Behavioral health integration best practices with Karen Smith, MD

AMA's Moving Medicine video series amplifies physician voices and highlights developments and achievements throughout medicine.

Featured topic and speakers

In today’s episode of Moving Medicine, AMA Chief Experience Officer Todd Unger welcomes back Karen Smith, MD, a family medicine physician in private practice in Raeford, North Carolina, who shares her personal experience and recommendations on integrating behavioral health care into private practice.

Learn more about the AMA Behavioral Health Integration Compendium.

Additional behavioral health integration (BHI) resources

- Behavioral health integration "Overcoming Obstacles" webinar series
- Behavioral health integration in private practice (adult populations) (PDF)
- Behavioral health integration in private practice (pediatrics) (PDF)

Speaker

- Karen Smith, MD, family medicine physician

Transcript

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Hello, this is the American Medical Association's Moving Medicine video and podcast. Today we're joined by Dr. Karen Smith, a family medicine physician in private practice in Raeford, North Carolina, who's going to talk to us about how to integrate behavioral health care into private practice. I'm Todd Unger, AMA's chief experience officer in Chicago.

Dr. Smith, thanks so much for joining us again. I'm excited, because today we're going to talk about not only the whys of behavioral health care integration, but also the how, and specifically around private practice. Let's just first start off the conversation by talking about how you personally, initially decided to pursue behavioral health care integration in your own practice.

Dr. Smith: Thank you, Todd, for having me here to share these comments. It's really appreciated to kind of give some insight. But in terms of my own practice, ours starts off with a story. I actually had a patient who came in, an older lady in her 70s, and we couldn't get her blood pressure under control. As we were speaking, she was taking her medicine, she was following all of our instructions, I said, "What else is going on?"

She says, "Dr. Smith, I'm just going to have to share with you, I can't go home because I don't know what's going to happen when I arrive. The last time I went home, my kitchen table was in the driveway. My son, who's been using heroin for over 10 years, had sold the kitchen table to close a drug deal. I am amazingly stressed out." I was like, "There is no pill that is going to take care of the anxiety that this lady was dealing with."

Here we were, we're dealing with generalized anxiety disorder, we're dealing with a family who is now part of a substance use disorder problem, and individuals who really don't have a lot of money and time to get the services that they were looking for. We had to do this in our own patient-centered medical home. Those stories like that really said, "We have to integrate behavior health in the medical home."

Unger: That is an amazing story, and a real perspective check and just a really great answer on the "why" front. Integrating behavioral health care can be a very different process for private practice than it might be for a larger health system. Talk to us a little bit about the challenges that you encountered and how you've worked through those.

Dr. Smith: It's the same three issues in terms of the private practice. Payment, are we going to be able to get paid for our services, recognizing that we have a lot of skill and education in this area. Administrative burden, the documentation, how do we get that done to make sure that our payment is commensurate with the work that we're doing? And then the last part of it was a little bit different in terms of just the respect for the profession. And as a family doctor, we have training in behavior health services that we provide to our patients. Well, in a larger system, we're often carved out, meaning we just want you to do chronic disease management. If the patient just happens to start crying because they have depression, you need to send that to another specialty. Well, that's not how we are trained.
So, when we look at those three areas, in terms of the challenges, making sure that we do have respect as a profession, a physician who's able to provide those services from our insurers. Don't carve us out, put us back in. Let us be able to provide those services. Administrative burden, documentation, this is not where we need it. We want to have good documentation and make sure that we're taking care of our patients from the clinical side of it, but when we are checking boxes for the payment side of it, that's administrative burden.

And the other is we really need to understand that these services require a full staff, a full team, and is part of what we do. So those three areas, payment, administrative burden, and just respect as a professional who is able to provide those services.

_Unger_: That issue that you talked about in terms of carving out, that's got to be particularly important to a private practice like yours, which is located in a rural area. So that must make it even more important. Did that have a big impact on why you chose to integrate these services into your own practice?

_Dr. Smith_: Exactly. Because when we carve out the rural area, where are we carving to? Where are the patients going to go to? We can provide the services. We don't have the luxury of multiple psychiatrists or child and pediatric psychiatrists in our area, yet our patients are dealing with the same issues. And so for us, it does make a difference to provide it in our own medical home that they're comfortable with. And I want to say, I know I'm a rural physician, but when I speak with my colleagues in other underserved areas, even in the inner city and urban areas, they're dealing with the same thing. So it is not necessarily a rural problem, it's more of a physician access problem.

_Unger_: Very interesting. Private practices right now, obviously a lot of attention on the financial end as well. When you think about sustaining a private practice, it's really patient needs, and also the business case for the decisions that you make. Talk to us a little bit about the business case for integrating behavioral health care in your practice. And you mentioned that big word, the P word, payment, how's that factor in?

_Dr. Smith_: It really matters. We are part of a value-based payment model, and if we expect to see improved outcome for hypertension, diabetes, other chronic diseases, as well as making sure that our patients are healthy and that they are following along with the medication adherence, that we're decreasing the emergency room utilization, that we're decreasing the increased hospitalization, all of that falls into that shared savings. And that adds into the business model of why we need to pay attention.

Yet beyond that, we want to do the right thing for our patients. We want to make sure that we are providing those quality services that folks need in order to have happy and healthy lives. And so the business model is there, definitely with value-based payment model, it's there even if you're not in a value based payment model and you want to make sure that your patients are getting the best care in...
order to decrease their total cost of care. So it's present and it's an area that physicians in private practice maybe haven't paid close attention to.

I'll go ahead and throw in social determinants of health, we know, drives 70% of health outcomes and oftentimes mental health disorders and social determinants of health are very well intertwined with one another. So it also allows us to achieve elements of health equity.

**Unger:** Now we hear issues around staffing shortages every day in lots of different settings. Many people probably wouldn't think necessarily about staffing shortages in the health care space, but we're hearing that from everyone, in private practice, health systems, across the spectrum. Are they still a factor for you? And especially as you think about the training involved around this, any challenges there?

**Dr. Smith:** So staffing shortages continue to be an issue. And with the public health emergency with COVID, it worsened, it really did. And for our office, the solution was to utilize more of the telehealth platform. We used a platform for our substance use disordered patients called the recovery platform. And all of that is technology, all of that is telehealth, and it removed the need to have a physical individual to provide those services. It also increased access for our patients. And so, yes, the face-to-face shortages is an issue to have behavior health individuals who provide counseling, who want to be in our area, and then the payment issues that they run into, that's an issue. So we had to figure out how do we become more efficient yet still provide those services. And I'll be honest, telehealth was a technology that allowed us to advance in this area.

**Unger:** Kind of along those lines, when you think about the before and after of any kind of system level change, I'm curious when you would kind of think about those two things before behavioral health integration and after, how's this impacted you, your patients, and your staff?

**Dr. Smith:** The workflow with the new changes that we put in place really does, it makes a difference. And I will say it is not one of just, "Okay, I'm going to integrate behavior health into my system." Well, you do have to change your workflow. It is a little bit different. And because we were so involved with telehealth, we had to change how we were doing things. For example, our patients with urine drug screening who we're treating for opiate use disorder. Well, yeah, we could do the whole meeting, our whole office visit on telehealth, but how do I do the urine drug testing? And that meant we had to figure out how do we schedule to have patients come in. And so it does require us to make some modifications and making sure that the staff understood how to use that technology. So the workflow does change, but it changed to create efficiency.

**Unger:** How would you advise other physicians out there who are thinking about integrating behavioral health care into their practices and don't know where to start, are going to possibly run into some of the other big roadblocks that you did.
Dr. Smith: Well, the first thing that I would say is study your population, really. What is your data? The anecdotal stories are wonderful. We all have them. We have stories as doctors, but where is the data to support your stories so that you know how much of an impact is undiagnosed or untreated conditions are playing a role in terms of your ability to provide good care for your patients. But that’s your baseline. Once you decide and look at those common presentations, is it depression? Is it anxiety? Is it substance use disorder? So create your baseline.

And then at that point, look at the different strategies that are available with all of our associations in terms of how do you now provide the best care for those individuals? And then look at your workflow. Pull your team together and start your plan—plan, do, study, act—in terms of how am I going to now address the needs of these individuals that have been identified in my patient population. And then we look at our performance. Are we making a difference? And I’ll also throw in there, look at your surrogate markers. So for us, one of the ones that we’re looking for is taking high blood pressure, uncontrolled, from just controlled blood pressure and getting rid of the severity of hypertension. And so those are our markers that we’re paying attention to for clinical outcome.

Unger: I’m curious, you’ve got your behavioral health care integration up and running. And when you think about practices kind of getting in that foundation there, what are kind of the next steps in the evolution to meet needs as they change or grow?

Dr. Smith: I think our next step is, because we have been able to review the population data, what other resources are beyond the doors of the office that we can address? Do we need other support groups like Celebrate Recovery, AA? What about the health department? What other services do folks need? In our state, we also have the ability of using something called NCCARE360 where we can access resources for people who need it. Food deserts, housing issues, all of this plays into the mental health problems that we’re seeing. And so we are now looking at what’s beyond the doors of the office, where we know we can’t always affect the change, but can we guide and direct our patients and maybe improve the outcome for their mental health problems?

Unger: Dr. Smith, thank you so much for being here today and sharing your perspective and your learnings. I hope everybody out there finds your experience to be really helpful as they think about integrating behavioral health into their own practices.

That’s it for today’s episode. Want to let you know that the AMA offers a lot of different resources to help physician practices, including private practice, adopt behavioral health integration. Including strategic practice guides, webinars and BHI compendium. So you can find the links to all of these resources and more in the description of this episode, as well as if you just search BHI on the AMA’s website.

We’ll be back soon with another Moving Medicine video and podcast. To make sure you don’t miss great episodes like this, hit subscribe there on your YouTube channel, or check out all of our videos.
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