evolent HEALTH

Condition Care

2020 Program Description

- Asthma
- CAD/Hypertension
- COPD
- Heart Failure
- Diabetes

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Evolent Health

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I. Introduction

The Evolent Health, LLC (Evolent) Condition Care Program (referred to in the rest of the document as Program) was developed to systematically and comprehensively assess, monitor, measure, evaluate, and implement strategies to improve the quality of integrated care and healthcare services delivered to enrollees. Developed in accordance with the corporate vision and mission, the Program was designed to uphold and mirror the values of Evolent Health while administering client benefits and services to improve the treatment outcomes and care experience for their enrollees. A productive relationship between physician, clinical team, and enrollee is key to better health care outcomes, safer care, and a better care experience for the enrollee.

The Program is a system of coordinated healthcare interventions and communications for populations with conditions in which enrollee self-care efforts are significant. Evidence-based medicine and a team approach are used to:

- Empower enrollees
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the physician/enrollee relationship
- Emphasize and reinforce use of clinical practice guidelines

The Program Description defines the scope, goals, objectives, and necessary structure for promoting and improving quality of care and services. This document serves as a guide to providing general information on the structure, processes and measures used for accountability and performance improvement.

II. Program Scope

The Program supports the practitioner-enrollee relationship and plan of care, emphasizing the prevention of exacerbations and complications through evidence-based practice guidelines, and evaluating clinical, enrollee experience, and economic outcomes on an ongoing basis with the goal of improving overall health.

The Program employs an enrollee-centric approach that helps enrollees/caregivers understand and engage in attaining or maintaining their optimal health. The Program implements strategies to support and enhance the practitioner-enrollee relationship to improve the quality and coordination of care delivered to the enrollee.

The Program uses a multidisciplinary care team with emphasis on the enrollee's primary care physician (PCP) and enrollee in successfully implementing interventions/action items identified through a comprehensive enrollee screening. The team-based model focuses on optimizing the health of the enrollee utilizing the broad skills of the PCP, care advisor (CA), health coach, registered dietitian, social worker and pharmacist to develop and implement person-centered care plans or action plans for each eligible, covered enrollee. The enrollee's primary care team

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member is either a CA or a health coach for moderate risk enrollees. The CA performs a comprehensive assessment and develops a care plan while the health coach performs a comprehensive screening and develops an action plan.

The health conditions included in the Program are:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)/Hypertension
- Diabetes
- Heart failure (HF)

The Program scope covers:

- Identification of enrollees meeting the enrollment criteria for a specific disease program
- Self-management support through personalized enrollee interventions
- Collaboration with providers to reinforce treatment plans
- Feedback to enrollees and practitioners on specific chronic management issues and/or successes
- Coordination of referrals to other clinical programs, members of the extended care team or available community programs and/or resources to address the enrollee's individual needs
- Evidence-based practice guidelines to support enrollee-informed decision-making
- Evaluation and improvement of clinical outcomes, as well as enrollee experience with the Program

III. Program Goals

The goal of the Program is to improve the behavioral and physical health outcomes and quality of life of enrollees with chronic conditions by using a multi-faceted approach to achieve the best possible therapeutic outcomes based on assessment/screening of enrollee needs, ongoing care monitoring, evaluation, and tailored enrollee and practitioner interventions. The Program also aims to reduce hospital length of stay and lower overall costs.

Program Goals include:

- Partner with the enrollee, their caregiver and their primary and specialty care practitioners to develop a plan of care (by a CA) or action plan (by a health coach)
- Improve medication adherence
- Facilitate appropriate communication across the entire care team
- Close relevant gaps in evidence-based care
- Educate enrollees and their caregivers on diagnosis and self-management

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IV. Clinical Practice Guidelines – Program Evidence Base

Evolent uses current, applicable, national evidence-based clinical guidelines from recognized sources for the basis of its Program. Evidence-based, medical society and national industry standards are referenced in development, ongoing maintenance, and updates of the Program. Nationally recognized clinical guidelines are reviewed and updated as appropriate, at least every two years or at the time any new scientific evidence or national standards are published or a change to the guideline is made available. If the national guidelines have not been developed, reviewed or revised by the recognized source within the past five years, Evolent retains board certified practitioners specializing in care for the condition to review and attest to the relevancy and accuracy of the proposed guideline (see Addendum B).

V. 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. The data will be broken down by product line to facilitate an understanding of similarities and differences in health needs and status. Each year Evolent Health examines data to evaluate the:

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

When the data analysis is complete, it is used to determine if changes are required to the Programs or resources to meet enrollee's needs. In addition, there is an evaluation of the extent to which the Programs facilitate access and connection to community resources that address enrollee 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.

VI. Identification and Stratification

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. Enrollees are identified for a program in multiple ways using both automated (rules-based) and manual (query and clinical referral-based) processes from numerous data sources.

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Identification of Enrollees

Information from the following sources are used monthly to identify enrollees who might benefit from one of the Programs and provide continuity of care via data integration:

- Enrollment data
- Health Information Line
- Medical and behavioral health claims
- Data from HRA, when available
- Pharmacy claims
- Assessment screening results
- Referrals from practitioner, enrollees and client organizations
- Data collected through utilization management (UM), other clinical program activities
- Data collected from health management or health coaching programs
- Laboratory results
- Electronic medical/health records

Stratification of Enrollees for the Program

The proprietary analytic predictive modeling programs and condition-specific enrollee profiling tool generate paths and algorithms in identifying and stratifying enrollees, for example, utilizing 1) new diagnoses, 2) emergency or hospital visits, 3) national standards/evidence-based clinical guidelines and 4) gaps in care. Enrollees with one of the Program conditions are assigned a risk score. Basic scoring rules are applied to available data sources and, if additional data sources become available, then altered accordingly. Scores are refreshed every time client eligibility is received and/or at least monthly. Stratification is a dynamic process, and a stratification level can change as an enrollee's condition changes, linking to the appropriate level of risk and corresponding intervention.

In addition to the monthly identification process, enrollees can be referred to the Program from physicians, caregivers, self, hospital discharge planners, utilization and care management staff, and clients.

The table below illustrates the risk factors used to stratify enrollees for the Program and the support offered for enrollees in each stratification level.

	Condition Care
Risk Criteria to determine Enrollee Stratification	Adult enrollees with primary diagnosis of asthma, diabetes, COPD, HF, CAD or hypertension in all prior medical history available to Evolent Health, and are identified as moderate risk score based on Evolent Health's proprietary predictive modeling, AND at least one of the followings: • inpatient admission for the condition within six months • condition related ER visit within three months • no PCP or condition related specialist visit within twelve months • care gap specific to that condition (N/A for heart failure) Enrollees under 21 with Asthma or Diabetes AND at least one of the following: • inpatient admission for the condition within six months • condition related ER visit within three months

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	• no PCP or condition related specialist visit within twelve months • care gap specific to that condition
Enrollee Support by Stratification Level	Support is provided by licensed/non-licensed staff for enrollees with a poorly controlled chronic condition as evidenced by lack of practitioner engagement or recent hospital/emergency room (ER) visit with appropriate inclusion of specialized delivery system resources (e.g., heart failure clinics, tobacco cessation, mental health.)

Coordination of Programs

Evolent uses the following tactics to coordinate and enhance enrollee care across Programs and services:

- All enrollees participating in a program have a completed personalized care plan or action plan, which will be shared with their practitioner
- Enrollees will only be selected for participation in one Program. If an enrollee's condition changes and is best managed in a different Program, the current Program is closed.
- Any staff of the care team can access current and past program documentation in Identifi
- Care team staff participate in trainings to enhance care coordination across the extended care team (social work, behavioral health, pharmacy,) and for appropriate referrals to community resources

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 clinical assessment/screening 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, the physicians and the care team.

Identifi leverages chronic care guidelines and evidence-based assessments and screening tools such as the PHQ-9, GAD-7 and PSC-17 to ensure the enrollee treatment plan and adherence to evidence-based standards of practice are assessed.

The assessment/screening 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 enrollee problems and corresponding action items to ensure consistent delivery of the program across the care team.

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 staff member assigns the next follow-up via 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.

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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.

VIII. Enrollee Program Information

Once the enrollee is identified and stratified, Identifi has a standard care plan template that includes a library of problems, goals and interventions (PGIs) that have been informed by the evidence-based clinical guidelines. Based on those clinical guidelines, the staff can establish priority problems, goals and interventions with the enrollee to achieve self-management of his/her condition. All identified enrollees receive written information about the Program.

Information about the Program

- Program services and how to use
- How the enrollee became eligible to participate
- Care 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

Eligibility to Participate

- Enrollees may self-refer to these Programs by calling the toll-free access line
- Practitioners may refer enrollees to 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

IX. Program Interventions

The Program is tailored for each condition and delivers interventions to enrollees based on their individual needs identified through an enrollee screening or assessment during initial and ongoing interactive contacts.

Using outreach and educational materials, enrollees are encouraged to 1) be accountable for their chronic condition(s), 2) adhere to their physician's recommendations for preventive care

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and treatment, and 3) embrace educational opportunities for informed decision-making when accessing the healthcare system.

In addition to the interventions listed above, enrollees engaged in the Program can receive disease-specific interventions.

When enrollees show evidence of needing additional support around behavioral health needs, appropriate referrals to members of the extended care team and/or behavioral health specialty providers are made, and communication with the provider occurs when indicated.

Interventions

Interventions	Condition Care
1. Welcome Letter explaining the program, hours of operation, the importance of self-management for their chronic condition, etc.	✓
2. Outreach to the enrollee to enroll in the Program	✓
Interventions below contingent on enrollment in program	
1. Completion of an assessment by a licensed member of the care team, that includes coaching/education/self-management during the interaction (HF program)	✓
2. Completion of a screening by a non-licensed member of the care team, that includes coaching/education/self-management during the interaction	✓
3. Development of a Care Plan that identifies personalized goals	✓
4. Mailing of an educational booklet to the enrollee/caregiver, at the enrollee/caregiver request	✓
5. Self-management support, health education and coaching to improve knowledge and self-management skills	✓
6. Outreach occurs at least every 15 business days unless otherwise requested by the enrollee or physician	✓

Enrollee-Centric Interventions

Consideration of the individual enrollee needs in targeting interventions is facilitated through condition screening/questionnaire responses and ongoing enrollee contacts and assessments.

Key areas include:

a. Comorbidities and other health conditions, including behavioral health program content provided to enrollees considers other health conditions and cognitive and physical limitations, which impact the target condition
b. Depression screening and screening results - Enrollee interventions and/or care referrals are implemented for those enrollees who screen within target thresholds on the PHQ-9, and/or indicate psychological distress that has significant impact on daily functioning more days than not
c. Screening for child/adolescent psychosocial functioning - The Pediatric Symptom Checklist-17 (PSC-17) is a parent/caregiver-completed measure that covers a broad range of emotional and behavioral problems and is meant to provide an assessment of psychosocial functioning. Enrollee interventions and/or care referrals are implemented for those enrollees who screen within target thresholds
d. Screenings for Anxiety and Substance Use help to identify enrollees in need of more targeted provider support and/or community resource linkage. Enrollee interventions

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and/or care referrals are implemented for those enrollees who screen within target thresholds on the GAD-7 and CAGE-AID tools and/or indicate psychological distress that has significant impact on daily functioning more days than not

e. Health behaviors - Enrollee materials and interventions encourage enrollees to develop healthy behaviors (e.g. nutrition and activity) and reduce unhealthy behaviors (e.g., quit tobacco use)
f. Psychosocial issues - Factors that may influence the enrollee's adherence to the treatment plan and/or interventions, such as social, emotional, or financial barriers are identified, and interventions are adjusted to better meet the enrollee's needs and increase accessibility
g. Caregiver support - Identifying types of support or lack of support and delivering information to promote understanding about the enrollee's condition is provided when the enrollee has given consent. Support is provided through 1). Direct caregiver interaction, increasing involved caregiver's emotional resources, to improve their ability to support the enrollee. 2). External/community-based resources as appropriate (i.e. caregiver support groups, respite, development of coping skills). Additional considerations are addressed, such as physical limitations, the need for adaptive devices, barriers to meeting care needs/treatment requirements, visual or hearing impairment or language or cultural needs

Program content and interventions are specific to the individual's condition and circumstances, tailored to improve self-care and management of their condition, address the following:

a. Condition monitoring, including self-monitoring (e.g., foot and skin care for diabetics) and reminders about tests the enrollee should perform themselves or complete through their practitioner
b. Educational disease specific booklets are available and reviewed with enrollees,Booklet content includes disease specific education, detailed planning tools for self-management, symptom management information (e.g., managing and treatments for coronary artery disease, managing and adherence to medications, heart healthy eating).
c. Communication with practitioners about enrollee's health conditions, self-management/condition monitoring activities and care plan/goal progress (e.g., what to do before a visit to physician; writing down important questions/issues)
d. Additional resources external to the organization, as appropriate (e.g., community and wellness programs, American Diabetes Association, American Lung Association, American Heart Association web sites)

Case Closure

Condition Care cases may be closed upon confirmation of any of the following factors:

- 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

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- Enrollee died
- Enrollee no longer covered by client health plan
- Enrollee transferred to another care management program
- Discontinued by Provider

X. Practitioner Support

In addition to the Programs outlined above, Evolent also conducts the following activities targeted at supporting practitioners. The activities may include the following:

- Proactive Care Gap Reports – A list of attributed enrollees who have an open care gap at a given point in time will be shared with the practitioner
- Quality Compliance Report (QCR) – Physician-level report by line of business and measures compliance rates for quality measures compared to target/benchmarks and peer average. This report also quantifies the difference and calculates the number of care gaps to be addressed in order to reach target compliance levels
- Patient Roster – Physician attributed patient list with care program participation and risk percentile
- Practice Optimization – Evolent partnering with the physician practice to optimize workflows within the practice
- Communicate enrollee care plan/action plan, goals or pertinent information discovered through care management activities, which includes seeking practitioner input or advice when necessary. Practitioner input or advice may be solicited, as needed. Situations that require practitioner outreach may include, but are not limited to, individual with reported severe or worsening symptoms, medication discrepancies, assistance in program participation and care/action planning/interventions
- Collaborate with practitioner in enrollee participation and involvement in clinical programs, i.e. care plan/action plan development

XI. Program Operations

Evolent has developed policies and procedures which support and maintain the operational aspects of the Program. Those Program operations include, but are not limited to:

- Hiring and evaluating clinical and nonclinical qualified staff
- Training and supervision of staff interacting with enrollees, physicians and other involved health professionals
- Responding to enrollee and provider concerns
- Addressing enrollee safety issues
- Protecting the privacy, security and confidentiality of enrollee information

Evolent solicits feedback from enrollees, physicians and other involved health care professionals and clients in the development of the program content. Mechanisms for feedback can range from surveys, enrollee and/or caregiver contacts, physician contacts, complaint data, practice site meetings and client reviews. Upon analysis of data, actions are taken accordingly to maximize the Program's effectiveness. Enrollees have access to Program staff 24 hours a day, seven days a week, through routine business hour coverage and recorded messaging. Enrollees calling after hours will have calls returned on the next business day. The normal

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business hours are 8:00 a.m. to 5:00 p.m. EST/EDT. Program services are predominantly performed telephonically. Care team staff communicate with providers through fax, mail, email, EMR and telephonic outreach. Toll-free telephone and fax numbers for Evolent are available for enrollees and practitioners.

XII. Performance Evaluation

Annually, Evolent assesses the impact of the programs by collecting data on process or outcome measures, measures of cost/utilization and enrollee experience, and participation rates. Quality improvement activities include measuring, trending, analyzing and interpreting results against performance goals and/or benchmarks specific to each of the conditions and/or for the overall Program. (Please refer to Addendum C for the list of clinical measures. Internal benchmark is Quality Compass 50th percentile all LOB).
Each of the clinical measures meets the following criteria:

- The measures capture a relevant process or outcome
- The measure specifications are clearly identified
- Uses a valid method that provides quantitative results
- Establishes a benchmark or performance goal (Quality Compass 50th percentile)
- Comparison of results to a benchmark/goal
- The measure is population-based

Additional performance data, as follows, may be collected and analyzed to better understand Program effectiveness:

- Condition Care Performance Metrics (Claims Driven Data)
- Average length of stay (ALOS)
- Bed Days/1000
- Admissions/1000
- Denied Days
- 30-Day Readmission Rates
- Emergency Room visits/1000
- PCP visits/1000
- Specialist visits/1000
- Inpatient Utilization
- Outpatient Utilization
- Ambulatory Care Sensitive Conditions
- All cause unplanned 30-day readmission rates

At least annually, enrollee experience with the Programs is evaluated through enrollee feedback obtained through a satisfaction survey and complaints data. This allows for identification of opportunities to improve satisfaction with the programs.

Enrollee active participation rates will be measured annually by collecting the number of enrollees who have received at least one interactive contact per condition, divided by the number of enrollees identified as eligible for the Program. As an 'opt-out' Program, total enrollment rates will not be used in the calculation, rather, the total number of identified eligible

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enrollees will be divided by the total number of identified, eligible enrollees with at least one interactive contact. Interactions with enrollees will include activities such as educational mailings, Interactive Voice Response (IVR) surveys and staff phone interactions.

Action is taken as needed for metrics that do not meet the goal(s) or are deemed to be an opportunity for improvement. Interventions or actions to make improvements to identified areas of the Programs are implemented to maximize health outcomes, experience and satisfaction, and effectiveness.

XIII. 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 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
Care Advisor	Clinical	License required in each state where CA is serving enrollees (may be through Compact arrangements)	• 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)	• Identifies 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	• Identifies and coach enrollees needing support with medication adherence strategies and behaviors • Works with providers to modify medication regimens, when appropriate, to better meet the needs of the enrollee

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Health Coach/ Health Educator	Non-Clinical	No licensure requirements	• Conducts initial outreach to enrollees to assess health status, health risks and social needs factors to identify and address language, cultural, and other barriers associated with access to care and self-management • Provides ongoing follow-up and self-management support utilizing motivational interviewing techniques with enrollees and caregivers • Assists enrollees with scheduling appointments with PCP and specialist(s) and link enrollees to supplemental services/programs
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 team work list/action item list • Sends out letters and helps the team manage to service level and timeliness metrics • Takes inbound calls from enrollees and connects them to the CA team

Staff Training

All Care Team members 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 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
- Evidence used to develop the programs
- Behavioral change models
- Program step by step processes
- Goal setting
- Referral process
- Cultural competence
- Enrollee engagement techniques
- Social determinants of health
- Barriers to self-management
- Motivational interviewing and self-management support skills

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- 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 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.

Ongoing Monitoring of Staff Licensure, 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.

XIV. Enrollee Rights and Responsibilities

The organization communicates its commitment to enrollee rights and expectations through enrollee 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

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- 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:

- Follow mutually agreed upon case management plan offered by the organization or notify a care team member 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, which includes:

- 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.
-

XV. 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.

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

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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: Complex/Condition Care Program Review History

Description of Review/Revision	Approved By	Date Approved
New Program Description	Clinical Quality Committee	3/16
Revisions	Clinical Quality Committee	6/16
Annual review	Clinical Quality Committee	5/17
Revision of Program Goals	Clinical Quality Committee	5/18
Criteria/Measure revisions	Clinical Quality Committee – Email Vote	11/16/18

Condition Care Program Review History

Description of Review/Revision	Approved By	Date Approved
New Condition Care Program Description Annual Review	Clinical Quality Committee	2/12/2019
	Clinical Operations and Performance Committee	

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Appendix B: Program Evidence Base

Asthma Program

Source:	NIH, National Heart, Lung and Blood Institute
Article Title:	**Guidelines for the Diagnosis and Management of Asthma: Clinical Practice Guidelines, NIH Publication N. 97-4051**
Publication Date:	July 2007
Link:	http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf

Source:	NIH, National Heart, Lung and Blood Institute
Article Title:	**Asthma Quick Reference Guide**
Publication Date:	Updated September 2011
Link:	https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf

CAD/Hypertension Program

Source:	American College of Cardiology/American Heart Association
Article Title:	**2018 ACC/AHA Guideline on the Lifestyle Management to Reduce Cardiovascular Risk**
Publication Date:	2018
Link:	2018 ACC/AHA Guideline on the Assessment of Cardiovascular Risk

Source:	American College of Cardiology/American Heart Association
Article Title:	**2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk**
Publication Date:	2013
Link:	http://circ.ahajournals.org/content/129/25_suppl_2/S49

Source:	JAMA
Article Title:	**2014 Guideline for the Management of High Blood Pressure in Adults**
Publication Date:	2014
Link:	https://jamanetwork.com/journals/jama/fullarticle/1791497

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COPD Program

Source:	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Article Title:	**Global Strategy for the Diagnosis, Management and Prevention of COPD**
Publication Date:	2019
Link:	The Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2019

Heart Failure

Source:	ACC/AHA/HFSA
Article Title:	**2017 Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure**
Publication Date:	2017
Link:	http://circ.ahajournals.org/content/early/2017/04/26/CIR.0000000000000509

Diabetes Program

Source:	American Diabetes Association
Article Title:	**Standards of Medical Care in Diabetes**
Publication Date:	2020
Link:	https://care.diabetesjournals.org/content/diacare/suppl/2019/12/20/43.Supplement_1.DC1/Standards_of_Care_2020.pdf

Source:	Case Management Society of America
Article Title:	**Guidelines for Improving Patient-Centered Care for Diabetes**
Publication Date:	2015
Link:	http://cdn-ci62.actonsoftware.com/acton/cdna/10442/f-00e2/0/0

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Appendix C: Program Measures

Program	Measure	Description
Asthma	Medication Management for People with Asthma	Patients with persistent asthma who were dispensed appropriate medication and remained on an asthma controller medication for at least 75% of their treatment period.
CAD	Medication Adherence for Cholesterol (Statins)	Patients 18 years of age with a proportion of days covered (PDC) of at least 80% for statins during the measurement period.
COPD	Pharmacotherapy Management of COPD Exacerbation	COPD exacerbation for patients 40 years or older who had an acute inpatient or ED discharge and dispensed a bronchodilator within 30 days of the event.
COPD	Use of Spirometry Testing may be indicated	The percentage of patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received spirometry testing to confirm the diagnosis.
Diabetes	Comprehensive Diabetes Care: Hemoglobin A1c HbA1c Testing	Patients 18-75 years of age with Diabetes who had a HbA1c testing.
Diabetes	Medication Adherence for Diabetes Medications	Patients 18 years and older with a PDC of 80% or over across classes of diabetes medications during the measurement period.
Heart Failure	Persistence of Beta-Blocker Treatment After a Heart Attack	Adults 18 years and older who were hospitalized with AMI and received beta-blocker treatment.
Heart Failure	Annual Monitoring for Patients on Persistent Medications: Total	Members 18 years and older on persistent medications who received annual monitoring.
Hypertension	Medication Adherence for Hypertension (RAS antagonists)	Patients 18 years and older with a prescription for RAS antagonist medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
ACSC Measure – All Programs	Ambulatory Care Sensitive Conditions	Age-Standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents/reduces need for admission (Per 1,000 members). Benchmark comparison to previous year results.

*Benchmark is Quality Compass 50th percentile all LOB unless otherwise requested by clie

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Appendix to Evolent Health Complex/ Condition Care Program

Miami Children's Health Plan

IX. Program Interventions

Use of Telehealth

Telehealth will be offered to patients with diseases that are identified as chronic medical conditions that could benefit from rapid access to medical advice so as to prevent an ED visit or admission. Examples of these types of diseases include asthma, COPD, heart failure, diabetes, epilepsy, etc. These members would have access to providers that could answer their disease related questions and keep them healthy and at home.

Telehealth will be used to help bridge any gaps that can prevent members from seeing needed participating specialists. This program will bring new levels of access for patients that cannot travel or whose geographic location is prohibitive for the routine follow up to a particular specialist.

Telehealth will be offered to members for routine episodic care. Information regarding how to download the appropriate apps and guidelines for usage will be mailed to plan enrollees. This program is not a substitute for care via a PCP but rather is to provide access during times access to the primary care physician is limited.

Other uses of telehealth can include non-medical uses such as nutrition consults, social work evaluations and disease education.

In region 11, telehealth can be utilized in the public schools to address any type of student related monitoring, counseling and disease management via nurses specifically assigned to act as virtual school health nurses. These nurses can address medical issues ranging from simple rashes to monitoring the medication of members with ADD to addressing age appropriate medical screening all via telehealth.

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