoperability and collaboration among all key stakeholders**.

Continued enhancements and expansions to the Program are influenced by the Advisory Council and current users of the Program. With the recent legislative changes to the Program, the team continues to rely on engaged stakeholders and partnerships to shape and further refine the Program. The continued support of the General Assembly, state agencies, healthcare providers, health insurance plans and nonprofit organizations help the Program advance these shared goals.

Any questions or suggestions about this report may be directed to Virginia Health Information at EDCCPsupport@vhi.org or by telephone at 804-612-8187.

APPENDIX A – § 32.1-372. SMARTCHART NETWORK PROGRAM

§ 32.1-372. Smartchart Network Program established; purpose.

A. The Smartchart Network Program (the Program) is hereby created to provide a single, statewide technology solution that connects all health care providers, insurance carriers, and other organizations with a treatment, payment or operations relationship with a patient in the Commonwealth to facilitate real-time communication and collaboration and improve the quality of patient care services.

B. The Commissioner shall ensure that the Program:

1. Receives real-time patient visit information from, and shares such information with, every hospital in the Commonwealth through integrations that enable receiving information from and delivering information into electronic health records systems utilized by such hospitals;

2. Requires that all participants in the Program share patient information and have fully executed health care data exchange contracts to ensure the secure and reliable exchange of patient information in compliance with the patient privacy and security requirements of applicable state and federal laws and regulations, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.);

3. Enables health care providers, health care entities, and insurance carriers to access information necessary to evaluate and monitor the care and treatment of a patient in accordance with the patient privacy and security requirements of applicable state and federal laws and regulations, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.);

4. Allows health care providers in the Commonwealth to receive real-time alerts triggered by analytics to identify patient-specific risks, to create and share care coordination plans and other care recommendations, and to access other clinically beneficial information related to patients receiving health care services in the Commonwealth, including strategies and methods to continue to improve care coordination in hospital emergency departments and reduce the frequency of visits by high-volume emergency department utilizers;

5. Provides a patient's designated primary care physician and supporting clinical and care management personnel with treatment and care coordination information about a patient receiving health care services in the Commonwealth, including care plans, lab results, images, and hospital admissions, transfers, and discharges;

6. Provides a patient's designated managed care organization and supporting clinical and care management personnel with care coordination plans, lab results, images, and discharge and other treatment and care coordination information about a member receiving health care services in the Commonwealth; and

7. Is integrated with the Prescription Monitoring Program established pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 and the Advance Health Care Planning Registry established pursuant to Article 9 (§ 54.1-2994 et seq.) of Chapter 29 of Title 54.1 to

enable automated query and automatic delivery of relevant information from such sources into the existing work flow of health care providers.

C. The Commissioner shall enter into a contract with a third party to create, operate, maintain or administer the Program in accordance with this section, which shall include provisions for the protection of patient privacy and data security pursuant to state and federal law and regulations, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.). The third-party contractor shall continue and rename the Emergency Department Care Coordination Advisory Council established by Chapter 836 of the Acts of Assembly of 2017 as the Smartchart Network Program Advisory Council (the Advisory Council), which shall consist of representatives of the Department, the Department of Medical Assistance Services, the Department of Health Professions, the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Chapter of the American Academy of Pediatricians, and the Virginia Academy of Family Physicians, to advise the Commissioner and the third-party contractor regarding the establishment and operation of the Program, changes to the Program, and outcome measures for the Program.

The Advisory Council established pursuant to this subsection shall continue to ensure that information is shared among emergency departments throughout the Commonwealth and all hospitals operating emergency departments in the Commonwealth, all Medicaid managed care contracted health plans, the state employee health insurance plan, all Medicare plans operating in the Commonwealth, and all commercial plans operating in the Commonwealth, excluding ERISA plans, and shall participate in the emergency department information exchange program to continue to improve care coordination in hospital emergency departments and reduce the frequency of visits by high-volume emergency department utilizers.

D. Information submitted to the Program shall be confidential and shall be exempt from disclosure under the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

2017, cc. 475, 600; 2023, cc. 628, 629.

APPENDIX B – ACRONYMS AND ABBREVIATIONS

ACO - Accountable Care Organization

ACPR - Advance Health Care Planning Registry

ADT - Admission, Discharge, Transfer feed

ARTS - Addiction and Recovery Treatment Services

DHP - Department of Health Professions

DMAS - Department of Medical Assistance Services

ED - Emergency Department

EDCC - Emergency Department Care Coordination

EHR - Electronic Health Record

ENS - Event Notification System

ETA - Exchange Trust Agreement

HIE - Health Information Exchange

HIPAA - Health Insurance Portability and Accountability Act

MAT – Medication Assisted Treatment

MCO - Managed Care Organization

MDRO - Multidrug Resistant Organism

MES - Medicaid Enterprise Systems

PCC - PointClickCare

PCP - Primary Care Physician

PMP - Prescription Monitoring Program

SDoH - Social Determinants of Health

SMART on FHIR - Substitutable Medical Apps, Reusable Technologies on Fast Healthcare Interoperability Resources

SNF – Skilled Nursing Facility

SSO - Single Sign-On

VDH – Virginia Department of Health

VHHA – Virginia Hospital and Healthcare Association

VHI - Virginia Health Information