Karen Smith, MD, on the value of physicians and payor contracting

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Featured topic and speakers

In today’s episode of Moving Medicine, AMA Chief Experience Officer Todd Unger talks with Karen Smith, MD, a family medicine physician in private practice in Raeford, North Carolina, to discuss the important issue of payor contracting.

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Hear more from Dr. Smith during a special educational session convened by the AMA.

Speaker

- Karen Smith, MD, family medicine physician

Transcript


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Unger: Hello, this is the American Medical Association's Moving Medicine video and podcast. Today we are joined by Dr. Karen Smith, a family medicine physician in private practice in Raeford, North Carolina to discuss the important issue of payor contracting. I'm Todd Unger, AMA's Chief Experience Officer in Chicago.

Dr. Smith, hello. Thanks so much for joining us. You've been in private practice in a rural community for 29 years and you've had the opportunity to watch the evolution that's occurring in our payment models. Can you tell us about the Accountable Care Organization or ACO that you're in now and your own evolution in getting to that model?

Dr. Smith: Excellent. I appreciate the opportunity to share my insights and a little bit of history in terms of our payment models in the private practice setting. Rural medicine we know has its challenges but no different than any other settings. Just to kind of start though, I entered practice and we were in a fee-for-service market. We knew that we provided a service, we would get paid a little bit of what we had asked for and then we noticed over the course of years that what we were asking for was actually dwindling, and we simply were not getting paid enough to even run our practices and it became a little difficult.

We then saw the opportunity come about where we could actually collaborate and join either larger practices, hospital systems but I didn't really want to lose our autonomy. Then all of a sudden we had this opportunity to be part of a Accountable Care Organization. I could maintain my independence, provide the services that I always hoped to provide with our patients but maintain that good quality. That's how we found ourselves being part of an Accountable Care Organization or ACO.

Unger: That sense of independence and freedom, that's what we hear many physicians are drawn to private practice but with that freedom can come a lot of additional pressures which we hear about, especially over the last two years in this pandemic. Can you tell us about how value-based payment arrangement that you have with your ACO can help protect you from some of the challenges that private practices have encountered over the last two years?

Dr. Smith: It was really a good feeling to hang our shingles, just like any other business, but hanging your shingles as a physician also means that you were the one that's responsible for doing your contract negotiations, reaching out to those patient populations who you really wanted to take care of and negotiating those payments that you felt was necessary, not only to take care of the patient but also to make sure that they were getting the good quality and that that cost didn't exceed what patients could actually pay.

So, kind of to put it all together. I never forget one of my mentors saying to me, "Well, you need to go down the street and contact, not the pharmaceutical, but the chicken plant and get all the patients that you can and see if you can get on that insurance plan that they have. Why don't you even try to be their medical director?" I was like, "A chicken plant? I don't even know how to do this." So I thought
you just hung up your shingles and people came to you but that's the business model.

What we found that by participating in a value-based payment model, when we brought together the largest number of lives that we could care for within our region and my colleague over in the next county does the same thing and the county over does the same thing, and we're all part of an ACO, now we are applying efficiency and we're scaling out all of those strategies that we knew worked well. That's what the ACO brings in terms of the value of an independent physician collaborating with others. We bring together joint negotiation and power in providing health care to our communities.

Unger: I'm just curious. Hearing you talk about these things that you maybe didn't expect, did you have the kind of training and background to be able to do these things that you're now talking about that are part of being in an ACO?

Dr. Smith: I really did not have the training and as a family physician we know in our third year we get a two-week course of how do you set up your practice? The two weeks was a bare introduction in terms of going into an independent practice. So, no, I didn't have the training but I did have the desire and I had a little bit of knowhow and I really stressed the importance of my mentors.

Those doctors who were already in practice, who were already independent, they had already seen some of the ups and they saw the downs and they taught me a lot. Still not quite enough because quite frankly business negotiations is really not in our training. It's not in medical school nor is it in residency. But when we come into a ACO which has a structure that is set up to allow us to access the data to utilize the analytical power and to have those individuals who are really good at negotiating but on behalf of the entire group of physicians, that was the comfort level.

Unger: Well, let's talk a little bit about a word you just mentioned in that response, which is data, because you've talked about how important it is to have a good data collection model when you enter a payor relationship. Why is that so important? What tips can you offer other physicians for improving those data collection efforts?

Dr. Smith: The first step that I would suggest to another doctor is make sure that you are collecting your data and how are you collecting your data? When we speak about our electronic health records, you know those devices that was forced upon us? That's your friend, not your foe. The electronic health records does have what's necessary to collect the data, your patient's blood pressures, the BMIs. Did your patient have their vaccinations? So, the EHR is a friend. If we use greater than 30% of it, we will find that the other 70% has wealth. Well, it was that wealth of information that I could now share with the ACO.

Now, we know that the ACO is pulling information from other sources that we typically don't tap into. For example, if I have Medicare patients, where is that information coming from? CMS has a lot of information but it isn't landing in my lap in front of the patient as we are reviewing their historical
medical conditions.

That's what the ACO does. It's able to pull all of that information together, connect up with I have in my EHR and I put that information in through claims data, and now I have quite a bit of information on one patient, but I take care of more than just one patient. I need to have information across the spectrum or the population of people I care for. What we know is our attributes.

I need to have that entire population of information available to know how well am I taking care of the individuals with diabetes at our practice? I need to know about the individual patients sitting right in front of me. How well am I taking care of that individual compared to the other people across the spectrum of folks who have diabetes mellitus? What else do we need to do to make sure they get the best quality of care?

Unger: Well, it's interesting to hear about all of the things that go into just that part, not to mention the rest of managing your practice. You've said that it's very, very important for the physician to stay engaged and involved in the decision-making, whatever arrangement they're involved in and also kind of in those operations and the data and everything else that you laid out. What are some of the ways that a very, very busy physician, especially in the middle of a pandemic, can stay connected?

Dr. Smith: I appreciate the connection word but I'm going to add two other words. We want to connect, we want to communicate and we want to collaborate. Those are the three C's that I have definitely used during the pandemic, because you see in a pandemic, all of a sudden we found ourselves isolated. We were told to shelter in place and some of our practices we even closed for fear of what COVID was going to do. The C that I really don't want to talk about today, but we were told to remain isolated and that disconnected us.

We had to go back and connect with all of those support services, including the ACO, because it was the ACO who helped us to get the personal protective equipment that we needed to help us to continue to collect that data that we could attain through telehealth to show us how we could use telehealth. So, that connection with the ACO made a difference.

Then the communication, the feedback to the ACO, "Hey guys, I'm struggling, I'm having a hard time. Financially I'm not able to make it, I don't know how I'm going to pay the next payroll." So to communicate and not hold all of those scary thoughts on the inside, and then we collaborated. We collaborated in terms of, well, it's not just you Dr. Smith who's having the problem but your colleagues across the board are having problems. So, how can we collaborate and take all of our energies together and have the ACO actually work with all of us and come up with the solutions, that, yes, I need in my small rural practice but what about my colleagues who are to the north in larger metropolitan areas?

Connection, communication and collaboration, and that's what the ACO allowed us to achieve.
Unger: You clearly have a background in marketing, because I always love three of anything like that. It's a great framework to communicate like you're talking about there. Dr. Smith, we know there are issues with rural health care. How has being in a rural environment influenced your practice and your approach to payor contracting? Are there different kinds of considerations for someone that are location-dependent?

Dr. Smith: I absolutely agree that all of the work that we do is location-dependent and we hold our discussions with our policy makers regarding regional benchmarking. My area is different, our patients are sicker. We don't have a lot in terms of the financial infrastructure of our communities, we are a poorer community. All of that matters but by being a physician in the rural area, living, working and playing in the community with people who I take care of every day, I understand the nuances.

When it's time for me to go and advocate, I also know I'm advocating on behalf of our community but my colleagues are also advocating on behalf of their community. So what it is that we can find in common to start working with and I believe that's very important.

One of the things that the pandemic definitely brought out that those of us already knew was that of equity. How is it that we now apply the principles of equitable health care across the board as part of those communications, as part of those policy strategies that we are advocating for? The pandemic merely highlighted what was already there, and now we have an opportunity.

Let's highlight the solutions that's going to work for all of us, let's get into the social determinants of health and understand the impact that it has on the quality of health and the quality of life that people have across the board, regardless of where we live.

Unger: That's fantastic. This is the last question for you. We talk a lot about value but why is it so important to talk about the value of physicians as care and payment models evolve?

Dr. Smith: The value of physicians cannot be overstated. I can't say it enough. We appreciate our colleagues, the nurse practitioners, our physician assistants as part of the physician-led team-based care. The doctor cannot possibly accomplish all that's necessary to get the best outcome for patients without having a team. I worry when we have policies or we have new payment structures that come out that are advocating for our PAs and our nurse practitioners to actually have payments or be reimbursed close to that of the doctor.

We all know. Those of us who are real life practicing, we know the value of team-based care but we also know that the physician did put forth that education, that time, the payment for medical school, the residency training, and even took on a little bit more of the risk of taking care of patients, yet we're not getting the value in terms of the respect as a doctor and payment goes along with that.
The value of the physician is so vitally important right now. I worry when we see some of our doctors giving up practice, because they're burnt out or because they just can't achieve the well-being in practice that they hope for. I really think let's start at home and see what we can do to get our physicians back to where they feel comfortable and they can actually achieve what it is that they desire for the care of their patients. We value our doctors, we value all the players in our system but we need to keep an eye on making sure the system does not send doctors away. Whatever we can do to retain, let's do it.

**Unger:** Dr. Smith, thank you so much for being here today. It was such a pleasure to talk with you and to hear your perspective. That wraps up today's episode. The AMA offers many resources to help physicians with payor contracting, including a private practice toolkit and a two-part contracting bootcamp series. You can also hear more from Dr. Smith during a special educational session convened by the AMA. You can find all the links to these resources in the description of this episode, so definitely check those out.

In the meantime, we'll be back with another Moving Medicine video and podcast soon. Remember to click subscribe on AMA's YouTube channel wherever you listen to your podcasts. You can find all our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us.

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