THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

2026 Annual Open Enrollment Period Closes on November 17, 2026!

Personal Insurance Options Available at Excellent CAP Group Rates

SYMPHONY RISK

Members of the Cooperative of American Physicians (CAP) have until November 17, 2026, to take advantage of competitively-priced insurance products through Symphony Health.

As a CAP member, you can benefit from excellent group rates and the expertise of licensed insurance agents who have a deep understanding of your unique needs as a physician. **This is the only time of year that all members can upgrade their existing benefits and select new coverages.**

With healthcare costs continuing to rise, now is the time to get added protection from the following policies for you and your family **all at CAP group rates with no medical exams required.**

The new coverage period goes into effect January 1, 2027.

- **Life Insurance** – Up to $500,000[1]
- **Short-Term Disability** – $1,000/week[2]
- **Long-Term Disability** – Up to $15,000/month[2]
- **Critical Illness Insurance** – Up to $30,000 lump sum benefit
- **Accident Insurance** – Less than a $1/day with cash benefits for ambulance, hospital stays, follow-up care—and much more
- **Dental and Vision Insurance** – Significant savings on routine care and major services
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- And many more!

Learn More and Enroll! **www.CAPphysicians.com/Enroll**

If you need help registering for the portal and/or would like assistance with navigating and selecting the insurance selections, please call Symphony at 213-576-8530.

[1]New CAP members within the first 90 days of membership have the option to purchase up to $500,000 in life insurance with no required health exams. For members who are currently enrolled in supplemental life coverage and not at the current $500,000 maximum, you may get an additional $50,000 of life insurance benefits with no medical underwriting required.

[2]To be eligible, you must be working in healthcare at least 17.5 hours/week and cannot be currently disabled or at the time coverage becomes effective. Other limited time preexisting condition exclusions may apply.

Submit Your CAP Coverage Update Form by November 17

Complete your Coverage Update Form (CUF) no later than Tuesday, November 17 to report any actual or planned changes to your practice before the 2027 assessment is levied by the Mutual Protection Trust (MPT) Board of Trustees.

Your CUF must be submitted to CAP by November 17 to avoid coverage gaps and evaluate eligibility for a reduction in your 2027 assessment. Any changes reported after November 17 cannot be used to modify your assessment.

The CUF takes two to three minutes to complete (less if you have no changes to report).

Log in to **member.capphysicians.com**. You will be prompted to **"Update/Verify Your Information Now."**

Changes which require reporting include, but are not limited to:

- Retirement from practice at age 55+
- Part-time practice or reduction/change in the scope of your practice
- Employment with a government agency or non-private practice setting
- Employment with an HMO or other self-insured organization
- Moving out of state
- Termination of membership

Even if you do not have updates or changes that may take effect from now through December 31, 2027, review your practice information and respond by selecting **"No Changes"** on the bottom of the CUF.

If you have any questions, please contact Membership Services at **MS@CAPphysicians.com** or **800-610-6642**.

NOVEMBER 2026

Case of the Month



At Risk for Sexual Misconduct Liability

by Deborah Kichler, RN, MSHCA
Senior Risk Management and Patient Safety Specialist

Over the past decade, the issue of sexual misconduct liability (SML) in clinical settings has received growing attention, fueled by the frequency and severity of associated claims and substantial settlement amounts. Claims of misconduct can encompass a broad scope of liability and may arise from employees, patients, independent contractors, or visitors. Similarly, the alleged perpetrator could be a practitioner, healthcare staff member, supervisor, or other professional personnel.

Most professional liability insurance policies typically exclude coverage for practitioner-patient sexual misconduct, as such behavior is not classified as medical malpractice. These incidents can lead to civil and criminal legal proceedings, disciplinary actions by licensing boards, and potential imprisonment. The financial impact of such claims can also be substantial, given many are high-severity, high-profile cases.

Healthcare involves close physical contact and a high degree of vulnerability, creating opportunities for abuse, which can be heightened by the trust and confidence patients often place in healthcare professionals. Instances of sexual abuse can occur when medical staff have the opportunity to convince their patients or their caregivers that certain procedures are necessary or take advantage of a patient's inability to consent. Because healthcare providers may see many patients and often work across multiple facilities, the potential scope of abuse and the number of victims can be sizable.

Research shows that offenders need three things to abuse: 1) access to a vulnerable individual; 2) privacy to be able to offend without detection; and 3) control to manipulate the individual and the community.[1] Sexual abuse by a healthcare provider can include inappropriate touching during an exam, unnecessary genital or rectal exams, groping, sexual comments, forced exposure, photographing patients, or using medical authority to make a patient submit to conduct that was not medically necessary.

Sexual abuse is not confined to a specific specialty or healthcare setting, nor is it limited to physicians or other allied professional practitioners. Nursing and ancillary staff also pose a risk of committing sexual abuse.

Claims Involving Healthcare Sexual Misconduct

- **2024 in Virginia:** Civil trial in Richmond Circuit Court awarded three women $300 million in damages. The physician, who taught at Virginia Commonwealth University for 20 years, was accused of inappropriately touching the women during femoral pulse exams.[2]
- **2025 in New York:** A New York court ordered that a pediatrician pay $1.6 billion to over 100 women who accused him of sexually abusing them as children during routine medical visits over decades.[3]
- **2026 in New York:** Weill Cornell Medicine was ordered to pay $1 billion to settle civil claims of patients who were sexually abused by a former assistant professor and urologist who worked at Weill Cornell from 2003 to 2019. The physician often conducted exams alone on male patients as young as 13 years old and was also sentenced to life in prison.[4]

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Managing Sexual Misconduct Liability

The occurrence of sexual misconduct by providers inflicts lasting harm on patients, undermines public trust, damages both organizational and personal reputations, and can permanently jeopardize or end medical careers. Implementing communication strategies, consistently using chaperones, and maintaining documentation practices that safeguard both patients and providers can help establish effective policies to prevent actual or perceived boundary violations.

To strengthen patient protection, California Assembly Bill 849: Health Providers: Medical Safety Chaperone Act, will go into effect on January 1, 2027. The law mandates the presence of a medical chaperone during ultrasound or similar imaging procedures involving sensitive areas, including genitalia, breasts, or rectum. This law requires providers performing sensitive examinations to inform patients that a medical chaperone will be available upon request to assist with or observe the examination.[5] Providers have the right to refuse to perform a sensitive exam without a medical chaperone if the provider determines that one must be present. The use or refusal of a medical chaperone must be documented in the medical record.

Policies and Protocols for Use of Chaperones During Examinations

Examinations or procedures involving sensitive areas may be a distressing experience for some patients. Chaperones may provide patients with comfort, dignity, and safety during these examinations or procedures. They may help the patient understand the procedure, answer questions, or ease anxiety for patients who are uncomfortable due to their cultural or religious backgrounds. Chaperones may also assist with dressing and undressing patients, setting up medical equipment or supplies, ensuring continued consent, and protecting the provider if the patient becomes violent or aggressive.[6]

Physicians should develop a policy that describes who can serve as a chaperone, when chaperones should be present, how they are to be proposed or requested, and what to do when a patient declines.

A trained member of the healthcare team (MA, RN, LVN, technician) who acts as an impartial observer during an examination, treatment, or procedure may serve as a formal chaperone. A parent, guardian, or caregiver present at the patient's request does not replace the requirement for a formal chaperone during sensitive exams.[7]

A key component of a successful chaperone policy is ensuring training for those who will serve as chaperones for sensitive exams and the healthcare providers. Training for both chaperones and providers should include review of expectations for each role, improve communication between the team, suggest neutral terms for intervention in the case of patient distress or chaperone discomfort, and set expectations for provider behavior and the procedure.[8]

Training should occur upon hire and be renewed regularly with knowledge/skill competency to include cultural sensitivity and trauma-informed practices. Key components for chaperone training include:

- Ensuring patient comfort and dignity while maintaining privacy.
- Informing the patient that the chaperone will be present if a sensitive exam is performed, or for any other exam as requested by the patient or provider.
- Positioning of chaperone during exam to visualize point of contact during the exam or procedure.
- Assisting patient with undressing/dressing before and after exam.
- Review how chaperone may intervene or stop an exam if they are concerned about patient distress or inappropriate steps during the exam.
- Documenting the chaperone's presence during the exam or the patient's declination of a chaperone.

Key components for provider training include:

- Proper communication with patients about why

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the sensitive exam is needed.

- Proper communication before and during a sensitive exam to explain what to expect from the exam and what will happen during the procedure.
- Documentation of patient education provided.
- Documentation if the patient declines any part of exam.
- Documentation of chaperone presence (including chaperone's name) or declination of chaperone use.
- Chaperone communication to signal the need to pause an exam due to obscured view or patient discomfort.
- Importance for providers to minimize the amount of sensitive information asked and shared in front of the chaperone to protect patient confidentiality.

Patient Education

Prior to the exam, it is important to educate the patient about why the examination is needed, what the exam entails, the purpose and availability of a chaperone, and the patient's ability to decline or stop any portion of the exam. Patient education may be provided using a variety of educational resources or materials, including an explanation from the chaperone or provider, in-room postings or written materials, and web-based written information or videos.[9]

Key patient education elements:

- Information about the practice's chaperone policy, including when chaperones are mandatory or available upon request, and when a chaperone may be declined by the patient, including the consequences for declining a chaperone, e.g. exam or procedure may be rescheduled or canceled.
- Information outlining the components of a sensitive exam, the role of the chaperone, and how to report concerns about inappropriate exams.
- Verbal explanation of the planned examination by a provider.
- Education on the patient's right to request clarity on the exam, express discomfort, or to terminate an exam at any point.
- The ability of the patient to request the gender of a chaperone.

Information should be provided to patients through an informed discussion between the provider and the patient.[6]

Documentation Requirements

Document in the medical record the use of a chaperone or the patient's decision to decline a chaperone. Include:

- Name of the chaperone, date, and time of the exam or procedure (example; "Sensitive portions of the exam were chaperoned by [Name, title]").
- Patient's informed consent regarding the presence of the chaperone, or their refusal (example; "Patient declined chaperone").
- If the patient declines a chaperone, document any actions taken, e.g., providing patient education, rescheduling or cancelling the procedure, referring the patient to another provider, or proceeding to perform the exam without a chaperone.
- If a chaperone is not available, document their unavailability, offer to reschedule the exam, and the patient's decision.
- Document the patient's gender preference and whether it was accommodated. If not, note the reason and the patient's acceptance or an alternative.

Physician and Patient Communication During Sensitive Examinations

Clearly define appropriate and inappropriate interactions between healthcare personnel and their patients. Always maintain clinical and respectful language, avoiding personal remarks or humor. Casual or lighthearted comments regarding a patient's body during sensitive examinations are frequently considered unprofessional and inappropriate. Although these remarks may be intended to alleviate tension, they have the potential to compromise

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patient dignity and erode patient trust.

Healthcare providers must prioritize maintaining professional boundaries and fostering a respectful clinical environment to minimize the risk of sexual misconduct liability. By establishing clear policies and expectations, providing ongoing education and training, and promptly addressing concerns or allegations of inappropriate conduct, healthcare providers can help safeguard patients, maintain professional boundaries, and mitigate the risk of sexual misconduct liability.

Deborah Kichler, RN, MSHCA, is a Senior Risk Management and Patient Safety Specialist. Questions or comments related to this article should be directed to DKichler@CAPphysicians.com

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When Adverse Events Don't Become Lawsuits

by Tanha Ahmed, MPH
Senior Risk Management and Patient Safety Specialist

What determines whether an adverse event escalates to a lawsuit or becomes a situation that can be resolved through proper communication?

Adverse events are an unavoidable reality in the practice of medicine. An adverse event is defined as an unintended outcome or injury that can occur even when the care provided met the appropriate standard of care. Most physicians may automatically assume an adverse event will result in a malpractice lawsuit, particularly when a patient accuses them of "medical negligence" or "substandard care." What many people may not realize is that an unexpected complication or outcome does not necessarily mean there was negligence. It is important, however, to separate the unexpected outcome from the objective facts of the patient's care.[1] The patient's experience following an adverse event—particularly the physician's response—can influence what happens next.

Research on communication and resolution programs suggests that transparent communication, investigation of what occurred, appropriate apology or acknowledgment, and fair resolution can be implemented without increasing malpractice liability.[1] Evidence also suggests that these actions may reduce certain malpractice-related costs and claims by addressing patient concerns before disputes escalate into litigation.[1]

The First 24 Hours Matter the Most

Disclosure isn't merely about communicating with the patient; it is part of a broader process of identifying what went wrong, learning from the event, and preventing recurrence. The American Medical Association (AMA) emphasizes that physicians have an ethical obligation to promote patient safety and communicate honestly with patients when an adverse event/outcome or error has occurred.[2,3]

Physicians involved in an adverse event/outcome should:

- Disclose the outcome
- Explain the potential harm
- Provide information necessary for future medical decisions
- Acknowledge the error and express compassionate concern
- Explain the efforts being taken to prevent reoccurrence of similar errors
- Ensure continuity of care to preserve patient-physician relationships

Communication Can Change the Trajectory

The Agency for Healthcare Research and Quality (AHRQ)/Communication and Optimal Resolution (CANDOR) framework advocates early disclosure, investigation, communication, and resolution rather than a traditional "deny-and-defend" approach.[4] The CANDOR process is designed to provide a timely, thorough, and just response to unexpected patient harm to help prevent medical liability claims in the long term and improve patient satisfaction.[1]

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The California Physician's Legal Handbook introduces the Fair and Just Culture model, which emphasizes learning and accountability over blame and punishment and recognizes that reporting errors allows organizations to identify system problems, learn from them, and prevent future errors.[5]

"I'm Sorry" vs. "I'm Admitting Fault"

One of the most difficult moments following an adverse event is deciding what to say to the patient. Physicians may often worry that expressing sympathy or acknowledgment of what has occurred will later be characterized as an "admission of liability."[6]

California law recognizes an important distinction between expressing sympathy and admitting fault. *California Evidence Code Section 1160* protects certain statements, writings, or goodwill gestures expressing sympathy or a general sense of benevolence relating to a person's pain, suffering, or death from being used as evidence of an admission of liability in a civil action. However, the protection does not extend to a statement of fault.[6] In other words, a physician can express genuine concern for a patient's experience without necessarily making a legal admission that the physician was negligent.

Documentation, Documentation, Documentation

It is important to note that the patient's medical record is not the place to speculate about legal liability, point fingers, or shift blame. Remaining objective in documentation is crucial to ensuring that the clinical facts and care provided to the patient are accurately documented.[1]

After an adverse event, consider documenting:

- **What happened:** Objective description of the event and relevant clinical circumstances.
- **The patient's condition:** Symptoms, findings, vital signs, examination findings, and changes from baseline.
- **Actions taken:** Treatment, monitoring, consultation, transfer, referral, or other interventions.
- **Who was notified:** Appropriate members of the care team and, when applicable, leadership, or risk management.
- **Patient communication:** What was explained to the patient/family, questions asked, and information provided about ongoing care.
- **Follow-up:** Instructions, appointments, monitoring, and plans to reassess the patient.
- **Ongoing investigation:** When appropriate, participation in the organization's quality/safety or event-review process.

Documentation should capture the clinical facts and the patient's care—not phrases such as "this was malpractice," "I was negligent," or "this will probably result in a lawsuit."

Compensation Supports Prevention

The University of Michigan Health System conducted a study examining a medical error disclosure program, which found that offering appropriate compensation was associated with a decrease in malpractice claims, lawsuits, and liability-related costs. Following implementation, the average monthly rate of new claims decreased by 36%, lawsuits decreased by 65%, and total liability costs decreased by 59%.

For physicians and risk management professionals, the takeaway is simple: fear of admitting liability should not become a reason to stop communicating with the patient. An adverse event should prompt an organized response—not avoidance. Transparent communication and early resolution can be part of an effective risk-management strategy without necessarily increasing malpractice liability.[5] The physician's responsibility is to communicate compassionately, ensure the patient receives appropriate care, preserve the facts, and work with

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the appropriate risk management or quality team to determine what happened and what should happen next.

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New Disclosure Statement Now Available

CAP members can access the updated Disclosure Statement, which gives an overview of operations for the Cooperative of American Physicians, Inc. (CAP) and the Mutual Protection Trust (MPT) pursuant to California Insurance Code Section 1280.7.

The 2026 Disclosure Statement is now available and can be reviewed at any time in the Member's Area of the CAP website at **https://member.capphysicians.com/**

For questions, contact CAP at **800-252-7706**.

SECOND ANNUAL CAP ADVOCACY IN ACTION PROGRAM

The Cooperative of American Physicians (CAP) hosted its second annual *Advocacy in Action* program on October 14 at CAP's headquarters in downtown Los Angeles, bringing independent physicians together with California Assemblymembers Blanca Pacheco (D-Downey), Mark Gonzalez (D-Los Angeles), and Nick Schultz (D-Burbank) for an opportunity to discuss issues affecting independent medical practice and patient care.

This year's program, ***Policy, Politics, and Independent Practice***, was designed to encourage direct dialogue between physicians and state legislators as healthcare funding, legislative proposals, and election-year issues continue to shape the practice of medicine in California. Attendance was intentionally limited to encourage open discussion and meaningful participation.

The legislators addressed pressing issues impacting physicians and patients alike and discussed the midterm elections, healthcare funding, current legislation, and the advocacy priorities supporting the future of independent practice.

CAP is deeply grateful to our members for participating in this important dialogue. Your presence and perspectives help strengthen our collective voice to ensure policymakers are informed and educated on the realities of practicing medicine today.

Through continued advocacy and future initiatives, CAP remains committed to supporting independent physicians and advancing meaningful policy change across the state.





Ask My Practice

by Jenny Kroska
CS Credentialing Manager

Understanding CAQH: Simplifying Provider Data Management in Healthcare

In the fast-paced healthcare administration world, managing provider data efficiently and accurately is crucial. Enter **DataSpring, powered by CAQH**—formerly known as the Council for Affordable Quality Healthcare—an essential part of the credentialing and data management process for healthcare providers and organizations across the United States.

If you are a healthcare provider or manage credentialing for a practice, you have heard of—or worked with—CAQH, the industry-standard platform for storing and sharing provider information. But what exactly is CAQH, and why does it matter?

What Is CAQH?

Founded in 1999, CAQH was originally established as a non-profit alliance focused on streamlining healthcare administration by developing standardized, technology-driven solutions for data sharing and process automation. Its mission has centered on reducing administrative burdens, cutting costs, and improving the accuracy of healthcare provider information.

In January 2026, CAQH transitioned from a nonprofit organization to a for-profit company owned by major health insurance companies. In June 2026, it subsequently rebranded as DataSpring, powered by CAQH.



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The most widely used tool is the CAQH Provider Data Portal, previously known as CAQH ProView, and before that, the Universal Provider Datasource (UPD). This online platform allows healthcare providers to securely input, update, and share their professional and credentialing information with multiple health plans, hospitals, and other healthcare organizations—all from one centralized location.

Key Features of CAQH Provider Data Portal

When used correctly, CAQH Provider Data Portal simplifies the credentialing and recredentialing process by enabling providers to:

- Enter personal, professional, and practice data (e.g., education, licenses, certifications, malpractice history)
- Upload supporting documents (e.g., DEA certificate, malpractice insurance)
- Authorize specific organizations to access their information
- Receive reminders for updates or expiring documents

For organizations, this system streamlines the process of collecting and verifying provider data, reducing redundant requests, and improving data accuracy.

Why CAQH Matters

The traditional process of collecting credentialing information involves mountains of paperwork and endless back-and-forth between providers and payers. The CAQH Provider Data Portal helps solve that problem by acting as a centralized data hub, benefiting both sides of the process.

Benefits for providers:

- Enter data once, share with many
- Save time on repeated credentialing paperwork
- Maintain control over who sees their data

Benefits for organizations:

- Reduce administrative costs
- Improve accuracy and compliance
- Accelerate onboarding and recredentialing processes

Common Challenges with CAQH

Although the CAQH Provider Data Portal offers significant benefits, maintaining an accurate and compliant profile requires ongoing attention.

- **Incomplete profiles:** Missing or outdated information can delay credentialing or payer enrollment.
- **Neglected updates:** Providers need to regularly log in to attest that their data is accurate, or it may be flagged as inactive.

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- **Misunderstanding its role:** CAQH does not perform credentialing or enrollment; it simply stores and shares data.
- **Expired Attestations:** CAQH requires providers to review and attest to the accuracy of their profiles **every 120 days**. Failure to complete this requirement may prevent participating payers from accessing current provider information, potentially delaying credentialing, recredentialing, and provider enrollment.

To avoid these issues, regular profile reviews, timely document updates, and consistent attestations help avoid unnecessary delays.

Final Thoughts

CAQH, now operating under DataSpring, powered by CAQH, has become a cornerstone of modern healthcare administration, helping to reduce inefficiencies and improve the flow of accurate provider data. By using tools like CAQH Provider Data Portal effectively, providers and organizations can support more efficient credentialing, reduce administrative duplication, and focus more on delivering quality patient care.

In an industry where time, accuracy, and compliance are everything, DataSpring, powered by CAQH, continues to play a vital role in moving healthcare forward—one provider profile at a time.

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 MedCycle Solutions will 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 Organization?

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?

The 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 can access 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.

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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.

Sign Up To Start Saving!

Signing up is simple and it takes just two minutes. Visit cappurchasingalliance.com and provide your contact information. Once registered, an account manager will reach out to help you begin saving.

Questions?

Website: cappurchasingalliance.com
Call: 855-907-9227
Email: support@CAPpurchasingalliance.com



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The information in this publication should not be considered legal or medical advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.