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INNOVATION PROFILE

At Martin's Point In Maine, Primary Care Teams For Chronic Disease Patients

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SYSTEM **Martin's Point Health Care is a not-for-profit primary care health system based in Portland, Maine. Its fifty-four primary care physicians work in nine practice locations and treat approximately 70,000 patients. Martin's Point also has a health plan with 60,000 members, including a Tricare Prime US Family Health Plan for military families.**

KEY INNOVATION **To improve care for patients with chronic disease, Martin's Point is reorganizing practices into patient-centered "care teams" capable of anticipating patients' needs and facilitating communication about their care. Population health tools, including registries, are used to track patients with chronic illnesses and proactively manage their care.**

COST SAVINGS **As yet, data are unavailable.**

QUALITY IMPROVEMENTS **In pilot practices that have applied these innovations to patients with hypertension, the percentage of patients with controlled hypertension went from 55 percent in July 2007 to more than 82 percent in July 2010.**

CHALLENGES **The care team increases in size from an average of 4.3 employees per primary care physician to 6 employees per physician. But the current primary care payment models don't support the additional staff. Physicians skilled in leading care teams are also in short supply.**

In early 2010 a team led by Doug Couper at Martin's Point Health Care in Portland, Maine, went through the electronic medical records of the patients with hypertension in his practice and that of his colleague, Margaret Shepp. They found that 220 of the patients with hypertension—about 20 percent—had elevated blood pressure in the past eighteen months. The result was better than the national average for controlling blood pressure but short of what Martin's Point was aiming for, given its participation in the Triple Aim program of the Institute for Healthcare Improvement. Specifically, Martin's Point had set a goal of addressing patients' chronic conditions to improve their health and avoid costly interventions. So Couper launched an effort to bring the proportion of patients with hypertension who had "controlled" blood pressure—a rate below 140/90 mm Hg—up to 82 percent.

The first step was deceptively simple: to check patients' blood pressure at the beginning and end of each visit. Patients with elevated blood pressure are not permitted to leave until a staff member explains their health risks and crafts a plan for follow-up monitoring and care. Patients who do not want to return to the office to have their blood pressure monitored can sign out loaner blood pressure cuffs to take home with them and report their results by phone.

This straightforward strategy is supported by a

complex reorganization of how Couper's practice operates. The practice has reorganized itself into what Martin's Point calls a "care team" that includes a physician, a nurse, a medical assistant, and a patient service representative. The care team meets weekly to devise strategies for the patients it has identified as needing extra support, and quarterly to review the entire patient pool and see if others need to be given extra attention. This is made possible by the electronic health records that Martin's Point began adopting in 2005 and by analysis provided by the system's fourteen-person informatics team.

Martin's Point president and chief executive officer David Howes says that two particular features distinguish the new approach. "The physician and the rest of the care team feel a responsibility for the care of a population of patients," he says, while they also try to anticipate the population's care needs. This change in provider mind-set is complemented by "patient-friendly processes that are utilized to engage the patient," such as following up by phone.

Couper's team far exceeded the goal of controlling blood pressure in 82 percent of patients with hypertension, reaching 88 percent. Similar results were achieved in a parallel project run by another Martin's Point physician, Margaret Shepp. The results from these pilots have been so strong that other Martin's Point doctors are adopting them, and innovation is spreading through the organization "just by osmosis," Howes says.

Care Teams And Chronic Disease

A key to success has been careful efforts to design and build the care teams and provide them with ongoing support. The system has found that teams work best when headed by a strong physician-leader who can direct their vision and allocate resources appropriately.

Also critical is equipping the team with tools to assess its patient population—including an overall information infrastructure that can give the team usable data on patients' health, as well as a routine for reviewing the data and adjusting the practice to improve outcomes. Physicians and other medical staff also receive additional compensation for training in the use of electronic health records and registries for recording and analyzing population health data.

Creating registries spotlights gaps in patient care, showing that "docs do a very good job taking care of patients who come in on a regular basis" but not with those "who don't come in [or] who don't take their medicine," Couper says. The team regularly meets to review the files of patients who are having difficulty and try to identify strategies to improve management of their conditions. In the hypertension program, for example, patients who are not coming in to have their blood pressure monitored may be loaned a blood pressure cuff and asked to call the office with their results.

Physician Alain Montegut and medical assistant Maria Gleason, members of a Martin's Point Health Care team, examine a patient at the Martin's Point Portland, Maine, health center. The teams are designed to improve care of chronically ill patients by anticipating their needs and coordinating their treatment.

Photo: Kevin Bruise

Providing patients with such simple ways to take control of their own care can have a dramatic effect, Couper says. He gave the example of one patient who had been using a loaner cuff who started off with blood pressure readings of 224/98. Today he's down to 152/76 and is saving up to buy a cuff of his own.

Couper is now preparing to expand his model to target cholesterol. Just under two-thirds of the patients in his practice have a low-density lipoprotein level under 100; he's now aiming for vastly more to have their cholesterol controlled.

Hanging on his office wall is a classic "fishbone" or Ishikawa diagram from the quality improvement movement listing impediments to patients' ability to manage their cholesterol. These include transportation difficulties that keep patients from making appointments, failure to follow prescribed diets, insurance issues such as gaps in coverage, and process issues such as whether patients come in for routine checkups. Then the team starts identifying where additional interventions can be most effective.

Financing

Better management of chronic conditions may help patients avoid costly hospitalizations and other interventions, but they are not cost-free. As

Martin's Point continues to reorganize around the care team model, the system will need to increase the average number of nurses and other employees per primary care physician from 4.3 to 6. "That will allow them to see more patients [, and] it will allow them to be far more effective in the care of the populations," Howes says. But the additional staff time is not directly reimbursable under a fee-for-service model that rewards "production" rather than population health management, he adds. "The revenue streams are simply not there, and the business models that we need to support that are not preeminent in our community," he says.

However, through its own health plan, Martin's Point is already moving to build the new payment model. It has adopted a system of capitation, in which its doctors will be paid almost double if they simultaneously achieve higher patient confidence, better quality, and lower total cost for care. The system is also exploring moving physicians to some version of a salaried system with incentives for quality improvement.

Howes and other Martin's Point officials hope that results from their pilot and similar innovations will persuade others to adopt their model. In the meantime, other findings have surfaced. "An unexpected group of frontline physicians have become very interested" in the notion of boosting patients' confidence and self-efficacy to deal with their conditions, Howes says. And recruiting more doctors committed to the new model is a challenge: "We really need primary care clinicians interested in, and excited about, leading care teams." ■

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