

Transition Care

2020 Program Description

Approved - May 19, 2020

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I. Introduction

The Evolent Health, LLC (Evolent) Transition Care Program (referred to in the rest of the document as Program) was developed to improve the enrollee's experience and health outcomes as they transition along the health care continuum. By focusing on the enrollee's transition from an acute hospitalization to home, the team hopes to lower the enrollee's risk for readmission back to the hospital or emergency department. Today, with hospitalized enrollees being sicker and hospital length of stays decreasing, the need to coordinate transitions of care for chronically ill populations is even more critical. The Program aims to enhance the enrollee and practitioner experience through a collaborative and multidisciplinary care management approach with the goal to achieve quality outcomes, manage medical costs and avoid inappropriate utilization.

The care team will collaborate with the hospital discharge planning team to ensure appropriate post-discharge resources and services are arranged prior to discharge, enhance enrollees' education around diagnoses, provide self-management support and perform medication reconciliation, with the goal of preventing avoidable readmissions.

II. Program Components and Goals

The Program focuses on improving transitions of care for an enrollee population with multiple chronic conditions and high rates of utilization of medical services. This community-based program consists of a care team that may include a regional or market medical director, care advisors (CA), health educators, social workers, , pharmacists, community health workers, care coordinators and program coordinators.

The primary point of enrollee contact during the transition process is the CA or Health Educator. Prior to an enrollee's discharge from the hospital, the CA or health educator will collaborate with the hospital discharge planning team to coordinate and implement the discharge plan. Once the enrollee is discharged from the hospital, they will assist the enrollee/caregiver with discharge needs and services.

A. Responsibilities include:

- Collaborate with the hospital discharge planning team to ensure that appropriate post-discharge services are arranged
- Educate enrollees about diagnoses and care plan with specific focus on self-management activities
- Improve medication adherence
- Address enrollee/caregiver needs and assess if there are adequate support and resources in the home
- Assist in arranging post-discharge outpatient provider appointments, as needed
- Identify enrollee/caregiver needs and services post-discharge and, if needed, help in coordinating durable medical equipment, home care and other community and home care arrangements

- Review enrollee education materials using appropriate educational method(s) such as teach-back and self-management
- Refer enrollee to extended care team, as appropriate e.g., pharmacists, social worker
- Refer enrollees to Complex Care Management or another clinical program, as appropriate

B. Program interventions include:

Interventions	
1. Welcome Letter explaining the program, hours of operation, contact information for the care management team, etc.	✓
2. Outreach to the enrollee to enroll in the Program	✓
3. Completion of an assessment within 2-3 business days of notification of discharge to home	✓
4. Development of a Care Plan that identifies personalized goals	✓
5. Outreach occurs at least every 5 business days unless otherwise requested by the enrollee or provider	✓

C. Individualized Enrollee Care Plan Elements

- Summary of physical, behavioral, social and environmental needs, with a focus on the elements driving transitions of care
- Community services currently in place and identify any issues with those services. (e.g. enrollee receives services for home assistance such as laundry, home cleaning and shopping)
- Depression and Anxiety screening and screening results - Enrollee interventions and/or care referrals are implemented for those adult enrollees who screen within target thresholds on the PHQ-9 and GAD-7, and/or indicate psychological distress that has significant impact on daily functioning more days than not. PHQ-A: A 13-item self-completion screening questionnaire designed to detect symptoms of depression and suicide risk for enrollees 11-17 years of age. This tool may be a component within a larger assessment or screening or can be utilized as a stand-alone screening whenever staff feel it beneficial or appropriate.
- Screening for child/adolescent psychosocial functioning – The Pediatric Symptom Checklist 35 (PSC-35): A parent/caregiver-completed measure for enrollees 4-16 years of age. The screening covers a broad range of cognitive, emotional and behavioral problems to address the need for appropriate interventions.
- Health education materials and interventions aimed to develop healthy behaviors (e.g. nutrition and activity) and reduce unhealthy behaviors (e.g., quit tobacco use). Education is focused on enrollee-identified needs/interests, with the goal of enhancing their ability to self-manage

D. Program Goals

- Provide high-quality enrollee care and reducing avoidable readmissions
- Improve adherence to the hospital discharge care plan
- Educate enrollees and their caregivers about medical and behavioral diagnoses and self-management activities
- Improve care coordination for enrollees across care settings
- Assist the enrollee in identifying questions or concerns they have about their diagnoses or treatment plan so that they can have an informed discussion with their provider
- Improve medication adherence
- Address enrollee/caregiver needs regarding adequate support and resources at home

E. Communication

All enrollees are informed of the care management programs through various written and electronic communication vehicles. The information provided includes information on:

- How to use the services
- How enrollees become eligible to participate
- Whom to contact in an urgent situation
- Hours of operation and contact information
- Enrollee Rights and Privacy Statement
- How to make contact if you have questions, feedback and complaints
- How to opt-in or opt-out
 - Enrollees can opt-out of the Program by notifying the care team or health plan customer service
 - Opt-out information is documented in Identifi

F. Frequency of Contact and Case Closure

- Outreach to enroll in the Transitions Care Program within 1 business day of notification of discharge to home
- Post-discharge assessment will be submitted within 2-3 business days of notification of discharge to home
- Outreach occurs at least every 5 business days unless otherwise requested by the enrollee or provider
- Transition Care Program 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
 - Enrollee died
 - Enrollee no longer covered by client health plan

- Enrollee transferred to another care management program
- Discontinued by provider

G. Practitioner Support

In addition to the Program components outlined above, Evolent also conducts the following activities and services to support the practitioners. The activities may include the following:

- Communication of enrollee care plan, goals or pertinent information discovered through care management activities, which includes seeking practitioner input when necessary
- Collaboration with practitioner and enrollee to enhance participation and involvement in clinical programs, e.g., care plan development

H. 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.

I. Evidence-base for the Program

Evolent uses current, applicable, evidence-based clinical guidelines and/or scientific evidence from nationally recognized sources for the basis of its Program. Evidence-based, medical society and national industry standards are referenced for the development, ongoing maintenance, and updates to the Program. Nationally recognized clinical guidelines and/or

scientific evidence are reviewed and updated as appropriate, at least every two years or at the time new scientific evidence or national standards are published; revised, or changes are made available. The Clinical Operations and Performance Committee (COPC) has responsibility for review and approval of clinical guidelines.

Evidence-base for the Transition Care Program

https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf

<https://caretransitions.org/>

<http://www.bu.edu/fammed/projectred/>

III. Enrollee Identification and Stratification

Evolut stratifies individuals based on their risk of 30-day readmission. Stratification is the result of a predictive model which was developed using a modern machine learning algorithm which maps out the complex relationships between several types of enrollee risk factors. At least monthly, the predictive model leverages data that builds a holistic enrollee view, using a combination of data sources including:

- Enrollment data
- Medical and behavioral health claims
- Social Determinants of Health
- Pharmacy claims
- Demographics
- Laboratory results

Some examples of risk factors and criteria used by the predictive model are:

- Increasing or decreasing rate of healthcare utilization in last 3 months
- Recent lab results testing albumin, bilirubin, glucose, and eGFR levels
- Total disease specific prescriptions in the last 12 months
- History of being discharged to a setting other than home
- Level of housing and transportation cost burden in enrollee's census tract

The predictive model outputs a transition readmit risk score, which measures the relative risk of having a readmission within 30 days after discharge from the inpatient setting. The minimum risk score threshold for creating a Transition Care program can be customized for each population and line of business to fit specific business needs.

Programs are automatically created when an ADT message (either Admit or Transfer) is received and one of the following criteria are met:

1. Corresponding transition readmit risk score
2. One or greater inpatient hospital admission or observation discharge(s) in last 30 days

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 Care 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, client organization, or staff from community agencies

IV. Care Monitoring and Case Management System

Evolut Health utilizes a clinical documentation system, Identifi, which automates the evidence-based clinical guidelines and algorithms used to perform the clinical assessment and ongoing management of the enrollee. Identifi is at the heart of Evolut 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, such as the PHQ-9, GAD-7, PHQ-A and PSC-35 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 enrollee identified 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 activity or when an interaction with the enrollee has occurred. The care advisor or Health Educator schedules follow-up encounters within the system, based on the enrollee's preferences and requests. 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 advisor to prompt their next interaction with the enrollee.

V. Program Operations

Evolut 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, orienting, and supervising staff interactions with enrollees, physicians and other involved health professionals
- Responding to enrollee and physician concerns
- Addressing enrollee safety issues
- Protecting the privacy, security and confidentiality of enrollee information

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

VI. Performance Evaluation and Metrics

Annually, Evolut assesses the impact of the programs by collecting data on process or outcome measures, measures of cost/utilization 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.

Metrics and Targets for the Program

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

Measure	Description	Goal
Avoidable Inpatient Hospitalizations	<u># of enrollees admitted within 60 days of Program Graduation</u> # of Program Graduates	0
Avoidable ED Visits	<u># of enrollees with ED visit within 60 days of Program Graduation</u> # of Program Graduates	0

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

- Emergency Room visits/1000
- Urgent Care Visits/1000
- ED Observation Visits/1000
- PCP visits/1000
- Specialist visits/1000

Enrollee Experience and Participation

At least annually, enrollee experience with the program 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 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 goal 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.

VII. Training and Licensure for Staff

A. Staffing

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

Staff Role	Role Type	Licensure Required	Primary Responsibilities
Care Advisor Team Manager	Clinical	Licensure required in each state where team is managing enrollee	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Conducts assessments • Provides self-management coaching, care coordination services and refers enrollees to other care team members as appropriate

			<ul style="list-style-type: none"> Responsible for development and implementation of the care plan
Registered Dietician	Clinical	License required in each state where RD is serving enrollees	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Supports CA 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	<ul style="list-style-type: none"> Supports CA to identify and coach enrollees needing support with medication adherence strategies and behaviors Reviews medication reconciliations for enrollees during care transitions, and assists Care Advisor with completion of medication reconciliation as needed Works with providers to modify medication regimens, when appropriate, to better meet the needs of the enrollee
Health Educator	Non-Clinical	No licensure requirements	<ul style="list-style-type: none"> Works under the direction and guidance of a CA Care Advisor to provide self-management and care coordination support to enrollees and to complete screenings and action plans with enrollees and caregivers Conducts outreach to enrollees regarding health status, health risks and social need factors to identify and address language, cultural, and other barriers associated with access to care and self-management Calls to encourage enrollees and caregivers to participate in care management programs
Health Coach	Non-Clinical	No licensure requirements	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Conducts interviews with enrollees to determine health literacy and need for interpreter services <ul style="list-style-type: none"> Conducts outreach calls to encourage enrollees/caregivers to participate in care management programs Provides ongoing follow-up and self-management support utilizing motivational interviewing techniques with enrollees and caregivers <ul style="list-style-type: none"> Assist in providing information/referrals to governmental and community agencies Scheduling provider visits on behalf of enrollee

			<ul style="list-style-type: none"> • Maintain library on current available community resources
Care Coordinator/ Community Health Worker	Non-Clinical	No licensure requirements	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

B. Initial and Ongoing Training

Care team members receive comprehensive new hire orientation, specific to their role. 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
- Evidence used to develop the programs
- Behavioral change models
- Goal setting
- Referral process
- Cultural competence
- Enrollee engagement techniques
- Program step by step processes
- Social determinants of health
- Barriers to self-management
- Motivational interviewing and self-management support skills
- 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, 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 formal, bi-annual performance evaluation process.

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

C. Verification of Licensure

All clinical staff are required to have an active, unrestricted license. Evolent Health verifies clinical licensure in all states where clinical services are conducted. License 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.

D. Ongoing Monitoring of 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.

VIII. 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
- 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.

A. 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

B. Handling and Resolving Complaints

Evolut Health has a policy and procedure for registering and responding to enrollee complaints about the Program and/or the care team 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

IX. 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.

X. Authority and Program Oversight

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.

APPENDICES

Appendix A: Transitions Care Program Review History

Description of Review/Revision	Approved By	Date Approved
New Program Description	Clinical Quality Committee	2013
Program Description Modified – HTP redesign	Clinical Quality Committee	09/13
Program Description Updated – UM redesign	Clinical Quality Committee	11/13
Program Description Updated – evidence base and metrics update, redesign	Clinical Quality Committee - email vote	11/16/18
Program Description Annual Review	Clinical Quality Committee	2/12/19
	Clinical Operations and Performance Committee	