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Patient Focused Care: A Prescription to Reduce Healthcare Costs

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Thank you, Chairman Collins, Ranking Member Casey, and members of the Committee on Aging for this opportunity to provide testimony regarding the health care innovation, quality and transparency for seniors in Maine.

My name is Dr. David Howes, and I am the President and CEO of Martin's Point Health Care based in Portland, Maine. In my testimony today, I want to share with you a picture of the health care landscape for seniors in my home state of Maine (a landscape shared, I'm sure, by many states with significant aging populations in rural areas.) I also will tell you what my relatively small (but mighty) health care organization is doing to address the significant needs of this population.

I earned my medical degree from Dartmouth Medical School in Hanover, New Hampshire, and served residencies at the Dartmouth-Hitchcock Medical Center, the Medical Center Hospital of Vermont in Burlington, and the Eastern Maine Medical Center in Bangor, Maine.

I began my medical career as a family physician serving the rural, island fishing community of Stonington, Maine.

This experience has taught me the power of primary care in improving health outcomes and reducing the cost of care. I brought this philosophy to Martin's Point Health Care in 1989 as a primary care physician and now serve as the President and CEO, a position I have held since 1996. I am deeply committed to the Martin's Point mission of creating a healthier community and have dedicated my career to doing so–both as a physician and as president and CEO.

Martin's Point Health Care is a forward-thinking, not-for-profit organization providing primary care and health insurance plans to the people of Maine and beyond for over 35 years. We own and operate seven primary care health care centers with over 70 health care clinicians in Maine and New Hampshire. We also administer two health plans: Generations Advantage, the largest Medicare Advantage plan in Maine (also offered in New Hampshire), and the US Family Health Plan (TRICARE Prime®) for military families and retirees in Maine, New Hampshire, Vermont, and parts of New York and Pennsylvania. Our Medicare Advantage plans have received the highest quality ratings in Maine by The Centers for Medicare and Medicaid Services and our US Family Health Plan is rated "excellent" by NCQA and is the highest rated plan of its type in the country, based on Consumer assessment of Healthcare Providers and Systems (CAHPS) scores.

As a not-for-profit health care organization serving our local population, offering both primary care and health insurance coverage, we are uniquely positioned to deliver the highest quality care at the lowest cost with the best overall experience for our patients and members. In fact, we are long-standing members of the Alliance of Community Health Plans (ACHP), a national leadership organization based in Washington, DC, advocating for not-for-profit health plans across the country. Members of ACHP are similar to Martin's Point in that they have deep ties to their providers, a dedication to the health of their communities and a commitment to striving for the highest quality ratings. Many Senators serving on the Committee on Aging have ACHP-member health plans operating in their states.

Maine is certainly known for its seafood industry, and this summer my son worked in one of the most physically demanding careers in Maine—he served as an apprentice on a lobster boat, under the tutelage of "Captain Mike." I mention this because the Captain is a Martin's Point health plan member as well as a patient at one of our health care centers, and before and after each lobster season he makes the long journey from the island of Vinalhaven to visit our health care center in Brunswick, some 70 miles to the south. He comes to have his knees treated for increasing arthritis, the result of many years hauling and heaving lobster pots. Now at an age when many would be planning retirement, Captain Mike is teaching a new generation the intricacies of catching crustaceans. In the off-season, he returns to the mainland as an art teacher. As Senator Collins well knows, his career reflects the way many Mainers make a living – doing what they do best, often combining a variety of passions to add up to a satisfying and sustaining whole. Mike could choose to have his knees worked on closer to home, but he chooses to travel to Martin's Point because we have earned his trust. By providing both his primary care and his insurance coverage, we are uniquely positioned to consider the full spectrum of his health and support him on land or sea, reliably and affordably.

At Martin's Point we believe we have much to offer members like Mike and thousands of other rural seniors in Maine, who seek a trusted health care partner who shares their local roots. All in all, we care for the lives of more than 155,000 patients and plan members. At the heart of all we do, though, is our "true north"— we are people caring for people—our patients, members, each other, and our community.

THE STATE OF MAINE—A SNAPSHOT OF THE HEALTH CARE LANDSCAPE IN AN AGING, RURAL STATE

Maine, as you may know, is a state that is aging rapidly, and by 2020 it is projected those over the age of 65 will outnumber those under 18—a statistic that is 15 years ahead of the national projected date of 2035 (Valigra, 2018). We have the highest median age in the country and roughly 22 percent of our population is over the age of

65 (Amy Newcomb; Julie Iriondo, 2017). By 2040 that number is expected to jump to 28 percent (Qian Cai, University of Virgina , 2017). While this demographic shift is occurring on a national level, Maine is at the forefront and is experiencing this shift ahead of most other states.

In addition, an increasing number of our seniors are chronically ill. Adding to the complexity of this issue, 31 percent of our senior population lives below 200 percent of the poverty line and 51 percent live in rural areas (Cubanski, Casillas, & Damico, 2015).

In short, Maine's senior population is old, chronically ill, poor, and mostly living in rural areas. Lack of access to quality affordable care and community resources, isolation, lack of transportation, and, in many cases, food insecurity, all translate into an ever-growing, vulnerable population living largely in suboptimal circumstances.

In the nation's most rapidly aging state, Maine health care providers are on the frontline of tackling a constellation of senior health care challenges other states will likely face in the years ahead. These challenges demand an innovative and strategic approach to care. Martin's Point is several years into adopting just such an approach, and as an organization offering both direct primary care and health plans (primarily to those over age 65), as well as investing in like-missioned community organizations, we are committed to leveraging our resources to effect tangible improvements in the health of our seniors.

Because many of our senior health plan members also receive care as patients in our practices, we have unique access to both their health record and claims/utilization data. Through the use of clinically oriented data analytics—a cutting-edge function complete with a dedicated team of data scientists and distributed analysts—we glean the information we need to support our chronic disease management and care coordination efforts for our most vulnerable seniors. We then use additional data to drive performance and track overall progress.

Below you will find several examples of innovative programs and methods of care we have developed to support the seniors we serve. At Martin's Point, we believe that by focusing on advanced prevention, we can build care models that allow our patients and members to live longer, healthier lives with a minimum of costly acute interventions. These efforts are our contribution to the steady transformation of health care in our state—improving the health outcomes and the experience while driving down costs for our patients and members, our providers, and our overall health care delivery system.

PROGRAMS AND METHODS OF CARE

Addressing Quality: Annual Quality Metrics

In 2018, Martin's Point implemented a multi-dimensional measure of quality, designed with components we believe are essential to improving health outcomes through managing chronic conditions and early detection of common cancers. For the most reliable data, we set the target group for this measure as those who receive both primary care and health insurance coverage from Martin's Point.

This integrated set of quality measures includes five areas of focus to deliver evidence-based care for adults and seniors:

- Annual physicals
- Diabetes recommended testing (retinopathy screening; nephropathy screening; HbA1c screening 2x/year)
- Breast cancer and colorectal cancer screenings
- Hypertension management
- Medication adherence for cholesterol management

RESULTS

As 2018 is the first year following these measures, we are still in the evaluation phase of these efforts. To date, we have met most targets through the second quarter of 2018 and are on track to meet our third quarter targets.

The combined quality measures are also one-quarter of our annual staff incentive plan, creating motivation and reward for performance of our providers who directly support better health outcomes for our patients and members.

PATIENT EXPERIENCE

In addition to the preventive health benefits of these quality measures, we have also found they create a meaningful touch point with our members. For example, interns from local colleges recently made outreach phone calls to our members overdue for preventive care visits. The simple act of calling and connecting was appreciated by many of our members—showing that someone cared enough to talk with them about their health.

"Ever since I started seeing my Martin's Point doctor, I have felt confident in my health care."
"I have had my Martin's Point doctor for over 20 years, and I credit her with my good health!"

Diabetes Care Management

The Martin's Point Diabetes Care Management program was created to improve quality of life and health outcomes for our members living with diabetes. Through member engagement, care management, and the removal of barriers, the program works to improve quality, manage disease progression, and reduce costs.

Martin's Point Health Plan Diabetic Population:

- 21 percent of our 2017 total health plan population have diabetes.
- They account for 32 percent of our health plan medical costs.
- 70 percent of these members have at least one of the following comorbid chronic conditions: chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease (most notably with CAD present in 32 percent).

2017 Utilization and Cost of Care Data:

- Across all members, 31 percent of ER visits and 36 percent of inpatient admissions were those of diabetic members.
- Those who were readmitted within 30 days of discharge represented 44 percent of all health plan membership readmissions.
- The average fee-for-service cost per diabetic member was 73 percent higher than a member without diabetes in 2017.

INTERVENTIONS
The health plan has three ways it addresses diabetic members' quality and cost of care:

1. **Member Engagement:** We mail a "diabetic scorecard" to members to share their completion/need for annual recommended preventive screenings and tests to help them track progress with their primary care provider (PCP). We follow up with members who are behind on their screenings and tests.

   Provider Engagement: Network providers are engaged via regular newsletters and reminders regarding quality-of-care gaps, as well as quality incentive payments, for the diabetic population.

2. **Care Management**: We deploy health plan nurse care managers to assist with individual diabetic members' needs.
   Generations Advantage Focus DC (diabetes care) Plan Members: This plan is a Medicare Advantage Chronic Condition Special Needs Plan (C- SNP) targeting care and services to individuals with diabetes. Qualified members are assigned a care management nurse who develops a holistic care plan and coordinates care with their PCP and care team, a pharmacist, medical director, social worker, specialists, and other community providers.

   The care plan contains SMART (specific, measurable, achievable, relevant, timebound) goals and interventions that meet the member's needs and provides a framework for monitoring. Care managers use motivational techniques to help members identify barriers and develop interventions, fostering self-management skills enabling members to achieve incremental accomplishments while improving their well-being and health.

   An annual interdisciplinary care team (ICT) meeting assesses current state and sets goals. PCPs are in-network, ensuring adherence to nationally-recognized clinical protocols which are used for their care. Social workers assist with an emphasis on addressing behavioral health and social well-being. A clinical pharmacist provides a comprehensive medication reconciliation and review, identifies adherence and cost barriers. The Medical Director is on site and present at the ICT meetings to provide

medical direction, if needed. Members and providers are also invited to join the ICT to promote engagement and alignment.

Other Generations Advantage Plan Members: All Martin's Point Generations Advantage members are eligible for services as part of our Care Management program focused on chronic diseases. Diabetic members can enroll based on their diagnosis, or any other chronic comorbid illness. Care managers work with members, both in their homes and telephonically, to close gaps in care, reduce risk for complications and progression, and decrease ER and hospitalization utilization. These nurses focus on helping members achieve their goals by providing diabetic self-management education, aiding in navigating community resources, and ensuring collaboration between PCP and specialty providers.

3. **Removing Barriers to Care:**

Access to Care: Better diabetic and preventive care occurs when members have regular visits with their PCP. When data shows these visits have not taken place, or that gaps in care persist after visits, we offer health-plan-sponsored mobile health visits or in-home nurse practitioner visits to provide recommended preventive screenings and tests to members with limited access to care. The visits include point-of-care testing including diabetic eye exams, A1C testing and overall health risk assessments. We always recommend the member return to their PCP for follow-up care.

Medication Adherence: Pharmacy claims data is used to identify members who may not be taking oral diabetic, statin and ACEI/ARB medications as directed. Written and telephonic outreach from pharmacists, pharmacy residents, and senior pharmacy students remind members of the importance of medication adherence and provide guidance in the case of cost or other barriers. Similar outreach and information is shared via mail with diabetic members' provider offices.

RESULTS

Pharmacy Data and Trends:

The three pharmacy outcomes we measure are:

- Non-insulin diabetic medication adherence
- Angiotensin Converting Enzyme Inhibitor(ACEI)/Angiotensin Receptor Blocker (ARB) medication adherence
- Statin use in patients with diabetes

Health plan pharmacy outreach efforts have yielded an average of 2 percent increase in adherence in the above measures on a year-over-year basis following implementation.

Quality Data and Trends:

Key diabetic quality-of-care measures are: rates of retinopathy screening, nephropathy screening, and blood sugar control (measured by A1c < 9). Our 2017 Healthcare Effectiveness Data and Information Set (HEDIS) sample performance data for these are as follows:

- Diabetic eye exam: 86 percent
- Kidney disease monitoring: 95 percent
- Blood sugar controlled: 88 percent

Health plan interventions have yielded positive results on these measures. When the plan launched the diabetic scorecard to engage and educate members, all three measures increased by a range of 2 to 5 percent. Similarly, our efforts to engage members and eye care providers to schedule diabetic exams yielded a 2 percent increase in year-over-year performance.

Care Management Data and Trends:

Diabetic members engaged in care management have shown a greater than 10 percent reduction in 12 month pre- versus post-program enrollment for Emergency Department (ED) visits and ED-specific per member per month (PMPM) cost.

Inpatient admissions rates and inpatient cost reductions have shown similar success with a greater than 30 percent decrease in 12 month pre- versus post-program results.

Home-Based Care: Comprehensive Care Program

In December 2017, Martin's Point launched our Comprehensive Care Program, expanding our capability around home-based care. This program currently serves 159 Generations Advantage plan members with heart failure, diabetes, ischemic heart disease, and/or chronic obstructive pulmonary disease with multiple medications and acute care use. This is a longitudinal program where members receive care and support in their homes and across all care settings from their assigned, community-based registered nurse. The program aims to help seniors improve and maintain overall health and independence, thereby reducing unnecessary ER/inpatient utilization. This is accomplished through symptom-response planning, patient education, regular medication reconciliation, and addressing psychosocial determinants of health.

The program, implemented through our partnership with Health Quality Partners based in Doylestown, PA, focuses on all factors that may be impacting seniors' health—physical, emotional, social, and environmental—including key factors that lead to unnecessary medical interventions and hospitalizations like untreated depression, loneliness, food insecurity, beginning dementia, errors in the use or prescribing of medication, unsafe home environments, alcohol use, or neglect. There is no end date to the program—building on the consistent relationship with the community-based registered nurse, enrollment is lifelong or until the member terminates their relationship with Martin's Point.

INTERVENTIONS

Comprehensive Care Program nurses are community-based and trained to the advanced preventive model developed at Health Quality Partners. They are part of the members' care team, sharing insight into the member's home environment dynamics, close communication with their primary care provider, and providing advanced preventive care, including medication reconciliation, symptom monitoring, and timely communication to the care team. Based on the needs of the individual, a nurse may:

- Provide personalized health assessments, education, and support
- Teach the individual to manage their chronic health conditions

- Encourage the individual to receive preventive care and services to lower the risk of complications
- Monitor and work with the member's doctors as needed
- Visit the member at home or wherever they receive care (rehab, hospital)
- Go with the member to doctors' visits and coordinate follow-up care
- Help to manage medications and treatment plans
- Provide an individualized action plan based on the member's goals to stay healthy
- Assist with long-term planning to help the member stay as independent as possible

RESULTS

Exceeding expectations, 54 percent of invited members are accepting our nurses into their home for the first visit and then inviting them back again and again.

Embedded Nurses: Integrated Care Connection Program

Another way we care for our senior population is by embedding nurse managers in our primary care practices to help manage complex care, advocate for our patients and doctors, and help patients navigate an increasingly complex healthcare system. In 2016 we launched our Integrated Care Connection (ICC) Program, which is designed to improve the coordination of care for Martin's Point patients with chronic conditions. Through this program we identify patients with chronic conditions and ER/Inpatient utilization in the past year. We then conduct a comprehensive office visit with the patient, PCP, and ICC nurse care manager to develop a care plan designed to meet the patient's health goals. Throughout the program we provide ongoing access and support, including both face-to-face and phone outreach, customized to meet the patient's needs and preferences. Participants are provided with the direct phone number of their nurse care manager, supporting continuity of care and avoidance of redundant efforts.

INTERVENTIONS

ICC nurse care managers partner directly with participants and their health care providers to ensure participants get the best care possible from everyone who is involved in delivering care. ICC nurse care managers work to promote participant well-being in a number of ways, including:

- Working to develop realistic health goals

- Coordinating care by sharing participant health information with other providers or facilities in the community
- Helping to manage medications
- Supporting participants, and their families/support systems, as they manage their medical conditions
- Identifying and reducing barriers to getting the care needed
- Facilitating and conducting advance care planning and end-of-life discussions
- Closing gaps in care and promoting preventive health care

The trusting relationship formed between participant and nurse care manager is a core component of the program. Many patients face social barriers, including isolation and loneliness. The nurse care manager focuses on building both autonomy and community connections, while honoring the participant's personal goals.

Program Components

- Collaborative office visit with patient, PCP, ICC nurse care manager
- Access through face-to-face and telephonic support
- Core components to guide conversations and educate
- ICC nurse care manager and patient develop patient-defined goals and action planning

Topics of Discussion Between Nurses and Their Patients

- Symptom-response plans
- ER use and inpatient hospital services
- Monitoring health at home
- Meal planning
- Adding activity
- Managing medications
- Recommended testing and follow-up appointments
- Emotional health
- Advance care planning
- Smoking and substance use
- Barriers to care
- Support systems

RESULTS

- 59 percent of those invited agreed to participate
- Up to 65 percent decrease in emergency room utilization
- A significant decrease in hospitalizations, number of inpatient days, and no readmissions for our graduated group

PATIENT EXPERIENCE

"I just feel so spoiled and attended to! It's almost like 40 years ago when the doctor knew you and insurance companies didn't rule a physician's practice. My ICC nurse care manager makes a BIG difference. I KNOW how big the practices are and I don't expect this sort of attention. I LIKE it but I don't expect it."

"Thank you so much for being such an important part of my Mom's health care. I don't know what we would do without you!"

PROVIDER EXPERIENCE

"Pt successful in remaining tobacco free for 8 months, despite smoking since an early age of 13. Has also recently lost weight. He has done well with an established trusted practice contact and ongoing support (by ICC nurse care manager)."

"With (ICC nurse care manager's) diligent and compassionate care our mutual patients have done SO VERY WELL!!!"

"The ICC nurse care manager researches the patient and prepares the visit so well that they are now well cared for during and between visits."

"The ICC nurse care manager helps the patients feel engaged. Patients love her and the extra attention."

Reflections from our ICC nurse care manager, Christina:

"One of the unfortunate realities of modern medicine is that care is often fragmented.
Patients receive care from multiple providers, from different systems, including the VA, using different medical records that do not connect to each other. Our patients are often taking multiple medications from different prescribers. It is often overwhelming, especially to those who are ill. As a nurse care manager integrated in the primary care provider's office, we are able to communicate with the different specialists and systems, identify discrepancies, coordinate care, and advocate for the patient.

Medication errors are one of the leading causes of adverse events and readmissions. As part of the Integrated Care Connection (ICC) program, we can reconcile medication lists from various providers, review what the patient is actually taking, remedy errors, and help with cost issues. We then provide the patient with a corrected medication list, ensure they understand it, and empower them to carry it with them and advocate for themselves.

We are able to facilitate care and help patients and families navigate the medical system. For example, I was able to help a veteran and his family, who were overwhelmed, contact the VA and coordinate extra help so he could remain safely at home while his wife had extensive surgery with an extended rehabilitation stay.

We are fortunate to have the time to develop relationships with patients and families, get to know them as people, understand their goals, concerns and questions, and facilitate communication with the health care team.

Staying on Top of Trends: Congestive Heart Failure Pilot Program

At Martin's Point, we leverage our data to analyze trends in our members' health and make plans to address them. In the summer of 2017, we saw an increase in recurrent hospitalizations in the Portsmouth, NH region where we largely serve military retiree and dependent members covered by our US Family Health Plan. We have a primary care practice that also serves many of those members in the same area. As we drilled down into the data, we found there was a cohort of patients, most of whom with a diagnosis of congestive heart failure (CHF), who were being admitted to a local hospital and then readmitted within 30 days to the same or a different hospital.

While representing only 3 percent of the total health plan population, members with CHF accounted for 28 percent of the total health plan inpatient hospitalizations in 2017. This represented the highest hospitalization rate of any of the plan's chronically ill population, including those with CAD, COPD, diabetes and asthma. In addition to having the highest hospitalization rate of any chronically ill cohort, the CHF population experienced the most rapid month-over-month increase in hospitalizations, averaging a 5 percent month-over-month hospitalization rate increase from 2015–2018.

The hospital costs on the health plan side were unusually high. In 2017, the average health plan medical cost of a 65+ year-old member with CHF was over three times that of a similar member without CHF. Even more striking were the stories of human suffering—patients not understanding their conditions or triggers and, as a result, being displaced from their homes when hospitalized, sent to an unfamiliar rehabilitation unit

and then back home only to end up returning to the hospital. The situation was a revolving door of confusing and disruptive moves.

In response, we pulled a multidisciplinary team of leaders and technical experts together to perform a root-cause analysis. The group was led by senior clinical staff (medical directors from plans and practices, nurse and nurse practitioners, embedded care managers from the practices, pharmacist leaders, primary care physicians and a cardiologist). The team focused on creating goals to decrease hospitalization, reduce medical expense, and improve quality of life.

Leveraging the in-home assessment/care team model we had initiated through our association with Health Quality Partners, we obtained more information about this at-risk Portsmouth CHF population. We ensured that:

- Each member would have at least one in-home assessment
- A full medication reconciliation would be completed while in the home
- Each member would be offered telemonitoring devices
- Each member would receive a CHF educational packet

The CHF Pilot Program launched in December 2017. Originally 63 members in the Portsmouth, NH area were identified by their primary care providers. Of those, 42 engaged with the program and received an in-home visit. Currently we have 34 members enrolled. (Those no longer in the program left for a variety of reasons. Some transitioned to hospice, were admitted to long term care or assisted living, a few passed away and one disenrolled from the health plan.) The pilot will continue, at least, until the end of December 2018.

INTERVENTIONS

Starting in December 2017, two nurse case managers from the Martin's Point health plan visited each member in their home. While the home visit was focused primarily on the above-stated goals, the case manager also completed an in-home evaluation including assessing caregiver burden, fall risk, and home safety. Subsequent contact was primarily telephonic, with additional home visits depending on individual need. The case managers also had frequent contact with the PCPs and clinical staff at our

Portsmouth health care center and collaborated with the on-site pharmacy team for full medication review and reconciliation.

After six months, the CHF pilot team from the delivery system and the health plan met to review preliminary outcomes, discuss success stories and opportunities. The decision was made to extend the pilot program.

Through this combined effort, we learned that most of our patients and members were lacking basic information on their health conditions, use of their medications, and the triggers for their conditions. Most importantly for them is developing a “symptom response plan” that allows them to act earlier and more effectively to prevent an acute worsening of their condition. We checked in with them more frequently—by phone and in-person. We arranged closer follow up with their doctors.

RESULTS

Our program’s approach had yielded improvements in members’ medication adherence, and decreased hospital admissions and readmissions. Preliminary outcomes included:

Medication Adherence

- 3 Months pre-engagement: 69.7 percent
- During engagement: 86.2 percent (23.6 percent improvement)

Admits/1000

- 3 Months pre-engagement: 126
- During engagement: 115 (8.7 percent improvement)

Readmits/1000

- 3 Months pre-engagement: 63
- During engagement: 20 (68.2 percent improvement)

ER Visits Per 1000

- 3 Months pre-engagement: 81
- During engagement: 115

While we did not see a large reduction in use of the emergency room, we did find a significant reduction in hospitalization rate. We are able to intervene earlier and provide participants with a better quality of life while also keeping them in their home. With these preliminary findings in mind, our two case managers did additional home visits in August 2018 for those members who visited the emergency room. The objective of these visits was to:

- Provide additional education about the disease process
- Complete a full medication reconciliation and collaborate with the PCP and pharmacist, as needed
- Provide information on urgent care centers and walk-in clinics in the Portsmouth area

We have identified that not all emergency room visits for these members are related to CHF. This has underscored the need to understand individual members' barriers to primary and urgent care, and to educate members on their care options during and after normal business hours.

The in-home component of the pilot was extremely helpful for the case manager, especially in identifying safety concerns, allowing a first-hand view of the member and how they function in their environment. This built additional trust with the member and provided a strong opportunity for the nurse to gain additional understanding of how their social needs impact their overall health.

Another key finding in this work was our recognition that many patients with advanced heart failure had not had conversations about advance directives and few, if any, had conversations about palliative approaches as they near the end of their lives. As a result, we are now piloting a palliative care program that will support those conversations and allow patients to understand all the options available to them.

In-Home Telemonitoring: Congestive Heart Failure

For our health plan members with congestive heart failure, we offer an in-home telemonitoring program. This program encourages members to be active participants in their health care by promoting self-management and reinforcing positive behavior, increasing their ability to stay independent in their home. It provides both the member and family peace of mind, knowing they are being monitored and that their health care providers are promptly informed of changes.

We implemented this program in 2014 and have enrolled 711 members to date—an average of 16 new members per month. In 2017, we averaged 280 members per month and in 2018 that number has jumped to 293 members per month.

Promoting Medicare Benefit and Clinical Strategy Alignment: Opioid Management

The Senate Special Committee on Aging dedicated a hearing earlier this year to opioid use among seniors. Addiction, whether opioid, alcohol, or others, is quite common among the senior population and is an issue we are confronting directly at Martin's Point. The states located in the Martin's Point Medicare Advantage service area—Maine and New Hampshire—are among the ten states with the highest drug-overdose mortality rates in the nation.[1] As recently as 2012, nearly all counties in our service area were in the top quartile of opioid prescribing rates, including a designation as a national hotspot.[2] While opioid prescribing rates have been following national downward trends, the effects of high opioid-prescribing rates continue to affect our population. In fact, Maine reported a significant increase in opioid overdose Emergency Department visits from 2016 to 2017.[3] Decreased access to providers who treat mental health and substance use disorders has only exacerbated the issue, especially in our rural communities. Martin's Point recognizes that a wide array of stakeholders is involved in tackling the opioid crisis through many modalities, and thus the organization is focused

[1]National Center for Health Statistics, Centers for Disease Control and Prevention. Drug Overdose Mortality by State. https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm
[2]Centers for Disease Control and Prevention. Opioid Overdose Data: U.S. Opioid Prescribing Rate Maps. https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html
[3]CDC's Enhanced State Opioid Overdose Surveillance (ESOOS) Program, 16 states reporting percent changes from July 2016 through September 2017.

on innovative ways health plans can provide cooperative and complementary benefits and clinical programs.

Comprehensive Opioid Management Strategy

Martin's Point's approach to opioid management has long been rooted in the education and engagement of members, providers, and pharmacy partners. At the core, pharmacy management and care coordination activities, including those listed below, have driven our opioid management strategy.

- Formulary design and management that promote appropriate utilization
- Drug utilization review, both at the time of filling a prescription and retrospectively by pharmacists at Martin's Point
- Care coordination by care managers and social workers working with physicians and other health care professionals
- Providing access to medication-assisted treatment (MAT)
- Data collection and analysis to assist in conversations with health care providers and identify populations and/or geographies where action is needed

Using these opioid strategy elements, Martin's Point saw over a 10 percent decrease in opioid utilization from 2016 to 2017 and continues to see decreased utilization into 2018.

Leveraging Medical Benefit Design

As we continue to look at opportunities to assist our population in the management of opioid utilization and opioid use disorder, one key consideration is how to align medical benefits and offerings with the clinical needs of the population. The Centers for Medicare & Medicaid Services (CMS) recently updated guidance for Medicare Advantage plans in order to promote value-oriented medical (Part C) benefit strategies. In 2019, Martin's Point will be taking full advantage of the new CMS guidance, in conjunction with our overall opioid management strategy, to better care for our beneficiaries affected by or at risk of opioid use disorder.

To remove barriers to prevent and alleviate opioid overuse, we are reducing member costs and adding additional supplemental benefits. For plans that do not already have $0 cost sharing, Martin's Point is eliminating the member cost share for individual and group mental health, psychiatric, and substance use disorder therapies for members

with opioid use disorder. All our plans currently cover acupuncture, fitness services, and naturopathic services members can use for alternative pain management. For members with opioid use disorder and chronic pain syndrome, we are adding coverage for additional acupuncture coverage and therapeutic massage as part of a non-opioid pain management care plan.

Most importantly, the new clinically-nuanced benefits require member participation in a plan-sponsored wellness or care management program to incentivize and facilitate member engagement in their care plan and supportive activities. Program components include a behavioral health focus, care coordination, addressing social determinants of health, and member-driven goals and activities for non-opioid pain management.

Opioid Strategy: Looking Forward

Martin's Point is dedicated to living out the organization's mission to create a healthier community. We are striving to improve the collection and use of information to better enhance the care of our community, including information that will help us better address social determinants of health and other opioid use disorder risk factors. We will continue to grow our community partnerships and multidisciplinary stakeholder engagement so we are positioned to amplify the impact we have in our community in an environment of limited resources. Finally, Martin's Point remains open to novel ways to address the opioid crisis.

LEAN JOURNEY: CREATING CUSTOMER VALUE THROUGH AN ALIGNED ORGANIZATION

Our success in serving seniors, and all our customers, is directly attributed to our management system. We drew inspiration from the lean health care principles advanced by Dr. John Toussaint in his book *Management on the Mend*, with each component of the management system contributing to an aligned organization. At Martin's Point, our management system acts as our central nervous system, pulsing with ways to solve problems, eliminate waste, and create value. Our management system enables us to align focus throughout our organization, to identify problems, and to work together—in real time—to solve them. There a variety are reasons why some

organizations function better than others. In our organization, it's the intentionality behind how we work together as framed by our management system. Our management system components include:

- Developing People
- Deploying strategy
- Managing visually
- Following up
- Standardizing work

In his book *Management on the Mend,* Dr. Toussaint describes the management system as a "cultural transformation," not an operational project. The expansive nature of this effort requires involvement from every part of the organization. Our senior leaders are actively engaged in the application of lean concepts in health care, and our story was featured in a May 2018 white paper by the lean health care network and research group Catalysis. As a not-for-profit team of experts, Catalysis is dedicated to helping leaders improve their health care systems, change organizational behaviors, and enhance delivery of patient care while lowering its cost.

Martin's Point is in the eighth year of our lean transformation journey. Our current focus is to make lean principles management driven, supporting the implementation of our strategy while also contributing to the success of our ongoing business results. In this phase, lean principles are well integrated into the management system, and improvements are driven by customer needs and wants. If you were to stop by the Martin's Point campus on the third week of each month, you would find our entire senior leadership team in a room displaying key operating indicators, with red or green status flags illustrating current performance. Any red indicators need to be addressed by a problem-solving and improvement discussion. The discipline of measuring these items month over month helps us improve through the intentional conversations of our top-most leadership around problem solving. In addition to our internal discussions, we regularly visit other organizations who are leading the way in lean health care, including UMass Memorial Health Care of Massachusetts and Intermountain Healthcare of Utah.

Leaders throughout Martin's Point have also invested time in defining "standard work," in the context of 10 competencies. The core set of competencies for all employees includes:

- Customer focus
- Business acumen
- Learning on the fly
- Process improvement
- Driving for results
- Dealing with ambiguity

In addition to the core set, Martin's Point leaders are expected to be proficient in four additional competencies: creating vision, strategic agility, managerial courage, and developing high-performing teams. Leader standard work is intended to document the recurring actions needed to demonstrate these competencies, the expressions of which will vary according to a leader's role in the organization.

For our patients and members, the results of our investment in a lean management system have allowed us to improve the ways we fill prescriptions, schedule patient appointments, and verify accuracy of medical coding. We have not only realized improvements in our day-to-day work, but have also received high marks in recent evaluations from CMS and the Defense Health Agency. For our employees, we believe our management system contributes to increased connection and engagement. Our data shows that 89 percent of our employees say they understand how their work connects to our strategic initiatives and goals, which means the daily experience of the majority of our employees drives our "true north" of serving our patients, members, each other, and our community. And in 2017, Martin's Point was named to the list of Best Places to Work in Health Care and Biopharma by the Great Place to Work Institute. We believe the positive experience of our employees better enables them to provide an enhanced experience for our patients and members.

IN CLOSING

In all we do at Martin's Point, we retain a core connection to our community. Not too long ago, a bus pulled up in front of our Health Care Center in Scarborough, just a few

miles south of Portland, Maine. A crowd of 50 seniors emerged from the bus and made their way inside. At first glance, it may have looked like we had overbooked for medical appointments—but this gathering was to receive a different kind of care. These seniors were coming to the Community Center at Martin's Point to attend a Fire and Fall Prevention session offered by the Scarborough Fire Department. The Community Center is a senior-centered gathering place we intentionally included in our floor plans when we designed our new state-of the-art facility in Scarborough, with the intent of partnering with the Town of Scarborough, the Southern Maine Agency on Aging and the Southern Maine Strong Balance Center to offer programming for the local senior community. The presentation was one of a full slate of programs offered at the Center, ranging from educational and social to health and wellness. The activities include: senior yoga, balance classes, Tai Chi, bingo, senior movie night and a weekly lunch program. The Center's programs are offered Monday through Friday and are an important way to offset senior loneliness and isolation year-round. We are able to do this because we are a not-for-profit organization. The return on our investment in this dynamic and vibrant space is measured in the smiles and great reviews that we receive, and in knowing that we are fulfilling our mission as we create a healthier community through authentic relationships, one person at a time.

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