Catastrophic Care Program Description 2017

Evolent Health Catastrophic Care
2017 Program Description

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I. Introduction

The comprehensive Evolent Health Catastrophic Care (CC) Program Description describes the components of the CC Program, explains how Evolent identifies patients and assesses their individual needs, provides evidence on which the CC Program is based, presents the criteria for identifying eligible patients, details the services offered and conveys the CC Program goals. Evolent's CC Program is designed to deliver maximum effectiveness for patients, providers and clients.

The integrated CC Program focuses on two distinct patient populations:

- **Patients that experience a catastrophic event** – The focus is on managing and supporting patients and caregivers in instances where a patient experiences a significant, potential life changing event or diagnosis, such as malignant cancer, degenerative neurological disease, respiratory failure and liver disease etc. The majority of these patients are identified through daily utilization management (UM) authorizations for patients admitted with one of the targeted conditions listed under *Catastrophic Care Identification Criteria*. The primary goal is to support the implementation of the patient's specialist treatment plan to prevent avoidable readmissions, reduce unnecessary emergency room (ER) visits, manage the patient's pain and remove barriers that may prevent the patient and his/her care giver from adhering to his/her treatment plan.

- **Patients with multiple, severe, intensive conditions** – Management and support is provided to patients and their caregivers in instances where a patient has multiple chronic conditions with other significant comorbidities, or significant diagnoses and barriers, such as serious mental illness, cognitive and/or functional deficits, degenerative neurological diseases, etc.

II. Program Philosophy

The Evolent Health CC Program employs a patient-centric approach that helps patients and their caregiver understand and engage on attaining or maintaining their optimal health. The objectives of the Program are to:

- Improve care coordination for patients in collaboration with their primary care physician (PCP) and specialist treating physicians
- Support the physician's treatment plan
- Facilitate and coordinate transitioning the patient to the least restrictive setting
- Optimize chronic condition management by educating patients about diagnoses and self-management
- Implement personalized care plans
- Improve medication adherence

- Address patient/caregiver needs regarding adequate support and resources at home
- Improve adherence to the hospital discharge care plan for patients discharged to home
- Decrease “avoidable” utilization events (e.g., readmissions) and increase the number of patients engaged with health plan Care Advisors

Evolent Health’s CC Program coordinates services for patients with catastrophic and intensive needs using a multi-disciplinary care team, led by the patient’s PCP and overseen by a primary registered Nurse (RN) Care Advisor (CA). The team-based model focuses on optimizing the health of the eligible, covered patient utilizing the broad skills of the PCP, RN CA, registered dietitian, licensed social worker and pharmacist, to develop and implement personalized care plans.

The care team focuses on the comprehensive needs of the patient and caregiver, incorporating the patient’s physical and behavioral health status, personal preferences and confidence level, and current lifestyle risks. Psycho-social, cognitive and functional disabilities, transportation and economic barriers, which may impede health and adherence to the treatment plan, are also addressed. The care team then considers the patient’s health plan benefits, local community and government agency resources that may provide services to improve the health and well-being of the patient.

The CC Program also emphasizes early identification of patients that are at risk for adverse clinical outcomes, increased utilization, and higher cost. Patients are identified through multiple methodologies including real time utilization management authorizations and Evolent Health’s predictive modeling algorithms that are based on independent medical, pharmaceutical, laboratory and behavioral health claims, as well as, eligibility and demographic variables.

Operational Model and Catastrophic Care Program Focus

The Evolent Health CC Program operates at the local and national level. This structure enhances efficient resource utilization and is designed to maximize administrative efficiency. Since each client has unique needs based on the maturity of its markets and the demographics of its patients, the Program can be tailored to fit needs, as appropriate, while focusing on maintaining consistency in approaches.

The focus of the CC Program is to provide patients with access to quality care and services while coordinating benefits based on clinical need. The Program defines quality care as treatment that:

- Supports the implementation of the physician’s treatment plan to stabilize the patient’s condition
- Works with the physician to ensure the patient appropriately transitions to the least restrictive setting with caregiver support
- Improves the patient's physical and emotional status

- Promotes health and healthy lifestyle beliefs and behaviors
- Encourages early treatment
- Is based on accepted medical principles and follows evidence-based practices
- Assesses palliative care needs
- Identifies patients' end-of life care preferences
- Updates or revises advance directives based on patient care preferences
- Uses technology and other resources effectively
- Provides service from a clinical team that is sensitive to illness, racial, ethnic and cultural issues
- Is accessible to patients in a timely fashion
- Is sufficiently documented.

Catastrophic Care Program Goals and Objectives

- Immediately identify catastrophic and highly intensive cases through the utilization management process, member self-referral, provider referral and the Evolent predictive model
- Facilitate safe care transitions
- Honor the patient's preferences for care
- Partner with the patient, his/her caregiver and the primary and specialty care providers to develop a personalized plan of care in the least restrictive setting
- Improve medication compliance
- Address patient/caregiver needs regarding adequate support and resources at home
- Coordinate a comprehensive community based and home health care network of services
- Identify and negotiate contracts with those services outside of the existing network
- Facilitate appropriate communication across the entire care team
- Support end of life and palliative care options with patients and their physicians
- Optimize chronic care management and close relevant gaps in evidence based care
- Educate patients about diagnoses and self-management
- Lower total medical expense by avoidance of readmissions, ER visits, duplicative and unwarranted services, and specialist costs through coordinating care during acute, intensive care episodes.

Metrics and Targets of the Program

The following metrics are used to measure the overall effectiveness of the CC program. These measures are used annually for trending, analysis and identifying opportunities for improvement.

Measuring Effectiveness Metrics

Performance Metric	Numerator	Denominator	Data Source	Program Level Target
Process Performance Metrics				

Performance Metric	Numerator	Denominator	Data Source	Program Level Target
Graduation Rate	The cases closed with a status-of "Problem Resolved/ Goals Met"	The cases assessed and closed in the given reporting month	Identifi	≥70% or a 10% relative improvement Year over Year
Referral rates of patients with positive behavioral health scores on initial assessment screeners	The # of qualifying assessments with a care note by a SW / BH addressing the referral from the PHQ or GAD questions	The # of qualifying assessments generating a referral to a SW / BH from the PHQ and/ or GAD questions	Identifi	>80% or a 10% relative increase year over year
Patient Experience Performance Metrics				
Patient Experience	The # of patients that respond "strongly agree" or "agree" to questions, 7, 8, and 9.	Total survey respondents	Patient Surveys	>82%

III. Clinical Evidence and Guidelines Used to Develop the Program

Evolent references evidence-based, medical society and national industry standards in development, ongoing maintenance, and updates of its CC Program. The evidence is reviewed by at least two clinical staff with appropriate knowledge of clinical guidelines and peer reviewed, evidence based studies. A multidisciplinary team of clinical operations leadership and other subject matter experts, such as research and evaluation analysts, then review the evidenced based sourcing to assure alignment with program content and processes.

The evidence base for the Program contents are reviewed on an annual basis, or more frequently as needed. At the time of annual review, clinical staff, including Medical Directors, suggest revisions to Program content based on clinical evidence and areas where operational improvements are needed to improve program performance. The Case Management Quality Committee (CMQC) is ultimately responsible for approval of the underlying evidence base guidelines adopted. Training materials are updated and presented to staff when changes are approved and incorporated into program design. Patient program materials are updated based upon current evidence, cultural and linguistic appropriateness, and are distributed as indicated.

To ensure measures used for reporting are consistent with any recommended changes in clinical practices, updates that may impact measures are shared with Evolent's reporting solutions team to update analytics.

Catastrophic Care Program Clinical Evidence Base Guidelines and References

The clinical evidence based guidelines (EBGs) and references used to inform program

design and performance metric reporting for the CC program are cited in Appendix A.

IV. Annual Population Health Assessment

In order to assure that CC programming supports the needs of insured patients, an assessment of the characteristics of the population and sub-population is completed annually and compared against the CC programming and resources. The assessment results serve to inform updates to the CC processes, procedures, and resources required to serve the specific needs of each population. The population assessment includes an evaluation of the following population characteristics as data is available:

- Analyses conducted at the client level;
- Analysis of claims data revealing historical utilization and diagnostic trends for prior inpatient, outpatient, pharmacy, laboratory, and radiology services, reported separately for adults and children under the age of 19;
- Analysis of the needs of eligible individuals with 1) disabilities and 2) serious and persistent mental illness (SPMI);
- Analysis of patient demographics, including: age, race, ethnicity and gender distribution;
- Other data elements as population trends emerge.

Once a population characteristic assessment is completed, analysis of the EBGs is conducted to determine best practices for addressing the identified needs. The population assessment is reviewed annually with the CMQC with recommendations for program enhancements based on the EBG review. The CMQC makes decisions regarding the prioritization and type of CC programming enhancements necessary to positively impact population health outcomes. As a result of the CMQC review, requests are submitted to the appropriate development team responsible for developing CC programming enhancements and providing status updates to the CMQC regarding the operational implementation of such activities.

Enhancement opportunities for populations include the development and implementation of additional specialty condition CC programming, changing staffing requirements, developing specific preventive educational materials or outreach interventions.

V. Identifying Patients for Catastrophic Care

Catastrophic Care Identification Criteria

Multiple data sources, identified below, are utilized to identify patients appropriate for the CC Program. The profile of the patients identified for the CC Program are as follows:

The presence of either of the following two criteria.

1) Total sum of inpatient length of stay days across all inpatient encounters in the last 12 months is greater than or equal to 6 days and the presence of at least one of the following diagnoses:

or

2) A financial threshold of total amount paid greater than or equal to $100,000 in the last 12 months and the presence of at least one of the following diagnoses:

Primary Diagnoses

- Amyotrophic Lateral Sclerosis
- Hemophilia and Coagulation Disorders
- Gauchers Disease
- Guillain-Barre Syndrome
- Liver Failure
- Cystic Fibrosis
- Respiratory Failure
- Ventilator Dependency
- Burns >20% Total Body Surface Area or 2nd/3rd Degree Burns
- Spinal Cord injuries and "plegias" (mono di para and quadra)
- Severe Cognitive Functional Impairment
- Sickle Cell Disease
- Head and Neck Tumors
- Pulmonary /thoracic tumors (including breast)
- Gastrointestinal/abdominal tumors (including colorectal)
- Lymphatic and hematopoietic (blood) system
- Genitourinary/pelvic tumors
- Endocrine Tumors
- Cerebrovascular Accident and Hemorrhage
- Acute and Chronic Osteomyelitis
- Sepsis (all cause)

Any patient meeting the eligibility criteria for the CC program with a complicating behavioral health (BH) diagnosis will be discussed with the market medical director and the BH Medical Director to determine if the patient is appropriate for the CC Program and/or referral to the BH organization. In instances when collaboration between medical and behavioral health programs is appropriate for the patient, he or she will be co-managed across both programs.

Evolent leverages both automated (rules-based) and manual (query and clinical referral based) processes to identify patients for the Program. The data sources below are used in a proprietary predictive model that analyzes the severity of diagnoses across three dimensions – 1) diagnosis progression, 2) management interventions, and 3) addressing complications -- to target clinically those patients in which an impact is possible.

The following data sources are used within the predictive model and run on a monthly basis. Other data sources, indicated below, are factored into the model based on availability.

Data Source	Typical Update Frequency
1. Medical Claims	Monthly
2. Pharmacy Claims	Monthly

Data Source	Typical Update Frequency
3. Health Risk Appraisal/Patient Questionnaire	Annually
4. Electronic Medical Record data (when available)	Weekly
5. Data collected in Identifi from Condition Care or Practitioners	As available
6. Hospital Admission, Discharge & Transfer feeds	Daily
7. Laboratory Values, as available	As available

Currently Evolent's clients do not have access to purchaser data to provide to Evolent. In the future, when this data becomes available, it will be integrated into the Evolent data warehouse and used as appropriate to identify members/patients for the Catastrophic Care Program.

In addition to the above data sources, patients can be referred to the Catastrophic Care Program through:

- The Utilization Management team
- The staff managing the patient as part of other Evolent Health Population Management Programs, such as the Complex and Condition Care, Transition Care or Unplanned Care Program
- A discharge planner
- Internal departments, such as Pharmacy
- The 24-hour nurse advice line (health information line), as applicable
- Patient, family or caregiver, self-referral
- Practitioners, including behavioral health providers
- Ancillary providers, behavioral health managed care organizations, pharmacists, disability management programs, employer groups, or staff from community agencies

The final step in identifying if a patient is eligible for CC services is an initial enrollment and clinical risk/barrier screening to determine if the patient has needs and/or barriers to care that could be impacted by enrollment and participation in the program.

Initial Assessment Processes

Patients eligible and identified for the CC Program are initially outreached and engaged through mail, telephone, or face to face contact to facilitate their participation in the CC Program. The patient's name, address, and/or date of birth are utilized to confirm the CA is speaking to the patient. Engagement, which ideally results in the patient agreeing to participate in a Program, precedes the case management assessment process, development of a care plan with prioritized goals, and active patient involvement. A patient's participation in the CC Programs is voluntary, not a requirement, and an opt-in model of participation is utilized.

Time Frames to Conduct Outreaches and Assessments

Patients are initially outreached to as follows:

- Within 2 to 3 business days of receiving the case via an Action Item in Identifi, a Care Advisor will begin outreaching to the patient and/or care giver.

- Initial assessments are completed within 30 days of patient eligibility for the program. The goal is to complete the initial assessment during the enrollment and initial screening interactions.

    - For patients identified through the automated algorithm, eligibility begins at the Assigned Date.
    - For patients identified through the Utilization Management process, eligibility begins when patient is discharged to home.

Assessments

The CC Program has its own distinct assessments based on its focus. The CC program assessment is intended to provide the CC team with a comprehensive assessment of the patient's needs, barriers, and preferences to inform the development of a personalized longitudinal care plan aimed at helping the patient adhere to his/her physician's treatment plan and enable the patient and caregiver to become proficient at self-managing his/her health.

The initial assessment includes, but is not limited to, the following:

- Clinical history, including medications
- Health status, including medical and behavioral health condition-specific issues
- Activities of daily living and cognitive functions, needs, preferences and barriers
- Mental and social-economic health status needs, preferences and barriers
- Life-planning activities such as living will, advance directives, and power of attorney
- Cultural and linguistic needs, preferences, or limitations
- Visual and hearing needs, preferences or limitations
- Health beliefs and behaviors including smoking, diet and exercise
- Caregiver availability and involvement
- Patient's available benefits and community resources

Based upon the results of the initial assessment, the patient may be enrolled into the Catastrophic Care Program.

VI. Care Planning Processes

Nurse Care Advisors, in coordination with the attending practitioner, patient and

caregiver, develop an individualized care plan. The care plan includes patient specific preferences, barriers, prioritized goals, self-management activities, referrals, a schedule of follow-up interactions and a process to assess progress. The Clinical teams' activities are targeted to facilitate the achievement of the patient's health goals and to resolve issues/barriers.

Personalized care plans take into consideration the following:

- Patient and/or caregiver preferences to prioritize goals;
- Re-evaluation of progress, including problem solving and re-setting of goals when progress is not being made; Assigning key responsibilities for specific care plan goals to the extended care team staff most appropriate to support the patient;
- Involving caregivers when the patient has a ready and willing significant other;
- Understanding the patient's plan benefits, network, and community based services.
- Care transitions and the need to reassess and modify to ensure appropriateness based on the patient's current level of care and needs.

Prioritized Goals

Development of the Care Plan considers the patient and caregiver goals and preferences, and his/her desired level of involvement in the CC Program. Development of the Care Plan includes but is not limited to:

- Identify barriers to meeting goals and complying with the care plan
- Develop follow-up coaching/care coordination encounter schedule with patient
- Develop and communicate patient self-management plans
- Assess progress against care plans, and modify as needed

Referrals and Barriers to Care

As part of the assessment and care planning process, patients may be referred to network, community, or governmental support agencies to address individualized needs. The RN CA is responsible for ensuring that patients are referred to the Extended Care Team including Pharmacists, Registered Dietitians, and Social Workers, when appropriate. The RN CA determines if patients are acting on referrals during follow-up.

In addition, the CA team is responsible for identifying all relevant barriers preventing a patient and/or caregiver from adhering to his/her physician's treatment plan and access to care. There are multiple forms of barriers including physical or mental disabilities, financial, language, hearing, motivation, culture, confidence barriers as well as social determinants of health. It is a core responsibility of a CA to identify options and solutions to mitigate and remove barriers.

Follow-up Schedule

A Nurse Care Advisor contacts the patient on a bi-weekly basis depending on the clinical needs of the patient and patient preference. At the end of most calls, the next appointment time is arranged. The CC program duration is 3 months; however, the program may be modified to accommodate the individual needs of each patient.

Assessing Progress

For each patient, active in case management, progress in meeting the patient's care plan goals and objectives is reviewed, monitored, and reassessed based on agreed upon priorities from patient and care advisor. Development and communication of patient self-management plans is an essential component of all care plans. Identification of barriers a patient faces is typically key to his/her ability to meet goals and accomplish his/her objectives outlined in the case management plan.

Development of schedules for follow-up and communication with patients is notated in the clinical documentation system.

Case Closure

Once a patient has regained optimum health or improved functional capability, he/she is evaluated for appropriateness of discharge from the Catastrophic Care Program based on his or her ability to meet graduation goals. Patients either graduate or are referred into an alternate care management program; catastrophic care cases may be closed for the following reasons:

- Condition has stabilized
- Needs have been met
- Goals have been met
- Patient declines continued participation
- Patient does not respond to outreach attempts after three attempts and an "unable to reach" letter
- Maximum benefit is obtained from the program
- Patient has expired
- Patient no longer enrolled in a client-sponsored health plan product

VII. Care Monitoring and Case Management System

Evolent Health utilizes a clinical documentation system, Identifi, which automates the evidence-based clinical guidelines and algorithms used to perform the CC assessment and ongoing management of the patient.

Identifi leverages chronic care guidelines and evidence based assessments such as the PHQ9 to ensure the patient treatment plan and adherence to evidence based standards of practice are assessed. See Appendix A for the guidelines being used to inform assessment questions, responses and actions.

In addition, the assessment leverages branching logic to allow follow-up questions to be skipped depending upon the response to the initial question. In addition, logic is applied for the automated creation of patient goals, action items and care notes aimed at ensuring consistent delivery of the program across the RN CAs.

From an ongoing management perspective, the Identifi platform has a standard care plan template that includes a library of problems, goals and interventions (PGIs) that have been informed by the aforementioned guidelines.

The system automatically documents the staff member's name, date and time of action on the case or when an interaction with the patient has occurred. The CA assigns the next follow-up via the system based on the patient's needs and request.

Staff are trained to schedule the next interaction with the patient at the end of each call and to create an action item reminder for the RN CA to prompt their next interaction with the patient.

Identifi is at the heart of Evolent Health's case management solution with a growing set of automated features to provide accurate documentation of the actions/interactions with the patient, the physicians and the care team.

VIII. Care Transitions

The Care Transition model includes analyzing data to identify patients at risk of an unplanned transition, as well as, analyzing rates of admissions and emergency room visits annually to identify areas for improvement. Evolent Health attempts to identify patients at risk for an unplanned transition. Once identified, interventions appropriate for the patient are implemented to minimize future risk. The primary goal is to transition the patient to the least restrictive setting. Collaboration and coordination of transitions across all sites of care is supported, including timely communications to patients, primary care physicians, and receiving and sending facilities. The process supports a comprehensive method for patients transitioning from an inpatient facility back to their homes.

IX. Measurement and Quality Improvement

Evolent Health measures and works to improve patient experience, program effectiveness and participation rates.

Patient Experience with Catastrophic Care

At least annually, Evolent Health measures patient experience and satisfaction with the program and the Nurse Care Advisors by:

- Obtaining feedback from patients

- Analyzing patient complaints

Evolent Health obtains feedback about patient's and/or caregiver experience with the CC Program and CA team. This feedback is obtained through an IVR survey sent to patients enrolled in the CC Program for at least 2 months. The survey measures various aspects of experience including: 1) overall satisfaction with program 2) improvements in patient's ability to manage his/her health 3) helpfulness of the CA team members 4) usefulness of information disseminated and 5) areas of the program/support that were most helpful and least helpful to the patient and caregiver. (See the Patient Experience Performance Metrics earlier in this document)

This data is analyzed 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. These analyses are conducted at least every twelve months. This 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 CA team.

Measuring Catastrophic Care Program Effectiveness

Evolent Health has defined a set of Catastrophic Care Program process, outcome (financial and clinical), experience, and timeliness metrics (*Measuring Effectiveness Metrics* table) that are utilized to measure, monitor and ultimately improve the performance of the program. Using at least three measures, Evolent Health annually measures the effectiveness of its case management program. For each measure, Evolent Health:

- Annually, identifies a relevant process or outcome and clearly defines the numerator and denominator definitions, time frames, inclusion and exclusion criteria for the measure;
- Uses valid methods that provide quantitative results, including providing tools and methodologies to support appropriate sampling and sample sizes for the specific measures.
- Takes into consideration seasonality, population types and regional geographic and demographic factors to normalize data results and ultimately inform the performance improvement initiatives;
- Sets goals for each of the performance metrics.

Annually, performance is measured, improvement opportunities are identified and interventions to improve effectiveness are implemented. The impact of the interventions is determined upon re-measurement.

Transparency in Reporting Outcomes

As part of the program outcomes evaluation reporting, Evolent Health is completely transparent with sharing the results with clients. This includes having clear definitions of the performance measures available to clients, sharing actual versus expected results,

and comparing and sharing of normative results across clients.

Measuring and Improving Patient Participation Rates in the Catastrophic Care Program

Evolent Health measures participation in the CC Program monthly because rates are viewed as a very early indicator of program effectiveness. The following table shows the participation related metric that is measured at the program, client, and CA level.

Performance Metrics	Numerator	Denominator	Data Sources	Calculated at a Program Level
Process Performance Metrics				
Participation Rate	CC cases with a completed, submitted assessment and 1 additional interactive contact with the patient	Total patients identified and deemed eligible for the CC program (Eligibility includes a screening process to ensure patient has needs/barriers)	Identifi	50% or greater or a 10% relative improvement year over year Identified Targets: Catastrophic: takes approx. 3 months to meet referred targets

Evolent Health evaluates participation rates at least annually by client and across clients and identities and implements at least one action to improve participation rates.

Transparency in Reporting Participation

Part of the program participation reporting for clients includes providing numerator and denominator definitions (see above), as well as a description of the time period and how it effects inclusions and exclusions in the numerator and denominator.

X. Staffing, Training and Verification

Evolent Health's Care Advising Team is composed of the following staff categories: role type, licensure requirements, and primary responsibilities.

Staff Role	Role Type	Licensure Required	Primary Responsibilities
Care Advisor Team Manager	Clinical	License required in each state where their team is managing patients	• Manages/supervises the day to day activities of the CA team • Facilitates case review conferences • Provides performance coaching and feedback to team patients • Evaluates reports and performance on a regular basis with the team
Registered Nurse Care Advisor	Clinical	License required in each state where CA is serving patients (may be through Compact arrangements)	• Owns primary relationship with the patient and their PCP • Conducts assessments for catastrophic and transition care patients • Responsible for development and implementation of the care plan • Provides self-management coaching, care coordination services and refers patients to other care team patients and other services

Staff Role	Role Type	Licensure Required	Primary Responsibilities
Registered Dietitian	Clinical	License required in each state where RD is serving patients	• Supports RN and works with patients to implement their nutritional/dietary plan • Identifies barriers and problems solves with patients to maintain their behaviors to adhere to the plan • Links patients with local network dietitians to develop a comprehensive nutritional/dietary plan
Licensed Social Worker	Clinical	License required in each state where the LSW is serving patients	• Supports RN to identify and remove behavioral, social, economic and safety related barriers to care and care plan adherence including referrals to psychiatrists and network social workers • Facilitates the identification and access to network, community and governmental support services to meet key needs of the patient • Maintains database of local resources for patients and their caregivers
Licensed Pharmacist	Clinical	License required in each state where pharmacist is serving patients	• Supports RN to identify and coach patients needing support with medication adherence strategies and behaviors • Conducts medication reconciliations for patients during care transitions • Works with providers to change medication regimens to better meet the needs of the patient
Program Coordinator	Non-Clinical	No licensure requirements	• Works under the direction of the CA team by running reports, pushing cases to team patient work list/action item list • Sends out letters and helps the team manage to service level and timeliness metrics • Takes inbound calls from patients and connects them to the CA team

Staffing needs are based upon specifically designed staffing models which support the needs of the programs and the population being served. The staffing models are provided to clients as appropriate.

The CA clinical team, including market Medical Directors and Senior Directors of Market and Central Clinical Operations have a minimum of three to five years of clinical experience. All staff are properly trained and supervised. The Evolent Health Sr. and Vice President of Clinical Programs and Performance has ultimate responsibility for oversight and implementation of the Catastrophic Care Program. Regional or Market Medical Directors, and Senior Directors of Market and Central Clinical Operations, are responsible for the daily departmental operational activities for each client and for the national remote staff that support multiple clients.

Process for CA Team Interactions

As part of case management staffing model, Evolent Health defines the roles and responsibilities of the various team members, as well as core processes and communications for implementing the CC Program.

The following grid reflects the essential processes for how CA team members interact

with patients, practitioners and other clinical staff.

Patient and Practitioner Interactions with the CA Clinical Team	Patient and Practitioner Interactions with the CA Non-Clinical Team	Providing Access to Clinical Staff for Practitioner Requests	Approval of Processes
RN CA owns the following: • Primary relationship with the patient and PCP. • Conducts initial assessments for catastrophic and transition care • Outreach of PCPs and specialists to inform on care plan and notify of changes in health status • Responsible for the care plan development and patient progress on the plan • Self-management coaching • Referrals and follow-up to network and community resources • Case conference presentations **RD owns the following:** • Dietary and nutritional counseling • Referrals to local RD resources • Helps patient adhere to plan by identifying and removing barriers and reinforcing plan • Responsible for communicating and updating care plan related to nutrition, diet and exercise **MSW owns the following:** • Identification and problem solving to remove/mitigate barriers related to social determinants of health, economic or patient disabilities; • Identifies local network resources to support psycho-social counseling • Responsible for communicating and updating care plan related to psycho-social issues and related barriers **PharmD owns the following:** • Conducts medication reconciliations during transitions • Counsels patients on medication adherence methods • Works with physicians on changing medication regimens when appropriate	**Non-Clinical Staff interact with patients in the following ways:** • Program Coordinators send patients' letters to enroll and when unable to contact • Program Coordinators receive inbound calls from patients trying to access a clinical CA team member and route the patient to appropriate staff; • Health Coaches outreach to patients to encourage program participation, and schedule visits with the patient's providers • Health Coaches conduct brief screening to help find patients a PCP, schedule follow-up appointments and educate patients on alternatives for accessing non-emergent care • Health Coaches also educate patients about gaps in care and helps patients schedule visits for lab work or diagnostic work **Situations when Non-Clinical Staff refer patients or practitioners to the clinical team:** • Patient or practitioner asks to speak to a clinician or have a specific clinical question • The non-clinical staff does not know how to respond to a patient or practitioner • The patient is expressing that they are experiencing signs and symptoms of their condition • An emergency situation where patient or physician need immediate help	**Practitioners in the network are informed on how to access the Catastrophic Care Program through the following means:** • Client clinical leadership meetings • Provider website provides an overview of the program, referral forms and phone numbers for contacting CA team patients • Care Plans provided to practitioners include the CA RN name and phone number • Health Coaches outreach to practitioners to inform them of patients enrolling and dis-enrolling from the program as well as notification of transitions	**The physicians on the CM Quality Committee are responsible for:** • Approving communication processes. • Approve clinical guidelines • Approve changes to program clinical content and design • Approve KPI and target changes

Initial Training, Monitoring and Ongoing Training for Staff

All case management staff receives a consistent and comprehensive role-dependent new hire orientation. Formal training is delivered via a blended methodology including face-to-face classroom sessions, virtual interactive sessions, and self-paced/e-learning modules. Both the design/development staff and the delivery staff have the responsibility of measuring the effectiveness of the curriculum. The initial training provided to the staff includes:

- Confidentiality/Handling of Protected Health Information
- How to handle emergency situations
- Evidence used to develop the programs
- Behavioral change models
- Goal setting
- Referral process
- Cultural competence
- Health Literacy
- Identifi system training

Staff are required to maintain competency by participating in internal and external educational programs, conferences and, as applicable, continuing medical education programs on an annual basis. To maintain consistent delivery, the staff are evaluated through an internal quality review process, which includes a focused performance coaching program of random sample file reviews, recorded or live call monitoring by managers, and reports. Staff are given feedback on their performance following these evaluations and through a standard, formal, bi-annual performance evaluation process.

When opportunities for improvement are identified through the internal quality review process, action plans are developed to meet defined goals. Actions include reassessment to measure progress. Training is provided to the clinical team or individual based on 1) coaching program findings, 2) changes to program design, 3) changes in populations being managed, 4) changes in guidelines and peer reviewed evidence, and 5) changes to Identifi workflow.

Verification of Licensure

All clinical staff are required to have an active, unrestricted license. A license is required in each state where patients are served and must be obtained within 90 days of staff starting at Evolent or within 90 days of notification of client membership in a new state. No staff member will engage patients in a state where the staff does not have a current, active, unrestricted license. The Human Resources (HR) department is responsible for conducting primary source verification for current, active licenses of the clinical staff prior to onboarding.

Ongoing Monitoring of Staff Licensure Verification and Sanctions and Complaints

The HR team is responsible for reminding individuals and their manager 90 days in

advance of the license renewal date. If an individual staff member fails to renew or obtain his/her additional license(s) within a 90-day period, he/she will not be allowed to engage patients in that state until an active license is obtained. Failure to procure a license within an appropriate timeframe may be grounds for termination. The HR team is responsible for conducting an annual sanction process for Medicare, Medicaid and licensure related sanctions. Staff may also report sanctions against themselves directly to HR and/or their manager. HR immediately validates any self-reported sanctions and implements appropriate action, if necessary.

XI. Patient Rights and Responsibilities

The organization communicates its commitment to the rights of patients and its expectations of patients' through patient enrollment packets. The information shared with patients addresses their rights to:

- Have information on the organization (includes programs/services provided on behalf of the client); its staff and its staff's qualifications; and any contractual relationships
- Decline participation or dis-enroll from programs and services offered by the organization
- Know which staff patients are responsible for managing their case management services and from whom to request a change
- Be supported to make health care decisions interactively with their practitioners
- Be informed of all case management-related services available, even if a service is not covered, and to discuss options with treating practitioners
- Have personal identifiable data and medical information kept confidential; know entities with access to information; know procedures for security, privacy and confidentiality
- Be treated courteously and respectfully by the organization's staff
- Communicate complaints to the organization and receive instructions on how to use the complaint process, including the organization's standards of timeliness for responding to and resolving issues of quality and complaints
- Receive understandable information

See Patient Rights and Responsibilities policy for details on procedures for distribution.

Patient Responsibilities/Expectations

Patients also receive information stating what expectations the organization has of them:

- Follow advice offered by the organization
- Provide the organization with information necessary to carry out its services
- Notify the organization and treating physician if patient dis-enrolls

See Patient Rights and Responsibilities policy for details on procedures for distribution.

Handling and Resolving Patient Complaints

Evolent Health has a policy and procedure for registering and responding to patient complaints about the CC program and/or the CC staff, including:

- Documenting the details and context of the complaint and actions taken
- Investigating the complaint, including any aspect of the clinical care involved
- Forwarding complaints not related to CM to the appropriate area or client
- Notifying and updating patients on the progress of the investigation and the final disposition of the complaint
- Turnaround times for resolving routine and urgent complaints. See complaint policy for time frames

XII. Privacy, Security and Confidentiality

The details of patient rights to privacy, security and confidentiality are described in two policies and procedures: 1) CORP028 Records Retention and 2) CMDM025 Care Management Compliance with HIPAA Privacy Regulations.

XIII. Accountability and Structure

Accountability for the management of the quality of clinical care and service provided to patients resides with the Care Management Quality Committee (CMQC). The Senior VP of Clinical Operations along with Regional Medical Directors are responsible for oversight of the Program's development and implementation. These responsibilities in addition to monitoring the effectiveness and improvement of the care management and population health programs are supported by the CMQC. 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.

Appendices

Appendix A: Catastrophic Care Program Clinical References

Core Program Design Features

Source:	Agency for Healthcare Research and Quality
Article Title:	Outpatient Case Management for Adults with Medical Illness and Complex Care Needs
Author(s):	Hickman DH, Wiess JW, Guise J-M, Buckley D, Motu'apuaka M, Graham E, Wasson N, Saha S
Publication Date:	January 2013
Link:	http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1369&pageaction=displayproduct

Source:	Milliman
Article Title:	Benefit Designs for High Cost Medical Conditions
Author(s):	Fitch K and Pyenson B
Publication Date:	April 2011
Link:	http://us.milliman.com/insight/research/health/Benefit-designs-for-high-cost-medical-conditions/
Source:	Professional Case Management
Article Title:	A catastrophic nurse case manager wears many hats
Author(s):	Clarke V, Broen K
Publication Date:	Nov/Dec 2007
Link:	http://journals.lww.com/professionalcasemanagementjournal/Citation/2007/11000/A_Catastrophic_Nurse_Case_Manager_Wears_Many_Hats.12.aspx

Source:	Hospitals in Pursuit of Excellence (HPOE)
Article Title:	Health Care Leader Action Guide to Reduce Avoidable Readmissions
Author(s):	Osei-Anto A, Joshi M, Audet AM, Berman A & Jencks S
Publication Date:	January 2010
Link:	http://www.hpoe.org/resources/hpoehretaha-guides/831

Tool Design Features

Source:	Evidence Based Medicine
Article Title:	The 2-item Generalized Anxiety Disorder scale had high sensitivity and specificity for detecting GAD in primary care
Author(s):	Skapinakis P
Publication Date:	October 2007
Link:	http://ebm.bmj.com/content/12/5/149.full

Source:	National Institute of Health
Article Title:	Predictive Validity of a Medication Adherence Measure in an Outpatient Setting

Author(s):	Morisky D, Ang A, Krousel-Wood M & Ward H
Publication Date:	May 2008
Link:	http://www.ncbi.nlm.nih.gov/pubmed/18453793

Condition Specific Evidence

Source:	BMC Health Services Research
Article Title:	What are the current barriers to effective cancer care coordination? A qualitative study.
Author(s):	Walsh J, Harrison J, Young J, Butow P, Solomon M and Masya L
Publication Date:	May 2010
Link:	http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-132

Source:	Center on Knowledge Translation for Disability and Rehabilitation Research (KTDRR)
Article Title:	Follow-up care for persons with spinal cord injury living in the community: a systematic review of interventions and their evaluation
Author(s):	Bloemen-Vrencken JH, de Witte LP & Post MW
Publication Date:	August 2005
Link:	http://ktdrr.org/cgi-bin/lib_systematic_search.cgi?location=sr&sel_1=88

Source:	Physical Medicine and Rehabilitation Clinics
Article Title:	The Person with Amputation and Their Life Care Plan
Author(s):	Meier R, Choppa A and Johnson C
Publication Date:	August 2013
Link:	http://www.pmr.theclinics.com/article/S1047-9651(13)00016-8/pdf

Source:	Physical Medicine and Rehabilitation Clinics
Article Title:	Traumatic Brain Injury Rehabilitation: Case Management and Insurance-Related Issues
Author(s):	Pressman HT
Publication Date:	February 2007
Link:	http://www.pmr.theclinics.com/article/S1047-9651(06)00087-8/abstract

Addendum

Evolent Health Catastrophic Program Exceptions

Evolent Health acquired Valence Health in October 2016. As Valence Health client populations transition to Evolent's Identifi platform by client, 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 II. Program Philosophy.** Metrics and targets of Program
   - 1.1. Graduation rate: Numerator: Cases closed with a case closure reason of "No longer needs services". Cases identified as being eligible for CM. Data source: Care Manager. Program Target Level: >= 10% or a 10% relative improvement year after year.
   - 1.2. Participation rates of patients identified for Behavioral Health Management: Numerator: Number of members agreeing to case manager contact/Number of members identified for Behavioral Health Management. Data source: Care Manager. Program Target Level= 50% or a 10% relative improvement year after year. Note: RightCare and Ingalls Provider Group are excluded from Behavioral Management per contract requirements.

2. **Section V. Identifying Patient's for Catastrophic Care.**
   - 2.1. Valence Health's case management platforms include Care Manager and ValenceCare.
   - 2.2. Data Sources used for identifying members for Catastrophic Care for Valence Health include:

Data Source	Typical Update Frequency
1. Medical Claims	Monthly
2. Pharmacy Claims	Monthly
3. Health Risk Appraisal/Patient Questionnaire	Annually
4. Electronic Medical Record data (when available)	Weekly
5. Data collected in vQuest. ValenceCare, Care Manager	As available
6. Laboratory Values, as available	As available

   - 2.3. Catastrophic Care Identification Criteria:
   - 2.4. Valence Health employs a screening process to identify members eligible for Catastrophic care when the member is identified outside of Evolent's automated rules based query.
   - 2.5. Valence Health uses the following categories for identifying members:

i. High Cost Claimants
    a. Potential $75K OR
    b. Actual >/= $100K
ii. CCMC
    a. CRG = 5: Single dominant or moderate chronic disease
        1. Examples: Congenital heart disease; asthma, type 1 diabetes, developmental delay, schizophrenia, obesity
    b. CRG = 6: Significant chronic disease in 2 organ systems
        i. Significant chronic condition is defined as a physical, mental or developmental condition that can be expected to last at least a year, will use health care resources above the level for a healthy child, require treatment of control of the condition, and the condition can be expected to be episodically or continuously debilitating
            1. Examples: Type 1 diabetes and static encephalopathy; type 1 diabetes and depression; developmental delay, Down syndrome and chronic pulmonary conditions
            2. OR
    c. Progressive condition that is associated with deteriorating health with a decreased life expectancy in adulthood
        1. Examples: Muscular dystrophy, cystic fibrosis, cerebral palsy, paraplegia, quadriplegia
        2. OR
    d. Continuous dependence on technology for at least 6 months
        1. Examples: Tracheostomy 6 ventilator assistance, renal dialysis, gastrostomy tube, cerebrospinal fluid shunt
    e. Body systems include: cardiac, craniofacial, dermatologic, endocrinologic, gastrointestinal, genetic, genitourinary, hematologic, immunologic, mental health, metabolic, musculoskeletal, neurologic, ophthalmologic, otologic, pulmonary/respiratory, and renal.
    f. CRG = 7: Dominant chronic disease in 3 or more organ systems
    g. CRG = 8: Dominant, metastatic, and complicated malignancies
        i. Excludes those in remission for >5 years.
            1. Examples: Lymphoma, leukemia, brain tumor
    h. CRG = 9: Catastrophic conditions
iii. High Risk OB
    a. Currently pregnant AND one or more of the following:
        i. HTN;
        ii. DM (A2 or greater);
        iii. PTL (Previous history; Threatened preterm labor; Cerclage);
        iv. Multiples;
        v. Other (systemic conditions only i.e. lupus, cancer, autoimmune disease);
iv. Oncology
    a. New diagnoses with chemotherapy or surgical therapy OR
    b. Recurrence of the above AND
        i. Two or more hospitalizations, urgent care, or ER visits in the past 12 months
        ii. One or more hospitalization in the past six months
    c. Terminal cases (i.e. CMS hospice eligible)
v. Chronic Care Coordination

a. ***Member has two or more uncontrolled chronic conditions and three or more of the below criteria*:**
    i. Two or more abnormal clinical indicators (elevated hemodynamic measurements, elevated tests or diagnostics, such as BMI greater than 35, uncontrolled hypertension, hemoglobin A1C ≥ 9)
    ii. Two or more hospitalizations, urgent care, or ER visits in the past 12 months
    iii. One or more hospitalization in the past six months
    iv. Two or more specialists involved in care
    v. Eight or more prescribed medications – polypharmacy
    vi. Two or more barriers to care (financial, psychosocial, cultural, language, access, noncompliance, lack of understanding)
    vii. LACE score ≥ 9
    viii. Minimal evidence of a social support system
    ix. Members with known diagnosed psychiatric conditions
    x. Vision or hearing impairments that impede the ability to execute self-care measures
    xi. Home based interventions (home O2, assistive devices, PICC lines, G-tube, etc.)
    xii. New diagnosis of a chronic condition within the last three to six months
    xiii. An Acuity Score of at least __

vi. Behavioral Health
    a. One of the following:
        i. MDD
        ii. Personality Disorder
        iii. Bipolar Disorder
        iv. Substance Abuse
    b. With two or more hospitalizations, urgent care, or ER visits in the past 12 months or one or more hospitalizations in the past six months.

2.5.i. Members identified with a behavioral health diagnosis are managed directly by the RN or LMSW/LCSW case manager. Cases will be discussed with the Market Medical Director as deemed clinically appropriate.

2.6. Initial Assessment Process: Valence Health uses an opt-out participation approach and participation is voluntary on the part of the member.

2.7. Timeframes to conduct outreach and assessments:

2.7.i. Initial assessments are completed within 30 days of patient eligibility for the program. The goal is to complete the initial assessment during the enrollment and initial screening interactions.

2.7.i.1. Valence Health employs a screening process to identify member eligibility. Eligibility begins the date it is confirmed that the member is eligible based on member screening.

3. Transitions of Care

Valence Health employs a collaborative process of handling transitions of care for patients across care settings. Frequent communication with the treating physician, hospital case manager, market medical director, and patient and patient family occurs to ensure safe and successful transitions across the continuum of care. Post discharge calls are conducted to

ensure transition to the home setting occurs with minimal disruptions to the patient and patient family and to ensure all necessary services and referrals have been established.

4. Measurement and Quality Improvement

4.1. Participation Rate.

4.1.i. Numerator: Members with a completed assessment and successful outreach

4.1.ii. Denominator: Members identified as eligible for case management through the Valence Health screening process are included in total patients eligible.

4.1.iii. Valence Health conducts an annual Patient Experience Survey telephonically. The survey measures various aspects of experience including: 1) overall satisfaction with program 2) improvements in patient's ability to manage his/her health 3) helpfulness of the Case Management team members 4) usefulness of information disseminated and 5) areas of the program/support that were most helpful and least helpful to the patient and caregiver.

4.1.iv. On at least an annual basis, Valence Health measures the effectiveness of the case management program using at least three measures, based on the established goals of:

4.1.iv.1. Engagement of eligible members
4.1.iv.2. Improve Member Activation
4.1.iv.3. Improve Self-Management
4.1.iv.4. Increase Member Satisfaction
4.1.iv.5. Decrease Cost of Care
4.1.iv.6. Reduce Utilization of Intensive Services

4.1.v. For each identified measure, the following steps will occur:

4.1.v.1. A relevant process or outcome is identified
4.1.v.2. Valid methods that produce quantitative results are used
4.1.v.3. A performance goal is set
4.1.v.4. Specific measures are clearly identified
4.1.v.5. Data is collected and analyzed
4.1.v.6. Opportunities for improvement are identified (if applicable)

5. Staffing, Training, and Verification

5.1. Case Manager-The Valence Health Case Manager

5.1.i. Owns primary relationship with the patient and their PCP

5.1.ii. Conducts assessments for catastrophic and transition care patients

5.1.iii. Responsible for development and implementation of the care plan

5.1.iv. Provides self-management coaching, care coordination services and refers patients to other care team patients and other services

5.2. The Case Manager may be a Registered Nurse or Licensed Medical/Clinical Social Worker. Both are required to be licensed in the state where the patient is being served.

5.3. Process for CA team interactions- the Case Manager owns the following:

5.3.i. Primary relationship with the patient and PCP.

5.3.ii. Conducts initial assessments for catastrophic and transition care

5.3.iii. Outreach of PCPs and specialists to inform on care plan and notify of changes in health status

5.3.iv. Responsible for the care plan development and patient progress on the plan

5.3.v. Self-management coaching
5.3.vi. Referrals and follow-up to network and community resources
5.3.vii. Case conference presentations