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PRACTICE PROFILE

Transforming The Role Of Medical Assistants In Chronic Disease Management

PRACTICE UNITE Health Center.
WHO AND WHERE Multiservice health center in New York City, funded primarily by capitation, for union members and their families. Provides care to 10,000 patients, who make 55,000 visits annually.
CORE INNOVATIONS Medical assistants are trained to teach patients to manage their chronic diseases and facilitate behavior change. They monitor patients' progress and function as key members of medical home teams. Those who pass all modules of the nine-month curriculum are promoted to become health coaches, who work with patients individually, lead support groups, and coordinate care.
KEY RESULTS Between 2005 and 2009, a subgroup of 510 diabetics who were continuously followed showed statistically significant improvements in the percentage with control of their blood sugar levels, blood pressure, and cholesterol. The percentage with all three markers controlled rose from 13 percent to 39 percent. The entire cohort of 1,100 diabetic patients also showed significant improvement for each marker. Among 3,000 New York City union members, health care costs in 2007 were 17 percent lower, and emergency room costs 50 percent lower, for those receiving their care at the center.
CHALLENGES Medical assistants received training that included participation by nurses, other staff members, and consultants and required dedicated meeting time. An electronic health record system was essential for tracking patients. Monthly capitation payments permit the center to deliver innovative programs involving nonbillable services.

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In 1914, in response to a tuberculosis epidemic in garment factories on the Lower East Side of Manhattan, the International Ladies Garment Workers Union (ILGWU) established the first union health center in the nation. As the ILGWU evolved and merged with other labor unions, that facility became UNITE Health Center.

Today, the health center serves 10,000 patients—members of several unions and their families—and provides 55,000 office visits and 20,000 ancillary services annually. Its members are low-wage, largely immigrant workers, many of whom are intermittently employed. The center's staff reflects its community, with twelve bilingual primary care practitioners, thirty-three part-time specialists, and eighty-four bilingual support and administrative staff. The health center houses a pharmacy, a radiology department, and a physical therapy suite.

Affiliated union health and welfare funds pay the health center a monthly capitation for the

At UNITE Health Center in New York City, members of two medical home teams participate in daily "huddles" where patient care assistants, physicians, and health coaches coordinate patient care plans.

services provided to union members and their families. The rate is negotiated annually and covers all services provided on site. This system of capitation has permitted the health center to run programs that provide innovative, typically nonbillable services, such as health coaching and phone follow-ups, and to use medical assistants and other nonphysician staff in expanded roles.

In 2003, UNITE Health Center joined the New York City Department of Health and Mental Hygiene Diabetes and Depression Collaborative, through which it created a multidisciplinary care program for its patients with diabetes. Beginning in late 2005, the health center developed and implemented a more comprehensive primary care program, called the Special Care Center, for patients with diabetes and other chronic conditions. This project was based on the Ambulatory Intensive Caring Unit model, conceived by a group of health care policy experts led by Arnold Milstein and funded by the California HealthCare Foundation.

The model relies on certain principles: affordability can only be achieved by radically changing how care is delivered; efforts to improve care should focus on the sickest patients; doctors cannot successfully manage patients' diseases alone; self-management is crucial for treating chronic conditions; and using highly trained medical assistants to teach self-management will free up physicians and nurse practitioners to manage complex medical decisions.

Changing Roles

We expected that, if successful, the Special Care Center would radically alter the roles of nonphysician medical staff and patients alike. Also, the Ambulatory Intensive Caring Unit model projected potential first-year savings of up to 38 percent of net total spending for care of the highest-risk quintile of enrollees, with even greater savings predicted in later years.

UNITE Health Center decided to transfer most of the responsibility for patient teaching to its patient care assistants, who are hired with medical assistant credentials. The hope was that these assistants, who typically share the patients' cultural backgrounds, would foster a level of comfort and trust that would enable them to teach patients how to manage their chronic diseases, at a much lower cost than using registered nurses or certified diabetes educators. The center developed its own nine-month training curriculum, including didactic sessions on chronic disease management and interactive sessions to improve communications skills and teach self-management support and facilitation of behavior change. They were also coached on how to be successful participants in medical teams.

Materials were drawn from evidence-based resources and from the American Diabetes Association and the New York City Department of Health and Mental Hygiene clinical guidelines. The provider staff also developed materials on chronic disease management. Outside consultants were used for training on communication skills, motivational interviewing, and self-management support. Training was overseen by the center's nurses, who also supervise and evaluate the patient care assistants.

Those medical assistants who complete their nine-month training and pass all required modules are promoted to health coach. They then work individually with patients. Essential to the project was the health center's electronic health record system, which allowed patient care assistants to track patients and provided templates to guide their interactions. The center could also design and run registries to better identify patients requiring care management.

The Special Care Center model has increased front-end resources devoted to the sickest pa-

tients. Health coaches work with individual patients in the office and by phone, setting and following up on self-management goals and monitoring home blood pressure and glucose measurements. They lead groups in which patients with chronic diseases get support and advice from others who share their health problems. This model gave patients unprecedented access to the medical team through both phone and personal contact, and it reduced wait times for urgent consultations with specialists.

In 2006, based on the project's early success, the health center opted to spread best practices to the entire primary care staff by creating a medical home at the health center. The health center now boasts two medical home teams—primary care multidisciplinary teams with ten to fifteen members including primary care physicians, nurse practitioners, patient care assistants, health coaches, and administrative staff. Ancillary staff members from nutrition, social work, behavioral health, and physical therapy work closely with both teams.

The expanded role of patient care assistants has greatly reduced providers' workloads and has allowed us to build effective teams, with very few nurses. Not all patient care assistants are health coaches, but all have had training that allows them to review charts for preventive protocols and provide basic patient education. Daily team "huddles" are a mainstay of teamwork. The assistant provides information on patients' chronic diseases and health maintenance. The provider identifies patients who may need intensive intervention. The health coach reports back the prior day's blood sugar and blood pressure checks and reviews the plan for patients scheduled for appointments that day.

Improved Outcomes

An important measure of success in health care delivery innovation is better clinical outcomes. Between May 2005 and August 2009, the health center tracked and analyzed 510 diabetic patients who came to the center continuously over that period and had readings in all clinical parameters every year. The data show statistically significant improvements (the *p* value was less than 0.05, which means that the results are unlikely to be due to chance) in the percentage of patients with control of hemoglobin A1c at less than 7 percent; blood pressure readings below 130/80 mm Hg; and LDL cholesterol of less than 100 mg/dL. Markers of disease management such as yearly ophthalmology exams also improved significantly.

Furthermore, the number of patients who have all three ABC (A1c, blood pressure, cholesterol) markers controlled rose from 13 percent to 36 percent—a particularly difficult measure to attain across any population. These statistically significant improvements were nearly replicated in data from the health center's entire cohort of approximately 1,100 diabetic patients.

Of note, the percentage of patients with poorly controlled diabetes fell from 9 percent to 4 percent in the panel who were followed continuously for four years, but remained relatively constant among the entire group of diabetics at the center. These results suggest that there was a steady influx of poorly controlled diabetics during each year of the four-year period but that those who were followed continuously by medical home teams achieved excellent control.

Early data indicate important cost savings from the Special Care Center and medical home models. In a preliminary analysis of health spending in 2007 for a union local of 3,000 members based in New York City, members who were followed at the health center cost 17 percent less per member per month than those who weren't, and annual emergency room costs were 50 percent less for the health center group.

The broader skill set demanded of patient care assistants creates new career pathways for people who don't necessarily have advanced educational training. Abilities such as communication proficiency and emotional intelligence are rewarded. The need for a substantial presence of patient care assistant staff has also allowed the health center to hire from its communities. The center has thus been able to institutionalize the strong relationships and shared backgrounds between patients and caregivers that are so important to the success of this model.

The team approach has resulted not only in greater efficiency, but also an enhanced sense of accomplishment among providers and patients, as burdens are shared and support is provided. This approach represents a distinct change from the typical medical environment, which is often strikingly hierarchical. UNITE Health Center's use of highly trained medical assistants to do much of the educational work and follow up with patients with chronic disease, its emphasis on teams, and its success in achieving statistically significant clinical outcomes offer an innovative model for others to replicate. ■

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