Complex and Condition Care Program Description 2017

Evolent Health Complex and Condition Care
2017 Program Description

I. Introduction

Evolent Health, LLC (Evolent) supports health plans and physician-lead partners in providing patients with access to services delivered through a network of practitioners who are treated as allies trusted with, and held accountable for, decisions that affect patient care. A productive relationship between physician, practice team, and patient is key to better health care outcomes, safer care, and a better care experience for the patient.

The Complex and Condition Care Program (referred to in the rest of the document as Program) was developed to systematically and comprehensively assess, monitor, measure, evaluate, and implement strategies to improve the quality of integrated care and healthcare services delivered to patients. Developed in accordance with the corporate vision and mission, the Program was designed to uphold and mirror the values of Evolent Health while administering client benefits and services to improve the treatment outcomes and care experience for their patients.

The Program is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Evidence-based medicine and a team approach is used to:

- Empower patients
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the physician/patient relationship
- Emphasize and reinforce use of clinical practice guidelines

The Program Description defines the scope, goals, objectives, and necessary structure for promoting and improving quality of care and services. This document, serves as a guide to providing general information on the structure, processes and measures used for accountability and performance improvement.

II. Program Scope

The Program supports the practitioner-patient relationship and plan of care, emphasizing the prevention of exacerbations and complications through evidence-based practice guidelines, and evaluating clinical, patient experience, and economic outcomes on an ongoing basis with the goal of improving overall health. The health conditions included in the Program are:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)

- Diabetes
- Heart failure (HF)

The Program's scope covers:

- Identification of patients meeting the enrollment criteria for a specific disease program
- Stratification of patients into low, moderate or high-risk categories
- Self-management training through personalized patient interventions
- Collaboration with physicians to reinforce treatment plans
- Feedback to patients and practitioners on specific chronic management issues and/or
- successes
- Care coordination referrals to other clinical programs, such as catastrophic care
- management, when the acuity and/or medical stability of the patient is heightened
- Evidence-based practice guidelines to support patient informed-decision making
- Evaluation and improvement of clinical outcomes, as well as patient and practitioner
- experience with the Program

The Program for each condition is further described in a condition-specific program document. The condition-specific document provides detailed information on each program including: relevant clinical guidelines, criteria and stratification analytics, assessment tool, patient and physician program content and support tools, targeted relevant gaps in care, performance metrics, care plans, goals, interventions and condition alerts.

The Program employs a patient-centric approach that helps patients and their care givers understand and engage in attaining or maintaining their optimal health. The Program implements strategies to support and enhance the practitioner-patient relationship, in order to improve the quality and coordination of care delivered to the patient.

III. Program Goals

The goal of the Program is to improve the behavioral and physical health outcomes and quality of life of patients with chronic conditions by using a multi-faceted approach to achieve the best possible therapeutic outcomes based on assessment of patient needs, ongoing care monitoring, evaluation, and tailored patient and practitioner interventions. The Program can also reduce hospital length of stay and lower overall costs.

IV. Clinical Guidelines

Evolent uses current, applicable, national evidence-based clinical guidelines from recognized sources for the basis of its Program. Evidence-based, medical society and

national industry standards are referenced in development, ongoing maintenance, and updates of the Program. Nationally recognized clinical guidelines are reviewed and updated as appropriate, at least every two years or at the time any new scientific evidence or national standards are published or a change to the guideline is made available. If the national guidelines have not been developed, reviewed or revised by the recognized source within the past five years Evolent retains board certified practitioners specializing in care for the condition to review and attest to the relevancy and accuracy of the proposed guideline.

V. Patient Identification and Stratification

Evolent systematically evaluates patient data against a set of identification and stratification criteria. For each of the condition-specific programs, criteria are established to systematically identify eligible patients, and stratify by risk and level of needed interventions. Patients are identified for the Program in multiple ways using both automated (rules-based) and manual (query and clinical referral based) processes from numerous data sources.

Identification of Patients and Data Integration

Monthly, information from the following sources are used to identify patients who might benefit from one of the Programs and provide continuity of care via data integration:
- Enrollment data
- Health Information Line
- Medical claims or Patient referrals from the client
- Pharmacy claims
- Assessment screening results
- Referrals from practitioner, patients and client organizations
- Data collected through utilization (UM), condition care and care management (CM) activities
- Data collected from health management or health coaching programs
- Laboratory results
- Electronic medical/health records

Stratification of Patients for the Program

The proprietary analytic predictive modeling programs and condition-specific patient profiling tool generate paths and algorithms in identifying and stratifying patients, for example, utilizing 1) new diagnoses, 2) emergency or hospital visits, 3) national standards/ evidence-based clinical guidelines and 4) gaps in care. Patients with one or more of the Program conditions are assigned a risk score. Basic scoring rules are applied to available data sources and, if additional data sources become available, then altered accordingly. Scores are refreshed every time client eligibility is received and/or at least monthly. Stratification is a dynamic process, and a stratification level can change as a patient's condition changes, linking to the appropriate level of risk and corresponding intervention.

The algorithms applied yield two products: 1) a list of patient eligibility used to create a patient profile for the applicable longitudinal program and 2) a patient roster at the physician level, which includes the physician's panel of patients; indication of condition-specific Program; referral source, if other than through predictive modeling; and current status indicators, such as engaged, closed, unable to reach.

In addition to the monthly identification process, patients can be referred to the Program from physicians, caregivers, self, hospital discharge planners, UM and CM staff, and clients, employers and the nurse information line.

The table below illustrates the risk factors used to stratify patients for the Program and the support offered for patients in each stratification level.

	Condition Care – Low Risk	Condition Care – Moderate Risk	Complex Care – High Risk
Risk Criteria used to determine Patient Stratification	Patients with two paid claims for evaluation and management visits with primary diagnosis of asthma, diabetes, COPD, heart failure or coronary artery disease, in all prior medical history available to Evolent Health, are identified as Low Risk. These patients, have no significant care gaps.	Patients (as identified for Low Risk) with a moderate risk score based on Evolent Health's proprietary predictive modeling, **AND** at least one of the followings: • Patient has condition related inpatient admission within six months • Patient has a condition related ER visit within three months • Patient has no PCP or condition related specialist visit within twelve months • Patient's does not have a prescription(s) for a condition related medications.	Patients identified with added risks as identified using predictive modeling tool developed to identify patients most likely to incur a disease-specific adverse event. Some of the covariates include: co-existing chronic conditions, prior utilization, change in utilization rates, drugs that indicate disease progression or severity, medical equipment and gaps in care.
Patient Support based on Stratification Level	Support provided, such as educational mailings, to patients identified with a chronic condition and limited self-care needs.	Support is provided by a Health Coach, for patients with a poorly controlled chronic condition as evidenced by lack of practitioner engagement or recent hospital/emergency room (ER) visit with appropriate inclusion of specialized delivery system resources (e.g., heart failure clinics, tobacco cessation, mental health.)	Support is provided, by a Nurse Care Advisor, for patients and caregivers with three or more chronic diseases, high utilization and/or high healthcare costs, to manage their diseases.

VI. Patient Information and Interventions

Once the patient is identified and stratified, the Program software, Identifi, has a standard care plan template that includes a library of problems, goals and interventions (PGIs) that have been informed by the evidence-based clinical guidelines. Based on those clinical guidelines, the staff can establish priority problems, goals and interventions with the patient to achieve self-management of his/her condition.
All identified patients receive written information about the Program.

A. Information about the Program
   1. Program services and how to use
   2. How the patient became eligible to participate
   3. Care advisor resource team contacts, how to access and hours of operation
   4. Patient rights and responsibilities
   5. How to provide feedback/questions or communicate a complaint
   6. Whom to contact in an urgent situation

B. Eligibility to Participate
   1. All patients with one or more of the five conditions are eligible to participate and are automatically enrolled in the Program
   2. Patients may self-refer to these Programs by calling the toll-free access line
   3. Practitioners may refer patients to the Program.

C. How to Opt Out of the Program
   1. Patients are automatically enrolled in the Program until they opt out.
   2. Patients can opt out of the Program by notifying the care advisory team or Health Plan Customer Service.
   3. Opt-out information is documented in Identifi

Interventions by Condition

The Program content is tailored to each condition, providing education and support for each risk level and patients may move into different risk levels during the Program. Using outreach and educational materials, patients are encouraged to 1) be accountable for their chronic condition(s), 2) adhere to their physician's recommendations for preventive care and treatment, and 3) embrace educational opportunities for informed decision-making when accessing the healthcare system

In addition to the interventions listed above, patients engaged in the Program receive disease specific and risk level specific interventions. Examples of those types of interventions include: outreach calls to patients in the Moderate and High risk stratification, and condition specific materials and education. The condition specific program descriptions have a more detailed list of interventions by condition and risk level.

When patients show evidence of needing additional support around behavioral health needs, appropriate referrals to vendor partners and/or Behavioral Health Specialty providers are made, and communication with the provider occurs when indicated.

Patient Centric Interventions

Consideration of the individual patient needs in targeting interventions is facilitated through condition screening/questionnaire responses and on-going patient contacts and assessments. Key areas include:

a. Comorbidities and other health conditions, including behavioral health – program content provided to patients considers other health conditions and cognitive and physical limitations, which impact the target condition.

b. Depression screening and screening results - Patient interventions and/or care referrals are implemented for those patients who screen within target thresholds on the PHQ-9, and/or indicate psychological distress that has significant impact on daily functioning more days than not.

c. Screenings for Anxiety and Substance Use help to identify patients in need of more targeted provider support and/or community resource linkage. Patient interventions and/or care referrals are implemented for those patients who screen within target thresholds on the GAD-7 and CAGE-AID tools and/or indicate psychological distress that has significant impact on daily functioning more days than not.

d. Health behaviors - Patient materials and interventions encourage patients to develop healthy behaviors (e.g. nutrition and activity) and reduce unhealthy behaviors (e.g., quit tobacco use).

e. Psychosocial issues - Factors that may influence the patient's adherence to the treatment plan and/or interventions, such social, emotional, or financial barriers are identified and interventions are adjusted to better meet the patient's needs and increase accessibility.

f. Caregiver support - Identifying types of support or lack of support and delivering information to promote understanding about the patient's condition is provided when the patient has given consent. 1). Provide support through direct caregiver interaction, increasing involved caregiver's emotional resources, to improve their ability to support patient. 2). Provide external/ community based resources as appropriate (i.e. Caregiver support groups, Respite, development of coping skills). Including physical limitations, need for adaptive devices, barriers to meeting care needs/treatment requirements, visual or hearing impairment or language or cultural needs.

Program content and interventions are specific to the individual's condition and circumstances, tailored to improve self-care and management of their condition and addresses the following:

a. Condition monitoring, including self-monitoring (e.g., foot and skin care for diabetics) and reminders about tests the patient should perform themselves or complete through their practitioner

b. Adherence to treatment plans (including medication adherence) and tracking mechanisms

c. Communication with practitioners about patient's health conditions, self-management/condition monitoring activities and care plan/goal progress (example – what to do before a visit to physician – writing down most important issues)

d. Additional resources external to the organization, as appropriate (e.g., community programs, American Diabetes Association, Web sites)

VII. Informing/Educating Practitioners about Programs

Program information is provided to practitioners on available services and how their patients can use/access the services, how patients become eligible to participate, how Program staff works with patients, hours of operation and contact information, condition-specific program content and support tools, how to communicate a complaint or provide other feedback.

Program information is distributed to providers annually. Evidence based clinical practice guidelines are provided annually, or sooner if updates to the guidelines are made prior to annual distribution. Methods of clinical guideline distribution to practitioners include: provider newsletter, provider websites, and web portals. The client may also communicate guideline information to providers in provider manuals, training materials or provider orientation. All communication to practitioners includes contact information for providing feedback or comment on the guidelines.

Available written practitioner Program materials include information on how patients are identified for the specific condition program and types of integrated services offered. Decision support tools provide relevant information to allow practitioners to make knowledgeable decisions about care. Physician notification of patient engagement in the program occurs within 45 days.

The written Program information provided to practitioners includes:

- Available services for patients and practitioners and how to use services
- How the patients become eligible to participate
- The evidence-based clinical, behavioral health and preventive health guidelines,
- The program content information and the existing clinical practice decision support tools consistent with the guidelines
- Program staff contact information and access, regular business hours and after-hours access
- How program staff works with patients

Evolent utilizes medical and pharmacy claims to determine an eligible patient's Primary Care Physician (PCP) to appropriately direct Program information. An attribution algorithm uses up to 18 months of evaluation and management (E&M) claims to identify the patient's most frequently seen PCP, nurse practitioner or physician assistant. If the patient has not been attributed to an individual practitioner after these steps, the algorithm will search for E&M visits with medical specialists.

Care Opportunities

When the patient's practitioner needs to be notified of any conditions or concerns identified during patient contact or clinical information reviews, that notification takes place in a timely manner, depending on the urgency of the situation and care needs of

the patient. During the patient contact, the patient is referred to his or her physician when appropriate.

Care opportunities not of an urgent nature, but requiring physician notification to address, such as care gaps are communicated to the practitioner through a semi-annual Care Opportunity Report.

VIII. Program Operations

Evolent has developed policies and procedures which support and maintain the operational aspects of the Program. Those Program operations include, but are not limited to:

- Hiring and evaluating clinical and non-clinical qualified staff
- Orientation, training and supervision of staff interacting with patients, physicians and other involved health professionals
- Telecommunications and access to Program staff, meeting patients' communication needs.
- Disclosing marketing activities
- Responding to patient and physician concerns
- Addressing patient safety issues
- Protecting the privacy, security and confidentiality of patient information

Evolent solicits feedback from patients, physicians and other involved health care professionals, and clients in the development of the program content. Mechanisms for feedback can range from surveys, patient and/or caregivers contacts, physician contacts, complaint data, focus groups, practice site meetings and client reviews. Upon analysis of data, actions are taken accordingly to maximize the Program's effectiveness. Patients have access to Program staff 24 hours a day, seven days a week, through routine business hour coverage and recorded messaging. Patients calling after hours will have calls returned on the next business day. The normal business hours are 8:00 a.m. to 5:00 p.m. EST/EDT. Program services are predominantly performed telephonically. Care Advisors communicate with physicians through fax, mail, email, EMR and telephonic outreach. Toll-free telephone and fax numbers for Evolent are available for patients and practitioners.

IX. Performance Evaluation

Evolent has defined a set of Program processes, outcomes (clinical and financial), experience and timeliness metrics that are utilized to measure, monitor, demonstrate value, and ultimately improve the performance of the programs. Quality improvement activities include measuring, trending, and analyzing results against performance goals and/or benchmarks identified for the overall Program and/or specific to each of the chronic conditions.

Performance data is tracked and reviewed by the Care Management Quality Committee. Data gathered and presented for analysis may include:

- Complex Care Performance Metrics (Claims Driven Data)
- Average length of stay (ALOS)
- Bed Days/1000
- Admissions/1000
- Denied Days
- 30 Day Readmission Rates
- Emergency Room visits/1000
- PCP visits/1000
- Specialist visits/1000
- Inpatient Utilization
- Outpatient Utilization
- All cause unplanned 30-day readmission rates

At least annually, the Program effectiveness is evaluated using patient clinical outcome measures, and through patient experience reported from the satisfaction survey and patient complaints. Practitioner feedback is also collected and analyzed using data from the practitioner satisfaction survey, feedback and complaints, if any.

Patient active participation rates will be measured annually by collecting the number of patients who have received at least one interactive contact per condition, divided by the number of patients identified as eligible for the program. As an 'opt-out' program, total enrollment rates will not be used in the calculation, rather, the total number of identified eligible patients will be divided by the total number of identified, eligible patients with at least one interactive contact. Interactions with patients will include activities such as: educational mailings, IVR surveys and staff phone interactions.

Action is taken as needed for metrics that do not meet goal or are deemed to be an opportunity for improvement. Interventions or action to make improvements to identified areas of the Program are implemented to maximize health outcomes, experience and satisfaction, and effectiveness of the Program.

X. Authority and Program Oversight

The Senior VP of Clinical Operations along with the Regional Medical Directors are responsible for oversight of Program development and implementation, including Program content approval. For behavioral health aspects of the Program, a Medical Director specialized in behavioral health oversees design and implementation. Evolent Care Management Quality Committee (CMQC), which meets quarterly, is responsible for monitoring the effectiveness of care management and population health programs through review of patients' ability to meet care plan goals, addressing patient disease-specific education needs, identifying improvement opportunities, recommending interventions to improve Program performance, medication compliance, adherence to

the hospital discharge plans. It additionally monitors Program compliance with government program and accreditation standards. Committee membership includes Vice Presidents from Clinical Operations and Quality, Directors from Pharmacy, Analytics and Care Management, as well as, Behavioral and Physical Healthcare Practitioners.

Addendum

Evolent Health Complex and Condition Care Program Exceptions

Evolent Health acquired Valence Health in October 2016. Prior to Valence Health client populations transitioning to Evolent's Identifi platform, certain exceptions in policy and process will exist. The purpose of this addendum is to define and address the exceptions within the Evolent Catastrophic Care program that are applicable to Valence Health. Unless otherwise stated, Valence Health will operate under the Evolent Health Catastrophic Care Program Description and will be identified as Valence Health for purposes of differentiation.

1. **Section V. Patient Identification and Stratification:**
    1.1.   Valence Health's disease management platform includes Care Manager.
    1.2.   Valence Health Complex and Condition Care Program focuses on Asthma and Diabetes.
    1.3. Stratification of Patients for the Program: Valence Health does not generate a patient roster at the physician level.
    1.4. Stratification Table for Valence Health:

	Condition Care – Low Risk	Condition Care – Moderate Risk	Complex Care – High Risk
Risk Criteria used to determine Patient Stratification	Patients with two paid claims for evaluation and management visits with primary diagnosis of asthma, diabetes, COPD, heart failure or coronary artery disease, in all prior medical history available to Evolent Health, are identified as Low Risk. These patients, have no significant care gaps.	**Asthma:** • Controller/reliever + controller ratio of </= 0.5 (use HEDIS specifications for ratio calculation). **Diabetes:** • Diagnosis of diabetic co-morbidities (neuropathy, nephropathy, retinopathy, limb ulcer/amputation with diabetes diagnosis)	**Asthma:** Members hospitalized or treated at the Emergency Department at least once in the past 12 months, where asthma was the principle diagnosis **Diabetes:** Members hospitalized or treated at the Emergency Department at least once in the past 12 months , where diabetes was the principle diagnosis.
Patient Support based on Stratification Level	Support provided, such as educational mailings, to patients identified with a chronic condition and limited self-care needs.	Support is provided by a Health Coach, for patients with a poorly controlled chronic condition as evidenced by lack of practitioner engagement or recent hospital/emergency room (ER) visit with appropriate inclusion of specialized delivery system resources (e.g., heart failure clinics, tobacco cessation, mental health.)	Support is provided, by a Nurse Care Advisor, for patients and caregivers with three or more chronic diseases, high utilization and/or high healthcare costs, to manage their diseases.

.

2. **Section VII. Informing/Educating Practitioners about Programs.**
    2.1. Valence Health collaborates with clients in developing practitioner education regarding the programs. Clients communicate guideline information to providers via provider manuals, training materials and provider orientation. Contact information regarding the program is distributed via Client communication channels.

2.2. Valence Health identifies the patient's PCP via plan enrollment information.

2.3. Valence Health notifies the patient's PCP of any conditions or concerns identified during patient contact. Patients are referred back to their PCP as deemed clinically appropriate.

3. Section VIII. Program Operations

3.1. Valence Health solicits feedback from patients on an annual basis via a member satisfaction survey. Upon analysis of data, actions are taken accordingly to maximize the Program's effectiveness. Patients have access to Program staff 24 hours a day, seven days a week, through routine business hour coverage and recorded messaging. Patients calling after hours will have calls returned on the next business day. The normal business hours are 8:00 a.m. to 6:00 p.m. EST/EDT. Program services are predominantly performed telephonically. Care Advisors communicate with physicians through fax, mail, email, EMR and telephonic outreach. Toll-free telephone and fax numbers for Evolent are available for patients and practitioners.

4. Section IX. Performance Evaluation

4.1 At least annually, the Program effectiveness is evaluated using patient clinical outcome measures, and through patient experience reported from the satisfaction survey and patient complaints.

4.2 Goals used to assess the effectiveness of the program include:

4.2.1 Reduction in Asthma/Diabetes-related emergency department utilization

4.2.2 Reduction in Asthma/Diabetes -related inpatient hospital admissions

4.2.3 Improvement in appropriate medication treatment for members with asthma (controller versus reliever medications)

4.2.4 Improved adherence to guideline-recommended laboratory screenings and other services in order to reduce gaps in care. HEDIS measures are used as a baseline measurement for gaps in care, however, measures may be modified by the client as requested:

4.2.5 Annual cholesterol screening (Diabetes)

4.2.6 Biannual HbA1c screening (Diabetes)

4.2.7 Annual nephrology screening (Diabetes)

4.2.8 Annual foot exam (Diabetes)

4.2.9 Annual dilated eye exam (Diabetes)

4.2.10 Biannual office visit 2 x year (Diabetes)

4.2.11 Improvement in Member Experience, as measured by:

4.2.12 Satisfaction with the disease management program, improvement in self-management, and improvement in overall self-health rating

4.2.13 Appropriate complaint handling, as identified

4.3 Valence will work collaboratively with each client to establish appropriate targets for the clinical and utilization goals, based on their population and improvement opportunity, compared with applicable benchmarks. A common improvement target could be in the range of a 5-10% reduction in claims for the Emergency Department and Inpatient Use and a 5-10% improvement in adherence to recommended guidelines.