The Extensivist Clinic: Role in Value-Based Care

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Changing the way care is provided to patients who are the sickest and require the costliest treatment... offers the greatest opportunity for improving the population’s health and for reducing the cost of health care.

High-Need, High-Cost Patients

Top 5% account for 49 percent of overall U.S. healthcare spending

Breakdown of the “High-Need, High-Cost” Patient

11% last year of life

40% persistent year to year high costs

49% discrete high-cost event

What is the Biggest Source of Spending among High-Need, High-Cost Patients?

Acute care makes up more than 55% of the costs for this population.


Inpatient costs were the primary driver of expenditures for terminal illness decedents (up to 70%).


Acute hospitalization is the largest component of Medicare spending (48%) for patients with advanced cancer.

The Economics and Reimbursement of Congestive Heart Failure

Fig. 2.4 Costs for heart failure in the United States (2009). Costs for heart failure in the United States by type of service.

Post-Hospital Syndrome

An acquired transient period of vulnerability ...that might derive as much from the physiological stress that patients experience in the hospital as they do from the lingering effects of the original acute illness.

Post-Hospital Syndrome

Sleep deprivation/disturbance

Nutritional deficits

Deconditioning

Cognitive overload

Hospital 30 day Readmissions: 2007-2009

CHF: 24.8%; median 12 days
MI: 19.9%; median 10 days
Pneumonia: 18.3%; median 12 days


A Culture of Hospitalization

Limited options for acutely ill patients

The “Fee-for-service” model

The Hospitalist movement
  Hospitalist
  Primary care providers
What is an “Extensivist Clinic?”

Clinic for recently discharged hospital patients
(Post Acute clinic)

Disease specific clinic to help manage chronic illness

Clinic for those at risk of hospitalization
Extensivist Clinics: Do they Work?

(+): Extensivist clinic decreased LOS, lowered readmission rates and resulted in below average inpatient utilization in high-acuity population


(-): Post-discharge clinic readmission rates no better

36% PCP: LOS:6.2 appt: 13.7 days readmit:9.4%
53% Urgent Care: LOS:5 appt: 9.4 days readmit:11.1%
11% Post-Discharge: LOS:3.8 appt: 5 days readmit:13%

The HMG Extensivist Clinic

Complex hospital follow-ups/Transition of Care

Disease Management of High-Need, High-Cost patients

A care venue comparable to a general medical floor of a hospital, but without beds or overnight stays
Case Study #1: Pneumonia

90 year old farmer with bilateral pneumonia, newly diagnosed atrial fibrillation, nausea, vomiting, acute renal injury & mild delirium

Pneumonia risk (CURB-65) score: 3
   2 or higher recommended for inpatient admit, possible intensive care unit

Pneumonia Severity Risk score: 131
   >90 should usually be admitted, >130 consider ICU care
The Patients

Filtered to the capabilities of the clinic

Given a choice of care site

Must have social support

High-Need, High-Cost

- End of life
- Chronically ill with persistently high costs
- Discrete high cost individuals
Extensivist Clinic Staff

Physicians
Hospitalists/Extensivists

Nursing
Registered Nursing
ER/ICU background
Case managerial skills
Pharmacy skills
Clinic Infrastructure

- Cardiac & Respiratory
- Radiology
- Proximity to Referrals
- Phlebotomy
- Pharmacy

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Case Study #2: Acute Pancreatitis

66 y/o male with 2 prior hospitalizations for pancreatitis presents with abdominal pain

Day #1: diagnosis, IV fluid, pain and nausea control
Day #2: IV fluid, pain and nausea control, outpatient MRCP
Day #3: IV fluids, diet resumed and released to PCP
Patient Access

Referrals from:
Primary Care Provider
Specialty Care
Urgent Care

Hospital and ER follow-up
Care Managers
Home Health Nursing
Disease Management
Extensivist Clinic Limitations

No ICU care
No ischemic events
  - Chest pain/myocardial infarction
  - TIA/Stroke
No nocturnal care
When Care Needs Exceed the Extensivist Clinic’s Capabilities

20% of patients deemed hospital level ultimately require hospital admission

- Clinical deterioration or need for higher level of care
- Lack of social support
- Patient or family misgivings

Direct patient admission bypassing ER

- Avoids duplication of services
- Patient dissatisfaction with ER stay
- Minimizes ER congestion
Hospital Illnesses Successfully Treated

COPD exacerbation
Respiratory failure (non-ventilator)
Acute bronchitis/asthma
Pneumonia, Bronchiectasis
Early sepsis, Bacteremia
Acute renal failure
Nausea, vomiting, dehydration
Atrial fibrillation with RVR
Acutely decompensated CHF
Recurrent ascites and pleural effusions

Cellulitis failing oral antibiotics
Ileus
Pancreatitis
Hypokalemia, Hyponatremia
Symptomatic hypercalcemia
Hyperkalemia
Colitis, Diverticulitis
Pyelonephritis
UTI requiring IV treatment
Diabetic ketoacidosis
Neutropenic fever
Case Study #3: CHF Exacerbation

81 y/o male CKD, DM2, HTN, CABG, CHF EF 40%, baseline weight 201 lbs. presents with shortness of breath, SpO2 85% and 216 lbs.

Three consecutive days of aggressive daytime intravenous diuresis. Discharge weight: 201 lbs

Total episodic cost: $975.94.
-Humana claims data

Average CHF hospital cost per stay: $10,400.00

HCUP Facts and Figures: Statistics on Hospital-based Care 2009, Exhibit 4.1 Cost by Diagnosis.
Financial Considerations

Fee-for-Service

Office codes & Infusion codes
Not run on volume or production

Break even: 2 registered nurses, 1 hospitalist,
5 rooms, Monday-Friday 8am-8pm
10.5 patients a day

Value-Based Payment

Risk-based contracts with private insurers
Medicare’s Shared Savings
Not all contracts offer risk sharing or capitation
Not all patients are attributable
Other Considerations

Symbiosis with Urgent Care
Broadens acuity level and care capacity of Urgent Care
Urgent Care is the primary source of Extensivist referral
Urgent Care provides radiology and laboratory services

Mid-level providers
Robust referral source
Extensivist Clinic offers secondary oversight
Conclusions

Clinical care appears equivalent, if not better, than care provided within the hospital setting for the subset of patients treated.

Patient satisfaction is extremely high.

Reward in value-based contracting is present and continues to grow as payers recognize cost savings, MACRA is implemented and alternative payment models proliferate.

The Extensivist Clinic offers an alternative venue for the High-Need, High-Cost patient, which is significantly more cost-effective than the hospital.
A Hospital’s Perspective

Keeping beds at capacity

- Decreasing length of stay front end back end
- Decreasing readmissions
- Minimizing low reimbursement admissions and raising case mix index
- Decreasing ER congestion
“The solution to the cost problem in hospitals is not efficiency within that business model.

Rather, significant improvement will come only through the creation of fundamentally focused business models that in the end are highly disruptive to the present profit formulas of general hospitals.”

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