IN THE MATTER OF	*	**BEFORE THE**
TREVIA F. HAYDEN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D53096	*	**Case Number: 2014-0109**

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CONSENT ORDER

On November 19, 2014, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") voted to offer the following Consent Order to **TREVIA F. HAYDEN M.D.,** (the "Respondent"), License Number D53096, after determining that Disciplinary Panel B has grounds to charge the Respondent under the Maryland Medical Practice Act (the "Act"), Md. Code Ann. Health Occ. ("H.O.") §§ 14-101 *et seq.* (2014 Repl. Vol.).

The pertinent provisions of the Act under H.O. § 14-404 provide the following:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

Prior to the Disciplinary Panel B's issuance of formal charges, the Respondent agreed to enter into the following public Consent Order, consisting Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Disciplinary Panel B makes the following findings of fact:

I. Background

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland in March 1998. The Respondent last renewed her license in or about August 2014, which will expire on September 30, 2016.

2. The Respondent maintains an office, "Vitality Health Associates," for the solo practice of medicine, specializing in psychiatry, in Frederick, Maryland.

3. The Respondent is board-certified by the American Board of Psychiatry and Neurology, in Psychiatry, which will expire on December 21, 2019.

4. The Respondent does not hold any hospital privileges.

II. Complaint

5. On or about July 29, 2013, the Board received a complaint from the mother of one of the Respondent's adult patients (the "Complainant"). The Complainant stated that her daughter is addicted to an opioid, Opana, which has been prescribed for her by the Respondent. The Complainant further stated that in July 2013, she tried to alert the Respondent to her daughter's condition but she did not receive a response to her two telephone calls.

III. Investigation of Complaint

6. In August 2013, the Board initiated the investigation. The Board issued subpoenas to two national chain drug stores and to three local pharmacies in the vicinity

of the Respondent's office for computer printouts of controlled substances prescribed by the Respondent from January 2013 to the date of the subpoena, August 23, 2013.

7. On December 2, 2013, the Board issued a subpoena to the Respondent, requiring the Respondent to submit the medical records of four of the patients who were listed on the computer printouts, including the medical records of the daughter of the complainant. The Respondent was also asked to submit written summaries of her care of each of the four patients.

8. On December 11, 2013, the Respondent responded by providing the medical records and summaries of care of three of the patients, and stated that the fourth named individual has not been a patient of hers.[1]

9. On February 21, 2014, Board staff interviewed the Complainant under oath.

10. On March 6, 2014, the Board notified the Respondent that it had opened an investigation and requested a written response to the allegations of the complaint.

11. On March 12, 2014, the Respondent submitted her response which included the following:

a. The Respondent was out of the office from July 19, 2013 through July 23, 2013 due to a family medical emergency;

b. On July 23, 2013, the Respondent's answering service received a call from the Complainant which the Respondent's office staff returned. Office staff explained that the Respondent was out of the office and they could neither confirm nor deny that her daughter was a patient. The Complainant did not submit a written statement nor attend any of her daughter's appointments; and

c. The Respondent prescribed Opama for the daughter as a "short term intervention due to access of care issues."

[1] The patient's name may have been inadvertently misspelled on the subpoena.

12. On March 25, 2014, the Board issued a subpoena to the Respondent for the medical records of two additional patients.

13. On June 2, 2014, Board staff interviewed the Respondent under oath who stated:

a. She has had her private practice since 2004;

b. Her practice is general psychiatry that combines conventional and complementary medicine;

c. Her areas of expertise include psychopharmacology, psychiatric aspects of medical patients including treating chronic pain, women's health, anxiety and PTSD of veterans;

d. Her patients have complicated medical histories, fibromyalgia, chronic fatigue, rheumatoid arthritis, cystitis, thyroiditis, post partum depression, or complicated pregnancies;

e. Approximately 30% of her patients have a single primary psychiatric diagnosis; the remainder have either women's health issues or patients with a concomitant medical condition;

f. Less than 5% of her patients are cash paying;

g. All five of the patients reviewed had "access to care issues," meaning their insurance had lapsed or they were no longer receiving workers compensation so they were self-pay; two of the patients are military people, were diagnosed with Gulf War Syndrome, and had transportation difficulties to the Veterans Administration facility in Baltimore or Martinsburg, Virginia; and

h. The majority of her patients who have chronic pain are managed in a chronic pain clinic.

14. On June 17, 2014, the Board sent the complaint, the Respondent's written responses, transcripts of the interviews of the Complainant and the Respondent, the five medical records as received, summaries of care, and pharmacy computer printouts to two physicians, both board-certified in psychiatry, to conduct independent peer reviews and on June 27, 2014, the Board sent the same documents to a second

physician, also board certified in psychiatry, to conduct an independent review.

15. On July 15, 2014 and August 22, 2014, respectively, the Board received the peer review reports. The peer reviewers concurred that with regard to five of the five patients reviewed Respondent failed to meet the appropriate standards for the delivery of quality medical care and failed to keep adequate medical records.

16. The Board sent copies of the peer review reports to the Respondent with the names of the reviewers redacted requesting a Supplemental Response.

17. On September 12, 2014, the Board received the Respondent's Supplemental Response, which was subsequently reviewed by the two peer reviewers.

IV. Findings of Violation of Maryland Medical Practice Act, Specifically Violation of H.O. § 14-404(a)(22) and (40)

18. According to the two independent peer reviewers, based on their review of the medical records, the Respondent failed to maintain adequate documentation in regard to her care and treatment of Patients 1[2] through 5 in violation of Health Occ. § 14-404(a)(40) for reasons including but not limited to that she:

a. Failed to maintain organized, chronological, legible, comprehensive and coherent medical records;[3]

b. Provided minimal documentation in her initial assessments, with the exception of Patient 4, had very minimal or missing progress notes, and did not use medication flow sheets;

c. Failed to provide support in the medical record for the care which she testified she was providing;

d. Failed to provide documentation sufficient to permit another clinician to understand:

[2] Patient names are confidential and are not used in the charging document. Respondent is aware of the identity of the patients.

[3] The Respondent states that she has been using electronic recordkeeping since 2010.

i. The clinical phenomenology that led to the diagnostic conclusions;

ii. The interim history and examination of current status that led to the treatment interventions such as starting medications, stopping medications, changing medication dosages, the use of dosages in atypically high ranges, and/or the need for and the focus of psychotherapy;

iii. When treating chronic pain, the detailed subjective and objective data demonstrating the nature of the chronic pain, other attempts to treat the pain with methods which have lower risks than narcotics, the rationale for the choice of narcotics, and detail of the specific somatic responses, or lack of response, over time to justify maintenance of narcotics or dosage changes;

iv. If using more than one narcotic, and/or high doses of narcotics, and or large quantities of controlled substances that have risks of addiction, abuse, diversion and overdose, such as narcotics and benzodiazepines, the clinical observations and rationale that justify the use of "outlier" clinical choices;

v. The history of all prescriptions given to the patients, either in a medication flow sheet, or in the progress notes, with dates and quantities so that the flow of medication prescribed and the changes are coherent and can be followed; and

vi. The psychological issues that are being addressed and their progress over time.

19. According to the two independent peer reviewers, based on their review of the medical records, the Respondent failed to meet appropriate standards for the delivery of quality medical care in regard to her care and treatment of Patients 1 through 5[4] in violation of Health Occ. § 14-404(a)(22) for reasons including but not limited to that:

a. In regard to Patients 2 and 3, when prescribing opiates, benzodiazepines and other medications with potential for abuse, addiction, and diversion, the Respondent failed to use the minimal dosages that are effective, with documentation of how a dosage levels is achieved. When levels were particularly high, the Respondent failed to document justification for such high doses and their continuation;

[4] Patients 3 and 4 are husband and wife.

b. In regard to Patients 2 and 3, when prescribing opiates, the Respondent failed to use the minimal number of different opiates to minimize the risk of drug interactions, overdoses, especially in these patients with documented psychiatric issues such as mood disorder, misuse, or diversion. When the Respondent prescribes more than one opiate at a time, the Respondent failed to use a short acting and longer acting (e.g. oxycodone and Oxycontin) of the same kind of opiate and instead prescribed two different kinds of opiates (e.g. oxycodone and hydromorphone), and used three or more different kinds of opiates simultaneously in the same patient;

c. In regard to Patients 1, 2, 3, and 5, when prescribing opiates and/or benzodiazepines, the Respondent provided multiple copies of the same prescription written in advance "just in case" there are limited supplies at the pharmacy. The Respondent failed to document a conversation with the pharmacist confirming the shortage before furnishing an early refill or replacement prescription;

d. In regard to Patient 3, Respondent failed to document evidence of a seizure disorder and collaboration with a neurologist when treating Patient 3 with anticonvulsants for a seizure disorder;

e. When treating chronic pain disorder with opiates, as with Patients 1, 2, and 4, the Respondent failed to make attempts to have Patients 1, 2, and 4 seek other forms of non-pharmacotherapy as part of a multi-modal approach to pain, such as acupuncture, hypnosis, chiropractic, massage, exercise, meditation, physical therapy, injections, orthopedic consultations, to lessen the need for potentially addictive or abusable opiates;

f. When prescribing large quantities and varieties of opiates, as is the case with Patients 2 and 3, Respondent failed to make efforts to advise patients, and to document the measures, to safeguard others in their home such as workers, children, elderly people, and visitors from obtaining these medications. This is particularly important when dispensing large quantities of abusable and addictive substances to multiple members of the same household, as is the case with Patients 2 and 3, due to a multiplication of the risk potential for confusion of medications, utilization of each other's prescriptions, and expanding the availability of large supplies that could be used for overdosing by either patient, both of whom are being treated by the Respondent for depression;

g. When treating patients with opiates for chronic pain, such as Patients 1, 2, 3, 4, and 5, the Respondent failed to collaborate with other medical professionals who are addressing the underlying physical conditions causing the pain for example, pain treatment specialist,

orthopedic, rheumatologist, and/or primary care physician. When prescribing very high doses of opiates or a complex regimen of multiple opiates, the Respondent failed to consult or collaborate with the pain treatment specialist; and failed to document the details of such collaborations, either by describing phone conversations, or including notes from the other specialist in Patient 1, 2, 3, 4, and 5's records;

h. When treating Patients 2, 3, and 5 with anticonvulsants, opiates and combining these potentially hepatotoxic medications, the Respondent failed to obtain at least yearly monitoring with liver function tests; and monitoring of Depakote blood levels for Patient 3;

i. In regard to Patient 2, for whom the Respondent was prescribing a tricyclic with oxycodone and hydrocodone which can markedly increase oxycodone and hydrocodone blood levels, and in regard to Patient 3 for whom the Respondent was prescribing Wellbutrin and Oxycodone, the Respondent failed to consider and document the risks of drug-drug interactions and to document having discussed this with Patients 2 and 3;

j. When utilizing medications with Patient 2, such as nortriptyline, a tricyclic, or Patient 3 with Depakote, for which established therapeutic blood levels are available and shown to have clinical utility, simultaneously with, SSRIs and opiates, the Respondent failed to obtain blood levels and liver function tests for the purpose of correlating with clinical response, and to rule out potentially toxic blood levels;

k. In regard to Patient 2, when the Respondent prescribed large numbers of pills with numerous refills of medications that could be lethal in an overdose, such as benzodiazepines or opiates, particularly for Patient 2 who may be at higher risk of suicide due to depression, the Respondent failed to document her clinical rationale and discussion of the justification for providing extremely large amount of medications that could be used for self-harm, or diversion;

l. In regard to Patient 2, the Respondent failed to gradually titrate lamotrigene in order to minimize the risk of Stevens Johnson Syndrome;[5]

m. The Respondent diagnosed delirium in regard to Patient 1, suggesting underlying organic medical problems, but failed to

[5] Stevens Johnson Syndrome, a form of toxic epidermal necrolysis, is a life-threatening skin condition, in which cell death causes the epidermis to separate from the dermis. The syndrome is thought to be a hypersensitivity complex that affects the skin and the mucous membranes. The most well-known causes are certain medications, but it can also be due to infections, or more rarely, cancers.

perform a deeper evaluation of medical issues, the possibility of drug-drug interactions, and laboratory testing to rule out common metabolic causes of delirium;

n. In July 2013, when Patient 1's family member called the Respondent allegedly to express concerns about Patient 1, the Respondent failed to obtain information from the mother about her concerns and failed to address the concerns in Patient 1's treatment plan. The Respondent failed to acknowledge, or failed to have office staff or her answering service acknowledge, receipt of this information;

o. Following Patient 1's treatment in an inpatient psychiatric facility for depression and substance abuse, from which Patient 1 was discharged AMA ("Against Medical Advice"), the Respondent continued to prescribe opiates and Ambien, failed to justify the need for such a high risk decision, and failed to curtail the prescriptions as quickly as possible. The Respondent fails to review the treatment in the inpatient program as a component of ongoing care, to note it in the chart, and to discuss it with the Patient 1; and

p. In regard to Patients 1, 2, and 3 when combining different categories of medications that have potential for significant CNS depression, such as benzodiazepines, sedative hypnotics and opiates, the Respondent fails to monitor Patients 1, 2, and 3 for the additive effects of such mixtures on cognitive and motor functioning and failed to document a justification and to demonstrate the clinical rationale that can be understood by another physician who might pick up the case. The Respondent failed to monitor and discuss with Patients 1, 2, and 3 the precarious risk/benefit considerations of such prescribing.

V. Current Status of Patients 1 – 5

20. Since the date of the investigation, the Respondent has terminated her care of Patient's 1 and 4. Respondent referred Patient 1 to a psychiatrist/somatic medicine specialist and referred Patient 4 to her primary care physician.

21. As of the date of this Consent Order, the Respondent plans to refer Patient 5 to his primary care provider for management of his narcotic medication.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B of the Board

concludes as a matter of law that Respondent violated Health Occ. § 14-404(a)(22) (fails to meet standards of quality medical care) and (40) (inadequate documentation).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that Respondent is Reprimanded; and it is further

ORDERED, effective the date of this Consent Order, Respondent shall comply with the following terms and conditions:

1. Within three (3) months of the date of this Consent Order, Respondent shall enroll in, and within six (6) months of the date of this Consent Order, Respondent shall successfully complete, a Board-approved course which covers prescribing of controlled substances;

2. The course shall be in addition to any continuing education requirements mandated for continuing licensure. Any continuing education credits earned shall not count toward fulfilling continuing education requirements that Respondent must fulfill in order to renew her license to practice medicine;

3. Within six (6) months after the completion of the course, Respondent's quality of care, including prescribing and monitoring of CDS, and her documentation, including justification for her CDS prescribing, shall be subject to peer review by an appropriate peer review entity, or a chart review by a Board designee, to be determined at the discretion of the Board;

4. An unsatisfactory peer review by an appropriate peer review entity, shall be deemed a violation of this Consent Order;

5. Respondent shall comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining thereto; and

6. Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order; be it further

ORDERED, if Respondent violates any of the terms and conditions of this Consent Order, a disciplinary panel of the Board, in its discretion, after notice and an opportunity for a show cause hearing, or an opportunity for an evidentiary hearing

before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, and after such violation is proved by a preponderance of the evidence, may impose any sanction which a disciplinary panel of the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including a probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty; and be it further

ORDERED, after the conclusion of a satisfactory peer review or chart review, Respondent may file a written petition for termination of the conditions of this Consent Order. After consideration of the petition, the conditions may be terminated, through an order of the designated disciplinary panel of the Board. The designated disciplinary panel of the Board will grant termination of the conditions if Respondent has fully and satisfactorily complied with all of the conditions and there are no pending complaints related to the charges; and be it further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2014).

3/10/2015
Date

Christine A. Farrelly
Christine A. Farrelly
Executive Director
Maryland Board of Physicians

CONSENT

I, Trevia F. Hayden, M.D., License No. D53096, by affixing my signature hereto, acknowledge that:

1. I have knowingly and voluntarily elected not to consult with counsel, and knowingly and voluntarily elect to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 (2014 Repl. Vol.) and Md. Code Ann., State Gov't §§ 10-201 *et seq.* (2014 Repl. Vol.).

3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and my right to appeal any adverse ruling of a disciplinary panel of the Board that might have followed any such hearing, and any right to appeal this Consent Order.

5. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

3.3.15
Date

Trevia F. Hayden, M.D., Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF FREDERICK

I HEREBY CERTIFY that on this 3 day of MARCH, 2015 before me, a Notary Public of the State and County aforesaid, personally appeared Trevia F. Hayden, M.D, License number D53096, and gave oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires 5/18/2016