

Martin's Point Health Care, Evergreen Woods Practice, Bangor, ME

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Charlie Burger & David Hallbert have something special in Bangor, ME.

Leadership Meeting

My day started with a Leadership meeting. The purpose of this meeting was to review and plan the agenda for an upcoming Saturday retreat in which they would revise the Business Plan/Business Model, Principles of Practice and Strategic Imperatives. The “Leadership” encompassed half of the practice, physicians, nurses and staff. What is important is not the content of the meeting, but that it exists. That this practice meets together to think about their future, in an efficient, prepared and effective manner, is part of what makes it unique. There are some interesting features—hand rising is used to queue speakers, rather than boisterous output with relative position silencing quieter members. There is clearly a shared significant knowledge of Management and Organizational tools—LEAN, Covey’s Quadrants, True North and the Balanced Scorecard were all seamlessly interwoven into this meeting.

Daily Huddle

The daily huddle is a practice-wide kick off to the day, it encompasses all members of the office staff and is led by a rotating Huddle Facilitator—one of the Patient Service Representatives (PSR or phone staff) on the day I was present. This rotation works because of the elaborate template guiding the huddle. Briefly, the huddle begins with a discussion on how to improve the huddle where possible. Being on time was a common concern. The huddle formally opens with WOWs, opportunities for colleagues to call out exemplary behavior by a team member. Examples like “Lindsay jumped on the phones when they were busy, Gloria roomed patients” start off the day. There is then a review of metrics from the previous day’s schedule such as no shows, unfilled spots. Were patient’s roomed on time? How are they doing on teach back—the thing they are trying to get patient’s engaged on this month. The teachback topic was an assessment of confidence in patient-self care, accomplished through a paper instrument. Finally, learning opportunities from the day prior are logged in an ongoing Google document that is shared amongst the group.

Moving focus to the day ahead, first “orders reports” (See below) are shared, giving a number to the amount of patient-specific work that is to be completed that day. Team members quickly take work off of each other’s lists based on their anticipated workday. Issues such as who is training whom, who is covering which desk (See below) are sorted and assigned quickly. Staffing issues for the day are reviewed—who is out sick, has to leave early, etc. Finally, a look at the day’s capacity of open acute spots, patients expected and special needs are identified. The huddle ends with hands in, Go Team! Woo! Cheer. This is a huddle unlike I have ever seen.

Team member Role Descriptions:

Providers: 2MDs, 1 DO, 1 NP

The practice has 4 providers, two MDs, 1 DO, 1 NP all working with a traditional panel, with cross coverage for the practice’s patients for access purposes. The NP is an independent provider with her own panel. Providers sit at a permanent workstation with their Clinical Support person of the day at the desk next to them. There are 2 offices, each with 2 providers. This shared office space significantly minimizes hierarchical distance. Provider office visits are more notable for what is not done than what is done. The Clinical Support job description, and RN description for shared visits go into depth on each of these roles, and the work that is delegated away from the physician. One special feature of visits is that all providers are expected to complete the note by the end of the visit, and hand a printed copy to the patient. Many providers address their note to the patient, using the second person “You came in for a cough today” rather than the traditional third person.

Clinical Support Role: MA+

The clinical support role pushes the bounds of the traditional medical assistant role. They are responsible for rooming the patients, vitals, weights, but go much further. The MA starts the visit, determining a chief complaint/setting the agenda, takes basic history of present illness, medicine reconciliation, refill requests, performs age-appropriate screening questionnaires, and enters all this information into a note started for the physician.

Outside of the room, the Clinical support is the master of desktop management. They have access to their assigned provider’s Centricity desktop, and manage the incoming work. They are authorized to take tasks off the provider list: calling patients back, reviewing Coupler results,

passing work off to the scheduler, etc. The goal, and often the reality, is that the physician only sees physician level work; the rest is delegated to the rest of the team.

RN Role: Shared Chronic Care Visits

These visits grew out of a desire for greater nurse-patient contact, and a recognition that delegation of tasks away from the traditional physician-does-it-all model would result in superior care for chronic illness. The RN takes over the MA role to begin—rooming the patient, setting the agenda, and running through appropriate preventive screens. However, this visit is distinct as the RN begins to delve into current issues surrounding the chronic disease—medicines, testing/lab concerns, challenges in adhering to care, diet, exercise, etc. She is then able to begin necessary order entry for external screenings (eye exams), medicine refills, preventive screenings, etc. She and the patient also begin goal setting about health. Once this phase is complete, the MD is summoned (through a flag on the door).

On arrival of the physician, the visit continues with a quick presentation from the RN with updates. Issues are tackled in order of the agenda, and the RN roles switches to scribing and order entry as the physician performs the exam and finalizes the plan. The note is finished like all others, and the visit ends with the RN and patient reviewing the plan. These visits are notable, and feel somewhere between and MA/MD visit and the goal of a nurse managed chronic illness.

Admin Team:

Paula is the Practice Administrator and clearly keeps everything running. She has a biller/coder working with her as well. I did not directly observe the biller/coder role, but I did observe one of the clinical support staff becoming cross-trained in billing.

Patient Service representative:

The PSRs are masters of the phone and front desk. They have an elaborate job: screening new patients and entering the information into the system, queuing patient calls to the appropriate provider, queuing refill requests, providing logistical information, and scheduling patients for both acute and recurrent visits. Of special note, they are empowered by the customized Problem-Knowledge couplers to perform phone triage for refill requests and chief complaints. They talk the patient through the phone coupler, and determine if they need immediate office care, emergent care, or perhaps a home-based remedy would be more effective. There is always room

for clinical oversight, and the culture supports asking for help rather than making decisions above their level of comfort.

Scheduler:

The scheduler makes the plan a reality. As the clinical team orders tests, the scheduler works with the patient to make sure these tests happen. The scheduler calls specialists, labs, radiology, etc., providing much needed access in a medically limited environment. This role is also important for quality, as the scheduler monitors reports of unscheduled or incomplete tests. They operate on a 48-hour goal—all tests are scheduled within 2 days.

Of note, there is significant emphasis on training & cross training. In all roles, from date of hire to first day of full work is about 3-6 weeks of directly apprenticed training time. Additionally, wherever possible, each member of the team (providers excepted) are trained in and act as other members of the team, to allow for depth within the organization.

Available Services:

The practice has an in-house phlebotomy room and also has mental health. I did not directly observe much in these areas, as their counselor was not available. Interestingly, their counselor is not employed by the practice, but rather rents a room in the back and has done so for years. She provides mental health and counseling services to the practice patients and also the health care team.

Office Environment

The physical office floor plan is that of a large dumbbell, with the waiting room in the middle, administrative wing mostly off to the left, and the clinical area including the lab and all physician offices to the right. This is the legacy of an expanding practice leasing up the space next door. Lines of sight are not well preserved as there are many twisting corners, but within the administrative space there is much openness for communication, including several interior-sliding windows. Each of the 10 visit rooms has a 4 color-coded flag system, and every clinical person; MD, MA or RN has their own color combination. It is possible to know who is in every room at a quick glance. The workspace is quite human-friendly, with nearly every desk on a powered height system, so that each person can quickly transition from sitting to standing with the push of a button.

Problem-Knowledge Couplers

The Problem-Knowledge Coupler is the informational backbone/ace-in-the-hole of this practice. In brief, it is a series of questions that can be answered by the patient prior to the visit, or the phone triage staff during a call, which guide a broad differential and suggests management options. Patients fill out the coupler with history items; this information can populate within the EMR note for the upcoming visit, and provides the patient with a written record of recommendations. This saves time for the physician and patient, and avoids unnecessary visits.

Challenges:

One of the great challenges facing this practice is a common one—the perverse incentives of Fee For Service, or “Production Mode” as Charlie calls it. Production mode is the mode most physician offices spend most of their time—working as hard and fast as they can to solve the problems of as many patients as possible, as volume is the current standard for payment. Through an investment from Martin’s Point, there is time (and money) for the practice to step outside of production mode and manage itself. One of the most significant challenges ahead is trying to exist both in a fee-for-service world and capitated as Martin’s point offers both products.