Top 5 Changes Needed in Your Primary Care Practice

Primary care is the bedrock of a healthy community. When patients and families have access to, and seek preventative and wellness health care services, people are healthier. Plus, overall healthcare costs decrease and your practice is more likely to flourish.

Of course, the success of a primary care practice is a two-way street. Patients need to see the value in having a primary care physician, and you need to offer the services patients want, when they want them. In the end, both patients and the practice win. Patients experience improved health and quality of life; practices grow by building trust and becoming the preferred provider of specialized services for patients in need of advanced healthcare services.

It takes focus, the right processes, and coordination with others in your community who provide healthcare services. You will also have to effectively overcome the headaches and hassles of bureaucracy and red tape.

Building a successful primary care practice requires that your group has the wherewithal to address the ever-changing requirements of government agencies and insurance companies. This can be a challenge for even the most highly trained staff, but it is possible, and your practice can grow from it. You can leverage new requirements to generate increased revenue without adding any extra burden to your staff.

If you want to substantially improve your practice in 2016, you have to know what changes to make, how to leverage new mandates into growth for your practice and increase your bottom line. Here are five changes you can make in 2016 to improve your overall results.

Aggressively Promote Annual Wellness Visits

Most people try to avoid visiting the doctor until they are sick.

Research conducted by the federal government shows that annual wellness visits can keep people healthier by identifying cancer, heart disease and other serious illnesses before they become life threatening.

Unfortunately, most people do not take advantage of annual wellness visits, even though they are 100 percent covered by Medicare. This is unfortunate for both you and your patients.

If you aggressively promote annual wellness visits, your patients will be healthier, and you will have the opportunity to identify health issues that require additional treatment—and additional reimbursement.

For example, you can leverage wellness visits to increase revenue by using them as opportunities to offer men with a history of smoking Abdominal Aortic Aneurysm (AAA) screenings as recommended by CMS and the USPTF. There are three reasons this makes sense for your bottom line. First, the federal government recommends that all men who have smoked undergo the procedure. Second, the government allows you to provide the screening to patients who meet the qualifications free of charge. Finally, Medicare will pay your practice for providing the procedure.

In short: Annual wellness visits are beneficial to both your patients and your practice in ways that go well beyond the preventative services typically associated with most cases.

Focus on Transitional Care

Transition care most often affects older patients. It can be either a burden or a boon for your practice. Moving patients through the continuum of care—from clinic to specialist to hospital—can be incredibly complicated and expensive. But it can also become a profit-driver if you and your staff master the art and science of the passage of patients between levels of health care.

Coordinating among your staff and primary care physicians, pharmacists, medical transportation services, hospital staff and specialists can equate to as much as a four percent increase in payments to primary care physicians who have streamlined processes for moving patients through the continuum of care. Realizing these payments requires you to create systems in which you utilize TCM codes 99495 and 99496 to address patients who require transition care.

You will also need to make sure that you have proper documentation processes in place to ensure that Medicare policies are being adhered to including precise documentation of discharges, communication with patients and medication reconciliation.

Document Meaningful Use

Do you have processes and practices in place that allow you to document meaningful use? If not, you may not be compensated by Medicare for the treatments you are providing.

The provisions of the Health Information Technology for Economic Clinical Health (HITECH) act require any primary care practice that is enrolled in the Medicare Electronic Health Records (EHR) incentive payment program to prove meaningful use in order to receive payments. The Act was signed into law in 2009, but things get serious for primary care practices in 2016.

Since HITECH became law, primary care practices have been required to attest to meaningful use Stage 1 for two years before moving to Stage 2, which results in larger reimbursement payments. Then further attest to the second stage for two years before moving on to Stage 3. However, in 2016, all providers that are eligible for the program will have to demonstrate meaningful use to receive payment.

This means you will need processes and practices in place to ensure that your electronic medical records are up to date and accurate. In addition, to fully maximize the financial benefits of documenting meaningful use, you should also optimize ordering and referral workflows in EHR to capitalize on capturing services that can and should be performed in your office rather than being referred out. This helps meet meaningful use requirements while also capturing services and revenue that are leaking out of your practice.

Create a Patient-Centered Medical Home

It dates back to 1967, but is just now gaining popularity among patients and insurance companies. It is a way to organize primary care so that care coordination and communication is emphasized. Insurance companies believe it is a way to give patients what they want. It's also becoming a requirement to be paid.

It is, of course, the Patient-Centered Medical Home (PCMH), and it involves developing and cultivating a partnership among patients, primary care providers and specialists. PCMH puts the PCP squarely in the driver's seat of the patient's care. It also assigns the responsibility of delivering quality care at the lowest possible cost to the patient—across all specialties. Insurance companies are embracing the PCMH approach to improving overall patient health, and believe that using a patient-centered medical home model helps improve overall patient health, which reduces costs. Insurance companies feel that patients who have one primary doctor and medical team are more likely to take advantage of annual wellness visits. They also believe that physicians are more likely to understand their patients' needs and medical histories, which means that fewer unnecessary medical procedures will take place.

The PCMH model substantially benefits the PCP because it brings more services under the practice's roof. It helps to control quality and costs, improve patients' health and enhance patients' experiences with your practice. In other words, PCMHs achieve the Institute for Healthcare Improvements' "Triple Aim," which is an approach to optimizing health system performance across the country—but is often difficult to achieve.

If you want to increase your chances of being paid by the insurance companies, you need to focus on the patient-centered medical home and become certified in the practice. More and more insurance companies are requiring it for participation in plans.

Create or Join an Accountable Care Organization (ACO)

Accountable Care Organizations, or ACOs, are physicians, hospitals and primary care providers voluntarily working together to provide coordinated care that meets standards set by Medicare.

Together they deliver the right treatments to patients at the right times. Medicare believes this results in less duplication of treatments and fewer medical errors, which saves money. These savings are then passed along to practices in the form of incentives. According to The Centers for Medicare and Medicaid Services, 97 ACOs qualified for shared savings payments of more than $400 million in 2014.

Consider forming or joining an ACO.

No primary care practice is an island. As a physician and practice leader, you need to interact with a variety of people and organizations in your community that play an important role in reducing your costs. They are public health organizations, patients, families and other health care providers. Together, you can work to improve patients' access to preventive and chronic care services—and reduce the overall costs of health care.

If you start connecting with the people and organizations in your community, you can identify gaps in health care coverage, reduce unnecessary specialist referrals and diagnose disease earlier. This leads to improved outcomes because you are able to address patients' health issues before they become acute.

This year, resolve to focus on coordinated care, meaningful use, promoting annual wellness visits, and doing all you can to lower costs. There are challenges, including a multitude of government mandates and metrics to measure and meet, but these challenges also represent opportunity.