



Rising Opioid Pain Management Risks: What Doctors Must Know



Dr. Standiford Helm offers physicians advice on prescribing opioids safely.

Every good doctor providing care knows that pain management – sometimes on an ongoing and chronic basis – is essential.

And for a number of years, the consensus was that doctors were not doing enough. “For a time, beginning in the 1980s through the 2000s, there was a belief that patients were undertreated for pain. Many believed providing opioids for pain would not have serious risks,” explains Dr. Standiford Helm, founder of The Helm Center in Laguna Woods, California.¹

But recent data is troubling and has led to serious reevaluation by medical boards everywhere.

- Between 1999 and 2011, deaths from prescription painkillers quadrupled.
- In 2009, painkiller overdoses surpassed traffic accidents as a major cause of deaths.
- According to the Centers for Disease Control and Prevention (CDC), every day 44 people in the U.S. die from overdoses of prescription painkillers, and many more become addicted.²

In 2011, the CDC declared it an epidemic. And the focus isn’t just on teenagers raiding their grandparents’ medicine cabinets, or addicts breaking into pharmacies.

Growing Scrutiny of Doctors

The media and government are looking harder at the medical community. At the Cooperative of American Physicians, we’re seeing a small but concerning pattern of claims and MBC actions involving excessive or inappropriate prescribing of pain medications.

According to a 2012 *Los Angeles Times* study, “physicians played an important role in prescription drug overdoses. The *Times* analysis of 3,733 fatalities found that drugs prescribed by physicians to patients caused or contributed to nearly half the deaths.”³ And a study by *JAMA Internal Medicine* says opioids prescribed by doctors led to 92,000 overdoses in ERs in one year.⁴

In late 2014, the Medical Board of California (MBC) issued new opioid treatment guidelines, with much more rigorous requirements for how doctors must comply when prescribing them. “There are issues with doctors not adequately supervising patient levels, and complaints from families about prescribing into abuse being ignored,” says Dr. Helm. “It’s critically important that doctors take the new guidelines quite seriously. But what’s also concerning is how many conscientious physicians – who are really working very hard to stay in compliance -- are being criticized or having lawsuits brought after the fact. For example, if there is a death, family members who didn’t complain prior blame the doctors afterward.”

What Should Doctors Do?

In our interview, Dr. Helm offered the following advice.

- 1) Think before you prescribe.** Some doctors have been prescribing opioids for sprains and strains and that should be seriously reconsidered. It is simply not worth the risk in this environment.
- 2) Know the guidelines in detail.** Make sure you are fully aware of exactly what the current medical board guidelines are and how they are enforced. Before 2014, doctors were supposed to conduct physical/psychological function tests

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and ensure there were no substance abuse issues. If we're honest, we know that many doctors didn't do it. But today, a zealous medical board expert may see this as a departure from the standard of care and that can lead to sanctions.

3) Be diligent about compliance. Get the right records, the right drug screens, be able to document improvement with medications, be very clear about why medications are given, and be very clear about whether there is any history of substance abuse. Your duty now goes beyond being a good physician – you must get the technical details right.

4) Be smart about referring out. If you do not routinely prescribe opioids, consider referring that task out if you are doing anything more than a short-term course of medication. For patients who need pain management on a chronic basis, too much monitoring needs to be done. Try to find a pain management physician you have confidence in.

5) Don't get complacent. Even the best doctors are at risk. If your charts are reviewed zealously, any physician can be found to have shortcomings and will have to defend him or herself. This is very time consuming.

6) Pay attention to complaints. If you get a complaint from a family member about the care you are providing, do not ignore it. Assume they will complain to the medical board.

In the event of a medical board complaint, the board will evaluate it internally with an expert. If further investigation

is deemed necessary, the board will inform the complainant, and will likely seek other patients to approach and speak with the coroner if there had been a death.

"These are very detailed investigations, with as many as 50 different tabs including interviews with doctors, pharmacies, prescribing histories, and more before it is ultimately sent out to reviewers," explains Dr. Helm. "It consumes a lot of the doctor's time working to defend the case, and the sanctions can range from losing your patient flow or insurance from certain companies. In the worst case, it can be career-ending and civil actions can arise."

Stay Safe

The changes may seem daunting at first, but if you follow Dr. Helm's guidelines, it will help protect you, your practice, and your patients. In the end, it's all about doing what you have always worked hard to do: provide the best possible care and avoid preventable deaths. ⚡

¹The Helm Center website
<http://www.thehelmcenter.com/>

²Centers for Disease Control and Prevention, "Injury Prevention & Control: Prescription Drug Overdose"
<http://www.cdc.gov/drugoverdose/>

³Los Angeles Times, Nov. 11, 2012, "Dying for Relief, a Times Investigation: Legal drugs, deadly outcomes," Part 1 of 4
<http://graphics.latimes.com/prescription-drugs-part-one/>

⁴The JAMA Network, Oct. 27, 2014, "Prescription Opioids Involved in Most Overdose Seen in Emergency Departments"
<http://media.jamanetwork.com/news-item/prescription-opioids-involved-in-most-overdoses-seen-in-emergency-departments/>

2016 Litigation Education Retreat Schedule

Recognizing the damaging effects a lawsuit can have on a physician's personal and professional well-being, CAP invites its members to attend its daylong Litigation Education Retreat. CAP offers the free program several times each year.

At the program, a nationally recognized expert in the field of behavioral health provides valuable suggestions on alleviating the stress associated with being named in a lawsuit, while legal and communications experts help physicians develop the skills that will improve their chances for a favorable outcome.

The first Litigation Education Retreat of this year takes place in **Los Angeles on Saturday, April 23**. CAP, a CME-accredited provider, designates this educational activity for a maximum of six AMA PRA Category 1 Credit(s)TM.

CAP also will offer Litigation Education Retreats in **La Jolla on July 9** and in **Orange County on October 22**.

If you are interested in attending one of the retreats, please contact Andrea Crum at 800-252-7706 or at LERinfo@CAPphysicians.com. ⚡

Case of the Month

by Gordon Ownby



Court: Possible Exposure in Utilization Review

An injured worker will get another chance to make his case that an alleged injury induced by his withdrawal from a drug halted through utilization review should proceed outside the workers' compensation system.

Though the worker had not yet pleaded sufficient facts, the Court of Appeal said in a recent ruling the law supports his attempt to try again.

(As frequently happens in appellate decisions, all the facts relied on by the court come from the plaintiff's allegations; though the defendants argued the law merits a dismissal, they have not yet had the opportunity to rebut the plaintiff's alleged facts.)

In 2008, plaintiff Kirk King sustained a back injury at work. Three years later, Mr. King suffered anxiety and depression from the chronic pain from his back injury and received a prescription for Klonopin. The Klonopin was provided to Mr. King through workers' compensation, which in 2013 conducted a utilization review to determine whether the drug was medically necessary. Dr. Naresh Sharma, an anesthesiologist, conducted the utilization review and determined that the drug was unnecessary and decertified it. A psychiatrist who conducted another review reached the same conclusion.

Mr. King claims that the denial required him to immediately stop taking Klonopin and that the sudden cessation caused him to suffer four seizures, resulting in additional injury. Mr. King sued CompPartners, Inc. and Dr. Sharma for both professional medical negligence and general negligence.

The defendants argued at the trial court that Mr. King's claims are pre-empted by the Workers' Compensation Act because they arose out of utilization review in

connection with his original workplace injury. They also argued that Mr. King and the defendants did not have a physician-patient relationship (and thus no duty) because the defendants never personally examined or treated him.

Mr. King (whose wife is also a plaintiff) argued that he was not disputing the decision to decertify Klonopin. Rather, his claims centered on the failure to provide him with a Klonopin-weaning regimen. This allegation, according to the Kings, fell within the ambit of a negligence cause of action – and outside a dispute over a workers' compensation utilization review decision. In other words, the Kings contended, the dispute is not over the denial of the drug but rather over the decision by Dr. Sharma to abruptly stop the Klonopin rather than gradually stopping it. The trial court judge dismissed the Kings' lawsuit, but in doing so said the matter "needs to go up to the Court of Appeal. There is really no good law, any much law" on utilization review.

The Fourth District Court of Appeal in *King v. CompPartners, Inc.* noted that the law on collateral injuries in workers' compensation holds that if an alleged injury can be separated from the original workplace injury, it will not be pre-empted by workers' compensation.

"To the extent the Kings are faulting Sharma for not communicating a warning to Kirk, their claims are not preempted by the WCA because that warning would be beyond the 'medical necessity' determination made by Sharma," the appellate court said in favor of allowing the Kings to add further facts to their lawsuit.

The court also found in favor of the Kings on the issue of duty of care – to a point. "Case law provides

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a utilization review doctor has a doctor-patient relationship with the person whose medical records are being reviewed," the court said, citing a case from 2002, *Palmer v. Superior Court*.

"However, the existence of a duty does not mean 'a doctor is required to exercise the same degree of skill toward every person he sees,'" the court said, citing the major case from 1977 on the issue, *Keene v. Wiggins*. "The duty he owes to each varies with the relationship of the parties, the foreseeability of injury or harm that may be expected to flow from his conduct, and the reliance which the person may reasonably be expected

to place on the opinion received. A case-by-case approach is required."

The appellate court said the Kings should be allowed to amend their complaint "because it is possible, given the allegation that [Dr.] Sharma was the only doctor involved in the decision that, when more details are provided they could support a conclusion that, under the circumstances, the scope of [Dr.] Sharma's duty included some form of warning Kirk of or protecting Kirk from the risk of seizures." ✎

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

Upward Trend in Liability Costs Seen in Long-Term Care

MICRA

As California and other states prepare for the "Silver Tsunami" – a tidal wave of Baby Boomers who are reaching 65 – a national study on long-term care facilities sees liability expenses as an important driver of cost.

An ongoing analysis conducted by Aon Global Risk Consulting for the American Health Care Association (AHCA), which tracks the liability costs for long-term care providers at a national level, shows these costs continue to increase annually at an average of five percent. According to the AHCA's website, there are currently 15,655 skilled nursing centers in the United States with 1.7 million beds. The report analyzes the general liability and professional liability (GL/PL) claim costs for the long-term care profession in the United States.

An overview of the report posted on the AHCA's website shows that for the period of 2010 to 2015, the national upward trend began increasing around 2011. Projections for 2011 indicated a GL/PL loss rate of \$1,270 per bed with a severity of \$135,000 per claim at a facility with 100 occupied beds. The 2015 report has now projected a national 2016 loss rate of \$2,150 per occupied bed, which means that a nursing center with 100 occupied beds can expect

approximately \$217,000 in liability expenses in 2016. The dollar amounts represent a 5.9 percent increase in per bed loss rate and 6.2 percent increase in claims costs.

In California specifically, participants in the 2015 study represent approximately 12,600 occupied beds dedicated to long-term care — about 12 percent of the state's total beds. Looking at the eight-year period from 2007 to 2015, the loss rate per bed increased to a level above \$2,700 in 2012. That same year, the claim severity climbed to \$250,000 per claim and has been holding at that level, largely in part to the limits on awards imposed by California's Medical Injury Compensation Reform Act (MICRA). The same holds true for other states that enforce similar tort legislation, according to the report.

California's moderating effects notwithstanding, as a larger portion of the population continues to join the ranks of the elderly, long-term care facilities and their providers apparently will continue to struggle with increases in their liability costs.

Readers can view the AHCA Long Term Care GL/PL Actuarial Analysis at: http://www.ahcancal.org/research_data/liability/Pages/default.aspx. ✎



Optimizing Patient Care Transitions: Strategies to Reduce Readmissions

by Ann Whitehead, RN, JD

As of last year, the era of healthcare reform had fully taken effect. The many changes that resulted from it brought uncertainty to healthcare providers, as well as patients. The changes in quality measures and reimbursement were meant to bring about high-quality care at the lowest price.

As we read, listen, and participate in meetings, many terms and buzzwords are batted around to describe the changing landscape of healthcare, such as “continuum of care,” “collaborative care,” “transition of care,” and “value-based care.” But to most healthcare professionals, the bottom-line concern is still how to provide time-efficient, quality care that protects patients from harm and decreases provider liability.

The challenge for most healthcare professionals is to identify and implement systems/processes to optimize patient care transitions and avert costly new penalties for Medicare readmissions. This can be accomplished through a team approach. A patient’s post-discharge team includes hospital care coordinators, hospitalists, primary care physicians, nursing and rehab centers, community health workers, family members—and last but not least—the patients themselves. This “team” must be on the “same page” to ensure compliance with some very important processes:

- Comprehensive written discharge instructions
- Complete medication list, instructions, and side effects
- Scheduled follow-up appointments
- Healthcare provider contact information for questions.

Recent statistics show that 71 percent of hospitals are receiving reduced Medicare payments because of readmissions. The lost payments nationwide amounted to \$15 billion, and three-quarters of readmissions are preventable.¹

When healthcare providers look for strategies to decrease readmissions and thus improve patient outcomes and quality, TeamHealth, a provider of hospital-based clinical outsourcing, offers five core concepts to reduce readmissions. They are:

- **Recognition** — recognize potential post-discharge issues that may cause readmission.
- **Communication** — active communication between team members, patients, and families.
- **Intervention** — continuously manage patient expectations. Every contact with the patient should include post-hospital care management.
- **Education** — empower the patient/family to actively participate in discharge planning.
- **Reconciliation** — continuous electronic health record medication reconciliation, at admission, discharge, and throughout the hospitalization.

Risk strategies

To minimize readmissions, healthcare providers could implement the following:

1. The discharge summary should be complete and transmitted to the outpatient healthcare providers as soon as the patient is discharged. Like the admission note, the discharge summary is an important document.

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2. Tell the patient whom to call for questions or problems. Designate an office staff member to field calls from newly discharged patients.
3. Office staff should be aware of patient discharges. Systems for following up with the discharged patient are valuable in preventing readmission.
4. Patients should never be discharged without adequate instruction and education. All inpatient healthcare providers should share in this responsibility.
5. Many medication errors occur at the transition points. Computerized physician order entry (CPOE) systems are useful for reducing errors in prescribing, but they cannot detect an error if the provider does not prescribe a medication that the patient was taking at home. Electronic medication reconciliation may reduce these unintended discrepancies. ↩

Ann Whitehead is Vice President, Risk Management & Patient Safety for CAP. Comments or questions related to this article should be directed to awhitehead@CAPphysicians.com.



PER Foundation Benefit

Psychiatric Education and Research (PER) Foundation Advocate Awards

March 12, 2016

CAP is pleased to once again provide support and sponsorship for **Psychiatric Education and Research (PER) Foundation Advocate Awards** slated for **Saturday, March 12, 2016**. The Foundation supports research for children's mental Health.

This year, PER is honoring Commissioner Laura Hymowitz. The program also will feature Richard Kogan, MD's lecture and piano presentation on Tchaikovsky: Music & Melancholia.

For more information, visit PER's website at www.perfoundation.org, or contact MGlazerPERCoord@aol.com.



CAP Short Term Disability Plan: Protecting your biggest asset to your practice – YOU!

Long term disability insurance is critical to protect your income if you were to have a serious illness or accident that could prevent you from practicing medicine. Long term disability coverage usually starts about 90 to 180 days after you become disabled, depending on the policy you have chosen.

Have you considered how you will pay your bills and maintain your income until the long term disability coverage becomes effective? Last year, CAP Agency introduced a new program to help our doctors fill in the waiting period that occurs on most long term disability policies.

Since the core disability benefit provided to you with your CAP membership has changed to a 180 waiting period, this new Short Term Disability Plan is a great way to fill that gap.

The CAP Short Term Disability Plan¹ stacks on top of your State Disability Insurance (see right) and provides coverage to fill that waiting period gap.

- \$1,000 weekly benefit or \$4,000/month benefit
- 14-day elimination/waiting period
- 11-week or 24-week benefit period
- No medical or income documentation needed
- No income limitation

State Disability Insurance (SDI)*

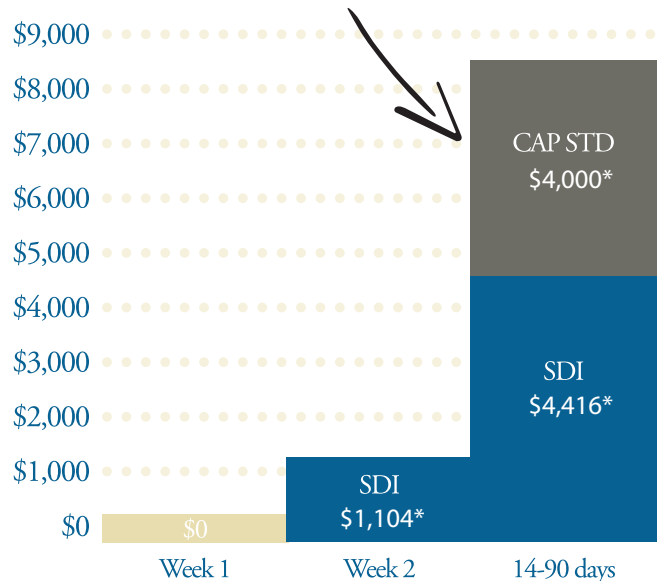
According to the State of California Employment Development Department, an individual's weekly benefit amount is approximately 55 percent or \$1,104, whichever is less, based on personal earnings for a maximum benefit period of 52 weeks with a waiting period of seven days.

CAP Short Term Disability Plan

A participant in the CAP Short Term Disability Plan can receive a weekly benefit of \$1,000 on top of SDI, with a benefit duration of 11 or 24 weeks. This helps fill the the gap for any required 90 or 180 day long term disability policy waiting period. ↩

¹ Must be working at least 17.5 hours per week and not currently disabled to apply; pre-existing exclusions do apply
*Based on the 2015 calendar year

Stacks on top of SDI benefit and fills in the gap of coverage starting in week 3.



Waiting Period and Benefit Duration

*Converted to monthly benefit amounts based on four weeks in a month.

February 2016





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February 2016

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

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Legal guidance for individual matters should be obtained from a retained attorney.*