A Hospital-Owned, Facility-Based Medical Home: Lessons from Ellis Medicine

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REINVENTING HEALTHCARE
ONE PATIENT AT A TIME

Topics

- Introducing Ellis Medicine
- Why we have a Medical Home
- Ellis Health Center (EHC) – Medical Home & Outpatient Services
- Transportation – Community Shuttle
- Navigators – Health Services & Community Services
- Community Involvement – Community Partners and Community Physicians
- Measures of Success
- Lessons

Introducing Ellis Medicine

- Located in Schenectady, New York
  - mixed urban/suburban/rural upstate county
  - 150,000 people, 60,000 in city, poverty pockets
- Current configuration formed 2007-2008
- Three hospitals (now the only acute care provider)
- Three primary care practices (the largest provider)
- Specialty care practices

As the sole provider of acute care, Ellis learned …

- **You can either wait for the patients to go to your Emergency Department**
  - Where they will get good clinical care
  - That is episodic in nature
  - And therefore lacks continuity in clinical management and is less effective
  - But is more expensive to provide

OR

- **You can provide more primary care**
  - Which encourages continuity of care and more ongoing clinical management
  - Which is more effective and of higher overall quality
  - And which is less expensive

Ellis MEDICINE

REINVENTING HEALTHCARE
ONE PATIENT AT A TIME

Ellis Hospital

Central location for inpatient and emergency care.

Bellevue Woman's Center

Location for inpatient OB/GYN services.

Ellis Health Center

Central location for outpatient services, primary and wellness care, and rehabilitation and long term care.

Medical Home

Ellis Health Center

EHC Medical Home

- Center for outpatient and primary/preventive services – easy parking, bus route
- Outpatient lab testing, state-of-the-art imaging (mammography, MRI, CT)
- Family Health Center, Pediatric Health Center, Dental Health Center (and Residencies)
- Outpatient mental health
- Retains 24/7 ED
- Navigators

EHC Outpatient Services

- Enhanced Day Surgery
  - Nearly 4,500 outpatient surgeries each year
  - From dental, general, orthopedic procedures, to ophthalmology, gastroenterology, otolaryngology
- Sleep Disorders Center
- Wound Care
- Infusion Therapy
- Diabetes Education
- Swallowing & Speech Therapy
- Nutrition Counseling
- Pain Center

Family Health Center

- Over 40,000 annual patient visits
- Site of Family Medicine Residency
- HIV grant program
- HepC grant program
- PCAP program
- Annual physicals
- Immunizations
- Sick visits
- Follow-up care
- Ob/Gyn care
- Specialty clinics

Pediatric Health Center

- Over 15,000 annual patient visits
- Check-ups
- Immunizations
- Sick visits
- Wellness care
- Hospital care
- Full care through every stage of growth and development

Dental Health Center

- Over 10,000 annual patient visits
- Moved to new, convenient, state-of-the-art first-floor location (handicapped accessible) in 2010
- Site of Dental General Practice Residency
- Teeth cleaning
- Fillings
- Extractions

Primary Care Visits

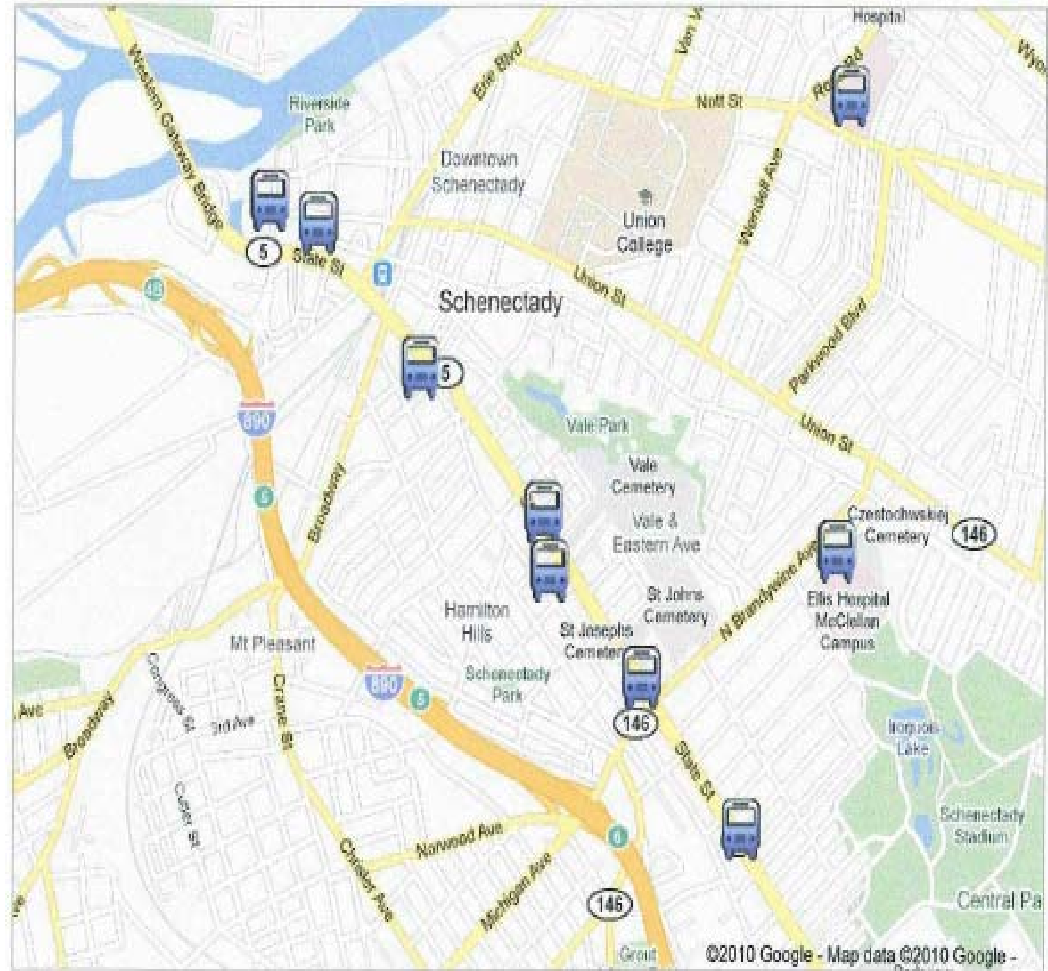
	2010 Visits	2009 Visits	% Change
Family Health Center	41,237	35,083	18%
Pediatric Health Center	15,454	13,456	15%
Adolescent Mental Health Program	4,642	1,707	172%
Dental Health Center	10,414	9,432	10%

Transportation

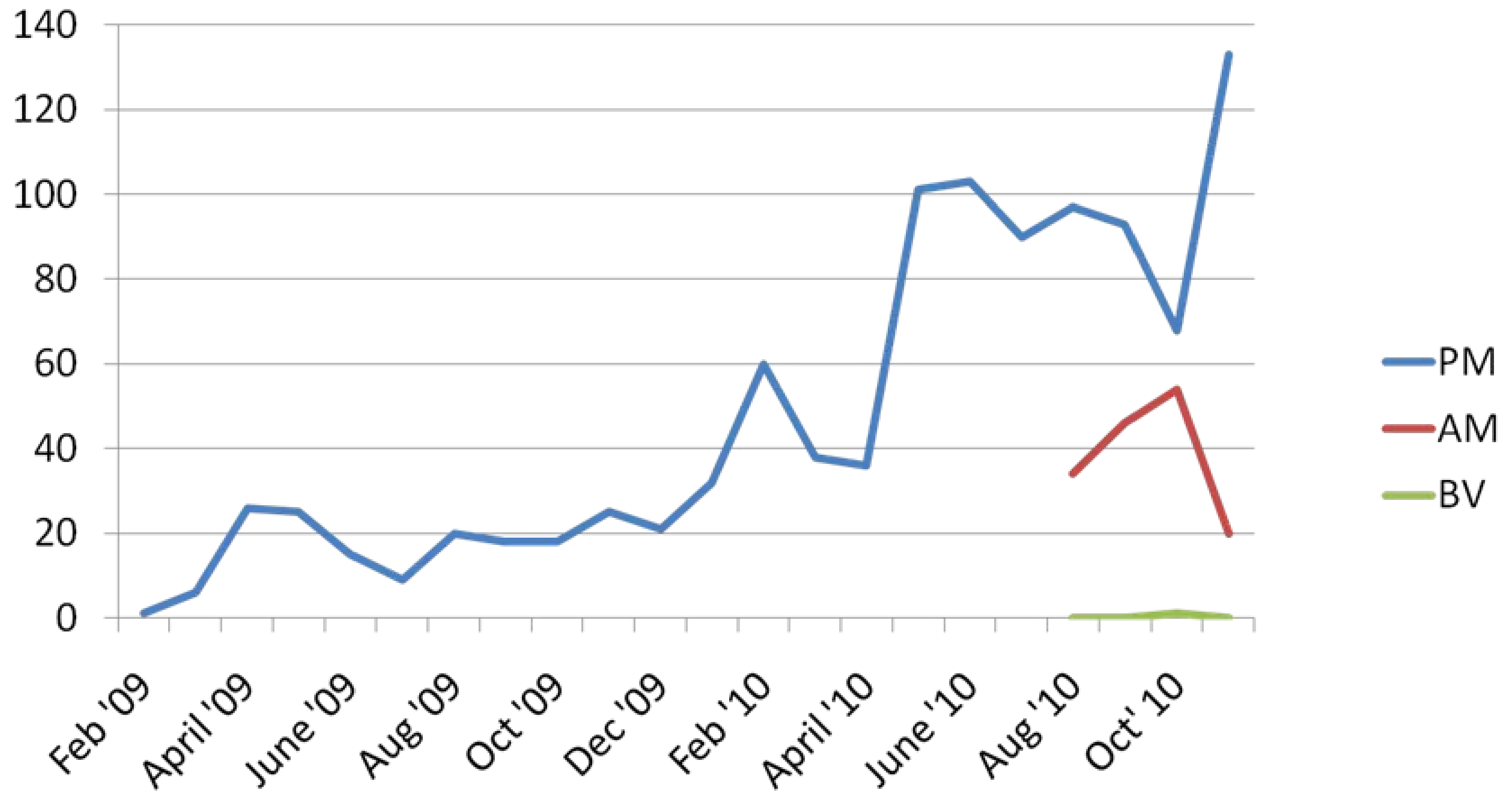
- **Free community shuttle van**
  - Runs twice-daily, Monday-Friday
  - Uses existing van, almost no cost
  - Pick-up at eight community partners
  - Deliver to EHC and Nott St.
  - Coordinates with appointments at
    Family, Pediatric, Dental Health Centers
  - Free bus token for return trip
- **Solves problem of lack of transportation**

Community Shuttle Stops

- Leave Ellis Nott St.
- YMCA
- YWCA
- Bethesda House
- Salvation Army & City Mission
- SCAP
- Collage
- Hometown Health
- EHC Campus
- Return Ellis Nott St.

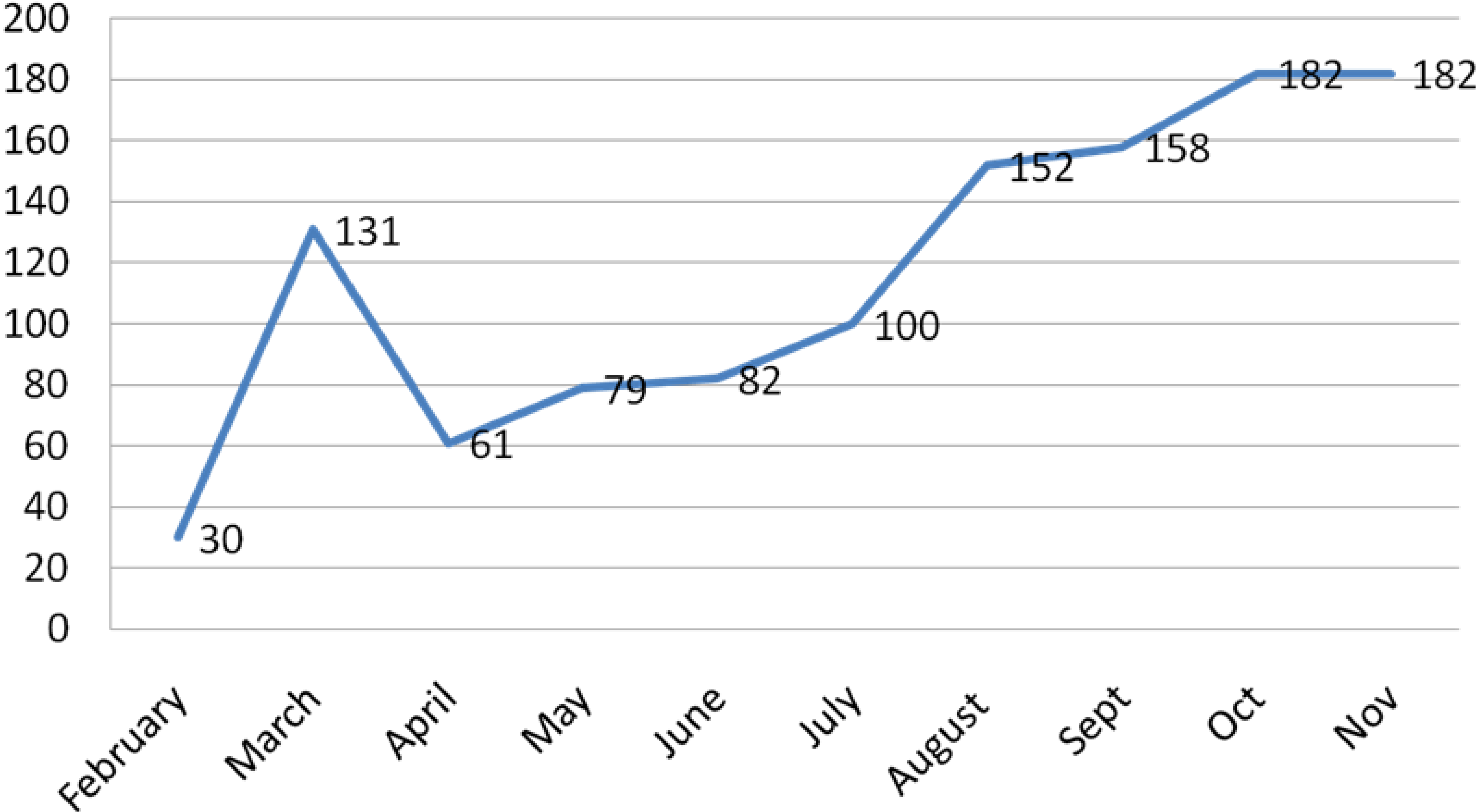


Community Shuttle Volumes



What is a Navigator?

- “An expert who helps you get where you are going.”
- Cornerstone of the program
- Health Services (Nurse) Navigators – R.N.s, public health and care management background
- Community Services Navigators – provided by Schenectady Community Action Program (SCAP)
- Started at EHC in summer 2009
- Elder Care Navigator in the future


Navigator Encounters
200
180
160
140
120
100
80
60
40
20
0
30
131
61
79
82
100
152
158
182
182
February
March
April
May
June
July
August
Sept
Oct
Nov

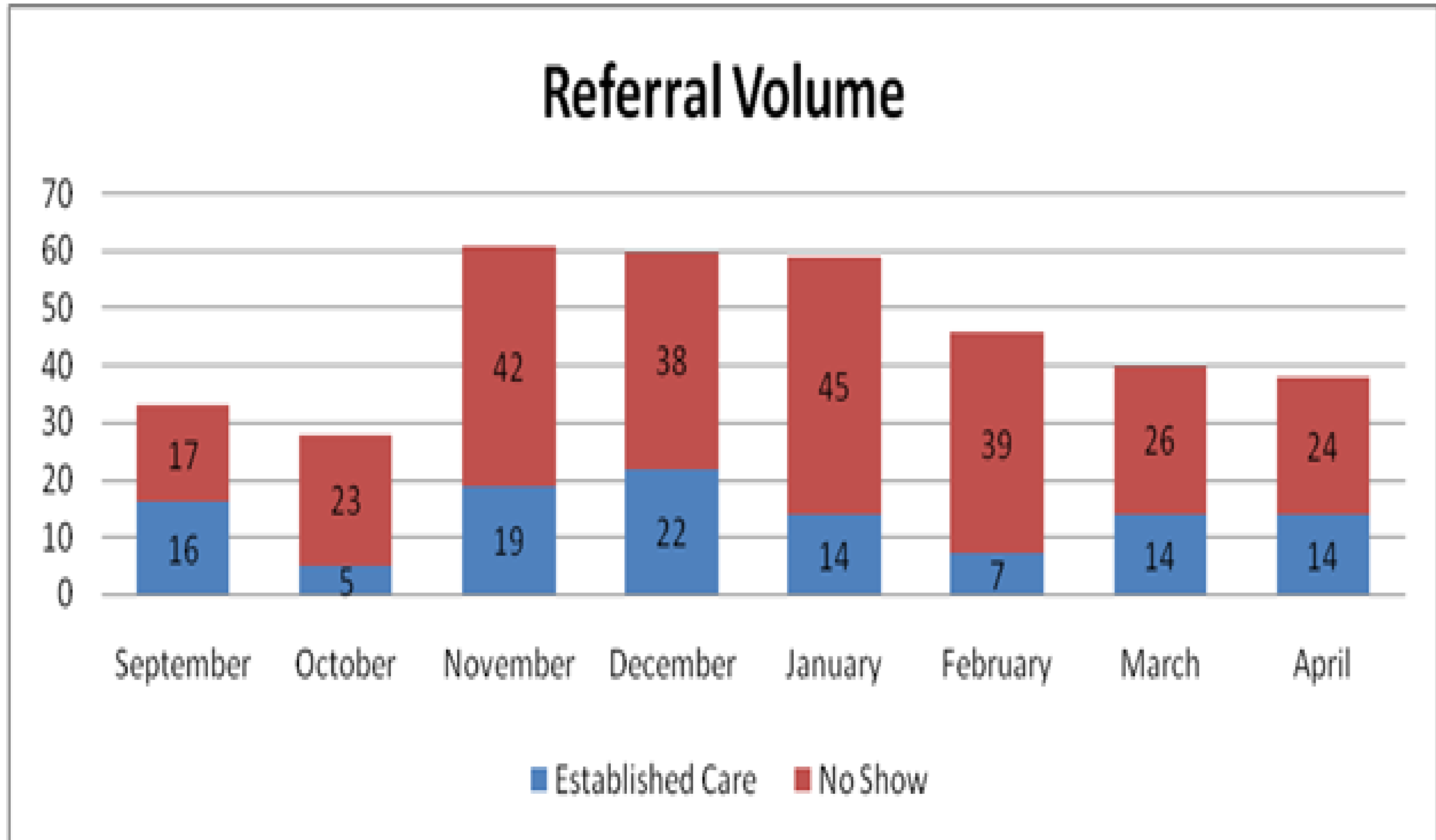
Follow up Phone Calls

- Navigators or facilitated enrollers affirmatively follow up with patients without insurance or primary care physician after ED visits
- Call each patient within 24 hours

Follow up Appointments

- ED at EHC directly makes Family Health Center appointments
  - For ED discharges which require primary care physician follow-up
  - If patient has no primary care physician, the ED makes a follow-up appointment with the Family Health Center before the patient leaves

Referring ED Patients for follow-up by the Family Health Center (Results of 8-month study)



Community Partners

- Bethesda House (homeless services)
- Catholic Charities
- City Mission
- Fidelis Care (facilitated enroller)
- Hometown Health (FQHC)
- Salvation Army
- Schenectady Community Action Program
- Schenectady Inner City Ministry
- Schenectady City School District
- Schenectady County Public Health
- YMCA
- YWCA

Involvement with Community Physicians

- Participate in screenings
- Accept referrals from Medical Home
- Participate in Primary Care Cabinet
- Jointly chose the EHR
- Provide specialty clinics

Screenings and Health Fairs

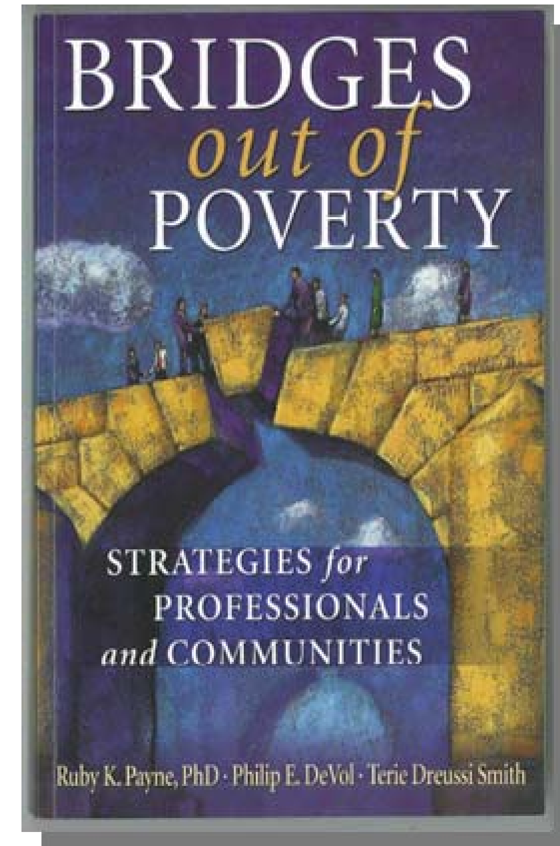
- Kindergarten screening
  - 114 kids, 10 partners
- Prostate screening
- Cervical/pap/breast exam screening
- Wellness Fair
- Women's Health Fair with the City Mission
- Farmers' Market

“Ready. Set. Kindergarten!”

- **Schenectady City School District** – kindergarten registration
- **Fidelis** – asked about insurance status
- **Dental Health Center** – dental exam, toothbrushes
- **Pediatric Health Center** – physicals, primary care appointments
- **Family Health Center** – physicals, primary care appointments
- **Schenectady County Health Services** – immunizations
- **SCAP** – Community Services Navigator
- **Health Services Navigators** – resources for other services
- **Ellis Medicine** – t-shirts, goodie bags
- **BOCES students** – babysat siblings

Community Education

- “Culture of poverty”
- Why primary care?
- ED avoidance for non-urgent/ primary care
- Medicaid enrollment meetings monthly with Fidelis



Other Current Projects

- NCQA Diabetes Certification
- CDPHP (local HMO) Medical Home Pilot Project
- Disease Management
  - Asthma
  - CHF
  - Diabetes
- NCQA Medical Home Certification
  - Now achieved for two **primary care practices**
  - Enhanced reimbursement

New York State's Medicaid Medical Home Incentives

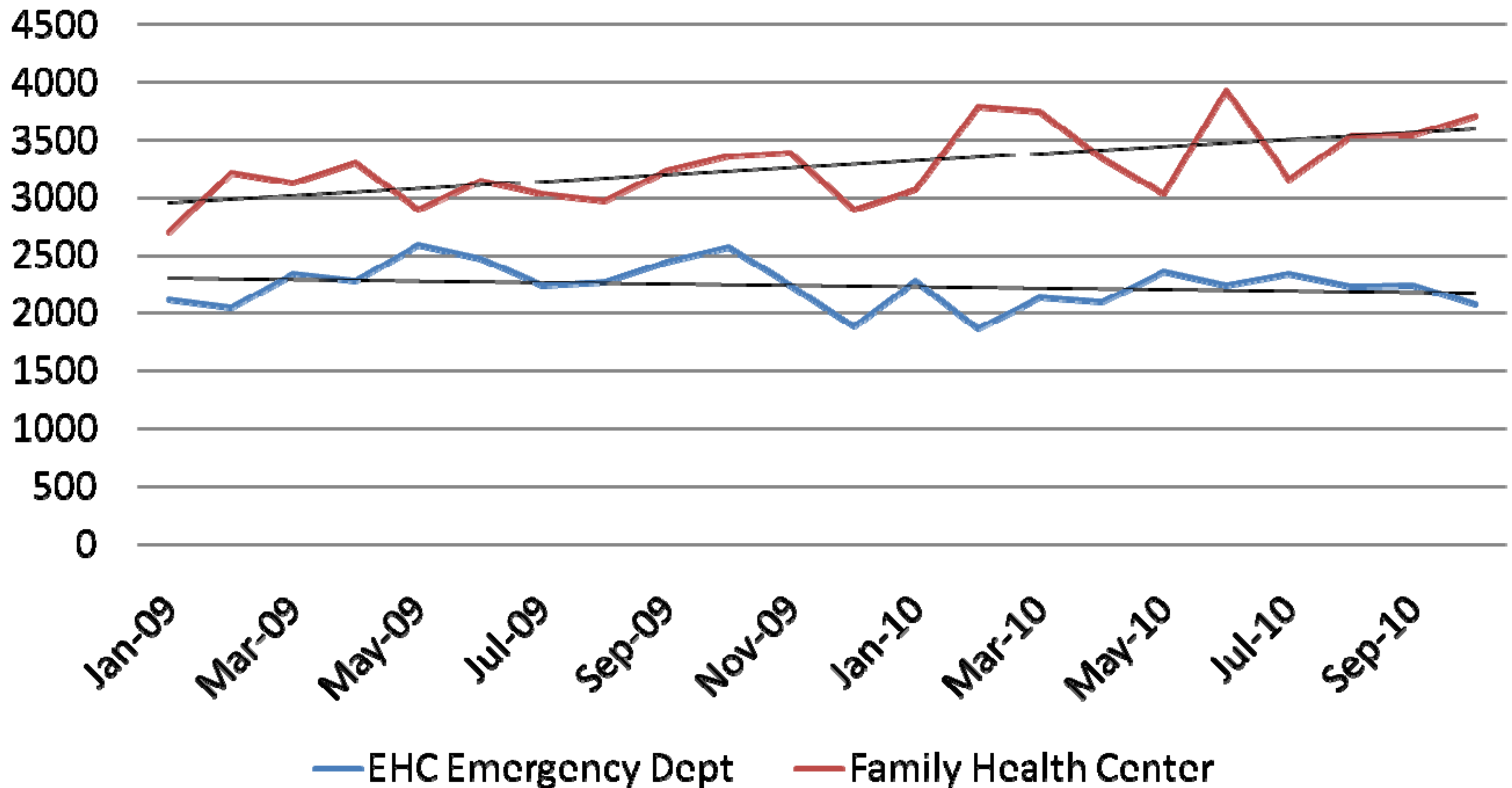
- Apply to office-based practitioners and primary care clinics recognized by NCQA
- Paid through eMedNY for Medicaid fee-for-service and as pass-through for managed care
- Effective July 1, 2010 for all managed care and for physicians/NPs/FQHCs fee-for-service
- Add-on rates:

Setting	Level 1	Level 2	Level 3
Clinics	$5.50	$11.25	$16.75
MDs/NPs	$7.00	$14.25	$21.25

Measures of Success

- Why does the Medical Home matter?
- Predict reduction in hospital admissions for target populations.
- Predict increase in optimal level of care for target populations as evidenced by adherence to national guidelines, such as NCQA for diabetes.
- Predict reduction in inappropriate ED use, with parallel increase in appropriate primary care.

The Patient Satisfaction & ROI Question:
Can we replace inappropriate ED visits with Primary Care visits?



2011 Goals

- Care management in primary care offices
  - Top 10% sickest using predictive modeling
- Implement EHR
- Formalize appointments for hospital discharged patients
  - Primary care physician appointment within 72 hours
- Additional NCQA accreditations
- Tools to better communicate with patients
  - Self-scheduling, test results
- Coordinate with Navigator at local FQHC
- Telemedicine with Visiting Nurse Service (VNS)

VNS Telemedicine Program

Automatic Blood Pressure Monitor With Bluetooth wireless - Professional accuracy via oscillometric method

Personal Scales Highly accurate and precise measurements for telemedicine applications

Pulse oximetry non-invasive method allowing the monitoring of the oxygenation of a patient's hemoglobin

Heart ECG - Heart rate variability (HRV) analysis of the resting heart rate and two challenge tests - deep metronomic breathing and orthostatic tests

Glucose meter (glucometer) Concentration of glucose in the blood. Patients with people with diabetes mellitus or hypoglycemia

- Reduce re-hospitalizations
- Daily monitoring of vitals for "frequent-flyers"
- "Real time" assessment when issues are identified
- Self-sustaining – Medicaid / Commercial homecare benefit

Date/Time	BP	SpO2	Pulse	Weight	Glucose
1/29/2010				166.2	
1/28/2010		99	69		
1/27/2010					
1/26/2010		98	78	163.4	
1/25/2010				166.8	
1/24/2010				164.0	
1/23/2010	130/91		86	164.6	
1/22/2010	125/87		78	165.6	
1/21/2010	141/94		86		
1/20/2010	140/86		86	162.2	

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	BP	S_pO_2	Pulse	Weight	Glucose
Maximum:	130/90	99	100	175	140
Minimum:	110/80	90	80	150	130

- -Hospital
- -Physician (PCP)
- -Medical Home

Lessons from our Year One Experience

- Aligning level of care with need for care improves quality **and** cost
- Community organizations are interested in partnering with the hospital
- The Medical Home and Navigators can "break down barriers" and "connect the dots"
- **But, it is still easy for an uninsured patient to receive "free" care in the ED**

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