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THE SCOPE

MEDICAL EDITION

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EXECUTIVE MESSAGE

To Our MLMIC Insurance Company Policyholders:

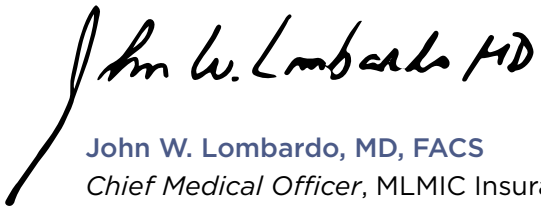
Despite the changes to our lifestyles, and society in general, that all New Yorkers have had to endure over the last year, we appear to be turning the corner on the COVID-19 pandemic as New York's hospitalization and infection rates continue to decline. The implementation and distribution of three newly developed COVID-19 vaccines is progressing rapidly, with priority appropriately being given to healthcare providers and those most susceptible to infection, in particular the elderly.

With this downward phase of the COVID-19 pandemic, there may be a temptation to dwell on the past. "If we had only done this, things may have been different." And there is certainly value in learning these lessons. With respect to our healthcare industry, what did we do correctly? What mistakes were made? What improvements can we make going forward? These questions will be asked and answered for years.

In the meantime, MLMIC continues to innovate for the benefit of its policyholders.

MLMIC.com and its portal are being updated with useful features for the administration of policies by both our policyholders and their staff, and its COVID-19 resources are being continually updated with the latest guidance, both national and local. And, later this month, MLMIC's Risk Management Department will release its latest CME program, *Diagnostic Error, Near Misses, and High Exposure Cases*, which will provide a 5-12% premium credit, 6.5 CME credits, and eligibility for the NYS excess insurance program to over 7,000 MLMIC physician policyholders.

While we can expect that COVID-19 will continue to throw us challenges, let's continue to face them with the determination and resolve that we demonstrated over the past year.



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Martin Clearwater & Bell LLP

Legal Considerations When Prescribing Psychotropic Medications to Elderly Patients

Elderly patients in long-term care (LTC) facilities and nursing homes are often prescribed psychotropic medications to manage psychological symptoms and behaviors, including anxiety, depression, agitation, and/or insomnia. Understanding the appropriate use, prescription, monitoring, and possible need to taper psychotropic medications is particularly important when administering such medications to elderly patients because they are more vulnerable to potentially serious side effects.

Common Psychotropic Medications

Anxiolytic medications are typically used to treat anxiety and may include Xanax, Klonopin, or Valium. These medications may cause sedation, memory issues, and/or psychomotor impairment, and long-term use may be especially risky for elderly patients. Antidepressant medications are commonly prescribed for depressive and anxiety disorders and/or insomnia, and may include Prozac, Lexapro, Zoloft, and Wellbutrin. Antipsychotic medications, such as Haldol or Seroquel, are typically prescribed to address psychotic symptoms, such as delusions or hallucinations, or disruptive behavior, especially in cognitively impaired patients. Such medications can have serious side effects, such as tardive dyskinesia or drug-induced Parkinsonism. Since each psychotropic medication has its own indications and potential adverse effects, the choice, dosing, and duration must be critically considered and reassessed in relation to the patient's medical conditions or symptoms.

Staff Training, Patient Assessment, and Informed Consent

Nurses, CNAs, and other staff members at LTC facilities and nursing homes who are typically responsible for monitoring elderly patients may need additional training, since they likely have varying degrees of knowledge about psychotropic medications and their potential side effects. All staff should also be appropriately trained to distinguish between signs of mental disorders and normal signs of aging. This may require psychiatric, geriatric, and/or pharmacological training and formal consultation with experts in such fields, as necessary. All medical staff should be aware of pharmacokinetic changes that occur naturally with age and may impact how a patient reacts to the intake of psychotropic medications. These include changes in the rate of absorption, metabolism, excretion due to reduced renal function, and/or

All staff should also be appropriately trained to distinguish between signs of mental disorders and normal signs of aging.

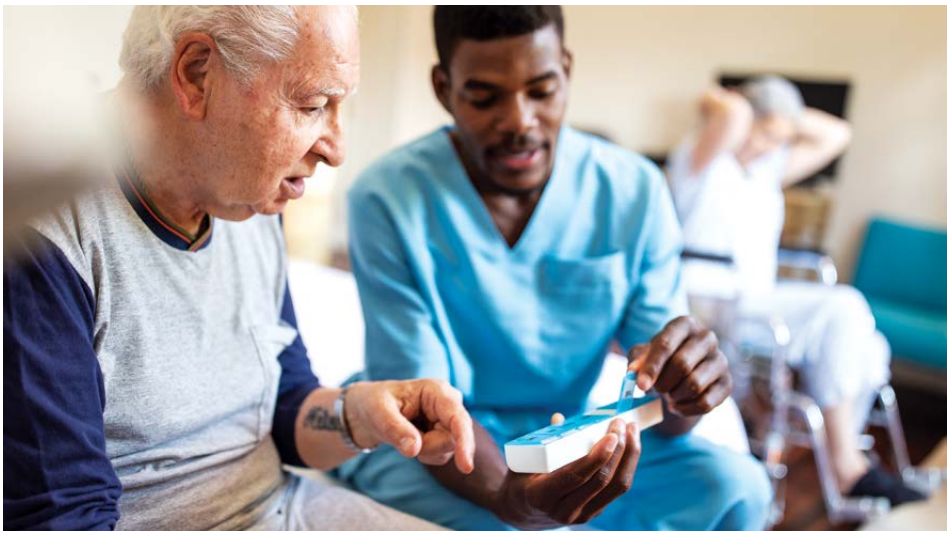
distribution caused by changes in body water and body fat.

Given the risks associated with prescribing psychotropic medications to elderly patients, physicians should consider a trial of alternative treatments first. Nonpharmacological approaches such as increased socialization and structured activities, as well as pet, music, massage, and/or aroma therapies may help with sensory issues, anxiety, and/or depression. Even if nonpharmacological techniques do not wholly address a patient's symptoms, their use may lead to the need for fewer or lower doses of psychotropic medications. Their use or attempted use may also be beneficial from a defense standpoint. The failure to respond to nonpharmacological treatments can be used to support the indication and

Even if nonpharmacological techniques do not wholly address a patient's symptoms, their use may lead to the need for fewer or lower doses of psychotropic medications.

judgment to proceed to prescribe psychotropic medications.

When it is determined that the prescription of psychotropic medications is appropriate, the healthcare provider should consider and follow several important steps. In this regard, before prescribing psychotropic medications to manage



behavioral disturbances and psychiatric symptoms, other possible causes should be ruled out, such as delirium, pain, fatigue, hunger, incontinence, and/or infection or other underlying medical condition(s). In the elderly population, altered mental status is often a sign of infection, including urinary tract infections. As such, the prescribing physician must evaluate and rule out an underlying medical cause of the symptoms.

Additionally, underlying social habits may be the source of behavioral issues, including withdrawal from alcohol, caffeine, or nicotine. Many elderly patients may have atypical symptoms of depression or anxiety, which must be evaluated by psychiatric consult. Various medications that the elder population are commonly administered can affect behavior, and it is important to avoid treating side effects of one drug with another drug. Thus, proper training and assessments by multiple specialties may be helpful or necessary.

The patient's entire list of medications should be reviewed to ensure that there are no adverse drug interactions or other drugs that the patient

Many elderly patients may have atypical symptoms of depression or anxiety, which must be evaluated by psychiatric consult.

is already taking that have adverse side effects, such as the risk of falls, which may be worsened by the addition of the psychotropic medication. This review will help confirm the appropriateness of prescribing the psychotropic medication and help determine the appropriate dose, as well as to what extent the patient will need additional or new forms of monitoring, testing, or other precautions. Typical recommendations include starting psychotropic medications at a low dose with gradual increases, as indicated. It may also be beneficial to time-limit prescriptions to

promote reassessment and a further determination of whether the medication is effective and/or necessary, long term.

Finally, it is also imperative to obtain a patient's (or his/her healthcare proxy's) informed consent before prescribing psychotropic medications, and to create detailed documentation of all related discussions.

Medication Risks and Policy and Procedure Evaluations

Each psychotropic medication has its own associated risks. Guidelines from the Food and Drug Administration, American Medical Association, American Psychiatric Association, and/or Physicians' Desk Reference may be helpful resources for learning about such risks and each drug's prescribing recommendations. Information from such guidelines may further assist medical staff in properly informing patients about psychotropic medication options that may be prescribed, and ensure their proper administration with reduced, if any, side effects. Electronic prescribing software may also be helpful if it provides alerts about potential medication problems and/or updates about newly issued warnings.

LTC facilities and nursing homes will also want to ensure that their policies and procedures comply with the aforementioned guidelines and, more so, with the current federal and state laws. The Omnibus Budget Reconciliation Act of 1987 (OBRA) is a federally implemented act that was developed after there was a spike in severe adverse side effects and inappropriate prescribing practices associated with psychotropic medications in nursing homes. OBRA comprehensively mandates minimum requirements for nursing homes that administer such medications and limits their use. The Centers for Medicare and Medicaid Services (CMS) also issues guidelines about the pharmacy services allowed in long-term care settings. For instance, CMS issues F-tag guidelines, which correspond to specific stipulations within the Code of Federal Regulations. These include Tag F-329, which states "Unnecessary Medications." Such guidelines are often revised, so they must be monitored for updates and applied appropriately, which may require legal consultation.

OBRA was developed after there was a spike in inappropriate prescribing practices associated with psychotropic medications in nursing homes.

Collaboration, Communication, and Monitoring

Geriatric psychiatrists should provide consults prior to the administration of psychotropic medications if possible. The prescribing physician should be aware that he/she is likely to bear the brunt of liability for any medical malpractice or negligence claims related to the administration of psychotropic medications. Thus, it is critical to be familiar with current prescribing information in order to make appropriate medical decisions for individual patients. It is also beneficial to ensure collaboration with the nurses and other clinical staff who monitor the patient day to day, more than the physician who is not with the patient as regularly. Nurses and other clinical staff should work collaboratively with physicians to promptly identify side effects as they develop and share this information with the prescriber. The physician may then carefully address those findings and consider dose titration or other medication options before the side effects become severe or cause injury.

... clinical staff should work collaboratively with physicians to promptly identify side effects as they develop ...

Common side effects to be aware of include, but are not limited to, sedation, hypersalivation, gastrointestinal effects (nausea, constipation, diarrhea), liver effects, endocrine effects (weight gain, diabetes), and epilepsy. Monitoring for changes in symptoms is critical and may require bloodwork on a regular basis. Some psychotropic medications can also cause diabetes, blood clots, stroke, or cardiac arrest, and may put

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Feeling the weight of extra worry and pressure?

We Can Help.

As a doctor, you face stress on the best of days. With pandemic conditions fueling widespread depression, anxiety, emotional distress, and worry, you need support more than ever.

MLMIC Insurance Company and the Medical Society of the State of New York (MSSNY) are here for you.

Call the free Physician Support Hotline (888) 409-0141

8 a.m. to 12 a.m. ET, 7 days a week

Supportive therapy from peers to help you manage stress, whether or not it's linked to the pandemic. No appointment necessary.

For additional COVID-19 resources, including hotlines, FAQs, executive orders, blog posts, and more, visit **MLMIC.com/covid-19**.

MLMIC is proud to partner with MSSNY to provide these resources and services for our medical community.

For more information on MLMIC, call (800) ASK-MLMIC or visit MLMIC.com.

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POLICYHOLDER NEWS AND PERKS:

MLMIC's Mobile App; 24/7 Legal Advice

Mobile App

MLMIC Insurance Company's popular mobile app is now available on Google Play. While previously available in the App Store® for Apple® mobile device users, the expansion to accommodate Android™ device users puts the power of on-the-go access to MLMIC's membership perks in the hands of more policyholders and their authorized representatives. When you download the MLMIC app, you can tap into over 45 years of exclusive, New York-focused medical professional liability expertise, wherever you are.

Using the MLMIC mobile app, policyholders can log in to MLMIC.com's secure portal to address a range of policy-related matters, including obtaining policy documents such as certificates of insurance, checking on the status of renewal application updates and invoicing, and reviewing online payment options. Available and applied policy premium discounts can also be viewed using the portal.

MLMIC mobile app users can access and complete Risk Management courses online to obtain CME credits, a premium discount, and eligibility for the NYS excess insurance program, as well as explore the extensive library of MLMIC publications and educational materials. The MLMIC app also allows the user to make contact with MLMIC's Risk Management professionals directly via phone and email.

The MLMIC mobile app also allows the user to request a call or email from a MLMIC representative for service and assistance with a policy-related question, a request for a rate quote, questions about CME, and questions on possible or existing claims.

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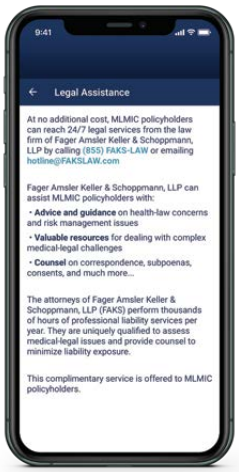
FAKS 24/7 Legal Advice



One of the most valuable, exclusive perks MLMIC offers its policyholders is the ability to avail themselves of around-the-clock, fee-free access to the legal expertise of the healthcare attorneys at Fager Amsler Keller & Schoppmann, LLP (FAKS). Reaching FAKS is now even easier, since the MLMIC mobile app enables the user to call or email FAKS directly from within the app.

FAKS can also provide answers to healthcare law questions and guidance on risk management issues, as well as offer resources to assist MLMIC insureds in dealing with the increasingly complex medical-legal challenges they face every day.

Policyholders can contact FAKS for assistance with matters such as:

- providing legal representation in court and legal counsel for administrative proceedings;
- providing expert guidance on risk management issues;
- offering ongoing education on medical-legal topics;
- reviewing and preparing a variety of healthcare-related medical-legal documents, including, but not limited to, consent forms, memoranda, practice policies and procedures, and general releases;
- addressing difficult patients, as well as a variety of other office-related risk management, regulatory, and compliance issues, by providing practical solutions; and
- providing MLMIC policyholders with the most up-to-date articles, publications, presentations, and information on the most timely medical-legal topics affecting healthcare providers.

Please do not hesitate to contact FAKS at any time to avail yourself and your practice of these services. MLMIC policyholders can reach FAKS 24/7 for assistance with legal emergencies by calling **(855) FAKS-LAW** or emailing **hotline@FAKSLAW.com**.

CASE STUDY:

Failure to Follow up on Testing Referral Results in CVA

Initial Treatment

A 51-year-old male stockbroker who had been treated by a cardiologist and bariatrician was referred to the MLMIC-insured internist, whose practice took a holistic approach to medicine using nutritional supplements. When first seen by the internist in February 2007, the patient's medical history form indicated stress, hypertension, and headaches in 1988, for which he was hospitalized for three days and underwent an MRI of the brain, which was negative.

The patient had been off medications and taking supplements for three years. His family history included his deceased mother and sibling having myotonic dystrophy and his living father having undergone coronary bypass. The patient was a divorced father of two adult children, living with his girlfriend and her teenage children.

The patient had been off medications and taking supplements for three years ...

During this initial visit, the patient complained of being off-balance with light-headedness and blurry vision. His blood pressure, which was controlled by diet, was 120/90. An EKG showed normal sinus rhythm, poor R wave progression to V3-V6, and no ST-T wave changes. The insured felt the EKG findings could be indicative of a blood glucose abnormality due to gastrointestinal complaints of gas and bloating. A glucose tolerance test was negative, but the patient was advised to add acidophilus and avoid food with yeast/fermentation. Laboratory studies were obtained and reported to the patient four days later. A Vertical Auto Profile

His glucose tolerance test result was very low, indicating the patient was insulin resistant.

(VAP) test was used for cholesterol screening. The patient's LDL was elevated and his TSH was borderline. His glucose tolerance test result was very low, indicating that the patient was insulin resistant. He was advised to decrease sugar intake, dietary supplements were prescribed, and he was provided with a daily health guide.

Follow-up Examination

The patient was next seen in February 2008, at which time he reported that, one week earlier, he had become disoriented and had to sit down. He had also experienced chest pain that originated in his neck muscles and was associated by the internist with muscle spasms. At the time of this visit, the patient made no complaints of chest pain or shortness of breath, and his blood pressure was 108/70. An EKG demonstrated T-wave inversion of V4-V6, normal sinus rhythm, left atrial enlargement, and no R wave progression. Labs revealed that the patient's cholesterol was 191, HDL 51, LDL 123, and his triglycerides were 62.

The patient was advised that his CT scan, troponin, and cardiac enzymes were normal and, as such, an Electron Beam Computerized Tomography (EBCT) test for coronary artery disease was recommended. The insured had a telephone conversation with the patient on February 29, 2008, and advised him to hold off on taking his thyroid supplement, increase his vitamin D to 800 units, repeat his labs, and have them rechecked again in four months.

Our insured communicated with the patient via email in April, May, and August of 2008, and they had a telephone conversation on October 7, 2008, at which time the patient complained of stomachaches and requested a referral to a gastroenterologist. During this period, the insured did not see the patient and did not question why the patient had not had the recommended EBCT test or returned to the office for follow-up.

Patient Hospitalized

On December 4, 2008, the patient was admitted to the hospital via the emergency room due to speech disturbance and altered mental status. He was aphasic, confused, had elevated cholesterol, and his EKG showed a left anterior

He underwent speech and physical therapy for CVA, expressive language disorder, and aphasia. The patient could read multi-page complex material and answer questions with 90% success.

fascicular block with abnormal ST-T waves. A day later, the patient was able to name objects and follow commands.

On the following day, the patient's girlfriend requested a transfer to another hospital, where the patient was seen by a neurologist who

diagnosed middle cerebral artery (MCA) syndrome with non-fluent expressive aphasia due to a cerebrovascular accident (CVA). An EKG showed regular sinus rhythm, and the findings of a cerebrovascular duplex scan included left internal carotid artery stenosis of 40-60%.

On December 10, 2008, the patient was discharged to a rehabilitation center, where he remained for three months. He underwent speech and physical therapy for CVA, expressive language disorder, and aphasia. The patient could read multi-page complex material and answer questions with 90% success. During his admission, he was aware that he had had a stroke, was now not able to speak, and had anomic aphasia, but he had no problems with auditory comprehension or reading.

... [the patient] was aware that he had had a stroke [and] was not able to speak ... but he had no problems with auditory comprehension or reading.

The patient's speech improved, but he had to think about words. He was noted to be functioning at an average level, whereas prior to the injury, he would have scored in a high average range. His processing speed was variable, and he had mild difficulty with basic attention and significant difficulty with arithmetic. The patient had some residual problems, but was functioning well cognitively. During this period, the patient's cardiologist advised him that the MLMIC-insured internist had missed an extensive anteroseptal myocardial infarction that had occurred prior to the patient's initial visit.

Subsequent MI and Lawsuit Filed

In April 2009, the patient underwent cardiac catheterization with stent placement due to a diagnosis of myocardial infarction. Despite rehabilitation, it was clear that the patient had plateaued and, as such, it would be argued that his functional level was permanent. Given language and communication problems that included hesitant speech, the patient felt unable to adequately function at work. He was ultimately deemed disabled.

This case was reviewed by various MLMIC consultants, who found problems with the care provided by the internist, notably the failure to recognize changes in the EKG, the failure to diagnose an MI, the failure to refer the patient to a cardiologist, the failure to recognize that the patient had an embolic stroke, and the failure to follow up with the patient when he did not return to the office as requested.

Outside expert reviews were also critical of the internist for his lack of follow-up and failure to refer the patient to a cardiologist.

Outside expert reviews were also critical of the internist for his lack of follow-up and failure to refer the patient to a cardiologist. While MLMIC's cardiology expert could defend most of the case, he found a departure from the standard of care in that the insured did not follow up with the patient as to why he did not have the EBCT that had been recommended. In addition, he found no proximate cause defense as he believed that the failure to treat the heart condition likely deprived the patient of a reasonable chance of avoiding a stroke. MLMIC's neurology expert also could not defend the care provided as he noted the patient would have had a 20-25% decrease in the chance of having a CVA had the patient been diagnosed and given Plavix. As a result, it was recommended that this case be settled.

The defense counsel provided an evaluation of this case that included a sustainable value of $4 million for pain and suffering, and lost earnings of $1.3 million. The plaintiff was receiving long-term disability benefits as well as Social Security Disability. The plaintiff's counsel made a settlement demand of $4 million. A consent to settle was sought from the internist and, despite his initial refusal to sign the consent, he eventually acquiesced. The case was settled prior to trial for $2,250,000. This amount included the insured's full primary professional liability insurance layer as well as a portion of his excess insurance coverage.

A Legal and Risk Management Analysis

The MLMIC-insured internist's inadequate medical assessment led to a misdiagnosis that contributed to life-altering and irreversible injuries for the patient. These injuries could have been avoided if the internist had referred the patient to the appropriate specialist for a more detailed comprehensive workup.

At the office visits, the internist failed to appreciate the patient's

complaints of being off-balance with light-headedness and blurry vision, being disoriented, and experiencing chest pains that originated in his neck muscles and were associated with muscle spasms. The failure to appreciate these complaints revealed that the physician lacked specialized knowledge in this area of medicine and the patient should have been referred to the appropriate specialist. The standard of care for referring patients requires a physician to refer when any other reasonable physician with similar qualifications would refer a patient to another physician because he/she does not have the specialized knowledge to treat that patient. This duty protects patients from inadequate treatment and protects doctors from being held liable for providing care beyond the scope of their qualifications.

The failure to appreciate these complaints revealed that the physician lacked specialized knowledge in this area of medicine and the patient should have been referred to the appropriate specialist.

Also, the internist failed to appreciate the patient's significant family medical genetic history, which included myotonic dystrophy and cardiac issues. The fact that the patient provided positive, pertinent responses about his family's medical history and had similar symptomology himself indicated that further evaluation by a specialist should have been considered. Obtaining an accurate family health history from a patient is an effective tool for all physicians and other healthcare providers, as it provides for a more comprehensive approach to the overall care and treatment of the patient. Family history plays a critical role in assessing the risk of inherited medical conditions and single-gene disorders. It can identify people with a higher-than-usual chance of having common disorders, and can also provide information about the risk of rare diseases and conditions.

During treatment, the internist recommended that the patient undergo an EBCT and have a retest in four months. The patient failed to follow this medical advice. Although there was non-compliance on the part of the patient, it was still the internist's responsibility to follow up with him. The patient's failure to get a recommended test with no follow-up put his health in jeopardy and made the treating provider a potential target in malpractice litigation.

The internist had direct communication with the patient on four separate occasions ... but he made no attempt to reinforce the importance of the required test.

The internist had direct communication with the patient on four separate occasions during a five-month span regarding complaints of abdominal pain, but during these communications, he made no attempt to reinforce the importance of the required test. The internist also failed to discuss the need for follow-up or attempt to schedule an appointment when the patient was in his office, despite the patient's continued additional physical complaints.

The internist was required to discuss the importance of compliance with recommended testing, the benefits of the test, and the risks involved in not adhering to the proposed treatment plan. The internist also needed to remind the patient that timely follow-up is vital for ensuring proper future care. These combined failures resulted in the large settlement that was awarded in this case.

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RM TIP#

27 Utilizing Telehealth in Your Practice

THE RISK: Telehealth continues to rapidly expand, due in large part to the COVID-19 pandemic, and is viewed as an effective method of healthcare delivery. It may reduce costs, increase access, decrease wait times, enhance patient compliance, and increase patient and family engagement. Conversely, with the use of telehealth come considerable costs associated with obtaining the necessary equipment, unclear or evolving reimbursement issues, and an increased risk of privacy breaches. Patients and providers alike must also be motivated to "buy in" to the process. Additionally, many providers have concerns that significant clinical signs and symptoms may be missed by the distanced examination.

A properly selected telehealth system can provide an effective format for healthcare delivery absent an in-person visit. Many factors must be considered when implementing telehealth technology in your practice. The following recommendations will help you determine if the use of telehealth technology will benefit you and your patient population:

RECOMMENDATIONS:

1. Assess the needs of your providers and patients to determine which telehealth platform is best suited to your practice. This may include one or more platforms. The four main categories are:

- Live Video-Conferencing
- Asynchronous Video (Store-and-Forward)
- Remote Patient Monitoring (RPM)
- Mobile Health (mHealth)

2. Waivers have been put in place during the COVID-19 pandemic that allow for the use of FaceTime and other non-HIPAA-compliant platforms. This will require diligent monitoring by the practice for the potential removal of such waivers in the future.

3. As part of the vendor selection process, ensure that they offer a secure, HIPAA-compliant platform that also provides data encryption and allows you to protect patient data and comply with privacy regulations and disclosure protocols in case of privacy breaches. Vendors must provide a Business Associate Agreement.

4. Include key staff and providers in the system selection process. Explore the ability of the vendors to customize platform options that fit your needs.

5. Create an informed consent process and a document for the use of telehealth services, as recommended by the American Telehealth Association.[1] Contact the law firm of **Fager Amsler Keller & Schoppmann, LLP** to obtain their sample consent form.

6. Generate and retain formal documentation of all telehealth patient care appointments. This documentation should be part of the patient's record, and all aspects of the encounter should be thoroughly documented.

7. Establish a monitoring program or quality improvement process to evaluate patient care outcomes and technical performance issues. Include questions regarding the telehealth experience in patient satisfaction surveys.

8. Prepare a contingency plan for use in case of a technology failure. Communicate any disruption in service to the patient as soon as possible in advance of a scheduled telehealth encounter.

9. Engage in continuing education to ensure key competencies. Both providers and staff should receive ongoing education regarding updates to the practice's telehealth system, along with refreshers on patient privacy and engaging patients via telehealth.

[1] https://www.americantelemed.org/

FROM THE BLOG

MLMIC's blog provides ongoing and up-to-date news and guidance on important events and announcements that affect the practices of our insured physicians and other healthcare providers.

If you are interested in receiving informational posts such as the following, please be sure to sign up to receive MLMIC's *Healthcare Weekly* – the latest MLMIC Insurance Company news and links to relevant and valuable industry articles.

FEB 10, 2021

How the 2021-22 Proposed NYS Executive Budget Impacts Medical Liability and Healthcare in New York

MLMIC's newest edition of *The Albany Report* helps policyholders understand the potential impact of New York State's proposed 2021-22 Executive Budget on the healthcare provider community. **READ MORE**

FEB 9, 2021

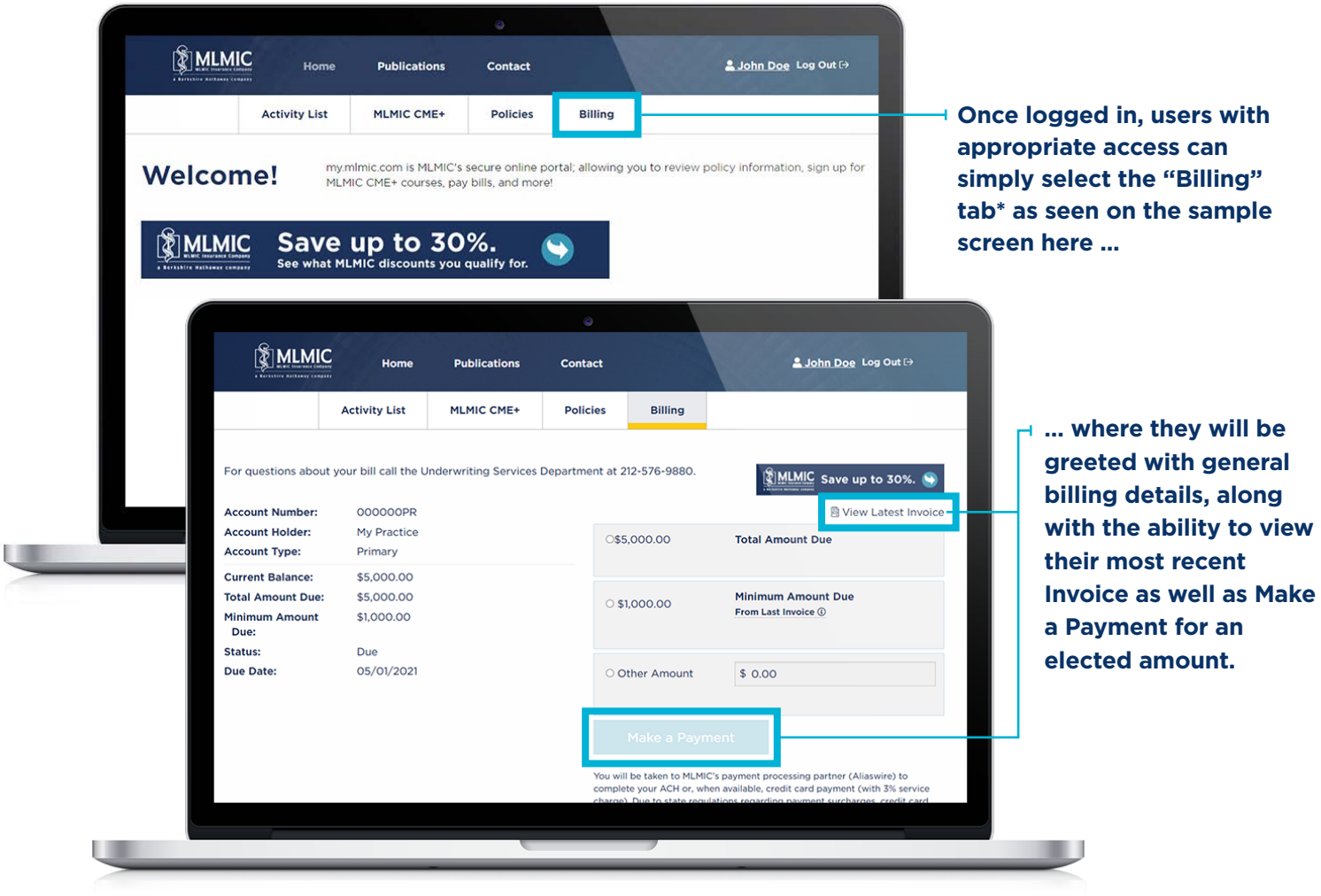
ECRI Releases Top Health Technology Hazards for 2021

The Emergency Care Research Institute's 2021 list of technology hazards can help healthcare facilities effectively manage risks involving the use of medical devices and systems. **READ MORE**

MLMIC's Online Portal Access

Online Policy Premium Payment Options

Save time and effort by making premium payments online through the MLMIC Portal. Designated portal users whose accounts have been enabled for electronic payments ("ePayments") may make expedited premium payments via the MLMIC online portal, which is accessible 24/7 on our website, **MLMIC.com.**



Once logged in, users with appropriate access can simply select the "Billing" tab* as seen on the sample screen here ...

... where they will be greeted with general billing details, along with the ability to view their most recent Invoice as well as Make a Payment for an elected amount.

*If the Billing tab is not visible, please contact MLMIC.com Portal login assistance at the number provided on the following page.

Premium Payment Options

When directed to the payment processing screen, available payment options will include a no-fee Automated Clearing House (known as "ACH") offering that allows for paperless payments to be made electronically in place of having to issue and mail a check. ACH payments process more quickly than traditional payments and are more secure. We encourage our policyholders to utilize this payment platform upon receipt of their next installment invoice. Credit card payments are also accepted and are subject to a 3% surcharge fee. Completed ePayments will generate an automated email receipt from our payment processing partner, which will be sent to the portal user's email address, confirming the transaction.

MLMIC.com Portal login assistance, if needed, is available at (888) 234-0752.

‹ *Prescribing Psychotropic Medications continued from page 5*

elderly patients at greater risk for these complications given their medical history and current clinical condition. For these reasons, it is also important to carefully monitor the length of time a patient has received psychotropic medications.

Deviations from the Standard of Care

Medical malpractice and/or negligence claims related to the administration of psychotropic medications will often involve allegations that the defendant medical professional and/or the LTC facility or nursing home deviated from accepted standards of care by improperly prescribing such medications. More specifically, patients may claim that they were prescribed an excessive amount of psychotropic medications, and/or for a duration of time that was too long, resulting in injury. Patients may also claim that their adverse symptoms or reactions were not properly monitored or appreciated because there was insufficient staffing, testing, and/or training.

Overmedication is a common allegation for patient falls and associated injuries. Therefore, nursing should reassess the fall risk for patients starting psychotropic medications, which may increase this risk. Additionally, it is commonly claimed in litigation that the sedative effect of psychotropic medications caused the patient to be unable to comply with physical therapy, setting back their recovery or resulting in a deterioration of overall status. Another common allegation is that such medications resulted in incontinence and/or other medical complications.

The use of psychotropic medication often results in punitive damages claims being alleged, with the plaintiff contending that, rather than providing increased socializing or other interactive interventions, sedation was used for the convenience of staff since it made it easier to manage the patient. When defending against such claims, documentation should reflect that nonpharmacological interventions were attempted, that underlying medical issues were considered and ruled out, that the patient and family were informed of the indications for the pharmacological treatment and provided consent, and that the patient was monitored, and changes in treatment and/or dosage of medication were made if/when necessary. If the patient had been previously administered such medications, this will be helpful in defending the administration at issue. If there is a history of prior use of such medications, any side effects experienced should be documented.

The Importance of Documentation

Thorough documentation regarding the patient's underlying functional status may be helpful in defending claims that the psychotropic medication resulted in deterioration of the patient's condition. Preexisting comorbidities are the likely source of a patient's deterioration, and clear documentation as to those conditions throughout the admission will support the defense that the decline was related to those underlying medical conditions, rather than having been caused by the psychotropic medications. If a patient is DNR/DNI, evaluated and/or accepted by hospice, and there are documented discussions with the family regarding the patient's condition and prognosis, this information can be used as a defense in litigation.

Documentation as to the patient's prior use of psychotropic medication(s) and the effect of the prior treatment will be helpful in supporting the use during the admission at issue.

While there are many ways to defend against claims associated with the allegedly improper prescription of psychotropic medications, in most cases, the success of the defense will depend in large part on the medical record. Documentation as to the patient's prior use of psychotropic medication(s) and the effect of the prior treatment will be helpful in supporting the use during the admission at issue. Attempts at

alternative nonpharmacological interventions, including increased socialization and activities, and nursing documentation supporting frequent attempts to redirect the patient, will assist in countering claims that sedation was used for the convenience of staff.

It is critical that appropriate consults take place to rule out an underlying medical condition as the source of the behavior, particularly in cases where the patient experiences a change in behavior during the admission. In the elder population, underlying infections, including urinary tract infections, are often associated with an alteration in mental status, so this and any similar possible causes must be considered. Psychiatric consults may be obtained prior to prescribing psychotropic medications, and the patient and their family must be informed of the indication for the treatment and provide consent. When psychotropic medications are administered, they should be started at the lowest recommended dosage. Adjustments can always be made based on the patient's response.

In the elder population, underlying infections ... are often associated with an alteration in mental status ...

Critically, nursing assessments, particularly those related to fall risk, must be performed, and the impact of the psychotropic medications must be considered. The administration of psychotropic medications may very well increase the fall risk for patients, depending on the medication and patient. Thus, it is important to keep the aforementioned risk factors and the standard of care in mind when administering psychotropic medications to elderly patients. Such clinical practices and appropriate documentation will ultimately promote a stronger defense if litigation is initiated years later.

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