Catastrophic Care Program Description 2018
Evolent Health Catastrophic Care  
2018 Program Description

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I. Introduction

The comprehensive Evolent Health Catastrophic Care (CC) Program Description outlines 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/caregiver(s), 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 caregiver(s) 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 diseases, etc. The majority of these patients are identified through the utilization management (UM) authorization process 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 Primary Care Physician (PCP)/Specialist treatment plan to prevent avoidable readmissions, reduce unnecessary emergency room (ER) visits, manage the patient’s plan and remove barriers that may prevent the patient and his/her caregiver(s) from adhering to his/her treatment plan.

- **Patients with multiple, severe, intensive conditions** – Management and support is provided to patients and their caregiver(s) 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(s) understand, maintain their optimal health. The objectives of the Program are to:

- Improve care coordination for patients in collaboration with their PCP and Specialists
- Support the PCP/Specialist treatment plan
- Facilitate and coordinate the transition of 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(s) 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 the Care Advisor

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 Care Advisor (RN 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(s), incorporating the patient’s physical and behavioral health status, personal preferences and confidence level, and current lifestyle risks that have been identified through the completion of the patient assessment. Psycho-social, cognitive and functional disabilities, medication review, 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 and local community and government agency resources that may provide services to improve the health and well-being of the patient.

The CC Program 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, 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 those needs, 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(s) 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(s) 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

<table>
<thead>
<tr>
<th>Performance Metric</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Source</th>
<th>Program Level Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process/Outcome Performance Metrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Plan Timeliness</td>
<td>Patients with a completed care plan within 14 days of a completed assessment.</td>
<td>Patients enrolled in the Catastrophic Care Program.</td>
<td>Identifi</td>
<td>85% for 14-day completion rate</td>
</tr>
<tr>
<td>Avoidable Inpatient Admits and ED visits</td>
<td># of Closed Cases with Avoidable Inpatient Admit or Avoidable ED Visit</td>
<td># of Closed Cases with Status &quot;Problem Resolved/Goals Met&quot;</td>
<td>Identifi</td>
<td>No avoidable inpatient admissions or ED visits within 60 days of graduation from the program</td>
</tr>
<tr>
<td>Patient Experience Performance Metrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Experience</td>
<td>The # of patients that respond &quot;strongly agree&quot; or &quot;agree&quot; to survey question , &quot;I am happy with the services I received from my Nurse Care Advisor.&quot;</td>
<td>Total survey respondents who answered the question</td>
<td>Patient Surveys</td>
<td>&gt;85%</td>
</tr>
</tbody>
</table>

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 from clinical 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 evidenced-based guidelines for the Program are reviewed on an annual basis, or more frequently as needed. At the time of 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 Clinical Quality Committee (CQC) is ultimately responsible for approval of the underlying evidence-based 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 Analytics team.

Catastrophic Care Program Clinical Evidence-Based 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 ensure 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:

- Analysis conducted at the client level by LOB;
- 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 CQC with recommendations for program enhancements based on the EBG review. The CQC makes decisions regarding the prioritization and type of CC programming enhancements necessary to positively impact population health outcomes. As a result of the CQC review, requests are submitted to the appropriate development team responsible for CC programming enhancements and providing status updates to the CQC 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 the total amount paid is 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
- Malignant Head and Neck Tumors
- Malignant Pulmonary /thoracic tumors (including breast)
- Malignant Gastrointestinal/abdominal tumors (including colorectal)
- Lymphatic and hematopoietic (blood) tumors
- Malignant Genitourinary/pelvic tumors
- Malignant Endocrine Tumors
- Cerebrovascular Accident and Hemorrhage
- Acute and Chronic Osteomyelitis
- Sepsis (all cause)

The pediatrics Catastrophic stratification criteria are as follows. Some of the criteria are shared with the adult program, while others are unique for the pediatric population;

The presence of one of the following criteria along with one of the listed conditions:

1. ≥ 2 Inpatient encounters in the last 12 months (restricted to children ≥13 months since we don't want to include birth as an IP encounter)

2. ≥ 9 unique medications prescribed within the last 6 months (unique defined as medications belonging to the same subclass)

**Pediatric Conditions**

- Malignant lymphoma
- Pediatric sickle cell anemia
- Hemiplegia
- Metastatic Solid Tumors
- Pediatric Epilepsy
- Leukemia
- Hemophilia and Coagulation Disorders
- Pediatric Juvenile Rheumatoid Arthritis

Any patient meeting the eligibility criteria for the CC program with a complicating behavioral health (BH) diagnosis can be referred to the Behavioral Health Care Advisor on the care team. Because BH is integrated into CC, the patient will have both their physical and behavioral health needs address within the CC program.

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.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Typical Update Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Claims</td>
<td>Monthly</td>
</tr>
<tr>
<td>2. Pharmacy Claims</td>
<td>Monthly</td>
</tr>
<tr>
<td>3. Health Risk Appraisal/Patient Questionnaire</td>
<td>Annually</td>
</tr>
<tr>
<td>4. Electronic Medical Record data (when available)</td>
<td>Weekly</td>
</tr>
<tr>
<td>5. Data collected in Identifi from Condition Care or Practitioners</td>
<td>As available</td>
</tr>
<tr>
<td>6. Hospital Admission, Discharge &amp; Transfer feeds</td>
<td>As available</td>
</tr>
<tr>
<td>7. Laboratory Values, as available</td>
<td>As available</td>
</tr>
</tbody>
</table>

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 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 Care team staff managing the patient in another Evolent Health Population Management Program, such as the Complex and Condition Care, Transition Care
- A discharge planner
- Internal departments, such as Pharmacy
- The 24-hour nurse advice line (health information line), as applicable
- Patient, family or caregiver(s), 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

**Initial Assessment Processes**

Patients eligible and identified for the CC Program are initially outreached and engaged through mail, telephone, or face to face contact. The patient’s name, address, and/or date of birth are utilized to confirm the CA is speaking to the patient.
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:

- For patients identified through the automated algorithm, eligibility begins at the Create (Identified) Date.
- For patients identified through the Utilization Management process, eligibility begins when a patient is discharged to home.
- 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 caregiver.
- 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.

**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 socio-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
- Social determinants of health
- 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
VI. Care Planning Processes

Nurse Care Advisors, in coordination with the PCP/Specialist, patient and caregiver(s) 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(s) 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 appropriate extended care team staff
- Involving caregiver(s) when the patient (provides consent)
  - 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(s) 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:

- Identifying barriers to meeting goals and complying with the care plan
- Developing follow-up coaching/care coordination encounter schedule with patient
- Developing and communicating patient self-management plans
- Assessing 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 that include pharmacists, registered dietitians, social workers and behavioral health care advisors, 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**

The RN CA contacts the patient on a bi-weekly basis depending on the clinical needs of the patient and patient preference. At the end of each call, 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 active patient, progress in meeting the care plan goals and objectives is reviewed, monitored, and reassessed based on agreed upon priorities from patient and care advisor. Development and communication of the patient’s 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 the objectives outlined in the case management plan.

Development of schedules for follow-up 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 screening tools, 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 and problems 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 within 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 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:

- Analyzing patient complaints
- Obtaining feedback from patients

Evolent Health obtains feedback about patient’s and/or caregiver’s experience with the CC Program and CA team. This feedback is obtained through an IVR survey sent to patients enrolled in the CC Program. 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) 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 per 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 their needs and expectations. These analyses are conducted at least every twelve months. This data is also reviewed by the Clinical Quality Committee to identify areas to improve and enhance 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 tracks 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 numerator and denominator, a description of the time period and how it effects inclusions and exclusions in the numerator and denominator, viewing
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.

<table>
<thead>
<tr>
<th>Performance Metrics</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Sources</th>
<th>Calculated at a Program Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Performance Metrics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation Rate</td>
<td>CC cases with a completed, submitted assessment and 1 additional interactive contact with the patient</td>
<td>Total patients identified and deemed eligible for the CC program</td>
<td>Identifi</td>
<td>20% or greater or a 5% relative improvement year over year</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Staff Role</th>
<th>Role Type</th>
<th>Licensure Required</th>
<th>Primary Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Advisor Team Manager</td>
<td>Clinical</td>
<td>License required in each state where their team is managing patients</td>
<td>• Manages/supervises the day to day activities of the CA team • Facilitates case review conferences • Provides performance coaching and feedback to team members • Evaluates reports and performance on a regular basis with the team</td>
</tr>
<tr>
<td>Registered Nurse Care Advisor</td>
<td>Clinical</td>
<td>License required in each state where CA is serving patients (may be through Compact arrangements)</td>
<td>• 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</td>
</tr>
<tr>
<td>Staff Role</td>
<td>Role Type</td>
<td>Licensure Required</td>
<td>Primary Responsibilities</td>
</tr>
<tr>
<td>----------------------------</td>
<td>------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Registered Dietitian</td>
<td>Clinical</td>
<td>License required in each state where RD is serving patients</td>
<td>• Provides self-management coaching, care coordination services and refers patients to other care team members as appropriate.</td>
</tr>
<tr>
<td>Licensed Social Worker</td>
<td>Clinical</td>
<td>License required in each state where the LSW is serving patients. In some markets, there may also be a Behavioral Health Care Advisor. (same licensure requirements apply)</td>
<td>• 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</td>
</tr>
<tr>
<td>Licensed Pharmacist</td>
<td>Clinical</td>
<td>License required in each state where pharmacist is serving patients</td>
<td>• 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</td>
</tr>
<tr>
<td>Program Coordinator</td>
<td>Non-Clinical</td>
<td>No licensure requirements</td>
<td>• Works under the direction of the CA team by running reports, assigning cases to team 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</td>
</tr>
</tbody>
</table>

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. Evolent Health’s Vice President of Clinical Programs and Performance and Vice President of Clinical Operations have 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 the 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:

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

All case management staff receive 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 clinical education programs on an annual basis. To maintain consistent delivery, the staff are evaluated through an internal quality review process monthly, which includes a focused performance coaching program of random sample file reviews and Identifi 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 performance/quality review process, action plans are developed to meet defined goals. 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 patient rights and expectations 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 is 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 relative to their educational level, needs and condition.

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. Please refer to policy CM.DM.022 Patient and Provider Complaints for timeframes.

**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) CM.DM.025 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 CQC. The VP of Clinical Operations, VP of Clinical Programs and Performance and 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 CQC. Committee membership includes Vice Presidents from Clinical Operations and Clinical Programs and Performance, Directors from Quality, Pharmacy, Analytics and Care Management, as well as, Regional Chief Medical Officers and Medical Directors. The CQC meets quarterly.
### Appendices

#### Appendix A: Catastrophic Care Program Clinical References

**Core Program Design Features**

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<thead>
<tr>
<th>Source</th>
<th>Agency for Healthcare Research and Quality</th>
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<tr>
<td><strong>Article Title:</strong></td>
<td>Outpatient Case Management for Adults with Medical Illness and Complex Care Needs</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>Hickman DH, Wiess JW, Guise J-M, Buckley D, Motu’apuaka M, Graham E, Wasson N, Saha S</td>
</tr>
<tr>
<td><strong>Publication Date:</strong></td>
<td>January 2013</td>
</tr>
<tr>
<td><strong>Link:</strong></td>
<td><a href="http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1369&amp;pageaction=displayproduct">http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1369&amp;pageaction=displayproduct</a></td>
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<th>Source</th>
<th>Milliman</th>
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<tr>
<td><strong>Article Title:</strong></td>
<td>Benefit Designs for High Cost Medical Conditions</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>Fitch K and Pyenson B</td>
</tr>
<tr>
<td><strong>Publication Date:</strong></td>
<td>April 2011</td>
</tr>
<tr>
<td><strong>Link:</strong></td>
<td><a href="http://us.milliman.com/insight/research/health/Benefit-designs-for-high-cost-medical-conditions/">http://us.milliman.com/insight/research/health/Benefit-designs-for-high-cost-medical-conditions/</a></td>
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<tr>
<th>Source</th>
<th>Professional Case Management</th>
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<tr>
<td><strong>Article Title:</strong></td>
<td>A Catastrophic Nurse Case Manager wears many hats</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>Clarke V, Broen K</td>
</tr>
<tr>
<td><strong>Publication Date:</strong></td>
<td>Nov/Dec 2007</td>
</tr>
<tr>
<td><strong>Link:</strong></td>
<td><a href="http://journals.lww.com/professionalcasemanagementjournal/Citation/2007/11000/A_Catastrophic_Nurse_Case_Manager_Wears_Many_Hats.12.aspx">http://journals.lww.com/professionalcasemanagementjournal/Citation/2007/11000/A_Catastrophic_Nurse_Case_Manager_Wears_Many_Hats.12.aspx</a></td>
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<tr>
<th>Source</th>
<th>Hospitals in Pursuit of Excellence (HPOE)</th>
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<tr>
<td><strong>Article Title:</strong></td>
<td>Health Care Leader Action Guide to Reduce Avoidable Readmissions</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>Osei-Anto A, Joshi M, Audet AM, Berman A &amp; Jencks S</td>
</tr>
<tr>
<td><strong>Publication Date:</strong></td>
<td>January 2010</td>
</tr>
<tr>
<td><strong>Link:</strong></td>
<td><a href="http://www.hpoe.org/resources/hpoehretaha-guides/831">http://www.hpoe.org/resources/hpoehretaha-guides/831</a></td>
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**Tool Design Features**

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<th>Source</th>
<th>National Institute of Health</th>
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<td><strong>Article Title:</strong></td>
<td>Predictive Validity of a Medication Adherence Measure in an Outpatient Setting</td>
</tr>
<tr>
<td><strong>Publication Date:</strong></td>
<td>2010</td>
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<td><strong>Link:</strong></td>
<td><a href="https://www.sciencedirect.com/science/article/pii/S0163834310000563">https://www.sciencedirect.com/science/article/pii/S0163834310000563</a></td>
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<td>Condition Specific Evidence</td>
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<td><strong>Source:</strong> BMC Health Services Research</td>
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<tr>
<td><strong>Article Title:</strong> What are the current barriers to effective cancer care coordination? A qualitative study.</td>
<td></td>
</tr>
<tr>
<td><strong>Author(s):</strong> Walsh J, Harrison J, Young J, Butow P, Solomon M and Masya L</td>
<td></td>
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<tr>
<td><strong>Publication Date:</strong> May 2010</td>
<td></td>
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| **Source:** Physical Medicine and Rehabilitation Clinics |
| **Article Title:** The Person with a Spinal Cord Injury – An Evolving Prototype for Life Care Planning |
| **Author(s):** Seiens, MD; Fawber, MEd, CCM, CRC, Yuhas; MEd, CRC CLCP, CCM |
| **Publication Date:** 2013 |

| **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 |

| **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 |