IN THE MATTER OF	*	**BEFORE THE**
TREVIA F. HAYDEN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D53096	*	**Case Number: 7715-0062 B**

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CONSENT ORDER

On December 15, 2016, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **TREVIA F. HAYDEN M.D.,** (the "Respondent"), License Number D53096, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.* (2014 Repl. Vol. and 2016 Cum. Supp.).

Panel B further charged Respondent with violating Conditions 4 and 5 of her probation as stated in the Consent Order of March 10, 2015.

The pertinent provisions of the Act under Health Occ. II § 14-404 with which Respondent failed to comply are:

> (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:
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> . . .
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> (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;
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> . . .
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

The pertinent conditions of probation as stated in the Consent Order of March 10, 2015, with which Respondent failed to comply are:

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[.]

On February 22, 2016, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of the DCCR, Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel B makes the following findings of fact:

I. Background

1. At all times relevant hereto, Respondent was and is licensed to practice medicine in the State of Maryland. Respondent was originally licensed to practice medicine in Maryland on March 11, 1998. Respondent last renewed her license in or about August 2016, which will expire on September 30, 2018.

2. Respondent maintains an office, "Vitality Health Associates," for the solo practice of medicine, specializing in psychiatry, in Frederick, Maryland. Respondent describes her practice as providing "integraded(sic) conventional and complementary behavior health services." Respondent states that she uses the Biopsychosocial[1]

[1] The biopsychosocial approach was developed at the University of Rochester by Drs. George Engel and John Romano. While traditional biomedical models of clinical medicine focus on pathophysiology and other biological approaches to disease, the biopsychosocial approach emphasizes the importance of understanding human health and illness in the context of biological, psychological, and social factors and their complex interactions. https://www.urmc.rochester.edu/medialibraries/biopsychosocial-model-approach.pdf.

("BPS") Model as the basis for her assessment, treatment, planning and recommendations.

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

II. Disciplinary History

4. On or about November 19, 2014, the Board charged Respondent with violating Health Occ. II § 14-404(a)(22) and (40) based upon the Board's investigation where a peer review of five patient medical records found that Respondent failed to meet the standards of care and documentation in each of the five cases.

5. On or about March 10, 2015, Respondent entered into a Consent Order with the Board. The terms of the Consent Order required that within six months Respondent successfully complete a Board-approved course on prescribing controlled substances. The Consent Order also required that within six months following the completion of the course, Respondent would be subject to a chart or peer review.

6. In May 2015, Respondent successfully completed the Board-approved course on prescribing controlled substances.

7. The terms of the Consent Order also required that:

> 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.

III. Peer Review

8. On October 7, 2015, the Board initiated the peer review by issuing subpoenas to three national chain drug stores and to three local pharmacies in the

vicinity of Respondent's office for computer printouts of controlled substances prescribed by Respondent from May 5, 2015, to the date of the subpoena.

9. On December 17, 2015, the Board issued a subpoena to Respondent, requiring Respondent to submit the medical records of ten specific patients who were selected from the pharmacy computer printouts. Respondent was also asked to submit written summaries of her care of each of the ten patients.

10. On December 28, 2015, the Board received Respondent's medical records and summaries of care of the ten patients.

11. On or about April 28, 2016, the case was sent to a reviewing entity for a confidential, independent peer review focusing on both the quality of Respondent's care, as well as the quality of Respondent's medical recordkeeping of six[2] patients, after May 15, 2015. The Board sent the Consent Order, Respondent's written response, six of the ten medical records as received, summaries of care, and pharmacy computer printouts to two physicians, both board-certified in psychiatry, to conduct independent peer reviews.

12. On June 2, 2016, Panel B received the peer review reports. The peer reviewers concurred that with regard to four out of the six patients reviewed, Patients 1, 2, 5, and 6[3], Respondent failed to meet the appropriate standards for quality medical care, and with regard to five of six cases, Patients 2 thorough 6, Respondent failed to keep adequate medical records.

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

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[2] Board staff randomly selected six of the ten records for review.
[3] Patient names are confidential and are not used in the Consent Order. Respondent has been provided with a Confidential Patient Identification List.

14. On June 24, 2016, the Board received Respondent's Supplemental Response, consisting of voluminous pages of boilerplate text about treatment rationales for various diagnostic categories, diagnostic criteria, justification for polypharmacy, and patient education materials, with citations to various books and periodicals. Respondent also included additional medical records of care, some of which preceded the period of care that is under review.

15. Respondent's Supplemental Response was subsequently reviewed by the two peer reviewers, prior to the issuance of Charges.

IV. General Allegations of Violation of Health Occ. II §§ 14-404(a)(22) and (40)

16. According to the two independent peer reviewers, based on their review of Respondent's medical records:

a. There was minimal to no usage of or referral for psychotherapeutic interventions, poor diagnostic differentials and formulations, and omission of Axis II (personality disorders) considerations;

b. Progress notes do not have the rationale for polypharmacy (using more than one narcotic, stimulant, or benzodiazepine) and in high/excessive doses; or for using these classes of medications for the conditions that Respondent is treating;

c. When using high doses of Schedule II and/or IV drugs and where there are several Schedule II and IV drugs being prescribed for the same patient, progress notes do not indicate that Respondent had discussions with the patients that made departure from generally accepted first and second line treatments a reasonable decision or that factored in benefits and risks for that departure; or discussions of treatment options that can have the same or better outcomes than use of scheduled medications;

d. There was lack of consideration for drug-drug interactions or possible treatment modification based upon consultation with another provider to achieve desired effects with the least number of medications at the lowest doses that are generally considered effective. For example, use of opioids is generally not recommended or indicated in the

treatment of fibromyalgia, but psychosocial, physical and non-scheduled prescribed medications are specifically recommended;

e. When using high doses of Schedule II/III opioids for pain relief or stimulants for attention deficit or Schedule IV Benzodiazepines and hypnotics for anxiety, Respondent did not give special attention to diversion, abuse and addiction potential, physiological dependence, tolerance, withdrawal, and drug-related or induced mood, anxiety, or thought disorder by documenting her evaluation of any of these complicating factors;

f. Respondent prescribed beyond the scope of psychiatric care in her prescribing of medications for medical conditions. This was seen most egregiously in the case of Patient 1 with multiple high dose opiate pain medications for unclear indications;

g. Respondent's documentation and progress notes, although they included most basic assessment categories such as mental status examinations, past psychiatric history, substance abuse, medical history, and medication lists, were sparse and minimal overall, often lacking in clinical rationale or justification for medications prescribed or changed, full notation of patient symptoms (aside from occasional use of clinical scales), psychosocial stressors, time spent in therapy, change in target symptoms, tracking outcome information, collaboration with primary care and specialty care providers. Current medication information is separated from the progress note with which it is associated;

h. Review of pertinent laboratory work and electrocardiogram results for certain medications, such as atypical antipsychotics and stimulants, were mostly missing; and

i. It is difficult to track clinical signs and symptoms that led to a diagnosis, treatment recommendations, and specific reasons to start/stop different medications. Respondent does not identify or discuss target symptoms being addressed by therapy or medication and it is difficult to track what might be working in terms of achieving remission and whether alteration of treatment plan, level of care changes, or specialty referrals have been discussed with the patients.

V. Patient Specific Allegations of Violation of Health Occ. II § 14-404(a)(22) (quality of care) and (40)(documentation)

Patient 1 (Quality of care)

17. In the Treatment Summary, which Respondent prepared on December 23,

2015, at the request of the Board and is not part of Respondent's medical record, Respondent stated that Patient 1 is a 61 year old male who is psychiatrically stable and compliant with treatment. Patient 1 had presented with symptoms of generalized anxiety disorder and panic attacks, related to managing his household, caring for his disabled wife, and work related stress. Patient 1 had reported that in September 2012, the police were called due to his erratic behavior and he received a concussion with subsequent memory issues. Respondent's diagnoses of Patient 1 are Generalized Anxiety Disorder and Panic Disorder without agoraphobia.

18. On February 2, 2012, Respondent saw Patient 1 for an initial assessment. According to the records, follow-up appointments were held on September 7, October 9 and 29, and November 5, 2013; and January 7, February 20, and March 19, 2014. The only visit that occurred during the review period was on October 28, 2015.

19. Respondent's treatment plan is "Circadian Rhythm Training[4]", consisting of light therapy, "Fisher Wallace stimulator[5]," nutritional supplements, mood and vital charting, stress management, and exercise; as well as medication management with Pristiq [6], Valium, and Ativan, Cognitive Behavioral Therapy [7] ("CBT"), life style management, and medical management.

20. Respondent fails to meet appropriate standards for the delivery of quality medical care in regard to her care and treatment of Patient 1 in violation of Health Occ. II § 14-404(a)(22) for reasons including but not limited to that she:

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[4] Respondent has not defined Circadian Rhythm Training.
[5] The Fisher Wallace Stimulator is a wearable neurostimulation device that is cleared by the FDA to treat depression and anxiety.
[6] Pristiq, in a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SNRIs), is used to treat major depressive disorder.
[7] Cognitive Behavioral Therapy is a short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Its goal is to change patterns of thinking or behavior that are behind people's difficulties, and so change the way they feel.

a. Prescribed two different benzodiazepines (Valium in addition to Ativan, which Patient 1 was already taking) instead of raising the standing dose of Ativan, which was quite low;

b. Prescribed a fairly high dosage of Valium at 10mg BID without medical justification;

c. Failed to provide medical justification for treating Patient 1, someone with neurological and cognitive findings, with high doses of multiple benzodiazepines, given the risk of his having worsening memory and falls;

d. Failed to justify in the treatment record why she did not try first-line medications (SSRIs[8] or SNRIs[9]), prior to prescribing two different benzodiazepines;

e. Failed to describe the type and usage of CBT she was performing or any other therapy, including the amount of time spent with Patient 1 to provide him with the skills to overcome anxiety and panic attacks, to assess the effectiveness of CBT techniques and how the therapy affected the medication management; or whether she had referred Patient 1 for psychotherapy;

f. Failed to provide a proper differential for the erratic behavior incident, such as rule/out bipolar, beyond "anxiety"; and

g. Provided limited documentation regarding her case management.

Patient 2 (Quality of Care and Documentation)

21. In the Treatment Summary, which Respondent prepared on December 23, 2015, at the request of the Board and is not part of Respondent's medical record, Respondent stated that Patient 2 is a 56 year old female whom she has treated for recurrent major depression and fibromyalgia since 2000. Respondent stated that "[a]round 2005-06 she became disabled by Gulf War Syndrome that she contracted from her Gulf War Veteran husband." Respondent's diagnoses are Atypical Depression

[8] SSRI medications are Selective Serotonin Reuptake Inhibitors, such as Lexapro, Paxil, Prozac, and Zoloft that are used to treat depression, stress and anxiety and panic disorder.

[9] SNRI medications are Serotonin–Norepinephrine Reuptake Inhibitors such as Cymbalta, Effexor, and Pristiq that are used to treat major depressive disorder and other mood disorders. They are sometimes also used to treat anxiety disorders, obsessive-compulsive disorder, attention deficit hyperactivity disorder, chronic neuropathic pain, and fibromyalgia syndrome.

and Gulf War Syndrome/Post-traumatic Stress Disorder.

22. Respondent's treatment plan is Cymbalta for depression and fibromyalgia, Lamictal for depression, Klonopin for muscle spasms, and Ambien for chronic insomnia. Respondent prescribes Percocet, Fiornal with codeine, Dilaudid, and Norco for chronic pain due to "Gulf War syndrome", which she "rotates based on the severity of symptoms which vary based on weather and activity." In addition, Respondent's treatment plan is Circadian Rhythm Training, consisting of light therapy, "Fisher Wallace stimulator," nutritional supplements, mood and vital charting, stress management, and exercise, as well as CBT, life style management, and medical management.

23. Respondent fails to meet appropriate standards for the delivery of quality medical care in regard to her care and treatment of Patient 2 in violation of Health Occ. II § 14-404(a)(22) for reasons including but not limited to that she:

a. Prescribed standing high doses of opiate pain medications, and rotated use of different opioids, in addition to high dosages of Klonopin, a benzodiazepines, with little to no medical documentation justifying these medications in the notes aside from a "benzodiazepine scale", chronic pain scales, and the history of a benzodiazepine withdrawal seizure in April 2015;

b. Failed to consider whether a slow supervised benzodiazepine taper or other modification of the treatment plan would be appropriate, given the withdrawal seizure history in April 2015;

c. Failed to provide evidence other than prescription of Cymbalta that Respondent considered a first line approach prior to prescribing high doses of benzodiazepines;

d. Failed to treat fibromyalgia/chronic pain with minimal or no benzodiazepines and opioids. Detoxification from both opioids and benzodiazepines would appear indicated and even desired by Patient 2, but needs much closer follow-up than Respondent provided;

e. Failed to refer Patient 2 to either a primary care physician or pain management specialist;

f. Diagnosed "Gulf War Syndrome," a patient with chronic multi-system illness, when this patient has never been to the Gulf or had military service;

g. Failed to consider whether Patient 2 may have a possible underlying personality disorder or traits and/or possible somatic symptom disorder when developing a differential diagnosis for Patient 2;

h. Failed to describe the CBT that she performed and whether she considered also using dialectical behavior therapy ("DBT")[10]; or whether she referred Patient 2 to a therapist for these therapies; and

i. Failed to provide medical justification for prescribing glyburide[11], which would require assessments such as baseline laboratory work and monitoring for kidney function, glucose levels, and alpha 1 hemoglobin, usually done within a primary care or internal medicine practice.

24. Respondent fails to keep adequate medical records in regard to her care and treatment of Patient 2 in violation of Health Occ. II § 14-404(a)(40), for reasons including but not limited to that Respondent:

a. Failed to provide clinical rationale or diagnostic formulations;

b. Failed to provide adequate documentation of behavioral and or psychotherapeutic care;

c. Failed to document justification for continuing use of high dose opioids and benzodiazepines, or treatment alternative;

d. Provided no indication that Patient 2's care is being integrated between the several providers who are managing the same class of medications. For example, in a note of an ER visit, a primary care provider and a neurologist were both mentioned for disposition and follow-up appointments;

e. Failed to document rationale for why opioids and benzodiazepines are being used for treating fibromyalgia muscle spasms and sleep disorder

[10] Dialectical behavior therapy (DBT) is a specific type of cognitive-behavioral psychotherapy developed in the late 1980s to help better treat borderline personality disorder. Since its development, it has also been used for the treatment of other kinds of mental health disorders.
[11] Glyburide is an oral diabetes medicine that helps control blood sugar levels.

instead of first line approaches such as, exercise, CBT, gabapentinoids (Lyrica), tricyclics, SNRIs;

f. Failed to track muscle spasms and sleep problems in the notes, which require specialty referral or consultation with the primary care provider; and

g. Failed to document a justification for prescribing glyburide.

Patient 3 (Documentation only)

25. In the Treatment Summary, which Respondent prepared on December 23, 2015, at the request of the Board and is not part of Respondent's medical record, Respondent stated that Patient 3 is a 35 year old male who historically has had psychosis, "apathy depression", mood swings, self-mutilation and suicide attempts. Respondent states that for the past seven years, Patient 3 "has been stable except for seasonal flares that readily respond to either circadian rhythm treatment or medication adjustment." Respondent's diagnosis of Patient 3 is Bipolar I, in remission.

26. Respondent's treatment plan is Circadian Rhythm Training consisting of light therapy, "Fisher Wallace stimulator," nutritional supplements, mood and vital charting, stress management, exercise, as well as CBT, social skills training, assertiveness training, life style management, support groups, and medical management. Respondent prescribes Prozac, Wellbutrin, Latuda[12], Xanax, and Ambien.

27. Respondent fails to keep adequate medical records in regard to her care and treatment of Patient 3 violation of Health Occ. II § 14-404(a)(40), for reasons including but not limited to that Respondent:

a. Failed to adequately document clinical rationale for medication changes and prescription increases which would allow a new provider to follow

[12] Latuda is an atypical antipsychotic. It is also approved for the treatment of depressive episodes associated with bipolar I disorder as well as bipolar II disorder in adults when used alone or in combination with lithium, valproate, or lamotrigine.

the logic for current medications chosen in relation to problems to be alleviated, shifting the use of Klonopin, Xanax, Ambien, and Lunesta;

b. Provided little to no documentation to indicate that laboratory work (lipid profile, fasting glucose) was reviewed, given that Patient 3 is on Latuda, an atypical antipsychotic. There was a checklist indicating laboratory work was up-to-date, but the laboratory work itself was not documented or provided in the records; and

c. Failed to document the use of circadian rhythm training and CBT in terms of gains made or changes in treatment plan.

Patient 4 (Documentation Only)

28. In the Treatment Summary, which Respondent prepared on December 23, 2015, at the request of the Board and is not part of Respondent's medical record, Respondent stated that Patient 4 is a 63 year old male, who she has treated for eight years for issues related to mood, attention, anxiety and marital problems. Respondent states that for the past eight years, Patient 4 "has been stable except for seasonal flares that readily respond to either circadian rhythm treatment or medication adjustment." Respondent's diagnoses of Patient 4 are Bipolar I, in remission, and Attention Deficient Disorder ("ADD").

29. Respondent's treatment plan is Circadian Rhythm Training, consisting of light therapy, "Fisher Wallace stimulator," nutritional supplements, mood and vital charting, stress management, and exercise, as well as CBT, social skills training, assertiveness training, life style management, and medical management. Respondent prescribes Vyvanse[13], Adderall, and Abilify.

30. Respondent fails to keep adequate medical records in regard to her care and treatment of Patient 4 in violation of Health Occ. II § 14-404(a)(40), for reasons including but not limited to that Respondent:

[13] Vyvanse (lisdexamfetamine) is a central nervous system stimulant used to treat hyperactivity and impulse control issues.

a. Failed to document which symptoms in the past led to her diagnosis of bipolar I, in remission, as opposed to unipolar depression with ADHD;

b. Failed to document a clear history of treatment;

c. Inadequately documented psychotherapeutic or behavioral interventions;

d. Failed to document the link between the use of screening instruments and the desired outcome for using these instruments; and

e. Inadequately documented reasons for prescribing high use of two stimulants at once.

Patient 5 (Quality of Care and Documentation)

31. In the Treatment Summary, which Respondent prepared on December 23, 2015, at the request of the Board and is not part of Respondent's medical record, Respondent stated that Patient 5 is a 64 year old female with a history of multiple hospitalizations, psychosis, and frequent suicide ideation. Respondent stated that she has controlled Patient 5's symptoms for the past decade. Respondent's diagnosis of Patient 5 is Bipolar I, mixed, in remission.

32. Respondent's treatment plan is Circadian Rhythm Training, consisting of light therapy, "Fisher Wallace stimulator," nutritional supplements, mood and vital charting, stress management, and exercise, as well as CBT, social skills training, assertiveness training, life style management, support groups, holistic care and medical management. Respondent prescribes Cymbalta, Reluti, Seroquel, Neurotin, Klonopin, Serax[14], and Ambien.

33. Respondent fails to meet appropriate standards for the delivery of quality medical care in regard to her care and treatment of Patient 5 in violation of Health Occ. II § 14-404(a)(22), for reasons including but not limited to that Respondent:

[14] Serax (Oxazepam) is a short-to-intermediate-acting benzodiazepine used for the treatment of anxiety and insomnia.

a. Overprescribed a number of drugs without providing adequate medical justification. Patient 5 is on two antipsychotics, Rexulti and Seroquel, although they have different mechanisms of action, nothing in the notes indicates why Respondent used both (i.e. why Rexulti was added instead of increasing Seroquel.);

b. Cited Neurotin as a mood stabilizer, but several studies have noted that Neurotin is ineffective as a mood stabilizer in bipolar disorder.

c. Failed to provide a rationale for the use of two benzodiazepines in an older patient, given their effects on cognition and mental status. Respondent did not document a history of anxiety or an anxiety disorder diagnosis, or a rationale for the chronic long-term usage of two benzodiazepines, with Ambien as an additional sleep medication, risking additive over sedation issues. The more commonly accepted medications in the treatment of bipolar disorder are anti-psychotic/mood stabilizing medications with/without antidepressant; and

d. Failed to consider whether there has been a drug-related or induced bipolar, panic or sleep disorder.

34. Respondent fails to keep adequate medical records in regard to her care and treatment of Patient 5 in violation of Health Occ. II § 14-404(a)(40), for reasons including but not limited to that she:

a. Failed to provide a clinical rationale for the medications used, particularly justification for the polypharmacy and usage of two benzodiazepines and two antipsychotics;

b. Failed to provide adequate documentation of psychosocial stressors and symptoms;

c. Failed to provide an explanation for Patient 5's adverse reaction to Wellbutrin[15] and her decision to prescribe and then discontinue Rexulti;

d. Failed to document target symptoms. Instead, Respondent describes the mental status as "normal" and her assessment is "baseline;" and

e. If levels of benzodiazepine and hypnotic medication are maintained because of difficulty stopping medication and possibility of a withdrawal syndrome, failed to document having a discussion with Patient 5 about

[15] Patient 5, on an undated "Psychological General Well-Being Index" questionnaire, checked the box that he had been bothered by being anxious, worried, or upset in the past month and added the word, "Wellbutrin."

continuing these medications fully knowing the potential risks and benefits.

Patient 6 (Quality of Care and Documentation)

35. In the Treatment Summary, which Respondent prepared on December 23, 2015, at the request of the Board and is not part of Respondent's medical record, Respondent stated that Patient 6 is a 31 year old female who has a history of drug abuse, panic attacks, depression, and self-mutilation. Patient 6 has had chronic pain for many years for which she was evaluated by her primary care doctor, rheumatologist, and a pain management specialist. Respondent's diagnosis of Patient 6 is Bipolar I, mixed, in partial remission.

36. Respondent's treatment plan Is Circadian Rhythm Training, consisting of light therapy, "Fisher Wallace stimulator," nutritional supplements, mood and vital charting, stress management, and exercise. Respondent did not provide information in the Treatment Summary of the medications which she prescribes for Patient 6.

37. According to Respondent's records, since May 15, 2015, Respondent has prescribed Reluxti, Lamictal, Valium, Xanax, Nortrel[16], Viibryd[17], and Adderall.

38. Respondent fails to meet appropriate standards for the delivery of quality medical care in regard to his care and treatment of Patient 6 in violation of Health Occ. II § 14-404(a)(22), for reasons including but not limited to that Respondent:

a. Failed to perform an adequate diagnostic differential, given the co-morbidity of multiple conditions (bipolar, anxiety, pain, self injurious behaviors) which points towards personality disorder pathology and/or complex PTSD issues;

b. Failed to provide rationale for prescribing Adderall 60 mg/day. Respondent did not diagnose attention deficit disorder, and failed to give

[16] Nortrel, an oral hormone medication used to prevent pregnancy, contains progestin and an estrogen.
[17] Viibryd, an antidepressant in a group of drugs called SSRIs, is used to treat major depressive disorder.

a rationale for using amphetamine in the treatment of bipolar disorder; in a patient with history of drug abuse;

c. Failed to provide sufficient medical justification for placing Patient 6 on long-term, high dosage, multiple benzodiazepines;

d. Failed to describe and evaluate the performance CBT and/or whether she referred Patient 6 for psychotherapy;

e. Failed to provide adequate medical justification or properly screen Patient 6 prior to prescribing a contraceptive, Nortrel, at high doses; and

f. Failed to recognize the potential for Patient 6 becoming psychologically dependent on medications.

39. Respondent fails to keep adequate medical records in regard to her care and treatment of Patient 6 in violation of Health Occ. II § 14-404(a)(40), for reasons including but not limited to that Respondent:

a. Failed to adequately document a clinical rationale for the drugs prescribed, particularly the multiple high-dose benzodiazepines, and the lack of consideration of psychotherapeutic interventions and/or Axis II pathology or a full diagnostic differential;

b. Failed to integrate key components of assessment and treatment into periodic progress notes; and

c. Indicated that documents have been scanned into the record; but failed to provide those documents.

VI. Violation of Probation

40. Respondent's unsatisfactory peer review, as described above, constitutes evidence of violation of Condition 4 of the Consent Order of March 10, 2015.

41. Respondent's failure to comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining thereto, as described above, constitutes evidence of violation of Condition 5 of the Consent Order of March 10, 2015.

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 by Disciplinary Panel B hereby:

ORDERED that Respondent is **Reprimanded**; and it is further,

ORDERED that Respondent is permanently prohibited from prescribing opioid medication; and it is further,

ORDERED that Respondent is placed on **PROBATION** for a minimum period of **eighteen (18) months**.[18] During the probationary period, Respondent shall comply with all of the following probationary terms and conditions:

1. Within nine (9) months, Respondent shall successfully complete a Board disciplinary panel-approved course in medical record-keeping. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. Respondent must provide documentation to the Board that Respondent has successfully completed the course;

2. Respondent's medical practice shall be supervised by a panel-approved peer supervisor who is board-certified in psychiatry. Within 30 days, Respondent shall provide the panel with the name and professional background information of the supervisor whom she is offering for approval. The Board will provide the panel-approved supervisor with the relevant Board and Panel orders and peer review reports concerning Respondent. Respondent consents to the release of these documents to the supervisor. Each month the supervisor shall review at least eight patient files of patients prescribed controlled Dangerous Substances ("CDS"), chosen by the supervisor. The supervisor shall meet in-person

[18] If Respondent's license expires while Respondent is on probation, the probationary period and any probationary conditions will be tolled.

with Respondent at least once a month. Discussion at their in-person meetings shall include the care Respondent has provided for specific patients, the documentation of that care, and detailed feedback from the supervisor on Respondent's practices. The supervisor shall be available to Respondent for consultations on any patient and shall have access to Respondent's patients' records and shall maintain the confidentiality of all medical records and patient information. Respondent shall ensure that the supervisor provides the Board with monthly reports. The monthly reports shall detail the quality of Respondent's practices; deficiencies, concerns and needed improvements; and measures to improve patient care. If there are indications that Respondent poses a substantive risk to patients, the supervisor shall immediately report his or her concerns to the Board;

3. Respondent shall register with the Chesapeake Regional Information System for our Patients (CRISP) in order to obtain access to the Maryland Prescription Drug Monitoring Program (PDMP) and shall regularly query prescription information for patients for whom she is prescribing opiates and other CDS;

4. Respondent shall place a copy of the information obtained from the PDMP in the medical records of all patients for whom he is prescribing opiates and other CDS patients;

5. The Panel will issue administrative subpoenas to the PDMP on a quarterly basis for Respondent's CDS prescriptions. The administrative subpoenas will request a review of Respondent's CDS prescriptions from the beginning of each quarter;

6. Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II §§ 14-101-14-702, and all laws, statutes and regulations pertaining thereto; and

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

ORDERED, if the Board or Panel B determines, after notice and an opportunity for a hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before the Board or Panel B if there is no genuine dispute as to a material fact, that the Respondent has failed to comply with any term or condition of probation or this consent Order, the Board or Panel B may reprimand Respondent, place Respondent on

probation with appropriate terms and conditions, or suspend or revoke Respondent's license to practice medicine in Maryland. The Board or Panel B may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon Respondent, and it is further

ORDERED, that, after eighteen (18) months, if Respondent has fully and timely complied with the terms and conditions of probation, and there are no pending complaints related to the charges, the board or Board disciplinary Panel B will administratively terminate the probation. The administrative termination of probation will be issued through an order of the Board or Board panel; 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).

04/06/2017
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 elected to consult with counsel Joan Cerniglia- Lowensen, Esquire, prior to entering 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. II § 14-405 (2014 Repl. Vol. and 2016 Supp.) and Md. Code Ann., State Gov't II §§ 10-201 *et seq.* (2014 Repl. Vol. and 2016 Supp.).

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.

4.3.17
Date

Trevia F. Hayden, M.D., Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Frederick

I HEREBY CERTIFY that on this 3 day of April, 2017 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 1/26/19

NATHANIEL S. HALLOCK
Notary Public
Frederick County
Maryland
My Commission Expires January 26, 2019