example, will the health system be required to pay for building maintenance (e.g., replacing boilers or roofs)? This is a fairly common requirement. Sometimes landlords ask hospitals to fully fund select maintenance projects up front (from the proceeds from the sale) even though the projects won’t be needed for years. Landlords also tend to require tenants to pay for any physical improvements to the plant, such as redesigning a surgical suite.

In the end, each lease contract is unique. There are an infinite number of games landlords try to play. For example, if a landlord is part of a bank, it might insist that the hospital deposit funds in the bank. Or a landlord might demand a percentage of a hospital’s operating growth. Successfully negotiating these diverse contract clauses requires knowledge of the related legal, financial, regulatory, and clinical issues.

Get references. Before signing a contract to sell and/or lease real estate, it’s wise for hospital finance leaders to seek references from other hospitals that have been involved in sale-leaseback transactions with that buyer. How easy is the landlord to work with? What are the hospital’s costs associated with the deal?

Seeking a Higher Return
As hospitals take on insurance risk, they are going to have to devote more time, energy, and resources to building population health capabilities. Strategically selling real estate frees up capital to invest in the future, while also freeing hospitals from a relatively low-performing investment.

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Tending to the Flock: How to Optimize Value in a Primary Care ACO
By Lauren Phillips

ACO success begins with the annual wellness visit and depends on attentive care transitions and coordination.

The best way to achieve real value in a primary care accountable care organization (ACO) is to “wrap your arms around your population,” according to Sheila Fusé, executive director, and Kelly Conroy, Florida executive director and senior advisor, of Aledade, which operates Medicare Shared Savings Program primary care ACOs in 11 states across the country.

Fusé and Conroy are pioneers in this type of Medicare ACO. Since its founding in June 2014, their company, Aledade, has doubled in size and now encompasses 110 physician practices and nearly 100,000 beneficiaries.

More than money or infrastructure—both of which are important in optimizing communication and coordination, two hallmarks of ACOs—wrapping your arms around a given patient population means doing many small things right, says Fusé, including the annual wellness visit, care transitions, care coordination, and effective care of patients with chronic conditions.

The Annual Wellness Visit
The first annual wellness visit creates a partnership between provider and patient in four ways, according to Conroy.

> It establishes a baseline of the patient’s current health status so the practice and the patient can track changes and measure the effectiveness of activities and interventions.
> It allows for development of a personalized care plan designed to enhance a patient’s well-being, resolve health issues, and reflect patient and physician expectations.

Transition of Care Management Cuts Readmissions

Aledade’s Transitional Care Management (TCM) impacts 30-day readmissions.

![Transition of Care Management Cuts Readmissions](chart.png)

Source: Aledade, 2016. Used with permission.
Making Sure You Have the Right Physicians

Obviously, every ACO wants to have the best physicians, but clinical excellence is not all the job requires. Aledade believes other criteria are just as important in making accountable care work, and the company recruits for these characteristics as well.

- Independence (i.e., not being employed by a hospital, so the goal of always caring for the patient in the appropriate setting at the lowest cost per capita is not compromised)
- Quality (i.e., top practices in the community)
- Willingness to embrace and lead change (i.e., understanding that being completely responsible for a patient’s care is not easy, and being willing to work hard to achieve that aim)
- Leadership in their communities (i.e., physicians who lead local chapters of the American Academy of Family Physicians and other professional groups)
- Tech savvy (i.e., the ability to use technology meaningfully to coordinate care)

A track record in accurate coding is another desired characteristic, as it indicates the skill and attitude required to capitalize on new codes the Centers for Medicare & Medicaid Services has introduced for ACO patients. For example, in many practices, patients with chronic obstructive pulmonary disease (COPD) are not coded as such until they see a pulmonologist or go to the emergency department with trouble breathing. A good ACO physician will spot that COPD even if the patient comes in with a urinary tract infection.

- It introduces the patient to the practice’s goals and operations, the patient’s rights and responsibilities, and the various methods of patient access.
- It starts a conversation between the doctor and the patient that will extend throughout their relationship.

An essential part of this process is medication reconciliation. “It’s about knowing all the medications the patients are on, but also making sure they’re actually taking the medications,” Conroy says. “Sometimes patients aren’t taking their pills because they can’t afford them, and primary care physicians need to address the problem.”

Also on the agenda are setting up checklists of preventive measures and screening for risk factors such as falls and depression.

“During the annual wellness visits, we’re identifying a remarkable number of patients at risk for falls,” says Conroy. “So, in addition to following standard, evidence-based practices designed to cut this risk, we find doctors are coming up with other, innovative ways to take closer looks at these patients. For example, we can send at-risk patients for one-time physical therapy evaluations so physical therapists can help figure out the problem and make a better plan for the patient.”

In fact, 11 of Medicare’s 25 quality measures are met on the annual wellness visit. And, says Fusé, “We’ve seen that ACOs that do more annual wellness visits tend to have higher Medicare quality scores.” Of course, people’s health can change, so savvy ACOs see patients at least twice every 12 months.

Care Transitions

Getting patients safely from one care setting to another and home again is the point of the Centers for Medicare & Medicaid Services’ Transitional Care Management Services (TCM). Within 30 days following discharge, the guidelines require the ACO to provide an interactive contact, such as a follow-up phone call with a medication reconciliation within two days; a face-to-face visit within seven to 14 days, depending on the complexity of the medical condition; and services such as establishing referrals and arranging for community resources, educating the patient and/or caregiver, and interacting with specialists and those who will assume patient care. Medicare reimburses the ACO for these visits.

The reason is simple: If patients see their primary care physician (PCP) within a week of discharge from a hospital, skilled nursing facility, or rehabilitation facility, it prevents a lot of downstream complications. It also reduces the rate of readmissions and emergency department (ED) visits (see the exhibit on page 7). Here, too, medication reconciliation is critical.

“A discharged patient is a ticking time bomb until you get that done,” says Fusé. “Patients had certain medications before they went into the hospital, they get different ones during their stay, and they come out with new prescriptions—trying to put everything together on their own is dangerous. Often we find they’re taking the same medication twice and they don’t realize it.”

So how does the ACO know if one of its patients is discharged from a hospital or another facility? This notification happens automatically if the ACO is connected to a state’s health information exchange system, which receives notice of admissions, discharges, and transfers (ADT) (see the exhibit on page 9). If not, says Fusé, Aledade ACOs reach out proactively.

“We go to community stakeholders, like the hospitals and nursing homes and even the specialists, and we say, ‘If you discharge one of our patients, we want you to let us know about it. You can do it any one of a number of ways—for example, through a secure portal or with a secure text.’”

But even that is unnecessary if the facility has the Aledade App. Designed specifically for primary care practices, the app is a cloud-based population health platform that overlays and supplements the individual electronic health records (EHRs) of physician practices belonging to the ACO.

“We probably work with more than 30 different EHRs,” says Conroy. “The app pulls data from those records, from hospital records, from HIEs [health information exchanges], and from Medicare so physicians can see information from all sources and get a big picture of where a patient is.”

This allows practices to:

- Learn which patients are eligible for their annual wellness visit
Coordinating Care

Primary care ACOs are accountable to the federal government for their patients’ care, wherever it is provided, and they get a lot of data from Medicare to help them do that.

“The ADT data shows us where a patient is going, so we can call up those providers—whether an acupuncturist, an urgent care center, a podiatrist—and ask for their help in coordinating,” Conroy says.

Aledade ACOs are proactive on this front when it comes to specialists, she adds. “We go out and talk to them and form care compacts or agreements with them: We’re transparent with our data, we lay out our expectations of excellence, and we ask if there’s anything we can do to help them. For example, if a doctor’s office says, ‘Well, every time I call you, it takes forever for somebody to answer the phone,’ then we may appoint somebody to be that specialist’s exclusive contact person, or we may give them a special phone number.”

Chronic Care Patients

Earning the loyalty of chronic care patients, which an ACO must do if it is to earn high patient satisfaction and quality care ratings and cut costs—thus qualifying for shared savings—starts at that first annual wellness visit. New patients are stratified according to risk and reassessed at every subsequent annual wellness visit, so the organization knows at all times who qualifies for chronic care management services under Medicare. The ACO is reimbursed $40 per month for every patient who qualifies for chronic care.

These patients must have two or more conditions expected to last at least 12 months that put them at risk of death, deterioration, or functional decline. If they sign up for chronic care management, the ACO ensures continuity of care, secure communication with a designated practitioner, and coordination of services.

The Wow Factor

Aledade leadership compares participating physician practices to shepherds watching over their flocks. Practices that are good shepherds treat every patient in every encounter attentively, says Conroy.

That is why all Aledade practices offer same- or next-day appointments for patients with urgent needs, and 95 percent of Aledade physician partners provide 24/7 patient access to an on-call doctor.

One result of the vigorous attention to patient care is that Aledade ACO practices have increased preventive care visits by 400 percent and vaccination rates by 250 percent in the last year.

What they are pursuing, says Conroy, is the “wow factor”—whatever it takes to engage patients and gain their loyalty. Because real value comes not in growing a patient panel but in satisfying the ones you have.

Impact of HIEs and ADT Alerts

The impact of admission, discharge, and transfer (ADT) alerts provided by state health information exchanges (HIEs) is seen here in lowered emergency department visit rates.

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<tr>
<th>11 of 11</th>
<th>87% vs. 63%</th>
<th>$0-$12</th>
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<tr>
<td>States where community-based HIEs are offering ADT alerting services</td>
<td>Percentage of emergency department (ED) visits with alerts when a patient panel is used for matching vs. national provider identifier (NPI)</td>
<td>Cost per patient per month for ADT panels</td>
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<td>9 of these HIEs can provide ADT alerts in near real time (within 1 hour of the event)</td>
<td>Providers receive alerts on a greater proportion of ED visits when ADT data are matched on patient demographics rather than NPI</td>
<td>Matching ADT feeds with patient panels often incurs a fee for each person on the panel</td>
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<tr>
<td>2 can provide ADT alerts from all hospitals in the state</td>
<td>Most common patient panel demographics requested by HIEs:</td>
<td>Before ambulatory providers may receive alerts, most HIEs also require them to become HIE participants, which often involves separate fees</td>
</tr>
</tbody>
</table>
> Medicare ID
> Social Security Number
> Phone
> Address
> First and last name
> Gender
> Birth date
> Race

Source: Aledade, 2016. Used with permission.