To Prescribe or Not To Prescribe

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Presented by:
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Disclosures

- None
OBJECTIVES

- List three common classes of medications which tend to be inappropriately prescribed.
- Identify at least two reasons unnecessary medications may be prescribed for patients.

LET’S LOOK AT THE LOSSES

- MICA closed 82 medication related claims and suits between 8/1/2012 - 8/31/2017
- 44% of these claims resulted in a fatality
- The three most prevalent drug classes represented in medication related claims were:
  - Anticoagulants 22%
  - Opioids 18%
  - Antibiotics 13%
- These three drug classes represented 53% of the medication related claims closed during this timeframe
MEDICATION RELATED INDEMNITY PAYMENTS

- 48% Closed With Indemnity Payment
- 52% Closed With No Indemnity Payment

FIVE MOST EXPENSIVE MISADVENTURES

- Medication Related
- Treatment Related
- Surgical Related
- Diagnosis Related
- Obstetrical Related
Contributing Factors

CONTRIBUTING FACTORS: ASSOCIATED PERSON

- Other Physician / Surgeon: 32%
- Nurse (RN or LPN): 19%
- Non-Licensed Staff: 10%
- Advanced Healthcare Professional: 30%
- Other: 9%
CONTRIBUTING FACTOR: COMMUNICATION

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Inadequate Communication with Patient/Family</td>
<td>34%</td>
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<tr>
<td>Inadequate Hand-Off</td>
<td>20%</td>
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<tr>
<td>Failure to Timely Communicate with Team</td>
<td>17%</td>
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<tr>
<td>Failure to Instruct Patient</td>
<td>13%</td>
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<td>Inadequate Communication of an Unexpected Critical Finding</td>
<td>7%</td>
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CONTRIBUTING FACTOR: SYSTEM RELATED

Top Three Issues

- Inadequate follow up or failure to close the loop
- Inadequate policies and procedures
- Inadequate supervision of staff
CONTRIBUTING FACTOR: MEDICAL RECORD ISSUES

78% of the medical record issues contributing to a medication related claim or lawsuit involved
incomplete notes

CONTRIBUTING PARTY

- Patient
- Family or Others Associated with Patient
ANTICOAGULANTS: ALL OR NOTHING CASE

- IM physician saw 51 y/o female to establish primary care
- Complex medical history that included antiphospholipid syndrome (Hughes Syndrome)
  - Had been on Coumadin for approximately 6 years
- Over the next 6 years IM managed Coumadin therapy
- The result of a routine INR draw was 4.3
- The next day after the draw and before the physician had called the INR results, the patient called and reported she was having oral surgery in 4 days and asked when to stop Coumadin
ANTICOAGULANT (CONT.)

- Physician called patient and instructed her to decrease Coumadin from 7mg daily to 5 mg daily
  - Further instructed to cancel surgery and reschedule when INR in therapeutic range
  - Stop Coumadin 7 days prior to surgery

- One week later patient was called by RN and instructed patient to take Coumadin 5 mg, BID and reminded patient to stop Coumadin 7 days before oral surgery
  - Patient reported surgery scheduled in 2 weeks

- Patient stopped Coumadin 7 days before surgery – post-op instruction included contacting PCP regarding resuming Coumadin

- The next day the patient called to schedule an appointment for INR
  - This would be on a Friday, but physician’s schedule was full
  - Appointment with PA offered but patient said she would wait until Monday to come in

ANTICOAGULANT (CONT.)

- On Monday, patient’s INR was 1.1 and she was instructed to take Coumadin 10 mg daily.

- The next day the patient presented to ED with complaints of headache, left-sided weakness and confusion

- Diagnosed with embolic right frontal parietal infarct
  - Impairment of coordination, cognition, speech, balance and strength

- Lawsuit settled in mid-six-figure range

- Defense attorney called this an “all or nothing case” because it depended on who the jury believed
  - Patient instructions were not consistently documented
  - Experts were critical regarding 7 day discontinuation and that INR was not re-assessed
Opioid Therapy

DATA SHARING PROJECTS (DSP):
OPIOID-RELATED CLAIMS ANALYSIS FOR 2006-2015

PIAA DSP OPIOID CLAIMS TRENDS ACROSS TWO 5-YEAR PERIODS

<table>
<thead>
<tr>
<th></th>
<th>2006-2010</th>
<th>2011-2015</th>
<th>Increase</th>
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<tbody>
<tr>
<td>Paid/Closed Ratio</td>
<td>20%</td>
<td>40%</td>
<td>20 ppt.*</td>
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<tr>
<td>Average Indemnity</td>
<td>$200,000</td>
<td>$265,000</td>
<td>32%</td>
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<tr>
<td>Average Defense Costs</td>
<td>$35,000</td>
<td>$70,000</td>
<td>100%</td>
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*Percentage points


OPIOID THERAPY: CASE EXAMPLE

- A 42 y/o male employed as airline mechanic seen by PCP for first time
  - Recently moved to state
  - History included hypertension and multiple carpal tunnel surgeries in last 2 years
    - Also seeing a psychiatrist and receiving Cymbalta and Xanax
- Patient reported continued pain from surgeries for which Oxycodone was only relief
- Patient was asked to sign authorization for release of prior records but patient left without signing
- Patient called office next day stating employer required a random drug test asked physician to tell them his Oxycodone script was twice as much as prescribed
OPIOID (CONT.)

- Ten days later physician received fax from pharmacy warning that patient was taking benzodiazepines and Oxycodone which could result in respiratory depression hypotension, profound sedation or coma
  - Physician spoke with patient and was told psychiatrist changed meds and he was no longer taking benzodiazepines
- Three weeks later patient called to report a death in family required him to travel across the country and requested early refill of Oxycodone
  - Physician would not refill at this time but gave patient a script dated for the appropriate refill date

OPIOID (CONT.)

- Patient filled the prescription on the date allowed
- The same day was on a flight to New Jersey – on landing was found unconscious in his seat
- The patient passed away the next day
- Autopsy report listed acute intoxication due to combined effects of Oxycodone, Xanax and Estazolam
- Unaware of patient’s death, physician contacted patient’s wife and expressed concern for addiction
- Wife retained an attorney and sent physician a demand letter for $10M
- Allegations: failure to obtain previous records, failure to ensure the patient completed necessary paperwork, failure to follow up on the medication alert from the pharmacy, and failure to monitor the patient
- Settled in high six-figure range
OPIOIDS: PROBLEMS WITH CASE

1. Conversation regarding discontinuation of benzodiazepine was not documented
2. Response to pharmacy warning not documented
3. Records from previous treating physician never requested
4. Possible HIPAA violation

Antibiotics
**ANTIBIOTICS**

- 13% of MICA's medication related closed claims and suits related to antibiotics
- CDC estimates that 47 million excess prescriptions for antibiotics\(^1\)
- Additional risks for patients include
  - Allergic reactions
  - Clostridium difficile
  - Interactions with other medications


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**SURVEY: U.S. DOCTORS PRESCRIBING UNNECESSARY DRUGS**

- 5000 American College of Physician members were asked to identify two treatments frequently used by internists that are unlikely to provide high value care to patients
- Antibiotics
  - 27% respondents said antibiotics administered when they have no benefit
  - Most commonly prescribed to treat upper respiratory infections even though most are caused by viruses
  - Expense versus value
    - Value is a function of benefits, risks and cost of intervention

ANTIBIOTIC: CASE EXAMPLE

- 54 y/o male presented to establish care with primary care physician
- History included hypertension and a chest x-ray revealed mild cardiomegaly with globular heart – referred to cardiologist
- Five years later, testing revealed:
  - Non-ischemic cardiomyopathy, probably secondary to viral cardiomyopathy, plus possible alcohol contributing and
  - Atrial fibrillation
- Medications:
  - Digoxin, Coumadin, Lopressor and Diovan

ANTIBIOTIC (CONT.)

- The next year the patient had failed direct current cardioversion and Multaq (dronedarone) administration
- The cardiologist admitted the patient (now 60 y/o) to hospital and started him on Tikosyn (dofetilide)
  - Patient was educated on risks and benefits
  - Specifically told not to take Bactrim
  - Converted to sinus rhythm after a few doses of Tikosyn
- Patient seen in PCP’s office by PA and informed office he was taking Tikosyn
  - Requested the PA complete a crossbow permit application for him
ANTIBIOTIC (CONT.)

- Over the next two years the patient continued to regularly see his PCP and cardiologist – it was noted that he experienced atrial fibrillation and ventricular tachycardia while on Tikosyn
- Patient was seen in PCP’s office by PA with complaint of six-inch vertical wound on lower left leg (knife slipped while skinning a rabbit)
- Patient was given Ceftriaxone (IM) and a prescription for Bactrim DS – told to return in three days
- PA discussed case with PCP who signed off on note
- Returned in three days – wound culture performed and Ceftriaxone (IM) was administered
- Instructed to continue Bactrim DS, return in two weeks – again supervising physician signed off

ANTIBIOTIC (CONT.)

- Ten days later patient collapsed while walking into post office
- EMS arrived and found patient in v-tach
- Taken to ED in full cardiac arrest – resuscitated for 25 to 30 minutes before B/P and rhythm stabilized
- Patient suffered severe neurologic injury, life support removed
- Lawsuit filed against pharmacy, PA and physician
- Allegations included:
  - Failure of physician to appropriately supervise PA
  - PA failed to meet the standard of care by not recognizing the significant risk of ordering Bactrim DS for a patient taking Tikosyn
  - Pharmacy inappropriately filled the prescription for Bactrim DS
- Global settlement in seven-figure range
TO PRESCRIBE OR NOT TO PRESCRIBE

PRESSURE NOT TO PRESCRIBE
- Pressure From regulatory agencies and other organizations
  - Opioids
  - Watchful waiting encouraged with antibiotics
- From formularies
- From patients who cannot afford medication

PRESSURE TO PRESCRIBE
- From patients or family members
- From advertising
- Sincere desire to provide relief

WHAT CAN YOU DO TO REDUCE YOUR LIABILITY?
- Counsel patient / family on medication risks, benefits, side effects and alternatives
- Provide written medication instructions and verbally review them with patient/family
- If medication carries significant risks, get a consent form signed
  - Use pain management contract when prescribing opioids
- Use drug information aids such as phone apps or websites
- Pay attention to pop-up alerts on EMR
- Address patient noncompliance with medication regimen
REDUCING LIABILITY (CONT.)

- Develop policies and procedure regarding medication management and monitor that they are consistently followed
  - For opioid therapy this will include drug screens
- Document staff competencies
- Document objective rationale for prescribing
- Seek to coordinate care between primary and specialist care to ensure responsibility for medication management is clearly delineated
- Finally, document, document, document

THANK YOU FOR INVITING US!

Questions