Catastrophic Care

2020 Program Description

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Evolent Health

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I. Introduction

The comprehensive Evolent Health Catastrophic Care (CC) Program Description outlines the components of the CC Program (referred to in the rest of the document as Program), explains how Evolent identifies enrollees and assesses their individual needs, provides evidence on which the Program is based, presents the criteria for identifying eligible enrollees, details the services offered and conveys the Program goals. The Program is designed to deliver maximum effectiveness for enrollees/caregivers, providers and clients.

The integrated Program focuses on two distinct enrollee populations:

- **Enrollees that experience a catastrophic event** – The focus is on managing and supporting enrollees and caregivers in instances where an enrollee experiences a significant, potentially life changing event or diagnosis, such as malignant cancer, degenerative neurological disease, respiratory failure or liver diseases, etc. The majority of these enrollees are identified through the utilization management (UM) authorization process for enrollees admitted with one of the targeted conditions listed under *Catastrophic Care Identification Criteria*. The primary goal is to support the implementation of the enrollee's Primary Care Physician (PCP)/Specialist treatment plan to prevent avoidable readmissions, reduce unnecessary emergency room (ER) visits, and remove barriers that may prevent the enrollee and his/her caregiver(s) from adhering to his/her treatment plan.

- **Enrollees with multiple, severe, intensive conditions** – Management and support is provided to enrollees and their caregivers in instances where an enrollee 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 Program employs an enrollee-centric approach that helps enrollees and their caregivers understand their plan of care and maintain their optimal health. The objectives of the Program are to:

- Improve care coordination for enrollees in collaboration with their PCP and Specialists
- Support the PCP/Specialist treatment plan
- Facilitate and coordinate the transition of the enrollee to the least restrictive setting
- Optimize chronic condition management by educating enrollees about diagnoses and self-management
- Implement personalized care plans
- Improve medication adherence
- Address enrollee/caregiver needs regarding adequate support and resources at home
- Improve adherence to the hospital discharge care plan for enrollees discharged to home

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- Decrease “avoidable” utilization events (e.g., readmissions) and increase the number of enrollees engaged with a Care Advisor (CA)
- Ensure enrollee/caregiver receives referrals to appropriate programs and/or services, and is assisted with scheduling as needed to meet their individual needs

The Program coordinates services for enrollees with catastrophic and intensive needs using a multidisciplinary care team, led by the enrollee’s PCP and overseen by a primary care advisor (CA). The team-based model focuses on optimizing the health of the eligible enrollee utilizing the broad skills of the PCP, care advisor, registered dietitian, social worker and pharmacist, to develop and implement person-centered care plans.

The care team focuses on the comprehensive needs of the enrollee and caregiver(s), incorporating the enrollee’s physical and behavioral health status, personal preferences and confidence level, and current lifestyle risks that have been identified through the completion of the enrollee assessment. Psychosocial factors, cognitive and functional abilities, medication management, transportation issues, and barriers which may impede health and adherence to the treatment plan, are also addressed. The care team then considers the enrollee’s health plan benefits and local community and government agency resources that may provide services to improve the health and well-being of the enrollee.

The Program emphasizes early identification of enrollees that are at risk for adverse clinical outcomes, increased utilization, and higher cost readmission. Enrollees are identified through multiple methodologies including utilization management authorizations. Evolent Health’s predictive modeling algorithms 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 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 enrollees, the Program can be tailored to fit those needs, while focusing on maintaining consistency in approaches.

The focus of the Program is to provide enrollees 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 enrollee’s condition
- Works with the physician to ensure the enrollee appropriately transitions to the least restrictive setting with caregiver support
- Improves the enrollee'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

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- Assesses palliative care needs
- Identifies enrollees' care preferences
- Facilitates updates or revisions of advance directives based on enrollee 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 enrollees 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 enrollee's preferences for care
- Partner with the enrollee, 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 adherence and compliance
- Address enrollee/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 enrollees and their physicians
- Optimize chronic care management and close relevant gaps in evidence-based care
- Educate enrollees about diagnoses and self-management
- Lower total medical expense by avoidance of readmissions, ER visits, duplicative and unwarranted services, and specialist costs through the coordinating of care during acute, intensive care episodes

Metrics and Targets of the Program

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

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Measuring Effectiveness Metrics

Performance Metric	Numerator	Denominator	Data Source	Program Level Target
Process/Outcome Performance Metrics				
Care Plan Timeliness	Enrollees with a completed care plan within 14 calendar days (10 business days) of a completed assessment.	Enrollees enrolled in the Catastrophic Care Program.	Identifi	85% for 14-day completion rate
Avoidable Inpatient Admits and ED visits	# of Closed Cases with Avoidable Inpatient Admit or Avoidable ED Visit	# of Closed Cases with Status “Problem Resolved/Goals Met”	Identifi	No avoidable inpatient admissions or ED visits within 60 days of graduation from the program
Enrollee Experience Performance Metrics				
Enrollee Experience	The # of enrollees that respond, "strongly agree" or "agree" to survey question, “I am happy with the services I received from my Care Advisor.”	Total survey respondents who answered the question	Enrollee Survey	>85%

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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 evidence-based sourcing to assure alignment with program content and processes.

The evidence-based guidelines for the Program are reviewed at least every two years, 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 Operations and Performance Committee (COPC) 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. Enrollee program materials are updated based upon current evidence and cultural and linguistic appropriateness. Materials are then 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 B.

IV. Population Assessment

Annually, Evolent Health evaluates the needs of its enrolled client populations and uses that information to assess whether current programs require modification to better address the needs of its membership. Each year Evolent Health examines available data to evaluate:

- the characteristics and needs of client populations, including an analysis of the impact of relevant social determinants of health
- the needs of relevant subpopulations
- the needs of child and adolescent individuals ages 2-19
- the needs of members with disabilities
- the needs of members with severe and persistent mental illness (SPMI)

When the data analysis is complete, it is used to determine if changes are required to Care Management programs or resources to meet member's needs. In addition, there is an evaluation of the extent to which the program facilitates access and connection to community resources that address member needs outside the scope of the health benefits. Modifications to program design and resources are made based on these findings. The data will be broken out by product line to facilitate an understanding of similarities and differences in health needs and status.

V. Identifying Enrollees for Catastrophic Care

Catastrophic Care Identification Criteria

Multiple data sourcesare utilized to identify enrollees appropriate for the Program. The profile of the adult enrollees identified for the 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 below primary 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 primary diagnoses:

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Primary Diagnoses

• Amyotrophic Lateral Sclerosis • Hemophilia/Coagulation Disorders • Gaucher's Disease • Guillain-Barre Syndrome • Liver Failure • Cystic Fibrosis • Respiratory Failure • Ventilator Dependency • Burns>20% Total Body Surface or 2nd/3rd Degree Burns • Spinal Cord Injuries and 'plegias' (mono di para and quadra)	• Sickle Cell Disease • Malignant Head/Neck Tumors • Malignant Pulmonary/thoracic tumors, including breast • Malignant Gastrointestinal/abdominal tumors (including colorectal) • Lymphatic/hematopoietic (blood) tumors • Malignant Endocrine Tumors • Cerebrovascular Accident and Hemorrhage • Acute and Chronic Osteomyelitis • Sepsis (all cause)

The Pediatric Catastrophic Care Program stratification criteria are as follows. The pediatric criteria sets vary among clients and are determined by the state and/or LOB of the client population served.

Criteria Set: Anyone under the age of 18 with at least one of the following 3 criteria:

1. ≥2 inpatient encounters in the last 12 months (restricted to children ≥13 months to avoid birth as an IP encounter)

OR

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

OR

3. Presence of any of the following conditions:
    - Malignant lymphoma
    - Pediatric sickle cell anemia
    - Hemiplegia
    - Metastatic Solid Tumors
    - Pediatric Epilepsy
    - Leukemia
    - Hemophilia and Coagulation Disorders
    - Pediatric Juvenile Rheumatoid Arthritis

Criteria Set: Anyone under the age of 21 with at least one of the following 3 criteria:

1. Presence of any of the following conditions:
    - Sickle Cell Anemia
    - Hemiplegia
    - Epilepsy
    - Hemophilia/Coagulation Disorders
    - Juvenile Rheumatoid Arthritis
    - Burns 3rd degree or ≥ 20% body SA
    - Respiratory Failure

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- Ventilator Dependency
- Sepsis (All Cause)
- Liver Failure
- Cystic Fibrosis
- Spinal Cord Injury
- Cerebral Palsy
- Transplant
- Muscular Dystrophy
- Spina Bifida
- Trauma Injury

OR

2. ≥9 unique medications (at sub-class level) in the last 6 months

OR

3. Age ≥13 months AND ≥2 IP admits in the last 12 months AND one of the following Oncology diagnoses:
   - Solid Tumor Metastatic
   - Leukemia
   - Malignant Lymphoma

Any enrollee meeting the eligibility criteria for the 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 the Program, the enrollee will have both their physical and BH needs addressed within the program.

Evolent evaluates enrollee data against a set of identification and stratification criteria. For each of the Programs, criteria are established to systematically identify eligible enrollees, and stratify by risk and level of needed interventions.

Evolent leverages both automated (rules-based clinical criteria) and manual (query and clinical referral-based) processes to identifyenrollees for the Program.

The following data sources are used to identify and stratify enrollees for the Program:

Data Source	Typical Update Frequency
1. Medical Claims	Monthly
2. Pharmacy Claims	Monthly
3. Grouper Data (Number of Inpatient Admissions)	Monthly
4. Cost/Utilization Data	Monthly

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In addition to the above data sources, enrollees can be referred to the Program through:

- The Utilization Management team
- The Care team staff managing the enrollee in another Evolent Health Population Management Program, such as the Complex Care, Condition Care or Transition Care
- A discharge planner
- Internal departments, such as Pharmacy
- The 24-hour nurse advice line (health information line), as applicable
- Self-referral by an enrollee, family member or caregiver
- Practitioners, including behavioral health providers
- Ancillary providers, behavioral health managed care organizations, pharmacists, disability management programs, employer groups, or staff from community agencies

Information about the Program

All identified enrollees receive written information about the Program that includes:

- Program services and how to use
- How the enrollee became eligible to participate
- Care advisor resource team contacts, how to access and hours of operation
- Enrollee rights and responsibilities
- How to provide feedback/questions or communicate a complaint
- Whom to contact in an urgent situation
- How to opt in or opt out of the program

How to Opt-Out of the Program

- Enrollees can opt-out of the Program by notifying the care team or health plan customer service
- Opt-out information is documented in Identifi

Initial Assessment Processes

Enrollees eligible and identified for the Program are initially outreached and engaged through mail, telephone, or face to face contact. The enrollee's name, address, and/or date of birth are utilized to confirm the CA is speaking to the enrollee. Enrollment, which ideally results in the enrollee agreeing to participate in a Program, precedes the case management assessment process, development of a care plan with prioritized goals, and active enrollee involvement.

Times Frames to Conduct Outreaches and Assessments

Enrollees are initially outreached to as follows:

- For enrollees identified through the automated algorithm (stratification), eligibility begins at the Create (Identified) Date

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- For enrollees identified through the Utilization Management process, eligibility begins upon notification of discharge to home
- Within 2 business days of case being assigned to a care advisor, a care advisor begins outreach to the enrollee and/or caregiver
- Initial assessments are submitted within 30 (calendar) days of enrollee eligibility for the program. The goal is to complete the initial assessment during the enrollment interaction with enrollee and/or caregiver

Assessments

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

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

- Clinical history documentation, including medication schedules and dosages
- Health status, including medical and behavioral health condition-specific issues
- Activities of daily living and cognitive functions, 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
- Evaluation of caregiver resources and involvement
- Evaluation of enrollee's available benefits and community resources

VI. Care Planning Processes

Care advisors, in coordination with the PCP/Specialist, enrollee and caregiver(s) develop an individualized care plan. The care plan includes enrollee-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 enrollee's health goals and to resolve issues/barriers.

Personalized care plans take into consideration the following:

- Enrollee 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 enrollee provides consent
- Understanding the enrollee's plan benefits, network, and community-based services

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- Care transitions and the need to reassess and modify to ensure appropriateness based on the enrollee's current level of care and needs

Prioritized Goals

Development of the care plan considers the enrollee and caregiver(s) goals and preferences, and his/her desired level of involvement in the 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 enrollee
- Developing and communicating enrollee self-management plans
- Assessing progress against care plans, and modifying as needed

Referrals and Barriers to Care

As part of the assessment and care planning process, enrollees may be referred to network, community, or governmental support agencies to address individualized needs. The CA is responsible for ensuring that enrollees are referred to the extended care team that include pharmacists, , social workers and behavioral health care advisors, when appropriate. The CA determines if enrollees are acting on referrals during follow-up.

In addition, the care team is responsible for identifying all relevant barriers preventing an enrollee 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, , cultural, motivation and 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.

Assessing Progress

For each active enrollee, progress in meeting the care plan goals and objectives is reviewed, monitored, and reassessed based on agreed upon priorities between the enrollee/caregiver and care advisor. Development and communication of the enrollee's self-management plan is an essential component of all care plans. Identification of barriers an enrollee faces is essential 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 enrollees is notated in the clinical documentation system.

Case Closure

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

- Enrollee's goals and needs have been addressed
- Key program graduation goals have been met or partially met
- Enrollee declines to continue to participate
- Enrollee is not appropriate for the Program, e.g., end stage, decline in cognition, placed in SNF or Hospice, etc.
- Enrollee does not respond to outreach attempts after three attempts
- Enrollee died
- Enrollee no longer covered by client health plan
- Enrollee transferred to another care management program
- Discontinued by Provider

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 Program assessment and ongoing management of the enrollee. 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 enrollee/caregiver, the physician(s) and the care team.

Identifi leverages chronic care guidelines and evidence-based screening tools, such as the PHQ-9, to ensure the enrollee treatment plan and adherence to evidence-based standards of practice are assessed.

The assessment leverages skip 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 identified problems and corresponding action items to ensure consistent delivery of the program across the care team. 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 clinical guidelines which supports the development, documentation, and ongoing management of patient-centered goals. .

The system automatically documents the staff member's name, date and time of action on the case or when an interaction with the enrollee has occurred. The CA assigns the next follow-up within the system, based on the enrollee's needs and request. All successful interactions and unsuccessful attempts with the patient and/or provider are documented in the patient's record in Identifi Care.

Care team staff are trained to schedule the next interaction with the enrollee at the end of each call and to create an action item reminder for the care team member to prompt their next interaction with the enrollee.

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VIII. Care Transitions

The Care Transition model includes analyzing data to identify enrollees 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 enrollees at risk for an unplanned transition. Once identified, interventions appropriate for the enrollee are implemented to minimize future risk. The primary goal is to transition the enrollee to the least restrictive setting. Collaboration and coordination of transitions across all sites of care is supported, including timely communications to enrollees/caregivers, primary care physicians, and receiving and sending facilities. The process supports a comprehensive method for enrollees transitioning from an inpatient facility back to their homes.

IX. Measurement and Quality Improvement

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

Enrollee Experience with Catastrophic Care

At least annually, Evolent Health measures enrollee experience and satisfaction with the program and care advisors by:

- Analyzing enrollee complaints
- Obtaining feedback from enrollees

Evolent Health obtains feedback about enrollee's and/or caregiver's experience with the Program and CA team. This feedback is obtained through an Interactive Voice Response (IVR) survey sent to those enrolled in the Program. The survey measures various aspects of the enrollee's experience including: 1) information about the overall program 2) enrollee's ability to manage his/her health 3) program staff 4) usefulness of information given 5) enrollee reported that the program helped them achieve health goals.

This data is analyzed per clientand across clients to understand the enrollee's and caregiver's perspective of how well the care team is performing and responding to meeting and exceeding their needs and expectations. This analysis is conducted at least every twelve months. This data is also reviewed by the Clinical Operations and Performance Committee (COPC) 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

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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 population types, 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 providing clear definitions of the performance measures numerator and denominator and a description of the time period and how it affects 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 Enrollee Participation Rates

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

Performance Metric	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 enrollee	Total enrollees identified and deemed eligible for the CC program	Identifi	20% or greater or a 5% relative improvement year over year

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

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Transparency in Reporting Participation

Part of 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 impacts inclusions and exclusions in the numerator and denominator.

X. Staffing, Training and Licensure

Evolent Health's Care 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	Licensure required in each state where team is managing enrollee	• Manages/supervises the day to day activities of the Care Team • Facilitates case review conferences • Provides performance coaching and feedback to team members • Evaluates reports and performance on a regular basis with the team
Care Advisor	Clinical	License required in each state where CA is serving enrollees (may be through Compact arrangements)	• Owns primary relationship with the enrollee and their PCP • Conducts assessments for catastrophic and transition of care enrollees • Provides self-management coaching, care coordination services and refers enrollees to other care team members as appropriate • Responsible for development and implementation of the care plan
Registered Dietician	Clinical	License required in each state where RD is serving enrollees	• Supports CA and works with enrollees to implement their nutritional/dietary plan • Identifies barriers and –problem-solves with enrollees to maintain their behaviors to adhere to the plan • Links enrollees with local network dietitians to develop a comprehensive nutritional/dietary plan
Social Worker	Clinical	License required in each state where the SW is serving enrollees. In some markets, there may also be a Behavioral Health Care Advisor. (same licensure requirements apply)	• Supports Care Advisor 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 enrollee • Maintains database of local resources for enrollees and their caregivers
Licensed Pharmacist	Clinical	License required in each state where pharmacist is serving enrollees	• Supports Care Advisor to identify and coach enrollees needing supportwith medication adherence strategies and behaviors • Reviews medication reconciliations for enrollees during care transitions, and assists Care Advisor with completion of medication reconciliation as needed

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			• Works with providers to modify medication regimens, when appropriate, to better meet the needs of the enrollee
Care Coordinator/Health Coach/ Community Health Worker	Non-Clinical	No licensure requirements	• Conducts interviews with enrollees to determine health literacy and need for interpreter services • Conducts outreach calls to encourage enrollees/caregivers to participate in care management programs • Assist in providing information/referrals to governmental and community agencies • Scheduling provider visits on behalf of enrollee • Maintain library on current available community resources
Program Coordinator	Non-Clinical	No licensure requirements	• Works under the direction of the CA team by running reports, assigning cases to teamwork list/action item list • Sends out letters and helps the team manage to servicelevel and timeliness metrics • Takes inbound calls from enrollees 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 care team , including market Medical Directors, Managing Directors and Senior Directors have a minimum of three to five years of clinical experience. All care team staff are properly trained and supervised. Evolent's SVP of Clinical Operations and CMO are responsible for oversight of the Program's development and implementation, strategic direction, and overall effectiveness.

Regional and/or market Medical Directors and market Managing Directors and Senior Directors, are responsible for the daily departmental operational activities for each client and for the national remote staff that support multiple clients.

Process for Care 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 care team members interact with enrollees, practitioners and other clinical staff:

Enrollee and Practitioner Interactions with the Clinical Team
Care Advisor owns the following: • Primary relationship with the enrollee and PCP • Conducts initial assessments for catastrophic and transition care

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- Outreach of PCPs and specialists to inform on care plan and notify of changes in health status
- Responsible for the care plan development and enrollee progress on the plan
- Self-management coaching
- Referrals and follow-up to network and community resources
- Case conference presentations

Social Worker owns the following:

- Identification and problem solving to remove/mitigate barriers related to social determinants of health, economic or enrollee disabilities
- Identification of local network resources to provide community-based support
- Responsible for communicating and updating care plan related to psychosocial issues and related barriers

Pharmacist owns the following:

- Reviews medication reconciliations for enrollees during care transitions, and assists CA with completion of med rec as needed
- Counsels enrollees on medication adherence methods
- Works with physicians on changing medication regimens when appropriate

Enrollee and Practitioner Interactions with the Non-clinical Team

Non-clinical staff interact with enrollees in the following ways:

- Determine the enrollees' needs and address barriers to care and self-care
- Outreach to enrollees to encourage program participation, and schedule appointments visits with the enrollee's providers
- Assist enrollees in selecting a PCP, close care gaps and educate enrollees on alternatives for accessing non-emergent care
- Review and discuss hospital discharge plan with enrollee/caregiver
- Provide information on community and government-based service agencies

Situations when Non-clinical staff refer enrollees or practitioners to the clinical team:

- Enrollee or practitioner asks to speak to a clinician or has a specific clinical question
- The non-clinical staff does not know how to respond to an enrollee or practitioner
- The enrollee is expressing that they are experiencing significant signs and symptoms related to their of their condition
- An emergency situation where enrollee or practitioner physician need immediate assistance help

Providing Access to Clinical Staff for Practitioner Requests

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 enrollees
- Care Plans provided to practitioners include the CA name and phone number
- Care Coordinators/Health Coaches/Community Health Workers outreach to practitioners to inform them of enrollees enrolling and disenrolling from the program as well as notification of transitions

Approval of Processes

The physicians on the COPC are responsible for:

- Approving communication processes
- Approving clinical guidelines
- Approving changes to program clinical content and design
- Approving KPI and target changes

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 manage emergency situations

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- Evidence used to develop the programs
- Behavioral change models
- Goal setting
- Referral processes
- Cultural competence
- Enrollee engagement techniques
- Social determinants of health
- Barriers to self-management
- Motivational interviewing and self-management support skills
- Health literacy
- Identifi system training
- Program step by step processes

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 enrollees 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 enrollees 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.

Monitoring of Staff Licensure Verification, 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 enrollees 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 a monthly 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. Enrollee Rights and Responsibilities

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The organization communicates its commitment to enrollee rights and expectations through enrollment packets. The information shared with enrollees 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 disenroll 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.

Enrollee Responsibilities/Expectations

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

- Follow mutually agreed-upon case management plan offered by the organization or notify the care advisor if they cannot follow the plan
- Provide the organization with information necessary to carry out its services
- Notify the organization and treating physician if enrollee disenrolls

Handling and Resolving Enrollee Complaints

Evolent Health has a policy and procedure for registering and responding to enrollee complaints about the Program and/or the care management 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 care management to the appropriate area or client
- Notifying and updating enrollees on the progress of the investigation and the final disposition of the complaint
- Turnaround times for resolving routine and clinically urgent complaints. Please refer to policy CM.PHM.022 Patient and Provider Complaints for timeframes.

XII. Privacy, Security and Confidentiality

The details of enrollee rights to privacy, security and confidentiality are described in two policies and procedures: 1) CORP028 Records Retention and 2) CM.PHM.025 Care Management Compliance with HIPAA Privacy Regulations.

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XIII. Accountability and Structure

Accountability for the quality of clinical care and service provided to the enrollees in our Programs reside with the Clinical Operations and Performance Committee (COPC). The SVP of Clinical Operations and CMO are responsible for oversight of the Program's development and implementation, strategic direction, and overall effectiveness.

In order to monitor performance and effectiveness of the care management, population health, and utilization management programs, the COPC oversees a variety of regular KPI, delegation oversight, and quality related reports. The committee is also responsible for and serves as the formal oversight body for review and approval of annual program documentation, such as program descriptions and evaluations, guidelines and standards, QI projects, and NCQA driven initiatives, amongst other ad hoc clinical items.

Committee participants include Medical Directors, CM, Quality, UM, and A&G leadership, and representation from Compliance, Pharmacy, Accreditation, and Reporting. The committee is chaired by the Lead UM Medical Director and the Lead Behavioral Health Medical Director. The committee meets monthly.

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APPENDICES

Appendix A: Catastrophic Care Program Review History

Description of Review/Revision	Approved By	Date Approved
New Program Description	Clinical Quality Committee	3/1/16
Revision of Program Goals	Clinical Quality Committee	06/16
Approval	Clinical Quality Committee	05/17
Approval	Clinical Quality Committee	05/18
Updated Template, Criteria revisions	Clinical Quality Committee – Email Vote	11/18
Annual Review, minor revisions	Clinical Quality Committee	02/12/19
Annual review/update to update processes and alignment to NCQA CM requirements	Clinical Operations and Performance Committee	

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Appendix B: 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

Article Title:	The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: A systematic Review
Author(s):	Kroenke, MD, Spitzer, MD, Williams, DSW, and Lowe, MD PhD
Publication Date:	2010
Link:	https://www.sciencedirect.com/science/article/pii/S0163834310000563

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

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Publication Date:	May 2008
Link:	http://www.ncbi.nlm.nih.gov/pubmed/18453793

Source:	U.S. Department of Health and Human Services
Article Title:	Health Literacy and Patient Engagement
Author(s):	Advisory Committee on Training in Primary Care Medicine and Dentistry
Publication Date:	September 2015
Link:	https://www.hrsa.gov/advisorycommittees/bhpradvisory/actpcmd/Reports/twelfthreport.pdf

Source:	U.S. Department of Health and Human Services
Article Title:	Quick Guide to Health Literacy
Author(s):	Office of Disease Prevention and Health Promotion
Publication Date:	Download from 2018
Link:	https://health.gov/communication/literacy/quickguide/Quickguide.pdf

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:	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
Link:	http://www.pmr.theclinics.com/article/S1047-9651(13)00018-1/abstract

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

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Pediatric Condition Specific Evidence

Source:	Pediatric Transplantation
Article Title:	Pediatric Solid Organ Transplant Recipients: Transition to Home and Chronic Illness Care
Author(s):	Lerret, S. M., Weiss, M., Stendahl, G., Chapman, S., Menendez, J., Williams, L., Simpson, P.
Publication Date:	Feb 2015
Link:	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4280334/

Source:	Pediatrics
Article Title:	Preventing Hospitalizations in Children with Medical Complexity: A Systematic Review
Author(s):	Ryan J. Coller, Bergen B. Nelson, Daniel J. Sklansky, Adrianna A. Saenz, Thomas S. Klitzner, Carlos F. Lerner, Paul J. Chung
Publication Date:	Dec 2014
Link:	http://pediatrics.aappublications.org/content/134/6/e1628

Source:	Journal of Pediatric Nursing
Article Title:	Systematic review of the impact of transition interventions for adolescents with chronic illness on transfer from pediatric to adult healthcare
Author(s):	Chu, P. Y., Maslow, G. R., von Isenburg, M., & Chung, R. J.
Publication Date:	Sept-Oct 2015
Link:	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4567416

Source:	Professional Case Management
Article Title:	Managing the Social Determinants of Health, Part II: Leveraging Assessment Toward Comprehensive Case Management.
Author(s):	Fink-Samnick, Ellen
Publication Date:	Sept/Oct 2018
Link:	https://www.ncbi.nlm.nih.gov/pubmed/30059462

Source:	Pediatric Blood & Cancer
Article Title:	Healthcare utilization and spending by children with cancer on Medicaid.
Author(s):	Mueller, E., Hall, M., Berry, JG., Carroll, AE., Macy, ML.
Publication Date:	Nov 2017
Link:	https://www.ncbi.nlm.nih.gov/pubmed/28417587

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