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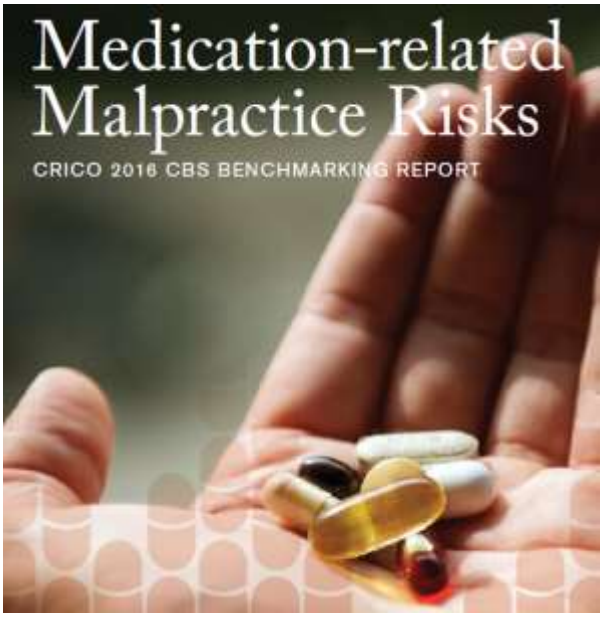
OPIOIDS:
Principles of Prescribing and Patient Management

Shari Moore, RN, BSN
Vice-President, Risk Management
PLICO/a MedPro Group Berkshire Hathaway company

Objectives

- Recognize the impact of medication errors in professional liability claims
- Discuss examples of medication related events leading to patient harm
- Identify strategies to address medication errors
- Discuss the scope of the opioid crisis in the US and Oklahoma
- Describe interventions in healthcare that have been shown to reduce the use of opioid medications
- Discuss the current legal requirements for opioid prescribing in Oklahoma



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Malpractice Risks with

Medication

1 in 9 malpractice cases involves a medication-related problem

We examined 28,527 cases asserted from 2010–2014 and identified 3,067 in which medication issues contributed to patient harm.

The most commonly identified categories were:

- **18%** analgesics
- **17%** anticoagulants
- **13%** antibiotics
- **8%** cardiovascular

N=2,187 cases in which the specific medication was identified

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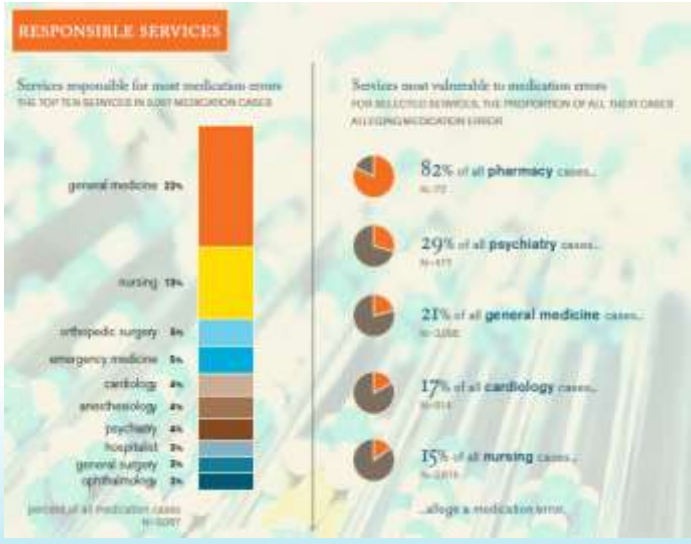
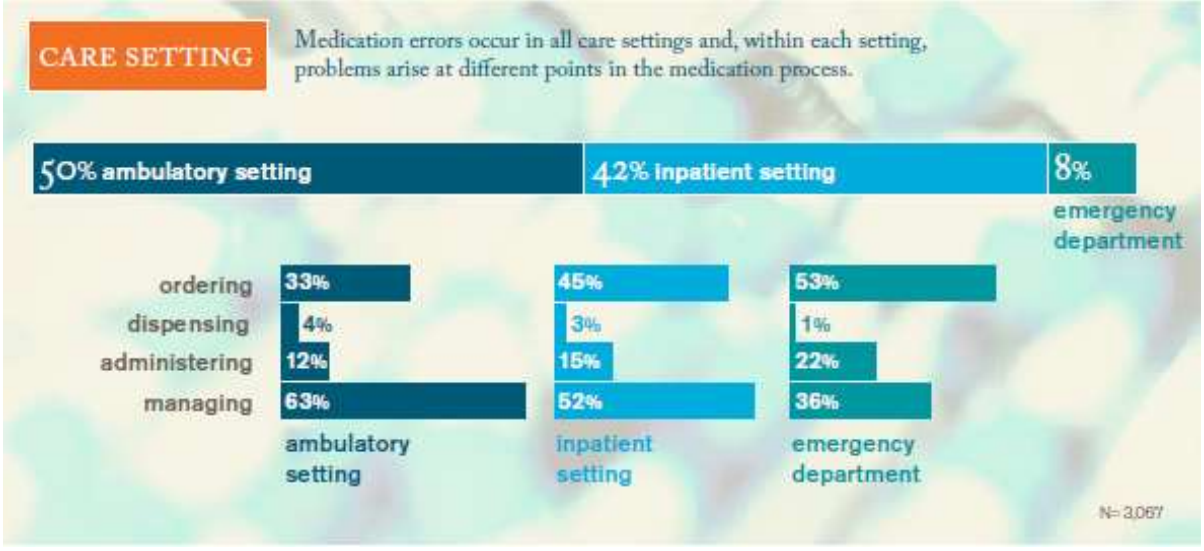
Who?



Where?



The Medication Process

- Ordering
  - From the point a decision is made to order/prescribe a medication until that order is received by the pharmacy or other dispensing service
- Dispensing
  - From the point the order is received by the dispensing service until it is administered to the patient
- Administering
  - The act of delivering the right medication to the right patient in the right dose via the right route at the right time
- Monitoring and Managing
  - From the point the patient receives a medication, including refills, until he or she is no longer taking it

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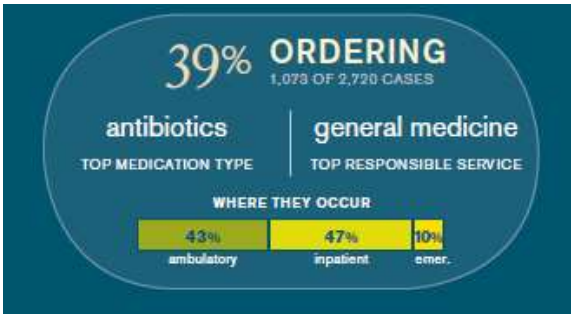
Breakdowns in the Medication Process

- Ordering
  - The clinician ordered the wrong medication for the patient's condition
  - The clinician ordered a medication contraindicated by:
    - a patient's known allergy
    - a patient's concurrent medications
    - a patient's underlying comorbidity
  - The clinician's order included a wrong dose or route



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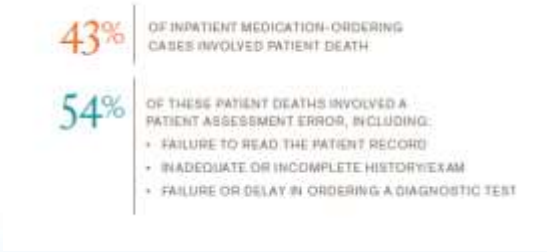
Ordering Errors

Inadequate assessment of hospitalized patients prior to medication ordering increases the likelihood of severe injuries or death.

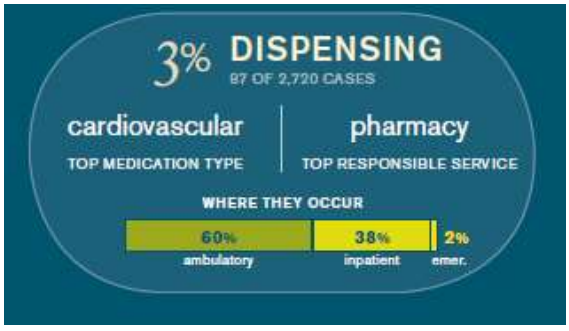


Ordering Errors

- Opportunities for improving ordering safety:
  - Robust medication reconciliation
  - Pharmacist-managed allergy registries
  - Medication-related decision support tools
  - Standardized assessment of inpatients prior to medication ordering

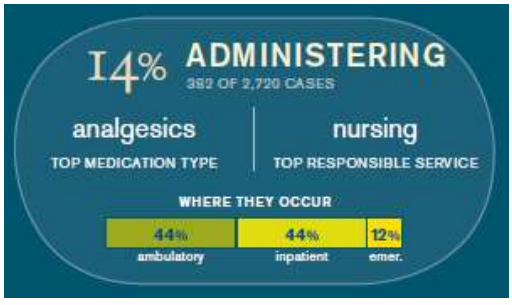
Breakdowns in the Medication Process

- Dispensing
  - The pharmacy dispensed the wrong medication, dosage or composition
  - The pharmacy incorrectly prepared the medication
  - The pharmacy failed to recognize and flag an allergy or an intolerance to a dispensed medication



Breakdowns in the Medication Process

- Administering
  - Wrong patient
  - Wrong time
  - Wrong medication
  - Wrong dose
  - Wrong route

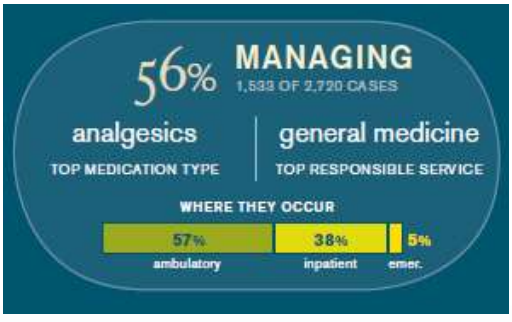


Dispensing and Administering Errors

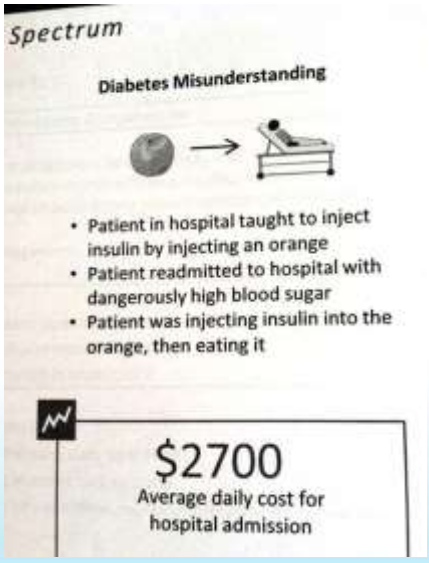
- Opportunities for improving dispensing and administering safety:
  - Monitor adherence to policies and procedures
  - Structured practice for dispensing cabinets
  - Question atypical medication orders/deliveries
  - Identify and improve faulty systems
    - Look-alike packaging
    - Easy overrides
    - EHR challenges
  - Communication
    - Provider to provider
    - Patient to provider

Breakdowns in the Medication Process

- Managing
  - Inadequate monitoring or assessment of:
    - A patient's adherence to his/her medication regimen
    - A patient's physiological response to new, changed or short-term medications
    - A patient's physiological response to long-term medications
    - Abrupt or temporary alterations in a patient's medication regimen
  - Inadequate education to patient/family about the risks related to taking, incorrectly taking or ceasing to take medication



the "Non-Compliant" Patient



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Managing Errors

- Opportunities for improving monitoring and management safety
  - Medication-specific patient education
  - Standardized outreach (i.e., phone call) to recently discharged or non-adherent patients
  - Systematic reconciliation with change of status/care transitions/discharge

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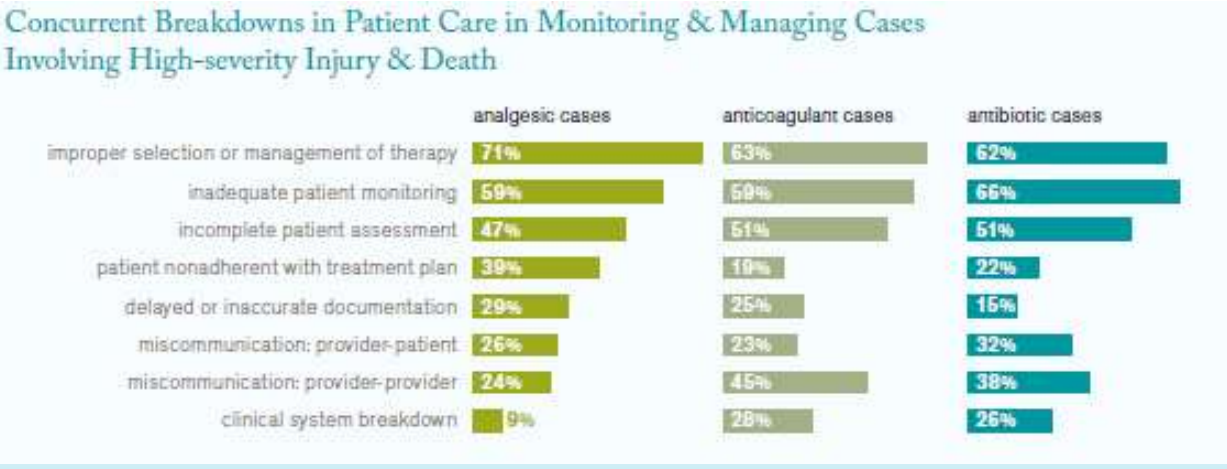
Managing Errors



Managing Errors-Antibiotics

- Opportunities for improving antibiotic management
  - Monitor drug-drug interactions, allergies
  - Antibiotic stewardship

Managing Errors-Anticoagulants

- Opportunities for improving anticoagulant management
  - Assess competence of patient (or family member) as a partner in care
  - Anticoagulant clinics

Managing Errors-Analgesics

Which factors affect the probability of patient death?

To identify the strongest predictors that a medication-related malpractice claim would involve a patient who died, 3,067 cases asserted from 2010–2014 were assessed.

+163%

ANALGESIC-RELATED ERRORS INCREASE THE ODDS OF A CASE INVOLVING A PATIENT DEATH BY 163%

- Opportunities for improving analgesic management
  - Provider education on post-operative pain management
  - Vigilance re: polypharmacy and medication reconciliation

Managing Errors-Analgesics

- Risks beyond malpractice
  - Regulatory Agencies
    - DEA
    - OBNDD
  - Licensure Boards
    - Oklahoma State Board of Osteopathic Examiners
    - Oklahoma Medical Board
    - Oklahoma Nursing Board
  - Criminal charges

Managing Errors-Analgesics

Another physician is indicted for opioid overdose deaths—and the DEA warns it's 'sending a message'

In 2015, Hsiu-Ying "Lisa" Tseng, M.D., faced a trial on murder charges for writing painkiller prescriptions that led to the death of three young men and was sentenced to 30 years in prison.


Company accused of deception

One family loses two sons to opioid epidemic: It's 'overwhelming'


Feds seeking a portion of $270M opioid settlement

By Carmen Forman
Staff writer
cforman@oklahoman.com

The federal government is seeking a portion of Oklahoma's $270 million settlement with opioid maker aware of the state's landmark settlement with the maker of OxyContin and "the federal government is entitled to a portion of that amount."

In the two-page letter, Bill Brooks, the director of Centers for Medicaid and CHIP Becky Pasternik-Ikard to respond with an explanation of what the state believes to be Medicaid's portion of the settlement.

Gov. Kevin Stitt blasted Thursday he disagrees with the idea that Oklahoma owes further comments."

Stitt declined to elaborate on what exactly he disagrees with, saying he will hold off commenting further to avoid say anything that could hurt the state's position in ongoing litigation against opioid

Managing Errors-Analgesics

Unprecedented prosecution: Doctor charged with murder after prescribing 'excessive' opioids

According to court documents, prosecutors allege that between January 2010 and October 2014, Nichols prescribed more than three million doses of controlled dangerous substances. Five people who died were prescribed more than 1,800 opioid pills in the same months of their deaths.

National issues

- Opioid deaths
  - Major reason for CDC, national and state legislative involvement
  - Over 67,000 overdose deaths in 2017, down b 4.6% in 2018
  - Diversion: most deaths are from "non-prescribed" opioids
  - Lethal combinations especially with benzodiazepines
- Illegal opioids outpacing prescribed opioids

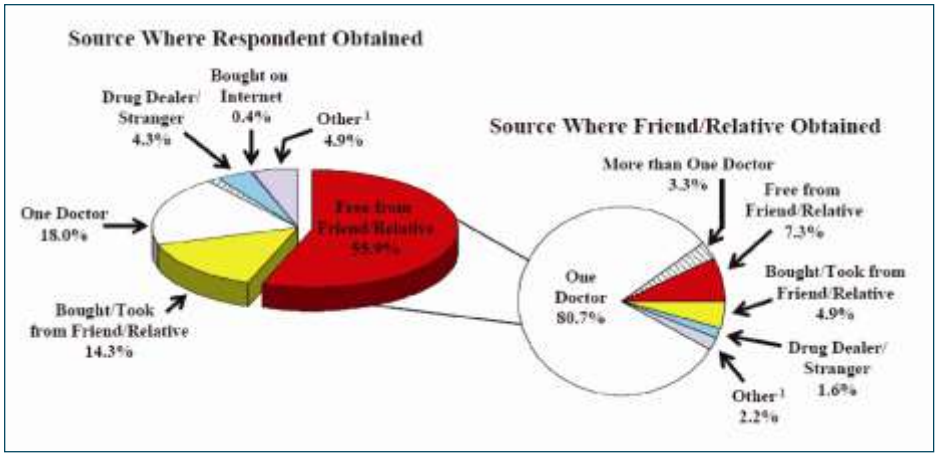
National strategies

- CMS actions at 90 MMEs
- DEA reducing manufacturing of opioids 25% in 2017 and a further 20% in 2018 and more in 2019
- Pharmacy chains and insurance payors with varying policies
- Numerous states capping at <90-100 MMEs
- Numerous laws regarding initial prescriptions
- Increased investigations of providers and pharmacies

Opioid overdose surveillance 2017

- 11 states participated including Oklahoma
- 59% of deaths due to illicit opioids
- 18.5% combined prescription and illicit opioids
- 18% positive for only prescription opioids
- 50% of these deaths also positive for benzodiazepine

"Findings indicate that illicit opioids were a major driver of deaths… and were detected in approximately three of four deaths"



Managing Errors-Analgesics

Things to Consider

- Sustained pain relief over time not established
- Improved function and quality of life uncertain
- Serious risks associated with opioids

Managing Errors-Analgesics

- The “ideal” patient
  - Well defined pathology
  - Good insight and desire to improve
  - Willing to “work hard” to improve
  - Interested in other modalities and work-up
  - Not focused on opioids but desire to improve
  - Good understanding that opioids will provide “some” relief to help them improve

Managing Errors-Analgesics

- The “wrong” patient
  - Diffuse and poorly localized pain
  - No interest in work-up or other modalities
  - Focus is on opioids alone
  - Poor insight and unrealistic expectations
  - Poorly motivated with no desire to “work hard”
  - Poor functionality

Senate Bill 1446-effective November 1, 2018
Senate Bill 848-effective May 21, 2019

SB 1446 was introduced as an initial effort to implement strict standards for prescribing and managing opioid medications. SB 848 was introduced to provide clarity and guidance to SB 1446. Relevant impact to the physician's practice will be highlighted.

Opiate or opioid means any Schedule II, III, IV or V substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

Senate Bill 1446/848

- Major points of emphasis
  - Addiction and abuse
  - Dose reduction and cessation
  - Emphasis on lower MMEs
  - Alternative non-pharmacological/non-opioid therapies
    - Behavioral therapies
    - Functional therapies
    - Adjunctive medications
  - **Strong language for assessing, documenting and specifying your care of the opioid patient**

Senate Bill 1446/848

- Chronic opioid therapy
  - Consensus agreement that it can be useful in carefully selected patients with moderate to severe pain
  - These guidelines demand constant attention to attempts at lowering doses
  - Absolutely demands:
    - Compliance
    - Documentation
    - Vigilant monitoring for abuse and diversion
    - Assessment of opioid related side effects
    - Understanding of opioid use in chronic pain

Senate Bill 1446/848

- Patient selection and risk stratification
  - History, physical examination and diagnostic testing
  - Psychosocial risk assessment
  - Expectations: physician and patient
  - Emphasizes documentation of the progress of the patient to the treatment objectives

Senate Bill 1446/848

- Patients at risk
  - Psychosocial issues
  - History of addiction
    - Risk of relapse, harm and treatment failure
  - Adverse Childhood Experience (ACE)
    - Abuse, neglect, household dysfunction and traumatic stressors
  - Poor motivation and lack of insight
  - Disability, Medicaid and even prior criminal activity
  - Unrealistic expectations
  - Prior overdose

Senate Bill 1446/848

- Chronic opioid therapy

When an opioid drug is continuously prescribed for 3 months or more for chronic pain, the practitioner shall:

- Review and document at a minimum every 3 months
  - The course of treatment
  - Any new information about the etiology of the pain
  - Progress of the patient toward treatment objectives
- Periodically make reasonable efforts, *"unless clinically contraindicated,"* to
  - Stop use of controlled substance
  - Attempt to decrease the dosage
  - Try other medications and treatment modalities in an effort to reduce the potential for abuse or development of an opioid use disorder as defined by the American Psychiatric Association

Senate Bill 1446/848

- Chronic opioid therapy
  - Check PMP
  - Monitor the compliance with the pain management agreement and any recommendations that the patient seek a referral
  - DOCUMENT with SPECIFICITY the efforts undertaken
  - In the first year of the patient-provider agreement, assess patient prior to every renewal to determine if the patient is experiencing problems with an opioid use disorder *and* ***document*** the results of that assessment.
  - Following one (1) year of compliance with the patient-provider agreement, the practitioner shall assess the patient at a minimum of every six (6) months.

Senate Bill 1446/848

- Acute opioid therapy
  - Initial 7 day prescription
    - Acute pain in an opioid naïve patient
    - Acute pain episode due to surgery or new condition in a patient on opioids.
      - Dental procedure
      - Renal stone
      - ER visit for unrelated pain complaint
    - Shall be for the lowest effective dose of immediate-release opioid drug
      - Upon receipt of a valid Schedule II opioid prescription issued pursuant to the provision of Section 2-309I of Title 63 of the Oklahoma Statutes, a pharmacist shall fill the prescription to the specified dose, and shall not be permitted to fill a different dosage than what is prescribed. However, the pharmacist maintains the right not to fill the valid opioid prescription.
    - Prescriptions must state “for acute pain”
    - Must check PMP (document and/or include in chart)
    - Failure to check PMP may, after investigation be grounds for discipline

Senate Bill 1446/848

- Acute opioid therapy
  - Initial 7 day prescription
    - Take and ***document*** a thorough medical history
    - Include experience of the patient with non-opioid medication and non-pharmacological pain management
    - Screen for substance abuse and addiction
    - Conduct and ***document*** a physical examination
    - Develop a treatment plan with particular attention focused on determining the cause of pain of the patient
    - Patient-Provider Agreement required for under 18 and pregnancy

SAMPLE

OPIOID THERAPY PATIENT PROVIDER AGREEMENT

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to ensure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. Our goal is to provide you with the best quality treatment of your pain. To accomplish this goal, your physician will customize your treatment plan to best fit your healthcare needs. Your pain management treatment plan may include, but is not limited to, injection therapy, physical therapy, medication therapy, psychological counseling, relaxation therapy and exercise and weight loss programs. When opioids and other controlled medications are the best option, it is important to review and follow the policies to ensure your safety and our continued ability to treat you in the most effective way possible.

Please read this carefully, as these policies will be enforced. If you do not understand any of the information below, or require additional clarification on the policies of this practice regarding prescribed medication, please ask. You are required to initial next to each section and sign this agreement stating your understanding and compliance before receiving any pain medication.

_____ The pain management treatment plan has been discussed, understood, and agreed to by you and your physician. You understand the reason why this prescription is necessary. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to you, and you still desire to receive medications for the treatment of your chronic pain. You are expected to comply with and actively participate in all aspects of the plan and the responsible use of medications.

_____ You understand that opioids and other controlled medications are prescribed to increase your function, activity level and quality of life. These medications may reduce your pain but may not provide complete relief. Your treatment plan will be evaluated, at least, every three months. You agree to fully communicate your pain level, functional ability and any side effects of the medication to the best of your ability. If these aspects do not improve with these medications, the risks of the medication outweigh the benefits or there is the potential of negative effects related to another medical condition or medication, your provider may reduce or eliminate the medications from your treatment plan.

_____ You agree to inform your physician of all medications you are taking, including herbal remedies, since Opioid medications can interact with over-the-counter medications and other prescribed medications. This is especially true of cough syrup that contains alcohol, codeine or hydrocodone.

_____ To ensure your safety, **it is your obligation and responsibility to take medications exactly as prescribed by your physician** (dose and frequency). You understand that these medications can lead to physical dependence and/or addiction, and can be associated with other risks including, but not limited to, decreased effectiveness, physical and psychological dependence, confusion, itching, difficulty urinating, constipation, allergic reactions, decreased sex drive, drowsiness, nausea or vomiting, trouble driving and/or operating machinery. Taking more opioids than prescribed or mixing sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression.

_____ You agree **to only take pain medications prescribed by the providers of this medical practice**. Do not take any pain medication given to you by another person or provider (health, dental, clinic or emergency department) or increase your dosage without authorization from this physician. You understand that taking more medication than prescribed or taking pain medication from another source may lead to **overdose** that could result in slowed or stopped breathing, brain injury from lack of oxygen, coma, or death.

_____ You understand that there is an increased risk of overdose associated with the use of opioids in combination with medications used to treat anxiety disorders, panic attacks, insomnia or seizures (benzodiazepines), alcohol and other central nervous system depressants. If you are prescribed these medications by another provider at any time during your

1 of 3

Senate Bill 1446/848

- Acute opioid therapy
  - Initial 7 day prescription
    - Specific documentation requirements
      - Risks of addiction and overdose and risks of combining alcohol, benzodiazepines and other central nervous system depressants
      - The reasons why the prescription is necessary
      - Alternative treatments that may be available
      - Specifically that opioids are highly addictive, even when taken as prescribed
      - Risk of developing physical and psychological dependence on the controlled dangerous substance
      - Taking more opioids than prescribed can result in fatal respiratory depression
      - Mixing sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression

Senate Bill 1446/848

- Acute opioid therapy
  - Subsequent 7 day prescription
    - A second 7-day prescription of an immediate-release opioid drug in a quantity not to exceed seven (7) days may be issued on the same day as the initial prescription if:
      - The subsequent prescription is due to a major surgical procedure and/or “confined to home” status as defined in 42 U.S.C. 1395n(a)
      - The practitioner provides the subsequent prescription on the same day as the initial prescription (prescription must state “acute pain”)
      - The practitioner provides written instruction on the subsequent prescription indicating the earliest date on which the prescription may be filled (i.e. “do not fill until” date)
      - The subsequent prescription is dispensed no more than five (5) days after the “do not fill until” date indicated on the prescription

-COMPLIANCE AND BEST PRACTICE FOR AN ACT REGULATING THE USE OF OPIOID DRUGS OKLAHOMA SENATE BILLS 1446 & 848

Senate Bill 1446/848

- Acute opioid therapy
  - Subsequent 7 day prescription

Following the initial seven (7) days, after consultation* (in person or by telephone), a subsequent 7-day prescription may be issued if the prescriber determines the prescription is necessary and appropriate, documents the rationale for prescribing, and determines and documents the prescription does not present undue risk of abuse, addiction or diversion. * For best practice, the 7-day consultation should be performed by the physician; however, it does not appear to be required. If a medication needs to be changed due to allergy, ineffective dose or other medical condition, document thoroughly in the record the need and rationale for change.

-COMPLIANCE AND BEST PRACTICE FOR AN ACT REGULATING THE USE OF OPIOID DRUGS OKLAHOMA SENATE BILLS 1446 & 848

Senate Bill 1446/848

- Acute opioid therapy
  - Subsequent 7 day prescription
    - Practitioner determines that the prescription is necessary
    - ***Document*** rational for subsequent prescription
    - Practitioner determines the subsequent script does not present a risk of abuse, addiction or diversion and ***documents*** in the chart
    - Practitioner: physician; podiatrist; physician's assistant under the supervision of a licensed medical doctor or osteopathic physician; or mid-level practitioner licensed, registered or otherwise permitted to prescribe, distribute, dispense…or administer a controlled dangerous substance in the course of professional practice…in this state
    - "Mid-level practitioner" means an Advanced Practice Registered Nurse as defined and within parameters specified in Section 567.3a of Title 59 of the Oklahoma Statutes

Senate Bill 1446/848

- Acute opioid therapy
  - Prior to issuing a 3rd prescription
    - Similar to issuing the initial prescription
    - Practitioner shall discuss and ***document*** with a note in medical record of the risks not limited to:
      - Risks of addiction and overdose and risks of combining alcohol, benzodiazepines and other central nervous system depressants
      - The reasons why the prescription is necessary
      - Alternative treatments that may be available
      - Specifically that opioids are highly addictive, even when taken as prescribed
      - Risk of developing physical and psychological dependence on the controlled dangerous substance
      - Taking more opioids than prescribed can result in fatal respiratory depression
      - Mixing sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression

Senate Bill 1446/848

- Acute opioid therapy
  - Prior to issuing a 3rd prescription
    - Patient-Provider agreement
      - Provides informed consent
      - Essentially an opioid “contract”
      - Needed before the 3rd prescription and for chronic pain treatment
      - Needed at initial prescription for under 18 and pregnancy

Senate Bill 1446/848

- Acute opioid therapy
  - Prior to issuing a 3rd prescription
    - Patient-Provider agreement required elements
      - Explain the possible risk of development of physical or psychological dependence in the patient and prevent the possible development of addiction
      - Document the understanding of both the practitioner and the patient regarding the patient-provider agreement of the patient
      - Establish the rights of the patient in association with treatment and the obligations of the patient in relation to the responsible use, discontinuation of use, and storage of opioid drugs, including any restrictions on the refill of prescriptions or the acceptance of opioid prescriptions from practitioners
      - Identify the specific medications and other modes of treatment, including physical therapy or exercise, relaxation or psychological counseling, that are included as a part of the patient-provider agreement
      - Specify the measures the practitioner may employ to monitor the compliance or the patient including, but not limited to, random specimen screens and pill counts
      - Delineate the process for terminating the agreement, including the consequences if the practitioner has reason to believe that the patient is not complying wit the terms of the agreement

Senate Bill 1446/848

- Patient-Provider agreement

Compliance with the “consent items” shall constitute a valid, informed consent for opioid Therapy. The practitioner shall be held harmless from civil litigation for failure to treat pain if the event occurs because of nonadherence by the patient with any of the provisions of the patient-provider agreement.

Senate Bill 1446/848

- Further requirements
  - Any prescription for acute pain pursuant to this section shall have the words "acute pain" notated on the face of the prescription by the practitioner
  - Any prescription for chronic pain pursuant to this section shall have the words "chronic pain" notated on the face of the prescription by the practitioner
  - All disciplines have the following noted as "unprofessional conduct"
    - Prescribing, dispensing or administering opioid drugs in excess of the maximum limits authorized in Section 2-309I of Title 63 of the Oklahoma Statutes.
      - Thirty-day supply
  - Educational requirements (pain management or opioid use or addiction)
    - MDs/DOs-1 hour
    - PAs-1 hour
    - APRNs-2 hours
    - Podiatrists-2 hours

Senate Bill 1446/848

- Further requirements
  - "Any practitioner authorized to prescribe an opioid drug shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the prescribing practitioner and "qualifying opioid therapy patient".
  - PPA in combination with written policy
- Qualifying opioid therapy patient
  - *A patient requiring opioid treatment for more than 3 months*
    - Does not matter if low dose or high dose
  - *A patient who is prescribed a benzodiazepines and opioids together for more than one twenty-four hour period*
    - What about different doctors prescribing each?
    - Psychiatrist and PCP
  - *A patient prescribed a dose of opioids over 100 MMEs*

COMPLIANCE AND BEST PRACTICE FOR AN ACT REGULATING THE USE OF OPIOID DRUGS
OKLAHOMA SENATE BILLS 1448 & 1642

Pain Management of Tulsa

SAMPLE: Written Policy for Physicians as required for the "Qualifying Opioid Patient"

The appropriate management of chronic pain should rely primarily on non-opioid therapies and should incorporate a multi-model treatment plan to obtain the best outcome for the patient. We utilize non-opioid therapies such as adjuvant medications, psychological assessments, physical therapy, manipulative therapy and other modalities for our patients.

We support the CDC position that opioids are not recommended for routine use in chronic pain but that they can be helpful in those patients with moderate to severe pain unrelieved by other treatment modalities.

At regular three month intervals the "qualifying opioid patient" is evaluated and a physical examination is performed. The course of the treatment is reviewed as well as any new information on the etiology of the pain. The progress of the patient toward treatment objectives is evaluated and documented. Discussion of other treatment modalities are addressed.

Periodically, reasonable efforts are made to possibly change therapy or reduce the opioid dose. At times, it may be clinically contraindicated to reduce the opioid dose or eliminate the opioid. We realize that opioids have risks that require vigilance to identify patients with Opioid Use Disorder, addiction and diversion. We rely heavily on risk mitigation strategies to achieve the best outcomes and safety for our patients. These risk mitigation strategies include, but are not limited to, urine drug screening, pill counts, PMP queries and risk assessments.
Through the utilization of the signed Patient-Provider Agreement we educate our patients on their personal responsibility to be compliant with their medication therapy and require that they read the Agreement in full and ask any questions they may have.
Our physicians realize we have an obligation to refer patients for the appropriate treatment when we are concerned that a patient exhibits behaviors consistent with abuse and addiction.

Adopted: [Date] _____

Signature: _____

[Print Practitioner Name]

Senate Bill 1446/848

- OBNDD is authorized to:
  - Provide unsolicited notification to the licensing board:
    - If a patient has received one or more prescriptions for CDS in quantities or frequency inconsistent with recognized standards or safe practice
    - If a practitioner has exhibited prescriptive behavior indicating potentially problematic prescribing patterns
    - Failure to check PMP as required under law may, after investigation, be grounds for licensing board to take disciplinary action
- OBNDD shall report:
  - Registration of prescribers and dispensers in the central repository (PMP)
  - Data regarding the checking and using of the PMP
  - Data from boards regarding continuing education
  - Effects on the prescriber work force
  - Changes in the number of patients taking more than 100 MMEs
  - Data regarding quantity of opioid medications prescribed in MMEs

Senate Bill 1446/848

- Shall not apply to patients with active cancer pain, end of life, palliative, hospice care or long term care facility
- Shall not apply to medications for the treatment of substance abuse or opioid dependence
- "The provider shall be held harmless from civil litigation for failure to treat pain if the event occurs because of the non-adherence by the patient with any of the provisions in the patient-provider agreement".

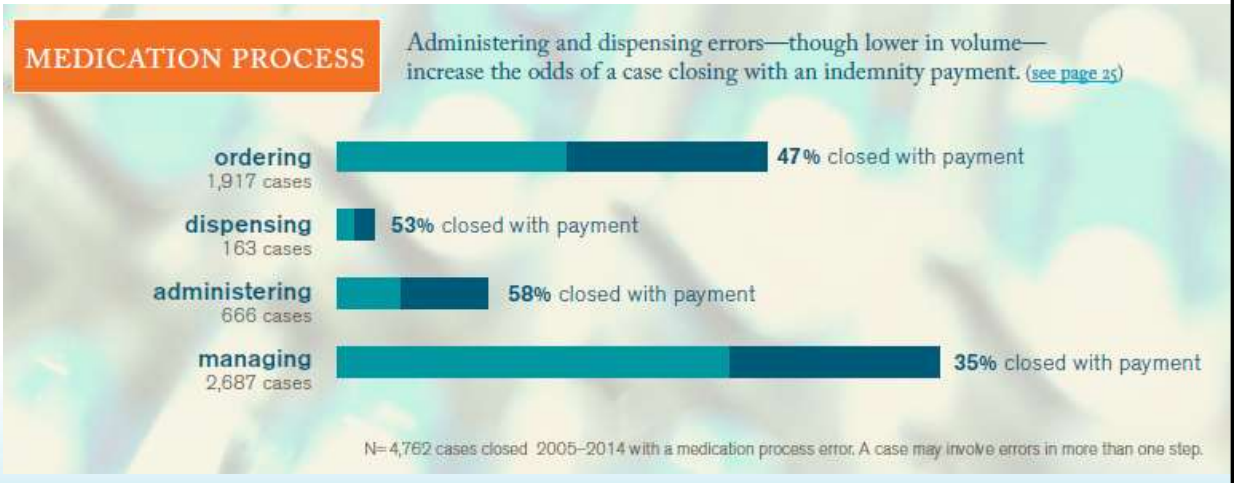
Consequences

Consequences

Driven by an above average injury severity profile, medication-related cases are more likely to close with an indemnity payment

	MEDICATION CASES	ALL CASES
CASES CLOSED	5,279	43,521
CLOSED WITH PAYMENT	41%	32%
CLOSED WITH PAYMENT >$1M	4%	2%
AVERAGE INDEMNITY	$453K	$354K

Consequences



What to consider with each medication

- Is the patient already taking any prescribed medications, and are they helping?
- Is the patient taking any over-the-counter or recreational drugs?
- Is another clinician prescribing for or monitoring this patient?
- Does the patient have any drug allergies?
- Did I double check or confirm the drug, dose, and route?
- Do I understand the indication for each medication and any potential contraindications?
- Will the patient heed any medication-related restrictions?
- How does this patient's medications impact tests or treatment I might order?
- Are there psycho-social issues that might interfere with adherence?
- Does the patient need assistance with his/her medication regimen, and is help available?

Final Thoughts

- Medication-related treatment encompasses the vast majority of patients and virtually every healthcare service area. This study validates that the risk of medication error is universal.
- When compared with non-medication events, medication-related malpractice cases:
  - Involve a larger percentage of deaths
  - More frequently close with an indemnity payment
  - Close with considerably higher average payments
- A commitment to communication and coordination is essential to preventing medication errors, patient harm and allegations of malpractice.
- Medication errors are a top patient safety failure in the outpatient setting making it a prime area of opportunity for improvement.

Resources

Institute for Safe Medication Practices www.ispm.org

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1er.pdf

Applying CDC's Guideline for Prescribing Opioids: An Online Training Series for Healthcare Providers https://www.cdc.gov/drugoverdose/training/

MedPro *Medication Inventory Management for Healthcare Practices Checklist* https://www.medpro.com/documents/10502/2899801/Checklist_Med+Inventory+Mgt.pdf

MedPro *Medication Inventory Management for Hospitals and Healthcare Facilities Checklist* https://www.medpro.com/documents/10502/2899801/Checklist_Med+Inventory+Mgmt.pdf

MedPro *Risk Q&A High-Alert Medication Monitoring* https://www.medpro.com/documents/10502/3019648/Risk+Q%26A_High-Alert+Medication+Monitoring.pdf

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Thank you!

Shari Moore, RN, BSN
Vice-President, Risk Management
PLICO/a MedPro Group Berkshire Hathaway company