FloridaMD
JANUARY 2018 • COVERING THE I-4 CORRIDOR

Central Florida Inpatient Medicine

Hospitalists Shifting the Paradigm to Meet Patients Needs

Central Florida Inpatient Medicine

Hospitalists Shifting the Paradigm to Meet Patients Needs

By Katie Dagenais

In the past decade the role of hospitalists has evolved, from a role once focused on working with patients solely in inpatient facilities to the role of integrated caregiver in multiple locations helping patients to transition from one location to the next and navigate today's healthcare landscape. Today, the 135 providers of Central Florida Inpatient Medicine (CFIM) work with primary care physicians, hospitals, acute care facilities and skilled nursing facilities to ensure that patient care is coordinated with a single point of contact. Utilizing the latest in technology to streamline care, CFIM is at the forefront of shifting the hospitalist paradigm. Focused on collaboration, they strive to provide the best quality care for patients in an ever-changing healthcare world. The fastest growing specialty in the country, hospitalists are changing the way care is delivered throughout the country. At CFIM, currently based in nine hospitals and over 45 post-acute centers across three different hospital systems in Central Florida, shifting the paradigm isn't a cliche, it's a new approach to hospital medicine that is changing patient care to meet ongoing needs in a variety of environments.

Founded in 2001, CFIM is the largest private Hospitalist, SNFist and Transitional Care group in the state of Florida. Their hospitalist services are provided at more than 8 area hospitals in Central Florida and their skilled nursing program takes place in more than 45 post-acute facilities. Last year alone, CFIM practitioners managed more than 75,000 discharges and annually they tally 300,000 patient encounters.

Prior to the introduction of the Affordable Care Act healthcare was being practiced in various silos. The Hospitals and Skilled nursing facilities had laser like focus on what was happening with their patients within the four walls of the institution. As Value Based Care was introduced through the ACA, the focus shifted more toward quality rather then quantity. New terminologies in medicine such as Transition Care and Integrated Care came to the forefront. Each institution and the healthcare providers in those instisutions were responsilbe for the quality of care provided not only during that stay but also needed to ensure the healthcare needs of its patients were going to be met until they could transition safely back to the community.

With the rise in increasing number of physican groups who were responsilie not only clinically but also financially for delivering healthcare to their patients, the preexisting silos had to be taken down. Hospitalist seemed to be the missing part in bridging the information and clinical gap in the community. CFIM set out on a mission to create an organization that could help fill in the gaps.

"When the Affordable Care Act started focusing on quality rather than quantity, healthcare was in a silo. The focus was on hospitals and not beyond those four walls," explains Krishan

Caption.

PHOTO: DONALD RAUHOFER / FLORIDA MD

Nagda, M.D., President and CEO of CFIM. "One of the big shifts is that now each provider is responsible for patients outside of that setting. It is our responsibil-ity as hospitalists that for the next 30 days the patient has the tools that will help them stay at home and not return to the hospital. Our group plays a critical role in creating an integrated delivery model which includes everything from inpatient services to home health services to hospice services. Patients can't do it alone and we are their navigators."

PHOTO: DONALD RAUHOFER / FLORIDA MD

Caption

VALUE BASED CARE LANDSCAPE

Central Florida Inpatient Medicine has been actively observing the landscape in healthcare as it continues to evolve and create different programs from Accountable Care Organizations (ACOs), Managed Service Organizations (MSOs) to Bundled Pay-ment Models. With this shift in care, CFIM has added experts in each of these fields to their team. The Chief Quality Officer for CFIM, Cardiologist Dr. Lillian Alevato's role is to coordinate the whole circle of care as she comes from a group who were trailblazers in the Florida MSO world. Dr. Alevato is knowledgable from the Primary Care arm and understands the importance of population health management strategies by bridging the gap between PCP and Hospitalist.

"We are the acute and post-acute providers with a transition of care component. The primary care physician (PCP) cannot be everywhere, so as Hospitalists and SNFists we can coordinate patient care in an optimal way as an extension of the PCP. We are not operating in isolation and always keep our lines of communication open with the patient's PCP and Specialists. Our goal is to keep the patient in the same circle of provid-ers to increase quality of care."

Value Based Care has also increased the exchange of big data analytics to provide support for clinical decisions. CFIM has created technology allowing partners to follow their patients throughout their continuum of care while capturing the data to optimize care and increase communication. Keyur Gohel, Director of Network Development is responsible for managing and interpreting data at a rapid pace to identify any trends which can contribute to Central Florida Inpatient Medicine's commitment of where quality meet care. "The patient is at the top of every-thing we do," explains Keyur Gohel, Director of Network Development. "Our focus is that everything related to a patient's care needs to be driven clinically by utilizing data appropriately. That's where we work to do the right thing for the patient. It's all about collaboration with other healthcare providers and sharing data. Our goal is to make sure all parties are on the same page coordinating patient care."

The coordination often begins inside the hospital, then continues after discharge.

"When a PCP hands off a patient to our practitioners we coordinate that care and continue to monitor that patient. We do a lot of coordination with the PCP office," says Dr. Nagda. "A patient is with a PCP their whole life, they are with us sometimes just five days. We want to ensure they feel comfortable and we do that by providing a trusted voice. A voice that can help them navigate through the hospital, their PCP, their specialist and their health plan."

That single point of contact is a new shift for health care that CFIM makes sure their pa-tients have, every step of the way.

"The Affordable Care Act has changed the way healthcare is delivered," explains Dr. Nagda. "For patients, having that single person who can be there for them for the next 30 days, that is a shift that hasn't been there before. If you look back at the way things used to be done, providers operated in silos. The primary care physician rarely knew what happened in the emergency room or the nursing home. We are in a key position to be the bridge and that single point for patients to call. It's our role that

Caption

PHOTO: DONALD RAUHOFER / FLORIDA MD

when patients make that call, we know what is happening with the patient's care and we can take action. Everything is being refined to have a short and long term positive impact for the patient."

CONNECTING PATIENTS - CARE CONNECT

One of the tools CFIM uses to keep that connection with patients is their Care Connect program. The telephonic, clinical outreach program is staffed by experienced registered nurse navigators. The nurse navigators offer clinical guidance and education, ensuring patients have a smooth and successful transition, often from the hospital to home. This program weaves in the Primary Care Physician to provide optimal care for those who may be at high risk of returning to the hospital.

PHOTO: DONALD RAUHOFER / FLORIDA MD

Caption

Helping patients is three-fold explains Dr. Nagda.

"From post discharge follow up, to medications, to providing a single health care point provider, we work with patients to help them heal in the best environment possible and avoid readmissions."

CFIM's Care Connect Program provides patients with unprecedented individualized care, tailored to the patient's specific needs. For patients who either can't schedule a follow up with their PCP, or don't have a PCP, Care Connect offers an at home option. Appointments with a CFIM practitioner are scheduled in real-time for an in home physi-cian visit within 7 days.

At the first Care Connect provider visit a full in-person medication reconciliation is com-pleted to ensure the proper medications and dosage are being taken. Nurse navigators also work to ensure that ancillary services are met, such as home health and durable medical equipment needs that may arise.

I-MED THE GAME CHANGER

CFIM tracks and coordinates care through I-Med, their proprietary technology that helps to drive operational, clinical and financial benefits. This is a successful tool which increases physician to physician engagement to keep patient care front and center.

The platform is called I-Med," explains Dr. Nagda. "It's a big differentiator in communication. We customized this because each entity looks at things differently. The I-Med software allows shar-ing of the same data from different view points, so we can start to make decisions about where care is being provided and bridge a patient's transition from pre-hospital, to hospital and back home. We are excited about the ability these tools are giving us to standardize our communication and share information between different providers and different hospital systems."

Streamlining patient care is one of CFIM's differentiators and also one of their continued challenges for the future.

"One of our goals is to obtain more information about the patient when they are hospitalized," says Dr. Alevato. "There are a lot of complications and at times a delay of care because providers do not always have full access to a patients health record, which is important if they have not consistently seen a PCP. Our objective is to ensure we have full access to things such as X-rays and post acute records to optimize care."

The next evolution of hospitalist medicine will rely on continued engagement according to Dr. Nagda. "I think that the message is hospitalists have been very positive but the experience hasn't been standardized for everybody. Some communication issues will exist, the exciting part is that with integration of technology those issues can improve. For example, we try to call doctors but PCP's have a very busy practice. They need information at their fingertips when they have the time to access it. We need to not just push information but allow the PCP to pull information when they have time."

"The evolution of hospitalist medicine depends on how the hospitalist will continue to be part of the the community and integrated care rather than a siloed piece," Dr. Nagda adds. "We want and need to be engaged with the PCP's and the care on both sides. Ultimately this sharing of the information will drive down costs and improve quality and care for patients. This is the next evolution of hospital medicine." ■