

## Union Health Center: Update 2014

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### ABSTRACT

In 2005, the Union 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. This 2014 summary updates the original 2010 case study with new information on staffing, clinical outcomes, reimbursement, and more.

Started by the International Ladies Garment Workers Union in 1914, the Union Health Center or UHC (formerly UNITE HERE Health Center) 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 lab work 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.

UHC was created in response to a tuberculosis epidemic, but by the end of the 20<sup>th</sup> 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

### Practice Profile 2014

**Name:** Union Health Center (UHC)

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

**Location:** New York City, NY

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

- 12 bilingual primary care providers,
- 35 part-time physician specialists
- 64 bilingual administrative, clinical, and non-clinical support staff including:
- 31 Patient Care Assistants (MAs)
- 7 health coaches/floor coordinators (also MAs)

**Number of Patients:** 13,186

### 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 are not native English speakers. Almost all (99%) have incomes less than 200% of poverty level.

population that was experiencing a high rate of chronic disease.

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

In 2005, Dr. Karen Nelson, the health center's former Executive Director, sat on the review committee for a white paper written by a group of health care policy experts led by Dr. Arnold Milstein and funded by the California HealthCare Foundation. Inspired by the paper's description of a cutting-edge model of health care provision called "The Ambulatory Intensive Caring Unit," or A-ICU, she brought the model to the attention of the rest of UHC's leadership.

The new model was based on the premise that health care can be made more affordable by redesigning the care process, focusing on the needs of the "sickest" patients with multiple chronic diseases and engaging them in managing their own care. This new model is made possible by employing frontline staff to perform relationship-based care management including close and continuous contact with patients to coach and support lifestyle changes. Physicians and other providers are reserved for patients' clinical needs. Health information technology enables the delegation of key tasks to frontline staff and allows for tracking and documentation of outcomes.

UHC already had on staff a pool of experienced and motivated medical assistants, called "*patient care assistants*" (PCAs), who could potentially be trained as health coaches. Because the PCAs were more likely to share linguistic and cultural background with patients, administrators speculated that employing them as health coaches might serve to inspire more trust and rapport with patients working on self-management goals. The UHC piloted the model in 2006 and spread the initiative to the entire center as a result of the pilot's success.

### **Training**

The UHC administrators developed their own didactic and clinical curriculum to enable PCAs to take on patient education activities historically assigned to nurses or clinical diabetes educators. The initial training for MAs includes dedicated two-

hour weekly sessions held during the clinic workday over a nine-month period.

The program's didactic sessions feature topics such as chronic disease education, medical terminology and charting, hands-on equipment training, and consultant-led sessions on "soft" skills such as communication, motivational interviewing, and self-management support. PCAs are also coached on how to be successful participants in medical teams.

All PCAs are required to participate in the training and are capable of providing some patient education as a result. PCAs who pass the written competency exams for each of the nine modules may qualify to become health coaches. To date, all PCAs have gone through the training and seven currently serve as health coaches.

Ongoing biweekly training for PCAs and health coaches keeps these skills current.



### **The A-ICU in Practice**

The UHC has two primary care teams and a specialty team. The primary care teams includes six providers, six PCAs, one RN, two health coaches, one health coach/floor coordinator, and two patient support service staff.

Eight of the PCAs also rotate to the front desk where they answer the appointment line, register new patients, and greet new and established patients for scheduled visits and walk-ins. PCAs received additional training in customer service for these roles. There were previously more clerical staff in this role in 2010, but the elimination of paper files and increase in preventive and chronic disease management tasks resulted in a decrease in the number of clerical staff and an increase in the

number of PCAs from 17 in 2010 to 31 in 2013. Hence, through cross-training and technology, the UHC is serving almost 3,500 more patients in 2014 than in 2010 with the same number of staff.

Each provider/MA dyad huddles (meets) for about 20 minutes every morning to discuss the day's work. The providers inform the MA which patients need health coaching. A weekly team meeting helps keep the whole group up-to-date.

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 assist in interpretation and translation (all PCAs are bilingual).



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 spend 20-30 minutes with each patient, but may spend more time with a patient who needs additional help. Health coaches can also revert to PCA duties as needed.

Three 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 providers have coverage, and assisting PCAs, especially if they fall behind.

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 electronic health record. UHC developed custom EHR templates that provide staff with prompts for providing patient care and education. The center has done away with its phone tree, enhancing patient access by providing patients with direct lines to different departments, and assigning PCAs cellphones to answer patient questions between visits.

### Outcomes

The center has realized a number of positive outcomes as a result of ongoing redesign initiatives. There has been a reduction in patient cycle times from up to two hours in the early 2000's down to an average of 48 minutes by 2010-2013, which includes those visits where a patient also meets with a health coach or a social worker.<sup>1</sup> There has been a decrease in no-show rates and walk-in visits as patients receive timely reminders from PCAs prior to appointments and can always reach a PCA by phone to cancel or reschedule. However, this policy, the introduction of e-prescribing, and an increase in new patients increased call volume to UHC.

UHC has used its EHR system to track patient outcomes and document statistically significant improvements. The data show that the number of patients who had all three ABC (A1c, blood pressure, cholesterol) markers controlled rose from 13 to 36% during the initial introduction of this model of care.

In order to evaluate cost-savings, UHC staff analyzed data from the Laundry Fund, a self-insured fund of UNITE, for total per member per month (PMPM) spending in 2007. They found that

<sup>1</sup> The UHC used to calculate the total PC cycle time starting from when the patient stepped off the elevator to completing one visit with the PCP, a visit to the pharmacy and then exiting the Center. As of Dec 3, 2013, the pharmacy was closed and most patients now use e-prescribe.

members who were followed at UHC cost 17% less PMPM than those who were not served by UHC, and annual emergency room costs were 50% less for the health center group.

Recent data on patient outcomes indicate that the UHC is doing well by NCQA (National Committee for Quality Assurance) standards:

October 2013	UHC	NCQA Goal
% diabetic patients with A1C <8	72%	65%
% diabetic patients with LDL <100	58%	40%
% diabetic patients with BP < 140/90	80%	65%
% diabetic patients who received an annual foot exam = 82%;	82%	80%

In 2010 the organization applied for and received level 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA). To date, this designation in and of itself has not led to increased revenue.

### Career Advancement

The A-ICU initiative has expanded the job description for MAs and created a career path for them within the organization. All PCAs 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 progressive salary increases. A PCA who qualifies as a health coach receives a 12% pay increase. Three months successfully meeting health coach competencies translates to a wage that is 20% above that of the regular PCA. Promotion to floor coordinator results in a 27% pay differential.

### Challenges

The major challenges to implementing this model include gaining the trust and support of 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. An additional challenge is the changing patient base, which impacts the focus of services and reimbursement options.

It was initially difficult to convince providers that the PCAs could be trained and trusted to offer consistent and reliable health education support. By asking the providers' assistance in developing the curriculum and in conducting competency exams, administrators were able to engage providers in the change process and convince them of the PCAs skills and abilities.

The PCAs were initially reluctant to engage in the new model because they did not think the providers would allow them to conduct health education. 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.

Many MAs are still reluctant to take on the health coach role. Most MA schools do not provide MAs with the critical thinking and relational skills they need to become health coaches. Few MAs receive any training in how to work in teams or in a patient-centered medical home. Administrators have focused efforts on recruiting and retaining MAs with the right mix of attitude and skills for this new role.

UHC leadership does not think the enhanced services performed by non-provider staff in this model are sustainable in a fee-for-service environment. The A-ICU model is best supported here by a monthly per-member-per-month capitation from union 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 on what is covered by the capitation. As U.S. union membership continues to decline, it has become more challenging for the UHC to maintain the patient base on which this model relies. The UHC is working with its primary union partner, 32 BJ, to increase the number of its union members served by the clinic. It is encouraging all its union partners to move to a

capitated model. While the UHC was 48% capitated as of 2013, its goal is to go to 100% capitation.

During the economic downturn, some of the unions utilizing UHC's services had to cut back on coverage of dependents and spouses. Many of these patients wanted to continue receiving care from UHC, and an onsite patient navigator helped them apply for coverage through the new health care exchange resulting from the Affordable Care Act.

### Moving Forward

Rather than expecting an influx of new patients from the Affordable Care Act, UHC anticipates gaining new patients via its union partner encouraging members to sign up for care with UHC. A conservative estimate of growth is 150 new union patients per month with a projected total of 2,000 new patients by the end of 2014.

To meet higher demand, the clinic will work on increasing productivity rather than growing the number of staff and providers. As a part of this move, administrators are developing specific standing orders for the PCAs.

### Conclusion

The Union 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.

### Acknowledgments

*Innovative Workforce Models in Health Care* is a series of case studies showcasing primary care practices that are expanding the roles of medical assistants and other frontline workers in innovative ways. The organizations selected are implementing practice models that improve organizational viability and quality of care for patients while providing career development opportunities to frontline employees. This research is supported by the The Hitachi Foundation as part of its Pioneer Employers Initiative.



To read the full 2010 case study, please see: UNITE HERE Health Center—Pioneering the Ambulatory Intensive Caring Unit

Special thanks to the staff, providers, and administrators at Union Health Center for their ongoing assistance with this project.

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