

## PeaceHealth Team Fillingame: Update 2014

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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 tailored and coordinated patient care to fit patients' levels of activation and acuity. Cross-trained medical office assistants (MOAs) played a key role in providing health coaching, protocol-based supervised phone triage, and pre-visit planning. This 2014 summary updates the original 2011 case study with new information on staffing, clinical outcomes, reimbursement, and more.

*Note: Team Fillingame did close its doors in 2012. One of two pilots being conducted in PeaceHealth primary care practices, Team Fillingame showed promising early results, but its model was not adopted by the larger organization. The following case study documents its innovations and provides some commentary on the reasons for its demise.*

After many years as a family physician, Dr. Ralph Fillingame was ready to close his doors. 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. Unable to provide the high level of care he felt his patients deserved, he remembers feeling "like I was on a treadmill going as fast as I could without producing very many results."<sup>1</sup>

Therefore, when an opportunity arose to pilot a new team-based model of care, Dr. Fillingame volunteered. He was recruited to form Team Fillingame to test a Patient-Centered Medical Home (PCMH) that integrated behavioral health, patient activation, health coaching, and extensive self-management support into the delivery of care. This initiative required redesigning the workflow and revising roles to reallocate some of the work formerly performed by the physician to other qualified staff members. The roles of medical office assistants (MOAs) and the front desk staff person

### Practice Profile 2011

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

**Type:** Nonprofit faith-based health care organization, family practice

**Location:** Eugene, Oregon

#### Staffing

- 1 physician (0.75 FTE in patient care)
- 1 nurse practitioner (NP) (0.65 FTE)
- 1 registered nurse (RN) care manager
- 1 care facilitator
- 1 wellness coordinator (0.25 FTE)
- 3 health coaches (2 medical office assistants [MOAs] and 1 licensed practical nurse [LPN]; ideally 4)

Supported by some clinicwide staff such as clinic manager

**Number of Patients:** 1,500

**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 or Medicare, and 5% self-pay. Demographics reflect the surrounding area, which is primarily White with a high rate of unemployment.

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 and Background

PeaceHealth is a nonprofit, Catholic-based, integrated health-care organization headquartered in Bellevue, Washington, that serves many regions in the Pacific Northwest.

In 2008, PeaceHealth and Regence Blue Cross/Blue Shield decided to collaborate by creating and supporting primary care innovation in the Oregon region. Dr. Fillingame was recruited to pilot one version of the new model in Eugene, Oregon. Another PeaceHealth practice in Florence, Oregon, also participated in this pilot but with 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 visited SouthCentral Foundation in Alaska to learn from what they were doing to engage frontline staff and community in providing patient-centered care.

Team Fillingame initially began implementing the Patient-Centered Medical Home model in its office space in downtown Eugene. After a year, the entire team was moved to a shared site 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 the spread of the medical home model by example.

### Developing the Medical Home Pilot

The PCMH model of care is gaining popularity in the wake of the passage of the Affordable Care Act (ACA) in 2010. The model encompasses a number of key principals, including providing each patient with a personal physician who coordinates patient care in a team-based model by utilizing health information technology to plan and document care and measure performance. The PCMH also ideally

encompasses enhanced access and communication between patients and practice staff and providers. The patient is to be better incorporated as a team member as the ultimate manager of health. An especially important component of the PCMH is the idea that payment should reflect the work that “falls outside of the face-to-face visit,” including the work of ancillary staff providing care.<sup>2</sup>

### Staff Roles

Implementing the new model of care required redistributing work by redesigning 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. Titles were specifically chosen to emphasize team members’ relationship to the patient rather than to medical hierarchy.

The **Care Facilitator** served as a greeter, registered patients and accepted payment, verified insurance, arranged for ancillary testing, initiated referrals, and served as a backup for incoming calls. She administered the Patient Activation Measurement (PAM) questionnaire—a survey that measures domains that are required for effective self-management to occur. The survey also includes the PHQ-2, a brief depression-screening instrument. The care facilitator followed up with patients at the end of the visit and went over instructions for referrals and lab tests with them as needed.

**Health Coaches** were two medical office assistants (MOAs) and a licensed practical nurse (LPN) who performed some traditional medical assistant tasks as well as tasks related to patient education and engagement. The MOA was cross-trained to cover two basic roles, the role of the roomer and the role of the health coach. MOAs rotated between these two roles every week.

When the MOA served as the roomer, she or he roomed patients and collected vital signs, prepared the patient for the provider, administered immunizations and ordered prescription refills by protocol, handled prior authorizations for

prescriptions, conducted medication reconciliation, assisted with procedures as necessary, and administered the PHQ-9 depression-screening tool and Beck Depression Inventory if indicated. Finally, the MOA could conduct some health promotion and patient education based on protocol. This task might include providing the patient with handouts and shared decision-making programs (DVDs). Each exam room was equipped with a computer, so the MOA could schedule the next visit in the exam room and close the visit.

The health coach answered most patient calls and emails. Team Fillingame found that patients liked to know the person on the other end of the phone, a benefit that is lost if the calls are delegated to an off-site call center. The health coach answered patient questions if they were within the MOA scope, scheduled patients, and conducted any necessary follow-up and reminder calls. Under nurse supervision, MOAs could conduct limited triage based on protocols. MOAs did not make decisions—they used structured protocols. MOAs were seated next to the registered nurse (RN) and nurse practitioner (NP), who monitored calls. MOAs forwarded questions that they could not answer to the nurses and providers on staff.

MOAs reviewed patient records and prepared materials on upcoming patient visits for discussion in daily team “huddles.” MOAs could identify which patients needed x-rays, preventive tests such as mammograms, or updated PAM screenings, and they ensured that patients had all necessary tests before they arrived for their exams. MOAs also were responsible for managing the lab and imaging in-box. In addition, they assisted with shared medical visits.

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

The **Wellness Coordinator** provided mental health services to patients with anxiety and depression,

provided acute crisis intervention, coordinated smoking cessation efforts, and served as a liaison with psychiatric resources and social services.

The **RN Care Manager** was responsible for care coordination, working closely with the wellness coordinator to address patients’ psychosocial needs. She managed and coached patients with complex medical needs and conducted panel management for the group. She also helped patients manage the transition from hospital to home and followed up with patients who had been to Urgent Care or the Emergency Department (ED). In addition, she mentored and oriented health coaches and supervised them when they were on the phones.

The **Nurse Practitioner (NP)** administered direct patient care for chronic conditions and acute simple conditions, provided preventive medicine exams and services, conducted shared medical appointments, and promoted population management.

The **Physician’s** services were 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

The group was using information technology in a unique way, incorporating what it called the “new vital sign,” patient activation. A 10- to 13-question survey was used to assess patients’ knowledge, skills, and confidence essential for self-management.<sup>3</sup> This assessment uses an evidence-based Patient Activation Measurement (PAM) Scale developed by Judy Hibbard of the University of Oregon.<sup>4</sup>

Because the group could assess motivation levels along with medical conditions, it could delegate patient coaching and education to appropriate staff members. Patients were rated on a scale of 1 to 4 based on acuity and activation. So, for example, a patient with high acuity and any level of activation would generally be seen by a nurse, physician, and/or wellness coordinator, whereas a patient with

lower levels of acuity and higher levels of activation could be delegated to an MOA health coach.

Team members could conduct motivational interviewing utilizing protocols on the [Coaching for Activation website](#), which prompts them to suggest different types of interventions based on patient activation levels and conditions.

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

An electronic health record (EHR) system helped staff manage patient records and provided an online patient portal so that patients could access their own health records.

### Training and Start-up

At start-up, the team 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. Team members also received training on shared decision-making and motivational interviewing from Health Dialog, a consulting group that specializes in health coaching, health care analytics, and decision support.

Over time, MOAs received more informal on-the-job training through shadowing experienced health coaches and one-on-one coaching from the RN care manager.

At a monthly training session held during a staff meeting, a provider or guest speaker would present material on a specific issue such as diabetes, hyperlipidemia, or women's health. These trainings helped MOAs understand the logic behind the protocols as well as how to follow them.

### Challenges

The original staffing plan had to undergo some changes to fit conditions on the ground. The original plan called for a part-time physician supported by

two NPs. However, only one NP could be recruited and retained during the grant period.

The team also found it difficult to recruit and retain MOAs capable of serving as health coaches. Some MOAs could not develop the skills necessary to work in this more advanced capacity, so the clinic was occasionally understaffed. Attempts to convince Human Resources to adopt a three-tiered career ladder for MOAs were unsuccessful as systemwide resources were being allocated more toward basic clinical skills training for existing MAs.

The original plan was for the RN care manager to serve an additional role as clinic manager. However, the administrative duties inherent in the clinic manager role were more time-consuming than anticipated and tended to supersede the clinical work. With the move to the shared clinic space, the team was able to pool resources with the other on-site practices, which included an existing clinic manager.

Sharing clinic space addressed some challenges but created others. The MOAs and care facilitator were able to compare their expanded responsibilities and workload with the lighter workload of comparable staff in the other practices. Some providers at other practices questioned whether phone triage is within MOAs' scope of practice.

PeaceHealth's older custom-developed EHR was not flexible and could not support population management or ambulatory care very well. Consequently, the group had to use two data systems to conduct business and document outcomes.

### 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 conditions that could be appropriately treated in primary care during business hours. There was an improvement in patient access to clinic appointments over this time period, with an

increase from 60% of open slots available at the beginning of the month in September 2009 to 74% in September 2010.<sup>5</sup>

There was a steady improvement in the proportion of hypertensive patients with controlled blood pressure from a baseline of 56% in January 2009 to 77% of such patients in January of 2011 as well as improvement in LDL and A1C measures for diabetic patients.<sup>6</sup>

### MOA Career Impacts

MOA health coaches were reclassified and received approximately a dollar more per hour than regular MOAs did. MOAs receive a full package of benefits, and PeaceHealth also offers an employee tuition reimbursement program.

The relative level of autonomy and the opportunity to be more engaged with patients were very satisfying to MOAs. They valued the trust of the providers and the chance to have a voice in team decision-making.

### Moving Forward/Looking Back

Team Fillingame was one of two primary care practice sites where PeaceHealth was piloting new models of care. At the other site, medical assistants were accompanying some patients with chronic diseases throughout the visit and scribing throughout the exam. However, despite some positive results at these sites, in the end neither model was adopted.

First, PeaceHealth is a multistate organization that was in the process of moving toward greater standardization across regions. A reexamination of the state nursing standards resulted in the conclusion that MAs could not do the final medication reconciliation, request refills or lab orders, or review normal lab results with patients—duties that were all key elements of the Team Fillingame model.

Another issue had to do with how return on investment was realized. As with many other health systems, PeaceHealth was looking at ways

to reduce costs while retaining or improving quality of care. Although Team Fillingame was producing some data that suggested that its model of care was reducing downstream costs such as unnecessary ED visits and hospitalizations, the decrease was not enough to make the business case for a very hospital-based system to invest heavily in a model of care that involved enhancing staffing without increasing volume.

As part of the standardization, the PeaceHealth system was also upgrading from its legacy EHR to Epic—an enormous task that required much attention. The way in which the earlier EHR had been configured made it difficult to track the overall cost of care for most patients. Team Fillingame was not able to consistently and reliably track the outcomes of its model with this data system.

As noted in other case studies in this series, an important factor for success is consistent support from top leadership. Leadership changes within PeaceHealth at the system and regional levels meant that some administrators who understood and supported the goals of the project left.

One key element piloted by Team Fillingame, the Patient Activation Measure, has, however, been picked up by a major regional health-care innovator, Fairview Health Services in Minnesota, with success.

### Notes

1. R. Fillingame, personal communication, March 8, 2011.
2. Joint Principals of the Patient-Centered Medical Home," originally posted on the Patient-Centered Primary Care Collaborative website, reposted on the American Academy of Family Physicians website, Accessed August 18, 2014, [http://www.aafp.org/dam/AAFP/documents/practice\\_management/pcmh/initiatives/PCMHJoint.pdf](http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf).
3. M. Minniti, *Team Fillingame PAC Presentation* (2011) (PowerPoint slide show presented February 25, 2011), slide 7.

4. See Judy Hibbard, "Patient Activation Measurement (PAM) Scale," accessed October 23, 2014, <http://www.insigniahealth.com/products/pam.html>
5. Definition of *future capacity* for primary care: "percentage of appointment slots that are open and available for booking patients over the next four weeks." Institute for Healthcare Improvement website, Accessed August 29, 2014. <http://www.ihl.org/knowledge/Pages/Measures/FutureCapacity.aspx>.
6. M. Minniti, *Patient-Centered Primary Care Medical Home Rollout Kit Section C: Results and Recommendations* (internal document outlining preliminary evaluation results on the Team Fillingame Initiative, 2011).

Special thanks to the Team Fillingame for their ongoing assistance with this project.

To read the full 2011 case study, please see PeaceHealth's Team Fillingame Uses Patient Activation Measure to Customize the Medical Home.

## Acknowledgments

*Innovative Workforce Models in Health Care* is a series of case studies showcasing primary care practices that are expanding the roles of medical assistants in innovative ways. Profiled organizations are implementing practice models that improve organizational viability and quality of care for patients while providing career development opportunities to frontline employees. This research is funded by the Hitachi Foundation as part of its Pioneer Employers Initiative.



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