

PeaceHealth's Team Fillingame Uses Patient Activation Measure to Customize the Medical Home

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ABSTRACT

PeaceHealth Medical Group received a grant to pilot a patient-centered medical home in one of its practices in Eugene, Oregon. "Team Fillingame" revised staff roles and added a part-time mental health worker to address patients' social, behavioral and medical needs. Using a patient activation measure (PAM), the team tailors and coordinates patient care to fit patients' level of activation and acuity. Cross-trained medical office assistants play a key role in providing health coaching, protocol-based supervised phone triage, and pre-visit planning.

Dr. Fillingame was ready to close his doors. After serving many years as a family physician with [PeaceHealth Medical Group](#) in Eugene, Oregon, he was frustrated with the pace and volume of work in the fee-for-service environment. As his panel aged, he was increasingly faced with patients who had chronic conditions and psychosocial concerns that required more attention than he had hours in a day. He felt he could not provide the quality of care his patients needed. He remembers feeling "like I was on a treadmill going as fast as I could without producing very many results."

He thought about starting a concierge-style practice where he could provide quality care at a slower pace to a smaller panel of patients who would pay an annual membership fee for his services. However, this model conflicted with PeaceHealth's mission, which includes the "just distribution of health care resources" for everyone.

So, when an opportunity arose to pilot a team-based model of primary care, Dr. Fillingame was very interested. He was recruited to form "Team Fillingame" to test a patient-centered medical home model that integrated behavioral health, patient activation, health coaching, and extensive self-management support into the delivery of care. This initiative required redesigning workflow and revising roles to re-allocate some of the work formerly performed by the physician to other qualified staff members. The roles of medical office assistants

Practice Profile

Name: Team Fillingame, part of PeaceHealth Medical Group's Santa Clara Clinic

Type: Non-profit faith-based healthcare organization, family practice

Location: Eugene, OR

Staffing

- 1 physician (.75 FTE in patient care)
- 1 nurse practitioner (.65 FTE)
- 1 RN care manager
- 1 care facilitator
- 1 wellness coordinator (.25 FTE)
- 3 health coaches (currently 2 MOAs & 1 LPN) (ideally 4)
- Supported by some clinic-wide staff such as clinic manager

Number of Patients: 1,500 in last 18 months

Patient Demographics: The patient panel is primarily older adults and their adult children as well as some minor children and infants. Payer mix includes approximately 60% commercial insurance, 30% Medicaid/Medicare, and 5% self-pay. Demographics reflect the surrounding area, which is primarily Caucasian with a high rate of unemployment.

(MOAs) and the front desk staff person were expanded to integrate greater responsibility for patient engagement and care, and a new part-time mental health-worker was introduced to the practice.

Inspiration & Background

[PeaceHealth](#) is a non-profit Catholic-based integrated healthcare organization headquartered in Bellevue, Washington. It operates seven hospitals and a number of medical groups, a chemical dependency program, health care joint ventures, laboratories and other services in southeast Alaska, northwest Washington, southwest Washington/northwest Oregon, Oregon's Willamette Valley, and Oregon's central coast.

In 2008, PeaceHealth and Regence Blue Cross/Blue Shield decided to collaborate by creating and supporting primary care innovation in the Oregon Region. Dr. Ralph Fillingame was recruited to pilot one version of the new model in Eugene, Oregon. Another PeaceHealth practice in Florence, Oregon, was also participating in this pilot, but with somewhat different workforce redesign components including a greater focus on the role of the RN care manager.

Dr. Fillingame spent some time studying the patient centered medical home model. He went to conferences on practice improvement sponsored by the Institute for Healthcare Improvement and the American Association of Family Physicians. He also went on a site visit to [SouthCentral Foundation](#) in Alaska to learn from what they were doing to engage frontline staff and community in providing patient-centered care.

Dr. Fillingame, along with a cadre of health care staff, patients and family advisors developed a proposed model for changing primary care in Dr. Fillingame's practice. Once funding from Regence and PeaceHealth was approved, Team Fillingame began implementation of the proposed model in its own office space in a central downtown Eugene location. After a year of innovation, the entire team was moved to a shared site in the Santa Clara neighborhood in a northwestern suburb of Eugene. This decision to move was a strategic one—administrators hoped that by moving the team into a shared clinic space, they could promote spread of the model beyond one practice.

“Most docs are working too hard and know that other team members could be doing much of the important work that doesn't require a physician's skills. They are ready for someone to take that work off their plate...”

-Thomas Ewing, MD, Chief Medical Officer-

Developing the Medical Home Innovation Pilot

The group redesigned their practice to accommodate a team-based model with two basic principles:

- All staff “working at the top of their license”
- “Make it easy to do the right thing for the patient.”

The patient was to be better incorporated as a team member and “the ultimate manager of health”.

Because this pilot is envisioned as a patient-centered medical home, it has adopted measures to implement the basic tenets of this model of care, which include:

- *Personal provider:* “each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.”
- *Physician-directed medical practice:* “the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.”
- *Whole person orientation:* “the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals.”
- *Care is coordinated and/or integrated* across all elements of the health care system and the patient's community. Care is facilitated by information technology and other tools to aid in coordination.

- *Quality and safety* are to be assured by a care planning process in which patients and clinicians participate as partners. Evidence-based medicine, clinical decision-support tools, and performance measurement guide decision making.
- *Enhanced access to care is available*, including open scheduling, expanded hours and open communication between patients and practice staff and providers.
- *Payment must "appropriately recognize[s] the added value provided to patients" via the PCMH.* Payment should reflect the value of "work that falls outside of the face-to-face visit," include the work of ancillary providers and additional communication with patients outside the patient visit.¹

Staff Roles

Implementing the new model of care required redistributing work through re-designing a number of roles to address the concept of "whole person orientation". The group eliminated positions for scheduler and triage nurse and added a part-time behavioralist. The team currently consists of one physician, one nurse practitioner, a master's-level behavioralist (wellness coordinator), one RN-level care manager, a front office team member called a care facilitator, and 3 MOAs, who serve as health coaches. Titles were specifically chosen to emphasize team members' relationship to the patients rather than their relative standing within the office hierarchy.

All along the line, from care facilitator to clinical staff, team members spend time speaking with patients and documenting their observations of patient needs and passing that information on to the next person in the care team.

The Care Facilitator is a front desk position that has been revised to include additional responsibility and training to serve as a part of the medical team. The care facilitator serves as a greeter, registers patients and takes payment from them, verifies insurance, arranges for ancillary testing, initiates referrals and serves as a backup for incoming calls. The care facilitator initiates the Patient Activation Measurement (PAM) questionnaire—a survey that measures the patient's perception of their

confidence, knowledge and skills. The instrument measures those domains that are required for effective self-management to occur. The survey also includes the PHQ-2, a brief depression screening. If indicated, a more comprehensive depression survey is administered. The care facilitator is the one who greets the patient at the beginning of the visit and follows up with them at the end of the visit. She may go over instructions and directions for referrals and lab tests with patients.

The Team Fillingame care facilitator currently sits with the front desk staff (Patient Access Specialists) for other providers in the Santa Clara Clinic. This provides an interesting contrast in that her role entails additional responsibilities such as referral coordination and patient screening not required of the Patient Access Specialists.

Health Coaches are medical office assistants (MOAs) and an LPN who perform some traditional medical assistant tasks as well as additional tasks related to patient education and engagement.

The MOA is cross-trained to cover two basic roles, the role of the roomer health coach and the role of the phone health coach. MOAs rotate between these two roles every week.

"This is not a task-oriented job; you get more of a chance to talk to and work with patients."

-Becky Smith, LPN, Health Coach-

When the MOA serves as the roomer, s/he rooms patients and collects vital signs, prepares the patient for the provider, administers immunizations and prescription refills by protocol, conducts medication reconciliation, assists with procedures as necessary, handles prior authorizations for prescriptions, and may administer PHQ-9 depression screening tool and Beck Depression inventory, if indicated. Finally, the MOA can conduct some health promotion and patient education based on protocol. This may include providing the patient with handouts and shared decision-making programs [DVDs.] The MOA can

then close the visit and schedule the next visit in the exam room. Each exam room is equipped with a computer.

Based on skill and experience, the health coach may be assigned to work one-on-one with patients by phone or in person based on their [Patient Activation](#), or “PAM”, scores. (See further description below in “Tools”.)

The scheduler position has been eliminated at Team Fillingame because the group found that most calls to the office have to do with simple health or procedural questions that can be handled by MOAs. The phone health coach answers most patient calls and emails. Team Fillingame found that patients like to know the person on the other end of the phone, a benefit that is lost if the calls are delegated to an offsite call center.

The phone health coach will answer patient questions if it is within their scope, schedule patients for their panel, and conduct any necessary follow-up and reminder calls. MOAs can conduct limited triage based on protocols and under nurse supervision. Staff emphasized that MOAs do not make decisions—they use structured protocols and the RN and NP sit very close to them in order to monitor calls. MOAs forward questions that they cannot answer to nurses and providers on staff.

“I feel comfortable that the crew we have now will ask if there is any uncertainty or question. We try not to hire someone that is so sure of themselves that they would not ask questions.”

*-Cathy Davenport, RN, BSN,
Care Manager-*

Upcoming patient visits are reviewed by the team two days in advance of the visit in daily “huddles”. MOAs review patient records and prepare materials on upcoming patient visits for discussion in the huddles. MOAs can identify which patients are in need of x-rays, preventive tests such as mammograms or updated PAM screenings and insure that patients have all necessary tests before they arrive for their exam. MOAs are responsible for

managing the lab and imaging inbox. MOAs also assist with shared medical visits.

The main elements of the Team Fillingame health coach role that distinguish it from the regular PeaceHealth MOA role are a) health coaching, b) phone triage, c) scheduling responsibilities, and d) closer coordination and communication with providers.

The **Wellness Coordinator** provides mental health services to patients with anxiety and depression, provides acute crisis intervention, coordinates smoking cessation efforts, and serves as a liaison with psychiatric resources and social services. This was a grant-funded half-time position that is now a one-quarter time position covered by the practice.

The RN Care Manager provides care coordination and works closely with the wellness coordinator to address patients' psychosocial needs. She manages and coaches patients with complex medical needs and conducts panel management for the group. She calls patients within 48 hours of discharge from the hospital to help them manage the transition from hospital to home, making sure they have their medications, equipment, home health care and meals arranged. She follows up with patients who have been to urgent care or the emergency room. She mentors and orients health coaches and supervises them when they are on the phones.

The Nurse Practitioner provides direct patient care for chronic conditions and acute simple conditions, provides preventive medicine exams and services, conducts shared medical appointments and promotes population management. She may also supervise health coaches when they are on the phone.

The Physician's services are reserved for clinical education of the team, direct care for unstable or complex medical conditions and overall management of the Plan-Do-Study-Act (PDSA) cycles of learning in the group.

Tools for Patient Engagement

[Patient Activation Measurement](#): The group is using information technology in a unique way, incorporating what it calls the “new vital sign”, patient activation. Patients are asked to complete a 10-13 question survey that allows the group to

assess the patient’s knowledge, skills and confidence essential to self-management.ⁱⁱ This assessment uses an evidence-based Patient Activation Measurement (PAM) Scale developed by Judy Hibbard of the University of Oregon. A website, “[Coaching for Activation](#)” developed by Insignia Health, provides support to staff in goal setting with patients and is aligned with the PAM levels of patients. The site also provides access to educational materials appropriate to the four activation levels.ⁱⁱⁱ

Activation levels are intended to help clinicians understand how to effectively coach patients based on the PAM scores. The following levels are paraphrased from the Insignia website material:

1. Patients start become aware of their condition and/or preventive measures, but are not confident or knowledgeable enough to take an active role.
2. Patients gain knowledge and start to build skills to take first steps in managing their own health.

3. Patients have key facts and are starting to take action to monitor their own health and consider lifestyle changes, but lack key skills and confidence to fully support new behaviors.
4. Patients have adopted new behaviors and work to develop strategies to maintain positive changes even in times of stress or health crisis.

Because the group can screen their patients, including those with chronic conditions, for appropriate levels of intervention based on survey results, it can delegate patient coaching and education to appropriate staff members. Patients are rated on a scale of 1-4 based on acuity and activation. So, for example, a patient with high acuity and any level of activation will generally be seen by a nurse, physician and/or wellness coordinator, whereas a patient with lower levels of acuity and higher levels of activation can be delegated to an MOA Health Coach. (See Fig. 1.)

Figure 1. Coaching Matrix

Activation Level ↓	Coaching For Activation – Team Members Assigned		
4	Care Facilitator / Peer Support	Health Coach RN, WC	NP + Team
3	Health Coach	NP + Team	NP, RN, WC
2	Wellness Coord	RN, WC, NP	MD, RN, WC
1	RN Care Mgr	NP	MD, RN
Acuity →	Low	Medium	High

Source: Mary Minniti, CPHQ, Quality Director, PHMG

Team members can conduct motivational interviewing utilizing online protocols which prompt them to suggest different types of interventions based on patient activation levels and conditions.

Electronic Health Records: The team also utilizes an electronic health record system (EHR) to manage patient records and provides an online patient portal so that patients can access their own health records.

Other: The group has introduced peer support for patients via share medical appointments, and provided motivational incentives such as pedometers and other forms of recognition as well as quarterly newsletters on health and wellness.

Training and Startup

Early on, Team Fillingame staff received formal training relevant to the new practice model. This included training conducted by Insignia; the software group that developed the "Coaching for Activation" online tool. They also received training on shared decision-making and motivational interviewing from Health Dialog, a consulting group that specializes in health coaching, healthcare analytics and decision support.

It has been difficult to sustain ongoing formal training for such a small staff, especially one that has experienced turnover and periods of understaffing.

Later MOA recruits have received more informal on-the-job training for their roles as health coaches. MOAs shadow experienced health coaches and train with the RN care manager and nurse practitioner. MOAs receive one-one-one coaching from the RN care manager on answering patient calls and phone triage. She sits with them for several days to ensure that they are comfortable and competent on the phone. Team Fillingame has its own competency checklist.

There is a monthly training session held during staff meeting during which a provider presents material on a specific issue such as diabetes, hyperlipidemia, or women's health. Most of this is in-house, but on occasion the clinic brings in a guest speaker. MOAs and providers report that these trainings help MOAs understand *why* they are being asked to follow certain protocols, which improves the quality of care because MOAs

understand the importance and logic of what they are doing. As one MOA noted, "We don't learn that in MA school."

Staff meetings and daily huddles also allow staff to discuss patient issues and learn from daily experience.

Finally, PeaceHealth also provides an initial orientation and training for new hires that covers broader organizational issues. The organization also requires some online clinical training sessions.

Resources

Grant Funding: The initial grant from Regence Blue Cross Blue Shield ran from October 2008-December 2010. It included \$379,229 shared between the Team Fillingame and Team Florence sites. The total support for Team Fillingame was \$171,140, which covered the time of one full-time MOA, 20 hours of a behavioral health specialist per week. The two sites shared costs for the initial training and license fees for use of the online PAM tool.

PeaceHealth Medical Group supported the pilot by reducing the expectation that the team generate a positive bottom line in 2009-2010 with the expectation that it would break even in FY 2010. It allowed Dr. Fillingame to reduce his patient care FTE to 75% in order to allow him time to train the team and develop the model.

Information Technology and Data Management: The clinic manager developed some special tracking measures to collect data on the initiative's progress. She set up a separate cost center number for Team Fillingame so they could track financials over the course of the grant. They were able to track patients across the system to follow up on hospitalization and ER use. A series of pseudo-codes were developed in the billing system to track interventions by team roles so that the system could be used to report activity and service interventions that were outside the role of a traditional primary care practice. An analysis was completed to understand how utilization changed with those patients targeted for these new service interventions.

Challenges

Perhaps the most significant challenge facing the team was the need to manage the constant change necessitated by piloting a new model. The team also faced some difficulties finding and retaining staff, which made it more difficult to fully implement their model or develop a working team.

Recruitment and Retention: The original plan called for a part-time physician supported by two nurse practitioners. However, the team had extreme difficulty in recruiting even one nurse practitioner willing to work in this model. They recruited and lost two NPs before they finally found an NP comfortable with the team and the model. This set the project back considerably.

The team also found it hard to recruit and maintain MOAs capable of serving as health coaches. Some could not develop the skills necessary to work in this more demanding role. One MOA, who was very good as a health coach, ended up training and retraining new MOAs and covering for vacant positions until they were filled. She became burned out with the responsibility and left the organization.

The team has stabilized and members report that they have a good rapport, but they are somewhat short-staffed and any absences can cause hardship.

“(Some MOAs) don’t get when they come here that vital signs are *not* your main job. There are relationships and these are real people. You are going to provide patients an education...”

-Becky Smith, LPN, Health Coach-

Defining Roles: The original plan called for an RN care manager who would serve as both a care manager and as clinic manager. However, the administrative duties inherent in the innovation clinic manager role turned out to be more time-consuming than anticipated and tended to supersede the clinical work. In the interim, the Quality Director served as the manager for the Team to allowed the RN care manager to refocus

her energies onto clinical care. For long term sustainability, the team was able to move into the shared facility.

Recognition and Reimbursement: As a result of moving into a shared space in the Santa Clara Clinic, the MOAs are able to compare their responsibilities and workload to that of the MOAs in the other practices. As one staff member put it, “we work really *hard* here”. While the Health Coach role does entail more pay for the MOA than the regular “roomer” position, the contrast can be glaring. The team had proposed a 3-tier ladder to allow MOAs career opportunities for growth, but found that their HR department was not yet ready to take that step.

Technology: PeaceHealth was an early adopter of electronic health records (EHRs). This has been challenging in that the enterprise application the organization uses is not flexible and cannot support population management or ambulatory care well. The group has had to use two data systems, Centricity 6.7 EMR and FlowCast Scheduling, to conduct business.

Financial Sustainability: Some of the benefits of the innovation are likely to be in the form of long-term savings at the system level resulting from better patient health and decreased use of urgent care and hospitalization. There would also be return to scale if some of the training and resources required for this model were spread across a greater number of practices. The yearly license for the PAM tool, and training for MOAs are examples of costs that could be shared across more sites.

In the short-term, this model may initially result in greater costs than the traditional model of primary care partially because it is being implemented on a very small scale and partially because it is still in the innovation phase.

The grant for the pilot ended December 2010, and Team Fillingame is now working on sustaining the model without grant funding. Hence, the question of financial impacts is especially relevant to PeaceHealth as an organization that functions on a fee-for service model.

As one staff member noted, getting insurers to pay for the Patient Centered Medical Home model is a chicken-or-egg problem; you cannot receive the

money to run it until you can demonstrate that it works, which requires investment.

Integration and Spread: There were some initial challenges to integrating Team Fillingame into the existing space and organizational structure at the Santa Clara Clinic. As noted above, Team Fillingame staff noted that MOAs and front desk staff with the other practices had “more down time”.

“I don't think I initially realized that in innovation, you don't know where you are going to end up. That is a mind change that you have to grasp, otherwise your frustrations are many.”

*-Cathy Davenport, RN, BSN,
Care Manager-*

The space in the clinic is also less conducive to team work as the Care Facilitator's desk is in the main lobby far from her team, which is located in a long hallway on one side of the building.

While Team Fillingame was moved to this clinic largely to start the process of spreading the team model, other providers are leery of adopting key pieces of the initiative. Some providers and RNs are opposed to the idea of MOAs doing phone triage because they feel it is outside of the MOA scope of practice. Some MOAs are likewise concerned about the triage piece because they feel it is beyond their level of training. There has been a leadership decision to support the health coach model as it transitions other clinics in the region to the medical home model. The model will likely be customized to fit individual practice sites.

Outcomes

While the team has had its struggles, it has achieved demonstrable success on a number of clinical and efficiency measures.

Clinical Outcomes: From April 2009 to September 2010, the team saw a steady decrease in the number of patient visits to the emergency department or urgent care for those conditions appropriately treated in primary care if access was

available. (See Fig. 2.) The team has also seen an improvement in patient access to clinic appointments over this time period, with an increase from 60% open slots available at the beginning of the month in September of 2009 to 74% in September of 2010.^{iv}

There has been a steady improvement in the proportion of hypertensive patients with controlled blood pressure from a baseline of 56% in January 2009 to 77% of patients in January of 2011 (See Fig. 3) as well as improvement in LDL and A1C measures for diabetic patients.^v

Financial Outcomes: Project staff noted that they broke even on non-grant supported positions in the last fiscal year, and overall made a positive contribution despite losing grant support in December 2010. Once the team is fully staffed and stabilized, they believe they will be in the position to generate more revenue because they will be able to increase their panel. They also note that the cost-savings of this model will be reflected in decreased costs to the overall system in terms of disease prevention and management and demonstrated decrease in hospitalization and visits to the emergency room. Analysts are still assessing the financial costs and benefits of this model.

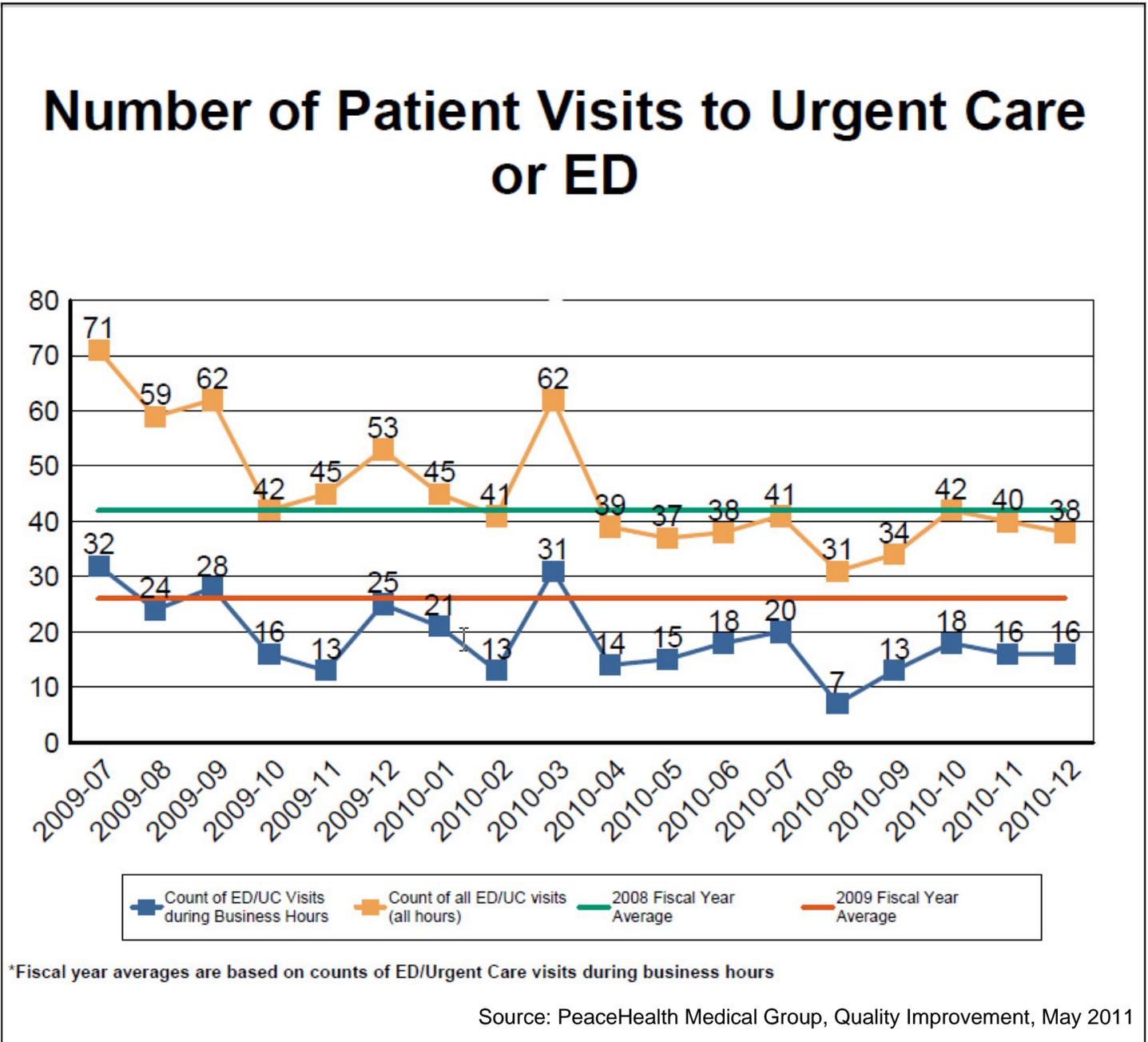
Patient Satisfaction: Providers and other staff, including MOAs, reported that they felt that patients trusted *everyone* on the team to give them reliable information on their care and trusted that the entire team was on the same page in this

The majority of patients (over 98%) agreed with the following, among a number of other statements about patient care:

1. Team Fillingame showed “concern about your health and how you were feeling.”
2. Team Fillingame “know important information about your medical history.”
3. “Front desk treated you with courtesy and respect.”^{vi}

Provider Satisfaction: This initiative was intended to delegate to other staff tasks that do not require a physician's skills and training. Hence, physician time is reserved for only those issues that truly require his or her attention. While both providers currently working with Team Fillingame appreciate

Figure 2. Number of ED or UC Visits for Conditions Appropriately Treated in Primary Care if Access Was Available



this model, it has yet to be fully implemented due to the difficulty in recruiting and retaining an additional nurse practitioner. Providers in the beta test team at the Santa Clara clinic are very excited about the potential of this model for relieving provider workload, which is a powerful incentive for provider buy-in.

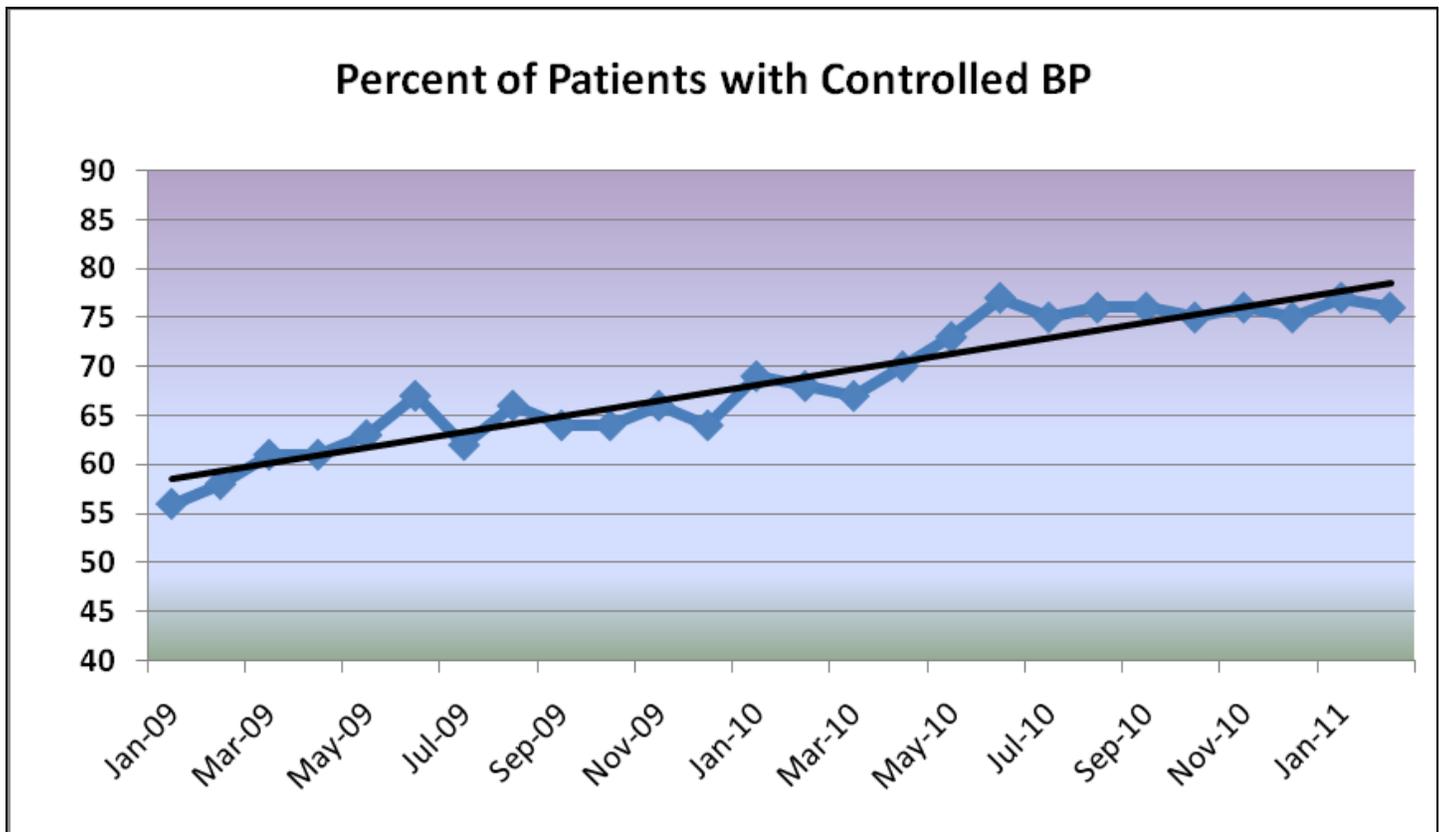
MOA Career Impacts

MOAs who do health coaching have been re-classified and receive approximately a dollar more

per hour than regular MOAs who do not have the expanded role.

Certification: Medical office assistants must be certified or receive certification within six months of hire.

Benefits: Staff reported that PeaceHealth had attractive benefits. The organization provides employees medical, dental, and vision coverage; employer-paid core term life and accidental death and dismemberment insurance, disability coverage,

Figure 3. Percent of Hypertensive Patients with Controlled Blood Pressure

Source: PeaceHealth Medical Group, Quality Improvement, May 2011

flexible spending accounts, a flexible paid time off plan, transportation benefits, a retirement plan with additional tax-deferred retirement savings options. PeaceHealth also offers an employee tuition reimbursement program. Staff at PeaceHealth Medical Group are not part of any union, although at the regional level, nursing staff at PeaceHealth hospitals are unionized.

“I really enjoy it. It’s not just *my* job, but everybody’s job. It is much better patient care. You don’t just say, “There you go,” and let the patient leave. You do follow-up, you check on how they are doing...”

-Jennifer Houlihan, MOA, Health Coach-

Satisfaction & Aspirations: MOAs observed that getting to be more engaged with patients and having some autonomy was very satisfying. They also noted that they felt that they had the trust of providers, and a voice in team decision making.

Skills: MOAs appreciated the training in clinical and communication skills. One noted that the field of health coaching was growing and that experience in this field might lead to advanced career options.

Future Plans and Replication

PeaceHealth is experimenting with a number of pilot initiatives and attempting to develop a common set of metrics to compare them. These include the two Lean Engineering model adapted from Virginia Mason Medical Center in Seattle, and an “All-in-One” project that utilized an MOA throughout the visit, including as a scribe during the exam.

They may want to take elements from each model, or adopt one or two for further implementation. At the Santa Clara Clinic, two additional providers were

invited to try the Team Fillingame model. This beta test team includes the newest physician at the clinic and the physician with the greatest seniority. They are meeting as a group and will develop a new team with two providers, three MOAs, one patient access specialist, a scheduler, an RN care manager, and a wellness coordinator. No new staff will be hired; rather, individuals will be re-allocated from within the clinic.

The new team ("Team KitKat", named for the first names of the two physicians) is adapting the protocols from Team Fillingame to fit their own ideas. In this new team, the MOAs will not rotate between duties. The team has decided to integrate the PAM and will train staff in its use, although they are still discussing whether MOAs will do any triage. However, the providers are very interested in implementing team huddles and the more proactive patient care and preventive measures developed by Team Fillingame.

The group hopes to qualify with the National Committee for Quality Assurance as a level 2 patient-centered medical home by 2013.

Lessons Learned

- *Organizational and leadership support* is critical for supporting an innovative pilot through its infancy. Perfecting a new model requires a significant investment of time and resources.
- *Innovation* is time consuming and can be frustrating and lead to burnout.
- *Team building* is essential to creating a successful model.
- *Careful staff selection* is vital to creating successful teams. This model of care requires different skills and capacities than those generally required of medical assistants and other staff.
- *Dedicated meeting time* for communicating, educating and problem solving is also important for team-building and perfecting a new model.
- *Respect and develop the intellectual capacity of non-licensed staff.* Patient care can be improved if staff understand the rationale behind procedures as well as the mechanics of performing them.

- *Protocol Development* is important to document and standardize processes and to allow for organization-wide adoption.
- *Measurement and documentation* are essential to proving the efficacy of these models. The ability to develop and analyze pilot-specific data is vital.
- *Costs savings* may be realized at the system level as well as at the individual cost center level.

“By and large people have been pre-occupied with, and somewhat distracted by, acute care. The result of that is clearly more expensive care, hospital care, procedures and such that will eventually bankrupt the healthcare system and country if we don't do things differently.”

-Dr. Ralph Fillingame, MD-

Notes

- i. Joint Principals of the Patient-Centered Medical Home, Patient Centered Primary Care Collaborative website
<http://www.pcpcc.net/joint-principles>
(Accessed January 11, 2011).
- ii. Minniti, M. (2011) Team Fillingame PAC Presentation, February 25, 2011. PowerPoint Slideshow; slide 7.
- iii. Ibid. 2 and Activation Levels from <http://www.insigniahealth.com/solutions/coaching-for-activation> (Accessed April 4, 2011).
- iv. Institute for Healthcare Improvement website, definition of "Future Capacity" for primary care. "Percentage of appointment slots that are open and available for booking patients over the next four weeks." <http://www.ihl.org/knowledge/Pages/Measures/FutureCapacity.aspx> (Accessed Jan 4, 2012).
- v. Minniti, M. *Patient-Centered Primary Care Medical Home Rollout Kit Section C: Results and Recommendations*. April 2011. Internal document outlining preliminary evaluation results on the Team Fillingame initiative.
- vi. Ibid v.

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(www.HitachiFoundation.org)



This case study is part of the [Innovative Workforce Models in Health Care](#) series of case studies prepared by the UCSF Center for the Health Professions. These case studies highlight organizations that are expanding the roles of medical assistants and other frontline health care workers in new directions that benefit both the organization and its patients while providing career development opportunities to the employees.

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Views expressed in this case study are those of the authors and do not necessarily reflect those of the Center for the Health Professions; the University of California, San Francisco; the Hitachi Foundation, or PeaceHealth Medical Group.

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