



Love of Unique Challenges Drives Pioneering Hospitalist to Innovate

Being close to patients keeps Dr. Jeff Shapiro focused on quality and efficiency of care.

Not so long ago, native Californian Jeff Shapiro, MD, had a promising future at a *Fortune 500* oil company. Yet something was missing.

"It was a great company, but I had a constant urge to find work that was more interesting – more personally meaningful," Dr. Shapiro remembers.

His mind kept returning to conversations with a family friend, a doctor he had known since childhood. "What struck me was how much he enjoyed his job. He loved being a doctor, doing something good for the world. I wanted to help others as well, so I decided I'd become a doctor too."

A graduate of the University of California, Santa Cruz, Dr. Shapiro majored in biology. "I was the first member of our family to attend college. My parents were so proud, my dad even framed my acceptance letter," he says.

When he left school, Dr. Shapiro became a pioneer in the field of hospital medicine, specializing in caring for hospitalized patients. "When I began, the specialty of Hospital Medicine was in its infancy. Now it's one of the fastest-growing specialties in medicine," he explains. In fact, Vice Admiral Vivek Hallegere Murthy, Surgeon General of the United States, was trained as a hospitalist.

"I love the challenge of it. I meet a patient with a problem, sometimes an acute one, and have to diagnose it quickly. I can order a test for a patient

"I've always liked CAP and have had nothing but really good experiences. They have a 24-hour hotline, I can call any time. They will not only offer help at the time of my call, but they will actually follow-up afterward. So when Bruce Weimer, who chairs the CAP Education Committee, asked me to chair the Hospital Education Subcommittee, I was happy to help. I've been doing that for about two years now and really enjoy being able to contribute to CAP and assist my colleagues."

in the morning, then drop by later that same day to see how he or she is doing. That quick feedback is really valuable and does not easily happen in private practice," he notes.

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DR. JEFF SHAPIRO AT-A-GLANCE

Medical Specialty: Hospitalist

Practice Location: Glendora, CA

Years in Practice: 17

CAP Member Since: 2002

Dr. Shapiro works for Southern California Hospitalist Network at Citrus Valley Health Partners, the same hospital system where he started 17 years ago. "We started with four doctors covering four hospitals and today we have more than 20 doctors in the Citrus region. As the business grew, I eventually became regional medical director," he says. In addition, Dr. Shapiro has chaired multiple departments, and just came off a two-year term where he served as chief of staff at Foothill Presbyterian Hospital.

Dr. Shapiro has also made significant contributions to the Cooperative of American Physicians. "I've always liked CAP and have had nothing but really good experiences. They have a 24-hour hotline I can call any time. They will not only offer help at the time of my call, but they will actually follow-up afterward. So when Bruce Weimer, who chairs the CAP Education Subcommittee, asked me to chair the Hospital Education Subcommittee, I was happy to help. I've been doing that for about two years now and really enjoy being able to contribute to CAP and assist my colleagues," Dr. Shapiro explains.

Dr. Shapiro is busy, but always ready to pioneer something new. "My partners and I saw a real problem with how patients were discharged from hospitals. When they leave, there's a need for an efficient way to get the patient's regular doctor all of the updated information. We couldn't find any system that could meet this need, so we consulted with some amazing technology experts and created our own solution. We invented a system called SignOutNow that works with any health system and any kind of EMR. In just three minutes, the right patient information can be safely transferred. And since there is a data trail, it is also great from a risk management point of view. You can improve patient care and ensure you've disseminated the correct information to the receiving physicians," he explains.

Dr. Shapiro's personal life is as busy as his professional one. He is happily married, with a five-year-old daughter and a two-year-old son, all thanks to some

friendly hockey matchmaking. "One of my oldest friends is a guy I've known since I was four years old. Jim used to play on a coed roller hockey team and he kept telling me about this beautiful teammate of his who would be perfect for me," he explains. "We each told Jim we weren't interested in getting set up, but Jim wouldn't hear of it. He was so relentless, we finally went out on a date just to make him stop. But he was 100 percent right about us. Thank you, Jim! That was 10 years ago and my wife and I still play hockey together." ➦



Post jobs for free on the CAP JOB BOARD

As an exclusive benefit of CAP membership, you are entitled to post physician job openings on the free CAP Job Board, exposing your practice to qualified physicians of all specialties. Once your 90-day listing expires, you can renew at no cost.

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Long Term Disability and Business Overhead Coverage Available Through the CAP Medical Practice Program

The medical professionals in your practice have worked hard for many years to establish successful careers, but a disabling illness or injury could mean a significant loss of income for both the individual and your practice. One of the largest costs to any medical practice is losing really good employees. The CAP Medical Practice Program can help protect your employees and your practice.

With revenue protection, a benefit of 50 percent of your covered monthly earnings to a maximum of \$5,000 monthly is paid directly to your practice.

- You must have between one and nine employees to be eligible for this coverage.

Key Features of the CAP Medical Practice Program

- For CAP members who have added supplemental coverage through the CAP Disability Insurance Program – you are eligible to increase your monthly long term disability benefit by an additional \$5,000 per month.
- If you do not currently have supplemental coverage through the CAP Disability Insurance Program, you are eligible for up to \$5,000 per month of long term disability benefits.
- Your employees are eligible to enroll in a disability benefit plan that covers 60 percent of their basic monthly earnings to a maximum of \$5,000 that is payable until age 65.
- Revenue Protection (business overhead expense) **at no additional cost**

A key physician's disability can mean a significant loss of revenue to your practice. The CAP Medical Practice Program helps protect against the loss of revenue when a key partner is disabled.

Case Study

Practice Profile: Dr. Chang is a 50 year old who has a family medical practice with his income reaching \$120,000 per year and a staff of three. He has an office manager earning \$45,000, a nurse earning \$75,000, and another staff member earning \$35,000.

The Problem: Dr. Chang wants to provide a benefit plan to help retain his staff without increasing his expenses, but at the same time protect his practice. He would like to protect his personal income as well, but is too busy to gather together his tax returns or to set aside time for his own medical exam. Allowing his staff to take time off for medical exams would be problematic as well.

Solution: CAP can provide an Income Protection Program that is Guaranteed Issue so Dr. Chang and his staff do not have to get medical exams. It also provides him with additional personal income protection, as well as protecting the staff he worked so hard to hire and train. ➦

Example – Coverage Breakdown

COST	BENEFIT	COVERAGE	MONTHLY PREMIUM
Dr. Chang	\$5,000 per month	Disability	\$196.00
	\$5,000 per month	Overhead Expense	Included
	\$20,000	Term Life	\$5.00
Staff Plan (three staff members)	Up to \$5,000 per month	Disability	\$57.00
	\$20,000	Term Life	\$15.00

CAP Physicians Insurance Agency, Inc. is dedicated to providing you solutions to help you attract and retain the best employees and protect your practice. For additional information about the CAP Medical Practice Program or other insurance we may be able to assist you with, contact the CAP Physicians Insurance Agency, Inc. at 800-819-0061 and press selection 5. You can also email us at benefits@CAPphysicians.com.





The Successful Physician

by Carole A. Lambert, MPA, RN

Do You Know DSRIP?

In 2010, California's 21 public healthcare systems (PHS) took a bold and collective step to transform and streamline their complex delivery systems. The new federal pay-for-performance initiative was called the Delivery System Reform Incentive Program (DSRIP) and it was the first of its kind in the country. It was part of California's 2010 Medicaid waiver titled "The Bridge to Reform." Since then, the Centers for Medicare and Medicaid Services (CMS) has approved DSRIPs in Massachusetts, Texas, Kansas, New York, New Jersey, and New Hampshire with Washington pending review.

Why is DSRIP important to CAP members and their practices? California's 21 PHS include county-owned and operated facilities and University of California medical centers in 15 counties where more than three-fourths of the state's population lives. Engagement with these facilities and medical centers is part of life for CAP members.

California's PHS serve more than 2.85 million patients annually, provide 40 percent of all hospital care to the state's uninsured, and provide 10 million outpatient visits each year. They operate primary and specialty clinics, trauma and burn centers, and train more than half of all new doctors in the state. With such breadth and depth of responsibility, their embracing DSRIP made perfect – and courageous – sense.

PHS are transforming primary care from a reactive model, focused on patients who arrive with serious conditions, to a more proactive and preventive model. This new approach uses medical homes to coordinate care, disease management registries for systematic monitoring and management, and chronic disease management models. Throughout the course of the DSRIP, all of California PHS have decreased the rate of diabetes patients being hospitalized for short-term complications by 20 percent.

PHS are broadening the scope of care, using DSRIP as an opportunity to embrace population health by improving preventive health programs in a few specific areas, including pediatric weight screening and mammography. The program is now providing mammography services to more than 42,000 who would not have been screened otherwise.

The work of CAP members, committees, and staff on patient safety, transitions of care, the patient experience, use of technology, EHR implementation, effective communication modalities, and other areas, is aligned with DSRIP. The work reflects CAP's sensitivity to the environments in which members practice and CAP's leadership in producing publications and programs to support members' practices and participation in California's dynamic system reform and redesign.

PHS are addressing urgent improvements needed in inpatient safety through a focused effort to reduce hospital-acquired infections and complications. Central line associated bloodstream infections have averaged a 17 percent decline in PHS acute care units and a 22 percent drop in their intensive care units. The typical PHS experienced a 17 percent decrease in sepsis mortality.


All systems are required to report on the same 21 measures spanning the areas of patient experience, effectiveness

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of care coordination, prevention, and health outcomes of at-risk populations (e.g. blood sugar levels in patients with diabetes).

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The last five years have laid the groundwork for transformation by proving that delivery system reform incentive programs work and by doing it in a way that will lead to even stronger outcomes if this momentum is maintained. The next five years are critical if the public healthcare systems are to build on this foundation and

more fully transform them into high performing health systems that provide timely access to safe, high-quality, and effective care for the many patients who rely on them. On December 30, 2015, CMS approved Medi-Cal 2020, a five year renewal of California's Medicaid waiver, designed to give public systems the incentive and opportunity to achieve their longterm strategic goals. CAP members will continue to play their part as leaders in providing safe and effective patient care. 

Sources:

- California's Delivery System Reform Incentive Program 2010-2015 Successes to Build On
- Issue Brief: The Medi-Cal 2020 Waiver and the Work Ahead for Public Health Care Systems
- California Public Hospitals and Health Systems
- California Health Care Safety Net Institute, Oakland

Carole Lambert is vice president, Practice Optimization and Residents Program Director for the Cooperative of American Physicians. Questions or comments related to this article should be directed to clambert@CAPphysicians.com.

Can Data Encryption Make You Safe?

by Jeff Mongelli

For good reason, many healthcare providers are increasingly concerned about protecting their patients' information. That is not surprising, considering the almost daily deluge of news about healthcare organizations being hacked or held hostage by the latest variants of ransomware, not to mention the recent launch of the next round of federal HIPAA audits.

While there is no silver bullet to protect your sensitive data, there are a few cost-effective steps every practice should take to reduce their security risks. One commonly discussed method is data encryption. Encryption is readily available and, in many cases, it is free. For example, BitLocker is a free encryption tool that Microsoft includes with many of its products.

To understand more about how encryption can protect you, let us consider two basic uses: encrypting data at rest and encrypting data in transit. Data at rest refers to stored data on your Electronic Medical

Record (EMR) server (local or offsite), flash drives, Picture Archive and Communication Systems, and other storage media. Conversely, data in transit refers to data being transmitted over an electronic medium. A few examples of encrypted data in transit include Secure Sockets Layer (websites using HTTPS), Virtual Private Network tunnels, Secured File Transfer Protocol for file transfers, and Wi-Fi Protected Access 2 for wireless transmissions. For HIPAA compliance, your office should have a data transmission policy and those recipients should be included in your Risk Assessment.

Because data at rest is almost always going to be your responsibility to protect, there are a number of options to consider when implementing encryption. For example, encryption can be implemented on a hard drive, on a database, on a folder, or even on an individual file. Each option has different implications regarding overall security, performance degradation, and ease of access for authorized users. To make

things even more complicated, it is also possible to implement combinations of the above. The best solution typically balances these considerations. If that is not confusing enough, consider the potential of getting locked out of your own data. Many encryption tools require you to safely store a printed copy of the decryption key (a.k.a. recovery key). If you lose this key, or fail to print it, you could be locked out of your data – forever. For this reason and others, we strongly recommend working with an experienced IT professional prior to implementing any level of encryption on your sensitive data.

If you do decide to implement encryption on your own, we strongly urge you to have a current and functional backup. To ensure things are functioning properly, restore a few files as a test to confirm that those files are accessible. Determine what you are going to encrypt, what technology you will use, what level of encryption you need, and who will have access to the data going forward. Document all of it.

Is encryption something you should implement?

Is encryption the Holy Grail of protection for your PHI? Generally speaking, the answer is "absolutely." Actually, the answer is "no." At a recent healthcare information security conference in Washington, DC, Kevin Stine, manager of Security Outreach for the National Institute of Standards and Technology, was quoted as saying encryption is not a panacea for all cybersecurity ills. Outsiders who steal authorized users' access credentials will still have unfettered access to the encrypted data. Regardless of what cybersecurity measures you implement, the weakest links in your security chain are your authorized users. While implementing encryption should be taken by even the smallest of healthcare offices, failing to create a security-aware and cautious workforce is still your most likely point of failure. ➦

Jeff Mongelli is CEO of Acentec, Inc., a nationwide provider of HIPAA compliance and medical IT management services.

Drug Pricing Is Subject of State Initiative and Legislation

The rising cost of prescription drugs is the subject of a new state initiative campaign as well as several bills circulating in the state legislature. Expect a vigorous debate on all fronts.

Currently in California, a measure to control prescription drug pricing has qualified for the November ballot. The initiative is sponsored by Michael Weinstein, chief executive officer of the Los Angeles-based AIDS Healthcare Foundation. If passed, the "California Drug Price Relief Act" would connect the amount the state of California spends on a drug to the price the U.S. Department of Veterans Affairs pays, which is typically 20 percent below current market value. The ballot measure is being targeted for defeat by Pharmaceutical Research and Manufacturers of America (PhRMA).

While that initiative battle looms, two bills moving through the California legislature aim to require

greater transparency from drug manufacturers by telling consumers how much they and their plans are paying for a drug and by obligating drug manufacturers to notify and explain to health plans when a drug's price is increasing by more than 10 percent. Proponents of Senate Bill 1010 and Assembly Bill 2463 say such disclosures can be useful tools when negotiating drug prices.

Highlighting the debate over drug prices is the cost of specialty drugs, which the federal government defines as costing \$600 or more per month. A Kaiser Family Foundation study published in *The Journal of the American Medical Association* in May 2016 describes current concerns over pricing. "Prices for many specialty drugs are higher in the United States than other developed countries, and about one in four people in the U.S. who take prescription drugs report difficulty affording them. http://kff.org/JAMA_4-05-2016. ➦

Three Smart Ways to Improve Practice Management

As the business of healthcare becomes increasingly complex and regulatory issues pile on more layers of stress, CAP is continuing to offer members programs and services to help lighten your practice management load. Here are three smart new practice management solutions we encourage you to consider:

1. Real-Time Data to Improve Patient Satisfaction and Prepare for VBC

CAP's new **Patient Experience Survey Program** is a specialty-specific online survey tool that enables you to quickly gauge where your practice is excelling and where performance can be improved. This HIPAA-compliant survey helps you expeditiously address patient issues and stay one step ahead of value-based compensation, so you can pursue prompt and fair payment and deliver a superior overall patient experience.

CAP has negotiated a steeply discounted monthly rate with SE Healthcare, the internationally recognized professional service firm that administers the survey on our behalf. From what many members are telling us, it is money well spent.

To schedule a free demo, or for more information, visit www.CAPphysicians.com/PESP, or contact Laura Tejero at 213-473-8638 or ltejero@CAPphysicians.com.

2. Drive Revenue and Maximize Clinical Productivity

Now you can combine EHR, practice management, and care coordination into a single, powerful solution to help optimize revenue and stay better focused on patient care. Or you can pick and choose solutions that complement your current office operations. Through our partnership with *athenahealth*, members have easy access to an integrated practice management tool that provides real back-office support to help:

- **Secure full payment faster** and reduce administrative cost and drag.
- **Improve the patient experience** and get patients more fully engaged in their own care.
- **Maximize clinical productivity** by organizing the moment of care.

CAP Vice President of Membership Programs Sean O'Brien



is happy to tell you more about the athenahealth practice management suite, or facilitate an initial consultation with an athenahealth representative. Contact Sean at 213-473-8740 or sobrien@CAPphysicians.com.

3. Connect With Vendors You Can Trust

Whether you are looking for a business consultant or a uniform supplier, a financial planner, or sanitation service provider, the CAP Marketplace has a comprehensive, easy-to-search directory of CAP reviewed businesses. The CAP Marketplace features a robust online directory with consultants, services, and products that are vital to running your practice efficiently. The CAP Marketplace helps take the guesswork out of vendor selection.

We invite you to peruse the CAP Marketplace and recommend a trusted vendor to help grow this list and be of help to other members seeking similar services. Simply visit www.CAPphysicians.com/directory.

As always, we at CAP are dedicated to the protection and the success of our member physicians and hope you take advantage of the many benefits available to you. If you have questions about any of these benefits or your coverage, contact CAP Membership Services at ms@CAPphysicians.com.

Note: The Cooperative of American Physicians, Inc. and subsidiaries contract to receive compensation from certain product vendors as commissions or marketing fees. CAP uses these funds to control costs and provide additional services to its members. ➦

Case of the Month

by Gordon Ownby



Court Explains Higher Threshold in Denying Access to Psych Records

While last month's case showed the balancing test that courts will perform in deciding when to allow government access to a patient's medical records, a different standard applies to psychotherapy records.

In 2012, the Medical Board of California (MBC) initiated an investigation of Dr. P, a psychiatrist, following a complaint from the former husband of a patient that Dr. P had engaged in a sexual relationship with the patient as well as "overprescribing, unprofessional conduct, and substandard care." When the woman spoke with an MBC investigator, she said she was no longer a patient and she denied having had a sexual relationship with Dr. P. She also denied Dr. P had ever engaged in inappropriate conduct as her therapist and refused the MBC's request to obtain her treatment records from Dr. P.

The MBC investigator subpoenaed Dr. P's treatment records of the patient; Dr. P objected and refused to produce the documents. When the MBC filed a petition to compel the production of documents, the patient filed an objection with the court, asserting the psychotherapist-patient privilege and her constitutional right of privacy.

When the trial court judge reviewed the medical records behind closed doors, he concluded that the patient's privacy interest in the documents outweighed the MBC's interest in their disclosure and denied the petition.

On its review of the trial court judge's decision, the Court of Appeal in *Kirchmeyer v. [P]* noted that a physician's engagement in sexual relations with a patient constitutes unprofessional conduct and that "sexual exploitation" of a patient by specified healthcare providers is a criminal offense. (The Court of Appeal's analysis dealt only with the dispute over compelling the production of records and did not attempt to ascertain the truthfulness of any underlying allegations.)

At the outset of its discussion, the appellate court cited established case law: "When the Medical Board seeks judicial enforcement of a subpoena for a physician's medical records, it cannot delve into an area of reasonably expected privacy simply because it wants assurance the law is not violated or a doctor is not negligent in treatment of his or her patient."

The appellate court went on to explain that the showing required to overcome a privacy right depends on the nature of the privacy right asserted. "In some cases, a compelling state interest must be shown, while a simple balancing act is used in other situations."

In denying the MBC's bid for the medical records of Dr. P, the Court of Appeal compared the facts to those in the recent case of *Fett v. Medical Board of California*. In *Fett*, the Court of Appeal backed an administrative subpoena for patient records in an investigation of an ophthalmic plastic surgeon after balancing the state's interests in the quality of medical care rendered in California versus Dr. Fett's patients' competing privacy interests.

"Although the *Fett* court used a simple balancing test, we use the compelling state interest analysis because we are dealing with records protected by the psychotherapist-patient privilege, which was not asserted in *Fett*," the court stated. "The psychotherapist-patient privilege is a kind of privacy that may be overcome only on a showing of a compelling state interest."

In finding that the state did not meet its burden of asserting a compelling interest in the protected patient treatment records, the Court of Appeal noted that the MBC could attempt to make its case that Dr. P engaged in an improper relationship using other evidence. The appellate court added, as the patient had argued in opposing the subpoena, "It is unlikely any such relationship would have been documented in the patient notes." ➦

Gordon Ownby is CAP's General Counsel. Comments on Case of the Month may be directed to gownby@CAPphysicians.com.

May 2016



California End of Life Option Act Effective June 9, 2016

by Ann Whitehead, JD, RN

Starting June 9, 2016, a terminally ill California adult who has been diagnosed with a disease that will result in death within six months, and who is mentally competent, can request a doctor's prescription for medications intended to end his or her life as long as all of the law's required criteria are met.

The California End of Life Option Act establishes procedures for patients making the request and for physicians who agree to prescribe aid-in-dying drugs, along with guidance on how to opt out of participation. Earlier this year, the California Medical Association (CMA) issued guidelines that explain to physicians and patients how the law works. The 15-page document can be downloaded free from the CMA website. (Nonmembers who register a new web account will have access to many, but not all, of CMA's website features.)

The following is a brief summary of some important physicians' obligations but cannot replace the additional information contained in the 15-page CMA document.

The Act requires two physicians, one attending and one consulting, to evaluate the patient. The attending physician is "the physician who has primary responsibility for the health care of the individual and treatment of the individual's terminal disease." The bulk of the legal and medical requirements must be fulfilled by the attending physician. The consulting physician is an independent second opinion evaluator of the patient's diagnosis and prognosis.

To request a prescription for an aid-in-dying drug, a patient must submit two verbal requests at least 15 days apart and one written request signed, dated, and witnessed by two adults, to their attending physician. Once the prescription is filled, the patient must complete a "Final Attestation" form within 48 hours prior to self-administering the drug.

The law is silent on what specific drug should be used and what cause of death should be identified on the death certificate. The guide says physicians can list the cause of death "that they feel is the most accurate," including the underlying terminal illness, or just write "pursuant to the End of Life Options Act." But it "shall not constitute suicide."

Participation is not compulsory – it is voluntary for all parties, individual providers, and institutions as well. A physician may refuse on the basis of conscience, morality, or ethics and cannot be subject to censure, discipline, or other penalty. Physicians who participate are also protected from criminal, civil, and administrative liability if they follow the law's requirements.

To protect yourself from liability, closely follow the requirements of the Act, document the steps taken in the medical record, use the required forms, thoroughly review options with the patient, and provide a fully informed consent. The CMA On-Call document #3459 cited below provides detailed discussion about what is required at each step, identifies the five required forms, and the reporting requirements.

Doctors across the state are grappling with their feelings about this law and whether they will be comfortable prescribing these medications. Physicians should bring themselves up to speed on the end of life options or identify where they can refer patients. But no matter which decision, this is a good opportunity for conversations about end of life care including palliative care, advanced care planning, hospice, and more with your terminally ill patients. ➦

Ann Whitehead is vice president, Risk Management and Patient Safety, for the Cooperative of American Physicians. Questions or comments related to this article should be directed to awhitehead@CAPphysicians.com.

¹ California's End of Life Option Act – (ABX2-15) Codified as Health & Safety Code §443 et seq. https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201520162AB15

² California Medical Association – CMA On-Call Document #3459 – The CA End of Life Option Act - <http://www.cmanet.org/resource-library/detail/?item=the-california-end-of-life-option-act>



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CAPSules® is a publication of the Corporate Communications Department of the Cooperative of American Physicians, Inc.
333 S. Hope St., 8th Floor, Los Angeles, CA 90071 | 800-252-7706 | www.CAPphysicians.com

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