August 2021

Connecting Care

Case Studies and Resources for Innovators in Population Health Management

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Southwestern Health Resources (SWHR), which blends the strengths of University of Texas Southwestern Medical Center and Texas Health Resources, includes a clinically integrated network of 29 hospital locations and more than 6,500 physicians and other clinicians, and is committed to being the national leader in population health. With more than 650 points of access to care, this provides for higher value and allows patients to access services across a full continuum of medical needs. The network serves people across 16 counties in North Texas. In total, Southwestern Health coordinates care for more than 730,000 patients, aligned with commercial health care plans and Medicare programs.

For more information, please visit **southwesternhealth.org.**

CASE STUDY

Connecting Care in a Pandemic: Data-Driven Outreach to At-Risk Populations

The Problem

The COVID-19 pandemic has disrupted healthcare. In North Texas, the impact was seen in three primary ways:

1. Community physicians faced the dueling responsibilities of treating patients infected with the coronavirus while safely maintaining continuity of care for all patients with chronic and complex conditions.

2. Providers needed to rapidly shift from face-to-face healthcare delivery to virtual and telehealth visits. This new mode of operation was immediately implemented to ensure patient safety, particularly for the elderly and patients with complex medical conditions.

3. Community physicians and acute-care facilities saw revenues plummet as patients avoided and delayed care. Elective surgeries ceased for months to manage the initial surge of COVID-19 patients and to accomodate any spikes in COVID-19 cases.

These factors created an immediate financial crisis across the continuum of care. They also put patients with chronic conditions at risk for dangerous health declines as they avoided routine care for fear of contagion. This predicament reached a crisis point during the second quarter of 2020 as primary care providers saw a more than 50% drop in volume. As patients delayed essential care, SWHR also recognized an increased risk to quality improvement due to the long-term impacts on already diagnosed cancers and other diseases.

These operational and clinical challenges required providers at every level to adapt to a total reorientation of the industry, nearly overnight.

The Opportunity

The SWHR model for value-driven population health management and operational infrastructure to support physicians reduced the strain of transactional payment models and ensured access to care.

Innovative care delivery, active patient monitoring, advanced analytics and accelerated value-based payments offered a lifeline to physicians and patients during the pandemic and a road map out of the crisis.

To make preventive and proactive interventions possible for rising- and high-risk populations, SWHR launched an immediate response to the pandemic in North Texas. The response demonstrated the inherent strengths of integrated, data-driven population health management philosophy over the legacy fee-for-service transactional system of healthcare.

Challenges and Opportunities in the COVID-19 Pandemic

	CHALLENGES	OPPORTUNITIES
 **Care Continuity in a Pandemic**	Patient avoidance of medical facilities increased the risk of losing traction on quality and outcome improvements due to continued disease progression.	The establishment of new care delivery models and alternate treatment processes allowed care maintenance to continue despite the pandemic.
 **Physician Payments Crisis**	The drop in primary care patient volumes posed an immediate risk to operations and illustrated that medical practices cannot survive public health crises in a transactional payment environment.	The continued development of value-based primary care models allowed for immediate adaptations to bridge the short-term volume concerns while building a stronger foundation for sustainability post-pandemic.
 **Targeted Communication**	COVID-19 posed increased risk to medically complex and underserved patients. Those with underlying health conditions needed early and ongoing engagement.	Claims and EHR data allowed for targeted patient communication across the network.
 **Case Management**	Patients did not experience seamless care from across facilities pre-pandemic and faced particular risk of quality and satisfaction risks during transitions between care providers due to the pandemic.	A coordinated response across clinical operations based in local modeling and analytics improved both quality of care and patient satisfaction.

The Solution

An agile, coordinated response

Leveraging its existing system of physician support tools and analytics, in March 2020, SWHR established a pandemic command center for operational and clinical leaders to coordinate agile responses to member needs. The command team immediately took action to:

1. Offer direct support for community physicians to adopt and scale telehealth
2. Initiate data-driven targeting of and outreach to at-risk patient populations, specifically patients with elevated risk due to care avoidance
3. Implement remote monitoring and care coordination for COVID-19 patients
4. Integrate with ancillary care services to execute the necessary clinical responses

By supporting community physicians, building a targeted patient engagement model, and coordinating with care partners, SWHR was able to mitigate risk for its more than 700,000 patient members, with all the efforts taking shape in the first week following the declaration of a national and regional emergency.

The response represents a sustainable framework for addressing complex factors affecting outcomes before, during and after public health crises.

The Results

Direct support and telehealth guidance for community physicians

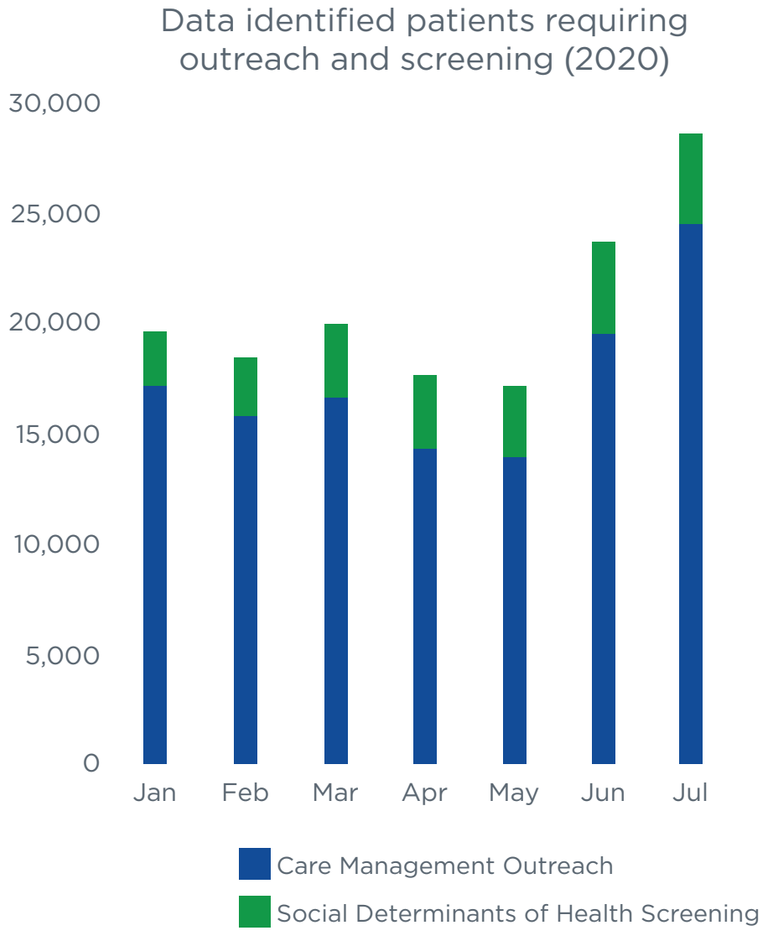
400 Practices Activated

SWHR enhanced community physicians' telehealth capabilities in approximately 400 independent practices in less than one month. As many of the network providers are on the same EHR and all are on the SWHR platform, practices could more easily adopt and integrate telehealth technology. Guidance from SWHR care management teams also eased the adoption of a new technology at a rapid pace.

8,000 Virtual Visits Per Day

Providers went virtual quickly, rising from nearly zero to approximately 8,000 telehealth visits per day across the network.

The Results

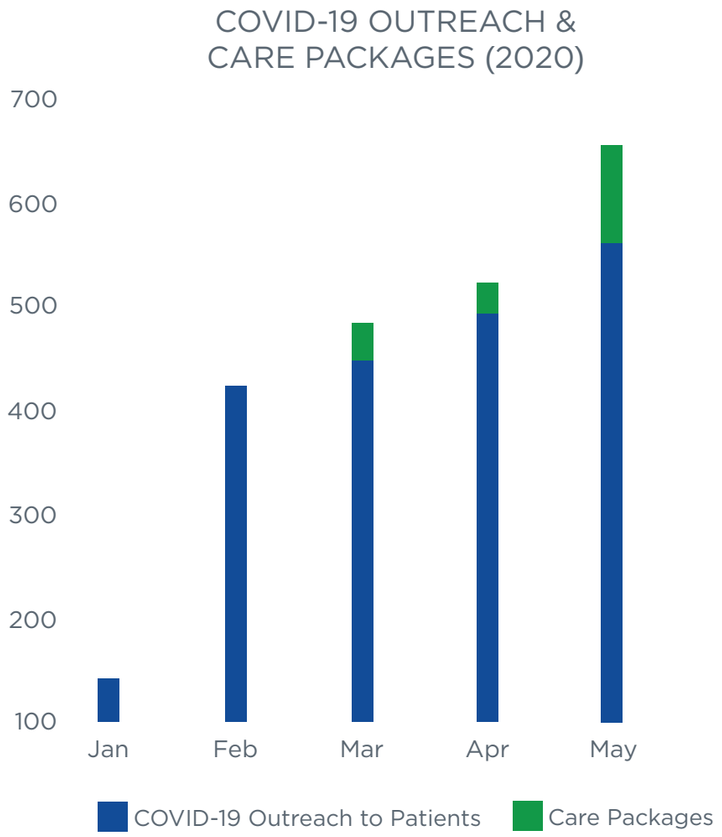


Data-driven targeting of patient avoidance

SWHR's crisis communications approach focused on both prevention and avoiding care delays, and mitigating the effects of any delays. The recent data from MedStar EMS, a participant in the Centers for Medicare & Medicaid Services' Emergency Triage, Treat, and Transport (ET3) voluntary payment program, revealed a dramatic uptick in severity of 911 calls and decrease in ambulance transports: Dallas-Fort Worth ambulances reported a 164% increase in dead-on-scene.

- The network put out more than 200,000 targeted communications to patients at risk of heart attacks and strokes, urging them to not delay care.
- Additionally, using advanced analytics from claims and EHR data, SWHR disseminated 250,000 amplified messages to patient members in high prevalence ZIP codes highlighting prevention of COVID-19 infections in the community.
- A second wave of messages aimed at all 700,000 patient members was planned.
- In response to data indicating people were not seeking care because of COVID-19 infection concerns, SWHR identified more than 150,000 patients at risk for cardiovascular disease and serious cardiac events.
- Emails and letters were sent to 150,000 patients to educate them about the symptoms of stroke and heart events, and when to seek emergency care.
- Furthermore, SWHR established a partnership with Univision, the Spanish-language media company, to reach more than 5.5 million people with messaging delivered by SWHR network physicians to encourage the Hispanic population of North Texas not to delay necessary care.

The Results



Established remote monitoring and care for COVID-19 patients

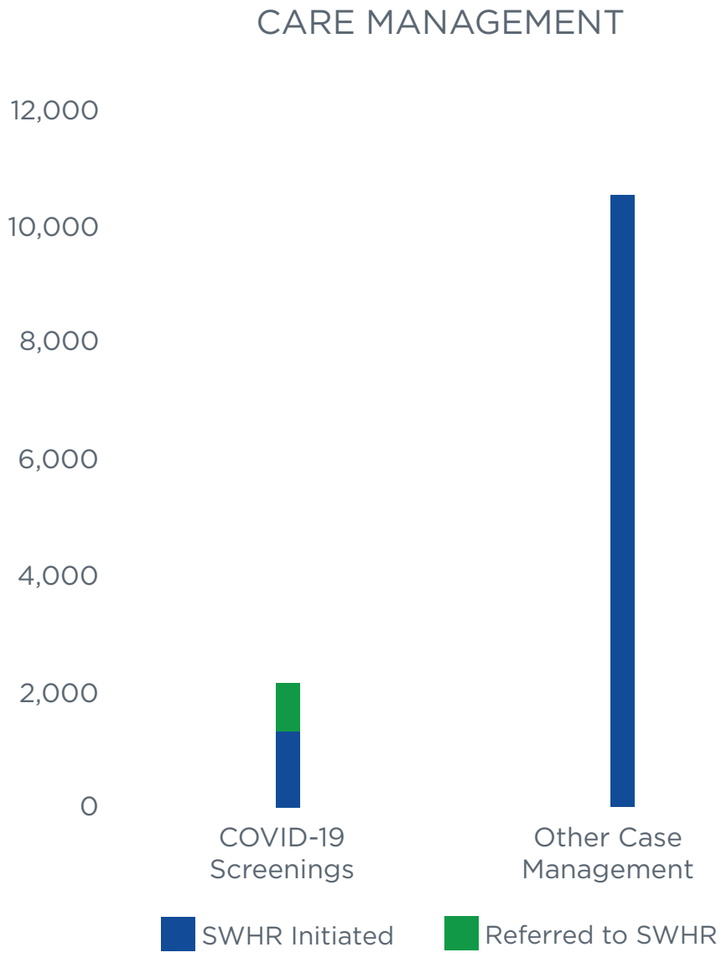
In the third quarter of 2020, SWHR had approximately 450 actively managed older adult patients with COVID-19 in case management. Over the second and third quarters of 2020, SWHR delivered nearly 1,000 vital “care-at-home” packages, which included toilet paper, paper towels, hand sanitizer, protein drink and bars, soap and other personal items that were hard for these patients to access, either due to the impact of their illness or other health complications, supply issues, transportation challenges, or concern about virus transmission. SWHR followed up with these individuals and documented positive patient feedback, as well as improvements in care, outcomes and quality.

Comprehensive case management efforts also included regular check-in calls to patients, assisting with transitions of care and in-home health assessments, all of which are vital for patients living with chronic illness.

Through a partnership with Encompass Health, a national post-acute health services organization, SWHR was able to create a network-to-doorstep pathway to reach patients with the greatest needs in their homes. Patient screenings identified social determinant gaps, which the network addressed through additional social work and case management resources, including meal delivery services and ride-sharing services.

In addition to Encompass Health, SWHR forged partnerships with other healthcare organizations, enabling the network to facilitate comprehensive care management through check-in calls, care transition support and in-home health assessments.

The Results



Integrated response with ancillary care services

Prior to the pandemic, SWHR developed capabilities among post-acute care (PAC) partners to increase clinical quality, ensure appropriate utilization, and improve the patient experience and outcomes. As the census of COVID-19 patients in North Texas increased, the need for COVID-19-specific discharge and post-acute care coordination became clear.

Those needs would shift from an early focus on low-acuity patients requiring additional support at home to more severely impacted patients requiring prolonged post-acute ventilator and ventilator-dialysis care.

Weekly communications for ancillary services became a priority, ensuring that home health agencies and skilled nursing facilities were equipped with information and support to meet the needs of COVID-19 and at-risk patients.

By strengthening communication and sharing real-time admission data with PAC facilities in their region, SWHR was able to establish collaborative task forces with skilled nursing facilities and home healthcare agencies to ensure safe and appropriate utilization for COVID-19 patients. The initiative included developing a tip sheet for acute-care hospitals to help care transition managers transfer COVID-19 patients safely and efficiently.

The Process

An agile response

Because COVID-19 created immediate and long-term challenges across SWHR's network, SWHR's response had to be equally multifaceted and collaborative. This required quick adaptations to operational and outreach approaches for physicians and patients alike.

In four steps, the response to the pandemic:

1. Supported community physicians
2. Used data to identify at-risk patients
3. Coordinated care for COVID-19 patients
4. Integrated care with ancillary services

1 Support for community physicians

Increasing in-person patient volume for primary care physicians wasn't possible in the early days of the pandemic, so SWHR addressed the sudden loss of revenue among community providers in two other ways:

Telehealth
SWHR helped enhance primary care delivery by providing guidance to help practices implement long overdue telehealth capabilities. This allowed community physicians to reach out to vulnerable patients, screen their health and needs, and collaborate with care partners to deliver in-home care if needed.

Small practices largely lacked the resources to interpret rapidly evolving and complex regulatory guidelines and billing and coding changes related to telemedicine. So, the network hosted weekly webinars for medical practices and launched a microsite that promoted guidelines, best practices and other telehealth resources. SWHR team members also provided direct support in the field to assist practices with telehealth coding in compliance with rules affecting virtual care and data capture for quality and risk adjustment.

Messaging for Patients
Building patients' trust in telehealth was essential to building and maintaining patient volume, especially with no evident end to the pandemic. A three-point message framework told patients that:

1. It's important to get the care you need
2. You have the option of using telehealth to receive care from the safety of your home
3. We can help you establish a relationship with a physician for ongoing, individualized care during the pandemic and beyond

Virtual visits supplemented only a portion of lost revenue for community physicians. To help shore up physician practices, SWHR made advanced quality and incentive payments to community physicians, providing a portion of these payments in May 2020 instead of the standard schedule of payments post-reconciliation in the third and fourth quarters of the year.

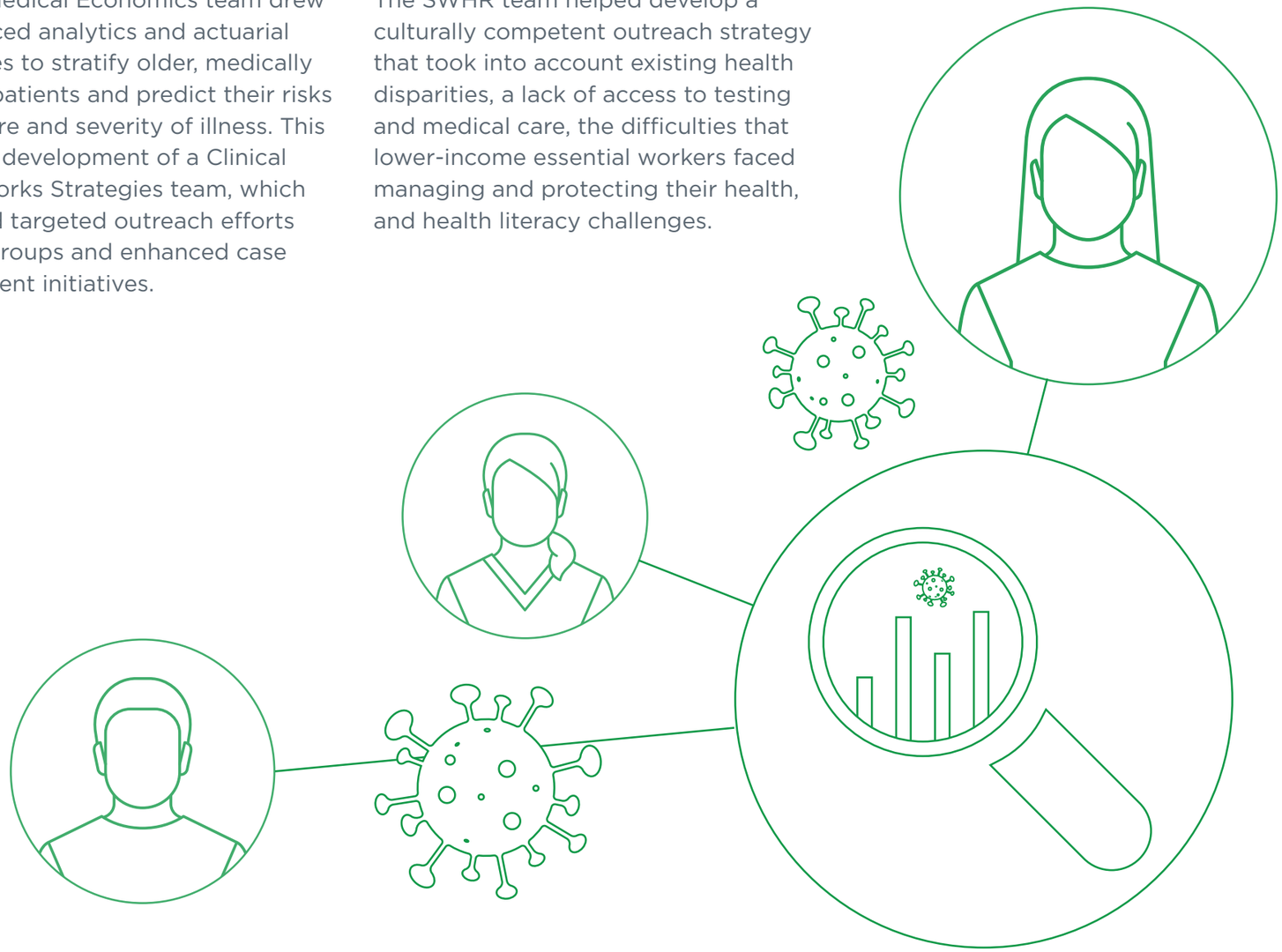
> **"We told patients: 'We're accessible. You don't have to go to the emergency room or an urgent care center. If something comes up, call us.'"**
>
> **— Morvarid "Mo" Rezaie, DO**

2 Data-driven outreach to at-risk patients

Assessing and addressing the impact of COVID-19 on patients' decisions to seek or avoid care required coordinated population health management interventions. The disproportionate impact of COVID-19 on underserved communities in particular presented an additional opportunity to apply population health management tactics to the unprecedented crisis.

SWHR's Medical Economics team drew on advanced analytics and actuarial capabilities to stratify older, medically complex patients and predict their risks of exposure and severity of illness. This led to the development of a Clinical and Networks Strategies team, which supported targeted outreach efforts to these groups and enhanced case management initiatives.

The SWHR team helped develop a culturally competent outreach strategy that took into account existing health disparities, a lack of access to testing and medical care, the difficulties that lower-income essential workers faced managing and protecting their health, and health literacy challenges.



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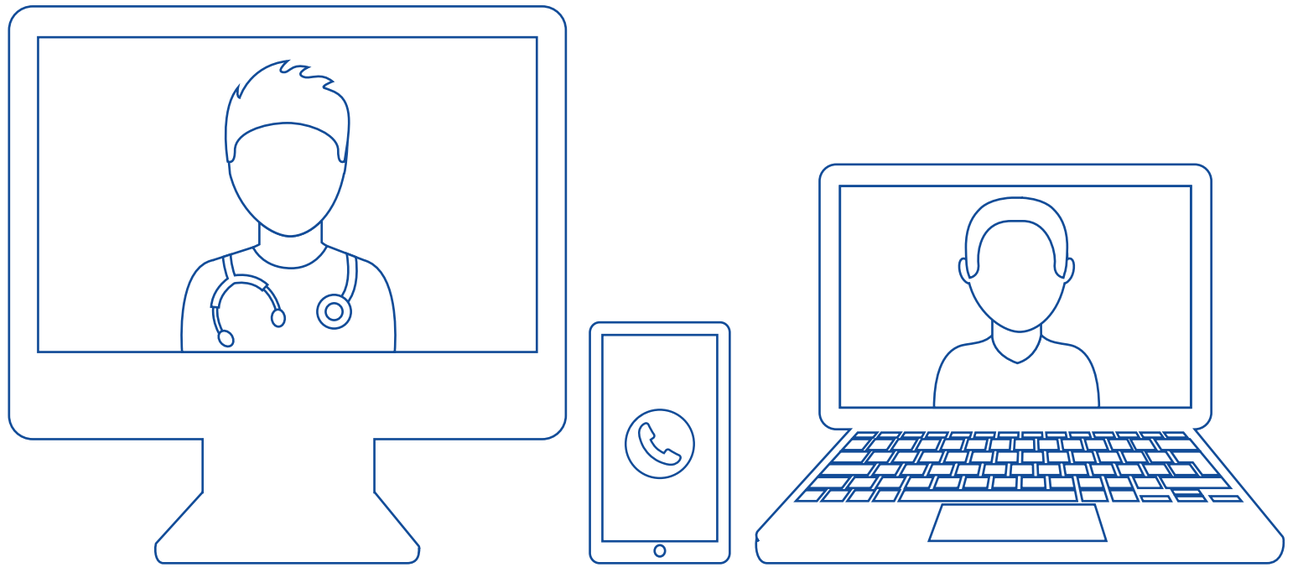
Remote monitoring and care coordination for COVID-19 patients

With the infrastructure in place for data-driven stratification of patients by risk, SWHR was able to develop targeted outreach efforts to close care gaps and improve quality and patient satisfaction. In doing so, SWHR also helped lower the net cost of care.

SWHR's Care Management team also supported providers by establishing a dedicated referral line. This allowed providers to refer members who identified as COVID-19 patients, whether in the hospital or ambulatory setting, to the Care Management team to provide collaborative support across the network for the patient.

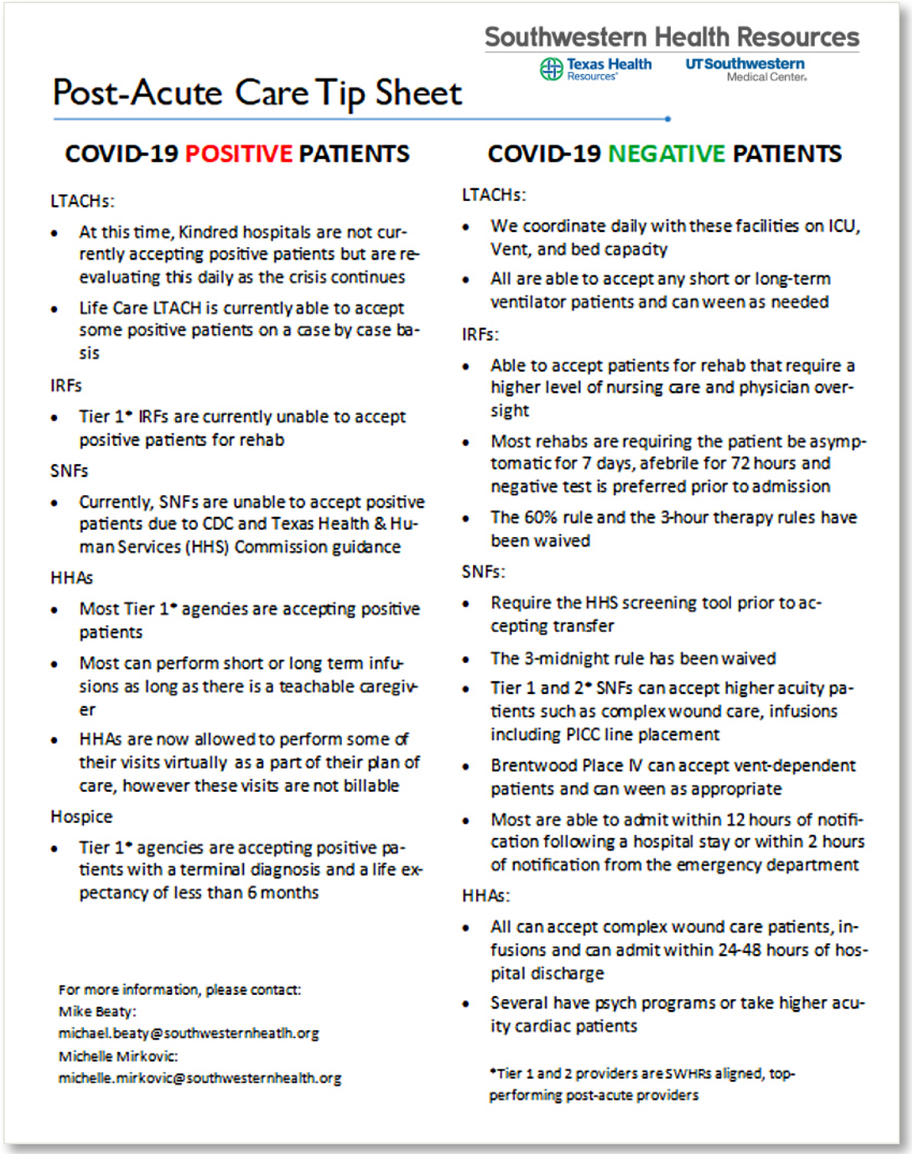
For the Medicare population, SWHR expanded its care delivery approach by leveraging telemedicine, emphasizing social determinants of health and developing in-home geriatrics care, including behavioral, home health and urgent home visits.



4 Integrated response with ancillary care services

SWHR's existing infrastructure enabled it to establish a networkwide command center to provide support for physicians and coordinate response teams early in the crisis.

Weekly communications for ancillary services, including home health agencies and skilled nursing facilities, ensured that clinical partners were equipped with information and support to meet the needs of COVID-19 and at-risk patients. This effort included creation of a tip sheet for acute-care providers discharging COVID-19 patients to post-acute care facilities.



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Post-Acute Care Tip Sheet

COVID-19 POSITIVE PATIENTS

LTACHs:

- At this time, Kindred hospitals are not currently accepting positive patients but are re-evaluating this daily as the crisis continues
- Life Care LTACH is currently able to accept some positive patients on a case by case basis

IRFs

- Tier 1* IRFs are currently unable to accept positive patients for rehab

SNFs

- Currently, SNFs are unable to accept positive patients due to CDC and Texas Health & Human Services (HHS) Commission guidance

HHAs

- Most Tier 1* agencies are accepting positive patients
- Most can perform short or long term infusions as long as there is a teachable caregiver
- HHAs are now allowed to perform some of their visits virtually as a part of their plan of care, however these visits are not billable

Hospice

- Tier 1* agencies are accepting positive patients with a terminal diagnosis and a life expectancy of less than 6 months

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COVID-19 NEGATIVE PATIENTS

LTACHs:

- We coordinate daily with these facilities on ICU, Vent, and bed capacity
- All are able to accept any short or long-term ventilator patients and can ween as needed

IRFs:

- Able to accept patients for rehab that require a higher level of nursing care and physician oversight
- Most rehabs are requiring the patient be asymptomatic for 7 days, afebrile for 72 hours and negative test is preferred prior to admission
- The 60% rule and the 3-hour therapy rules have been waived

SNFs:

- Require the HHS screening tool prior to accepting transfer
- The 3-midnight rule has been waived
- Tier 1 and 2* SNFs can accept higher acuity patients such as complex wound care, infusions including PICC line placement
- Brentwood Place IV can accept vent-dependent patients and can ween as appropriate
- Most are able to admit within 12 hours of notification following a hospital stay or within 2 hours of notification from the emergency department

HHAs:

- All can accept complex wound care patients, infusions and can admit within 24-48 hours of hospital discharge
- Several have psych programs or take higher acuity cardiac patients

*Tier 1 and 2 providers are SWHRs aligned, top-performing post-acute providers

Next steps in the population health management response to COVID-19

As patient needs evolve from immediate intervention to ongoing support, SWHR is poised to build on current response efforts to close care gaps and support patient volume recovery.

These efforts include:

Continued targeted outreach and innovative, in-home screening efforts for at-risk populations related to cancer and chronic disease

•

Increased investment in home-based geriatrics models, including urgent and behavioral care

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Value-based pharmacy initiatives including ambulatory optimization of non-cancer-related therapeutic opportunities for gastrointestinal, neurological, ocular and musculoskeletal care

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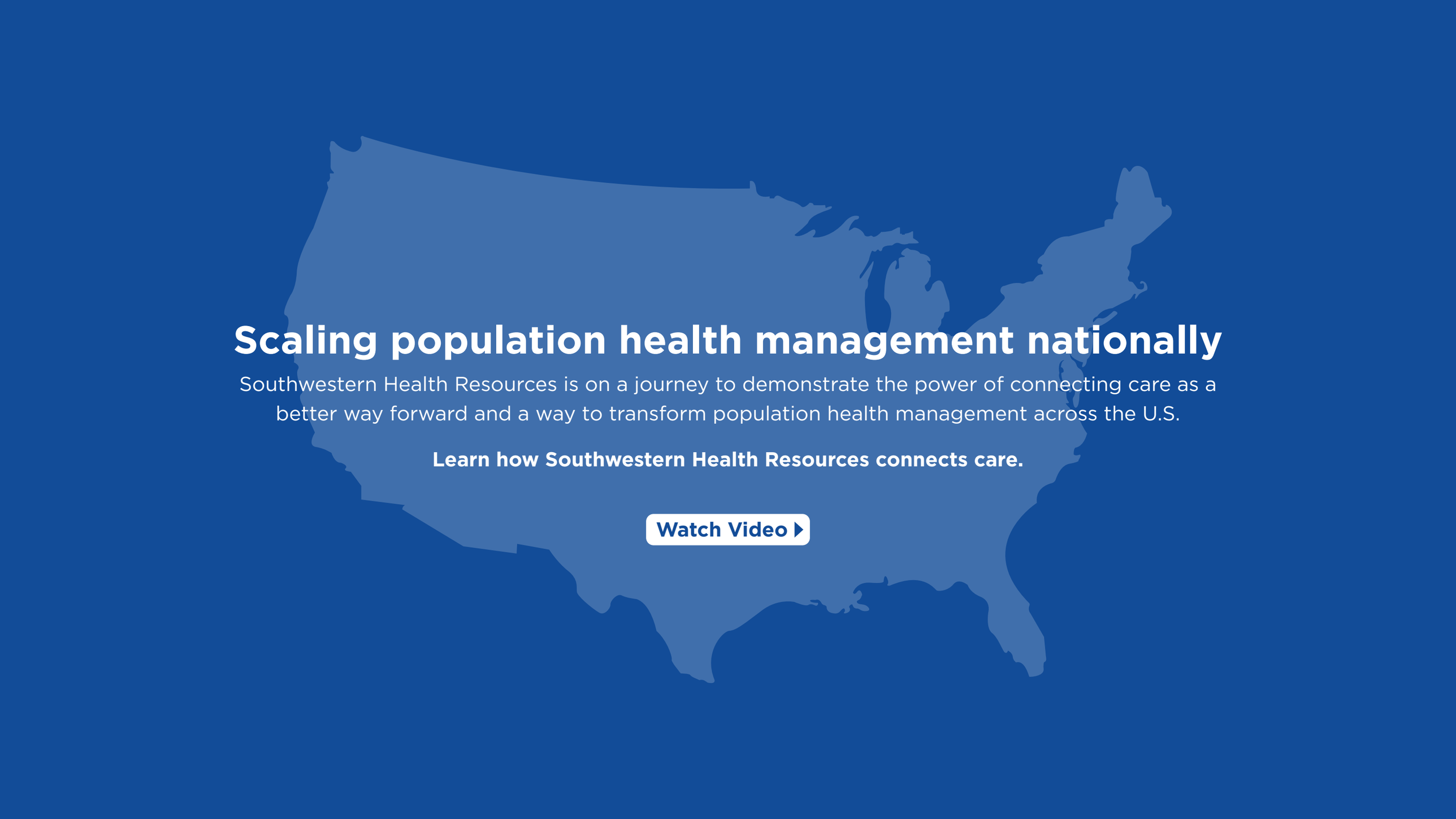
Further acceleration of value-based compensation models to address continued volume concerns post-pandemic


Scaling population health management nationally
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