One practice’s success in implementing advanced team-based care
AMA STEPS Forward® podcast

One Practice’s Success in Implementing Advanced Team-Based Care

Apr 12, 2023

- Listen on Simplecast
- Listen on Apple Podcasts
- Listen on Spotify

Featured topic and speakers

Gregory Duke Carlson, MD, family medicine physician at TexomaCare in Denison, Texas, shares his experience incorporating advanced team-based care into an accountable care organization. He discusses how the workflow has increased patient satisfaction and safety, increased access to care, and reduced physician burnout and work outside of work.

- Team-Based Care Toolkit
- Medical Assistant Recruitment and Retention Toolkit

Speakers

- Gregory Duke Carlson, MD, FAAFP, family medicine physician, TexomaCare, Denison, TX

Host

- Jill Jin, MD, MPH, senior physician advisor, AMA STEPS Forward®

Listen to the episode on the go on Apple Podcasts, Spotify, or anywhere podcasts are available.

Transcript:

**Speaker:** Hello and welcome to the AMA STEPS Forward® podcast series. We'll hear from health care leaders nationwide about real world solutions to the challenges that practices are confronting today. Solutions that help put the joy back into medicine. AMA STEPS Forward® program is open access and free to all at stepsforward.org.


Copyright 1995 - 2021 American Medical Association. All rights reserved.
Dr. Jin: Hello everyone, and welcome. This is Dr. Jill Jin, senior physician advisor at the AMA, and I'm your host today. Today on the podcast, we are joined by Dr. Duke Carlson, a family medicine physician with TexomaCare in Texas. We are going to discuss how he implemented an advanced team-based care model in his practice and how that has improved physician burnout as well as patient care.

Dr. Carlson, thank you so much for joining me today.

Dr. Carlson: Thanks for having me. I'm very excited to be here.

Dr. Jin: Can you tell our listeners a little more about yourself and your background?

Dr. Carlson: Yes. I am practicing in a group called TexomaCare. We're about an hour and 10 minutes north of Dallas, and we're a multi-specialty group with 10 clinics both in Texas and Oklahoma. As a primary care doctor, I see about 25 to 30 patients a day, I'm a full-time practitioner. But I've been on the board of TexomaCare for about 22 years now. And I was also a member, and I was the physician champion when we implemented the electronic medical record in 2008. And at that time, we saw improved patient care with the EMR, but we also saw the physician saddled with extra work, extra tasks, more clerical tasks to do. And so, I had been attending the last 10 electronic medical record conferences for our EMR eClinicalWorks, looking for that added edge of technology, that improved workflow, that special click that would help unburden physicians and make them have less time after work.

And it never really delivered, never found that perfect solution, unfortunately. And then, most recently, we joined an ACO, an accountable care organization, moving towards value-based care, and I was the physician director for that program. And again, at that point, most of our docs have been in practice for about 20 years. And so, we were asking them to do new activities and new tasks. And that was a challenge.

I, actually, Dr. Jin learned about team-based care really in my work with the in Indian Health Service. So, when I first came out of residency, I joined an Indian Health Service hospital in White River, Arizona. There were 13 doctors on our medical staff, and every doctor did everything. We had two pediatricians, two internal medicine doctors, we covered the ER, and we delivered babies, we took care of patients in the hospital.

And every morning we would huddle, we would meet and the doctor who'd been on call the night before in the ER would present what had happened. We would look at the clinic patients, we would look at the special challenges that we were facing, administration, pharmacy, the outreach nurses and home health nurses were all in that conference room. And we really, to take care of that special population, we had to work closely together. And so, that was my first introduction to the importance of team-based care.
Dr. Jin: Wow. That's so fascinating. You've really seen and experienced team-based care wearing different hats and seen it from different angles, which is fantastic. So that's a great segue because we talk about the importance of team-based care so much on this podcast, but it never gets old. And the reason we keep coming back to it is because, one, as you were saying, it's so fundamental as part of patient care and improving patient outcomes and optimizing value from that perspective. But it's also fundamental for reducing burnout, improving the culture of wellness, and because each practice's story is so different. Each practice has such unique needs and challenges and successes. It's always so fascinating for me to talk to people from different practices, different settings, different patient populations about it.

So, you told me a little bit about your background already and how you became interested in this concept in terms of what the problems were. In your practice, you mentioned the EHR was a big one in adopting that. Was there any other major, quote unquote, "problems" that you were hoping to solve when you entered this leadership role or anything else that you were really hoping to improve upon when you started this journey?

Dr. Carlson: Well, sure. The big movement that we were trying to make when we implemented was looking at fee for service. So, our model for the physician salaries was based on production, like most fee for service practices, and keeping down overhead. And so, the thought of adding employees was daunting. And our model, actually, we had pods. So, all the eight or nine family doctors in our office, if I added overhead, if I added employees and didn't increase production, that was going to affect the physicians that I practiced with. And that's kind of daunting because we would sit in a room together and look at each other's numbers and say, "What's going on? Why did your production... Why do you have this staff and that staff..." But then, you move towards joining an ACO and you say, "Well, if we don't have shared savings at the end of the day, we're missing an opportunity to perhaps finance a team." But you have to, you're not going to get those dollars to finance a team right away.

So, we were in this accountable care organization, you're showing your physicians their numbers. You're saying, "Okay. We've been in this organization for two years, and why haven't the doctors been able to decrease their home health expenditure? Why haven't they been able to decrease the number of times their patients are in the ER or getting admitted or decreasing the global cost of care per year? Why couldn't we make these improvements?"

And for most of our physicians, they'd been in practice for over two decades. They were basically over paneled, and because of our fee for service decreased overhead model, they were understaffed. And then, we're asking them in the ACO to do more with no more tools, with no more staff.

So, in that context, I heard about this training camp that Bellin Health put on in Green Bay, and I learned about these luminaries in team-based care, Dr. Jerzak, Dr. Sinsky, Dr. Hopkins, Dr. Bodenheimer, they were all going to be at this training camp. And so, attended that camp and it really was transformational.
Dr. Jin: Tell me more about that. What kinds of practical tools did you come away with?

Dr. Carlson: They were amazing. So, you had one, he example of Bellin Health. So, they weren't just talking about team-based care, they had done it for over 100 physicians, and they have the full support of their health care system. And then, they had a training manual that just laid it out. They had important statistics on, well, how many MAs should a physician have at a certain level of patients per day that they're seeing? How many physicians should...If you're going to add a registered nurse to the team, how many Medicare patients should that physician have? So, they laid out a really good example of how to do it and a nuts-and-bolts approach.

And also, part of what they did was they had great slide decks and education materials. So, when I came back, I could educate my administration, my fellow doctors, and my staff members on how we were going to do this. Their main recommendation was find somebody who's interested and passionate and create a prototype. You got to start with a prototype and then build on that prototype. And that's what we did.

Dr. Jin: Did you face challenges in getting your team to buy into this?

Dr. Carlson: No doubt. I mean, especially just the thought of adding staff members. And the rule of thumb was if you were going to be adding an MA, you need to see about two or three more patients per day. Doctors are thinking, "Gosh, is it really worth it to do that?" But then, you lay out to them how it's going to impact not only productivity, but how it's going to improve patient care.

One of the slides that was so impactful for me that was presented there, just looked at pajama time. And so, looking at that hour and a half, potentially, per hour of patient care time that physicians, some physicians, maybe your less efficient physicians, are expending. And then, more efficient physicians may be expending an hour per hour of patient care time. And then, looking at the team-based model where it's maybe a quarter of an hour. I mean, slashing that after-hours time that physicians put in. When I presented that to my physicians, that's probably what made the most impact.

Unfortunately, that's not necessarily measurable in productivity, right? Administrators who are looking at your productivity aren't really taking, "Well, if that's just your time after work, that's not..." They're not as cognizant until you start to talk about some of the stats that Dr. Sinsky laid out at that conference. If you have to replace a physician because of burnout, we're talking about a million dollars to your organization. And so, Dr. Bodenheimer, I know there was an article that just came out recently in Annals of Family Medicine. Dr. Bodenheimer has been a family doctor and a health care leader for over 50 years, talked about how primary care in the United States has been underfunded and panel sizes for physicians are just too large and there's just not an easy way out of that. And the avenue that makes the most sense is building teams.
When I first came back and looked at my medical assistant and said, "Okay. How do we start?" We just had her...first, she was owning things like immunization. So, you don't have to ask me about a flu shot, you don't have to ask me about pneumonia vaccine, mammograms. You will just go ahead and own that, and you go ahead and take care of those things proactively. I'll check on the backend, make sure it got done, but you just go ahead and do that ahead of time. And then, I would see the patient and then write down the three or four clerical tasks. I need you to make this referral. I need you to send this medicine to this pharmacy. I need you to go ahead and make this follow-up appointment. And so, I would just hand my medical assistant a paper and have them do those tasks. And that helped. That was a relief.

But the real magic came when my medical assistant actually came in the room. And again, Bellin Health, and these videos are available, demonstrate for the medicals, and that helped so much to see a Bellin Health medical assistant. And they relabeled their medical assistants care team coordinators. They would reconcile medications and obtain vitals. And then, they would come out like a resident and present the patient to me. We would look to see if there was other information that needed to be gathered. So, we would do our pre-visit planning right before the visit.

We had, in the early days, Dr. Jin, we had looked at looking, doing pre-visit planning in the beginning of the day, but it was so dispiriting if a patient didn't show up. You did this pre-visit planning, and the patient didn't show up, and you were just, if you're seeing 25, 30 patients and you did that at eight o'clock and it was 11 o'clock, it just wasn't fresh. So, having my CTCs, my medical assistants, do that presentation right before the visit, invaluable.

And then, we go in together and do the visit. And of course, I don't have a computer. At first, I had an iPad. I would be looking at things on my iPad. And then, I gained so much confidence in my MA that I really don't have any computer with me when I'm seeing the patient. I don't have to look away, and as I'm saying things, the medical assistant's making them happen.

You have to swap up the way you do things. So, because you're asking that medical assistant to order labs or to order a medication and send it to a pharmacy, that medical assistant can't do any of that until they have a diagnosis. So, you have to come up with a diagnosis prior, even though you may not be totally solid on that. If you want your medical assistant to start performing tasks, you have to get into the mentality that I've got to have that linked to a diagnosis.

So, for them to be doing the documentation, to be with my assistants, I'm speaking it and they're doing it. We have many, many templates. So, I'm doing the shoulder exam, she floats in the mini template for a normal shoulder exam. I say, "There's biceps tendonitis." She modifies that template and then I'll give a diagnosis, I'll give the treatment plan, speaking it to the patient. And the medical assistant is documenting and performing the clerical tasks real time.
If there's patient education, we've got a printer in the exam room, she's printing off patient education. If there's some new supplement that the patient's on that they throw out, the medical assistant's bringing it up on Google and having me look at it.

So, that was our first step, Dr. Jin, was to take that medical assistant and bring them up to the highest level of their licensure and really make them a vital part of the team.

Dr. Jin: I love how you break down your journey into steps like that, because I think it does seem very overwhelming from the get go. What you just described as the ideal patient care journey, which you've reached at this point, obviously, you didn't start there. You started, as you're saying, just with pending immunizations and it's incremental.

How long would you say it took to get to where you are now?

Dr. Carlson: Interesting. So, we're on year four now, and we've had several medical assistants. So, when you get a medical assistant, a CTC, up to that high level, which really depending on the aptitude of the medical assistants, takes anywhere from two to four months to get them up really where you just have...it's almost like one brain in there. I'm on my fifth medical assistant that I've taken through this process.

And so, what we did do was create a training manual, and that was very, very helpful. It was not until we were on our fourth medical assistant we were like, "We need to have a way to write this down and direct them." Because that didn't really come out of Bellin Health, they didn't have a training manual for these care team coordinators. So, created the training manual and have a really nice checklist.

And then, the next step that we took was to figure out how to finance an RN. Because the CTCs were great, but they're really...when you move to value-based care, I have about 350 traditional Medicare patients. We really are trying to figure out who are our sickest patients and how do we reach out to them on a regular basis? How do we follow up on every person that's been seen in the ER? How do we make sure, because some of the metrics were measured on in our ACOR transition of care visits. We're trying to make sure every one of our Medicare patients has a Medicare Well visit. And we are given our scorecards on that. We're looked at how much our expenditure for home health is and what are those patients who have been just perpetually on home health without really much value.

So, those are big tasks to do for physicians who are already over paneled. And that's where hiring an RN was invaluable. But how do you do that in a fee-for-service world? Because my RN currently does about four to six Medicare Well's and one to two transition of care visits per day. In addition to that, when she gets to the office in the morning, she looks at everyone who's been in the ER, anyone who's been in the hospital, and she's looking at their Cerner inpatient records, she's following them closely in the hospital. And we're co-located. That's another big team-based care concept that Bellin Health really put forth.
So, my workstation is within five feet of her workstation. And then, my phone person is within five feet of me. So, there's just a constant exchange that allows us to take care of our patients so well. And we're still in prototype mode, unfortunately. That part of that RNs salary is paid for by me. So, I took a salary cut in order to pay for that RN. Now, my productivity went up for sure, probably not quite to match the pay cut that I had. When we finally had some shared savings with our ACO, that compensates, the ACO shared saving, essentially made up for the salary of the RNs. But there were two years where we didn't have shared savings, and that was painful to have that pay cut in order to pay for an RN. So, you got to take the long view on that.

Dr. Jin: So, you were saying your productivity did go up, maybe not quite to compensate for the initial salary cut, but were you also doing less work after work and less pajama time?

Dr. Carlson: It's tough because that's hard to show to administrator and to physicians that are...because some docs just don't realize how corrosive it is to have those two extra hours a day. And it's corrosive personally, and it also can affect patient care because your enthusiasm may not be quite at the level that it could be if you weren't doing those tasks.

And especially if you know, at your core, that these are tasks that could be done by someone else. This is for my RN to spend time gathering documents, looking at gaps in care, explaining things to patients. That's something that they do really, really well and they have the time to do it. And for me, I might be forced to rush through it a bit.

So, you also just have that sense of things are being done right, and I think that's something that's not really addressed as much. When we talk about burnout, part of what can drive that is physicians have that vision of the way things really ought to be done to have the best patient care, and they know that they're just falling short of that because of a lack of members on their team or time. And that can really cause some dissonance in the mind and spirit of the physician.

Dr. Jin: The moral injury. You said at the beginning your goal was to tell...you were telling physicians their goal was to see two more patients a day. Is that what happened?

Dr. Carlson: That did happen. What didn't, and where I'm quite jealous of Bellin Health, what they had was, because they laid this out to 100 doctors, is before a new MA is branded a care team coordinator, they would sit in a conference room with their physician and they would work out how this co-documentation was going to work, who was responsible for what. They would practice and role play. And there would be an expectation, your MA may make a couple mistakes or may fall short, that doesn't mean you bail on them owning the documentation and owning the prescription, all of these tasks.

And that's what I've seen with some of my physicians, is they aren't as good as at making sure that their MAs are working at the highest level of their licensure. And this can be really challenging.
Again, Bellin Health, their experience was that about 80% of your MAs can move up to CTC level, but there is that 20% that it may be language skills, it may be typing, it may be just multitasking, but they just are not going to be able to do that. And so, how do you repurpose people who aren't able to rise to that level? One of my partners is exactly in that situation, and this is an MA that he's had for a decade and to just move them on, he just hasn't been able to do it. So, he's still stuck in doing the team-based care the way I did it initially, writing on a piece of paper what are the clerical tasks that need to be done, and handing them to his MA.

And he wishes he could do what I do, which is go from room to room. One MA is doing the co-documentation and finishing the visit. And I kind of hinted at it, but the other rich thing that happens after that, after I walk out of the room, is because that MA has been in the room and knows exactly what happened, there's an opportunity for the patient, after I leave, for them to... "Did he really... What did..." To ask a couple of extra questions and to close the visit and help the person out the door from the exam room and hand them a visit summary. That's really, really a rich part. And then, I'm on to another room. Well, I'm actually out there and the second MA is presenting and we're pre-visit planning for the next patient. So, it just makes things run so smooth.

And where it's really helped with value-based care is because our team is so able to flex up because we're efficient. If I have one of my hotspot patients call and they need to be seen, we can flex out to doing 33, 34 patients because we were just so efficient. Before team-based care, there was just no way I could do that. I mean, I never could see 30 patients in a day until I had this RN and two MAs. I mean, I was maxed at like 25, 26. And again, these are patients that are getting really, really good care. Because I have complicated patients that have lots of different tasks that need to accomplished, like you, like people who take care of elderly patients with lots of medical problems.

**Dr. Jin:** But that's such a great perspective, because I do think it's intimidating for physicians to hear, "You'll get an extra MA, but you have to go from seeing 25 patients to 33." That's very, I don't know if people would buy into that. But what you just said, you have such a well-oiled team that it's not extra work.

And the other piece of it I just want to emphasize again, is by increasing your access, you're actually increasing the work you are doing that you're getting paid for. Because if you weren't seeing those 33 patients, but you actually did have that need and the patients are instead messaging you at the end of your workday, you can't see them because you don't have space in your schedule, but you're replying to them via the patient portal, you're calling them.

At the end of the day, you're still doing that work, it's just not paid for as part of your workday. So, I think that shift in mindset, increasing access, increasing your RVUs is not making you busier if you're implementing these care, it's saving you from doing the work, yourself, after hours, that the team could be doing during the workday.
Dr. Carlson: Definitely. And the patients just so appreciate the fact that they can get in when they're sick. And it definitely shows up in your ACO measures. We have some of the lowest ER utilizations. Our home health utilization is the lowest, our per member per year cost is better than 90% of the physicians in the practice. So, in terms of what are the measures that we've seen beyond just productivity, we really have done well in the ACO arena.

And we decided, my RN and our team decided, that we weren't just going to have these services of tracking patients out of the hospital just for our...because our ACO is just for traditional Medicare, and I have about 350 of those patients. But any patient that's in the ER is going to get a call from our RN. Any patient that has been in the hospital is going to get a call from my RN.

So, even though we're not necessarily going to be paying her salary based on ACO dollars saved, the hope is that...I mean, a, it's just good patient care, it makes you feel good. But as other contracts move to value-based care and we start to own more of the after the office visit component of patient care, it's just great to have those skills and have that implemented.

Dr. Jin: And patient satisfaction probably has gone up as well, I would imagine.

Dr. Carlson: Definitely. My patients really appreciate... And they knew me that, often, if there was a lot of things going on in the visit, let's be honest, I would forget one or two things. And then, there'd be a phone message at the end of the day like, "He didn't call in my medicine." Or, "He was going to make this thing." Or, "He forgot to tell me about..." And so now, if I don't talk about something on the agenda because I got just hung up on a different problem, my MAs like, "Don't forget the toe rash. Don't forget the toe rash." So, we take of the toe rash and I don't get a call later on in the day, and that's pretty cool. That's pretty cool.

Dr. Jin: But I love your whole value perspective. I think you're the first person who's really honed in on that on this podcast, and it's so important. You're absolutely right, this is not just about productivity or whatnot, but it's about good value care, patient safety. And you coming at it from that perspective is so valuable.

Dr. Carlson: I think you can't underestimate how much safer the care of your patient is when you have a medical assistant that really is immersed in the care of the patient. When they're in the visit and they hear everything that happens and is responsible for documenting it. And then, when the patient comes back, they're going to be looking at their documentation and they're going to be presenting based on the quality of their documentation.

They are really invested in making sure that things are done properly. And their level of understanding is just deep so that when an issue arises, they are a backstop. They're a tremendous backstop because they have such deeper knowledge than just the typical MA that's just rooming patients and filling refills.

Copyright 1995 - 2021 American Medical Association. All rights reserved.
So, for me to know that I've got another human being that is just right there with me, working hard to make sure that things get done for the patient and that the patient sees that, two human beings in there, they know that they're being heard and cared for in a multiplied fashion. It's really satisfying.

**Dr. Jin:** It's an extra layer of health care, almost, from the team.

**Dr. Carlson:** No doubt about it. And my ability to really concentrate and focus is just so much better when I don't have to do clerical test. I'm 59, my prefrontal cortex is not doing the multitasking it used to. And if I'm clicking on something and it doesn't work, oh my gosh, I mean, I get flustered and I'm not 100% there for the patient.

And that doesn't happen. My MA who's in her early 30s just rocks that, the technology's no problem. And at first, you can just be looking over their shoulder and making sure that...I mean, that's the way it was for me, "No, put that. Put this." But one of the things I did want to talk about is EMR tools and how valuable they can be. So, for instance, we have macros in our electronic medical records so that my medical assistant's not having to write down the paragraph that I tell patients if they have diverticulitis. If you have diverticulitis, I'm going to give you a paragraph spiel on it. And it's the same spiel every time with a few little exceptions.

So, my MA, when I start talking, when I give the diagnosis of diverticulitis, she just puts in dot DIV in the notes, and boom, she doesn't have...she's going to write down exactly what I want because I constructed that macro. Really urge people, if they're digging into this, to get their macro game up. Order sets can also be very helpful so that if I mention a diagnosis of hypertension, the medications are all right. So, the MA just goes to the order set for hypertension, and there are all medications I use for hypertension, depression, anxiety, order set, order set, order set. And so, that really, really helps.

And some people are team-based care experts, but they're not necessarily EMR experts. So, find the people in your organizations that can really help you get the most out of your EMR when you're moving toward this team-based care.

**Dr. Jin:** That's a great tip. I use Epic, so, we call them smart phrases and smart sets. But yes, absolutely, to optimize usage of those, it's very important. Are there any other final pearls of wisdom you'd like to leave with our listeners?

**Dr. Carlson:** I think the last one would be just the importance of meeting regularly with your team. So, we have a clipboard that's right in the middle of what we do, and if you have an idea, write it down. And then, once a month we sit down and have lunch together and we just say, "What's working? What's not working? What are we talking about at the last meeting? Did we make it happen?" And then, unique challenges, we had one of our doctors abruptly retire and we decided we were going to take on 30 of his traditional Medicare because we didn't want it to adversely impact our ACO.

Copyright 1995 - 2021 American Medical Association. All rights reserved.
So, it was like, "Oh, my gosh. 30 new patients in one fell swoop. How are we going to do that?" And my phone person had great ideas, the RN talked, we all just worked on it, and we came up with a really good plan that wouldn't have happened if we just, happened on its own.

Dr. Jin: That's very inspiring. And I just want to thank you, again, so much for sharing that story, for your time, for all your wisdom and experience in this field of advanced team-based care.

Dr. Carlson: Excellent. Well, thank you so much for having me, Dr. Jin. It was really nice to meet you, and you take care.

Speaker: Thank you for listening to this episode from the AMA STEPS Forward® podcast series. AMA STEPS Forward® program is open access and free to all at?stepsforward.org. STEPS Forward® can help put the joy back into medicine by offering real-world solutions to the challenges that your practice is confronting today. We look forward to you joining us next time on the AMA STEPS Forward® podcast series,?stepsforward.org.