MedPOINT Management, Inc. provides all aspects of managed care management services to hospital clients and independent physician associations (IPAs), including Global Care Medical Group IPA. Global Care Medical Group IPA is a multi-specialty IPA of community physicians and practices providing care across a broad geographic area of Southern California, particularly in Los Angeles County.

A TRANSITION OF CARE PROGRAM TO IMPROVE HEART FAILURE OUTCOMES

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Introduction

Approximately 6.7 million U.S. adults have congestive heart failure (CHF). This condition accounts for 14% of all causes of death and annual health care expenses that will exceed $70 billion by 2030.[1,2] Among the many challenges of effectively treating patients with CHF are early diagnosis, ensuring adequate patient education and treatment adherence, and providing adequate transitions of care (TOC) when patients are discharged from the hospital. These challenges are especially pressing among underserved populations. Addressing TOC challenges can address the quadruple aims of improving outcomes, positively impacting patient satisfaction, and growing healthier communities, while simultaneously reducing health care spending.

The Challenge

In 2021 and the first half of 2022, CHF was the second leading diagnosis on inpatient and emergency department (ED) claims for Medicaid-eligible patients (Medi-Cal in California) assigned under a dual-risk arrangement between community-based IPAs and an area hospital in the Los Angeles County region. The Coordinated Regional Care model (CRC) was used to support this integrated, dual-risk network—addressing non-clinical health drivers and improving chronic disease care management—and to bridge critical service gaps for a complex Medi-Cal population. Under this arrangement, the hospital assumed responsibility for institutional services and costs (e.g., hospital stays, hospital-based surgeries, etc) and the IPAs assumed responsibility for professional services and costs (e.g., physician fees, lab/test costs). Between September 2022 and December 2024, 738 attributed members with both a CHF diagnosis and a recent inpatient or ED encounter were identified. The large number of CHF encounters signaled a need to understand and improve TOC and discharge management for these patients. Given the dual-risk arrangement, the hospital and IPAs were aligned and worked together through the CRC to address hospital discharges and TOC.

The Intervention

Working with Global Care Medical Group IPA and its affiliated MSO, MedPOINT Management, the CRC supported enhanced care coordination through personalized, integrated care that focused on disease management and preventive health. The goal of the CHF program was to build a team

PRE- AND POST PROGRAM CHARACTERISTICS OF A TRANSITION OF CARE PROGRAM FOR PATIENTS WITH HEART FAILURE

CHF PROGRAM FEATURES	PRE	POST	ABSOLUTE DIFFERENCE	% DIFFERENCE
ALL ENROLLED MEMBERS, N=99				
Number of claims	1150	1081	69	-6%
Cost of claims	$2,453,471.43	$1,829,513.81	$623,957.62	-25.4%
ENROLLED MEMBERS WITH ED VISITS, N=90				
Number of ED claims	298	167	131	-44%
ENROLLED MEMBERS WITH IP VISITS, N=98				
Number of IP claims	265	204	131	-23%

Table 1

that helped members take charge of their health and drive improved outcomes when they are discharged from the hospital.

The multidisciplinary team included a care transitions coach, community health worker, registered nurse, and a licensed clinical social worker, all with oversight from the medical director. Program groundwork included scripting outreach, creating program workflows, establishing an outreach cadence, and hosting weekly interdisciplinary team meetings. Hospital bedside visits established rapport with patients prior to discharge.

During the initial home visit, discharge instructions were reviewed, and participants received assistance scheduling followup provider appointments. They also received and were taught how to use a blood pressure cuff, a scale, and a blood oxygen saturation measurement device. Data from the devices were recorded on a clinical log that the nurse reviewed with participants each week for the first month of the program and monthly thereafter. The team also reviewed patients' medications and assisted participants with obtaining medications as needed. Social drivers of health (e.g. housing, utilities) were assessed, and participants were connected with resources. Educational tools addressing smoking and alcohol cessation, exercise, and diet were tailored to meet participants' needs. Participants were educated on self-care management, which included methods to better manage stress, prioritize sleep and social connections, and identify accountability partners to help support regular physical activity.

Of the 738 dual-risk patients with CHF who had an inpatient or ED encounter during the project period, 324 met the inclusion criteria to participate in the CHF program. These members did not have barriers to program participation such as dementia, lack of a caregiver, active substance use, homelessness without contact information, or severe behavioral health conditions. A Plan-Do-Check-Act assessment was used to evaluate the program.

The Results

Ninety-nine members consented and were enrolled in the CHF program. Data from 28 months of continuous enrollment showed a 6% reduction in overall claims. Among enrolled members, 62 (or 63%) had decreased or no CHF-diagnosis related claims post-enrollment, and 37 continued to have CHF claims post-enrollment. The program yielded a 44% reduction in ED visit claims, a 23% reduction in IP

visit claims, and nearly $624,000 in cost savings between the pre- and post-enrollment periods *(Table 1)*. The program evaluation revealed that participants liked the end-of-program graduation calls and the graduation certificates that were delivered upon program completion. Additional participant feedback resulted in reducing program duration from 18 to 12 months, a change that did not impact outcomes. To ensure appropriate referrals to the CHF program, it was essential to educate and clarify program eligibility with clinicians and care teams who initiate the referrals.

The Conclusion

A patient-centered CHF TOC program resulted in reduced CHF readmissions and ER encounters and a high degree of patient satisfaction, all critical outcomes in value-based care settings. This program can address critical care gaps, reduce costs, and enhance satisfaction for increasing numbers of vulnerable patients with CHF.

REFERENCES

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