Organization-Wide Commitment to Quality Improvement
Ellis Medicine

In recognition of ongoing commitment to improving transitions of care for patients and caregivers in the community.

Partnership for Community Health

BACKGROUND

Ellis Medicine is a 438-bed community and teaching healthcare system serving New York's Capital Region. With four campuses – Ellis Hospital, Ellis Health Center, Bellevue Woman's Center and Medical Center of Clifton Park – five additional service locations, more than 3,300 employees, and more than 700 members of its medical staff, Ellis Medicine is proud to provide a lifetime of care for patients. Ellis offers an extensive array of inpatient and outpatient services, including cardiac, cancer, emergency, neuroscience, and women's services.

APPROACH

Ellis Medicine is being recognized with an IPRO Quality Award for its ongoing commitment to quality and cross-setting community partnership approach to improve transitions of care for the patients and caregivers within its community. The system has worked in collaboration with IPRO to use a data-driven approach to investigate the drivers of avoidable readmissions, hospital utilization and interventions targeting improved care coordination.

For this effort, Ellis Medicine has successfully implemented the following strategies and interventions:

- Integrated case management between the acute and ambulatory care setting to support improved patient flow between care sites.
- Initiated screening of patients for social determinants of health to determine the impact on healthcare access and risk for readmission. Findings are integrated into the development of a community plan of care which includes scheduling of any required follow-up appointments and care management discussions with the next level of care.
- In partnership with the Congestive Heart Failure (CHF) Task Force, Ellis Medicine launched a Transitional Care Program to support CHF patients' post-acute care discharge into the community for a 30-day time period. The program, which is partnered closely with the outpatient CHF clinic, includes a weekly follow-up call to the patient/care partner for a four-week time period to assess their level of understanding of medications, diet, and activity. This helps patients and care partners self-manage their chronic disease so they can remain at home.

RESULTS

Ellis Medicine has demonstrated an 18% relative improvement rate in all-cause 30-day readmissions for the Medicare Fee-for-Service population, reducing their readmission rate from 17.5% for the 10/01/18 - 09/30/20 baseline time period to 14.4% for the 09/01/22 – 08/31/23 time period.

CONCLUSIONS

Ellis Medicine coordinated cross-setting communication and care management of patients with congestive heart failure to support the patient/resident/care partner. Ellis Medicine's goal was to help patients/residents/care partners understand their chronic disease and the important steps to self-management directly. This directly impacted utilization of services and the ability to remain safely in the community with improved outcomes of care.

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