Institute for ACCOUNTABLE CARE

The Holston Medical Group Extensivist Clinic: Delivering Hospital-Level Care in an Ambulatory Setting

January 2019

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Dr. Chris Neglia is a hospitalist physician and a co-founder of the Holston Medical Group's Extensivist Clinic in Kingsport TN. Rob Mechanic is Executive Director of the Institute for Accountable Care and Senior Fellow at Brandeis University. The Holston Medical Group is an independent multi-specialty physician group with more than 150 primary care physicians, specialists and mid-level providers, serving Johnson City, Kingsport and Bristol Tennessee and surrounding communities in Northern Tennessee and Southern Virginia.

Rob Mechanic: Today, I'm speaking with Dr. Chris Neglia of the Holston Medical Group. Dr. Neglia has established a unique program that cares for acutely ill patients in an ambulatory setting even though their illnesses would qualify for an inpatient hospitalization.

Rob Mechanic: Dr. Neglia thank you for being here. Tell us about your Extensivist clinic?

Chris Neglia: Thank you for having me. The Extensivist clinic is staffed with hospitalists who are physicians that traditionally manage patients inside the hospital. Rather than seeing patients in an inpatient setting, our physicians they work in a freestanding outpatient clinic. The clinic also employs experienced registered nurses (RNs) who have worked in emergency departments and hospital intensive care units. We employ RNs because our nurses need to administer IV medications. They are more comfortable treating more ill patients than a regular office nurse. Our goal is to deliver as much medical care that we would traditionally provide in a hospital, outside the hospital setting.

Rob Mechanic: What is your background?

Chris Neglia: I'm a family physician but during my residency training I developed a fondness for hospital medicine, where people were more acutely ill. I went straight into hospital medicine when I completed my residency and I've been doing that since 2003.

Rob Mechanic: How is your clinic different from an urgent care clinic?

Chris Neglia: Our patients are much sicker and require much more time to treat. The Extensivist clinic is more like an emergency department or an observation unit where we're watching patients for hours to make sure there is improvement and not decline. The illnesses are much more severe and complex.

Rob Mechanic: What inspired you to start the Extensivist clinic?

Chris Neglia: The inspiration was Dr. Harlan Krumholtz's article in the New England Journal of Medicine where he coined the term "post hospital syndrome " which is the weakness or a vulnerability people develop outside of their illness, just by the fact that they're in an American hospital. In the hospital patients become physically deconditioned by lying in a bed all day. They frequently suffer from malnourishment because of the fasting required for lab testing and the rigid meal schedules. They suffer from sleep deprivation. And patients have what I call cognitive overload that is particularly stressful for elderly patients with dementia or cognitive decline. These frail patients may be completely functional in their home environment but get confused and agitated when they're in hospital setting.

Chris Neglia: Everything Dr. Krumholtz said just clicked with our hospitalist team, what he was saying wasn't necessarily new to us, but we finally had it down on paper that people coming to hospitals run into problems.

Chris Neglia: I'm proud to say, that that article came out in January of 2013, and we had our Extensivist Clinic up and running by May of 2013. Our goal was to manage as many hospital-eligible illnesses as possible without the hospital. We were trying to deliver the same care we would deliver in the hospital but within a more condensed timeframe whereby allowing the patients to go home, sleep in their own bed, and be in their own environment. That's how it got started.

Rob Mechanic: Walk me through what happens to a typical patient who comes to your clinic. What's it like for them?

Chris Neglia: We're not a hospital and so we're not ready for somebody coming in with a gunshot wound or a heart attack. We're also not a walk-in clinic. Patients are referred to us by nurses or doctors who are part of the Holston Medical Group. We discuss the patient's symptoms with them by phone before we accept a referral because we don't want patients that are beyond our capability to care for safely. We also don't want patients with simple problems who could be treated in an urgent care center.

Chris Neglia: Our triage system for referrals is designed to make sure the patient's condition is appropriate for the clinic. If they are, the referring clinician would give them the option of the clinic or the ER. Most patients opt for the clinic. When they get here, we do a work up similar to what I would do in the hospital. If they have pneumonia they get X-rays, blood work, antibiotics and IV fluids. And we monitor the patients closely for up to several hours.

Chris Neglia: After the treatment we re-evaluate the patients. If we feel they don't need further intervention and can go home safely, then they are discharged home with a return appointment for the next day. So a patient who might otherwise have a three-day hospitalization for pneumonia or heart failure would usually be seen in our clinic over three days. They receive the same treatments and diagnostics that they would get in the hospital. The only big difference is they go home at night.

Rob Mechanic: Do they need a family member to stay with them at home?

Chris Neglia: Well, not everyone gets to go home. We don't send home elderly patients without a family member or other responsible party to stay with them. And if I feel a patient is not stable or getting worse we strongly encourage the patient and her family to let us admit them directly to a hospital, bypassing the ER. It's akin to a hospital to hospital transfer. I'd request a bed and keep the patient in the clinic until their hospital bed is ready.

Rob Mechanic: You mentioned pneumonia, but what the other conditions do you commonly treat in your clinic?

Chris Neglia: We treat lots of patients with congestive heart failure or volume overload. The patients often need supplemental oxygen because their heart and lungs are full of fluid and they can't breathe. We treat them just the same as we would in the hospital, with IV diuresis and we arrange for supplemental oxygen be delivered when they go home that night.

Chris Neglia: We treat infections that have outstripped oral antibiotics. Infections of the skin (cellulitis), urinary infections, conditions like polynephritis, that needs IV fluids, IV antibiotics and further evaluation. Diverticulitis or colitis in patients who can't keep fluids or oral antibiotics down.

Chris Neglia: We get patients with atrial fibrillation that's has a rapid ventricular response, which is a common hospital admission. We slow it down with IV medications. We have the same medications as the hospital in our clinic and telemetry monitors where we monitor the heart rates until they slow down.

Rob Mechanic: How many patients would you see in a typical day?

Chris Neglia: Usually eight to 12 patients is a typical day because you're spending hours with these patients. Hospitalists would typically manage about 15 patients a day in the hospital.

Rob Mechanic: So the clinic treats about 2,500 encounters over the course of a year?

Chris Neglia: That sounds about right. But fewer unique patients because many of them are in the clinic for multiple consecutive days?

Rob Mechanic: So you're providing very intensive oversight of patients but in an ambulatory setting. How do you make the finances work?

Chris Neglia: It's tough. We figured out that with one hospitalist physician and two RNs our break even under fee-for-service is about 10.5 patients a day. We bill for professional services and don't receive a facility fee. We do bill for infusion codes and several other things but you're doing the work of a hospital in a clinic so there is a fair amount of expense. The goal is to break even on fee for service patients. I believe we deliver better patient care, but the way we justified it financially is that there is a lot of opportunity generate margin under value-based contracts. We have some contracts where we accept full financial risk. When we treat a patient with congestive heart failure for three or four days, we would generally be paid less than $1,000 dollars by a private managed care plan. If we treat the patient in the clinic and save a hospitalization we save a lot of money.

Rob Mechanic: Has the Holston Medical Group been able to get good value-based contracts?

Chris Neglia: It's been a struggle. I'm not involved in the financial end, but I know that a lot of the insurers, up until this point haven't been willing to engage in risk-based contracting. HMG has been pushing the payers to give us value-based contracts and some are coming along. We have been successful in the Medicare Shared Savings Program. But the extra reimbursement comes back 18 months later. One of the difficult things with the Extensivist clinic is quantifying what am I saving our group by avoiding these hospitalizations? It's not as clear cut as measuring what you generate in fee-for-service.

Rob Mechanic: Does the hospital view the clinic as a threat?

Chris Neglia: I don't think so, mostly because the patients that we're seeing are not their big money generators. I'm not taking away orthopedic surgeries or cardiac catheterizations. I know of some hospitals that have started their own Extensivist clinics to help them discharge patients faster to cut their length of stay.

Rob Mechanic: What challenges have you run into?

Chris Neglia: There are two big challenges that I see. Number one, you touched on already. To be successful financially you need value-based contracts. The other challenge is creating a culture that utilizes the Extensivist model. It's just easier for a lot of doctors to send the really sick patients to the ER. For me, the greatest challenge is creating a culture of keeping patients out of the hospital if we can do it safely.

Rob Mechanic: Do you have plans to expand the model?

Chris Neglia: Up to this point, our Extensivist clinic has been a reactive model. We are treating sick patients because that's what we've been doing all along as hospitalists. We want to start building a proactive model similar to CareMore or David Meltzer's Comprehensive Care Physician Model, where we focus on the sickest of sick patients, managing their illness on an ongoing basis so their condition doesn't decompensate. So proactively managing them so they need the hospital or the Extensivist clinic.

Rob Mechanic: That's exciting. I know you've had a lot of interest in this model from other groups, and particularly from ACOs. If a group comes to you and wants to stand up this type of a clinic, what advice would you give them?

Chris Neglia: The most important thing is building that culture within your group to utilize this model because it outside of some providers' comfort zones. The actual infrastructure is straightforward. We have regular office rooms with reclining chairs, a half-dozen IV antibiotic choices and several heart rate controlling medications. So, the startup costs aren't high.

Chris Neglia: You still need to find hospitalists who are willing to step out of their comfort zone and work in an office. But good internists and ER docs could also do well in this model. Getting the right nurses is really important. Extensivist nurses need some case managerial skills, because they're setting up things that are normally managed in the hospital by case managers. The nurses need to have some pharmacy experience. We don't have a pharmacist to mix some of our medicines so our nurses are doing that. But the most important things are the value-based contracting and creating a culture of hospital avoidance.

Rob Mechanic: Dr. Neglia, congratulations. I think your approach is really the direction that healthcare needs to move. Thank you for talking with me today.