Grant Outcome Report

Developing and Implementing a Primary Care Model for Low-Income Retired Patients with Diabetes

KEY INFORMATION:

GRANTEE
UNITE HERE Health Center

GRANT TITLE
Development and Implementation of an Innovative Primary Care Model for Low-Income Retired Patients with Diabetes

DATES
January 1, 2008 – August 26, 2009

GRANT AMOUNT
$460,042

FUNDING
2007 Setting the Standard: Advancing Best Practices in Diabetes Management Request for Proposals

The Problem

The UNITE HERE Health Center (UHC) provides health care services to enrolled union members in the greater New York metropolitan area. UHC developed and implemented a special care center for its patients, which was based on a primary care model designed specifically to improve the care of patients with chronic conditions. The model relies heavily on expanding the role of patient care assistants, who are hired with medical assistant credentials and share cultural backgrounds with the patients they serve. Patient care assistants are trained in chronic disease management and self-management education so that they may provide intensive health coaching and self-management support to patients with diabetes and other chronic conditions. Between May 2005 and May 2007, the percentage of patients in the special care center with controlled blood pressure and blood sugar levels doubled from 12% to 28%. While health coaching services performed by patient care assistants are typically not covered under traditional plans, UNITE HERE active union workers are reimbursed through a special capitated arrangement. These services are not reimbursed for retired workers who are covered under traditional fee-for-service insurance. With support from the New York State Health Foundation (NYSHealth), UHC sought to expand this service delivery model to its older patients with diabetes, and address these coverage limitations.

This project was funded under NYSHealth's 2007 *Setting the Standard: Advancing Best Practices in Diabetes Management* request for proposals (RFP). The goal of *Setting the Standard* was to move New York State's primary care system to adopt and spread best practices in disease management and establish them as the universal standard of care for patients with diabetes. At the time, multiple diabetes management programs already existed throughout New York State, along with established collaboratives to maximize the impact of these programs. Thus, NYSHealth expected the grants made under the RFP to advance these programs and build systemwide capacity to

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support, sustain, and institutionalize these efforts. The Chronic Care Model (CCM)—a highly respected and accepted framework for approaching the improvements sought through this initiative—was a major reference point in the RFP.

Grant Activities and Outcomes

Under the NYSHealth grant, UHC sought to take its existing special care center model and adapt it into a new program, called Bridge Care, for older patients with diabetes. UHC began by developing a training curriculum and a multidisciplinary tool that would aid staff members in individualizing treatment goals for patients with both uncontrolled diabetes and multiple chronic conditions. Patient care assistants were trained to work as health coaches, delivering diabetes education and providing enhanced self-management support to patients aged 60 years and older with poorly controlled diabetes. In addition, UHC used the grant to enhance the role of its on-site pharmacist, incorporating the pharmacist into the care team. UHC also conducted an examination of clinical outcomes and developed a business case to secure the sustainability of the project. UHC's goal was to demonstrate the efficacy and cost-effectiveness of its care delivery model to payers in order to obtain enhanced reimbursement that would sustain the model.

UHC has substantial experience in chronic disease care quality improvement work and has focused specifically on diabetes and patient self-management. It has participated in practice improvement collaboratives on a variety of topics, including diabetes and the business case with the New York City Department of Health and Mental Hygiene; redesign, open access scheduling, and revenue maximization with the Primary Care Development Corporation; and self-management education with the Institute for Healthcare Improvement. As a result, its leadership and care team was well acquainted with quality improvement methods and evidence-based diabetes practices.

UHC developed a multifaceted plan to support practice change that included staff member training; staff member skills assessment; design and implementation of customized diabetes education curricula specific to the target audience; workflow redesign; development of electronic medical record (EMR) templates to support new staff member functions and teamwork; and articulation of measures and evaluation activities to assess progress toward program goals and

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clinical impact. In total, UHC enrolled approximately 700 patients into Bridge Care (70% of its projected goal of 1,000 enrolled patients); trained 14 patient care assistants and 6 health coaches; and developed 2 primary care medical home teams.

After analyzing data for all patients enrolled in Bridge Care, UHF demonstrated improvements in the average score of all three clinical indicators of controlled diabetes, which met a very rigorous clinical standard. As part of the *Setting the Standard* initiative, NYSHealth supported an outside evaluation of 10 of the 12 participating grantees. In addition to observing whether each grantee advanced against its proposed objectives, the evaluators also assessed how well each grantee adhered to the CCM principles. From the evaluator's perspective, UHC was clearly focused on the core elements of CCM quality improvement: aim, measures, and selected changes.

UHC took a disciplined approach to achieving its well-defined aim. Because of its prior extensive work on its EMR registry and functions, UHC had the necessary tools to support clinical decision-making, team care, and performance measurement. UHC's approach also included staff competency assessments, which paid close attention to mastery of new skills.

Future

UHC gathered cost data to document what level of reimbursement would be required to make this approach sustainable. UHC was unsuccessful at engaging its major payer in negotiations for new reimbursement arrangements by the close of the grant. UHC recently received National Committee for Quality Assurance diabetes recognition, and has been certified as a level-3 patient-centered medical home (PCMH). It anticipates that payment for these specialized services will be available shortly under new PCMH mechanisms and will provide support for its new approach to care.

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BACKGROUND INFORMATION:

ABOUT THE GRANTEE

UNITE HERE (formerly the Union of Needletrades, Industrial and Textile Employees and the Hotel Employees and Restaurant Employees International Union) represents more than 450,000 active workers and more than 400,000 retirees throughout North America. Its membership is diverse—largely comprised of immigrant, African American, Latino, and Asian American workers. UHC patients come from 50,000 of those active workers and 40,000 retirees in the greater New York metropolitan area. The majority are poor, with average active workers earning $15,000 and 90% with incomes below 200% of the poverty line; 87% are non-white, and most speak limited English and had little access to primary care prior to enrolling at UHC.

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