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DIAGNOSTIC CARDIOLOGY MANAGEMENT

Partner One-Pager

A quick-reference leave-behind for presenting Evolent's diagnostic cardiology management program to employer, broker, and health plan audiences.

~$1.5M	97%	81%	75%
Annual savings potential (blinded partner)	Practices eligible for gold-carding	Cardio provider satisfaction	Portal ease-of-use rating

What it is

A standalone diagnostic cardiology management program — separate from advanced imaging and interventional cardiology. Evolent carved out a specific set of cardiac codes — transthoracic echocardiography (TTE), stress echocardiography, nuclear cardiac imaging, and diagnostic catheterization — because they take more clinical work to review than general imaging. Cardiologist-led review and gold-carding for high-performing practices align appropriate use across the code set.

How it works

- **Cardiologist-Led Review** — specialty-matched reviewers, guideline-based decisions, and records validation on every request
- **Gold-Carding** — 97% of ordering practices exempted from PA on covered TTE codes; engagement focused on the outlier tail
- **Provider Engagement** — subspecialty-matched P2P, performance scorecards, and consultative behavior-change support

Why it's credible

- 30+ years of specialty management experience across 15M+ members and 20+ health plan partners
- 215+ physicians across 70 specialties — including cardiology-specific reviewers with diagnostic, interventional, and EP expertise
- ~$1.5M in annual savings potential from cardio gold-carding in a single blinded partner analysis across three diagnostic codes
- 81% cardio provider satisfaction and 75% portal ease-of-use rating in Q4 2024 provider survey (N=178)

The close

"Let's find a time to walk through your cardiology numbers." Always end with a concrete next step — a follow-up meeting, a claims data request, or a one-page collaboration document.

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Train-the-Trainer Guide

The full talk track, supporting data, objection-handling appendix, and language guide for partners presenting Evolent's diagnostic cardiology management program externally.

1. THE TALK TRACK

Open: Establish the problem

Diagnostic cardiology sits in a specific gap — high volume, high variability, and rarely managed as its own category. Lead with the pattern before introducing Evolent — let the audience recognize the shape of the problem before you offer the solution.

- **TTE overutilization** — small numbers of practices drive disproportionate volume, often for inappropriate indications
- **Ordering variability** — TTE, stress, nuclear, and monitoring orders vary widely across otherwise comparable practices
- **Downstream cascade** — diagnostic decisions drive referrals, follow-up imaging, and procedures — the leverage point is upstream
- **Under-managed today** — diagnostic cardio is frequently bundled into advanced imaging or ignored; it needs a specialty lens

Establish credibility: Evolent at a glance

- 30+ years of specialty management experience across 15M+ members and 20+ health plan partners
- 215+ physicians across 70 specialties — cardiology-specific bench includes diagnostic, interventional, and EP subspecialists
- 50+ Scientific Advisory Board members; cardiology SAB informs guideline development
- Enterprise clinical bench: ~300 physicians, ~600 nurses, ~500 allied health professionals

Set the boundary: diagnostic cardio is a distinct product

This is the most important framing move — diagnostic cardiology stands on its own. Evolent identified a specific set of cardiac codes that take more clinical work to review than general imaging and carved them out to be managed as their own program. It is not advanced imaging with a cardiac wrapper, and it is not the same conversation as interventional cardiology. Practices and plans can opt in without taking either adjacent product.

- **Different reviewers** — cardiologists, not radiologists or general reviewers
- **Different ROI profile** — gold-carding drives the value case, not high denial rates
- **Different sales motion** — often the entry point that leads to an interventional conversation next cycle
- **Different scope** — TTE, stress echo, nuclear cardiac imaging, and diagnostic catheterization — not the interventional procedure set

Prove the model: TTE gold-carding math

This is your most concrete data story. Use it when a finance stakeholder asks "where does the savings come from?" or when a clinical stakeholder asks "how does this reduce abrasion?"

- In a blinded partner analysis: 805 practices ordered 16,285 TTEs over 14 months
- 97% of practices (780) had ordering patterns qualifying them for gold-carding — no more PA on covered TTE codes

- 3% of practices (24) accounted for 33% of TTE volume — targeted for provider engagement, not blanket denial
- Result: reduced abrasion for nearly the entire network, while driving behavior change in the outlier tail

Explain the model: three pillars

Walk through in order — each pillar builds on the last:

- **1. Cardiologist-Led Review** — specialty-matched reviewers, evidence-based guidelines, records validation on every request
- **2. Gold-Carding & Provider Engagement** — reward the 97% with reduced PA burden; focus engagement on the outlier 3%
- **3. Point-of-Care Technology** — purpose-built cardiology portal, NLP-based auto-approvals, gold-carding automation, and authorization bundles

Tailoring tip: if the audience is provider-abrasion focused, spend more time on gold-carding and P2P mechanics. If they're finance-focused, anchor on the $1.5M blinded partner analysis and the code-set carve-out narrative.

Prove it: results that matter

- ~$1.5M annual savings potential from gold-carding in a single blinded partner analysis across three diagnostic cardio codes
- 81% cardio provider satisfaction (N=178, Q4 2024) — engagement, not gatekeeping, drives the number
- 75% portal ease-of-use rating in the same cardio provider survey
- ~90% portal utilization across the enterprise book — providers use the tools when the tools are worth using
- 97% of TTE-ordering practices qualified for gold-carding in the blinded partner analysis

Close: ask for the next step

"Let's find a time to walk through your cardiology numbers." Never end a presentation without naming a concrete next step — a follow-up meeting, a claims data request, or a one-page collaboration-of-care document.

2. KEY STATS REFERENCE

Use this table as your source of truth when citing figures live. All stats are generalized or blinded-partner figures — do not cite client-specific numbers unless cleared for that audience. Pressure-test any borderline number with Katie Lewandowski (cardiology clin ops) or David Bauer (product) before it goes into a live pitch.

Metric	Value	Source / Notes
Years of specialty management experience	**30+**	Evolent enterprise
Unique members under management	**15M+**	Evolent enterprise
Health plan partners	**20+**	Evolent enterprise
Physicians across specialties (all programs)	**215+ / 70 specialties**	Evolent enterprise
TTE gold-card-eligible practices	**97% (780/805)**	Blinded claims analysis 7/24–8/25
Cardio provider satisfaction	**81%**	N=178, Q4 2024 survey

Metric	Value	Source / Notes
Portal ease-of-use rating (cardio)	**75%**	N=178, Q4 2024 survey
Portal utilization (all programs)	**~90%**	Evolent enterprise
Annual savings potential — gold-carding (blinded partner)	**~$1.5M**	Preliminary, 3 diagnostic codes
TTE annual auth volume (blinded partner)	**20,163**	Preliminary analysis
TTE unit cost (blinded)	**$555**	Preliminary analysis
Stress echo annual auths (blinded)	**856**	Preliminary analysis
Diagnostic heart cath annual auths (blinded)	**808**	Preliminary analysis
TTE outlier practices (engagement targets)	**3% (24/805)**	Ordering 33% of total TTE volume
Scientific Advisory Board members	**50+**	Cross-specialty; cardio SAB active
Physician bench (all programs)	**~300**	Evolent enterprise
Nursing bench	**~600**	Evolent enterprise
Allied health professionals	**~500**	Evolent enterprise

3. OBJECTION-HANDLING APPENDIX

"Isn't this just advanced imaging with a cardiology label?"

No — Evolent identified a specific set of codes (TTE, stress echo, nuclear cardiac imaging, diagnostic cath) that take more clinical work to review than general imaging, and carved them out to be managed as their own program. It's a distinct product with its own reviewers, its own guidelines, and its own ROI profile. Advanced imaging is radiologist-driven; diagnostic cardio is cardiologist-driven. Plans can opt into one without the other.

"How do we know the savings are real?"

The $1.5M annual savings figure comes from a real blinded partner claims analysis across three diagnostic cardio codes: TTE, stress echo, and diagnostic heart catheterization. The math is procedure-level — annual volume × current CDR × unit cost. Happy to run the same analysis on your book.

"Won't gold-carding just approve everything and drop utilization management altogether?"

Gold-carding is targeted — only practices with documented appropriate ordering patterns qualify. The 3% outlier tail still goes through active engagement and, if needed, prior authorization. It's the opposite of dropping UM — it's focusing UM where the variance actually lives.

"Will our cardiology providers push back?"

The 81% satisfaction rating in cardio (Q4 2024, N=178) says most don't. Gold-carding reduces PA burden for the majority; the specialty-matched P2P process means cardiologists talk to cardiologists on any denial. The friction is concentrated in the 3% outlier tail — and that's where the value lives.

"Can we do this without also doing interventional cardiology?"

Yes — that's the point. Diagnostic cardio is a standalone product. Many clients start here and add interventional in a later sales cycle once the diagnostic ROI is proven. If interventional is a hard no today, we can still stand up diagnostic on its own timeline.

"What's the implementation lift?"

Diagnostic cardio implementations run on Evolent's specialty management playbook — discovery, segmentation, provider onboarding, and clinical alignment. Timelines vary by market and network complexity; happy to sketch a specific one against your book.

"How do we handle providers ordering TTEs for inappropriate indications like fatigue or benign murmurs?"

That's exactly the 3% outlier engagement track. Clinical care path criteria (appropriate: CHF, congenital heart disease, chemo cardiotoxicity monitoring; inappropriate: isolated fatigue, palpitations without other signs, benign murmurs) filter the target list. Practices are prioritized by TTE volume and % inappropriate before any change in PA status.

4. CERTIFICATION CHECKLIST

Use this checklist to confirm a trainer is ready to present externally. All four items should be satisfied before sign-off.

- ✓ **Teach-back:** presents the problem, the carve-out narrative, gold-carding math, and results back to the group in under 8 minutes, unscripted
- ✓ **Objection drill:** responds live and accurately to at least two objections from the appendix, no notes — must include the "isn't this just advanced imaging" objection and one ROI or provider-abrasion objection
- ✓ **Accuracy:** cites only the generalized or blinded figures in the reference table — no client-specific numbers unless cleared, no invented statistics
- ✓ **Language discipline:** consistently frames diagnostic cardio as a standalone product, uses "partner," avoids overpromising on interventional or ASO outcomes, and closes with a concrete next step

Sign-off authority: trainer's manager or designated Evolent enablement lead. Route any objection encountered live that isn't covered in this guide back to the enablement team so it can be added to the next revision. Pressure-test net-new stats with Katie Lewandowski (cardio clin ops) or David Bauer (product) before use.