EVOLENT HEALTH, LLC

Heart Failure
Program Description
2017

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I. Introduction

The Evolent Health Heart Failure 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 care and healthcare services delivered to client 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 determine activities and influence outcomes related to the improvement of the care and treatment of patients.

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

Evolent Health's Program is intended to help guide the care of patients with heart failure 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 heart failure program emphasizes the prevention of the exacerbations and complications of heart failure 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 identified through a comprehensive patient assessment. 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), Registered Dietitian, Licensed Social Worker and the Pharmacist to develop and implement personalized care plans for each eligible, covered patient. The patient's primary care advisor is a nurse for both high-risk and moderate-risk patients. The nurse performs a comprehensive assessment and develops a care plan for each patient.

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.

III. Program Goals

The goal of the Evolent's 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 heart failure. 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
- Improve medication adherence
- Facilitate appropriate communication across the entire care team
- Optimize heart failure management and close relevant gaps in evidence based care
- Educate patients on heart failure 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 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. The Evolent Care Management Quality Committee has responsibility for review and approval of clinical guidelines.

Guideline used for the Evolent Health Heart Failure Program

ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult, 2013. http://circ.ahajournals.org/content/128/16/e240

V. Patient Identification

Evolent Health systematically evaluates patient data against a set of identification and stratification criteria. For the 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 heart failure 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 Records data (when available)	Weekly
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. Clinical data, including EMR and lab data, is used to indicate patients' specific disease states; potentially revealing when a patient needs attention. 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 heart failure 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.

VI. Stratification

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

Heart Failure - Low Risk

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

Heart Failure - Moderate Risk

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

- A heart failure related inpatient admission within six months
- A heart failure related ER visit within three months
- No PCP or heart failure related specialist visit within twelve months
- Patient's heart failure and hypertension prescription adherence is less than 80%

Heart Failure – High Risk

Criteria for High-Risk: These are the heart failure 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 participating in the Program unless they specifically request to opt-out. Patients are notified of their eligibility after the monthly identification and stratification process or after being referred by their practitioner, a health professional, or another program. This is done through a letter and program brochure that informs the patient of the program and how to utilize the services. The communication includes:

1. Information on how to use the heart failure program services.
2. How the patient became eligible to participate
3. Nurse care advisor 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 criteria for the Program again. If the patient has communicated that they do not want to be contacted again, we will respect their wishes.

The patient's practitioner is alerted when a patient engages in or declines care advising with a nurse 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 alerts the patient's practitioner of engagement within 45 days.

VIII. Patient Interventions

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

Interventions by Stratified Risk Level:

Interventions for Heart Failure	Low Risk	Moderate Risk	High Risk
1. Welcome Letter explaining the program, hours of operation, the importance of self-management for heart failure 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 an assessment, by a Registered Nurse, that includes some coaching/education/self-management during interaction		✓	✓
2. Mailing of a Heart Failure booklet to the patient after successful outreach			✓
3. Mailing of a Heart Failure booklet to the patient at their request	✓	✓	
4. Self-management support and health education and coaching to improve knowledge and self-management skills		✓	✓
5. Minimum of 3 outreaches during the 60 days following the assessment 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 heart failure is one of two or more comorbidities for this patient, education materials will be mailed based on the patient's clinical			✓
8. Outreach to the SNP patient will follow the MOC	✓	✓	✓
9. Outreach to the patient if identified for Unplanned Care	✓	✓	✓
10. Outreach to the patient if identified for Transition Care	✓	✓	✓

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

- Physician visits and pre-visit planning
- Schedule for tests and screenings
- Symptoms of heart failure and keeping a symptom record
- Treatments for heart failure
- Self-care

- Exercise planning form
- Heart healthy eating
- Urgent and Emergent symptoms and actions

Additional resources provided to patients include the following web sites:
American Heart Association – www.heart.org
American Lung Association – www.lung.org (for smoking cessation)

Consideration of individual patient needs in targeting interventions is facilitated through the assessment and on-going patient contacts.

The nurse care advisor utilizes a comprehensive heart failure assessment to identify patient needs and to target interventions. The assessment auto-identifies actions based on the patient responses to questions. Additionally, through ongoing interaction with the patient, additional barriers to effective management may be identified. Evolent Health understands that patients in the heart failure program have unique needs and therefore the program is individualized and patient-centric, assessing for, and addressing the following:

Comorbidities and Other Health Conditions

Heart Failure is often accompanied by various comorbidities. These comorbid conditions may include diabetes, hypertension, kidney disease, chronic obstructive pulmonary disease, obesity and sleep disordered breathing. Patients with multiple comorbidities are stratified at a higher risk level and are managed by registered nurses who address the comorbid conditions in collaboration with the patients' practitioner. Patients receive information addressing their comorbid conditions, including behavioral health referral, if appropriate. Additionally, patients will receive information on healthy eating, salt restriction, blood pressure control, exercise, etc. 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 specialist 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 heart failure and impact adherence to their treatment plans. Some of the targeted behaviors identified through an 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 heart failure 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 nurse care advisors screened patients for psychosocial issues that may impact their ability to effectively manage their heart failure. 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 support and resource barriers are referred to the social worker, a TTY service is provided for hearing impaired patients and language interpretation 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 heart failure, their motivation to change and confidence to effectively manage their condition is also considered. The 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, 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 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 improving their diet 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 daily weight log with their provider.

IX. Practitioner Support

Program information is distributed to providers 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.

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 less (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 semiannual Care Opportunity Reports to practitioners alerting them to potential care opportunities for their patients with heart failure. The focus of the report is to notify practitioners of their patients with heart failure that, based on Evolent claims data, have not filled a prescription for appropriate beta-blocker therapy or have not filled a prescription for an ACE or ARB medication. The Care Opportunity Report was developed to address important aspects of care and treatment for heart failure, as well as, to 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 heart failure disease management program.

Urgent Notification Alerts

If the nurse 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.

- Weight Gain: 2-5 pounds within 24-48 hours
- Increasing Shortness of breath or dyspnea on exertion that persists over 2 days (unable to walk as far as usual)
- Sputum or persist cough (possible signs of pulmonary edema)

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 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 then follows up with the patient to ensure the care coordination efforts have been successful and, if not, the care advisor 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 Heart Failure 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 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
Heart Failure (HF): Beta Blocker Therapy	Patients 18 years of age or older with a current or prior LVEF < 40% who were dispensed beta blocker therapy within the 12 months of an outpatient visit or at each hospital discharge.	PQRS
Coronary Artery Disease (CAD): ACE/ARB Therapy	Patients 18 years of age and older with a diagnosis of CAD and Diabetes or current or prior LVEF < 40% who were dispensed ACE inhibitors of ARB therapy.	PQRS

Cost or Efficiency Measures

Evolent at least annually:

- Selects and collects data for at least one (1) measure of cost or efficiency to report the cost or efficiency measure(s) for the Heart Failure Program 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
Heart Failure Ambulatory Care Sensitive Condition Admissions (ACSC)	The number of ACSC Admissions for patients with Heart Failure	Total Number of Patients Identified with Failure

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 Heart Failure patients with at least one interactive contact.
  - Denominator: Total number of eligible Heart Failure patients.
- Conducts 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.
- Provides 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.

Active Participation Rate

Numerator	Denominator	Goal
All Heart Failure Patients with at least one interactive content, including: • Phone or face to face contact with Nurse Care Advisor • Patient request for Heart Failure educational materials	All Heart Failure patients eligible for the Heart Failure 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 from patients that were engaged in working with the nurse care advisor through an IVR survey. 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 heart failure program staff.

Obtaining Consumer Input

Evolent utilizes input from patients to enhance the program's effectiveness. Each patient that engages with a nurse 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.

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 actively seeks feedback from practitioners whose patients were engaged in the Heart Failure Program. This feedback is obtained annually through a survey targeted to all practitioners that had three or more attributed patients engaged with a nurse. 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 heart failure.

This data is also analyzed at least every twelve months, by client and across clients to understand the practitioners' perspectives on the usefulness of the Heart Failure Program and its impact on their patients with heart failure. 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.