

# UNITE HERE Health Center— Pioneering the Ambulatory Intensive Caring Unit

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## ABSTRACT

In 2005, the UNITE HERE Health Center in New York City embarked on a new initiative that expanded the role of medical assistants (MAs) to provide team-based care and health coaching for patients with chronic diseases. This initiative includes the creation of a career ladder for medical assistants, which allows them to advance in responsibility and pay scale based on successful completion of training modules and high performance.

## Inspiration & Background

Started by the International Ladies Garment Workers Union in 1914, the UNITE HERE Health Center (UHC) was the first union health center in the United States. New York City has seen many changes since that time, and UHC has evolved with it.

Prior to 2000, when the organization served primarily as an occupational health center for union members, it was customary for the center's low-wage, union garment and laundry worker patients to take an annual "health day" off from work to get all of their exams and labs done. The entire day was necessary because it took so long to go through the process, and the patient did not return for another year unless absolutely necessary. It was difficult for patients to navigate through the UHC's convoluted telephone tree, and the no-show rate was high because patients found it difficult to contact anyone to reschedule or cancel appointments.

In the late 1990's, UHC hired a new CEO, who, with the Chief of Clinical Services and other administrators, began to work on renovating the facility, implementing an electronic health record system (EHR), and re-engineering patient flow. UHC changed from an occupational health center to a multi-service health center, offering both primary and specialty care services. The new administrators also began to look at the organization's patient base and

## Practice Profile

**Name:** UNITE HERE Health Center (UHC)

**Type:** Free-standing multiservice health center

**Location:** New York City, NY

**Staffing:** 140 staff and providers, including

- 15 bilingual primary care & OB/Gyn providers,
- 38 part-time physician specialists
- 84 bilingual administrative and support staff including:
  - 17 Patient Care Assistants (MAs)
  - 6 health coaches/floor coordinators (MAs).

**Number of Patients:** 9,700 per year

**Number of Patient Visits:** 68,000 per year

**Patient Demographics:** Low-wage, immigrant workers, primarily members of the Service Employees International Union (SEIU) Local 32 BJ, (building service workers) & members of Workers United (textile, commercial laundry and gaming industry workers). Most are non-white (87%) and many speak English as a second language. Almost all (99%) have incomes less than 200% of poverty level.

cost model.

UHC was created in response to a tuberculosis epidemic, but by the turn of the new century, the Center was facing a new and costly epidemic of chronic diseases like diabetes, heart disease, and hypertension. Physicians were too busy to provide all of the education and follow-up needed by patients with multiple chronic diseases, and nursing staff had become prohibitively expensive and increasingly difficult to recruit. UHC needed a model that provided affordable, comprehensive primary care to a low-income, largely immigrant population that was experiencing a high rate of chronic disease.

### ***The Ambulatory Intensive Caring Unit Model***

In 2005, a group of health care policy experts led by Dr. Arnold Milstein and funded by the California HealthCare Foundation released a white paper on a cutting-edge model of health care provision called “The Ambulatory Intensive Caring Unit,” or A-ICU. UHC’s Executive Director Dr. Karen Nelson was on the review committee for the 2005 white paper released by the group, and brought the model to the attention of the rest of UHC’s leadership.

The A-ICU model at UHC is based on certain premises:

1. Health care can be made more affordable by fundamentally redesigning how care is delivered.
2. The focus needs to be on the sickest patients, those who entail the most costs for the health care system and are least well-served by it.
3. Doctors and other providers cannot, due to time and cost constraints, be expected to successfully manage patients’ diseases.
4. Patients should take an active part in managing their own care using education and resources supplied by their providers.
5. Frontline staff can be trained to deliver some of this education, and can often do so more effectively than provider staff.

The A-ICU model entails what initiators call three “floors”:<sup>i</sup>

1. First Floor: Frontline workers trained to perform relationship-based care management including close and continuous contact with patients to provide coaching and support for lifestyle changes.

2. Second Floor: Providers such as physicians and nurse practitioners, whose services are reserved for patients’ clinical needs as visits are streamlined via use of IT resources and support by First Floor staff.
3. Third Floor: Referral to designated specialists and acute care as needed based on costs, efficiency, and quality.

UHC already had on staff a pool of experienced and motivated medical assistants, called “*patient care assistants*” (PCAs), who could potentially be trained to take on first-floor tasks. Because the PCAs were more likely to speak the same language and share a cultural background with patients, employing them as health coaches might serve to encourage more trust and rapport with patients when working on self-management goals.

We asked the patient care assistants, “If this was you, your mother, your child, what would you want from a visit?”

*-Audrey Lum, Chief of Medical Services-*

UHC began a collaborative planning process for the A-ICU in the fall of 2005 and started a pilot test of the A-ICU, that they called the “Special Care Center (SCC)”, in May 2006.<sup>ii</sup> Planners created a team of three providers, three PCAs, two Health Coaches, a greeter, and a patient support services person. The team used UHC’s electronic health record system to document “special care” services, and track outcomes. UHC eventually spread the initiative to the entire health center as a result of their success with the SCC. There are now three active teams.

### **Training**

Utilizing resources from the American Diabetes Association, the New York City Department of Health and Mental Hygiene clinical guidelines, as well as material developed in-house by providers, UHC developed their own didactic and clinical curriculum to enable PCAs to take on patient education activities usually assigned to nurses or clinical diabetes educators. UHC subsequently copyrighted the training materials.

The initial training included dedicated 2-hour weekly sessions held during the clinic workday over a 9-month period. The program's didactic sessions featured topics such as chronic disease education, medical terminology and charting, hands-on training on equipment, and consultant-led sessions on "soft" skills such as communication, motivational interviewing<sup>iii</sup>, and self-management support. PCAs were also coached on how to be successful participants in medical teams.

All UHC PCAs are required to participate in the training and are capable of providing some patient education as a result. Each of the nine training modules includes a written competency exam. PCAs who pass all nine modules may qualify to become health coaches. Those who qualify to become health coaches are given the opportunity to shadow an experienced health coach to determine whether they want to apply for the position. They must also undergo an observation so that a supervisor can assess their ability to engage patients in goal-setting and self-management. The trainees and instructors are released from patient care responsibilities during the training with other staff providing needed coverage. To date, all PCAs have gone through the training and six have become health coaches.

Beyond the initial training, there is an ongoing one-hour training session for the PCAs from each of the three medical teams every other week. Each team has a special day for the training so that another team can cover for them while they are in training. Health coaches take part in these trainings, but there is also a separate weekly meeting for the health coaches to talk with supervising providers and administrators about their cases. The assistant director of clinical services and the staff nutritionist, both of whom were trained by consultants to serve as trainers, conduct a majority of the trainings.

### The A-ICU in Practice

The UHC has two primary care teams, the Blue Team and the Green Team, each with six providers, five PCAs, two health coaches, two patient support service staff, a greeter, and an administrator. There is also a new Red Team for the specialty floor, which includes six PCAs who work with the specialists (4.66 FTE).

The teams huddle (meet) for about 20 minutes every morning to discuss the day's work. The physician or NP provider informs the team which patients need to be seen by a health coach.

The different aspects of the practice model each have characteristics that help make it work.

**Patient Care Assistants:** PCAs perform all of the basic clinical responsibilities of medical assistants such as rooming, taking vital signs and preparing patients for visits, and scheduling. They also work as part of a team reviewing charts for preventive protocols. PCAs provide basic patient education in a culturally and linguistically appropriate way so the patient can utilize the knowledge in their daily living. PCAs may stay with the provider during some procedures, and may assist in interpretation and translation (all PCAs are bilingual). While not all PCAs pass all of the modules to become health coaches, all receive the training that allows them to cover for the health coaches when they are ill or on vacation. Likewise, health coaches may fill in for PCAs.

"We work as a team; we all do the same kind of work. I back them up; they back me up if I am behind."

*-Andrea Pico, Patient Care Assistant-*

**Health Coaches:** Those PCAs who have been promoted to the role of health coach work one-on-one with patients in setting self-management goals, conducting telephone follow-up with patients, and leading group visits for patients with chronic diseases. Health coaches typically have 12-18 scheduled appointments per day. The appointments are individual visits or telephone follow-up for health education, self-management, blood glucose, or blood pressure checks. There is always availability for walk-ins or same-day appointments. Health coaches typically spend 20-30 minutes with each patient, but have the flexibility to spend more time with a patient who needs additional help. Health coaches document all of the education they provide in specially designed templates within UHC's electronic health record. They can also revert to PCA duties when needed.

**Floor Coordinators:** Most of the current health coaches also serve as floor coordinators, another promotion level within the UHC structure. The role of the floor coordinator includes assisting with scheduling provider time, assuring that the provider has coverage, assisting with walk-ins, assisting the PCAs, and covering for PCAs if they fall behind. Floor coordinators insure efficient flow of patients to providers, and within the larger team. A health coach might work five hours on health coach tasks and three hours on floor coordinator tasks in a typical day.

**Electronic Health Record:** The UHC EHR plays a major role in this initiative. Every month the care team receives a panel report on patients with diabetes and other chronic diseases, and reviews patient conditions to determine who to target for follow-up.

There are no paper notes; staff relies on in-room computers (or laptops) to document all encounters in the EHR. UHC developed custom EHR templates that provide staff with prompts for providing patient care and education. For example, UHC's extensive diabetes template includes nine modules. In Module One, staff are prompted to cover basic nutrition with the patient, including information about the "plate method" and carbohydrate intake, and are reminded which handouts to give to and review with the patient.

**Patient Access:** Patients are provided a single patient access card with a direct line for all departments in the UHC. There is no phone tree and patients rarely need to leave a message because there is always someone there to pick up the line. PCAs take turns answering a medical question line via a specially designated cell phone so that patients have easier access to UHC staff. PCAs make and take phone calls throughout the day so they can transmit information from the patient to provider and vice versa.

## Resources

**Financing:** The Special Care Center/A-ICU model includes an extensive array of non-reimbursed services including ongoing EHR customization, intensive staff training, care management, and patient education. Additional costs include increased pay for staff promoted to health coach/floor

coordinator roles.

The A-ICU is not fiscally feasible under the traditional fee-for-service reimbursement system of most payers. The model is primarily supported by a monthly capitation per-member-per-month fee from various unions through their respective health and welfare funds for the services provided to union members and their families.

The UHC calculated a rate that varies with each union fund depending what is covered by the capitation. Some funds pay a capitation fee that covers all services provided on-site while other funds pay a capitation fee for the non-billable services and provider visits are billed to the insurance companies at a fee-for-service rate.<sup>iv</sup> Over half of the patients are under capitation, the rest are in the Health Insurance Plan of New York fee-for-service plans with other major payers including Emblem, Blue Cross/Blue Shield, Magnicare, Medicare and some Medicaid products.

**Development Costs:** The United Hospital Fund provided the initial \$75,000 grant for developing the curriculum. This required twelve months of development, including more than a day a week of provider/administrator time in developing the materials. Additional time was required on the part of providers, PCAs, and other staff in providing input on the development of training materials and templates for the EHR.

In 2007, the organization received an 18-month \$460,000 grant from the New York State Health Foundation for implementation of an "Innovative Primary Care Model for Low Income Retired Patients with Diabetes". The grant included funding to develop an additional curriculum and train PCAs/health coaches regarding the special needs of the elderly, with a focus on geriatric syndromes that affect the care of elderly diabetic patients.

**Training:** Initial training for the A-ICU required at least two hours a week of time on the part of PCAs and at least one administrative/provider-level staff member over a nine-month period. Ongoing training includes approximately one hour for all PCAs every other week, plus weekly time for an administrator/provider level staff member serving as a trainer. The weekly health coach meetings also require dedicated staff time.

**Information Technology:** There is one part-time template developer who is primarily devoted to the development and upgrade of automated templates that serve as electronic charts and provide instructions to staff to conduct basic, standardized patient screening and education.

## Challenges

The major challenges to implementing this model include gaining the trust and support of physician providers, training the PCAs to implement the model, and building the confidence of the PCAs to take on the task of providing health coaching to patients. Some staff did not like the new model and left the organization early in the implementation stage. An additional challenge is the changing patient base, which impacts the focus of services and reimbursement options.

**Physician Providers:** Staff noted that it was initially difficult to get physician providers to support the initiative because they were not convinced that the PCAs could be trained and trusted to provide consistent and reliable health education support. Project initiators were able to overcome this challenge by asking the providers to help develop the curriculum for the training and to conduct competency exams. Bringing the providers into the process convinced many who were more skeptical to accept the change.

**Patient Care Assistants:** Some PCAs were initially reluctant to engage in the new model because they were concerned about the providers allowing them to conduct health education. One staff member noted that the PCAs were used to being “at the bottom rung” of the ladder and lacked confidence to step outside of their traditional role. After the first cohort of health coaches started working with patients, it became somewhat easier to convince other PCAs that this was a role they too could take on.

Staff cited ongoing difficulty in finding enough PCAs willing to take on the health coach role, despite the increase in pay. While some PCAs are not willing to “step outside their comfort zone” to work one-on-one with patients as health educators, others may simply enjoy being more involved in the clinical aspects of health care.

Administrators continue to work with existing staff and to target key medical assisting educational programs to find interns who are a good fit for this model of care and who may eventually become hired as PCAs, and then be promoted to health coaches.

**Reported Patient Responses:** One patient care assistant noted that the transition was hard for the patients because they were confused about the role of the Health Coach, who was not a doctor, NP, or nutritionist. It reportedly took some time for patients to get comfortable with the health coach role.

**Training:** Training the PCAs to take part in this model was costly in time and labor-intensive, requiring nine months of classes and nearly as much time in advance planning. There was a steep learning curve for all, and the new model increased PCA responsibility and the complexity of tasks.

**Changing Patient/Payer Base:** The patient population has changed over time. UHC initially served Eastern European women in the garment industry. Then, in more recent decades, the garment worker population shifted to predominantly Asian and Latino women. Since the 2001 attack at the World Trade Center, the garment industry in New York City has been in decline. UHC has had to shift focus to workers from other sectors, such as textile and hotel workers, and service staff at pharmacy and sundries chains. This has changed the UHC’s patient population again by incorporating a larger population of male patients (garment workers were predominantly female), slightly more affluent patients (hotel workers tend to earn more than garment workers), and more East Asian patients. This shift in patient population required shifting the focus of services. UHC may also take on members from the Freelancers Union, which will again shift its patient population to incorporate greater numbers of young, white, and possibly more affluent patients.

As union membership in the U.S. continues to decline, it has become more challenging for UHC to maintain the patient base of union members covered by capitation on which this model relies. Enhanced services performed by non-provider staff are not sustainable in an entirely fee-for-service environment. As the capitated patient base shrinks, the organization has moved to a Patient-Centered Medical Home model and recently received recognition status from the National Committee for

Quality Assurance with the hope that insurers may cover the additional preventive services provided in this model.

## Outcomes

As a result of the success of the A-ICU project, the UHC moved to a Patient-Centered Medical Home mode of care and received NCQA recognition as a Level 3 Patient-Centered Medical Home in April 2010. The expanded role of the PCAs has reduced provider workloads and allowed UHC to build effective teams as a result and reduced dependence on nursing staff.

**Wait Times:** A major outcome of a number of recent initiatives, including the A-ICU, move to EHRs, and development of medical home teams has been a decrease in patient wait times. As noted earlier, patients used to have to take an entire day off from work to get all of their exams and labs done. Even with some improvements, visits often used to take more than one and up to two hours. Now with a re-design of patient flow, including development of the floor coordinator position to enhance provider and PCA workflow, all visits – including the longer visits with health coaches – average 48 minutes.

The current wait-time is “value-added” wait time because while patients are waiting to see a provider, they are engaging with other staff from the team. This produces cost-savings by decreasing the amount of time patients need to spend with providers, and helps patients avoid worsening health conditions and hospitalization.

**No-Show Rates:** The shorter wait time and reminder calls may have resulted in the decrease in UHC’s no-show rate. UHC found that patients sometimes did not show up because they forgot their appointments. Now the PCAs call a day or two in advance to remind patients of upcoming visits.

**Walk-In Visits:** UHC used to have more walk-in visits - patients who could not navigate through the phone tree and would just show up. Because of increased access to staff made possible by the development of the all-department business card and elimination of the switchboard so that patients can always reach a PCA via cell phone, patients now often call in advance if they need to cancel an appointment and can call in on the “sick line” for

triage and possible same-day appointments. Finally, UHC designated slots within every provider’s appointment book as “MD Returns,” which are used for walk-ins and next-day appointments.

**Cost Savings:** UHC financial projections for the Special Care Center model suggested that the model had the potential to produce first year savings of up to 38% of net total spending for the care of the highest risk quintile of patients.<sup>v</sup>

In order to evaluate cost-savings, UHC staff analyzed data from the Laundry Fund, a self-insured fund of UNITE, for total PMPM spending in 2007. They found that members who were followed at UHC cost 17% less per member per month than those who were not served by UHC, and annual emergency room costs were 50% less for the health center group.<sup>vi</sup>

“Patients feel very well-taken care of. As health coaches, we do a lot of listening and a lot of that cannot be done with the provider. What the provider cannot do, we pick up. We can listen and figure out what they need.”

*-Iris Leon, Floor Coordinator and Health Coach-*

**Provider Satisfaction:** Anecdotally, the increase in support has made providers’ work with patients much more satisfying. There has been very little turnover in the provider staff in the past five years.

**Clinical Outcomes:** UHC has used its EHR system to track patient outcomes and document statistically significant improvements in patient outcomes attributable to its new model of providing care. UHC analyzed records from 510 diabetic patients who returned to the center continuously between May 2005 and August 2009. The data show statistically significant improvements in the percentage of patients with control of hemoglobin A1c at less than 7%; blood pressure readings below 130/80mmHg; and LDL cholesterol of less than 100 mg/dL. Markers of disease management such as yearly ophthalmology exams also improved significantly. The number of patients who had all three ABC (A1c, blood pressure, cholesterol) markers controlled rose from 13 to 36%.<sup>vii</sup>

UHC measures for diabetes outcomes also compare favorably to citywide measures. For example, the percentage of diabetic UHC patients with controlled A1C levels ( $A1C \leq 9\%$ ) as of November 2008 was 95% compared to 57% for 2006 Medicaid enrollees with the City's Department of Health and Mental Hygiene. The 2008 percentage of UHC diabetic patients with controlled cholesterol was 70% compared to greater than 40% for Medicaid enrollees with the Department of Health and Mental Hygiene.<sup>viii</sup>

**Patient Satisfaction:** Staff observed that patients will often tell their health coaches problems that they will not reveal to their providers because the patients find health coaches and PCAs less intimidating.

UHC has documented increases in patient satisfaction over time via patient surveys and patient testimonials.

### MA Career Impacts

The A-ICU initiative has expanded the job description for MAs and created a career path for them within the organization. They all receive additional training, which enhances their clinical and communication skills. Those who excel in the area of communication and critical thinking can move up into the roles of health coach and/or floor coordinator, and receive salary increases.

**Unionization:** UHC's patient care assistants, health coaches, and floor coordinators are unionized under SEIU 32BJ (Service Employees International Union). UHC works with the union on setting starting wages and developing new job classifications such as the health coach position. This contract is renegotiated every three years. The clerical staff is in a different union.

**Certification:** Upon hire, patient care assistants (PCAs) are not required to be certified. However, UHC requires that they become registered within three months of hire, preferably through American Medical Technologists, a certification agency and membership organization for medical assistants that require applicants to pass a standardized exam before certification and membership. MAs receive an approximately 17% increase in pay for becoming certified. This increase existed before the A-ICU initiative.

**Promotional Opportunities:** Prior to the A-ICU implementation, UHC gave pay increases for achieving registered medical assistant status and for performance.

Now, PCAs who successfully complete the nine-month training can qualify to become a health coach, which brings a 12% pay increase. Within three months, the successful health coach is eligible for another raise, bringing the wage of the health coach to 20% higher than that of a registered PCA. Finally, an experienced PCA could also become a floor coordinator, which includes additional responsibilities and a 27% pay differential compared to a registered PCA.

PCAs can also move to the specialty clinics with additional training, and some have moved to the physical therapy department as physical therapy assistants.

Supervisors prefer to promote from within for all of these positions rather than hire outside.

**Benefits:** Patient care assistants receive health, dental, and vision coverage, and a uniform reimbursement. A pension is provided through their union. UHC encourages ongoing education and provides staff with a \$1,000 annual tuition reimbursement to pursue further education. These benefits existed before the A-ICU implementation.

One fifth to one-quarter of the existing PCAs have made use of the tuition reimbursement over the last two years. While there are not many RNs/LPNs at UHC, the organization and its programs are always evolving and it is feasible that roles could be developed to accommodate long-term staff who upgrade their education.

**Retention:** While UHC initially lost some provider staff as a result of adopting this initiative, they have experienced stable staffing among primary care physician providers over the last four to five years. Staff report that the retention rate of PCAs has improved. In the last eleven years, UHC has lost approximately four PCAs to career advancement or move to another organization. Staff cite the great benefits, career ladder and learning environment as pluses. They also noted that the move to the A-ICU model and adoption of the Medical Home has instilled a spirit of teamwork. One staff member observed, "When people leave, we are devastated."

**Satisfaction & Aspirations:** Staff noted that this initiative has enhanced PCA confidence and self-esteem, and has encouraged some of them to become more interested in furthering their health care careers as a result. Several are using the annual \$1000 tuition reimbursement to pursue nursing degrees. PCAs and health coaches also cited job satisfaction as a bonus, noting that they enjoyed interacting with patients and watching patients improve.

**Recruitment:** UHC works with local medical assisting schools to place interns at the site. If these interns are a “good fit”, they may be hired to fill openings for PCAs. The Human Resources Department reportedly receives many inquiries from both MA schools and individuals about internships and employment at the UHC, and interns generally wanting to work there after completing their training.

### Future Plans

Because of the success of the initial pilot for this program, UHC has spread the A-ICU model to its entire operation. With certification as a Patient-Centered Medical Home, the organization hopes to sustain this model of health care by seeking appropriate reimbursement to cover the additional services.

Administrators are working with local colleges and universities to investigate next steps for education and career development for those choosing the health coach track, and looking at selective recruitment of MA interns to ensure the next generation of PCAs capable of becoming health coaches.

### Replication and Lessons Learned

This model could be replicated elsewhere, but there are certain factors that make replication more likely to be successful.

- The *reimbursement structure* must be such that it can cover the added costs of non-provider staff such as health coaches. Monthly *capitation*, specific to case management services, is what allows this health center to innovate and deliver non-reimbursed services.
- Administrators must develop *physician buy-in* and trust between the providers and patient care

assistant staff. Staff noted that starting with a pilot program before implementing this model center-wide helped to fine-tune the model and prove that it worked, which encouraged greater likelihood of acceptance. Including providers in competency evaluations for PCAs and health coaches also helped.

- *Extensive training* is required to enable patient care assistants to work within this model, and pre-selection of staff with the right attitude, interest, and communication skills facilitates this process.
- *Adequate protected meeting and training time* are essential to enhancing buy-in and a stronger overall team approach to providing care. An organization wishing to replicate this model, particularly the PCA training, needs to be large enough to cover the necessary dedicated staff time both financially and logistically.

The UNITE HERE Health Center has invested in existing staff by developing an intensive training program to capitalize upon the skills and qualities of its large pool of medical assistants. The standardized curriculum and customized electronic health record system developed by UHC support and sustain this effort. All MA staff members have enhanced skills as a result and the opportunity to advance in responsibility and pay. This has enabled the organization to adopt a team-based model that, in conjunction with other initiatives, has improved efficiency, clinician support, and patient outcomes. UHC has copyrighted its curriculum so that it can be shared with other organizations wishing to implement a similar model.



## Notes

- i. Health Technology Center. (2007). *Ambulatory Intensive Caring Unit (A-ICU): Report of the First Year*.
- ii. For an additional case study on an organization utilizing medical *assistants* to implement a variation of this model, see “The Special Care Center (SCC)—A Joint Venture to Address Chronic Disease”, also in this series.
- iii. *Motivational interviewing* is a client-centered method based in non-directive counseling which utilizes reflective listening to elicit the patient’s intrinsic motivation for change. The purpose is to engage patients in evaluating their own behavior and resolving ambivalence between that behavior and the achievement of self-defined health goals.
- iv. Nelson K., Pitaro M., Tzellas A. and Lum A. (2010) Transforming The Role Of Medical Assistants In Chronic Disease Management. *Health Affairs* 29(5), 1-3.
- v. Background material supplied by UHC staff.
- vi. Nelson K., Pitaro M., Tzellas A. and Lum A. (2010) Transforming The Role Of Medical Assistants In Chronic Disease Management. *Health Affairs* 29(5), 1-3.
- vii. Ibid.
- viii. Ibid.

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