EVOLENT HEALTH, LLC

Diabetes
Program Description
2017

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Evolent Health
Diabetes Program Description
2017

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I. Introduction

The Evolent Health Diabetes Program (referred to throughout the remainder of the document as the Program) was developed to systematically and comprehensively assess, monitor, measure, evaluate and implement strategies to improve the quality of care and healthcare services delivered to client members. 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 determine activities and influence outcomes related to the improvement of the care and treatment of members.

The Program is a system of coordinated healthcare interventions and communications for a population with a condition 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 is intended to help guide the care of patients with diabetes to improve the quality of their care, their adherence to treatment, and to control health care costs. Supporting the practitioner-patient relationship and plan of care, the Diabetes Program emphasizes the prevention of the exacerbations and complications of Diabetes through evidence-based practice guidelines while evaluating clinical, humanistic and economic outcomes on an ongoing basis.

The Program uses a multidisciplinary care team with emphasis on the patient’s primary care physician (PCP) and patient in successfully implementing interventions/action items identified through a comprehensive patient screening. The team based model focuses on optimizing the health of the patient utilizing the broad skills of the PCP, Registered Nurse (RN) Care Advisor (CA), Health Coach, Registered Dietitian, Licensed Social Worker and the Pharmacist to develop and implement personalized care plans or action plans for each eligible, covered patient. The patient’s primary care advisor is either a nurse for high-risk patients or a health coach for moderate risk patients. The nurse care advisor performs a comprehensive

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assessment and develops a care plan while the health coach performs a comprehensive screening and develops an action plan.

The Program employs a patient-centric approach that helps patients and their caregivers understand their condition and engage in attaining or maintaining their optimal health. The Program implements strategies to support and enhance the patient-practitioner relationship to result in improved quality and coordination of care.

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) 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. The CMQC meets quarterly.

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III. Program Goals

The goal of the Program is to effectively identify patients with potentially avoidable healthcare needs and intervene to positively impact the health outcomes and quality of life for patients with Diabetes. By using a multi-faceted approach to achieve the best possible outcomes the Program can lower costs through preventing avoidable episodes of care and better coordination of care. Program goals include:

- Partner with patient, their caregiver and their primary and specialty care practitioners to develop a plan of care (by a nurse care advisor) or action plan (by a health coach)
- Improve medication adherence
- Facilitate appropriate communication across the entire care team
- Optimize diabetes management and close relevant gaps in evidence based care
- Educate patients on diabetes diagnosis and self-management

IV. Clinical Practice Guidelines - Evidence Basis for Program

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

society and national industry standards are referenced for the development, ongoing maintenance, and updates to 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 revised information, or changes to the guidelines are made available.

Guidelines used for the Evolent Health Diabetes Program

American Diabetes Association, Standards of Medical Care in Diabetes—2017
http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf

Case Management Society of America, Guidelines for improving patient-centered care for Diabetes, 2015.
http://cdn-ci62.actonsoftware.com/acton/cdna/10442/f-00e2/0/0

V. Patient Identification

Evolent Health systematically evaluates patient data against a set of identification and stratification criteria. For the Diabetes Program, criteria are established to identify eligible patients, and stratify them by risk and level of needed interventions. Patients are identified in multiple ways, utilizing both automated (rules-based) and manual (query and clinical referral-based) processes from numerous data sources. In addition to the systematic identification process, patients or their caregivers may self-refer, and practitioners may refer their patients to the Program.

Evolent utilizes the following data sources for identifying patients for the Diabetes Program:

Data Source	Typical Update Frequency
Typical Patient Identification Program Frequency	
1. Patient Eligibility data	Monthly
2. Medical Claims data	Monthly
3. Pharmacy Claims data	Monthly
4. Health Risk Appraisal data (when available)	Annually
5. UM management process data	Daily
6. Patient/Caregiver data	Annually
7. Electronic Medical Record data (when available)	Weekly

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Data Source	Typical Update Frequency
8. Hospital Admission, Discharge and Transfer (ADT) data	Daily
9. Laboratory Data –when available	As Available
10. Eligibility Lists from the Client	As Available
11. Health Management, Wellness, or Coaching Programs	As Available

Evolent's predictive model is built on four unique data sources: medical and pharmacy claims, electronic medical record (EMR) data, laboratory data and self-reported data. This integration allows the model to predict from a comprehensive view of patients' health and react more quickly when patients' conditions change. Medical and pharmacy claims capture a patient's medical history. While claims trace a patient's medical history they often cannot quantify patients' health. For example, claims will indicate that a patient has had an admission related to his/her diabetes but will not capture the patient's blood glucose at that time. Clinical data, including EMR and lab data, is used to indicate patients' specific disease states; potentially revealing when a patient needs attention. For example, elevation in Hba1c might indicate that a diabetic patient's maintenance regime is no longer working. Finally, self-reported data can be used to track patients' perceived needs and goals. Self-reported habits (i.e. smoking, drinking and stress), perceived health status, as well as wellness goals can be used to successfully identify patients that are likely to become high risk.

Evolent Health conducts performance testing on the identification and stratifications (see Section VI) models to ensure accuracy. With clinical feedback, every one to two years the models are refreshed to improve the model performance. Currently, the focus is on how to improve the integration of clinical data elements to identify high risk patients early in their disease progression. There is also an extensive quality assurance process with each client launch to ensure that the models are working as expected on the client's data. Additionally, prevalence rates of diabetes identified by the model are compared, on an annual basis, against national benchmarks to assess accuracy. Also, reports of "false positive" identification, by patients or practitioners, are investigated to identify opportunities to improve the model.

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VI. Stratification

Once identified, patients with diabetes go through a stratification process, considering care gaps, comorbid conditions, and additional factors, to determine the appropriate level of intervention based on patient identified need and status. Patients may have more than one chronic condition. In this case, Evolent Health applies a hierarchy to ensure the patient is targeted for the appropriate program.

Through the stratification process diabetes patients fall into one of three risk levels. The stratification process runs monthly, however, re-stratification may occur on an individual basis anytime in between based on the patient screening or assessment or additional information that becomes available during the course of patient interaction.

Diabetes - Low Risk

The criteria for Low Risk: Patients with two paid claims for evaluation and management visits with the primary diagnosis of diabetes in all past claims history.

Diabetes - Moderate Risk

The criteria for Moderate Risk: Patients with two paid claims for evaluation and management visits with the primary diagnosis of diabetes, **AND** at least one of the following:

- A diabetes related inpatient admission within six months
- A diabetes related ER visit within three months
- No PCP or diabetes related specialist visit within twelve months
- Last HbA1c test was greater than twelve months ago

Diabetes – High Risk

Criteria for High-Risk: These are the diabetes patients most likely to incur a disease-specific adverse event. Criteria for the moderate risk level are expanded to include:

- Co-existing chronic conditions,
- Prior utilization, over past twelve months, that takes into account admissions, emergency room visits, PCP visits and Specialist visits
- Drugs that indicate disease progression or severity
- Medical equipment (e.g., home oxygen)
- Gaps in care

VII. Enrollment

The Program utilizes an opt-out model. Patients identified for the Program are considered participating in the Program unless they specifically request to opt-out. Patients are notified of the Program by mail. This notification includes a letter and program brochure that inform the patient about the Program and how to utilize the services. The communication includes:

1. Information on how to use the Diabetes Program services
2. How the patient became eligible to participate

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3. Nurse care advisor and health coach resource team contact information and how to access
4. Patient rights and responsibilities
5. How to provide feedback on the program or communicate a complaint
6. Whom to contact in an urgent situation
7. How to opt-out should they prefer not to participate

Patients that decline participation in the Program will be re-contacted if they meet the criteria for the Program again. If the patient has communicated that they do not want to be contacted again, they will be placed on a do not call list.

The patient's practitioner is alerted when a patient engages in or declines care advising with a nurse care advisor or health coach or if a patient opts out of the Program. The notification can be through letter, telephone, or where available, through the physician practice's electronic medical record (EMR.) The nurse care advisor or health coach alerts the patient's practitioner of engagement with 45 days.

VIII. Patient Interventions

The Program delivers interventions to patients based on their risk stratification and, for those in high or moderate risk, tailored to patient identified needs through a patient screening or assessment and ongoing interactive contact.

Interventions by Stratified Risk Level:

Interventions for Diabetes	Low Risk	Moderate Risk	High Risk
1. Welcome Letter explaining the program, hours of operation, the importance of self-management for diabetes control, etc.	✓	✓	✓
2. Letter encouraging routine visits to the PCP for preventive care and disease-specific follow-up (based on Client)	✓		
3. Notification to the patient of care gaps (based on Client for low-risk)	✓	✓	✓
4. Notification to the primary care provider of the patient's care gaps through semi-annual Care Opportunity Report	✓	✓	✓
5. Outreach to the patient to enroll in either the Moderate or High-Risk Program		✓	✓
Interventions below contingent on patient enrollment in program			
1. Completion of a screening, by a Health Coach, that includes some coaching/education/self-management during interaction		✓	
2. Completion of an assessment, by a Registered Nurse, that includes some coaching/education/self-management during interaction			✓
3. Mailing of a Diabetes Education booklet to the patient after successful outreach			✓
4. Mailing of the Diabetes Education booklet to the patient at their request	✓	✓	
5. Self-management support and health education and coaching to improve knowledge and self-management skills		✓	✓
6. A minimum of 3 outreaches during the 60 days following the screening submission, unless otherwise requested by the patient or physician		✓	

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7. Outreach occurs at least every 10 business days unless otherwise requested by the patient or physician			✓
8. If diabetes is one of two or more comorbidities for this patient, education materials will be mailed based on the patient's clinical needs			✓
9. Outreach to SNP patients will follow the MOC	✓	✓	✓
10. Outreach to the patient if identified for Unplanned Care	✓	✓	✓
11. Outreach to the patient if identified for Transition Care	✓	✓	✓

All patients that are high risk receive a Diabetes, "Take Control, Live Better" booklet, unless they decline. Moderate and low risk patients are offered, either through an encounter with the health coach and/or through the enrollment letter, an opportunity to request the booklet. Patients are encouraged to communicate regularly with their practitioner about their diabetes and their treatment plan. This is communicated through educational materials or in moderate and high risk levels, additionally through telephone interactions. The Program stresses the importance of patients taking an active role in their care. The booklet content includes diabetes education, detailed planning tools for self-management, and symptom management information:

- Physician visits and pre-visit planning
- Schedule for tests and screenings
- Testing and monitoring blood sugar
- Foot care
- Managing medications
- Exercise planning
- Urgent and emergent symptoms and actions

Additional resources provided to patients include the following:

- American Diabetes Association website – www.diabetes.org
- American Heart Association website – www.heart.org
- YMCA Information – www.ymca.net/health-wb-fitness (a national resource for fitness facilities)

The nurse care advisor or health coach utilizes a comprehensive assessment/diabetes screening tool to identify patient needs and to target interventions. The assessment auto-identifies actions based on the patient response to questions. Additionally, through ongoing interaction with the patient, barriers to effective management may be identified. Evolent Health understands that patients in the Program have unique needs and, therefore, the Program is individualized and patient-centric, screening for, and addressing the following:

Comorbidities and Other Health Conditions

Diabetes is often associated with various comorbidities and patients with diabetes often have comorbid hyperlipidemia, cardiovascular disease, hypertension and are

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at risk for chronic kidney disease. These conditions may influence diabetes control. Patients with multiple comorbidities are stratified as high risk and are managed by a registered nurse care advisor who addresses the comorbidities, and coordinates care with the patient's practitioner as needed. Complex patients are also screened for cognitive deficits and provided a social work referral if they screen positive.

Depression and Behavioral Health Screenings

Patients are screened for depression using the PHQ-9 tool. Patients with chronic health conditions have a higher prevalence of comorbid depression, which can impact the patient's ability to manage his/her condition and clinical outcomes. Patients that screen positive for depression are referred to a social worker or behavioral health care advisor who will assist the patient in managing his/her depressive symptoms, provide education about depression, and facilitate community based connections, as appropriate. In addition to screening for depression the patients are screened for alcohol abuse using the CAGE-AID questionnaire and anxiety using the Generalized Anxiety Disorder (GAD-7) scale.

Health Behaviors

Many patients present with health behaviors that impede their ability to manage their diabetes and impact adherence to their treatment plans. Some of the targeted behaviors identified through a screening/assessment, or in the course of ongoing patient contact, include:

- **Nutrition** – Patients identified with unhealthy diets are educated on the impact of diet on their diabetes and encouraged to adopt healthy eating. These patients may be referred, as appropriate, to a dietician.
- **Smoking** – Patients who smoke are encouraged to quit and offered support through a smoking cessation referral
- **Exercise –** The Program supports the practitioner prescribed exercise plan and provides an exercise planning form. Patients without a plan are encouraged to speak with their physician about appropriate exercise.

Targeted educational materials addressing smoking cessation, exercise and nutrition are available to all patients at all stratification levels.

Psychosocial Issues

The health coaches and nurse care advisors screen patients for psychosocial issues that may impact their ability to effectively manage their diabetes. The patients are screened to determine their needs related to caregiver support and resources, financial and transportation barriers, language, and hearing or communication needs. Plans and interventions are implemented to address the needs. Patients with significant support and resource barriers are referred to the social worker, a TTY service is provided for hearing impaired patients and language interpretation

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services are available for those who do not speak English. Staff receive annual "Cultural Competency" training to help assess cultural and linguistic needs for appropriate intervention.

Patient belief/perception of their diabetes, their motivation to change and confidence to effectively manage their condition is also considered. The health coaches and nurse care advisors utilize this information and their training in Motivational Interviewing to engage patients, understand what is important to them, and manage resistance.

Caregiver Support

The patient's caregiver support or need is also assessed. Patients who identify the need for a caregiver, or additional caregiver resources, that present with significant support and resource barriers, are referred to a social worker for assistance. The social worker will ensure that the appropriate level of support is being provided, the caregiver is functioning optimally, and fill in any resource or caregiving gaps. For patients who have a caregiver, the nurse care advisor, health coach or social worker requests their contact information and obtains permission, if appropriate, to speak with the caregiver as part of the patient intervention and support.

Self-Management Support

Patients engaged with a nurse care advisor or health coach receive verbal coaching to assist the patient with their self-management plan. Nurse care advisor or health coach disease specific coaching includes, but not limited to, assessing the patient's understanding of his/her treatment plan, educating the patient with the assistance of disease specific educational materials on testing, medication adherence, managing symptoms, and when to contact their provider. The nurse care advisor or health coach will also work with the patient to develop and execute personal goals related to their overall health or disease state such as weight loss and exercise. Patients will demonstrate their progress through teach back, verbalizing confidence and progress on both clinical guideline goals and personal goals. The nurse care advisor or health coach ensures that care is coordinated with the patient's provider and the patient is encouraged to share their blood sugar readings with their provider.

IX. Practitioner Support

Program information is distributed to practitioners annually. Evidence based clinical practice guidelines are provided annually unless updates 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.

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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

Identifying the Practitioner Delivering Care to the Patient

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 provider after these steps, the algorithm will search for a prescribing PCP from pharmacy claims, or E&M visits with medical specialists. Physicians are notified within 45 days (or based on client contracts) of their patients' engagement in the Program. Notification may be through a letter, secure email, fax, client EMR or phone call to the responsible physician.

Practitioner Decision Support

Evolent Health provides semi-annual Care Opportunity Reports to practitioners alerting them to potential care opportunities for their patients with diabetes. The focus of the report is to notify practitioners of their patients with diabetes that, based on Evolent claims data, have not completed their HbA1c screening or are non-adherent to appropriate diabetes medications. The Care Opportunity Report was developed to address important aspects of care and treatment for diabetes, as well as, help improve performance on evidence-based measures for the Program. The Care Opportunity Report has been reviewed and is consistent with the national clinical practice guideline adopted by Evolent Health for the Diabetes Disease Management Program.

Urgent Notification Alerts

If the nurse care advisor or health coach identifies any of the following urgent care opportunities, during an interaction with a patient, he or she alerts the patient's practitioner of the patient's status via telephone, secure email, or EMR, where available within one business day.

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- Hypoglycemia that occurs at least 2 days per week - blood sugars before meals <70 or 2 hours following meals <100
- Hyperglycemia that occurs at least 2 days per week - blood sugars before meals >120 or 2 hours following meals >180
- Open wounds or sores that are not healing

Coordinating Interventions with the Patient's Primary Care Practitioner

The Program works with the patient's practitioner to coordinate care, as needed. The nurse care advisor or health coach contacts the practitioner for services requiring physician oversight or orders (e.g., DME, medications, physical therapy, emergent/urgent medical concerns, changes to care plan, etc.). The practitioner is contacted via phone, client EMR, or in person (for example, if a nurse is embedded in the practice). The nurse care advisor or health coach then follows up with the patient to ensure the care coordination efforts have been successful and, if not, the nurse care advisor or health coach informs the patient's practitioner.

X. Quality Measures/Outcomes

Throughout the year, Evolent collects, tracks and analyzes at least two clinical quality measures for the Diabetes Program. On an annual basis, the data and program information, including any relevant interventions, activities, identified barriers and opportunities, are documented and reviewed by the Care Management Quality Committee. Program components will be enhanced or altered, if appropriate, based on the analysis. The Quality Measures follow the following criteria:

- The measures capture a relevant process or outcome.
- There is a quantitative result.
- There is a benchmark or performance goal.
- The data and methodology are valid for the process or outcome measured.
- Measurement results are analyzed in comparison with a benchmark and/or goal.
- The measure is population based

Measure	Description	Measure Steward
Comprehensive Diabetes Care: Hemoglobin A1c HbA1c Testing	Patients 18-75 years of age with Diabetes who had an HbA1c testing.	HEDIS/ NCQA
Medication Adherence for Diabetes Medications	Patients 18 years and older with a PDC of 80% or over across classes of diabetes medications during the measurement period.	PQA/CMS Stars

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Cost or Efficiency Measures

Evolent at least annually:

- Selects and collects data for at least one (1) measure of cost or efficiency to report to clients. The report includes the measure explanation, methodology for calculating reported measures, findings and analysis with recommendations for improvement opportunities as applicable.
- Identifies measures for data collection and analysis that are common industry measures as available, for example, cost trend measures, return on investment, utilization, relative resource utilization.
- Reports this data at the client level and/or in aggregate across all clients and if by specific condition and/or across all condition programs. In the event efficiency measures are reported in aggregate, reports are distributed to all clients.
- Provides reports to the client that includes transparency about the performance measures definitions and specifications.

Measure	Numerator	Denominator
Diabetes Ambulatory Care Sensitive Condition Admissions (ACSC)	The number of ACSC Admissions for patients with Diabetes	Total Number of Patients Identified with Diabetes

Active Patient Participation Measure

At least annually, Evolent will:

- Measure its active participation rates utilizing the calculation rate defined for the opt-out model across all three risk levels. The active participation rate is defined as:
    - Numerator: Total number of eligible Diabetes patients with at least one interactive contact.
    - Denominator: Total number of eligible Diabetes patients.

- Conduct an analysis of participation rates which includes:
    - Comparison of results against goals and past performance when applicable,
    - Identifying at least one (1) opportunity for improvement and
    - Implementing at least one (1) action to improve participation rates.
    - Provide reports to the client that includes transparency about the performance measures definitions and specifications.

Data collection and analysis may be performed across all clients or by each client, depending on Evolent and/or client preference.

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Active Participation Rate

Numerator	Denominator	Goal
All Diabetes Patients with at least one interactive contact, including: • Phone or face to face contact with Nurse Care Advisor • Phone contact with Health Coach • Patient request for diabetes educational materials	All Diabetes patients eligible for the Diabetes Program	10%

Patient Experience Survey

Patient experience and satisfaction with the Program and program staff is measured by:

- Obtaining feedback from patients
- Analyzing complaints
- Patient experience survey

Evolent Health obtains feedback about patient's and/or caregiver experience with the Program and staff. Feedback is obtained through surveys sent to patients that were engaged with a nurse care advisor or health coach at the time the case is closed. The survey measures 1) overall satisfaction with Program, 2) improvements in patient's ability to manage his/her health, 3) helpfulness of the team members, 4) usefulness of information disseminated, and 5) areas of the Program/support that were most helpful and least helpful.

This data is analyzed at least every twelve months, by client and across clients to understand the patient's and caregiver's perspectives of how well the care team is performing and responding to meeting and exceeding the needs and expectations of the patient and/or their designated caregivers. The data is also reviewed by the Care Management Quality Committee and Clinical Operations to identify areas to improve and enhance the services and training for the Diabetes program staff.

Obtaining Consumer Input

Evolent utilizes input from patients to enhance the program's effectiveness. Each patient that engages with a nurse care advisor or health coach is surveyed upon Program discharge. The survey includes open-ended questions encouraging patients to describe the aspects or the Program that they found most useful and those that were least useful in helping them manage their condition. Additionally, patient input is requested on the effectiveness of the initial outreach materials, including letter and Program brochure.

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Practitioner Experience Survey

Practitioner experience and satisfaction with the program and staff is measured by:

- Obtaining feedback from practitioners
- Analyzing complaints
- Practitioner experience survey

Evolent Health also elicits feedback from practitioners whose patients were engaged in the Program. This feedback is obtained annually through a survey targeted to all practitioners that had three or more attributed patients engaged with a health coach or nurse care advisor. The survey measures, 1) practitioner's perceived usefulness of the Program, 2) satisfaction with interactions with Program staff, 3) perception of Program impact on patient use of services, and 4) perception of the Program's impact on patients' health status relative to their diabetes.

This data is analyzed at least every twelve months, by client and across clients to understand the practitioners' perspectives on the usefulness of the Diabetes program and its impact on their patients with diabetes. The data is also reviewed by the Care Management Quality Committee and Clinical Operations to identify areas to improve and enhance the Program and training for staff.

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Addendum

Evolent Health Diabetes 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. **Patient Identification and Stratification.**
   1.1. Valence Health uses the following data sources for patient identification:

Data Source	Typical Update Frequency
Typical Patient Identification Program Frequency	
12. Patient Eligibility data	Monthly
13. Medical Claims data	Monthly
14. Pharmacy Claims data	Monthly
15. Health Risk Appraisal data (when available)	Annually
16. UM management process data	Daily
17. Practitioner/Patient/Caregiver data	Annually
18. Electronic Medical Record data (when available)	Weekly
19. Laboratory Data – when available	As Available
10. Eligibility Lists from the client	As Available
11. Health Management, Wellness, or Coaching Programs	As Available

2. **Section VI. Stratification**
   2.1. Stratification Table for Valence Health:

	Condition Care – Low Risk	Condition Care – Moderate Risk	Complex Care – High Risk
Risk Criteria used to determine	Patients with two paid claims for evaluation and management visits with the primary diagnosis	Diagnosis of diabetic co-morbidities (neuropathy, nephropathy, retinopathy,	Members hospitalized or treated at the Emergency Department at least once in the past 12

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Patient Stratification	of asthma in all past claims history.	limb ulcer/amputation with diabetes diagnosis)	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.

3. Section VIII. Patient Interventions

Interventions for Asthma	Low Risk	Moderate Risk	High Risk
6. Welcome Letter explaining the program, hours of operation, the importance of self-management for diabetes control, etc.	✓	✓	✓
7. Letter encouraging routine visits to the PCP for preventive care and disease-specific follow-up (based on Client)	✓		
8. Notification to the patient of care gaps (based on Client for low-risk)	✓	✓	✓
9. Outreach to the patient to enroll in either the Moderate or High-Risk Program		✓	✓
Interventions below contingent on patient enrollment in program			
1. Completion of a screening, by a Health Coach, that includes some coaching/education/self-management during interaction		✓	
2. Completion of an assessment, by a Registered Nurse, that includes some coaching/education/self-management during interaction			✓
3. Mailing of an Diabetes Educational Booklet after successful outreach		✓	✓
4. Self-management support and health education and coaching to improve knowledge and self-management skills		✓	✓
5. A minimum of 3 outreaches during the 60 days following the screening submission, unless otherwise requested by the patient or physician		✓	
6. Outreach occurs at least every 10 business days unless otherwise requested by the patient or physician			✓
7. If diabetes is one of two or more comorbidities for this patient, education materials will be mailed based on the patient's clinical needs			✓
8. Outreach to patient if identified for Unplanned Care	✓	✓	✓

3.1. All patients will receive and Diabetes educational booklet unless they decline. Low risk patients receive a welcome letter notifying them how to contact the disease manager for additional information.

4. Section IX. Practitioner Support

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4.1. 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.

4.2. Identifying the Practitioner delivering care to the patient.

4.2.1. Valence Health identifies the patient's PCP based on plan enrollment information.

4.3. Practitioner Decision Support

4.3.1. 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.

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