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2016 NCSBN Discipline Case Management Conference - "Is the Sky Falling?" Prosecution and Defense of Complaints Against Advanced Nurse Practitioners Prescription Practices

Event
2016 NCSBN Discipline Case Management Conference

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[[00:00:10]]
- [Robert] Thank you for your kind applause there and I feel very honored to be on this presentation with Ms. Hardy. I was equally impressed with her resume and as a good attorney or maybe just anybody, if you are going to be doing something with somebody you Google them, right? And Margaret, actually, she didn't... there was no skeleton in the closet, I will provide that disclaimer, despite the fact that she does defense practice, more of those recalcitrant nurses and other healthcare practitioners, allegedly. But it's been fun, it's been a real privilege here. We are going to try to do something different this morning. We're going to start out with a little bit of what we prepared in a PowerPoint presentation to kind of get you in the mood, so to speak. But the role that Margaret and I are going to play is to give you a very small snippet. And when I say snippet, it is no exaggeration of what would be done in a hearing if this type of a case were to go to a hearing and quite frankly, they don't go to hearing very often. But as most prosecuting attorneys know, and as most good defensive attorneys know, you prepare as if you're going. And if it doesn't go, and something else can be worked out, all the better. But you still have to do that level of preparation. So, one of the things that wanted to introduce to you... Oh, and before I get on to that, I want to say thank you to Randall. Randall has been utilized by me in a number of cases to do evaluation of patient records [[00:02:04]] and things of that nature when there's been an allegation against a nurse practitioner of improper or substandard prescription practices. And I think Mary Kaye Getter [SP], who is here in the audience, was the person who introduced me to Randall, he's been awesome and we were very grateful when he stepped in and agreed to be the expert witness for this portion of our presentation. So, getting back to the presentation, at the core of it, it's not

an unfair statement that this is going to be probably a greater topic of consideration. As most of you may know, the DEA has a very active campaign against doctors primarily but also nurse practitioners that are in the business of prescribing primarily pain medications when they are seeing a number of drug-related concerns: diversion, doctor shopping. And so this was a statement by the Colorado Department of Regulatory Agencies on the topic. Now, this came as a little bit of a surprise to me, but may not be a surprise to nurse practitioners is that APRNs do it better than doctors. But the reality is that they haven't come to the attention as much as doctors in prescribing issues and that probably will change over time. So that will be the next chapter. And there's going to be some uncertainty regarding potential disciplinary action and how you do it. Mr. Hudspeth will be talking about, later this morning, about rehabilitation. [[00:04:01]] Most of you in licensing regulatory environments don't necessarily view as what you do in taking disciplinary action to be punitive. In fact, the objective would be to, number one, protect the public and number two, if at all possible, to bring the nurse into a level of practice if possible so that that individual continue to practice. There was a great article that was in the Journal of Nursing Regulation, I'm putting in a plug for NCSBN about this regulatory implications of pain management because we're going to see it. The question is, is the sky falling? And the short answer is, we don't know. Chicken Little might know, we don't know. But the other thing that I need to emphasize is not all advanced practice nurses or nurse practitioners are created equal. Not all states permit nurse practitioners to have full prescriptive authorities. There are probably, I forget what the actual numbers but these are the states that do. There are other states such as Virginia where there was to be a collaborative relationship with an MD for a nurse practitioner to be prescribing. So what you'll be getting this morning, and hopefully you've had an opportunity when you didn't have anything better to do last night, or woke up in the middle of the night with nothing else to do, to read the case background. And what this case background is all about is an individual by the name that we've poignantly identified as Susie Ross and May West who was the executive director of the board of pharmacy in Absaroka, in the state of Absaroka. [[00:06:00]] Now, how many people here are Longmire fans? Anybody know Longmire? Well, for those of you who watch that TV series, Longmire takes place in the state of Wyoming in a town called Absaroka which does not exist. Absaroka exists, it's a Native-American identification, but there's no actual state of Absaroka but we decided to do that. The executive director for the state board of pharmacy had been tracking this particular nurse practitioner as they do with others and provided a report to the Absaroka Board of Nursing saying, "You know, there seems to be some excess of prescribing going on." And another report came in about the same time from Wyatt Earp, the US attorney in the state of Wyoming, alerting the executive director that there was an individual that had died from a fentanyl overdose and what had happened was that she and her boyfriend were smoking a fentanyl patch north of town in a van and she went into cardiac arrest and as they were trying to trace where she had got this, it was linked to an individual that this particular nurse practitioner had been prescribing fentanyl patches. And the presumption was that there was a sale of fentanyl patch and she ended up smoking it and ended up dying and that's why she had come to the attention of that. So that's the basic facts of this. You'll learn through the direct examination hopefully more of the details, the case background will provide you much more detail beyond that. Following in the investigation, the investigative board member determined that the nurse engaged in practices that deviated from acceptable nurse practice standards. [[00:08:04]] The nurse was sent a proposed settlement agreement for a reprimand and training which she declined to enter into. And there was a hearing before the board. So the

expert, Mr. Hudspeth will be providing direct testimony of the standard of care and how the deviations occurred related to the three patients. Ms. Hardy will be doing cross examination and then she and I will both be doing brief closing arguments. Before we get into the guts of it, though, you're going to have to engage in some imagination because in hearings of this nature, there's a lot that goes before and there's going to be evidence presented by way of witnesses as to what was obtained in the investigation. The medical records themselves would be introduced. Normally, although it can happen in any different sequences, the witnesses will be paraded before the board of nursing, the documents, the medical records submitted. You'll see objections. When you get to the experts, sometimes there will be a qualification phase where you undertake, or the attorney undertakes to provide the qualifications and why this person is capable or competent to express opinions on the subject matter at hand, what the standards are, how the standards were deviated from. And sometimes that's stipulated to so you get into it. There's all sorts of strategies that go into that. So, even when you get to the expert him or herself, [[00:09:59]] there is a lot of detail that goes into the actual testimony. And we only have an hour here and normally in a hearing, an hour would be taken up quite frankly with a lot of other stuff which would be putting most of you to sleep, it tends to put me to sleep so I have to have my paralegal make sure that my eyes are alert. Just kidding. But, it's a long process so when we put this together, it was just to really focus on what the testimony would be and then do a fast-forward to a closing argument. So, that's what you're going to have to do by way of imagination. What is not imaginary, however, is the backdrop of licensed disciplinary hearings and that has constitutional parameters under the due process clause of the state, and federal constitution. And the basic rule is notice and opportunity to be heard. So due process number one, notice is indicating the charges or grounds of discipline upon which the proposed disciplinary action will be based. That usually involves a contested case hearing in which you have to, or the prosecution has to meet a burden of proof. In most states, it's a clear and convincing standard. In some states, a preponderance. When you think about preponderance, it's a more likely than not, maybe a 51% standard, whereas a clear and convincing is probably up in the 70 to 80%. So that's the quantum proof that has to be established. And why is that? Is because when you are talking about an adverse action on the professional license, especially of a nurse practitioner that typically has to have at least a masters level education to be able to hold the license. [[00:12:01]] So it's not surprising that courts will be quite protective. So when you're talking about a Prima Facie Case and that's what we talked about with lawyers, what elements must be proven? Not only frames, what evidence must be proven at the hearing but also for you, investigators, the types of evidence that has to be obtained in the investigation. So, what you have here in this slide is just what elements. You have same cases where you go through the normal investigative, have a hearing. You got the elements of the offense that you're trying to present. And then you also have a phase where if the nurse seems to be a clear and immediate danger, a summary suspension and that's a little bit different. So you're going to need evidence of the standard of care, what is that standard? And as you'll hopefully see in the presentation, that is the question. And you're going to need to have evidence of how that nurse deviated from the standard of care because after all, he or she has the legal right to dispute the charges of substandard practice. And with that, what we're going to have you do is to imagine that Mr. Hudspeth has been sworn and that we're going to get into the bulk of his testimony. So, imagine he's on the witness stand and Ms. Hardy would not necessarily be sitting next to him, but you'll have to do some imagination even with that. So, yes could you please identify yourself for the board and your role?

- [Randall] So my name is Randy Hudspeth. I am a nurse practitioner. [[00:14:00]] I've been a nurse practitioner for 30 years. For the past 16 years, I have practiced in pain management, addiction recovery, palliative and hospice, as a nurse practitioner. During much of that time, I have been the administrator for our health system over three physicians, one physician assistant and six nurse practitioners who practice within those areas. And because of my relationship with our state board of nursing and my interest in my doctoral work in practice and regulation, I was approached to serve as an expert witness and evaluate these medical records.
- Okay. And let's talk more about your role, specifically your understanding of your involvement in this matter.
- I was asked by the board to evaluate two charts that were specific to a complaint the board received from the board of pharmacy about a potential of over-prescribing. Additionally, there was a third chart that was brought to the attention of the board that involved a patient's death, or not a patient's death, but a death of a person who received a drug prescribed by a nurse practitioner. So, I was asked to evaluate the standard of care as it was evidenced in the chart and to inform the board if the standards were met or not met on these specific cases.
- And so you looked at medical records and you consulted resources for purposes of determining whether the standard had been met, correct?
- Yes, that is correct.
- Did the board of nursing adopt any standards specifically that aided your evaluation of these cases? [[00:16:02]]
- This particular board of nursing does not have an organized statement, any rules, any policy or any formal document that is identified as a standard of care for safe opioid prescribing.
- Okay. And are there any recognized standards that otherwise existed that has aided you in your task?
- Yes. As most boards of nursing don't have that type of documentation and in fact probably only two have such a document, but there are documents by other organizations which can serve this purpose. In the regulatory arena, the federation of state medical boards has quite a detailed and long-standing standard of practice for safe opioid prescribing. All of the major pain societies in the United States, the American Society of Chronic Pain, the Acute Pain Society, the Fibromyalgia Society, the Cancer Society. All of those have very common, jointly promulgated statements that have been recognized as standards of care and have been used by the FDA in the development of the National REMS Program, REMS standing for Risk Evaluation Mitigation Strategies, that have served as the educational format to educate providers for safe opioid prescribing. So there are many national standards out there that you can use when or in the absence of a formal statement by a board of nursing.
- And please tell the board what those standards are.
- Well, the standards basically address the prescribing process into four areas. [[00:18:04]] The first area is identifying in a thorough physical and history evaluation of the patient, which includes the general things that most commonly you see in any diagnostic category as far as a history in physical. But in addition, it includes those specific things that relate to the reason for the pain, the history of the pain, what has been done to treat the pain, what's been successful, what's not been successful, what the functional goals of the patient are, what their current functional capabilities are. An assessment of any referrals made to therapies, physical therapy, psych therapy, counseling, any of those kinds of things. They also include an analysis of urine drug screen as a base line. And an interpretation by the provider of that, of those results. If a

patient comes to you and they are taking an opioid, for example, you would expect to find an opioid in there. But sometimes you might find something else and you have to be wise enough to know, is that a metabolite that's like morphine metabolites and it could appear that you have oxycontin or something, but you have to know how to read the assay that you're particularly using. Also, there are issues with states that have recreational marijuana being legalized now. So you might find metabolites of marijuana in there and then that leads to further interview and investigation. Then, you need to do a opioid risk assessment tool. [[00:19:59]] Now, there are many nationally vetted tools that are tested and they're easily available for providers. You need to do a risk assessment to see if that person is in a situation or they themselves might be an abuser of the drug. Then you need to check the pharmacy prescription drug monitoring program profile to see has this patient had prescriptions filled by multiple providers over what duration of time, how many different drugs, those kinds of things. So once you have gone through all of that and you've met the patient and completed your examination, then you move to phase two. And phase two is the decision to treat, or you enter into the relationship with the patient that, yes, you will treat them. And there are two important components that happen during that phase. One is to complete a patient-provider agreement. A lot of people in the legal world have called that a contract, a pain contract. A lot of people still use that term, but the current terminology, nationally, is a patient-provider agreement. The patient-provider agreement, those are easily available through most pain societies. And they call for specific things that a patient will only see one provider to obtain the pain medicine. That if the patient does go to an emergency department for some type of pain problem, then they will report that they are under a pain contract or have a PPA and who the provider is so that the ER can forward information. And they will notify, they will notify you, as the provider, that they went to the emergency department and what the result was, [[00:22:00]] especially if they received a prescription, that they will only use one pharmacy to fill their prescriptions, that they will submit to urine drug testing on an intermittent basis and that's pretty much up to the provider's discretion, how often you want to do that. That they might have to subscribe to drug counts or other types of things. And then, you decide with the patient what drug you're going to use. This is really the provider's independent progress. There's not a guideline nationally that says you're going to use hydrocodone versus oxycontin versus morphine versus dilaudid, any of those drugs. So, when you decide with the patient what drug you're going to use, then the current standard is that you will do an informed consent, much the same as surgeons do when you're going to do an operation that denotes the drug and the side effect and any possible adverse effects that they might experience. At that point... And if you change the drug, an informed consent needs to be changed. One informed consent doesn't cover all drugs for all time. Then you move to phase three and that is a trial of the opioid where you can expect that over a two week interval, maybe that expands up to three months, but you are trying to dose the patient to where they're treated appropriately. So your goal during that time is maybe to increase the drug or decrease the drug, but you set a limit on when the patient will return to you, how many drug prescriptions they can expect to take, and there's a finite time there. And there's no commitment and you need to tell the patient there's no commitment, [[00:23:59]] this is going to be a long term relationship. So at the end of the trial, then you move to the last phase which is the prescribing for the long term. So maybe this is going to be something for six months, a year, whatever. Or referring on to another provider. So, those are the essence of getting through the process of prescribing.

- Thank you. And to what extent does documentation of what the practitioner is doing play an

important role in those phases that you described?
- It's very important when you... My experience has been that most people don't enter into a relationship as a prescriber to mess up or to make mistakes, but adverse things happen. And you cannot always control what a patient's going to do and what they tell you and what they do are usually two different things. So, it's very important that you document, that you show that you have done what you can to protect the patient and the public against misuse.
- Okay. Now, focusing on the patients that were treated by Ms. Ross, did you form any opinions with respect to reviewing the records and application of these standards that you've just discussed?
- Yes.
- And what were those opinions?
- In the two patients that the board of pharmacy had issues with, I evaluated the prescription drug profile and they were complex patients, especially the first one, a very complex patient who had treatment for ADD in addition to the pain issues and in addition to insomnia. [[00:26:02]] So, there were multiple prescriptions that were given. I feel that the intention was good, but the documentation lacked any opportunity to evaluate a urine drug test, any opportunity for a patient-provider agreement to be evaluated at each visit. There were multiple visits during a short period of time and even though there was a patient-provider agreement in the chart, no one ever validated with the patient was that being followed, or were there issues with that. The same thing with the informed consent, that was not evident in the chart, that there was an informed consent. So, looking at the overall process and with the absence of documentation, I had to conclude that the standard, compared to the national center, was not met.
- Okay. And with respect to the patient who had been prescribed fentanyl patches, let's focus on that patient because you basically had talked about the other two, correct?
- Yeah.
- So let's talk about the patient that had been prescribed the fentanyl patches which lead ultimately to the death of the ultimate end user. What information did you look at and... what information did you look at?
- I looked at the PDMP to see what was going on with that patient. And I also looked at the old medical record of the patient. This particular case, to me, was interesting because it sounds serious to say someone is taking fentanyl. [[00:28:01]] But as a prescriber, fentanyl is a good drug for a problem patient because it's a transdermal and even though it's potent, it's not like you're giving someone 200 pills, you're getting one patch every 72 hours and you can control a small number of patches. So, there's a less chance that the person is going to misuse the fentanyl than they would be if you were giving them a 30-day supply of oxycontin, say. So in that perspective, it was okay. The issue that I found deficit was, again, there were no urine drug tests to see if other things were going on. Or if the patient was actually using the fentanyl. You would expect to test to see if the patient is actually taking the drug you're giving them or if there's a chance because of the social history of this particular patient and the problems, there might have been a chance that the person would have misused or misappropriated the prescription. So, you would want to check that, for example.
- And let's talk about that for a moment, what in this particular patient's history was significant in your view?
- Well, there are always red flags that are not...they're subtle. Red flags are subtle issues you have to deal with patients. And that a patient was discharged from a practice and the provider

removed them from their care and then the provider tends to see them in another setting and continue to prescribe for them, called into question that's not a common practice, that's really a one-off. That was a big red flag to me, that the patient had a high chance of being a problem patient, [[00:30:01]] that they were showing up at a free clinic. Also, that not all the drugs could necessarily be tracked on the PDMP. Now, that causes you to have questions as to why would that be? Do the pharmacies not participate in the PDMP data admission? Or are they not filling the prescription? Or are they getting it filled somewhere else and doing something differently with the drug? So that was a red flag to cause further question.
- And you determined that Ms. Ross did not meet the standard of care with respect to this patient, correct?
- Yes.
- And what was the basis of that opinion?
- Those were because the safe guards were absent from the chart, as far as a drug screen, the urine drug screen, as far as a test goes for opioid misuse, any of those. And a chronic long term patient has a higher tendency to deviate than a short term patient. So it's always important to do a psychological test to do a referral, and especially someone as complex as this patient. Another red flag is why would you not seek a referral to an addiction specialist or a pain management person versus trying to treat this complex of a patient as a family nurse practitioner in a community clinic.
- Very good. Did you understand that Ms. Ross had any responses to her care and treatment to these patients?
- Yes, I understood that after I had submitted my report to the board of nursing, [[00:32:02]] that she did submit a written response.
- And what is your general understanding of her response?
- Well, that she basically was concerned about the issues, that she did not want to be put in the role of prescribing opioids, that she had taken it upon herself to terminate her opioid prescribing relationships with many of her other patients and that she basically had taken the time to move those patients out to another provider.
- But over the course of her treatment of these patients, Ms. Ross, in your view, did not conform to the standards that you've just described.
- Yes, that's true.
- Did you have any opportunity to consider Ms. Ross' practice with respect to other patients?
- I know that of the total number... When you do the PDMP, you can check the over all provider profile for the, not only the patient, but for the provider. I saw that she had a fair number of prescriptions out there but I did not compare those with other charts.
- But you did see similar patterns?
- I saw similar patterns. I saw very high numbers of prescriptions.
- Okay, without undertaking the appropriate assessment that you would consider appropriate in these types of cases?
- I can't say that because I didn't review all the charts in depth, but I did see that it was... [[00:33:58]] Her prescribing pattern was consistent if you looked at the overall distribution of the number of prescriptions that she was giving compared to other practitioners.
- And these were patterns similar to what you saw with the two patients that were reported by the board of pharmacy?
- Yes.
- And also the patient that, or the patient that had been prescribed the fentanyl?

- Yes.
- Okay. No further questions.
- [Margaret] Good morning, Mr. Hudspeth.
- Good morning.
- You testified about the medical records that you reviewed in this case and I believe you testified that you reviewed only three medical records?
- Yes.
- And those were records that were provided to you by the board of nursing?
- Yes.
- So your opinions on Mrs. Ross' practice in this case was based on three medical records?
- Yes, that is true. I was asked to give the opinion based on three records.
- You're aware from your review of the records, or the information in this case, that the prescription of opioids in the treatment of chronic pain has never comprised more than 20% of Ms. Ross' practice, correct?
- Yes, I was aware of that.
- And in many cases, Ms. Ross was not the provider who initiated the opioid treatment?
- That I could not say because that was not evident in the record in the history part as to who was. It appeared, looking at the PDMP, that a lot of those were refills but it wasn't identified in her history the sourcing of the patient [[00:36:01]] or that she was continuing to prescribe something that had been prescribed by another provider initially.
- You just weren't unable to tell from the information that you had?
- Exactly.
- And in terms of the PDMP, you had no patient record to correlate that with or no specific patient information to put that into context. You had the PDMP except for three medical records.
- Yes, that's right.
- You would agree, would you not, that seeing patients and being able to talk with them and evaluate them face to face is an important part of assessing and treating patients?
- Yes.
- And that provides information to a provider that's not always contained in the medical record?
- Yes, there is an intuitive component that is not always documented in the medical record.
- And you didn't see any patients that were involved in this case?
- No, I did not see any patients.
- Didn't talk with them?
- No.
- Haven't talked with any other providers that treated those patients?
- No, I have not.
- You would also agree that the standard of care or the scope of practice for a nurse practitioner permits the use of professional judgment in treating patients?
- I would agree with that statement with certain caveats. But I would not say that is a blanket true statement.
- Well, you would agree that providers in evaluating patients can reach different conclusions about the best treatment for that patient, but still be in compliance with the standard of care?
- Yes. In this particular case, that would probably be whether you were going to prescribe a hydrocodone versus an oxycodone versus a morphine, but not that you would not be meeting the standard of care by doing a urine drug test or those other assessments. [[00:38:00]]

- Well, you would agree, Mr. Hudspeth, that regardless of the controls put in place, regardless of the agreements in place, a provider cannot control what a patient does with the prescription once it is written and that patient leaves the office.
- That is true.
- I want to ask you some questions that are specific to the records you've reviewed in this case. According to your report, you identified some things that you consider to be deficiencies or breaches of the standard of care, but you also found in my instances that the treatment provided was appropriate and good treatment, correct?
- Yes, absolutely and I think I have documented that in there that there were many good aspects to the care, good intentions, good outcomes and...good interventions and good outcomes.
- And in every record that you reviewed, although there were only three, in every record and in the information that's provided by Ms. Ross, it's your understanding that in every case, Ms. Ross had a patient contract or what you've referred to as a patient-provider agreement?
- Yes, that was always evident. What was not evident was that it was validated each visit that the patient was in compliance with the contract.
- And by saying it's not evident, you mean it wasn't something that you could read in the medical record?
- Yes.
- In every record that you reviewed, you found documentation that Ms. Ross had documented objective evidence for the reason for the patient's pain, the ideology of the chronic pain?
- Yes.
- She was not writing prescriptions at the request of a patient without some evidence of why that patient was having pain?
- Yes, that's true.
- And you also saw that Ms. Ross had discharged patients who'd been non-compliant with their treatment or with their agreement, correct? [[00:39:59]]
- I saw that on one patient of the three.
- Well...
- Yes.
- Okay. In reviewing the medical records that were provided to you by the board, you also saw that in every instance, Ms. Ross recommended non-opioid treatment in conjunction with the prescriptions, such as cognitive behavioral therapy, steroidal injections, physical therapy?
- Yes.
- And in reviewing those records, you also saw that Ms. Ross encouraged the participation of the patient's family members or significant others in their treatment?
- Yes, that's true.
- I mean, these patients were adults, they had to agree to that involvement, correct?
- Correct.
- But she recommended that in each case?
- Yes.
- You're familiar, I assume, with the guidelines published in March by the CDC for the use of opioids in the treatment of chronic pain?
- Yes, I am.
- And you would agree that those are just that, they're guidelines?
- Yes.

- And in those guidelines, the CDC recognized the use of opioids in the treatment of pain, correct?
- Correct.
- And in fact, according to the CDC, approximately 20% of all patients who present to primary care providers with pain-related complaints are given opioids?
- In that statement, that is what the CDC says. Although, I think within the pain world itself, that might be a low number.
- Well, but we're not talking about a chronic pain management practice, we're talking about the CDC. You're saying it could be even higher than that?
- Yes.
- And in fact, the 20% is in accordance with Ms. Ross' own practice with 20%, correct?
- Correct.
- Now, you would agree, and I believe you've already testified to the fact [[00:41:57]] that the Absaroka Board of Nursing has adopted no formal policy, rules, regulations, laws related to the use of opioids for the treatment of chronic pain?
- That's right. I could not find any evidence of that.
- Or, no rules, no regulations, no statutes, no laws related to the treatment by nurse practitioners of chronic pain patients, correct?
- Correct.
- Thank you. I don't have any further questions.
- So what you've seen, again, is a snippet of what would actually take place in a hearing. And this is just to kind of highlight some of the more important issues that would come up. Now, what we're going to do is I'm going to do a very brief closing argument. Bear in mind that we're having you in a somewhat imaginary world where you've seen other witnesses paraded and things of that nature. So, work with us on this. So members of the board, thank you very much for your attention to this very important case. And we say it's a very important case because it involves disciplinary action of a nurse practitioner. Now before we get into the specific elements that we believe we have proved this morning, we want to preface this by saying that Ms. Ross is not a bad nurse. And when we say that, we're not saying that she...her practice is so substandard that you need to take her out, she presents such a danger to the public. [[00:43:59]] What we are saying is that there was evidence of practice that reflects a need for improvement to protect the public. Ms. Ross was reported as a potential individual nurse practitioner who may be over-prescribing by the executive director of the board of pharmacy. That professional takes it upon herself to review prescribing patterns and if something seems to be a little bit high, in her professional opinion, she's going to make that referral to the board of nursing. It will be up to the board of nursing to do the investigation, to undertake a review of the medical records because after all the PDMP profile only is one indication, it is not the complete picture. The medical records themselves have to be evaluated. And that's exactly what was done here. But not only do you have to evaluate the medical records, you have to evaluate whether the medical records had met certain...what would be expected to be recognized standard. We're not going to try to blow smoke and suggest that there is an abundantly clear regulatory guideline in this state. However, as Mr. Hudspeth had testified, there are national standards that have been in place for quite a number of years that are applicable to prescribers, primarily doctors that would equally be applicable to nurse practitioners who have the capability of prescribing controlled substances. And he looked at those PDMP records, saw where those concerns might exist, also looked at those medical

records. [[00:46:00]] He was not asked to look at other records because the focus are what occurred with these particular patients, was the standard met? With respect to the individual that was identified as VH and of course the board knows we identified that person by acronym for her privacy purposes. That individual had gone to see Ms. Ross 11 times between December 17th and February 2015 for pain and ADHD, and were prescribed multiple controlled substances including hydrocodone and hydromorphone and tramadol. The other patient, that we identified as NM, likewise was seeing Ms. Ross numerous times over a short period of time and received controlled substance including oxycodone and hydrocodone. And lastly, the individual that was identified as DS who had quite the history of substance abuse and probably exhibited significant drug-seeking behavior and got so bad that he had to be fired as a patient from that one practice, but she resumed the treatment relationship when she was working in another context. And that went on for another year. And what happened and what we're able to surmise is that that patient had misused so that and ultimately lead to the death of an individual. So, what can we say about the standards? What had not occurred in this case, even though there were elements of good practice, were inconsistencies. Certainly inconsistencies in documentation, [[00:48:02]] but failure to do things that she needed to do to highlight that this could be a problem. For example, urine drug test, revisiting the pain management to where the patient-provider agreement to make sure that we were on track, appropriate referrals when it appeared to be necessary. So, as a consequence and Mr. Hudspeth had identified the national societies, the governmental agencies that do, in fact, provide those guidelines which in effect are an articulation of what the national standard of care. So, with that, we would submit that it has been proven by clear and convincing evidence that with respect to these three patients, Ms. Ross deviated from the standard of care and the board is authorized to impose disciplinary action against her. Thank you.
- This board has heard a lot of evidence in this case. Criticisms from Mr. Hudspeth about the care provided by Ms. Ross or in some instances, the documentation that she had in the medical records. But there are a number of points on which there is no dispute at all in this case. There's no dispute that Ms. Ross has been licensed as a nurse practitioner since 1995. She has never had a disciplinary action taken against her. She has never had, in all those years, a complaint before this board regarding her practice. She began treating chronic pain patients in 2008 when she was volunteering her time with Crossroads, [[00:50:01]] providing treatment to homeless patients. It was there that she began treating one of the patients involved in this case, DS. The records indicate, and you have copies of those records, that Ms. Ross did not initiate opioid treatment for that patient. She continued what was an existing treatment for that patient and for his chronic pain. She continued to provide some chronic pain management, some opioid treatment for patients in subsequent practices that she was involved in. That was never the focus of her practice. The treatment of chronic pain, the prescription of opioids, has never exceeded 20% of Ms. Ross' total practice. And you've heard from, not only Ms. Ross, but Mr. Hudspeth acknowledged that there were many aspects of Ms. Ross' care of these patients that was appropriate, and that met what he believes to be the standard of care. Ms. Ross provided no care to patients, prescribed no opioids for patients unless they had signed a patient contract, a pain management contract, a patient-provider agreement. She required some evidence, objective evidence, of the patient's reason for pain. This was not an instance that we've all heard about in other cases. This was not a case where patients walked in, requested a prescription and five minutes later walked out with one. That was not Ms. Ross' practice. She also looked for other treatments other than opioids. That was

not her focus, even for chronic pain patients, that was not her sole focus. She recommended other treatments, [[00:52:00]] cognitive behavioral therapies, physical therapy, steroidal injections. She tried to involve family members, tried to get information that would be helpful to her in providing care to these patients and trying to respond to their needs and to control their pain. The evidence also reflects that Mrs. Ross was not only willing but did discharged patients when they were unwilling to follow that contract, unwilling to follow the treatment that she had provided for them. Mr. Hudspeth has admitted and we all know that when a patient leaves an office with a prescription, the provider cannot control what happens with that medication. There's no question that this is a difficult population of patients to treat. We all know that there are challenges that are presented in treating these patients and in hindsight, Ms. Ross has told you in all candor, that there are things that she would do differently. Hindsight being what it is, looking back, there are things that she would do differently. But, like many providers who have found themselves in this situation before the boards, she has made the decision to no longer treat these patients. It is a risk inherent in treating these patients that the providers will end up before the licensing boards. And like many providers, Mrs. Ross is not willing to accept that risk any longer. So she's found other treatment settings, other chronic pain management providers who are willing to treat these patients and she has transferred them. But the one thing that I ask you to keep in mind, while there may be evidence, according to Mr. Hudspeth, that things could have been done differently, [[00:54:02]] should have been done differently, there is no evidence in this case that Ms. Ross was ever motivated by personal gain. She accomplished no personal gain. She made no more money. She had no reason to provide these prescriptions and care for these patients other than her goal to provide good care, to relieve these patients' pain. You've heard from Mr. Hudspeth about guidelines, standard of care, rules established by other entities, not adopted by this board, not adopted in this state. Mr. Walters has suggested that the rules in this state are "not abundantly clear." I think that's an understatement, they don't exist. It's not that they're not clear, this board has not adopted rules, regulations, statutes, even a policy that would guide Ms. Ross or other nurse practitioners in providing care to this challenging population. In your deliberations, I would ask that you take into account all of the evidence you've heard, not only the review of three patient charts, but the entirety of Ms. Ross' career, an unblemished career where she has provided good care to patients, a career that she's been dedicated to. And I would ask you on her behalf at the end of your deliberations, you not take a disciplinary action that would permanently mar that career. Thank you. [[00:56:06]]

- And thank you for your attention. There will not be a rebuttal in a real hearing. There will be a rebuttal and that would probably take us past our allotted time. But this is the type of environment you have. Hopefully what you've recognized here is even when you got cases where, "Oh my God, what is going on here? This kind of shocks me," there are other elements that provide challenges to boards of nursing, not the least of which is, in most states, the absence of clearly articulated guidelines or preferably, for us lawyers, a rule that does that. And it's no easy task. And so one of the purposes of this presentation was to prompt those issues and understand that this is how these types of things come up. In your handouts, you've been provided a database of statutes, regulations and other policies for pain management that were derived from the University of Wisconsin-Madison Pain and Policy Studies group. The link there if you want to access it. We also provided some resources and references for information about pain management, rules. Only two states, the state of New Mexico and the state of Washington have actually adopted rules. There are other policies and guidelines from

other agencies and organizations and a listing of notable cases. The balance of the PowerPoint was to reinforce a number of those policies, there's references to the CDC and a variety... [[00:57:57]] the Department of Justice, Practitioner's Manual, Federation of State Medical Boards, their policy which seems to be a very strong outline for these things. So, with that, this concludes the presentation and if there are any questions, we would be happy to take any of those up at this time. Any questions? Thank you very much for your attention, and enjoy the rest of the conference.