THE MONTHLY PUBLICATION FOR CAP MEMBERS

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CAP Announces Retirement of Deidri Hoppe from CAP Physicians Insurance Agency, Inc.; Vice President Michael Dyse Named Successor

Transition assures continuity and success of an already thriving agency

After 10 years of service to CAP members, Deidri (Dee) Hoppe, President and CEO, CAP Physicians Insurance Agency, Inc. (CAP Agency), will retire at the end of December. Ms. Hoppe will be succeeded by Michael Dyse, who is currently Vice President, CAP Agency.

Ms. Hoppe joined CAP in 2011 and previously held the position of Vice President, overseeing the property casualty insurance division for CAP Agency. She was promoted to President and CEO, CAP Agency in 2016. Prior to joining CAP Agency, Ms. Hoppe served as Vice President of Property Casualty for AIG insurance company and Director of Consulting at Aon Risk Management, overseeing 20 consultants in five different Aon offices.

"Dee has been a strong and effective leader, instrumental in the growth of all lines of the CAP Agency," says CAP Chief Executive Officer Sarah Scher. "Her use of technology to build the agency and the fact that she delivered almost $3 million in dividends to the CAP enterprise from the agency are particularly noteworthy. We will miss her and wish her much happiness in her retirement."

Michael Dyse will take the reins as President and CEO, CAP Agency, effective January 1, 2022. Mr. Dyse has worked at CAP since 2014. Before moving to the agency as Vice President earlier this year, Michael served as Assistant Vice President, CAP Membership Services, where he managed the largest groups and accounts across the CAP enterprise. Mr. Dyse holds a Bachelor of Arts degree, with honors, from Claremont McKenna College. He has extensive industry experience, handling multiple lines of insurance at various organizations prior to joining CAP, including Answer Financial/CalFed Insurance Agency, 21st Century Insurance, and American Fidelity.

Said Ms. Scher, "With Michael's extensive background, strong work ethic, and excellent interpersonal skills, he is sure to build upon the success of an already thriving agency. Michael has been working with the agency as he transitions into his new position, and we are excited about the innovative thinking he has already demonstrated."

Michael Dyse

November 2021

Case of the Month

by Gordon Ownby

Following Up When a Specialist Offers Advice

When a specialist comes back with less than clear-cut test results, it is not unusual to see a report that contains politely worded recommendations for further workup. Don't let the deferential language lull you into complacency.

A 37-year-old mother of three had been a patient of Dr. OB, an obstetrician, for seven years when she presented to him four weeks pregnant with complaints of nausea. Though the non-invasive prenatal testing the next month was characterized as "non-reportable," Dr. OB charted a call from the lab indicating possible trisomy 21 and other abnormalities that could relate to fibroids or occult malignancy. Dr. OB referred his patient to a maternal-fetal medicine specialist, where she underwent an AFP test, ultrasound, and amniocentesis. The AFP was normal and initial concerns from the ultrasound were later cleared with the amniocentesis results. When the patient returned to Dr. OB several days after the testing, she complained of a left breast lump. Dr. OB examined the breast and noted that it felt quite enlarged with no discrete mass.

Three weeks later, the genetics center's full report to Dr. OB addressed the earlier "non-reportable" blood test and commented that possible explanations included laboratory error, maternal fibroids, fetal aneuploidy, or maternal cancer. The report then continued, in bold print: "The patient's amniocentesis results are now available and indicated a normal fetal karyotype of 46,XX. Additionally, no evidence of maternal fibroids were found. Due to the indeterminate NIPT results we discussed the option of a repeat CBC to screen for cancers of the blood. Additionally, a referral to Oncology can be considered with discussion of full-body MRI. These recommendations were discussed with the patient."

The patient returned to Dr. OB three weeks later complaining of frequent headaches; the chart showed no discussion regarding the genetics center's recommendations. A fetal ultrasound three weeks later was normal as was an anatomical scan a month hence.

Two months later, an episode of chest pain, breathing pain, and coughing improved over several days, though the patient reported being very uncomfortable having "runs of contractions." Dr. OB scheduled the woman for an elective induction.

Following the delivery, the patient was noted to have a large, inflamed left breast. A consulting surgeon performed a punch biopsy, which showed high-grade infiltrative ductal carcinoma. An MRI of the breasts suggested malignancy in the right breast while the left breast showed an extensive tumor with distorted anatomy, skin thickening, nipple involvement, and left axillary adenopathy. A bone scan showed metastases and a chest CT scan indicated pathologic fractures at T3, T4, T5, and T10.

When the patient presented to an oncologist two weeks later, she reported having a breast lump prior to pregnancy, that nothing was found on exam, and that the lump grew during pregnancy.

The patient underwent chemotherapy, a craniotomy for brain metastases, radiation therapy, and a bone

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marrow transplant. The patient initiated a lawsuit against Dr. OB, but died before litigation concluded. Her family then pursued a wrongful death claim.

In addition to focusing on Dr. OB's failure to refer the patient to an oncologist following the genetics center's recommendation, the family claimed that pap smears performed by Dr. OB years earlier identifying atypical squamous cells and high-risk HPV DNA put the mother at high risk for breast cancer. The family also cited deposition testimony of the patient claiming that during a well-woman exam prior to her pregnancy, she asked Dr. OB about a left breast lump. Though Dr. OB's record of that visit shows "no breast problem," the patient's testimony was that Dr. OB responded to her question by asking her about her menstrual cycle, attributing the lump to hormones, and saying that she shouldn't worry about it.

The family and Dr. OB resolved the litigation informally.

Medical malpractice litigation often includes divergent testimony between a patient and physician and invariably involves competing views among expert witnesses, leaving a jury to decide whom to believe.

A recommendation in the medical record by a consulting specialist that is never addressed by the treating physician, however, can provide the tipping point for a plaintiff award against the physician.

More importantly (and long before litigation), a treating physician's timely discussion with a patient regarding a specialist's pointed concerns can give everyone the opportunity for the best possible medical outcome.

Gordon Ownby retired as CAP's General Counsel in November.

Risk Management and Patient Safety News

Adverse Event Disclosure, Difficult Conversations, and the Aftermath

by Rikki Valade, RN, BSN, PHN

Healthcare providers know that adverse events can and do occur in medicine despite the best medical experience and education. CAP defines an adverse event as either a known risk of medical care (a complication) or an injury caused by a medical error. Understandably, emotions run high for the physician, patient, and the patient's family after an adverse event occurs. In most cases, it is the physician's duty to inform the patient and/or family of the event.

Disclosure of an adverse event is a very difficult conversation to have. However, it is a critical conversation which requires "kid gloves," or very delicate treatment. The California Medical Association (CMA) states "physicians have an ethical obligation to honestly explain the various aspects of a patient's condition and treatment, which includes giving accurate information when there has been an unanticipated outcome in a patient's care".[1]

According to JAMA, patients and their families want and expect[2]:

- Disclosure of the error.
- To understand what happened.
- To understand why the error happened.
- To know how the consequences of the error will be mitigated.
- To be assured recurrences will be prevented.
- Emotional support, including an apology.

CMA also notes that disclosing an adverse event can help reduce the risk of litigation and indicates that studies have shown that not notifying a patient of a medical error, even a minor one, increases the risk of litigation. If a case involving an adverse outcome proceeds to litigation, the disclosure of the event could favorably impact the case. An analysis of jury opinions has indicated that jurors may consider disclosure as a sign of the practitioner's integrity.[1]

Disclosure

The disclosure conversation should happen as soon as possible after the event or after the event is discovered. Here are some helpful guidelines to follow:

- It is imperative to never use words that suggest fault, such as "error," "injury," or "mistake."
- Do not blame others, what we here at CAP refer to as "finger pointing".
- Take a deep breath and be sure you are not angry while having this conversation. (Ambrose Bierce is quoted as saying "speak when you are angry, and you will make the best speech you will ever regret".)
- Provide empathy during the disclosure process.
- Do not dismiss or trivialize the patient's experience and emotions.
- Speculation is never helpful, do not guess. Consider, "While we do not know the cause at this time, we are working to understand what happened and will keep you informed as information is learned."
- Give the patient or family your contact information. Be available to answer questions and return phone calls in a timely manner.
- Be patient and listen.

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A patient or members of their family may react differently to the disclosure and it is important to be prepared. ECRI Institute provides a list of the reactions that you may encounter during the disclosure process and recommendations for responding.[3]

Crying

- Give the individual permission to cry.
- If meeting in person, always have a box of tissue available.

Anger

- Do not try to talk the person out of being angry.
- Acknowledge that anger is a common reaction.
- Explain that the event is being taken very seriously and an investigation will be conducted.
- Express genuine empathy and regret for the situation, without taking blame.

Denial

- Inform the person that denial is a common reaction.
- Explain the facts of the event as they are known at the time. "The patient is entitled to know the facts of what happened, but not necessarily the ultimate legal facts regarding what happened (e.g., someone was negligent)" (ECRI).[3]
- Repeat the truth as often as necessary.

Apology/Sorry Works

Apologizing is an important factor in the disclosure process. You can apologize empathetically without admitting guilt or fault. "Results of one study indicate that 88% of patients wanted their physicians to apologize after an adverse event occurred" (ECRI).[3] However, there is a distinct difference between "I'm so sorry that you had this complication," versus "I am sorry this happened, we made a mistake". Some states have implemented "I'm sorry" laws intended to promote disclosure and apology in healthcare. As of 2012, 36 states have implemented such laws (Saitta and Hodge).[4] Saying "I'm sorry" is not an admission of liability in California (Evidence Code 1160a).5 However, the law varies state to state so it is advisable to be familiar with the laws where you practice.[5]

Examples of Empathetic Apologies:

- I'm sorry you are experiencing this
- I'm sorry this happened
- I'm sorry you are going through this
- I'm sorry this complication occurred

Examples of Admitting of Fault:

- I'm sorry; this was my fault
- This was my mistake
- I take full responsibility
- We made an error

In addition, apologizing can rebuild the patient's and family's feelings of trust in the provider, minimize feelings of hostility, and potentially aid in the recovery of the patient, their family, the physician, and other care providers.[4]

Disclosure is difficult, yet essential. Remember, early intervention and honest, open communication are key to maintaining a successful doctor-patient relationship. Studies show that if you are forthright with the patient from the beginning you can save the doctor-patient relationship, benefiting all who are involved.

A CAP Cares team member is ready to provide assistance from the moment the adverse event is recognized. Please call the CAP Hotline at (800) 252-0555 for expert guidance from an experienced Senior Risk Management and Patient Safety Specialist.

Rikki Valade is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to RValade@CAPphysicians.com.

References:

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[2]Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, and Levinson W. "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors." JAMA. 2003; 289: 1001–1007. https://pubmed.ncbi.nlm.nih.gov/12597752/

[3]ECRI Institute. Disclosure of unanticipated outcomes. Health Syst Risk Manage 2018 May 7. https://www.ecri.org/components/HRC/Pages/IncRep5.aspx

[4]Saitta, N. & Hodge, S. (2012). Efficacy of a Physician's Words of Empathy: An Overview of State Apology Laws. Journal of Osteopathic Medicine, 112(5), 302-306. https://doi.org/10.7556/jaoa.2012.112.5.302

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[5]California Legislative Information; Evidence Code 1160a

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=EVID&sectionNum=1160

Important Update to CyberRisk Insurance Benefits for CAP Members

December 2021

Providing the best medical malpractice coverage and practice support benefits to protect your professional and personal well-being are a hallmark of CAP membership. As today's risks grow more threatening and prevalent, it is important for you to remember the value-added insurance coverages CAP provides as part of your membership, including your CyberRisk insurance, which covers $50,000 and 5,000 patient notifications per covered claim should you experience a data breach in your practice.

For the last nine years, CAP has been pleased to have the ability to offer CyberRisk insurance to all active CAP members at no cost and with a $0 deductible.

As cyber criminals continue to target healthcare facilities and medical groups, including vulnerable solo and small practices, with egregious ransomware and phishing attacks, the medical industry is experiencing a dramatic increase in the frequency and severity of claims for the types of data breaches your CyberRisk insurance covers.

As a result, starting January 1, 2022, CAP members should be advised that their CyberRisk insurance will continue at no cost. However, because of the widespread increase in claims, your CyberRisk insurance will now include a $2,500 deductible per covered claim. In addition, your CyberRisk insurance benefit will now be subject to a shared annual aggregate limit of $10,000,000, which means that all amounts paid under CyberRisk on your behalf and on behalf of all other CAP members will reduce and may completely exhaust such shared annual aggregate limit. If the shared annual aggregate limit is exhausted, your individual CyberRisk Limits will also be deemed exhausted, and there will be no further CyberRisk insurance benefit available to you or others for the remainder of the year.

To avoid potential claims, CAP encourages all member practices to implement strict cybersecurity measures and reminds you that as part of your CyberRisk insurance benefit, you and your staff can access free HIPAA training, courses on how to prevent data breaches, and much more at https://CAP.nascybernet.com. (First-time users will need to sign up for a free account with your CAP member number as your "Sign Up Code." Once you have registered, you will be able to create username(s) and password(s) for your employee(s).)

Given the increased exposure to data breaches, now is a good time to explore purchasing additional CyberRisk insurance, available at excellent rates through CAP Physicians Insurance Agency, Inc. (CAP Agency). To learn more, call one of CAP Agency's licensed insurance professionals at 800-819-0061 or email CAPAgency@CAPphysicians.com.

In addition to CyberRisk insurance, CAP members also receive Life and Disability insurance coverages, and the MedGuard and Employment Practices Plan benefits, at no charge. Contact CAP Agency to learn more about your coverage limits and opportunities to purchase additional protection.

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Open Remote Desktop Protocol Ports Can Cost You

December 2021

Ransomware attacks have been on the rise for a few years, but when COVID-19 triggered a near-universal pivot to remote work, a whole new world of vulnerabilities opened to the criminals behind them, including the access of Remote Desktop Protocol ports.

What is Remote Desktop Protocol?

Remote Desktop Protocol (RDP) is a proprietary Microsoft communications protocol that allows individuals to remotely connect to corporate systems and services. RDP uses an encrypted channel and prevents attackers from eavesdropping on your connected session and provides fast, remote administrative access to a Windows machine.[1]

CAP Physicians Insurance Agency (CAP Agency) partners with Tokio Marine HCC – Cyber & Professional Lines Group (TMHCC), to provide CyberRisk insurance coverage for all CAP members with the opportunity to purchase a higher limit policy. TMHCC estimates that about 60 percent of all their ransomware attacks in 2020 originated from open RDP ports.

Did you know?

RDP is typically accessed with usernames and passwords and therefore susceptible to brute-force attacks and credential stealing campaigns. After an attacker compromises an RDP connection, they will often deploy malware (like ransomware), steal data, or move laterally in a corporate network to perform reconnaissance.[2]

How do you know if your practice is vulnerable?

Generally, a vulnerability scan can help determine whether a commonly used RDP port is facing the public internet and therefore potentially exploitable. These scans are noninvasive and use only public facing domains (i.e., website URL) to assess where ports are "open" to attack. Hackers can (and do) scan to identify open RDP in the same manner.

Helpful Tips[3]:

- Never have RDP exposed to the internet or open to any other network you do not trust.
- Always secure a virtual private network (VPN) or RDP Gateway with Two Factor Authentication (2FA).
- Always enforce strong complex passwords and enable an account lockout policy after too many failed attempts.

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- Restrict access to RDP by applying firewall rules to limit which IP addresses (individual or group) can access the RDP server from untrusted networks.
- Keep all remote access software (especially Windows Server) updated and patched.

Here's how CAP Agency can help:

For CAP members who purchase a stand-alone higher limit policy written by TMHCC, an RDP scan will be conducted by them at no cost to you to ensure you know about potential vulnerabilities before any hackers do. If an open port is discovered, it is recommended that you inventory all remote access connections that are exposed to the internet and take steps to ensure that they are properly secured. In partnership with TMHCC, CAP Agency will let you know if an open RDP is detected to help prevent potential ransomware or other cyberattacks.

As a reminder, CAP members are offered complimentary access to TMHCC CyberNET®, the most advanced cyber risk management training solution addressing the latest trends in data breaches and cybercrime, including best practices to protect against RDP remote access.

To access the trainings, visit https://CAP.nascybernet.com. (First-time users will need to sign up for a free account with your CAP member number as your "Sign Up Code." Once you have registered, you will be able to create username(s) and password(s) for your employee(s).)

For more information, please contact CAP Agency at 800-819-0061 or email CAPAgency@CAPphysicians.com. The licensed professionals with CAP Agency can also help you learn about your own personal cyber risk and about affordable coverage options and services available through Tokio Marine HCC.

[1]ePlace Solutions, Inc., Securing Windows Remote Desktop (RPD) Guide, TMHCC CyberNET.
[2]ePlace Solutions, Inc. via: https://www.pandasecurity.com/mediacenter/security/brute-force-rdp/
[3]ePlace Solutions, Inc., TMHCC CyberNET®.

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Physicians and the Holiday Season – Not Always a Joyful Time

by Gwen C. Spence, MBA

The holiday season is here. Many of us are preparing our homes for guests, family, and friends. The season begins in November and continues through the first of the year. As physicians think about the holidays, they must consider their personal health and listen to their minds and bodies. The holidays are supposed to be a time of joy and celebration but for some doctors, it is anything but.

The Holiday Blues, which is also referred to as the "winter blues" is a type of depression that occurs in about 14 percent of Americans, according to Timothy J. Legg, PhD, CRNP. Usually individuals that suffer from the winter blues have a propensity for depression throughout the year, although it is magnified during the holiday season. Doctors are saddled with the responsibilities of running practices, saving lives, meeting expectations of patient satisfaction and governmental compliance issues, and breaking even financially. Physicians are already feeling the anxiety of not spending enough time with their families and friends and admit they have a poor work/life balance, which leads to "burnout." When doctors do not address anxiety and mental issues, the probability is that when treating patients, the quality and safety of the services provided can be compromised.

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Typically, when doctors go to medical school, they develop a belief that their job is to treat patients, but they as individuals are not to be treated. This philosophy runs deeply when it is pertaining to physical health however, it runs even deeper when it comes to mental health. Doctors keep their mental health struggles to themselves because being honest about this condition has what they perceive as many pitfalls. According to a study from **locumstory.com**, more than half of physicians reported believing that mental health is a taboo topic to discuss and two-thirds would not consider meeting with a mental health professional.

Darrell G. Kirch, MD, says in, *Physician Mental Health: My Personal Journey and Professional Plea*, "The simple reality is that becoming a physician in no way removes one's shared human vulnerability to mental disorders." Doctors are people too.

Physicians should pay attention to these signs of depression, especially as we enter the holiday season.

- Changes in appetite or weight
- Changes in sleep patterns
- Irritable mood
- Feeling of worthlessness or guilt
- Feeling more tired than usual

In many cases, holiday depression can be treated with lifestyle changes and the support of those closest to them. Physicians should take the advice that they give to their patients:

- **Exercise.** Research studies have shown that as little at 20 minutes per day of activity can alleviate symptoms of depression.
- **Eat a healthy diet** and maintain regular sleep patterns.
- **Don't give in to holiday pressures.** You don't have to accept every invitation to holiday parties. Set aside time for yourself.
- **Drink only in moderation.** As you have advised your patients, alcohol is a depressant. If one is feeling blue or is depressed, alcohol isn't going to help.
- **Talk about your feelings to a significant other.** Express the need for support. If you are away from your family or friends, stay connected by FaceTime or telephonic conversations.
- **Seek professional help.** A prescription for antidepressants may be warranted, along with therapy. Ongoing therapy can help doctors with managing stress, communication and relationships.

Depression amongst physicians is not a new occurrence. Every doctor is vulnerable to mental illness just like any other physical problem. It has been something doctors have kept secret, fearing retribution and fear of reputation assassination. More doctors, however, are now speaking out about their struggles and are offering themselves as support for those who need it. Additionally, the National Academy of Medicine has created an action collaborative on clinician well-being and produced a study on how healthcare organizations can take a systems approach to promote well-being.

Visit **https://nam.edu/initiatives/clinician-resilience-and-well-being/ for more information**.

Gwen Spence is Assistant Vice President, Membership Services, for CAP. Questions or comments related to this article should be directed to GSpence@CAPphysicians.com.

December 2021

New California Health Laws in 2022

by Gabriela Villanueva

On October 10, the California Legislature completed the first year of its two-year cycle for legislative action, with Gov. Newsom signing 770 bills into law and vetoing 66. Of those bills, the majority go into effect on January 1, 2022. Below is a list of some of the bills signed into law in the healthcare space.

COVID-19 Testing (SB 510, Pan): This bill requires health insurers to cover the cost of coronavirus tests, ensuring California patients do not have to pay out-of-pocket fees or contend with prior authorization requirements. This bill protects patients from surprise medical bills and alleviates bureaucratic obstacles for both physicians and patients.

Telehealth (AB 457, Santiago): This bill ensures patients can access telehealth services from their selected healthcare provider, or other networked provider of their choosing, rather than having a health plan direct them to a third-party telehealth entity. If a patient does choose to be treated by a third-party corporate telehealth provider, this bill requires the provider to forward patient records from the visit to the patient's primary care physician or a physician of the patient's choosing.

Pharmacist Authorization to Initiate and Administer Certain Vaccines (AB 1064, Fong): Authorizes a pharmacist to independently initiate and administer any vaccine that has been approved or authorized by the FDA and received a federal Advisory Committee on Immunization Practices individual vaccine recommendation published by the CDC for persons three years of age and older.

Pharmacists Authorization to Perform Certain CLIA Waived Tests (SB 409, Caballero): Authorizes pharmacists and pharmacies to perform, in accordance with specified requirements and conditions, any aspect of an FDA-approved or authorized test that is classified as waived under Clinical Laboratory Improvement Amendments (CLIA) if the test is used to detect or screen for the below illnesses, conditions, or diseases:

- SARS-CoV-2 or other respiratory illness, condition or disease;
- Mononucleosis;
- Sexually transmitted infection;
- Strep throat;
- Anemia;
- Cardiovascular health;
- Conjunctivitis;
- Urinary tract infection;
- Liver and kidney function or infection;
- Thyroid function;
- Substance use disorder;
- Diabetes; and
- Other conditions as specified by regulation.

New Psychiatric Unit/Facility Emergency Service Requirements (AB 451, Arambula): Psychiatric facilities that are county-owned and operated and those with 16 or fewer beds are exempt from the new law, which will require psychiatric hospital units, psychiatric health facilities, and acute psychiatric hospitals (regardless of whether the facility operates

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an emergency department) to accept the transfer of a person with an emergency psychiatric medical condition from a licensed healthcare facility with an emergency department and provide emergency services to that person if all of the following requirements are met:

- The treating physician at the sending facility has determined that the patient is medically stable and appropriate for treatment in a psychiatric setting and has included that determination in the patient's medical record;
- The facility has an available bed; and
- The facility has appropriate facilities and qualified personnel available to provide the services or care.

New Limitations on Hospice Referrals (AB 1280, Irwin): The new law prohibits hospice providers (and their employees and agents) from paying referral sources for the referral of patients. It will also prohibit hospice salespeople, recruiters, agents, and employees who receive compensation or other remuneration for hospice referrals or admissions from consulting with a patient/patient's representative or a patient's family regarding hospice services, hospice election, or informed consent to a patient, patient's family, or patient's representative. Instead, specified persons including a registered nurse or medical social worker must complete the election of hospice, obtain informed consent, complete signatures, and counsel on the election of hospice with a patient, patient's family, or patient's representative. Finally, hospices will be required to provide verbal and written notice of the patient's rights and responsibilities to the patient or the patient's representative in a language and manner the person understands before providing care.

Moratorium on New Hospice Licenses (SB 664, Allen): New law temporarily halts the issuance of new hospice licenses. The California Department of Public Health will be prohibited from issuing new hospice licenses on and after January 1, 2022, and until 365 days from the date that the California State Auditor publishes a report on hospice licensure. CDPH may grant an exception to the moratorium imposed by this article upon making a written finding that an applicant for a new license has shown a demonstrable need for hospice services in the area where the applicant proposes to operate based on the concentration of all existing hospice services in that area. CDPH would not be prohibited from renewing existing licenses.

Gabriela Villanueva is CAP's Government & External Affairs Specialist. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

Ask My Practice

by Andie Tena

Thriving in Practice Through Value-Based Care

For independent primary care practices, the upside of adopting value-based care can be significant: increased revenue, more efficient workflows, and more accessible, impactful patient data. While data shows physician-led Accountable Care Organizations (ACOs) outperform other models, the process of transitioning is often more challenging for independent practices with limited human, technical, and financial resources.

With value-based care, physicians are reimbursed based on quality rather than volume. The goal is to support patients at their highest possible level of wellness rather than wait to provide care until they get sick, which is often more complex and expensive.

In value-based care arrangements, physicians contract with payers, such as Medicare, Medicaid, and commercial insurance companies, to care for a defined set of patients. Physicians can earn financial rewards by meeting specific performance and quality measures tied to better long-term outcomes for patients. These measures may include the delivery of routine and preventive care services and chronic disease management services.

Accountable care organizations, or ACOs, help physicians formalize their approach to value-based care. ACOs are groups of practices that contract with a payer to achieve the shared goals of improving outcomes and reducing unnecessary spending.

As the top-rated, physician-led ACO in the country, Aledade's proven process helps practices quickly improve financial performance and get more from the data and technologies they have. In 2020, 92 percent of Aledade Medicare Shared Savings Program (MSSP) ACOs achieved savings, reducing the cost of care by 7.4 percent, saving Medicare $315 million. For their success and work in providing care to over 400,000 Medicare patients, Aledade practices will share in over $93 million.

At the same time, Aledade's multi-payer ACOs also created savings — more than $146 million in total with over $50 million going to Aledade practices for quality care delivered to over 376,000 commercial, Medicare Advantage and Medicaid patients.

Aledade recognizes that primary care doctors cannot make the shift to value-based care alone. They need and want a partner who understands their unique needs, and who can provide regulatory expertise, cutting edge technology, data analytics, business transformation services, and all the other elements they need to succeed in value-based healthcare.

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CAP primary care practices considering joining an ACO can take advantage of the opportunity to determine their potential shared savings revenue at **https://info.aledade.com/aa-partner**.

CAP continues to work with Aledade, a company committed to helping medical practices thrive in value-based care programs, as a participant in the CAPAdvantage program to help our members' practices increase revenue and improve outcomes.

If you would like to learn more about the no-cost or discounted products and services exclusive to CAP members available through the CAPAdvantage program or would like assistance with general business or practice-related inquiries, please contact Andie Tena, CAP's Director of Practice Management Services, at ATena@CAPphysicians.com or call 213-473-8630.

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We welcome your comments! Please submit to communications@CAPphysicians.com.