THE MONTHLY PUBLICATION FOR CAP MEMBERS

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COOPERATIVE OF AMERICAN PHYSICIANS

Case of the Month

When the Information is Vital, Use Multiple Channels

by Gordon Ownby

Nothing good can result when important information sent between a patient's care providers is delayed. Including the patient in the communication process is not only the right thing to do, it can also help prevent an adverse event.

A patient with history of low back and neck pain stemming from a diving injury 40 years earlier visited his primary care physician, who referred the gentleman to Dr. N, a neurologist, after x-rays showed diffuse degenerative changes with multiple disc space narrowing and osteophyte formation.

At his first visit with Dr. N, the patient described his longstanding low back pain, right and left sciatic pain, and numbness in his leg. He described an onset four months earlier of low back pain radiating down the leg to the left knee. He also told Dr. N of a single episode of transient left-sided facial numbness spreading to the arm and leg — an event the patient attributed to his use of a statin, which he stopped.

On examination, Dr. N found the cranial nerves normal, mild weakness in the left leg, and no evidence of carotid, ocular, or cranial bruit. Dr. N's impression was lumbar radiculopathy and neuropathy. Dr. N's plan was for an EMG of both legs, an MRI of the head, an increase of gabapentin to 600 mg three times daily, and a prescription for pain medication to be used as necessary. A referral by Dr. N dated the next day was for a bilateral carotid artery ultrasound to evaluate "transient cerebral ischemia."

Dr. N interpreted and EMG/nerve conduction study of the patient's lower extremities as consistent with peripheral motor and sensory neuropathy and referred him to a neurosurgeon to evaluate treatment options. The brain MRI showed diffuse cortical atrophy and small vessel white matter ischemic changes without evidence of intracranial hemorrhage, mass, or acute infarct.

The neurosurgeon noted the results of the patient's lumber and lower extremity test results, which in his opinion warranted low back surgery. The surgeon referred the gentleman back to his primary care physician for medical and cardiac clearance for the surgery. A chest x-ray showed "no evidence of active cardiopulmonary disease to preclude surgery" and a cardiologist read the patient's ECG as abnormal for low voltage QRS, incomplete right bundle branch block, and left anterior fascicular block but cleared the patient as "OK for surgery cardiac wise."

While Dr. N was out of the country on a three-week

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vacation (leaving all of his patients under the care of his partner, Dr. N-Partner), the patient underwent the bilateral carotid artery ultrasound ordered by Dr. N some weeks earlier. That study, not read until five days later, noted "(1) severe 70 to 99% stenosis of the right carotid bulb; (2) large calcified plaque in the left carotid bulb without evidence of hemodynamically significant stenosis; (3) antegrade flow in the vertebral arteries and (4) heterogeneous nodular thyroid with pattern consistent with chronic thyroiditis." Upon receiving the report, Dr. N-Partner wrote on the document: "severe 70-99% stenosis in the right carotid bulb. Refer to vascular surgeon stat."

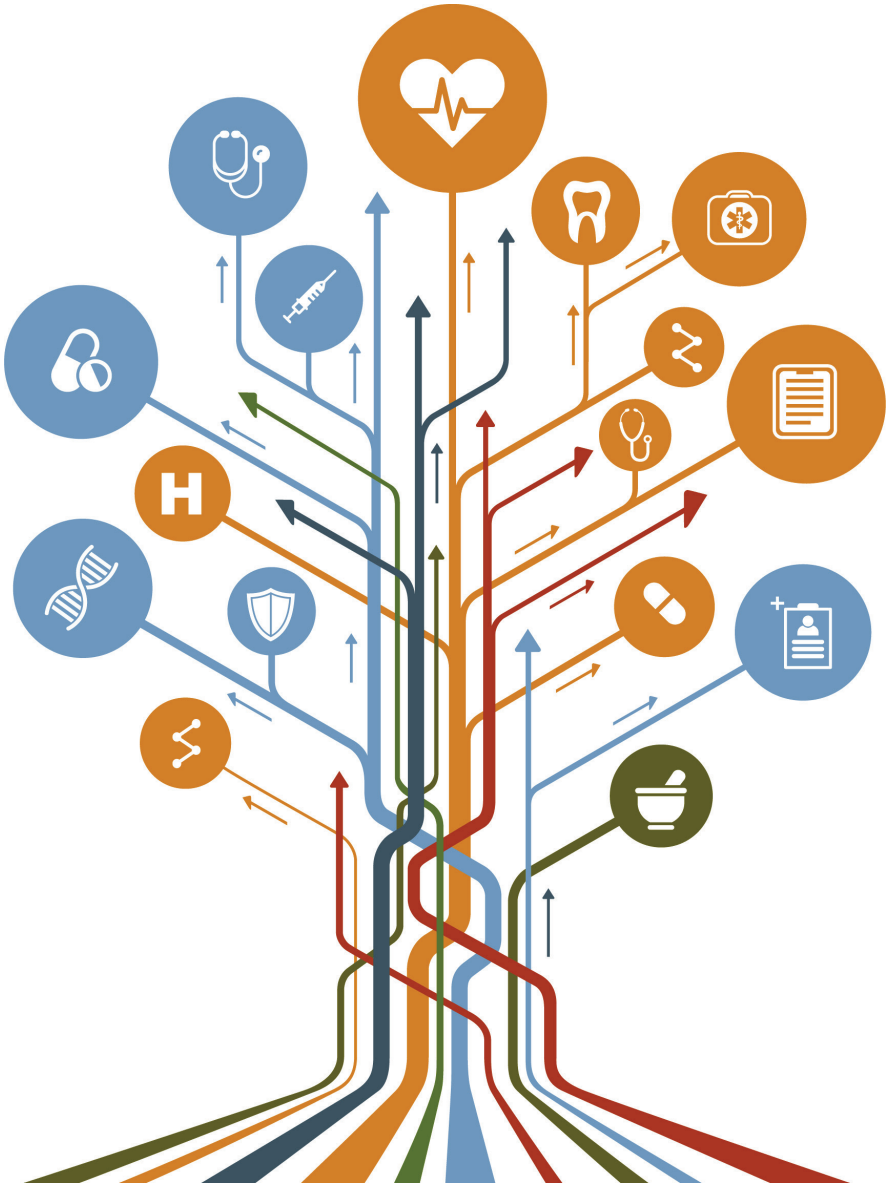
Dr. N-Partner did not inform the patient of the ultrasound results and relied on the medical office staff to make the stat referral to the vascular surgeon. Instead, the office made a routine referral, which delayed the vascular consult to after the patient's low-back surgery. Though the surgeon contacted the primary care physician to confirm the medical and cardiac surgery clearance, he did not contact the neurology group, nor did that group contact him with the carotid ultrasound result.

The lumbar surgery went forth as scheduled without complication, ending at about 4:30 p.m. During physical therapy the next morning, however, the patient was perceived as more altered and with hemiparesis. A stat head CT was negative, and a neurology consultation was ordered. The neurologist suspected a right middle cerebral artery infarct and followed up with a stat CT angiograms of the head and neck. On reviewing those studies, the neurologist assessed a right internal artery occlusion and right middle cerebral artery syndrome. Because of the recent lumbar surgery, the patient was not a candidate for TPA and the neurologist recommended transfer to a higher-level hospital for stroke treatment.

Claiming residual impairment, the patient sued Dr. N's medical group for failing to properly follow-up on the ultrasound results prior to undergoing the surgery. That dispute resolved informally.

One should never expect that a medical office would fail to properly execute a stat referral. But a physician's direct involvement in overseeing the referral — and an immediate report to the patient — are appropriate steps to take with urgent test results.

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.



Risk Management and Patient Safety News

Sugar and Spice: Preventing a Complaint from Snowballing into a Claim

by Rikki Valade

How does that old saying go? "A spoonful of sugar makes the medicine go down" (*Mary Poppins*, 1964). When it comes to customer service, this saying rings true. The moment a patient calls your office, the interaction leaves a lasting impression of your practice, your staff, and can ultimately spill over to you, the provider. Physician practices face many challenges today, one of the most challenging is managing a patient complaint. In April 2021, CAP presented a webinar titled *The Ins and Outs of Managing Patient Complaints.* The focus was on three areas:

- The Patient Experience: Customer Service
- Managing Difficult Patients and Situations: Understanding the Grievance Process
- Discontinuing the Physician-Patient Relationship: When to Consider and Understanding the Process

CAP knows receiving a complaint from a patient can be very stressful. While it is nearly impossible for any practice to avoid the occasional unhappy patient, how physicians and their staff handle a patient's concern can impact both your liability risk and your bottom line.

When a patient complaint is "ignored" or in the mind of the patient "discounted," the issue escalates. Viewing patient complaints and grievances from the patient point of view is imperative, regardless of whether a concern appears legitimate or not. If the patient feels the concern sufficiently to voice it, the complaint should be taken seriously and treated as such (ECRI 2016).

"Complaints carry a certain validity simply by virtue of being the perception of the patient or family member" (ECRI 2016). Unaddressed grievances can escalate into a Medical Board inquiry, insurance grievance, poor social media posting, or even snowball into a claim. Litigation is extremely time-consuming for physicians, in addition to being emotionally distressing.

When patients lodge a grievance, it is important to have an office policy and process for management of the grievance. At a minimum, your practice should have mechanisms in place to:

1. Inform the patient of the complaint process.
2. Receive and respond to complaints in a timely manner.
3. Implement corrective actions as necessary to resolve the complaint.
4. Reassure the patient that future care will not be compromised due to a registered complaint.

The process should identify the person in the office who will take the lead on the grievance process as follows:

- Complaints about medical care should involve the physician or provider.
- Billing concerns should be referred to the account representative or billing department.
- Other concerns should be given to the administrator or designee.

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All physicians and staff should be educated on the office grievance process and trained to listen effectively and manage patient and family expectations (ECRI 2016). It is important that your patients know you're genuinely interested in their feedback to improve the patient experience and respond appropriately to issues. Below are additional tips for responding to complaints.

- Don't avoid the patient
- Keep communication open
- Involve the patient in the process
- Treat the patient with dignity, courtesy, and privacy during the complaint-handling process
- Allow the patient to state the problem completely without interruption or argument
- Thank the patient for bringing the concern to your attention
- Make a statement of empathy without admitting fault or placing blame (e.g., "I'm sorry your wait time today was longer than expected")
- Do something for the patient
- Reassure the patient that you take all concerns seriously
- Assure the patient a full investigation will be completed

How CAP Supports Members

Complaints and grievances come in all sizes and shapes. In our experience at CAP, a portion of grievances accompany a request for a refund and/or charges for additional care to be covered by the member. CAP has a team dedicated to assist our members with grievances — our CAP Cares team. The CAP Cares team can help you navigate a complaint to reduce your liability risk and determine if there is any potential liability, with an end goal of maintaining a positive physician-patient relationship as well as preventing the grievance from escalating into a claim.

An example of how the CAP Cares Team can assist a member is our Patient Assistance Service Program (PAS). PAS is a no-fault, early intervention program designed to assist patients with expenses associated with complications of medical care — specifically copayments, coinsurance, deductibles, and other related costs. Certain criteria must be met for this program and is evaluated on a case-by-case basis by a CAP Cares specialist. Here is an example of the PAS program in action:

Patient Ms. A had a lesion removed from a digit. Immediately after the procedure, she suffered a vascular compromise of the digit, which was determined to be a very rare reaction to lidocaine. The vascular concern on the tip of her digit did not fully recover with the interventions provided in the office. The patient was referred to a tertiary care center for treatment with a hand specialist. She required almost daily visits for hyperbaric treatment for two weeks, medications, and monitoring. Ms. A complained to the physician and his office manager that she had to drive a significant distance to receive the treatment, was accumilating multiple medical bills, as well as the emotional crisis of potentially losing the tip of a digit. Ms. A asked the physician to help pay for her treatment. She also mentioned she was unhappy she was not informed of this potential complication of the procedure. As this was a very rare complication, it was not discussed during the informed consent process. The PAS program reimbursed the patient's unexpected out-of-pocket financial costs related to this known rare complication. Total reimbursement by the PAS program was $2,963.80, which included:

- **$1,881.98 – Tertiary care (physician/hospital/hyperbaric)**
- **$867.82 – Pharmacy and supplies**
- **$214.00 – Parking cost**

Ms. A was satisfied and appreciative of the member's assistance with her complaint. She made a full recovery after months of treatment and monitoring.

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The physician-patient relationship was maintained. It is important to note that PAS cases are not considered to be claims, but rather as a goodwill gesture by the member, and will not appear on a member's "claims history." Reimbursements made to a patient under typical PAS circumstances are not reportable to the Medical Board of California.

This is just one example of how the CAP Cares team has helped CAP members manage a grievance. Sugar and spice can make everything nice; responding to complaints with sugar, and adding a little spice for the patient can, in the end, help you make everything nice.

This information is provided as a service to CAP members from a risk management perspective and is not intended as legal advice. If you have questions or a specific patient situation and need guidance, please contact the Hotline at 800-252-0555. To view the CAP webinar, "The Ins and Outs of Managing Patient Complaints" from April 2021, click on this **link** (https://www.pathlms.com/capphysicians/courses/29451/video_presentations/193587).

Rikki Valade is a Senior Risk Manager for CAP. Questions or comments related to this article should be directed to rvalade@CAPphysicians.com.

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June 30 Deadline Looming for California Employers

If your medical practice employs five or more employees, then you should know that California state law requires that you register to facilitate CalSavers if you do not already offer an employer-sponsored retirement plan. For employers with 50 or more employees, the deadline to register is June 30, 2021.

CalSavers is a retirement savings program for private sector workers whose employers do not offer a retirement plan. This program gives employers an easy way to help their employees save for retirement, with no employer fees, no fiduciary liability, and minimal employer responsibilities.

The following deadlines to register based on the size of the business are:

Size of Business	Deadline
Over 100 employees	September 30, 2020 (Deadline Passed. Register as soon as possible to avoid penalties.)
Over 50 employees	June 30, 2021
Five or more employees	June 30, 2022

Are There Penalties for Not Enrolling in CalSavers?

If you do not offer a tax-qualified retirement plan or enroll in CalSavers by the registration deadline, you will be subject to the following penalties for noncompliance:

- **90 days after deadline** – $250 per eligible employee
- **180 days after deadline** – $500 per eligible employee

Registration Information

For more information about the CalSavers and to register, visit **https://employer.calsavers.com/.**

Ongoing Responsibilities

Once your CalSavers employer account is set up and ready to go, you'll be responsible for ongoing responsibilities: submitting employees' contributions and adding new employees or removing employees who have left your company.

Activities for Which You Are Not Responsible

CalSavers does not include any employer fees or employer match contributions. You are also not responsible for:

- Enrolling employees, disseminating information, or answering questions about the program.
- Managing investment options, including choice of investment funds and processing employee investment change requests.
- Processing distributions.
- Answering questions about investment options. Employers should not give investment or tax advice.
- Managing employee changes or account maintenance, which include but are not limited to contact information and beneficiary information.
- Your employees will be responsible for maintaining their account information once it is established.

This information is being provided to CAP members as a courtesy of CAP Physicians Insurance Agency, Inc. (CAP Agency) and our preferred insurance broker, Ashbrook-Clevidence to help make running the business side of your practice a bit easier.

If you are interested in satisfying this retirement savings requirement by using a 401K plan that can provide more choices for investments, tax savings, and the opportunity to save more for retirement, please reach out to the retirement plan specialists at Ashbrook-Clevidence.

For help with CalSavers, alternative retirement plan solutions, and even other areas of employee benefits, please contact:

Chris Clevidence | 800-447-4023 | chrisc@aclevidence.com

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California Impacted by 2020 Census

by Gabriela Villanueva

On April 26, 2021, the U.S. Census Bureau announced its 2020 Census results. The results show the country's population count at 331,449,281 residents as of April 20, 2020. Not surprisingly, California remains the most populous state in the union with 39,538,223 residents, while Wyoming came in as the least populous state with 576,851 residents.

On the same date, Secretary of Commerce Gina Raimondo delivered the population counts to President Biden to be used for apportioning the 435 seats in the U.S. House of Representatives. Each state must receive one House seat and additional seats are distributed proportionally based on state population size. Over the history of the past 23 decennial censuses conducted, with the year 1790 being the first census completed and 2020 being the 24th, the House has more than quadrupled in size (from 105 to 435 seats), and each member will now represent an average of 761,169 people.

As it follows in Title 2 of the U.S. Code, a congressionally defined formula is applied to the apportionment population to distribute the 435 seats and as a result of the count, Texas will gain two House seats, five states will each gain one seat (Colorado, Florida, Montana, North Carolina, and Oregon), seven states will lose one seat each (California, Illinois, Michigan, New York, Ohio, Pennsylvania, and West Virginia), and the remaining states' number of seats will remain the same. These changes in apportionment go on to inform the actions that will take place at the state level in congressional redistricting, which also takes place every 10 years. The census, apportionment, and congressional redistricting are all an interrelated process.

As a result of the 2020 census, California has, for the first time in its history, lost a congressional seat. California will go from holding 53 congressional seats (equaling Electoral College votes during a presidential election), to holding 52 congressional seats starting in 2022 because of a decrease in its population growth. Over the past decade, California's average annual population growth rate slipped to 0.06% — lower than at any time since at least 1900. As to what has caused this decrease, experts point to three major factors: declining birth rates; a long-standing trend of fewer people moving in from other states than leaving; and a drop in international immigration, which has in the past made up for residents moving to other states.

California is one of the few states in the nation to redraw its voting district lines via a Citizens Redistricting Commission. This body will soon be handed the task to redraw the state's congressional districts by eliminating one district in the process. Preliminary data points to losing that congressional seat in the greater Los Angeles area. Redistricting data include the local area counts states need to redraw or "redistrict" legislative boundaries.

The U.S. Census Bureau will begin the additional activities needed to create and deliver the redistricting data that were previously delayed by the pandemic. Because of modifications to processing activities, data collections delays, and the Census Bureau's obligation to provide high-quality data, states are expected to receive redistricting data by August 16, and the full redistricting data with toolkits for ease of use will be delivered by September 30.

Because the timeline to deliver the data and toolkits to complete the redrawing of new district lines has been considerably altered, California is now looking to possibly push out its own timeline for primary elections next spring.

While we may not stop to think much about a process that comes around every 10 years and what its numbers in population counts mean, these numbers in fact set off an interesting chain of events.

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

Public Policy

Ask My Practice

by Andie Tena

How to Find the Right Vendors for Your Practice

Searching for vendors to support your medical practice with the critical services and products it needs to run efficiently can be cumbersome and overwhelming. You need to make sure that you are getting the best value for your dollar… and the high level of service and quality you need. Getting to the point where you trust that your vendor partners are the best for what they were hired to do takes a lot of time and investment.

Here are some common issues you or your staff may have encountered when selecting vendors for your practice:

- You search endlessly for what you need on Google and get nowhere
- You ask colleagues for referrals, but do not like the recommendations they make
- You have had to try several vendors for a particular service or product
- The cost ends up being more than what you were told
- There is no customer support and you cannot get answers to simple questions
- You don't have enough time to even begin looking, and reluctantly stay with your current vendor

If you have been a victim of any of the above or have experienced any other mind-boggling difficulties in your efforts, now is a good time to review the benefits available to you through CAPAdvantage, CAP's comprehensive suite of no-cost or discounted practice management programs. The products and services available through CAPAdvantage are provided by industry-leading vendors who offer exclusive negotiated discounts and the superior service you expect and deserve — all in one place.

The CAP Advantage program has taken the guesswork out of finding reliable vendors in a variety of highly sought-after and hard-to-find areas, like:

- IT services
- Interpretation services
- Group purchasing program
- Practice marketing
- Commercial real estate services
- Document management
- HIPAA-compliant telemedicine services
- Online learning and compliance training, and much more!

Plus, through the free practice management support you receive from CAP's My Practice program, you have one-on-one personalized assistance to help you navigate your needs and get you to the right resource immediately and directly.

Here's what one member had to say about Gary Pepp from Bailes and Associates, the no-cost real estate program offered through CAPAdvantage:

I recently became a solo practice physician after 25 years of being in a group and had to find a new office space. At first, I used a realtor that represented both parties — building owner and me. I soon learned that I needed someone on my side. I contacted Gary Pepp, who was recommended by CAP, my malpractice carrier. Gary and I worked together for over a year to find the right practice location. He dealt with the realtors and only involved me when it was time for a final decision. He drew up the Letters of Intent as needed. Finally, he fought for me to get a competitive rate and some add-ons such as marketing and free rent. In the end, I was very comfortable signing my lease.

Andie Tena is CAP's Director of Practice Management Services. Questions or comments related to this column should be directed to atena@CAPphysicians.com.

Save your time and money with *My Practice* and CAPAdvantage. Contact Andie Tena, Director of Practice Management Services, at 213-473-8630 or via email at MyPractice@CAPphysicians.com to get assistance with any practice management issues or CAPAdvantage program. Visit https://www.CAPphysicians. com/practice-management-services#capadvantage to learn more.

The Physician's Contribution to the Greater Good

by Gwen C. Spence, MBA

In 2002, the American Board of Internal Medicine Foundation, the American College of Physicians, and the European Federation of Internal Medicine created "The Charter." It was meant to remind doctors of their responsibility to be ethical and professional while remaining aware of their responsibility and commitment to the primacy of patient welfare.

In recent years, it seems that there has been an increase in Americans behaving badly. Hate crimes have plagued our nation. General rudeness and lack of respect is more the norm, which begs the question, "what can I do to make a positive impact as a physician?" Gandhi said "You must be the change you wish to see in the world." One may ask, "How can I, in my own small way, live up to the ethical responsibility of assuring the equitable distribution of resources and promoting equitable healthcare to all?"

Charity begins at home: Ensuring your patients get the care they need

During the height of the COVID-19 pandemic and still, patients are unable to meet their day-to-day living expenses, let alone medical emergencies.

1. Have the money discussion. Physicians can help their patients receive necessary medical care in many ways. For an example, prescribing a 90-day supply of medicine can help reduce out-of-pocket costs for medications. Scheduling expensive tests for later in the year when annual deductibles have been met will contribute to a substantial cost savings.
2. Provide payment resources. The American Board of Internal Medicine Foundation's *Choosing Wisely* initiative offers several cost-effective options. There are many organizations, both federal and private that provide assistance for medical and pharmaceutical intervention.
3. Offer a payment plan. Or engage a finance company to facilitate a credit-based offering.
4. If you can afford this option, allow your patients to pay what they can. Or, rather than raising funds to travel to a third-world country to perform volunteer work, set aside monies to treat patients in your practice on a pro bono basis.

Volunteerism

Physicians have confirmed that volunteering and performing charitable work are as much a positive for them as it is for the patients they help. Physicians have said of volunteering that, "They don't have to see a patient every 15 minutes. There are no economics involved, and that's what makes it so enjoyable." Liz Meszaros, in an article entitled, "Physician Volunteerism: The Surprising Benefits for Doctors Who Do It," said doctors that "give back" and volunteer have a tendency to live longer, while providing an opportunity to focus on others.

Doctors can volunteer with large well-known organizations such as The American Red Cross. Free clinics are a popular choice and international volunteerism to third world countries, such as the U.S. Peace Corps, is always seeking volunteers.

Social/political involvement to promote fair distribution of care and resources to all

Every physician should be dedicated to social justice and equitable healthcare for all. Physicians are looked to as leaders and are the voices of reason. When in the absence of human rights and liberties and when social strife, racial discrimination, and exploitation of the disadvantaged are causing certain groups and individuals to succumb to disease and death, the profession must step forward to effect change.

Doctors should become intimately involved in their practice communities. Write a monthly letter or email to your local representative on issues that are important to you. Take action to support specific legislative initiatives, especially those that pertain to medical care. Get involved

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with a group in your community that supports your passion.

Be an example. Practice what you preach.

Physicians have a moral and social obligation to "take care" of mankind. Ryan Van Ramshorst, MD, mentioned in a recent article that a professor on the first day of medical school said to a classroom full of eager students, "Medicine is about service. We are all here to serve others. Our neighbors, our communities, and even complete strangers."

Do it well.

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

An Overview of Value-Based Care for Primary Care Practices

Over the past decade, the healthcare industry has gone through significant change. New concepts, workflows, and requirements can be confusing and frustrating for physicians who are already stretched to their limit caring for patients, which is why the world of value-based care can present physicians with exciting opportunities to improve patient outcomes while thriving financially.

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.

ACOs can contract with many different types of payers, including Medicare, Medicare Advantage, Medicaid, and commercial insurance entities. Financial risk and the opportunity to earn incentives for positive results are what makes these arrangements so innovative. If an ACO successfully meets its quality and spending targets, the practices in that ACO could receive a portion of the resulting shared savings, or the difference between what the payer expects to spend and what the payer actually spends on care for those attributed patients.

By prioritizing quality-driven accountable care, participating practices aim to make healthcare better for patients in need. For independent primary care practices, value-based care may bring more benefits. The potential to earn shared savings and other revenue enhancements can provide financial relief while allowing clinicians to strengthen the rewarding patient relationships that are the backbone of primary care.

CAP understands the financial hardships many of California's independent physicians are experiencing and continues to seek opportunities that can help our members' practices increase revenue and improve outcomes. CAP is pleased to welcome Aledade, Inc., a company committed to helping medical practices thrive in value-based programs, as the newest participant in the CAPAdvantage program, CAP's member-exclusive

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suite of no-cost or discounted practice management products and services specifically selected to support your success.

Aledade partners with independent practices, health centers, and clinics to build and lead ACOs anchored in primary care. Nationwide, Aledade's ACOs are empowering clinicians to stay independent, practice medicine like they've always wanted to, and thrive financially while keeping their patients and communities healthy. Together, these physician-led ACOs are reducing healthcare costs, improving outcomes for patients, uncovering new revenue opportunities, and diversifying revenue streams beyond fee-for-service through value-based care.

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.

CAP members who join an Aledade ACO before June 30, 2021, will receive special enrollment benefits, including a waived implementation fee as well as access to Aledade's expansive library of resources and support services for primary care practices. To learn more about this opportunity, visit **https://info.aledade.com/CAP_partnership.**

YOUR VOTE COUNTS!

The elections for the Cooperative of American Physicians, Inc. (CAP) Board of Directors and for the Mutual Protection Trust (MPT) Board of Trustees are currently underway—and the July 21st annual meeting date is fast approaching! All members of record as of May 24 should have received their voting materials for the CAP and MPT board elections in the mail, and we thank those of you who have already voted.

It Is Critically Important That All Members Vote Without Delay

There are four easy ways to submit your signed, dated, and completed ballot and proxy.

1. Vote Online: Log in to your members only account at https://member.capphysicians.com and follow the instructions. Register for an account if you do not already have one.

2. Vote by DocuSign: You have received emails from CAP and will be receiving additional emails if you have not voted yet asking you to sign your ballot and proxy via DocuSign, which allows you to easily and securely vote through your web browser in less than a minute.

3. Vote by Fax: Submit your ballot proxy to 213-576-8574.

4. Vote by Mail: Use the postage-paid envelope included with your mailed ballot and proxy materials.

If you did not receive your voting materials, if you need another copy of your ballot and proxy card, or need help voting, please contact Membership Services toll-free at 800-610-6642.

Please Save CAP and MPT the Expense of Additional Solicitation and Vote Today!

As a physician-founded and physician-directed organization, the members' best interests form the foundation of CAP. If we do not receive a majority of the members' votes, additional resources will need to be used for additional efforts to collect votes. The more votes we receive, the fewer resources will be required for follow up.

When you support CAP, you are joining 12,000 of California's finest physicians who benefit from superior and affordable medical malpractice protection provided through our Mutual Protection Trust, as well as access to outstanding physician support benefits. Please vote today—your participation in the 2021 CAP ballot and MPT proxy helps all members!

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