



Ellis Hospital – Schenectady, New York

Improving Care through Collaboration on a “Health Home” with Hometown Health Centers and Visiting Nurse Service of Schenectady and Saratoga Counties

Overview: Ellis Hospital, part of Ellis Medicine, provides emergency, inpatient medical/surgical and psychiatric care. The 350-bed facility features state-of-the-art diagnostic imaging, a modern 44-bed Intensive Care Unit and one of the most advanced health information technology systems in Northeastern New York. Ellis Hospital’s medical home provides full primary care and outpatient services for the entire family—all in one convenient location.

Hometown Health Centers (HHC), which is the only not-for-profit, federally qualified health center in Schenectady County, has set a standard for quality health care in the community. HHC offers its patients obstetrical care, pediatric medicine, family medicine, gynecology, podiatry, mental health and comprehensive dental services. For nearly 40 years, HHC has proudly been the primary care provider of choice for more than 15,000 local children and families.

In November 2006, the Berger Commission, a New York State Commission on Health Care Facilities in the Twenty-first Century, recommended the closing of nine hospitals and the downsizing of 48 hospitals throughout New York state. As a result, Bellevue Hospital and St. Clare’s Hospital, both of Schenectady County, closed their doors. Ellis Hospital consolidated the three hospitals in nine months—making it the area’s sole health care provider as of June 2008. Many residents had been using St. Clare’s emergency department for primary care. Ellis leaders were faced with the question: How do we best serve the indigent and uninsured? It became clear that better access to primary care was needed. Thus, Ellis worked with community leaders and developed a medical home and later, a health home.

Two Medical Homes, Two Models

In 2008, Ellis launched a medical home at its Ellis Health Center (EHC) campus. This initiative was connected with community-wide resources, such as the YMCA/YWCA, a homeless shelter, and HHC. The Ellis medical home provides primary care, pediatric care, dental care, mental health services, and outpatient services—all on one campus. Two patient navigators link patients to the services they need; transportation and scheduling services also are provided.

HHC is a clinic-focused medical home, offering pediatric, adolescent, adult, geriatric, perinatal, family planning, dental, social work and pharmacy services. The practice has one navigator, who was cross-trained with the Ellis navigators. In 2012, HHC was officially recognized as a Level-3 Patient-Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA). That is, HHC has achieved the standards for enhanced access and continuity, managing patient populations, and planning and managing care.

Together, and with other community partners, the medical homes provide high-quality care for a great many medically underserved children and adults. But community leaders realized that care coordination could be even better.

One Health Home: Care Central

In June 2010, the Visiting Nurse Service (VNS) of Schenectady and Saratoga Counties (affiliated with Ellis Medicine) held a strategic-planning retreat with community partners. Community members identified fragmented care as the #1 problem, with too many patients falling through the cracks. The

group decided that one organization should coordinate care, and Care Central, a “Health Home” concept, was born.

The goal of the Health Home is to keep the community healthy by providing a virtual “home” where people can get personalized care through access to and coordination of a comprehensive and continuous array of medical and community support services. This includes doctors who emphasize primary and preventive care, mental health providers, case managers for people with complex needs, community support organizations such as housing providers, an improved hospital discharge process, a “Field Team” to see patients in their homes, a “Central Team” of doctors, nurses, pharmacists, and other clinicians who are available 24/7 to answer questions by telephone, and “Navigators” to help people figure it all out. The program started with Medicaid patients who have complex health needs, such as multiple chronic conditions or mental health issues.

The Health Home is not a physical place, but rather is a coordinated set of services. Many services, such as the 24/7 “Central Team” and the “Navigators” will be primarily accessed by telephone (or other electronic means), while the “Field Team” by definition sees people in their homes, and the discharge process starts in the hospital. Depending on patient need, however, a “Central Team” doctor might make a home visit, while a “Field Team” home aide will likely make initial contact in the hospital before discharge. Although Health Home services will be delivered by many people and organizations, all will be tied together through a secure electronic Community Health Registry which will track each patient’s medical and community services, ensuring personalized, coordinated, and continuous care.

Care Central is led and administered by VNS, where an employee has been hired to manage day-to-day operations. Six navigators have been hired to provide 24-hour availability. They will identify and “bring on board” roughly 2,000 patients to participate in the pilot program. The patient-enrollee list is expected to be completed by the end of 2012. Ellis has established targets for number of enrollees, number of assigned to care managers, number of encounters, number of hospital admissions of enrollees, readmissions, partnering providers, and cost savings. VNS applied for funding from the New York Department of Health in September 2011 and received approval in December 2011 as one of New York’s first certified Health Home.

Impact: Due to the economy and a shortage of primary care physicians, ED visits are still on the rise. However, the medical homes are having a positive effect. From 2009 to 2011: primary care visits to EHC’s Family Health Center increased from 35,083 to 42,998; visits to the Pediatric Health Center increased from 13,456 to 15,042, visits to the Outpatient Adolescent Mental Health Program increased from 1,707 to 5,660, and visits to the Dental Health Center increased from 9,432 to 13,668.

As the Health Home is implemented, patients will benefit by receiving personalized, coordinated, and continuous medical services (for example, their primary care doctor will be notified if they are treated in the ED) which are linked to community services (such as involvement of a housing provider if mold in a patient’s home is causing asthma attacks). In addition, patients will have 24/7 telephone access to a medical team, reducing the need for an ED visit when health concerns can be resolved over the telephone.

The Health Home should improve patient care while reducing duplicative or unnecessary spending. With a comprehensive patient record maintained in the secure Community Health Registry, medical providers will be able to see which medical tests or images have already been given and can avoid duplication. Coordination between medical and community services may prevent the need for healthcare, such as helping a patient with diabetes improve their diet at home, reducing the need for an emergency intervention. And the 24/7 telephone access will empower patients to resolve health concerns themselves, reducing ED crowding and costs. Coordination of community social services with the primary care services of physicians and medical homes will also ensure that patients receive continuous, coordinated care that will help sustain their health and well-being in the community.

Challenges/success factors: Interaction among the community partners is open, transparent, and collaborative. Jim Connolly set this tone starting in 2008, leading the process to engage community partners to improve access to care for the area's indigent population. Ellis leaders host quarterly meetings at the Ellis Health Center for approximately 25 leaders from partner organizations to share best practices and innovations, as well as discuss future areas of focus. On the front lines, navigators at Ellis Hospital and HHS maintain good communication with one another. These positive relationships have been instrumental in achieving buy-in from community leaders for the Health Home pilot project.

Future direction/sustainability: Although there is no set time table for the Health Home pilot project, Care Central services will eventually be available to everyone in Schenectady who has been hospitalized and then discharged from a hospital. Transitions in care will be the next focus for the Care Central partners. Ellis Hospital was accepted to participate in the Community Based Care Transitions Program. Its goals are to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program. Ellis Hospital will lead this 10-hospital, 10-county program. The demonstration will be conducted under the authority of section 3026 of the Affordable Care Act.

Advice to others: Before embarking on any pilot projects, make sure you have solid data on your readmission rates and potential areas for improvement. Build relationships with community partners such as social service agencies and other health care providers. Each organization brings special expertise to the table. The whole is greater than the sum of its parts; working together, you can improve the health of your community.

Contact: James Connolly
President/Chief Executive Officer
Ellis Hospital
Telephone: 518-243-4141
E-mail: connollyj@ellismedicine.org

Contact: Joseph Gambino
Chief Executive Officer
Hometown Health Centers
Telephone: 518-370-1441
E-mail: jgambino@hhhc.org

Contact: Joseph Twardy
President/Chief Executive Officer
Visiting Nurse Service of Schenectady and Saratoga Counties
Telephone: 518-382-8050
E-mail: twardyj@vnshomecare.org