THE MONTHLY PUBLICATION FOR CAP MEMBERS

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Case of the Month

When Miscommunication Becomes Malpractice: Key Insights for Providers

by Dona Constantine, RN, BS

Clear and effective communication forms the foundation of safe, high-quality medical care. When healthcare providers fail to share essential information either with patients or with other members of the care team, the results can be catastrophic. Breakdowns in provider communication are a major factor in medical malpractice claims, patient injuries, and rising healthcare costs.

While many people assume malpractice results from surgical mistakes or misdiagnoses alone, communication errors are often the underlying cause of these incidents.[1]

Types of Communication Errors in Healthcare

Among healthcare professionals, communication errors include:

- Poor documentation
- Insufficient handoff of information during shift changes
- Failure to adequately review medical records
- Pharmacy errors or mistakes in administering medication

In comparison, examples of provider-to-patient communication errors include:

- Inadequate education about medication
- Failure to respond appropriately to a patient's complaint
- Miscommunication regarding informed consent
- Incomplete follow-up[2]

Trust and Verify: Failure to Review Medical Records

Believing his staff had submitted an insurance authorization to receive a pacemaker—defibrillator, a cardiologist, Dr. C, reassured his patient and the patient's wife that the authorization had been submitted. Unfortunately, the authorization had not been submitted; therefore, the patient did not undergo the procedure to receive the device and died.

In the subsequent wrongful death suit, his widow claimed that if the Dr. C had followed up on the authorization, he would have discovered it had not been submitted; after which, it could have been completed and her husband could have undergone the procedure, preventing his death.

Key concept: Physicians need to trust their staff but, as in this case, also verify that critical tasks, such as authorizations, have been completed. It is important for all staff to be clear about their office procedures and periodically review processes such as the handling of referrals, authorizations, and other critical communications.[3]

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Medication Refills: Inadequate Education About Medications

A new patient in her early forties presented to a primary care physician, Dr. PC, with a reported 10-year history of eye irritation. She stated that over-the-counter eye drops were no longer effective and requested a prescription medication. Dr. PC diagnosed allergic conjunctivitis and referred the patient to an ophthalmologist.

Approximately five months later, the patient returned with complaints of red, painful eyes. Dr. PC again referred her to an ophthalmologist. Two years after that visit, she re-presented with a cough and sore throat. Dr. PC documented red eyes on examination and issued another referral to an ophthalmologist.

One year later, the patient returned reporting that her eyes had been persistently red for approximately one month. During that visit, Dr. PC prescribed Tobradex ophthalmic suspension and documented instructions limiting use to five days, with a recommendation to see an ophthalmologist if there was no improvement.

The following month, the patient contacted the office requesting a refill of Tobradex. She reported she had seen an ophthalmologist who ordered other eye drops, but that Tobradex provided better relief. Dr. PC authorized the refill of the medication.

Approximately one year later, the patient requested an ophthalmology referral because she believed she had developed cataracts. Subsequently, the ophthalmologist confirmed the presence of cataracts due to prolonged use of Tobradex.

Although the Tobradex labeling warned that the medication should not be used beyond a short course and advised monitoring and caution with prolonged use, the patient filed a lawsuit against both Dr. PC and the pharmacist. She alleged that she did not recall being informed that Tobradex was not intended for long-term use and that she had not read the package insert describing the risks of extended use, including cataract formation.

Key concept: Implementing and consistently following standardized prescription refill protocols, such as reviewing the chart, confirming indication and duration, reconciling medications, and documenting patient counseling at the time of each refill may help prevent inappropriate long-term use of high-risk medications and reduce exposure to malpractice claims.[4]

Critical Results Not Communicated

A 33-year-old woman presented to the emergency department (ED) with complaints of dysphagia, shortness of breath, and facial swelling. A computed tomography (CT) scan was ordered and revealed that she was suffering from superior vena cava syndrome.

She was admitted under the care of a pulmonologist, Dr. P, employed by the hospital. The patient subsequently underwent a percutaneous transluminal angioplasty performed by an interventional radiologist. The procedure itself was successful, however, upon removal of the sheath, her blood pressure precipitously dropped from 161/90 to 81/50 mmHg. Shortly thereafter, she experienced seizures and became unresponsive. A code was called, and after resuscitation efforts, the clinical team successfully revived her.

Following the resuscitation, Dr. P ordered her transfer to the intensive care unit (ICU), where she remained hypotensive. Believing the patient to be stable, Dr. P left the hospital for the night without personally evaluating her or providing specific monitoring instructions to the nursing staff regarding her condition.

Overnight, the patient's condition deteriorated. Her urine output ceased and she appeared increasingly confused and lethargic. The nursing staff, unaware of the critical significance of her low blood pressure, did not contact Dr. P until the blood pressure had dropped into the 60s, at which point she was unresponsive and exhibited pulseless electrical activity. Despite resuscitation attempts, the patient had died by the time Dr. P arrived at the hospital.[5]

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Key concept: Clearly verbalizing and documenting handoff information helps prevent disagreements among physicians and nurses about what was communicated, which can ultimately strengthen the patient's position in any potential litigation. In contrast, inadequate documentation of key handoff details can lead to conflicting recollections and disputes later on.[6]

Dona Constantine, RN, BS, is a Senior Risk Management and Patient Safety Specialist. Questions or comments related to this article should be directed to DConstantine@CAPphysicians.com

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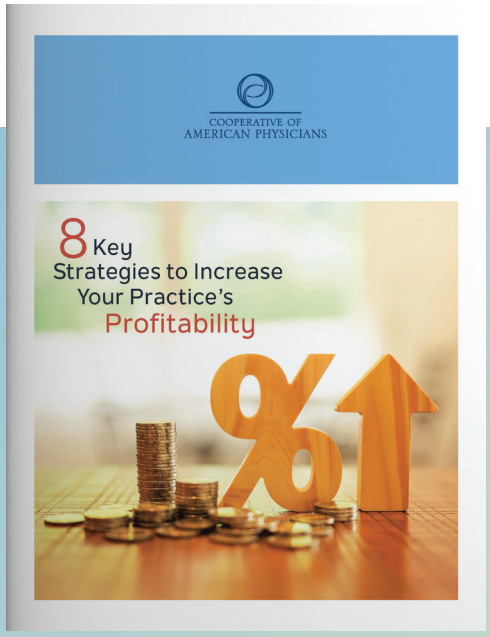

Free Guide: 8 Strategies to Increase Profitability in Your Practice

Get your free copy of ***8 Key Strategies to Increase Your Practice's Profitability***, a practical guide designed to help you and your staff optimize operations, uncover revenue opportunities, and reduce unnecessary costs. CAP created this practical guide to deliver straightforward, actionable tools you can put to work immediately for measurable impact:

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- Identify and correct common staffing mistakes
- Benchmark overhead categories specific to your specialty
- Maximize accounts receivables and cash flow
- Leverage technology to automate patient communications
- Properly manage supplies and inventory
- And more!

Patience With Portals: Balancing Convenience and Compliance

by Deborah Kichler, RN, MSHCA

Since the COVID pandemic, there has been a significant increase in electronic communications between patients and providers. From virtual visits via computer screen to email and text messaging, physicians and patients are now experiencing the "new normal" of patient care.

However, physicians need to be mindful of liability risks when communicating with patients electronically.[1] Practices that use technology to store, access, or transmit protected health information (PHI) must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and California's Confidentiality of Medical information Act (CMIA) and Health and Safety Code §1280.18.[2]

In the early 2000s, healthcare facilities began giving patients remote access to parts of their electronic health records, and in 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act further accelerated the adoption of electronic health information technology among practices and patients. By 2021, the 21st Century Cures Act Final Rule went further by requiring the immediate electronic release of test results and clinical notes upon patient request. While these advancements expanded access and aimed to increase patient engagement, they also introduced new risks for clinical practices.

Patient portals are accessed through secure, encrypted websites that require a user login and password. Patients can sign in at any time to view their health information and medical records. These portals enhance communication, improve information availability, and support better care management for both patients and physicians. Patients can review test results, visit summaries, medications, appointments, and educational materials. They can also pay bills, refill prescriptions, schedule appointments, complete forms, and exchange secure messages with their care team. These features help empower patients to better engage with their healthcare and adhere to treatment plans. Benefits include:

- 24/7 access to health information
- Convenient appointment scheduling with automatic reminders
- Easy access to test results
- Secure messaging with healthcare team
- Faster response to most patient questions

Physicians also can benefit from their patient's use of the portal, including:

- Increased patient engagement, leading to better adherence to treatment plans, appointment attendance, and chronic condition management
- Timely follow-ups and clear communication via secure messaging

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- Reduced administrative workload by minimizing phone calls for appointments, prescription refills and routine inquiries
- Reduced no-shows with convenient scheduling options
- More accurate patient information through electronic updates of personal details and completion of pre-visit questionnaires

Overall, patient portals can foster a collaborative healthcare environment that benefits both patients and physicians by improving access, communication, and health management.

Patient portals can also pose risks concerning privacy, security, communication, and workload. It is important for both patients and physicians to be aware of these potential issues.

For patients, risks include:

- Misinterpretation or misunderstanding of medical notes and results
- System downtime or technical issues
- Information overload
- Data breaches and unauthorized access
- Lack of internet access

For physicians, patient portals can present challenges such as:

- Increased workload due to a higher volume of messages and requests
- Delays in reviewing and responding to patient messages
- Patient misinterpretation of medical information
- Overreliance on digital communication methods
- Ensuring compliance with HIPAA regulations to safeguard patient data
- The need for staff training and establishing effective portal management protocols

Appreciating the patient-centered benefits of portal usage and acknowledging the substantial impact on provider and practice workflows are critical for successful management of a patient portal.[3] Physicians and practices should develop policies and protocols for portal usage that reduce potential risks.

Risk mitigation strategies should include the following:

1. Compliance and Legal Considerations

- Ensure the portal software adheres to all relevant regulations, such as HIPAA.
- Implement end-to-end encryption for data transmission and storage to safeguard PHI.
- Conduct regular security audits and vulnerability assessments to identify and address potential risks.
- Obtain and document patient consent for portal use and electronic communications.
- Ensure that portal communications are recorded in the patient's medical record.

Additionally, integrate digital care with in-person care by ensuring that practitioners have full access to the patient's medical record when responding through the portal. Remember, an active audit trail will verify whether you reviewed the patient's record before replying to their inquiry.

2. Clinical Communication and Workflow

- Establish clear protocols outlining expected response times for messages.
- Implement processes to effectively prioritize and delegate incoming messages.
- Provide staff training on portal usage and documentation standards.
- Incorporate portal discussions into in-person patient interactions.

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3. Technical Reliability and Usability

- Maintain regular system maintenance and back-ups to ensure reliability.
- Offer technical support services for both patients and staff.
- Design user-friendly interfaces that accommodate varying levels of digital literacy, minimizing errors, and promoting adoption.
- Ensure accessibility for users with disabilities and compatibility across a wide range of devices.

4. Patient Education and Support

Patient portal user agreement: This agreement functions similarly to an informed consent, detailing how the portal will be used, the nature of non-emergent communications, associated benefits and risks, and the option to opt out.

- **Permissible Communication Topics.** Define appropriate subjects for portal messaging, including communication with physicians or staff, obtaining test results, reviewing medical record notes, scheduling appointments, renewing prescriptions, and updating personal information.
- **Emergency instructions.** Clearly instruct patients not to use the portal for urgent or emergency situations (e.g., mental health crisis) and provide guidance on appropriate emergency contacts.
- **Code of conduct.** Establish guidelines prohibiting threatening, offensive, or inappropriate language within portal communications.
- **Access and Response**. Explain who may access and respond to patient messages, such as members of the healthcare team and administrative personnel.
- **Response timeframes.** Clearly communicate expected timelines for responses to patient inquiries.
- **Patient-Friendly Explanations.** Provide explanations of medical terms, lab results, and clinical notes in language that is easy to understand.
- **Patient Acknowledgement.** Require the patient's signature on the Patient Acknowledgement and Agreement form.

Additionally, include detailed Instructions for setting up portal registration and provide contact information for technical support or troubleshooting.

5. Address Digital Divide

- Offer alternatives for patients who lack internet access or digital literacy.

Patient portals provide significant advantages for both physicians and patients by improving communication and access to information. However, they also carry potential risks. To promote a safe and positive experience, it is crucial to establish clear policies and protocols.

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Reaching the Ballot Initiative Finish Line

by Gabriela Villanueva

As the November 3rd midterm elections quickly approach, California voters should prepare to face one of the longest and most comprehensive ballots of the last several election cycles. From electing a governor to voting in newly drawn congressional districts to choosing candidates for state and local offices, and understanding the additional initiatives, voters will notice a crowded landscape of competing priorities and candidates on this year's ballot.

While the candidate pool will narrow following the June 2nd primary elections, the list of ballot initiatives will increase as measures meet the signature thresholds and become certified by the California Secretary of State (SOS) office to appear on the ballot.

To date, up to 36 total statewide initiative proposals have been submitted to the SOS for potential placement on the 2026 ballot, triggering a separate race to collect the required number of signatures needed to qualify. Initiative statutes require valid signatures equal to five percent of votes cast for governor in the last election, which means that 545,651 valid signatures are needed for the 2026 cycle. Initiative constitutional amendments require signatures equal to eight percent of those votes, totaling 874,641 valid signatures needed.

Collecting signatures in this busy environment is competitive and expensive. Campaigns must far exceed the minimum number of signatures in order to compensate for the high rate of invalid signatures rejected during the SOS certification process. As a result, simply qualifying an initiative has become a costly undertaking for sponsors.

According to Ballotpedia.org, the cost-per-required-signature (CPRS) for citizen-initiative measures in California have varied widely—from a high of $21.98 for Prop 31, the 2022 Flavored Tobacco Products Ban, upheld by 63.42% of voters, to a low of $0.96 for Prop 2, the 2008 Farm Animal Confinement Initiative, also passed by 63% of voters.

How many proposals will ultimately reach the ballot remains uncertain this early in the cycle. Based on spending levels from the 2024 election, sponsors should expect to spend roughly $3.8 million to $7.2 million or more on paid signature collection alone. This represents one of the largest upfront costs of any initiative campaign, driven by how competitive the signature gathering market becomes and how aggressively each campaign moves to qualify early.

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

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Payer Enrollment: What Providers Need to Know

by Amy Fajardo, CS, from CAPAdvantage partner, MedCycle Solutions

In today's healthcare environment, payer enrollment is one of the most fundamental—yet often misunderstood—elements of a successful medical practice. Whether you are a new provider entering the field, expanding into a new state, or joining a group practice, understanding payer enrollment is essential for ensuring timely reimbursement and uninterrupted cash flow.

Unfortunately, even small mistakes in the enrollment process can lead to significant delays, lost revenue, and operational headaches.

Below is a clear, practical overview of what providers need to know about payer enrollment and how to navigate the process with confidence.

What Is Payer Enrollment?

Payer enrollment, also known as provider enrollment, is the process of becoming officially recognized by insurance companies so you can bill and receive payment for services. This includes enrollment with:

- **Commercial payers** (e.g., Aetna, Cigna, Blue Cross Blue Shield (BCBS))
- **Government payers** (Medicare, Medicaid, Tricare)
- **Managed care organizations**
- **Network-based plans** (Health Maintenance Organizations (HMOs), Preferred Provider Organization (PPOs), etc.)

Payer enrollment typically includes two key steps:

1. **Credentialing** – Verification of the provider's training, education, licensure, work history, certifications, and other professional qualifications.
2. **Contracting** – Establishing a formal agreement with the insurance plan, including reimbursement rates and participation.

Both steps must be completed **before** a provider can be reimbursed for services.

Why Payer Enrollment Matters

Timely and accurate payer enrollment is critical because it directly impacts:

1. Revenue Cycle Performance
If a provider is not properly enrolled or if their effective date is incorrect, claims will deny—often repeatedly—until the issue is resolved. This leads to cash flow delays and unnecessary rework.

2. Network Status
Patients increasingly seek in-network providers to reduce out-of-pocket costs. Without proper contracting, providers may be forced to see patients at reduced reimbursement as out-of-network, or not see them at all.

3. Compliance
Payers require specific documentation, signatures, disclosures, and attestations. Missing or incorrect information can result in compliance issues or delays that extend for months.

Key Details Providers Need to Know

1. Start Early—Enrollment Takes Time
Depending on the payer, enrollment can take anywhere from 90 to 180 days. Delays are common, so beginning the process as early as possible is essential.

2. Maintain an Accurate CAQH Profile
Most commercial payers rely heavily on the Council for Affordable Quality Healthcare (CAQH). Providers should:

- Keep all documents up to date
- Re-attest on schedule
- Ensure work history and education are complete and accurate—a stale or incomplete CAQH profile can stop the process in its tracks

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3. Have Required Documentation Ready

Providers typically need:

- Current state license
- Drug Enforcement Administration (DEA) certificate
- Board certification (if applicable)
- Malpractice insurance (face sheet)
- CV/work history (5+ years required)
- Hospital privileges or admitting arrangements
- W-9 form

Missing documents cause significant enrollment delays.

4. Know Your Effective Dates

A common misconception is that enrollment is effective on the day the provider starts working. In reality, effective dates depend on when:

- The application was submitted
- The payer approved the request
- Contracting was finalized

Never assume retroactive approval—always verify.

5. Track Every Application

Payer enrollment involves dozens of moving parts. Providers should maintain a tracking system that includes:

- Submission dates
- Payer contact information
- Reference numbers
- Follow-up dates
- Approval and effective dates

Without tracking, applications can easily fall through the cracks.

6. Revalidation and Recredentialing Are Ongoing

Enrollment isn't a one-time event. Payers require regular:

- Recredentialing (every 2–3 years)
- Medicare revalidation
- CAQH re-attestation (every 120 days)

Missing recredentialing deadlines can result in termination from a network.

Common Challenges Providers Face

- Incorrect or outdated demographic information
- Long payer processing times
- Rejections due to missing documents
- Group or facility affiliation issues
- Medicare Provider, Enrollment, Chain, and Ownership System (PECOS) discrepancies
- Inconsistent provider signatures or attestations
- Moving states or changing tax IDs

Because each payer has its own requirements, processes, and timelines, it's easy for errors to accumulate and cause months of revenue delays.

Payer enrollment is complex, time-consuming, and detail-heavy—but it doesn't have to be overwhelming.

This article is presented by MedCycle Solutions, a participant in the CAPAdvantage program, CAP's suite of no-cost or discounted practice management products and services.

MedCycle Solutions specializes in managing the entire enrollment lifecycle for providers, including:

- Initial credentialing and contracting
- CAQH maintenance
- Medicare and Medicaid enrollment
- Network participation management
- Provider adds/terminations
- Recredentialing and revalidations
- Ongoing enrollment tracking and follow-up

By partnering with MedCycle Solutions, providers can avoid costly delays, maintain compliance, and focus on delivering patient care—while we handle the administrative work behind the scenes. Learn more at **medcyclesolutions.com**.

Inside CAP's Group Purchasing Program: A Proven Benefit to Lower Costs and Increase Revenue

The CAP Purchasing Alliance helps medical practices reduce costs by harnessing the collective buying power of Group Purchasing Organizations (GPOs).

Why Join a Group Purchasing Program?

A GPO uses the combined purchasing volume of its members to negotiate better pricing and improve purchasing efficiency. This allows practices of all sizes to access stronger contract terms and lower costs.

What Is the CAP Purchasing Alliance?

CAP Purchasing Alliance is the **free group purchasing program** available to members of the Cooperative of American Physicians (CAP).

Through CAP's relationship with **HealthTrust Performance Group**, members gain access to some of the nation's most competitive pricing on medical, surgical, pharmaceutical, vaccine, and nonmedical supplies.

Even independent practices benefit from hospital-level pricing and savings typically reserved for large health systems.

Enrollment is quick, free, and requires no minimum purchasing commitments.

How It Works

CAP Purchasing Alliance partners with major national distributors—including McKesson, Henry Schein, Medline, and Cardinal Health—to deliver savings without disrupting your existing ordering process. You continue to order through your current representative—the only change is lower prices.

Savings also extend beyond medical supplies, with discounts on:

- Small parcel shipping
- Office supplies
- Waste management and shredding
- Interpretive services
- Travel, rental cars, environmental services, and more

How Your Practice Saves

Members save across multiple purchasing categories:

- **Distributed:** Medical and surgical supplies purchased through distribution contracts
- **Direct:** Items purchased directly from manufacturers (e.g., vaccines)
- **Nonmedical & Purchased Services:** Office supplies, cell phones, linen, and waste services
- **Capital Equipment:** Furniture, office equipment, and more

Savings can reach **up to 20%**, and contracts cover up to **85%** of a typical practice's spend. Reviewing distributor and vendor purchases helps ensure you're capturing all available savings.

Proven Results

Practices across specialties have realized substantial savings with no change to their workflow. Examples include:

- A cardiology practice reducing supply costs by 9% and saving 50% on Definity
- A radiology group saving more than $160,000 annually
- A surgery center saving $19,000 on Ethicon sutures alone

These savings come with **no fees** and **no disruption** to your ordering process.

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MARCH 2026

What Physicians Need to Protect Their Income Before Life Takes an Unexpected Turn

COOPERATIVE OF AMERICAN PHYSICIANS

SYMPHONY RISK

A physician's ability to earn an income relies heavily on maintaining the physical and cognitive capacity required for safe, effective patient care, which can be disrupted even by minor health setbacks. When an illness or injury prevents you from practicing, the financial impact can be immediate and significant.

To help protect against the professional and financial risks that can arise from unexpected health issues, securing comprehensive, physician-tailored disability insurance is essential.

Don't Risk Your Future.

Here are more reasons you should consider the powerful protection disability insurance can provide.

1. Your Income Is Your Most Valuable Asset

For most physicians, future earnings can outweigh the value of any other asset they currently hold. A disability can interrupt that income suddenly and without warning.

Without disability coverage, even a brief period away from work can:

- Deplete savings
- Disrupt long-term financial plans
- Create significant stress during an already challenging health situation

Disability insurance helps ensure your lifestyle, obligations, and financial goals remain intact.

2. Physicians Face Higher Physical and Occupational Risks

Even conditions that might seem minor for others, like back pain, hand injuries, and chronic illness, can be career-limiting for a physician.

Disability insurance helps safeguard your ability to maintain financial stability even when your medical skills are temporarily or permanently affected.

3. Student Loan and Lifestyle Pressures Increase Vulnerability

Many physicians continue to carry significant financial obligations throughout their early and mid-career years. Mortgage payments, student loan balances, childcare costs, and other commitments don't pause when you're unable to work.

A good policy will help you:

- Continue to meet financial obligations
- Protect your family's lifestyle
- Avoid tapping into retirement funds or savings

Disability insurance coverage is especially important to help you meet your financial obligations during long recovery periods.

4. Health Events Are More Common Than You Think

A disability that limits your ability to work can arise from everyday medical issues like:

- Musculoskeletal injuries
- Pregnancy
- Chronic conditions
- Acute illnesses

Short-term and long-term disability coverage helps physicians maintain income continuity across a wide spectrum of real-world scenarios.

Access Guaranteed Disability Coverage Through Symphony Health

Disability coverage, offered through Symphony Health, gives you the financial cushion needed to help preserve your assets and help you focus on recovering and returning to work as quickly as possible.

Short-Term Disability

Top benefits of Symphony Health's short-term disability coverage:

- $1,000 weekly benefit[1,2]
- Highly competitive rates
- Easy claims filing
- Begins paying after the 14th day of illness or injury
- Supplements wait-time gap for long-term disability insurance
- Benefit not reduced by state disability
- Guaranteed Issue: No medical exam required, no health questions asked!

Long-Term Disability

Top benefits of Symphony Health's long-term disability coverage:

- Up to a $15,000 monthly benefit[1,2,3]
- Highly competitive rates
- Reduced benefit waiting period and extended benefit duration
- Guaranteed Issue: No medical exam required, no health questions asked!

Learn more now by working with the insurance professionals at Symphony Health!

Email **HealthCareServices@SymphonyRisk.com** or call **213-576-8530**.

[1]Various deductibles and/or exclusions may apply.

[2]Must be currently working in healthcare at least 17.5 hours per week/per calendar quarter and not disabled currently or at the time coverage becomes effective. Limited time pre-existing condition exclusion may apply.

[3]Must be currently working in healthcare at least 17.5 hours per week/per calendar quarter and not disabled currently or at the time coverage becomes effective. Limited time pre-existing condition exclusion may apply; $200,000 annual income required to qualify for $10,000 monthly benefit otherwise benefit will be based on 60% maximum.

The Successful Practice Manager

Develop and Strengthen Essential Practice Management Skills for Success Beyond the Clinic

CAP's Free On-Demand Course Covers Six Core Areas of Practice Operations

Delivering excellent patient care is only part of running a successful medical practice. Behind the scenes, effective management of operations, finances, and compliance is critical to sustaining growth and stability.

This course offers 4.5 continuing medical education (CME)* credits and 4.5 continuing education (CE) credits** and can be taken on-demand at your own pace. Upon completion, you will:

- Understand the fundamentals of practice management and effectively oversee administrative tasks
- Implement human resources protocols to manage staffing, workplace culture, and payroll efficiently
- Manage coding, billing, and collections processes to ensure timely payments from patients and payers
- Support the practice in business planning, contract management, and credentialing processes
- And more!

The Successful Practice Manager is CAP's free online course that offers practical, on-demand learning designed to help physicians and their staff strengthen essential skills. This complimentary program provides **4.5 CME* credits and 4.5 CE** credits** and covers six key areas:

1. Office Administration
2. Human Resources Management
3. Business Management
4. Credentialing and Contracting
5. Billing and Reimbursement
6. Financial Management

Practice Administrators enroll for CE credit at:
www.CAPphysicians.com/SPM
Physicians enroll for CME credit at:
www.CAPphysicians.com/SPMCME

Administrators can claim a $100 gift card upon program completion! *(Limit one/practice. Practice administrators only. Final test and survey must be completed.)*

To enroll:

1. Complete the required fields on the sign-up page to create your account on CAP's online learning portal, or log in if you have an existing account.
2. Once you have created an account and/or logged in, go to your dashboard. The available course names will be displayed under the heading "Catalog."
3. Practice administrators, select the course titled "The Successful Practice Manager." Physicians, select the course titled "The Successful Practice Manager – CME Version."
4. Click "Start" to begin. You can start and return anytime, but remember, the modules are in sequential order and cannot be viewed separately.

Upon finishing the program, you will be able to download a copy of your certificate of completion and follow the process to receive your CE or CME credit.

For more information and for assistance with enrolling, email **MyPractice@CAPphysicians.com** or call 888-870-1885.

*The Cooperative of American Physicians, Inc. is accredited by the California Medical Association (CMA) to provide continuing medical education for physicians.

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