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Primary Care e-Letter
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In this Primary Care e-Letter we feature an interview with Audrey Lum, RN, and Jenny Tsang, MD, of New York's UNITE HERE Health Center. The UNITE HERE clinic has implemented team-based primary care that utilizes Medical Assistants in key roles. This interview highlights the development of the clinic model and the success with which it has met.

Happy Holidays!
The CEPC e-Letter Team

A New York City Primary Care Innovation: UNITE HERE Health Center

In 1914, the International Ladies Garment Workers Union (ILGWU) established the health clinic today known as the UNITE HERE Health Center. Initially the clinic functioned to treat tuberculosis among immigrant women workers, adding a wider range of services throughout the 20th century. In 1995 the ILGWU merged with the men's Amalgamated Clothing and Textile Workers Union to form the Union of Needletrades, Industrial and Textile Employees (UNITE). In 2004, UNITE merged with the Hotel Employees and Restaurant Employees Union (HERE), creating UNITE HERE. Today, providing health services to union workers and their families remains the central commitment of the health center. Over 85% of the center's patients are UNITE HERE members, the majority of them low-wage immigrant workers for whom English is a second language. The clinic cares for approximately 14,000 registered patients, providing over 1,000 visits per week.

Over the past few years, UNITE HERE Health Center has pioneered a team model of primary care delivery that has met with great success. A crucial component of this model is the role of Medical Assistants, known as Patient Care Assistants (PCAs) at the Health Center.

In August 2008, Rachel Berry Millett interviewed Audrey Lum, RN, MPA Chief of Clinical Services at the Health Center and Jenny Tsang, MD, Clinical Coordinator.

Your clinic is owned by UNITE HERE, the patients are members of the union, and the finances come from the union trust fund. In what ways is that an advantage for organizing care?

UNITE HERE Health Center is a freestanding Article 28 Diagnostic and Treatment Center. Most of our patients, however, are union members and their families, and the Health and Welfare funds of the union pay us on a per-member per-month (PMPM) capitated basis for the health services we provide. This fixed PMPM amount covers all Health Center services, regardless of whether or not they are provided by physicians or other non-professional staff. This arrangement

is important in several ways. First, we don't have to worry about fitting every service we provide into a typically reimbursable physician office visit so we can be innovative. We offer group visits and one-on-one sessions with health educators; medical assistants call patients at home and visit them in their workplaces. We rely on well-trained medical assistants to work independently and closely with patients, teaching them how to manage their chronic disease, which frees providers up to spend more time with high-risk patients who require more intensive medical intervention and attention. Much of what we do with patients would not be reimbursable under any traditional fee-for-service insurance plan. The capitation payment structure gives teams the incentive and the freedom to experiment with all kinds of non-traditional health education programs. Second, union employers pay into the Health and Welfare Fund that covers members' health, vacation, pension and other benefits. To the extent we can achieve savings by preventing emergency room visits and eliminating waste, redundancy and unnecessary hospital admissions in this union population, those savings can be used either to expand the members' health coverage or improve other benefits provided by the Health and Welfare Funds. It is unusual to work in a self-contained universe like this where money can be invested in a Medical Home like ours and then savings that are achieved can be essentially given back to the patients themselves in the form of enhanced benefits. The Health Center has always had an excellent relationship with the union. By investing in this kind of "intensive" primary care, the union expects that the improved health of its members will contribute to the long-term financial health and stability of the union.

What is the main innovation you have implemented?

The Health Center has been involved in primary care re-design projects for a number of years and we recently launched an "Ambulatory Intensive Caring Unit," based on a model of creating a highly-trained non-physician staff to provide care that doesn't need the expertise of a physician. The goal of this unit (re-named the Special Care Center) is to radically redesign the way primary care is delivered to high-risk patients with chronic disease and, in so doing, to create a much more affordable, higher quality, alternative model of care. One of the cornerstones of this model is its reliance on non-physician staff to teach patients self-management motivation and skills.

How are your primary care teams organized?

We have two primary care teams – the Blue team and the Green team. Each team consists of primary care physicians, PCAs, and a floor coordinator who monitors the flow of the team. There are also RNs who work throughout the health center. The health center boasts expanded patient health education services that are provided by well-trained PCAs who are called Health Coaches. In order to be promoted to Health Coach, the PCAs receive extensive training on chronic disease conditions like diabetes, hypertension, and asthma. The Health Coaches are supervised by a Clinical Coordinator and NP and provide one-on-one or small group education sessions to our patients with chronic diseases. Patients with chronic diseases are encouraged to work with the Health Coaches, and they often see the Health Coaches without seeing their primary care provider. Other Health Center PCAs work in the traditional medical assistant role, supporting the primary care providers while they are seeing patients. In addition, PCAs work with the specialty care providers at the Health Center.

Right now we have about 12 primary care physicians and approximately 18 PCAs, divided between primary care and health education. On a given day, 6 primary care physicians are working with 6 PCAs, and some of the PCAs also rotate through the specialty services for part of the day. There is also a floor coordinator on each team. The coordinators are PCAs who have worked with providers in primary care, as well as with patients in health education, and they have a good understanding of patient flow both in primary and specialty care areas. Their roles insure that patients receive all of their care in a timely manner.

We have 2 PCAs and 2 greeters who welcome patients at the registration desks. Having the PCAs greet patients has been helpful in directing patients appropriately, because the PCAs are familiar with the patients and their clinical needs. We also have walkie-talkies to improve communication between staff and to help us stay coordinated. The teams huddle prior to the start of each primary care provider's clinic session, allowing for communication between primary care and the health educators as well as the floor coordinators. These huddles allow the teams to prepare for the day. Availability for walk-ins, and distribution of tasks to be accomplished for patients are also discussed at huddles. Finally there are Project Support Managers for each team who support the teams, and help with administrative functions and data analysis.

You have been pioneering new ways for medical assistants (PCAs) trained as Health Coaches to work in your care team. Can you describe what Health Coaches do? Are particular PCAs teamed up with particular providers?

The Health Coaches provide all of our patient education. They're focused on chronic disease, health maintenance and preventive medicine. They work with patients with chronic diseases on self-management for diabetes, high cholesterol, hypertension, asthma, etc. They do basic nutrition education, though we also have a nutritionist for more complicated cases. The Health Coaches maintain a daily schedule of appointments by establishing relationships with new patients through education or with follow-up appointments by telephone or face-to-face visits with patients that they've established relationships with. They document their encounters in the patients' charts and utilize the EMR flag system to alert providers or Clinical Coordinators of more urgent needs that the patients expose.

In primary care, the PCAs on each team are paired up with a provider, unlike the Health Coaches who function independently of the provider/PCA teamlets and maintain a separate appointment book. Sometimes they're in the room with the provider and patient, doing more or less traditional medical assistant work, but not always. They're arranging social services, following up with patients, and completing other tasks that the providers hand off to them. They're on their feet all day, interacting with team members and patients. Sometimes we pair up specific PCAs and providers, but the teams do change from week to week and there can be a swap if there are particular language needs at a given time. All of our providers and PCAs are bilingual; we have PCAs who speak Spanish, French Creole, and Cantonese.

Do patients accept that they are cared for by a team rather than by a physician? If so, did that require some re-education of the patients?

We want patients to know that our work revolves around them, that we are patient centered. They see the new process happening, because they are receiving patient education, and they have greater access to their primary care team. Our patients know that we are always available to them for any question or concern. When we transitioned to this care model, we established a list of frequently asked questions that were distributed to patients, providing them with additional information about some of the changes that were happening at the health center. Overall the transition has gone very smoothly.

We've created additional telephone resources, like a direct line to the pharmacy for refills, and a cell phone line that is answered 24 hours per day, allowing patients to call at their convenience. Many patients used to come into the clinic if they needed to talk to someone; now we're getting fewer walk-in patients because they're calling in first. Initially, some of our patients didn't trust the phone system, but with additional points of access, patients are using the telephones and finding that they have easier access to their teams.

We set up a blood pressure monitor loan system, which has been an important resource for patients who are trying to control elevated blood pressures and who were having difficulties leaving work to have their blood pressure checked. With the loan program, patients can call in with their numbers if they have any concerns.

Do you have a training curriculum for the new functions that PCAs are doing as Health Coaches? What are the secrets of successful training?

UNITE HERE Health Center is an internship site for two medical assistant schools. From the MAs who come here for their internship training we are able to select those we think will work well and excel at patient interaction to become part of our team. We've developed a training curriculum with grant funding from The United Hospital Fund. The curriculum is supported by evidence-based guidelines and utilizes user-friendly teaching techniques such as role-playing, scripts, teach-back, shadowing and hands-on experiences. The MAs (PCAs) who join our team attend weekly education classes. The classes cover topics such as patient interaction, patient motivation, managing diabetes, hypertension, asthma, high cholesterol and other chronic diseases.

We've also had outside consultants do additional trainings with our staff. We had a group from Columbia University work with the PCAs on motivational interviewing. There was training on geriatric sensitivity and recognizing cognitive deficiencies. We've also had trainings that address the needs of the PCAs in the workplace and how to de-stress. Overall the training is organized and comprehensive. We do role-playing, test the PCAs working with different providers, and conduct competency evaluations. But we make sure that PCAs are comfortable with the pace and that they get a strong understanding of what they're doing. For example, they know not only how to take a patients blood pressure but also what it means, how to interpret it.

In addition to helping the patients, PCAs are given additional training to help lift some of the load from the providers' shoulders. We don't want providers inundated with all the work, so a well-trained staff can do a lot of the patient education. The training is ongoing, and it can be

redundant. The PCAs are giving a lot of the same information over and over, but when this information is relayed to patients repetitively, it really sticks. It also empowers the staff. They feel that they're really doing something – teaching, discussing cases with providers, and expanding their own horizons.

Are there scope of work issues that you have encountered related to PCAs performing new functions? Has there been any resistance to PCAs doing these new things?

It can be scary for PCAs to work with patients one-on-one for the first time, many having had limited experience with patients. We usually team up a new PCA with an experienced PCA/provider team, and let them shadow and observe at the beginning. We allow the PCA to say when they're ready to take on a more autonomous role. The PCAs have become very comfortable doing what they do. At first many of them were dependent on the traditional hierarchy in health care; now PCAs are more confident, so much so, that they are now facilitating meetings and taking on leadership roles within the teams and at the huddles.

How long did it take to move from being a traditional clinic to being the pioneering clinic you are now?

In 2000, senior leadership at the Health Center initiated patient flow redesign and improvement in patient access. We wanted a health center where patients would want to go. Our first clinical redesign was started in 2003 when the Health Center was invited to participate in a Depression and Diabetes collaborative with the city health agencies. We received a better understanding of the chronic care model and how effective teams are a key component to successful improvement. We wanted to find, secure, and implement resources that would help our patients no matter what stage they were at in terms of managing their overall health. As with anything this large in scale, we needed to make many systemic changes, which require great dedication and time.

The Health Center implemented use of our Electronic Medical Records (EMR) system in 2000 and in April 2006 we started EMR template development within our teams. Our templates allow data to flow into files that our Panel Service Managers convert into reports that our providers and staff are able to use to target and closely follow high-risk patients. We have always used templates to document visits with patients the but it is only in the past few years that we have begun using the data flowing from those templates to do this kind of proactive population-based disease management work. It has really allowed us to follow our patients with chronic disease much more closely and to monitor progress of patients who might otherwise get lost to follow up.

What challenges remain for your clinic?

Education of PCAs takes time. We wish there were a magic pill but the reality is that it takes over a year to train the PCAs to understand the model, the education templates, and the routine. Our main goal is to make the PCAs fluent and comfortable with their tasks, in particular with learning and practicing the principles of self-management, so that eventually they need less oversight. Our mission is to have a highly trained PCA staff that can utilize self-management

skills and teach patients how to better manage their chronic diseases and activities of daily life. One of our challenges has been the daunting task of finding PCAs who are interested in expanding their medical assistant skills beyond basic requirements of a MA certificate program. We found that medical assistants who have "emotional intelligence" go far beyond their training and are willing to learn, use and teach self-management skills to our patients.

Another challenge has been spreading the concept of self-management throughout the health center staff, both clinical and non-clinical, so that it becomes the foundation for the care we provide to all of our patients throughout the center. We want to do more staff development, continue to bring in outside resources for education, and to create an environment where staff is excited about ongoing professional development and team building.