



## An Entrepreneurial OB-GYN Practice that is Constantly Reborn and Growing

*Dr. Bryan Jick's efforts gave birth to a successful 35 person, diversified practice*

How do you spot a budding entrepreneur?

In Dr. Bryan Jick's case, the signs were all there long before he started his practice. An independent spirit. A sense of adventure. A willingness to do whatever it takes to reach a goal.

"I really wanted to travel before going to med school," Dr. Jick recalls. "But I come from a divorced family—we didn't have a lot of resources. It was just my mom, my brother, and me." Where others might have reluctantly given up on the idea, Dr. Jick didn't.

"I found a job as a waiter. Then, a second job as a waiter. I ended up waiting tables 55 hours a week for about a year. I saved as much as I could." That's a lot of waiting tables, but his grit paid off. He was able to jet off for a fantastic three-month adventure across Europe. He came home a week before starting medical school with plenty of memories, but not much else. "I had about \$50 to my name and a lot of loans," he laughingly says.

Despite a brief pre-med flirtation with becoming a chemistry professor, in his heart, Dr. Jick knew he'd rather be a doctor, but he wasn't sure which specialty to choose. "In my third year, I decided to see what was out there. I did all the rotations plus electives—heart surgery; eye surgery. There were so many opportunities. Finally, it came down to making a list—here's what I love to do and here's what I don't. Becoming an OB-GYN just felt right. You do surgery, deliver babies, and patients often stay with you a long, long time." And 30 years later, that decision still feels right. "In OB-GYN, you have opportunities for joy that you don't have in other areas of medicine."

In those 30 years, Dr. Jick's entrepreneurial spirit has been tested time and again. In 1990, just before going

into practice with two doctors, one of them—just 46 years old—died after emergency surgery. Overnight, the three-doctor practice became just two. His other partner suffered a severe spinal injury, and by 1995 Dr. Jick was the only partner remaining. After a brief stint in HMO medicine, Dr. Jick returned to solo private practice. Eighteen years later, he has built it into a thriving medical group with 35 people, including five (soon to be six) OB-GYN doctors.



Dr. Bryan Jick

His forward-looking approach has made all the difference. When planning a move to a new office in 2009, he designed it without any chart space. The practice converted to electronic medical records starting a year before the move. Today, the practice offers everything from high-risk pregnancy care (their doctors have delivered more than 200 sets of twins), to

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robotic hysterectomy, a full-time OB-GYN ultrasound department, a bioidentical hormone program, and a medi-spa.

“There’s some stress in having to manage as we grow—more overhead, more corporate issues,” Dr. Jick notes. “But now we have an amazing management team. Where I used to do nearly everything myself, now the team even hires people I haven’t met—and those new hires are wonderful!”

CAP has been with Dr. Jick every step of the way. “The very first doctor that ever hired me brought me into CAP in 1988. And every single time I needed CAP, it has given me their very best.”

Dr. Jick and his wife Marina have been married for almost 34 years and have two sons—the oldest a lawyer, and the youngest a video game concept artist.

Marina, who started her career as a software engineer, has become a nurse practitioner and runs the practice’s medi-spa.

The couple loves to travel. They’ve been all over the map from the Caribbean and Europe to Australia and New Zealand. But as you might expect from someone with his entrepreneurial drive, Dr. Jick’s main hobby is work.

“There’s always something new to think about and I love being able to help our patients as we continually incorporate technological advances in medicine and computers into our day-to-day practice.”

#### DR. BRYAN JICK AT-A-GLANCE

**Medical Specialty:** Obstetrics and Gynecology

**Practice Location:** Pasadena, California

**Years in Practice:** 30

**CAP Member Since:** 1988

## Offering Products and Services Beyond Standard Patient Care? You Could Be at Risk.

As a means of generating more revenue, physicians are becoming more creative with the types of programs and services they provide to patients and non-patients alike. The problem is some or all of these services may fall outside the scope of CAP’s medical liability coverage. Here are a few examples:

- Providing durable medical equipment (DME) to your patients
- Practicing telemedicine to patients outside of California
- Serving as a medical director for another organization, such as a medical spa
- Selling skincare products and/or nutritional supplements to patients
- Providing expert witness testimony, independent medical exams, and presentations to groups
- Writing a book
- Making and distributing videos

**You probably didn’t know that you could be at risk if a disgruntled patient files a lawsuit against you and you thought you had the right type of coverage.**

For example, if you provide DME to a patient and it malfunctions, causing an injury, did you know you could be sued for damages along with the manufacturer? The hope is the manufacturer will defend you, but you can’t always count on it. You need the right type of coverage to make sure all of your legal expenses are covered.

**Consultative services have risks.** Times have changed in California (and some other states as well). Attorneys may now sue the “friendly” expert witnesses they have hired for breach of contract or professional malpractice. If a defendant or plaintiff finds your conclusions as an expert witness damaging, they could bring a lawsuit against you.

If you offer through your practice any product or service that you think may put you at risk, contact CAP Physicians Insurance Agency at CAPAgency@CAPphysicians.com or 800-819-0061. One of our coverage professionals will be happy to help you determine your risk exposure and explore the correct coverage you will need.



# Risk Management — and — Patient Safety News



## Improving Handoff Communication: Five Things You Can Implement Tomorrow

by Anne Marie Lyddy, MHA, CPHRM

Last month's "Risk Management and Patient Safety News" column titled "Healthcare Communication Failure: 13 Ways to Improve Communication" emphasized that communication breakdowns are one of the root causes of preventable patient injury. It identified seven types of communication failures that result in patient injury and in malpractice claims. The first communication failure was incomplete handoff between providers regarding a patient's condition.

This article will provide specific information about the importance of good handoff communication.

Handoffs occur any time there is a transfer of responsibility for a patient from one caregiver to another. Regulatory and accrediting bodies are well aware of the dangers of ineffective handoffs. The Joint Commission issued the following Sentinel Event Alert on Inadequate Handoff Communication:

".... When a patient is handed off to another healthcare provider for continuing care, treatment, or services, the type of information the receiving provider needs may not be the information the sender provides. This misalignment is where the problem often occurs during handoff communication."<sup>i</sup>

Also, a recent study stated that hospitals and doctors' offices nationwide might have avoided nearly 2,000 patient deaths—and \$1.7 billion in malpractice costs—if medical staff and patients communicated better. "Communication failures were a factor in 30 percent of the malpractice cases examined by CRICO Strategies, a research and analysis offshoot of the company that insures Harvard-affiliated hospitals. The cases—including 1,744 deaths—involve some horror stories

that no family, and no medical professional, wants to experience. In one instance, a nurse failed to tell a surgeon that a patient experienced abdominal pain and a drop in the level of red blood cells after the operation—alarming signs of possible internal bleeding. The patient later died of a hemorrhage."<sup>ii</sup>

Mnemonics and standardized handoffs can be helpful in these instances. As the case example shows, it is vital to patient safety to ensure clear communication amongst the treatment team. CAP recommends that physicians and other members of the treatment team memorialize conversations about a change in a patient (positive or negative) in the medical record. To aid in this patient safety effort, several mnemonic tools have been developed to assist members of a patient's healthcare team in achieving systematic and standardized handoff communication. Three of the tools are listed below and include:

- **Document the FIVE-Ps** (Patient, Plan, Purpose, Problems, and Precautions)<sup>iii</sup>
- **SBAR** (Situation, Background, Assessment and Recommendations)<sup>iv</sup>
- **I PASS the BATON** (**I** = Introduction, **P** = Patient, **A** = Assessment, **S** = Situation, **S** = Safety concerns, **B** = Background, **A** = Actions, **T** = Timing, **O** = Ownership, **N** = Next)<sup>v</sup>

More importantly, and irrespective of which system you use, it is critical that you document your evaluation in your patient's progress notes, or if a form, such as

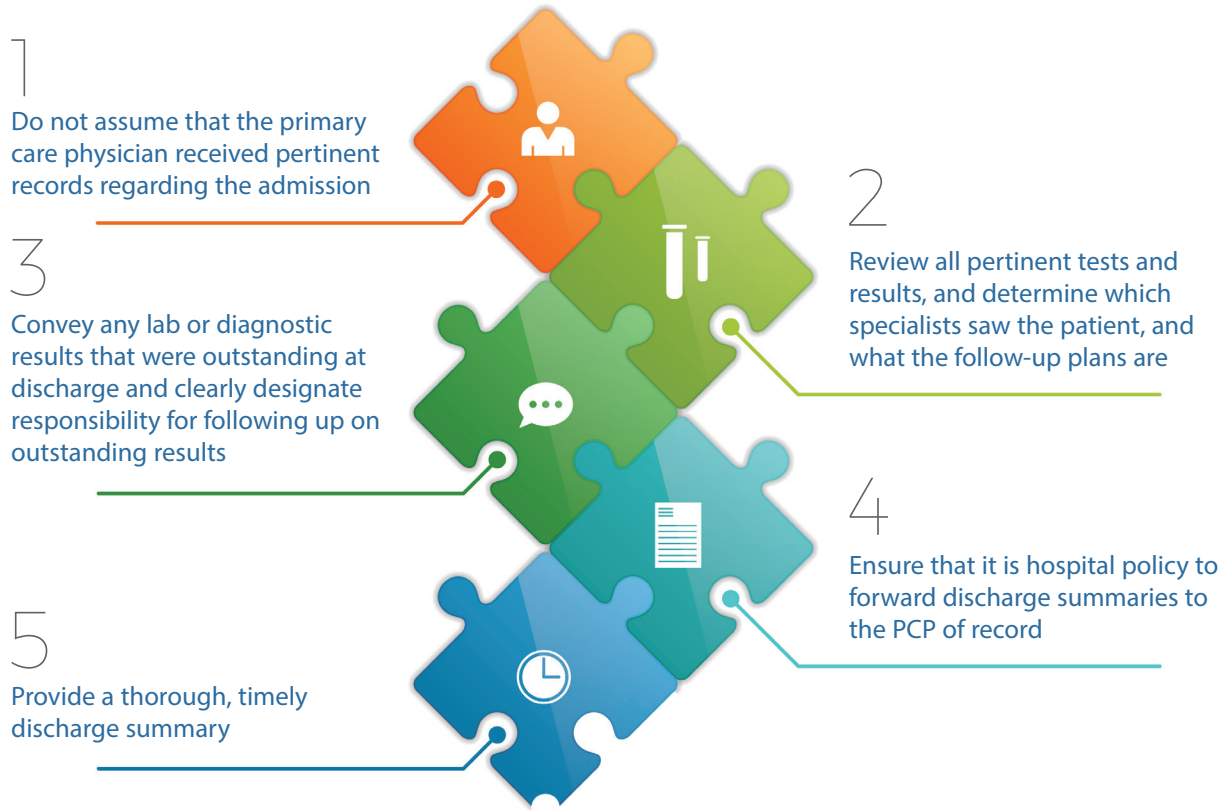
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a discharge form, is filled out, it is memorialized in the patient's records. Moreover, if you *know* handoff communication is a problem for you and for your patients, it is imperative to identify and correct systemic

issues that prevent effective handoffs, be it turf wars, interruptions, and/or the unavailability of pertinent or pending test results and other data.

Remember—it is vital to patient safety to ensure that there is clear communication amongst the treatment team. ↩

## CAP Recommends



<sup>i</sup> [https://www.jointcommission.org/sentinel\\_event\\_alert\\_58\\_inadequate\\_handoff\\_communications/](https://www.jointcommission.org/sentinel_event_alert_58_inadequate_handoff_communications/)

<sup>ii</sup> <https://www.statnews.com/2016/02/01/communication-failures-malpractice-study/>

<sup>iii</sup> *ibid*

<sup>iv</sup> <http://www.ihl.org/resources/Pages/Tools/SBARToolkit.aspx>

<sup>v</sup> <https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html>

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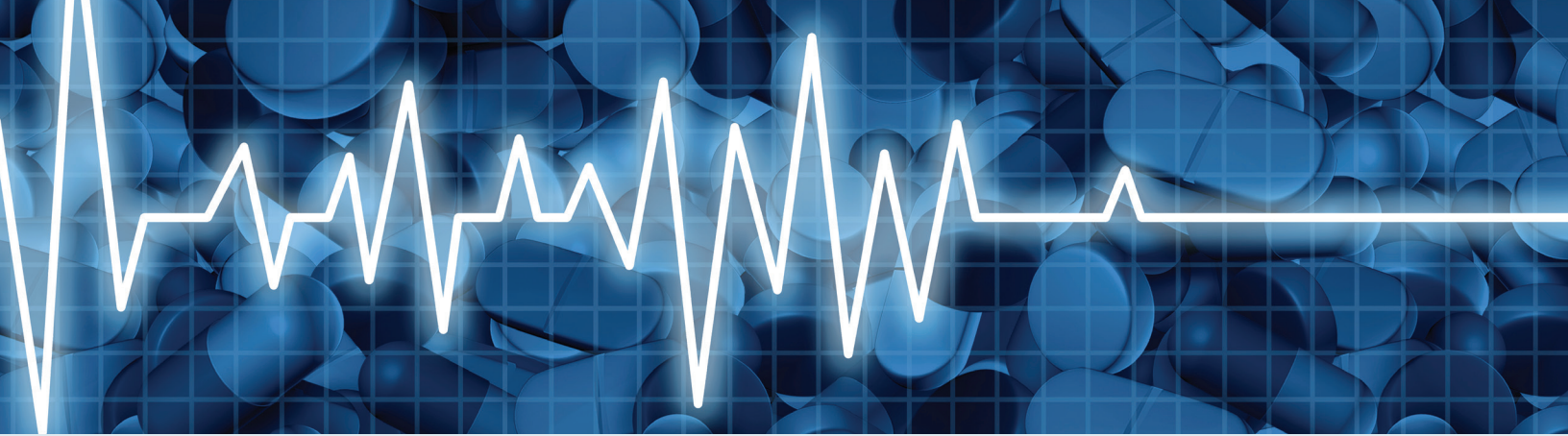
## Wayne Kleinman, MD, Elected CAP President and Chair

The Cooperative of American Physicians, Inc., Board of Directors has elected Wayne Kleinman, MD, as president of CAP and chair of the Board of Directors. Dr. Kleinman succeeds Béla S. Kenessey, MD, who continues to serve on the CAP Board of Directors after resigning as president

and chair. Paul R. Weber, MD, was elected vice president and vice chair.

The CAP Board of Directors has also elected Lisa Thomsen, MD, to the Board to fill a vacancy following the resignation from the Board of Amir Moradi, MD. ↩





## CURES Mandate on the Horizon

by Gabriela Villanueva

As the opioid crisis continues, calls to curb and prevent abuse have become more urgent.

In 2016, California passed SB 482, which will require physicians to check the Controlled Substances Utilization Review and Evaluation System, better known as CURES, before prescribing opioids and other controlled substances to a patient for the first time. The law also requires the authorized prescriber to check the CURES database at least once every four months while the drug remains part of the treatment. The law is to take effect six months after the state certifies the database is ready.

As of this writing, the database is not scheduled to be certified by the California Department of Justice until July 2018, meaning that authorized prescribers will be required to start checking January 2019 at the earliest.

In February, the California Assembly Committee on Business and Professions held an informational hearing on CURES. Among the topics discussed, and adding to the urgency of this crisis, is the concern by many healthcare professionals of the practice of “doctor shopping” by patients, addicts, and others looking for dangerous narcotics. Supporting such urgency is a finding by the U.S. Centers for Disease Control that 21.4 percent of unintentional prescription overdose deaths involve patients who had engaged in doctor shopping. In a written statement to the committee, the Attorney

General’s Office has said that the database’s capacity for handling information “was half of what is needed in order to be certified” and that the office has been in the process of both hiring more personnel and increasing the system’s capacity. The California Medical Association has also weighed in on the issue by suggesting further work needs to be done to make physicians’ access and reports using CURES less burdensome.

California is one of 39 states that mandate physicians and other authorized prescribers check their statewide prescription and drug-monitoring databases. While the emphasis of setting up and utilizing these tracking databases may center on the protection of patients and combatting the crisis, proper use of CURES can also be a strong tool for physicians to protect themselves from being “shopped.” The more the system is used and maintained, the stronger and more reliable the data will become.

If you have not yet registered as an authorized prescriber in the CURES database, you can do so at: <https://cures.doj.ca.gov/registration/confirmEmailPnDRegistration.xhtml> ↩

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# The Successful Physician

by Gwen C. Spence

## 10 Ways CAP Physicians Can Stay Healthy During Cold and Flu Season

The 2017–2018 cold and flu season has been one of the most aggressive in recent history and is wreaking havoc in 49 of America's 50 states. Over 600,000 hospitalizations have occurred as the result of flu/flu-like symptoms. There were 20 influenza-associated pediatric deaths reported as of the first week of January 2018 and 27 healthy adults have died in California alone. Hospitals and urgent care facilities are inundated, causing several hours' wait time. Medical centers have set up "war like" tented triage centers in hospital parking lots and are running low on IVs and antivirals. Dan Jernigan, MD, MPH, director of the Influenza Division at the National Center for Immunization and Respiratory Diseases, says "People are definitely working overtime, doing double shifts, and coming in extra days."

How can we keep the caregivers healthy so that they can continue to treat patients during this epidemic?

In a previous article, "Who Cares: Caring for the Caregiver—the Fourth Aim in the Quadruple Aim," we talked about improving the experience of providing care as the fourth aim. This aim resonates with the healthcare industry in a cold and flu season such as the one we are experiencing—supporting physicians and their staff for the common goal of successfully treating patients and keeping them well.

Here are 10 recommendations from healthcare industry resources for ways physicians and their staff can stay healthy during the cold and flu season.

- 1. Don't infect your colleagues.** If you are sick, stay home.
- 2. Get vaccinated.** The 2017–2018 flu seasons represents one of the most problematic in recent history. The current strain—H3N2—is one of the most harmful, historically known to cause many more hospitalizations and deaths than other strains, says the Centers for Disease Control and Prevention (CDC).
- 3. Hold your breath!** If you are around sick people and someone coughs or sneezes, hold your breath for 10 to 15 seconds. Most germs enter your body through your nose or mouth. MIT recently revealed that coughs and sneezes—and their potentially infectious droplets—travel much further distances than previously thought.
- 4. Don't bite your nails.** Can't you hear your mother's voice in your head? "Germs build up underneath your nails, and biting them is an absolute way to let bacteria into your body," says Scott S. Topiol, RN, and president of Nurseworld.com.
- 5. Did you ever think of washing your washing machine?** Wash everything you touch—including your washing machine. Shawn Westadt Mueller, MSN, RN, CIC, FAPIC, director of infection prevention and control at Medstar Union Memorial Hospital in Baltimore, says "Bacteria like warm, dark, and moist places, so your washing machine could harbor germs." Wash everything you touch, especially during this flu crisis. Clean your cell phone. Wash your remote control, light switches, doorknobs, bed rails, and your PC keyboard.

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Children's toys are incubators for germs. Good old soap and hot water, bleach, or alcohol will do the trick every time.

6. **Drink moderately.** The National Institute on Alcohol Abuse and Alcoholism has shared studies that show more than moderate alcohol consumption can suppress the immune system. A recommended limit is one drink per day for women, and up to two drinks per day for men.
7. **Limit sugar.** Avoid raiding the kid's Halloween stash on a regular basis especially during the cold and flu season. According to Michelle Katz, author of "Healthcare Made Easy," sugar inhibits white blood cells in the fight against bacteria and viruses.
8. **Include probiotics with your daily vitamin supplements.** The majority of our immune system is located in the stomach. Alexander Rinehart, a certified nutrition specialist, says, "Your gut is a barrier between the outside world and your body's internal world."
9. **Daily moderate exercise is recommended, but not too excessive.** Scott Weiss, MD, says that there is a 72-hour period following extreme exercise (for 40 to 60 minutes) that our bodies need to recover and are more susceptible to becoming ill.
10. **Get some fresh air.** A reason why colds and flu spread so quickly during the winter is that we have a tendency to spend more time inside, where the germs are, because it's cold.

As a closing thought, in addition to maintaining healthy lifestyle habits, the American Medical Association states that every physician should have a physician. Doctors who take care of themselves are better role models for their patients and, in return, remain healthy to take care of them. ↩

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# CAPAdvantage

## Have You Taken Advantage of CAPAdvantage?



No-Cost and Discounted Practice Management Services Exclusively for Members

As a never-ending advocate for our independent physician members, CAP is always looking for ways to help you remain safe and successful. One of those ways is our CAPAdvantage program.

Through CAPAdvantage, CAP members have exclusive access to a growing number of no-cost or highly discounted practice management products and services that we are able to secure through the power of your 12,000-member cooperative.

All CAPAdvantage program vendors have undergone extensive vetting by CAP, so you can feel confident that you're dealing with reputable, industry-leading organizations. A couple even offer a free trial period so you can test the waters (noted with an asterisk below).

The following lists the current products and services that fall under the CAPAdvantage umbrella:

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- Group purchasing program
- Medical practice financing
- Commercial real estate advisors
- CAP Visa Affinity credit card
- Residential mortgage services
- Physician-specialized financial planning and wealth management
- Pet insurance

### Regulatory, Reimbursement, and Risk Management Services

- HIPAA compliance solution
- Medical video recording platform\*
- Online compliance training
- Online reputation management/website development
- Office IT support
- Patient experience survey\*
- Revenue cycle management

### HR-Related Services

- HR/payroll/benefits administration solutions
- CAP Job Board

For additional information about any of these CAPAdvantage offerings, contact Sean O'Brien, Vice President of Membership Programs, at 888-645-7237, at [CAPAdvantage@CAPphysicians.com](mailto:CAPAdvantage@CAPphysicians.com), or visit the Practice Management section of the CAP website at [www.CAPphysicians.com/practice-management-services](http://www.CAPphysicians.com/practice-management-services). ➔

March 2018



# Case of the Month

by Gordon Ownby



## Set Your Internal Alarm with Noncompliant Patients

There will always be noncompliant patients. Physicians treating those patients need to foster a heightened sense of danger.

A patient nearing 40 years of age consulted with Dr. OB, an obstetrician who had delivered her previous five children. Ultrasound revealed an intrauterine single viable fetus with a gestation age of eight weeks and five days. Dr. OB asked the patient to return in two weeks, but she instead came back just over a month later, at which time the fetus was 13.5 weeks.

Though first trimester screening was still available by dates, Dr. OB instead planned a sonogram and second trimester blood work on the next visit, which was scheduled for three weeks hence. After the patient failed to show for a rescheduled visit, she finally returned to Dr. OB's office after a period of almost six weeks. At 20 weeks of gestation, the fetus was at the last day for a second trimester screening. Instead of doing a screening, Dr. OB planned for a one-hour glucose test on the next visit scheduled for about a month later.

The patient failed to show for that appointment and instead showed up when the fetus was at 30 weeks. An ultrasound showed a viable baby boy with adequate amniotic fluid. The patient failed to return for her scheduled visit two weeks later.

Approximately five weeks after her last visit with Dr. OB, the patient was admitted for labor and delivery through the emergency department. Dr. OB was called when an examination showed positive fetal movement. Among the findings were a decrease in fetal movement

and severe low amniotic fluid. Dr. OB arranged for the patient's transfer to a regional facility, where she gave birth to a son with Apgars of 8 and 9 and complete imperforate anus. Genetic testing confirmed the child's Down Syndrome.

The child's parents pursued a "wrongful life" lawsuit, which resolved informally prior to arbitration.

A review of Dr. OB's chart showed no signature by the mother on the California prenatal screening booklet, and Dr. OB testified in deposition that he did not do the first or second trimester screens because the ultrasounds showed the patient to be past the respective cutoffs.

Dr. OB's judgment on whether to perform those tests stood in sharp relief to a patient whose repeated, critical no-shows should have put him on red alert. Instead, the chart revealed no consideration of a referral and no discussion with the patient on the importance of prenatal testing.

A patient's noncompliance can be viewed as a challenge to a physician's plan of care. In the face of such a challenge, a physician who responds by reasserting his or her active role in meeting medical objectives can help avoid injuries and exposure. ➤

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