

The Special Care Center— A Joint Venture to Address Chronic Disease

by Lisel Blash, Susan Chapman, and Catherine Dower, Center for the Health Professions at UCSF
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ABSTRACT

The Atlantic City HEREIU Local 54 Health and Welfare Fund and AtlantiCare Regional Medical Center partnered to develop the “Special Care Center” (SCC), a new clinic that provides coordinated care management to patients with multiple chronic illnesses. The new center recruited and trained a group of frontline health workers to serve the functions of both health coaches and medical assistants. The SCC developed a new job category and wage scale within the AtlantiCare system to recognize the challenging and vital work of this group of Patient Care Assistants.

Inspiration and Background

Atlantic City has fallen on hard times. Profits from the city’s once-booming gaming industry continue to plunge as a result of the recession and competition from newly developed casinos in other states such as Pennsylvania and Delaware. Five major casinos are up for sale, and vacant lots once slated for development stand empty.¹ With the threat of casino properties closing, local residents and businesses have been feeling the pinch.

In 2007, the Local 54 Health and Welfare Fund, which provides for the health benefits of the City’s 14,000 union restaurant, hotel and casino workers, was experiencing rising costs as a result of an epidemic of chronic disease among members and a declining economic outlook in Atlantic City. Casino and hotel employees often work in conditions that are detrimental to their health, and their work is intermittent; interrupted by seasonal changes in demand in the tourist industry. The Fund did not want to raise co-pays or limit eligibility for union members, especially those who had lost their jobs as a result of the recession. AtlantiCare, the largest local health care provider in southern New Jersey, was looking for models that could reduce its spending on uncompensated care resulting from the use of emergency rooms and hospitalization by un- or under-insured individuals.

Practice Profile

Name: The Special Care Center (SCC)

Type: Comprehensive clinic;
part of the AtlantiCare Health System

Location: Atlantic City, New Jersey

Staffing: 17 staff and providers, including

- 2 FT physicians who serve as Medical Director & Associate Medical Director
- 2 nurse practitioners
- 7 health coaches (MA, LPN and RN)
- 1 administrative director
- 1 licensed social worker
- 2 client services representatives
- 1 PT nutritionist
- 1 consulting psychiatrist

Number of Patients: 1,000 per year

Patient Demographics: Low-wage, immigrant workers, primarily members of Union Local 54, (hotel and restaurant workers in the local casino and resort economy). Most are non-white (83%) and 58% speak a language other than English at home, including Spanish, Portuguese, French Creole and Asian Indian languages such as Gujarati and Hindi. All have multiple chronic diseases.

In response, these two organizations came together to develop the “Special Care Center” (SCC), a new clinic developed to serve only the “sickest” patients—people with multiple chronic illnesses—that relatively small percentage of patients that accounts for a majority of health care spending.ⁱⁱ

The SCC opened its doors in August 2007 with the goals of improving care for patients with serious chronic illnesses and lowering health care costs by helping patients better manage their own health conditions.

The Ambulatory Intensive Caring Unit

The Special Care Center (SCC) is part of the first wave of organizations adopting the “Ambulatory Intensive Caring Unit”, or A-ICU, model developed by a group of health care policy experts led by Arnold Milstein and funded by the California HealthCare Foundation.ⁱⁱⁱ

The president of Local 54 and a representative from AtlantiCare were on the review committee for the 2005 A-ICU white paper released by the Milstein group and both were quite interested in the initiative. Dr. Rushika Fernandopulle, one of the authors of the white paper and founder of the consulting group Renaissance Health, worked closely with the union and AtlantiCare to initiate the project and provides ongoing consulting. A group of representatives from the partnership travelled to California to learn from one of the early implementers, Latino Health Access. As one interviewee noted, both the Local 54 Health and Welfare fund and AtlantiCare look favorably upon innovation.

In 2007, the Robert Wood Johnson Foundation (RWJF) provided a grant for technical assistance and consultation to support the development of the SCC pilot in Atlantic City. The SCC opened in August 2007, about one and one-half years after the UNITE Health Center in NYC began implementing its own version of the A-ICU in a model described in another case study in this series.

The SCC is a comprehensive clinic within the larger AtlantiCare system. Renaissance Health consulted in designing and renovating the space, configuring the electronic health record (EHR) system, and hiring the initial staff. Unlike the NYC site, which trained its existing medical assistant staff as health coaches, the SCC hired new staff. They hired medical

assistants, licensed practical nurses (LPNs), and others to serve as health coaches.

Other innovative features of this model include a high staff-to-patient ratio, an interdisciplinary team model, and close tracking of disease markers. This model of population health management uses information technology, and integrates pharmacy, mental health, social work, and nutrition services.

“We get to connect with the patient; they socially bond with us as though to a family member. It is easy for them to talk to the health coach about anything, including depression and other issues.”

-Jaysbree Patel, Health Coach-

Health Coach Qualifications & Training

The role of health coach requires emotional intelligence, critical thinking skills, the ability to work in a constantly changing environment, and the ability to communicate with the patient population. The health coach must have bilingual and bicultural competency to work with at least one of the patient groups served by the SCC. This is at least as important as medical experience and knowledge in this model. All but one of the health coaches are bilingual in English and at least one of the following languages: Gujarati, Hindi, Spanish, French Creole, Vietnamese, Cantonese and Portuguese. Understanding patient’s cultural beliefs, traditional foods, and exercise practices has been important to realizing successful patient health outcomes.

Because the organization started without medical assistants already on staff, administrators had to fast-track on-the-job training. The clinic experimented with different modes of training. For about one year, a nurse practitioner/clinical coordinator led a weekly training for the health coaches using a formal curriculum she had developed. Now the weekly in-house training is more informal, addressing needs brought up by health coaches and patients. All health coaches and front office staff attend these trainings. The health coaches undertake additional training for patient care

associates on topics such as the use of glucometers and EKGs through the larger AtlantiCare system.

As several staff noted, informal training takes place throughout the day as the health coaches consult closely with providers about how to handle patient care during the course of patient visits. In addition, training occurs during the morning huddle when all staff meet to review the patient schedule and plan for their care.

The A-ICU in Practice

After a few false starts experimenting with the role of the health coach, the SCC adopted a teamlet^{iv} model which has been in place for the last three years.

Each day starts with a team huddle where the clinician providers (physicians and nurse practitioners), medical assistants, front office staff and administrators discuss issues affecting patients, including medical and psycho-social issues. Since the clinic has social workers and a psychiatrist on staff, they are able to address patient needs on a number of levels. The AtlantiCare pharmacy director is also an active member of the team and provides ongoing consultation about pharmacological issues and drug compliance. The associate medical director and a nurse practitioner assist health coaches in developing a plan of action for the day's patient visits and follow up.

Health coaches are matched to their patient population based primarily on language capability. Each manages a panel of 80-150 patients. Health coaches are responsible for meeting independently with patients, helping patients to set goals and manage their own care, monitoring patients' ability to adhere to their plan, and helping them to overcome barriers to meeting their health goals. Some of the health coaches also lead health education classes. For instance, one health coach recently started a yoga class for chronic pain management.

New patients take part in a "Welcome Visit" where they meet with a physician and a health care coach for an initial examination and orientation and to create a shared plan of action. The health coach introduces the new patient to the SCC, explains the program and benefits, and how to contact staff. The health coach also collects the bulk of the patient history, documenting medications, personal history,

and hospitalization record. The health coach stays with the patient throughout the visit, including through the exam. At the end of the visit, the health coach schedules the patient for a follow up visit.

Health coaches see patients on their own as well as in conjunction with patient's scheduled visits with the doctor. In the course of a visit with an ongoing patient, health coaches talk to the patients about their health goals. They may call for lab results, check for changes in medication, and remind patients of their next appointment. Diabetic patients are sent to the lab on their first visit and asked to return two weeks later for follow up with the health coach, who reviews their glucometer readings. If the reading is too high, the health coach confers with the provider to see if the patient needs to be seen to adjust the medications.

If the primary purpose of a patient visit is to see the provider, the health coach may serve more of a traditional medical assistant role. Health coaches also do paperwork and help schedule specialist appointments for patients who do not speak English. They also work with the pharmacy to follow up with patients who do not pick up their prescribed medications.

Health coaches may serve other functions depending on their training. For example, health coaches who are registered nurses or licensed practical nurses give immunizations and injections per doctor order and have access to the medications cabinet.^v The registered nurse that is a health coach also does patient triage.

All of the health coaches carry tablet computers in the office, which has a wireless system. They document visits via the SCC's electronic health record system and send and receive "tmails" (emails internal to the organization) about patient issues.

Resources

Financing: In 2007, the Robert Wood Johnson Foundation (RWJF) provided approximately \$194,500 for technical assistance and consultation to support the development of the SCC. This included contracting with Renaissance Health to assist in designing the space, configuring the electronic health record, and hiring and training the initial staff.

The existing AtlantiCare building was renovated and the suite was designed specifically for this the SCC. AtlantiCare underwrote the capital costs with Casino Reinvestment Development Authority funding. While there was a large upfront cost, clinic leaders anticipate long-term cost savings.

AtlantiCare and the Local 54 Fund each contributed 50% to cover initial costs. There is quarterly cost sharing based on an agreed-upon budget. Administrators are moving to a set per-member-per-month rate, for case management services only, for the new employer groups that are joining. Rates were set based on historical data on patient costs for this set of high risk patients. This process has been facilitated by the fact that the Fund has its own claims system to identify patient and costs and benefits.

This capitated system allows the SCC to provide the additional support and preventive services that patients need but are not covered under a traditional fee-for-service reimbursement system. The clinic accepts Medicare managed care, but not fee-for-service.^{vi}

“We do not do fee-for-service; fee-for-service is toxic for primary care.”

-Rushika Fernandopulle, MD, MPP-

The original contract with the Fund was for a three-year term, which put some stability into the funding structure. Staff also noted that this system works because this is not a right-to-work state, “If you work in a union classification, you must join the union.” The unionized employer pays into the Health and Welfare Fund to cover employee health benefits.

Training: Part of the initial training was paid out of the grant funding, and part was paid out of the general operating costs.

Formal ongoing education takes about one hour per week of the time of the health coaches, front desk staff, and a provider instructor. All staff also participate in a 45-minute huddle each morning to discuss the plan for the day. However, it is more difficult to quantify the informal training conducted by

providers on a daily basis.

Challenges

The major challenges to implementing this model include recruiting appropriate providers, defining the relative roles of providers and health coaches, training the health coaches to implement the model, finding health coaches with language and cultural concordance with patients, developing job descriptions and pay scales that adequately recognize the role of the health coach, and employment and insurance issues with patients. Early after implementation, the SCC reportedly lost half of its staff who could not work within this model, but staffing has stabilized over the last year.

Providers: It is difficult to find physician providers willing to relocate to the Atlantic City area because of concerns about poverty and crime.

Some of the initial provider staff had difficulty relinquishing patient education to the health coaches. As one interviewee noted, the exceptional providers want to do everything including health coaching, and it is often the exceptional providers who want to work in this setting. In the early days of implementation, the health coach would end up duplicating what the provider did because the provider also wanted to provide the patient education. They all had to come to an understanding that the clinic could not see as many patients and it was too costly to have those services provided by physicians.

Health Coaches: Being a health coach is a difficult job that requires skills and aptitudes not taught in medical assistant schools and not possessed by typical medical assistant program graduates. Initially, because health coaches were classified under the AtlantiCare system as Patient Care Assistants (basically medical assistants), their pay was relatively low compared to the skills required.

The SCC had to negotiate and change the job description to get a higher level of pay, which has produced better applicants. Administrators also found that the recognized job descriptions might not provide the flexibility to hire applicants based on less tangible skill sets other than medical training and experience. The job classification challenge continues although the director has developed creative methods to advance the careers and

compensation of health coaches.

Finding staff who are culturally and linguistically concordant with their patients is of primary importance. The SCC now has many more Vietnamese and Chinese patients as a result of hiring a Vietnamese health coach. Many of the patients do not speak English well enough to work with health coaches who are not bilingual and bicultural. Finding additional qualified staff that can speak Gujarati and Spanish has been a struggle.

Finding enough time to provide adequate health coach training within a relatively small clinic setting has been a major challenge. The SCC can only hire staff when they are really needed, and then training must take place largely on-the-job. The most recently hired health coaches are LPNs or RNs because “we need someone who can hit the ground running.” That move has reportedly taken away some of the original vision of using MA-level staff from the community and jeopardizes the model by making it more expensive to provide care. It is even more difficult to find culturally diverse staff at the LPN/RN level.

Finally, the SCC has had to screen for critical “soft skills”. Sometimes the health coaches may be tempted to over-step the appropriate bounds for their scope of practice, but more commonly there has been difficulty getting the health coaches to adopt the critical thinking skills and attitude necessary to work independently with patients.

Patients: The patients have a number of job-related issues that not only make it difficult to improve their health, but sometimes challenge the financial and administrative functions of the SCC. Casino and hotel workers have little access to healthy food at the worksite and work long hours at physically demanding jobs. This can make it difficult for them to follow-up on health goals or attend classes or group visits, and eat nutritious food.

Because of the economy and the seasonal nature of their work, these workers often move in and out of health plan coverage. The SCC has experienced fluctuating patient numbers as a result of job and coverage losses.

The Fund has addressed the instability in employment by allowing members two options: 1) they can self-pay for every hour they fall short of

qualifying as full-time (120 hours per month), or they can enter a “life-saver” (non-insurance) plan, which is \$75 for a single person or family for basic primary care with a co-pay for the doctor visit and for prescriptions. This latter plan does not cover hospitalization, but there is an “oops clause” that allows them to go back to self-payment, which does provide hospitalization coverage. The SCC staff also has to work hard to make sure patients know what type of work hours they can use for insurance eligibility. If these numerous options fail, sometimes the SCC has been able to get patients charity care through AtlantiCare.

Information Technology: Another challenge has to do with adapting the larger AtlantiCare electronic health record system (E-Clinical Works) to fit the small, team-based model. Most electronic health record systems are very “doctor-centric” as one administrator put it. They have not been able to customize the templates in the existing electronic health record system to fit their practice. In order to extract patient data that could document their success on quality initiatives, the clinic had to implement a secondary data system (DocSite). This provides them with a great deal of data on patient outcomes, but is more work for the health coaches in duplicate recording.

“We knew costs would escalate in the first 12 to 18 months, and they did. You assume a spike in cost because you have a spike in care, but now we are seeing a leveling off in emergency visits and non-planned hospital stays.”

-Theresa Meloni, Regional Director of Benefit Services, HERE IU Welfare Fund-

Outcomes

Despite some challenges, the SCC has realized a number of beneficial outcomes for staff, patients, and the organization as a whole. Because this initiative was started from scratch, there is trend data and some comparison data, but not “before and after” examples of successful outcomes.

Cost Savings: Initial analysis suggested that the A-ICU 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.^{vii}

Early SCC outcomes suggest that spending on primary care visits, prescription drugs, labs, and testing is actually up because SCC patients are now more compliant.

Using Fund data, analysts followed trends for this population before and after their enrollment with the SCC. They found that prior to enrollment, the cost of patient care was rising by 25% per year. Post-enrollment, the annual increase is just 4% compared to the rate of 12% for a similar non-SCC population served by the Fund.

One of the reasons for lower costs is that emergency department visits and hospitalization decreased by over 20% for SCC enrollees. The length of stay for those who were admitted was 8% shorter, and the average cost per day was 15% less than for the comparison group of non-enrollees. The SCC is working on increasing patient use of generic drugs to generate additional cost savings.

Clinical Outcomes: The SCC has been able to use its EHR system to document improvements in patient care. The SCC was able to meet a number of outcome benchmarks it set for itself, including increasing the percentage of patients with a blood

LDL (cholesterol) of less than 100 from 55% in July of 2008 to 65.2% in November of 2009. The clinic was also able to increase rate of patient drug compliance.

The SCC has implemented a smoking cessation program. The smoking rates among SCC patients is now 11% compared to a national average of 28%.

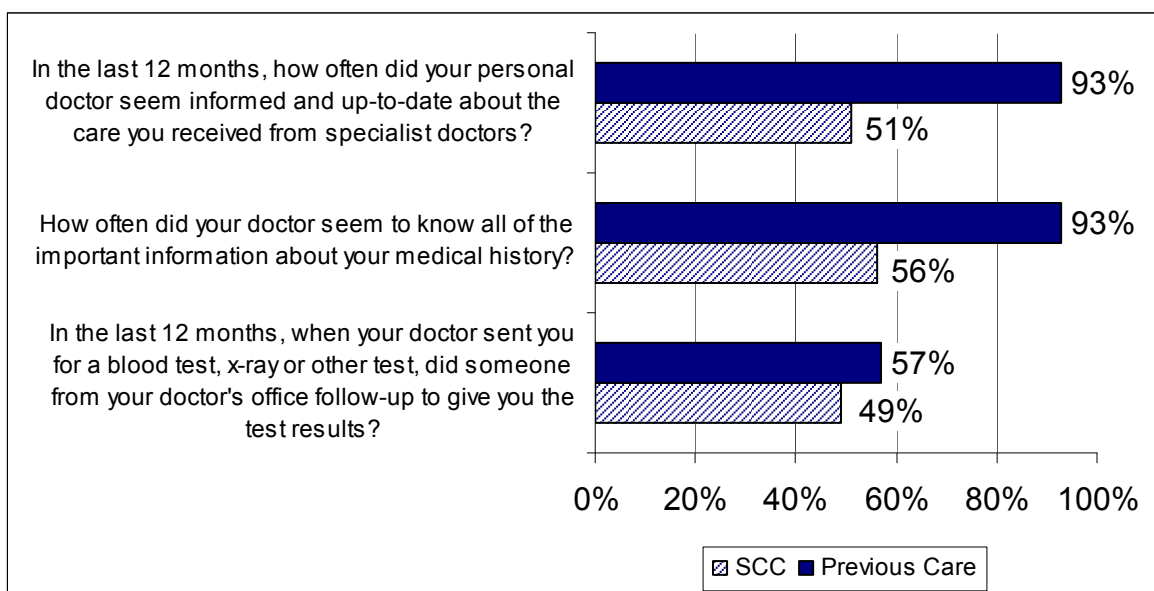
Patient Satisfaction: After implementation, two phone surveys of patients were conducted, one by Local 54 and one by an outside vendor. Both surveys documented positive responses from the majority of patients served by the SCC. (See Fig. 1.)

Clinical providers and health coaches report that patients are more engaged in their care as a result of SCC enrollment. Some even bring their family members to appointments so they can work together on improving their health.

MA Career Impacts

The SCC has added an additional job category or career opportunity within the AtlantiCare system. The initiative has created opportunities for MAs, LPNs, and some other frontline health care staff to utilize skills and aptitudes not usually recognized in MA and LPN positions. Health coaches receive additional training, which enhances their clinical and communication skills.

Figure 1. Special Care Center Patient Survey



Pay and Benefits: The SCC staff members, including PCAs and health coaches, are AtlantiCare employees and are not unionized.

Health coaches at the SCC start at a base rate that is, on average, 10-11% higher than the starting pay of MAs in the AtlantiCare system. Health coaches who are MAs are not required to be certified upon hire, but the SCC prefers that they eventually become certified. MAs receive a 50-cent per hour pay raise for certification. Staff also receives raises based on annual performance evaluations.

AtlantiCare also has an enterprise-wide “Share the Success” program that allows staff to participate in gain sharing on key measures. This annual bonus based on performance usually yields \$500-\$1000 per employee.

Promotional Opportunities: Staff are encouraged to obtain further education that will enable them to take on more responsibility and earn higher wages within the AtlantiCare system. The SCC also recently created a senior, supervisory role, and is looking for some of their current health coaches to step up to become trainers as they move to open a satellite site on the mainland.

Benefits: Medical assistants receive health, dental, and vision coverage through AtlantiCare. AtlantiCare provides up to \$5,000 per year in tuition reimbursement. Two health coaches are currently using this to further their education and will likely continue employment with SCC upon receipt of their health professional degrees.

Retention: Initially the SCC lost approximately half of its staff due to incompatibility with the new model. Over the last year the SCC has had 100% retention.

Satisfaction & Aspirations: Clinic staff noted that this initiative has enhanced the skills and competencies of health coaches, and has encouraged some to pursue further education in nursing and social work. They also cited job satisfaction as a bonus. Health coaches said that it was satisfying to watch patients improve, to be taken seriously by the providers, and to help people from their communities and/or with health conditions similar to their own.

Health coaches often become very invested in their roles and take the initiative to learn and offer more to the patients they work with. For example, one health coach became certified in acupressure and reiki so

she could help provide medication-free pain management resources to patients.

Recruitment: Many potential employees are eager to work with the SCC because of AtlantiCare’s reputation as a quality employer, even if the applicants do not know much about the SCC itself. Administrators not recruited from medical assisting because the training is not adequate for work at SCC. Administrators noted that some of their best referrals for potential Health coaches come from patients. For example, one health coach who previously worked in a fast-food restaurant was told about the job by an acquaintance who was a patient at the SCC.

Future Plans

The partner organizations are generally happy with the model as it is currently working. The same partnership is developing a satellite clinic in Galloway Township on the mainland, near Atlantic City. That site will include a pharmacy, congestive heart failure clinic, and a Coumadin (blood thinner) clinic. Because about 200 of the current patients live in the area of the new satellite, there may be an initial drop in the number of patients at the Atlantic City site. The goal is to have the Atlantic City site serve as the “training ground”, and staff the new site with existing trained staff. The new center will be staffed by an MD, NP, health coach, and a front desk person.

In addition to expanding the facility, the SCC is bringing on new patients via new payers and casino employers.

The SCC is also just starting “third floor services” in which it is establishing relationships with physician specialists. A psychiatrist and cardiologist are now consulting onsite at the SCC.

SCC administrators are exploring partnering with local community colleges to develop a curriculum for training medical assistants in engaging patients and interpersonal skills that would make MAs more qualified to work as health coaches.

AtlantiCare would like to start utilizing the A-ICU model of care with other groups of patients, including the uninsured and homeless patients served through AtlantiCare’s Federally Qualified Health Center, Mission Health.

Replication and Lessons Learned

This model could be replicated elsewhere. There are important factors that would make replication more likely to be successful.

- The *reimbursement structure* must be such that it can cover the costs of non-provider staff such as health coaches. Monthly *capitation* is what allows this health center to deliver an array of comprehensive non-billable services.
- Establishing a joint venture requires strong partners and a certain level of *transparency and support of top leadership in both organizations*. Costs need to be discussed openly between partners, no matter how difficult the conversation.
- The *collaborative team model* requires *provider buy-in* and providers must be willing to spend a great deal of time training and conferring with the health coaches and other staff about patient care.
- *Access to Data*: The Local 54 Fund is self-insured and has a claims system with which it can pull data to identify patients, costs, and benefits. Many union health and welfare funds are not self-insured in this way and hence lack the data for this kind of analysis. This, in conjunction with the patient outcome data collected by the SCC, is very helpful in establishing the business case for adoption and in evaluating outcomes.

The Ambulatory Intensive Caring Unit model depends upon identifying frontline staff with the right qualities to provide intensive one-on-one patient care, and upon the willingness of a select group of providers to work closely and collaboratively with these staff to supervise and mentor them on a daily basis. The Special Care Center has worked to develop an interdisciplinary team with the right balance of training, initiative, and cultural competency to serve a diverse group of patients with multiple chronic illnesses. Achieving this balance has required some trial-and-error, but the experimentation appears to be paying off in terms of decreased costs and improved patient outcomes.

Notes

- i. Berzon, A. April 22, 2010. Atlantic City Casinos: Buyers Wanted. The Wall Street Journal. Online. Retrieved August 19, 2010.
- ii. For instance, Johns Hopkins University researchers estimate that the 21% of the nation's population with multiple chronic conditions accounts for about 59% of all health care spending in the US. Johns Hopkins University. (2002). *Chronic Conditions: Making the Case for Ongoing Care*. Retrieved July 30, 2010 from <http://www.rwjf.org/files/research/chronicbook2002.pdf>
- iii. See UNITE HERE case study for an earlier implementation of this model.
- iv. "A *teamlet* (little team) model of care is proposed to extend the 15-minute physician visit. The teamlet consists of 1 clinician and 2 health coaches. A clinical encounter includes 4 parts: a pre-visit by the coach, a visit by the clinician together with the coach, a post-visit by the coach, and between-visit care by the coach." Bodenheimer, T. and B.Y. Laing. (2007). The Teamlet Model of Primary Care. *Annals of Family Medicine*. 5 (5), 457-461.
- v. According to AtlantiCare policy, MAs cannot give injections.
- vi. The SCC does not currently accept Medicaid, but is looking at a Medicaid population management program.
- vii. Shaw, G. (2009) Can Health Care Quality Improve and Cost Decrease? Pilot Project in Atlantic City May Show the Way. Robert Wood Johnson Foundation Grant Results, retrieved July 30, 2010 from <http://www.rwjf.org/reports/grr/056351.htm>
- viii. Community Health Centers are local, non-profit, community-owned health care providers serving all members of a community without regard to insurance status or ability to pay. Those that receive FQHC status are eligible for federal grant funding, including expansion grants to support the costs of otherwise uncompensated comprehensive primary and preventive health care, and favorable reimbursement policies for services provided for Medicaid and Medicare patients. Explanation provided by the Idaho Primary Care Association website, retrieved July 30, 2010 from <http://www.idahopca.org/community-health-centers/about-community-health-centers>

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Center for the Health Professions
University of California, San Francisco
3333 California Street, Suite 410
San Francisco, CA 94118
<http://futurehealth.ucsf.edu>