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K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1461

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY WERNER GRENTZ, D.O., LICENSE NO. 02269, 2197 PINE BROCK ROAD, LONDON, KENTUCKY 40741

SECOND AMENDED AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, and Werner Grentz, D.O. ("the licensee"), and, and based upon the licensee's request for practice location approval, hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER OF PROBATION:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Second Amended Agreed Order of Probation:

1. At all relevant times, Werner Grentz, D.O., was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is Family Medicine.
3. A release by Kerry B. Harvey, United States Attorney for the Eastern District of Kentucky, provided the following information about the licensee:

   The Internal Revenue Service (IRS) arrested the licensee on May 1, 2012. The licensee allegedly earned between $169,000 and $356,000 each of the years between 2005 and 2010, but failed to file tax returns for those years. The licensee practiced in hospitals and medical offices in London, Manchester, and Monticello, Kentucky and in Jellico, Tennessee.
   According to the indictment, which was returned on April 6 and unsealed on May 2, 2012, the licensee evaded taxes by providing one of his employers with an IRS form in which he falsely claimed that he was exempt from having federal income tax withheld from his earnings. He also allegedly had his earnings deposited into bank accounts of companies that he controlled in order to hide his income.

4. The federal grand jury for the Eastern District of Kentucky returned Indictment No. 6:12-CR-12-GFVT on April 6, 2012, under seal. The indictment charged the licensee with two (2) counts of violating 26 U.S.C. 7203, by failing to file income tax returns as required by law, and four (4) counts of violating 26 U.S.C. 7201, by attempting to conceal his income by certain transactions, all felonies.

5. On December 18, 2012, the licensee entered into a Plea Agreement with the United States, under which he agreed to plead guilty to Count 5 of the Indictment, in exchange for dismissal of Counts 1-4 and 6. The Plea Agreement specified the following factual bases for his plea to Count 5,

   In 2002, after he failed to file tax returns for several years, the IRS sent the licensee a letter to inform him that federal law contains criminal penalties for willfully failing to file tax returns. In 2007, agents told the licensee that he was under investigation.
   During 2009, the licensee worked as an independent physician contractor at a hospital in Jellico, TN, and at a medical office in London, KY. From that work, he received taxable income of $356,073. Although he owed a substantial amount of federal income tax based upon his taxable income, he failed to file an income tax return with the IRS on or before April 15, 2010, as required by law, or to pay the tax to the IRS.
   The licensee made affirmative attempts to evade and to defeat the tax by causing his compensation to be deposited into bank accounts that he had opened in the names of two shell companies and by withdrawing the deposited money from the accounts on the same day or within a few days after the compensation had been deposited into the accounts.

6. The licensee formally entered his plea to Count 5 in court on January 17, 2013. As part of his plea, the licensee acknowledged that he failed to pay $900,068 in taxes since 1999.

7. The licensee was incarcerated for approximately fourteen (14) months.

8. The licensee entered into an Agreed Order of Surrender on or about February 21, 2013.

9. In December 2014, counsel for the licensee requested to be placed on the Panel's February 2015 agenda regarding reinstatement of his osteopathic license.

10. Since he had not practiced osteopathy in over two (2) years, the licensee was advised at that time to obtain a clinical skills assessment from the Center for Personalized Education for Physicians ("CPEP").

11. On or about May 13-14, 2015, the licensee completed a CPEP clinical skills assessment. CPEP reported:

> During this Assessment, Dr. Grentz demonstrated a variable and, at times, outdated fund of knowledge in outpatient family medicine. His clinical judgment and reasoning, as demonstrated during this Assessment were inadequate, overall. His Simulated Patient (SP) documentation was adequate. His communication skills were adequate, with need for improvement, with SPs and professional with peers. Review of Dr. Grentz's health information revealed a report of unilateral vision deficit and hearing loss treated with amplification. If severe, these conditions may have the potential to impact the practice of medicine; the specific status of these conditions was not available in the information submitted. His cognitive function screen results were within normal limits.

12. In or around October 2015, CPEP developed an Educational Intervention Program ("Education Plan") to address the licensee's deficiencies in family medicine.

13. On or about February 18, 2016, the Panel reinstated the licensee's license to practice osteopathy pursuant to terms and conditions set forth in an Agreed Order of Probation filed of record on March 16, 2016.

14. In April 2016, the Chair of Panel A approved the licensee's request to practice family medicine for approximately thirty-two (32) hours per week under the direct supervision of James Miller III, M.D. at 100 Jay Street, Suite 330 in Stanford, Kentucky, pursuant to the terms and conditions in an Amended Agreed Order of Probation.

15. In June 2016, by entry of this Second Amended Agreed Order of Probation, the licensee requested and was granted practice location approval to practice family medicine for approximately thirty-two (32) hours per week under the direct supervision of Robert Hoskins, M.D., at Hoskins Medical Center, 1120 Rueben Street, London, Kentucky 40741 and at Home Town Clinic, 96 Highway 80, Suite 10, Hyden, Kentucky 41749.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Second Amended Agreed Order of Probation:

1. The licensee's osteopathic license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(4) and (10). Accordingly, there are legal grounds for the parties to enter into this Second Amended Agreed Order of Probation.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter and allow the licensee to resume the practice of medicine at an approved practice location by entering into an informal resolution such as this Second Amended Agreed Order of Probation.

SECOND AMENDED AGREED ORDER OF PROBATION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the licensee's request for practice location approval, the parties hereby

ENTER INTO the following **SECOND AMENDED AGREED ORDER OF PROBATION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by WERNER GRENTZ, D.O., is hereby reinstated and PLACED ON PROBATION FOR A PERIOD OF FIVE (5) YEARS, with the period of probation effective upon the filing of the previous Agreed Order of Probation on March 16, 2016.

2. During the effective period of this Second Amended Agreed Order of Probation, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

    a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine or osteopathy," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – unless and until the Panel or its Chair has approved, in writing, the practice location at which he will practice medicine. The decision whether to approve a particular practice location lies in the sole discretion of the Panel or its Chair. In determining whether to approve a particular practice location, the Panel or its Chair will particularly consider whether there will be appropriate supervision of the licensee, and may also consider the nature of the practice, including the licensee's proposed duties and hours to be worked. In approving such practice location, the Panel or its Chair may include specific conditions/restrictions to ensure patient safety;

        i. Once approved, the licensee SHALL NOT change practice locations without first obtaining written approval by the Panel or its Chair for such change. The parties agree that the Panel or its Chair may require additional conditions and/or restrictions as a condition of it granting approval for a new practice location;

        ii. The licensee is hereby approved to practice family medicine for approximately thirty-two (32) hours per week under the direct supervision of Robert Hoskins, M.D. at

            1. **Hoskins Medical Center, 1120 Rueben Street, London, Kentucky 40741, and at**

2. **Home Town Clinic, 96 Highway 80, Suite 10, Hyden, Kentucky 41749.**

b. Beginning immediately, the licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized. The controlled substances log SHALL include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets SHALL be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions SHALL be maintained in the following manner: 1) patient; 2) chart; and 3) log;

   i. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultants;
   ii. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Second Amended Agreed Order of Probation. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Second Amended Agreed Order of Probation;
   iii. The licensee understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Second Amended Agreed Order of Probation;

c. The licensee SHALL comply with and SUCCESSFULLY complete all requirements of the Educational Intervention Plan developed by CPEP, at his expense and as directed by CPEP, a copy of which is attached;

   i. The licensee understands and agrees that he SHALL be responsible for ensuring that his preceptor(s) comply with all directives and instructions of CPEP during the duration of the Educational Intervention Plan and he SHALL immediately report any noncompliance directly to CPEP;

   ii. The licensee understands and agrees that any failure to comply with the directives and instructions of CPEP during the duration of the Educational Intervention Plan shall constitute a violation of this Second Amended Agreed Order of Probation and shall be grounds

for immediate suspension of his license to practice osteopathy in the Commonwealth of Kentucky;

iii. In the event that the licensee's CPEP Educational Intervention Plan should be come suspended for any reason, the licensee SHALL immediately cease the "practice of medicine or osteopathy," as that term is defined in KRS 311.550(10), until further order of the Panel. His failure to do so, shall constitute a violation of this Second Amended Agreed Order of Probation and shall be grounds for immediate suspension of his license to practice medicine/osteopathy in the Commonwealth of Kentucky;

iv. If deemed necessary and appropriate by CPEP, the licensee SHALL SUCCESSFULLY COMPLETE the Post-Education Assessment, at his expense and as directed by CPEP;

v. The licensee SHALL TAKE ALL NECESSARY STEPS, including the execution of waivers and/or releases, to ensure that CPEP provides timely written reports to the Board outlining his compliance with the Educational Intervention Plan; and

d. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Second Amended Agreed Order of Probation, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Second Amended Agreed Order of Probation, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Order

would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Second Amended Agreed Order of Probation.

4. The licensee understands and agrees that any violation of the terms of this Second Amended Agreed Order of Probation would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13) and may provide a legal basis for criminal prosecution for practicing medicine without a license.

SO AGREED on this 30th day of June, 2016.

FOR THE LICENSEE:

W. Grentz D.O.

WERNER GRENTZ, D.O.

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COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

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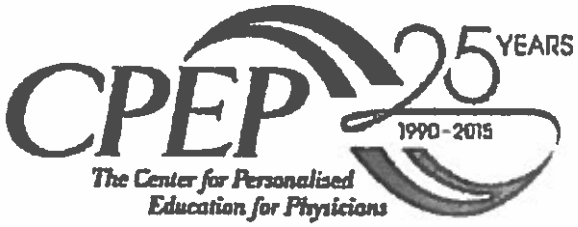

EDUCATIONAL INTERVENTION PROGRAM

EDUCATION PLAN

Developed October 2015

for

Werner Grentz, D.O.

NATIONALLY RECOGNIZED ▪ PROVEN LEADER ▪ TRUSTED RESOURCE

720 S. Colorado Boulevard, Suite 1100-N
Denver, Colorado 80246
Phone: 303-577-3232
Fax: 303-577-3241
www.cpepdoc.org

EDUCATION PLAN

OVERVIEW

APPENDICES

I. INTRODUCTION

According to the Kentucky Board of Medical Licensure's Agreed Order of Surrender dated February 21, 2013, Werner Grentz, D.O., may not petition for reinstatement of his license to practice osteopathy for a minimum of two years. Dr. Grentz completed a clinical skills Assessment in May 2015 as part of the process to reinstate his license. The Assessment identified areas of educational need. The development of this Education Plan (Plan) was based on those needs. The purpose of this Plan is to provide a framework in which Dr. Grentz can address his educational needs.

A glossary of Educational Intervention terms is enclosed.

FOCUS OF PLAN

This Plan addresses Dr. Grentz's practice of outpatient family medicine. If areas of educational need other than those addressed in this Plan are identified while Dr. Grentz is participating in the Plan, CPEP will notify the referring organization and Dr. Grentz and determine if the educational needs can be addressed within the context of this Plan.

LIMITATIONS

CPEP cannot guarantee that a Preceptor and/or an appropriate setting can be identified to address this Plan.

HEALTH CONSIDERATIONS

Dr. Grentz should continue to have his vision and hearing periodically monitored by his physicians. He should consider an evaluation by a physician health program in order to assess whether these conditions are severe enough to impact practice and what, if any, accommodations might be necessary.

Any requests for modifications of this Plan should be submitted to CPEP. CPEP will make reasonable efforts to meet the educational needs of Dr. Grentz and assist in reasonable accommodations but reserves the right to terminate the Educational Intervention if accommodations cannot be made.

LICENSING

Because CPEP Education plans are practice-based, physician-participants must have a medical license in order to complete a Plan. Some activities, such as self-study, may be completed without a medical license. *It is the participant's responsibility* to ensure that he/she practices within the parameters of his licensure status.

DESIGN

The individual Learning Goals described below in *Section II* were derived from the findings of the Assessment. This Plan was designed to address those Learning Goals through Medical Knowledge Enhancement and Patient Care Enhancement educational activities described in *Section III* as

Modules A and B. Evaluation of Dr. Grentz's progress and oversight of his participation will be provided by the CPEP Associate Medical Director. The Plan is designed around continuous and timely participation so that maximum educational benefit is received and ongoing progress is made. Following is more detailed information about the Modules and the Associate Medical Director oversight.

Note: The requirements of this Plan are not intended to supersede or exclude any requirements specific to his employer, credentialing, or licensure regulations. However, some activities may be applicable to both the Plan and such requirements.

A. Medical Knowledge Enhancement (Module A)

The Medical Knowledge Enhancement Learning Goals are addressed independently by the participant as well as through discussions with the Preceptor. The activities are designed to improve the participant's medical knowledge specific to the Learning Goals. Other improvements are generally realized as a result of the activities. A Preceptor is not needed to begin the activities described in Module A. CPEP encourages Dr. Grentz to begin the activities as soon as he has initiated the Plan. The recommended activities include:

- Independent/unsupervised self-study;
- Evidence-based research;
- Continuing medical education activities and/or courses.

B. Patient Care Enhancement (Module B)

Dr. Grentz will work with a Preceptor who has a practice similar to his. He will participate in Point of Care (PoC) activities as described below. Subsequently, Dr. Grentz will participate in a longitudinal learning experience that is reliant on regularly scheduled Preceptor Meetings. The PoC Experience will be completed prior to Dr. Grentz seeing patients independently/unsupervised as described in *Module B*. During these experiences, Dr. Grentz will:

- Address his more immediate educational needs by initially seeing patients with direct supervision. He will then progress through decreasing levels of supervision and ultimately see patients independently/unsupervised;
- Retrospectively review charts with the Preceptor of patients for whom Dr. Grentz provided independent/unsupervised care;
- Receive one-on-one coaching and constructive feedback with regard to medical knowledge, clinical judgment and documentation, particularly with regard to those areas identified in the Plan Learning Goals (see *Section II*);
- Discuss and reinforce new information and skills gained for full integration into daily patient care;
- Appreciate the value of lifelong learning, peer relationships, and self-assessment to the quality of patient care.

C. Oversight

The Associate Medical Director oversight includes Preceptor training, consideration of the feedback provided by the Preceptor and review of educational materials submitted by Dr. Grentz (see *Section V*). The Associate Medical Director will regularly communicate with and provide ongoing feedback and coaching to Dr. Grentz and the Preceptor with regard to Dr. Grentz's progress.

II. LEARNING GOALS

A. Medical Knowledge

To improve evidenced-based medical knowledge including, but not limited to, the following areas:

1. Comprehensive review of outpatient family medicine;*
2. Routine Health Screening:
   a. Evidence-based guidelines, such as those from the USPSTF;
   b. Guidelines for screening for STDs;
   c. Adult cancer screening recommendations: breast, prostate, cervical, and colorectal cancer;
   d. Pediatric and adult immunizations, including indications for pneumonia, hepatitis A/B, pertussis, tetanus, influenza, and herpes zoster vaccines;
   e. Guidelines for lipid management;
   f. Smoking cessation counseling;
   g. Assessment of hearing, vision, dementia screening, and of falls risk in the elderly;
   h. Screening for diabetes;
   i. Guidelines for lipid management;
3. Cardiovascular diseases:
   a. ECG interpretation;*
   b. Current guidelines (JNC 8) for hypertension management;
4. Pediatrics:
   a. Medications to avoid in young children;
5. Hematology:
   a. Assessment and management of anemias;
   b. Methods of lowering the INR in patients on warfarin;
6. Pain management:
   a. Safety aspects of narcotics;
7. Pulmonary medicine:
   a. Assessment for respiratory distress in children;
   b. Evaluation and treatment for DVT/PE and anticoagulation management, including novel oral anticoagulants;
   c. Management of COPD;
8. Gastroenterology:
   a. Evaluation and treatment of hemorrhoids;
   b. Evaluation and management of gastroesophageal reflux disease (GERD), including lifestyle interventions;

9. Endocrinology:
   a. Diagnosis and management of diabetes, including newer diabetes medications and indications for ACE inhibitors;
   b. Evaluation and management of thyroid disorders, including medication adjustment and timing of laboratory studies to assess efficacy of change in dosage of thyroid hormone supplement;
10. Neurology:
   a. Evaluation, risk stratification, and management of dementia;
   b. Stroke:**
      1) Evaluation and management of acute stroke;
      2) Recommendations for secondary prevention;
11. Infectious diseases:
   a. Evaluation and management of diabetic leg infections;
   b. Atypical pneumonia including potential causes, evaluation, and management;
   c. Evaluation and management of septic shock;
12. Nephrology:
   a. Potential causes of acute kidney injury;
   b. Evaluation and management of rhabdomyolysis and renal failure;
   c. Medication adjustments for kidney disease;
13. Urology:
   a. Evaluation and management of urinary incontinence;
14. Women's health:
   a. Recognizing potential pregnancy;
   b. Evaluation and management of post-menopausal bleeding;
   c. Indications for human papillomavirus (HPV) testing.

*Topic summary not required.
**Subtopics may be combined into one summary; two references required.
(See III.B below for description of topic summaries.)

B. Clinical Judgment

To *consistently* demonstrate appropriate clinical judgment in the areas that include, but are not limited to, the following:

1. Ability to consistently gather adequate clinical information;
2. Avoidance of premature diagnostic closure;
3. Structured and thorough formulation of differential diagnoses;
4. Ability to correctly assess acuity of illness and make appropriate plans;
5. Evidence-based approach to practice;
6. Avoidance of iatrogenic injury;
7. Treatment planning: attention to lifestyle modifications.

C. Documentation

The participant will learn principles of documentation that are based on recommendations and requirements of nationally recognized organizations such as the Joint Commission and Centers for Medicare and Medicaid Services (CMS) and recommendations of national specialty societies and will *consistently* demonstrate appropriate patient care documentation that includes, but is not limited to, the following:

1. Documentation of patient education.

Guideline

Adequate documentation requires inclusion of sufficient detail in visit notes such that the notes "stand alone" and determination of the level of care provided does not require verbal input from the documenting physician to be fully understood. Ultimately, adequate documentation includes chart organization and systems tools that allow another physician to easily assume care of a patient.

D. Practice-based Learning

1. Increased participation in CME activities;
2. Consider the use of evidence-based, medical content Internet-based resources.

E. Physician-Patient Communication Skills

To *consistently* demonstrate appropriate communication skills in the areas that include, but are not limited to, the following:

1. Continuing education on creating a more positive initial impression and providing more in-depth education on diagnoses and treatment plans.

III. PERFORMANCE OBJECTIVES

Performance Objectives are specific educational activities that provide focused learning experiences designed to assist the participant with achievement of the Learning Goals (*Section II*). The participant will integrate newly learned information into his daily practice and demonstrate long-term improved patient care during Module B Activities.

MODULE A
MEDICAL KNOWLEDGE ENHANCEMENT

Module A activities do not require approval of a Preceptor to initiate. Dr. Grentz will:

- Document all activities, including ongoing case-based activities, continuing medical education activities (CME) and self-study on an Education Log provided by CPEP;
- Participate in self-study activities during participation in the Plan that demonstrate lifelong learning skills;
- Submit certificates of completion for any courses, if applicable.

Timelines

The timelines below are recommended to maximize participation in the Plan.

- Independent/unsupervised activities, such as self-study, should be initiated immediately once the Plan has been signed.
- Topic/subtopic summaries should be completed by the sixth month of beginning the Plan activities.
- Courses and/or CME activities should be completed no later than the fourth month of participation.

Guideline

It will be important that Dr. Grentz develop a strategy that ensures he submits all topic/subtopic summaries within six months of initiating the Plan so that he has ample time to demonstrate his application of new knowledge to his actual patient care during the Precepted Education component.

Associate Medical Director Approval of Resources

Dr. Grentz may identify resources other than those mentioned below; however, the Associate Medical Director must approve those resources in order for the activities to be applicable to the Plan. He should receive approval of resources prior to incorporating those resources into his Plan activities.

A. Courses

Dr. Grentz will:

1. Complete a comprehensive review course, such as *The Core Content Review of Family Medicine* or the review course offered by American Academy of Family Medicine (AAFP). Information may be found at: http://www.corecontent.com/products.cfm and http://www.aafp.org
2. The Associate Medical Director will monitor Dr. Grentz's documentation skills to determine if he would benefit from participating in a documentation course. If such a recommendation is made more information would be provided to Dr. Grentz at that time.

B. Evidence-Based Self-Study

The purpose of this module is to demonstrate self-directed learning and to create educational resources for reference. Dr. Grentz will:

1. *For each of the topics and subtopics* listed in the Medical Knowledge Enhancement Learning Goals (except for those indicated with asterisks), submit a brief paragraph, case based discussion, outline, or algorithm to summarize the major points learned;
   a. In preparing the submission, Dr. Grentz will use *at least two resources for each of the topics and subtopics* listed in the Medical Knowledge Enhancement Learning Goals (except for those indicated with asterisks). The submission should explain the applicability of knowledge to his practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale;

1) Appropriate resources are current, peer-reviewed, evidence-based medical references. Notes from a pertinent conference may be utilized with prior Associate Medical Director approval;
   a) CPEP will provide an Education Notebook upon initiation of the Plan. (Refer to *Section IV.A.1.b* below. It will contain information about resources, such as: http://www.dartmouth.edu/~biomed/resources.htmld/guides/FindingGoodAnswers.pdf.)

2. Identify and become familiar with the resources for current guidelines relevant to the Medical Knowledge Learning Goals;
   a. Document and submit appropriate clinical guideline resources on an Education Log;
3. Regularly review *The Medical Letter*, *Prescriber's Letter* or other prescribing periodical (with the Associate Medical Director's approval) for current pharmacology review;
   a. Document this review in the self-study section of the Education Log;
4. Read Chapters 1-11 of Learning Clinical Reasoning, Second Edition by Jerome P. Kassirer, M.D., John B. Wong, M.D., and Richard I. Kopelman, M.D., and discuss with the Preceptor;
   a. Document reading and discussions on Education Logs;
5. If applicable and as needed, read Procedures for Primary Care, by John L. Pfenninger, M.D., FAAFP; Michael Tuggy, M.D.; Grant C. Fowler, M.D. and Jorge Garcia, M.D. and document reading on an Education Log;
6. Participate in self-study relevant to his practice for the duration of the Plan.

C. Electrocardiogram Interpretation Activities

Important to note:

- Dr. Grentz should not be responsible for ECG interpretation (without over-reading) prior to demonstrating competence to his Preceptor.

Dr. Grentz will:

1. Read the textbook Clinical Electrocardiography: A Simplified Approach by Ary L. Goldberger, or other approved resource, and review with the Preceptor;
2. Review at least 25 to 30 ECGs using resources such as:
   a. "Alan E. Lindsay ECG Learning Center" on the University of Utah School of Medicine website located at http://ecg.utah.edu/introduction
   b. http://www.ecg-interpretation.blogspot.com/
3. Document independent/unsupervised ECG reading and review as well as ECGs reviewed with the Preceptor on Education Logs;
4. Ensure that the Preceptor speaks with the Associate Medical Director prior to Dr. Grentz independently reading and interpreting ECGs.

D. Communication

Dr. Grentz will:

1. Read pertinent chapters of the Field Guide to the Difficult Patient Interview by Frederic W. Platt, M.D., and Geoffrey H. Gordon, M.D., and discuss with the Preceptor;
   a. Document chapters read on an Education Log;

   b. The Preceptor and Associate Medical Director may assign particular chapters;
2. At a time to be determined by the Associate Medical Director, submit to CPEP completed patient questionnaires addressing his communication skills.
   a. The questionnaire and more direction will be provided by CPEP.

E. Case-Based Activities

Dr. Grentz will:

1. Review cases in chapters 12-22 of Learning Clinical Reasoning, Second Edition that illustrate concepts applicable to identified needs;
   a. Document this review in the self-study section of the Education Log;
2. Pursue case-based learning through resources such as:
   www.aafp.org
   www.clinicalcases.org

F. Practice-based Learning

Dr. Grentz will:

1. Review current peer-reviewed, evidence-based medical literature pertinent to family medicine throughout the duration of the Plan;
2. Utilize appropriate Internet web sites and other medical resources.

G. Systems-based Practice

Dr. Grentz will:

1. Discuss with the Preceptor ways to augment his awareness of systems-based practice such as:
   a. Familiarity with different types of medical practice and delivery systems;
   b. Awareness of resources for patients and ways to help patients work within that system;
   c. Understanding of issues within the medical system which contribute to and reduce medical error;
   d. Understanding of cost effective resource allocation and appropriate prescribing patterns to that end;
   e. Participating in interdisciplinary teams as appropriate.

Core competencies which have been adopted by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education can be found here:
http://www.abms.org/maintenance_of_certification/MOC_competencies.aspx

H. Internet-Based Medical Information Resources

Dr. Grentz will:

1. Utilize electronic resources at the point of care, such as a computer with access to the Internet. Software or web sites should assist with immediate access to up-to-date medical information relevant to medication prescribing and drug interactions, and patient care decisions, including formulating an adequate differential diagnosis, interpreting test results and evaluating treatment options.

MODULE B
PATIENT CARE ENHANCEMENT

During the activities described in this Module the Preceptor will provide feedback to Dr. Grentz with regard to improvements in all areas of the Learning Goals. The Preceptor will coach Dr. Grentz to integrate improved knowledge, decision-making and documentation into daily patient care. All meetings and activities will be documented on an Education Log provided by CPEP.

Timeline

- See *Section IV* for complete time frames for the Preceptor approval process and initiation of Preceptor Meetings and the Point of Care Experience.
- Once initiated, Preceptor Meetings and chart reviews will continue for the duration of the Plan.

A. Point of Care Experience

During this experience, Dr. Grentz will:

1. Shadow:
   a. To become acquainted with the office setting, shadow the Preceptor for approximately one-half day;
   b. Discuss each case including diagnosis, management options and expected outcomes;
2. Supervision:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, manage patients with 100% direct supervision;
      1) Direct supervision is defined as side-by-side observation of the patient encounter by the Preceptor;
   b. Discuss each case including management options and expected outcomes;
   c. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
   d. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *Concurrent Case Review*;
3. Concurrent Case Review:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, review each case with the Preceptor prior to releasing the patient to determine if the exam and evaluation have been adequate and if the plan is appropriate;
   b. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
   c. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *End of Day Review*;
4. End of Day Review:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, review all patients at the end of each day with the Preceptor;
   b. Discuss each case including management options and expected outcomes;

c. Have each note for the above patient encounters reviewed for completeness and overall quality by the Preceptor when the note is completed or when the dictations are available, and receive feedback on the documentation of the patient visit;
d. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
e. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *Consultation*;

5. Consultation:
   a. Manage patients with immediate physician consultation available if needed for approximately one month;*
      1) The onsite physician may be someone other than the Preceptor, but should be someone approved by the Associate Medical Director;
   b. Implement weekly PoC meetings. During these meetings:
      1) Retrospectively review each case and outcome with the Preceptor;**
      2) Have each note for the above patient encounters reviewed for completeness and overall quality by the Preceptor and receive feedback on management and documentation of the patient visit;
   c. Document every case specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP and submit the Case Log along with the charts mentioned immediately below;
   d. After seeing patients for three weeks, submit six charts to the Associate Medical Director for review to evaluate Dr. Grentz's readiness to progress to the Precepted Education Experience;
6. Conclusion:
   a. At the completion of the above activities, Dr. Grentz will:
      1) Ensure that the Preceptor speaks with the Associate Medical Director and submits a written report documenting Dr. Grentz's readiness to proceed to independent/ unsupervised patient care;
      2) Receive notification from the Associate Medical Director that the PoC Experience has been completed.

*One month is an estimated timeframe and may be lengthened if it is determined that Dr. Grentz would receive educational benefit from extending the experience.

**If Dr. Grentz's patient volume is too large to allow review of each case, he and the Preceptor should review no fewer than six cases per weekly meetings that are relevant to his Plan Learning Goals as much as possible.

B. PRECEPTED EDUCATION

It will be important that the Preceptor Meetings and activities are thorough and that the Preceptor provides objective feedback sufficient to support Dr. Grentz's improvement with regard to the specific Plan Learning Goals. All meetings and activities will be documented on an Education Log provided by CPEP.

Guideline
Having knowledge is distinct from applying knowledge. It is essential that, when reviewing charts, the Preceptor determine whether or not the participant *applied* his knowledge to actual patient care.

PRECEPTOR MEETINGS
After completion of the PoC Experience, Dr. Grentz will:

1. Meet with the Preceptor twice monthly for the duration of the Plan. To provide a quality learning experience, CPEP recommends that each meeting be a minimum of two hours;
2. With the Preceptor and in conjunction with the activities described below in *Preceptor Meeting Activities*, utilize the following to address the Learning Goals:
   a. Chart review and case-based discussions;
   b. Hypothetical case discussions;
   c. Topic discussions;
   d. Current medical literature reviews;
   e. Utilization of appropriate Internet web sites and other medical resources.

Guideline
Although impromptu collegial discussions may occur outside of Preceptor Meetings, such discussions are separate from the Preceptor Meeting requirement.

PRECEPTOR MEETING ACTIVITIES

Chart Review Objectives
Charts are the primary method of evaluating the participant's application of knowledge and clinical judgment and reasoning. Therefore, charts submitted to the Preceptor and the Associate Medical Director as described below should demonstrate the participant's integration of feedback and information learned as a result of completing Module A activities. Submitted charts should reflect consistent improvements in overall patient care.

Charts reviewed during Preceptor Meetings will be those of patients for whom Dr. Grentz provided independent/unsupervised care. Charts as described below should address the Plan Learning Goals as much as possible.

During the Precepted Education, Dr. Grentz will:

1. Retrospective Chart Reviews:
   a. Submit to the Preceptor for review no fewer than 24 redacted* charts per month (12 charts per twice-monthly sessions);
      1) The Preceptor may specify cases to be reviewed;
      2) Redacted* copies of charts should be submitted to the Preceptor in time for the Preceptor to review them before the meetings;
   b. Submit to CPEP by the fifth of *every other* month (month to be determined), six of the 24 redacted* charts used in the Preceptor Meetings;
      1) The Associate Medical Director may specify charts to be submitted;

c. **Cases should be specifically relevant to the Plan as well as representative of the scope of Dr. Grentz's practice, as much as possible.**

2. Didactic Discussions and Coaching:
   a. Clinical Judgment:
      1) With the Preceptor, discuss the Clinical Judgment Learning Goals and application of knowledge to patient care;
      2) Develop and discuss with the Preceptor systems (protocols, algorithms, and/or chart templates) or other strategies for organizing the clinical evaluation to ensure that the Clinical Judgment Learning Goals are addressed and that improvements are integrated into his daily patient care;
   b. Documentation:
      1) Receive coaching from the Preceptor that addresses general documentation principles as well as the specific areas of need described in Learning Goal C, *Documentation*, including strategies and/or use of chart templates for improved documentation;
   c. Medical Knowledge:
      1) Discuss with the Preceptor each topic and subtopic identified in Module A, including applicable and current evidence-based guidelines as available. Dr. Grentz should also discuss his topic/subtopic summaries with the Preceptor;
   d. Communication:
      1) Receive coaching and review reference materials described in the Plan related to communication skills;
3. Lifelong Learning:
   a. Develop lifelong learning skills:
      1) Discuss and develop a plan with the Preceptor for maintaining current standards in family medicine after conclusion of the Educational Intervention. Discuss the plan with the Associate Medical Director and demonstrate ongoing learning throughout the duration of the Plan. The plan should:
         a) Incorporate Internet-based resources;
         b) Integrate evidence-based medicine resources;
         c) Promote lifelong learning;
         d) Include activities that address clinical decision-making, such as case studies.
   b. CPEP encourages Dr. Grentz to:
      1) Review and reflect on the status of his learning and improvements on an ongoing basis;
      2) Keep a learning journal on his reflections, including which activities were beneficial, or not beneficial, and why.

* *Refer to Appendix B, Privacy of Individually Identifiable Health Information*

Guidelines

- During the Preceptor Meetings, the Preceptor should provide coaching and recommendations to the participant to ensure that improvements in all Learning Goals

identified in the Plan are collectively and consistently applied to Dr. Grentz's actual patient care.

- The participant's progress will be determined based on the achievement of the Learning Goals and in consideration with generally accepted standards of care. The constraints of a physician's practice circumstances, such as the availability of local medical resources, are taken into consideration when reviewing a physician's actual practices.

IV. INITIATING THE PLAN

A. Determining the Start Date and Beginning Educational Activities

1. Dr. Grentz will sign and return the Plan to CPEP by November 6, 2015. He will then:
   a. Initiate the self-study components of the Plan the first day of the month following CPEP's receipt of the signed Plan;
   b. Receive an Education Notebook from CPEP with directions, Education Logs, resources, and other information to complete the educational activities;
   c. Initiate and document self-study activities and course participation;
   d. *After reviewing* the Preceptor qualifications described in the *Preceptor Overview and Agreement*, identify a Preceptor candidate if Dr. Grentz has not already done so;
      1) The Preceptor must be board certified in the same specialty and have a practice similar to Dr. Grentz's;
2. Provide a copy of the Plan, *Preceptor Overview and Agreement*, Confidentiality Statement, and a copy of the Assessment Report to the proposed Preceptor so that the approval process, as described below, can progress accordingly.

B. Preceptor Approval

1. Dr. Grentz will, *within 30 days of licensure reinstatement*, submit to CPEP:
   a. The proposed Preceptor curriculum vitae (CV) including the Preceptor name and contact information;
   b. Signed CPEP Authorization to Release/Receive Information form authorizing CPEP to communicate with the Preceptor;
      1) A telephone call with the Preceptor and the Associate Medical Director will then be scheduled as part of the approval process;
      2) The participant will be notified of the approval;
2. Upon notification of approval, Dr. Grentz will begin meeting regularly with the Preceptor. He should document meetings on an Education Log.

Guideline

For the participant's educational benefit, the Preceptor must meet the qualifications as described in the *Preceptor Overview and Agreement*. Additionally, CPEP must approve the Preceptor in order for any precepted activities to be applicable to the Plan.

V. PARTICIPATION AND MONITORING

Consistent participation in educational activities, including regular and timely submission of materials and participation in scheduled CPEP conference calls, enhances the educational experience. Such participation may also impact the duration of the Plan. Because the Associate Medical Director must be able to evaluate the participant's ongoing progress and provide timely and pertinent feedback, Dr. Grentz will:

1. Maintain Education and PoC Case Logs:
   a. Education Logs should document all educational activities including Preceptor Meetings and the content of the Meetings, and those activities that are outside of the scope of the Plan but relevant to his practice;
   b. PoC Case Logs should document PoC activities as previously described in Module B;
2. Submit materials:
   a. By the fifth of every month, submit:
      1) Education Logs;
      2) Preceptor Report forms completed by the Preceptor;
      3) Controlled Substances Log, if applicable;
      4) Other materials relevant to the Plan or as requested by the Associate Medical Director;
   b. By the fifth of every month and until the following has been completed, submit:
      1) Case Logs for the PoC activities;
      2) Topic/subtopic summaries;
      3) CME certificates and/or other documentation of completed activities specified in the Plan (if applicable);
3. Submit Charts:
   a. Either monthly or every other month, as directed by CPEP, submit charts,** as described in Module B. Charts must be complete and if possible, include one year of patient care and include the Preceptor's written comments either on or with the copies of the charts. More information will be provided when the Plan is initiated;
   b. At the request of the Associate Medical Director, submit randomly selected charts for review from Dr. Grentz's appointment schedule;
4. Communication:
   a. Participate in calls with CPEP as requested;
   b. Respond to emails or letters from CPEP in a timely fashion;
5. Be responsible for his and his Preceptor's participation in the Plan activities and his educational progress;
6. Demonstrate maintenance of improvements for all Learning Goals prior to conclusion of the Patient Care Enhancement activities.

**See *Module B, Retrospective Chart Review* to determine if charts should be submitted monthly or every other month

FORMATIVE EVALUATION
Evaluation of Educational Progress

Ongoing progress is measured using formative evaluation tools such as regular chart reviews, review of topic/subtopic summaries, participant and Preceptor discussions with the Associate Medical Director, and written Preceptor Reports.

Approximately every four months, Progress Reports will be generated and provided to Dr. Grentz and to other entities for which Dr. Grentz has provided authorization. The Progress Reports will capture Dr. Grentz's progress as demonstrated during Formative Evaluations conducted during that reporting period.

SUMMATIVE EVALUATION
Post-Education Evaluation

Following the completion of the Plan activities, Dr. Grentz will participate in a Post-Education Evaluation (Evaluation) to demonstrate that he achieved the Learning Goals and successfully completed the Educational Intervention. The Evaluation will be focused on the areas identified as Learning Goals in the Plan and will consider Dr. Grentz's scope of practice. (See Section 5.1(e) of the CPEP *Educational Intervention Participation Agreement* for more information.)

- Dr. Grentz will schedule the Evaluation no sooner than two months, and no later than four months, following notification from CPEP that he/she has completed the Plan activities.

VI. ESTIMATED DURATION

Plan Learning Goals and Performance Objectives
Most participants complete an Education Plan in approximately 12-18 months. The actual duration varies depending on many factors including the scope of educational needs identified.

CONDITIONS
- Modifying an approach to overall patient care, specifically application of knowledge, clinical judgment and documentation may be challenging. Additionally, certain aspects of the Plan cannot be predicted, such as spectrum of patients and cases presented, as well as the participant's dedication to the educational activities. Therefore, the duration of the Plan can only be estimated.
- CPEP reserves the right to change the content and/or duration of the Education Plan.
- CPEP is not responsible for ensuring that the participant obtains any required privileges or credentials while participating in the Education Plan; this is the responsibility of the participant.

- Once the participant has completed the Education Plan and/or has been authorized to complete the Post-Education Evaluation, CPEP is no longer reviewing charts or providing educational services to the participant.
- If Dr. Grentz does not engage in this Plan by October 14, 2016, CPEP may require completion of additional Assessment activities to ensure that Dr. Grentz's current educational needs are addressed.

SIGNATURES

_____ _____
Werner Grentz, D.O. Date

_____ _____
Abigail C. Anderson, M.D. Date
Associate Medical Director

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Preceptor candidates.

APPENDIX A
Prospective Practice Profile

Werner Grentz, D.O.

Dr. Grentz should notify CPEP of updates and changes to his profile while participating in the Plan.

Specialty

Family Medicine

Licensure

Licensing State	Status
KY	Surrendered

Practice Setting

Outpatient

Practice Profile – To Be Determined

Volume of patients per day:
Number of days worked per week:
Number of patients admitted per month:
Census of inpatients per month: approximately
Number of days on-call per month:
Number of patients in SNF:

Commonly Encountered Diagnoses

Inpatient Procedures:
Outpatient Procedures:

(The remainder of this page is intentionally blank.)

APPENDIX B

[Code of Federal Regulations]
[Title 45, Volume 1]
[Revised as of October 1, 2002]
From the U.S. Government Printing Office via GPO Access
[CITE: 45CFR164.514]

TITLE 45--PUBLIC WELFARE AND HUMAN SERVICES

PART 164--SECURITY AND PRIVACY

Subpart E--Privacy of Individually Identifiable Health Information

Sec. 164.514 Other requirements relating to uses and disclosures of protected health information.

(a) Standard: de-identification of protected health information. Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

(b) Implementation specifications: requirements for de-identification of protected health information. A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

(i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination; or

(2)(i) The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates

(including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;
(E) Fax numbers;
(F) Electronic mail addresses;
(G) Social security numbers;
(H) Medical record numbers;
(I) Health plan beneficiary numbers;
(J) Account numbers;
(K) Certificate/license numbers;
(L) Vehicle identifiers and serial numbers, including license plate numbers;
(M) Device identifiers and serial numbers;
(N) Web Universal Resource Locators (URLs);
(O) Internet Protocol (IP) address numbers;
(P) Biometric identifiers, including finger and voice prints;
(Q) Full face photographic images and any comparable images; and
(R) Any other unique identifying number, characteristic, or code; and

(ii) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

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APPENDIX C

CPEP GLOSSARY AND DESCRIPTION OF EDUCATIONAL PROCESS

EDUCATIONAL INTERVENTION

The Educational Intervention describes the entire educational program, which includes the development and monitoring of the Education Plan and services provided by CPEP, such as progress reports, ongoing support to the participant, and the Post-Education Evaluation.

EDUCATION PLAN

A CPEP Education Plan (Plan) is an individualized structured educational process based on the findings of the Assessment (see below). Because CPEP Plans are personalized, each Plan contains requirements that are specific to the needs of the participant for whom the Plan was developed. Requirements, such as the type of educational activity, the intensity or duration of an activity, or the level of supervision, will vary per Plan. Requirements may also be modified as the participant's needs evolve over time. The Plan typically concludes with a Post-Education Evaluation (Evaluation) so that the participant can objectively demonstrate that the Goals of the Plan have been achieved.

ASSESSMENT

The Assessment is designed to evaluate the participant through use of specialty-specific, individualized testing tools. An Associate Medical Director oversees the Assessment and attends clinical interviews to ensure that the process is reflective of the participant's practice specialty and takes into account any noted reason for referral. Results from the participant's performance in each assessment modality are incorporated into an Assessment Report. The Assessment Report reflects the effort and analysis of CPEP's Medical Director, Associate Medical Director, and administrative staff.

ASSOCIATE MEDICAL DIRECTOR

The CPEP Associate Medical Director (AMD) is a qualified physician who oversees the participant's educational progress and compliance during the Plan. The AMD also provides training to and communicates with the Preceptor (see below).

EDUCATIONAL PRECEPTOR (PRECEPTOR)

A Preceptor is a qualified physician who is approved by CPEP, and the referring organization if applicable. The Preceptor's main function is educational. He/She is expected to teach, provide educational guidance, and evaluate the participant's educational progress. The Preceptor provides one-on-one education, incorporates case reviews and discussions into the meetings, and may provide supervision (see below) during patient encounters or procedures as directed in the Plan. A secondary Preceptor may be identified to address specific/specialty areas (e.g., cardiology, pharmacology) or to address the unique needs of a participant.

LEARNING GOALS

A Learning Goal describes the measurable areas of knowledge, skills, and/or concepts that a participant will gain by completing the described educational activities. Learning Goals are developed based on the findings of the Assessment. At the request of a referring organization or the participant, other goals may also be included.

PERFORMANCE OBJECTIVES/EDUCATIONAL ACTIVITIES

Performance Objectives specify the educational activities that are recommended to achieve the Learning Goals. Appropriate completion of the activities demonstrates that the information/skills/concepts have been addressed by the participant's utilization of the defined strategies or learning tools. See *Description of Educational Activities.*

EVALUATION METHODS

CPEP incorporates both formative and summative evaluations:

- A formative evaluation occurs during the educational program to assess initial and ongoing learning as the educational experience progresses, i.e., AMD and Preceptor discussions, topic/subtopic summaries, chart reviews, etc.
- A summative evaluation focuses on the outcomes and impact of the learning experience at the completion of an educational program, i.e., Post-Education Evaluation.

PARTICIPATION/COMPLIANCE

The CPEP staff and AMD monitor the participant's participation/compliance with the Plan. Participants must regularly participate in acceptable educational activities as directed by the Plan and submit materials within the timeframes established by CPEP. The participant must also demonstrate progress toward attainment of the Learning Goals. Inappropriate participation/noncompliance will be reported to the referring agency. If a participant is not participating or progressing appropriately, the Plan may be placed in one of the following categories:

- *Hold:* Occasionally, CPEP, in conjunction with the referring organization, may allow a participant to postpone, or place educational activities on hold, for a predetermined period of time (typically one to three months). Generally the hold status is offered to allow the participant the opportunity to address personal or professional issues that would prevent him/her from appropriately focusing on educational activities. A postponement of educational activities is not recommended, and should be limited to a one-time occurrence.
- *Suspension:* CPEP may suspend the participant's Education Plan if it is determined that the participant has:
  - Participated in inappropriate or minimal educational activity;
  - Failed to provide documentation of educational activities,
  - Failed to respond to CPEP requests or direction;
  - Not benefited from participation in the Plan.

It may be possible for the participant to reengage in educational services.

COMPLETION OF THE PERFORMANCE OBJECTIVES

Completion of Performance Objectives with approval to participate in a Post-Educational Evaluation: Overall, formative evaluations indicate that the participant completed the Performance Objectives by adequately demonstrating appropriate gains in knowledge/skills to achieve the Learning Goals. The participant will be advised to schedule a Post-Education Evaluation.

- *Incomplete Performance Objectives:* The participant has made insufficient progress toward completion of Performance Objectives or toward achievement of the Learning Goals. Based on the areas of remaining educational need and CPEP staff review of the participant's activities, CPEP will provide recommendations that may include the following:
  a. *Termination due to Maximum Educational Benefit:* While the participant may have made progress in the Plan, he/she has not demonstrated successful completion in one or more of the Plan's Goals or Objectives. Prior improvements may not have been maintained and/or regression in the educational process was demonstrated. CPEP determined that there would be little or no benefit for the participant to continue with an educational program at that time.
  b. *Termination due to Non-Compliance:* The participant has violated or would not comply with the CPEP Participation Agreement and/or the Education Plan such that an appropriate working relationship with the participant is not possible. Future CPEP services would not be available to the participant.

POST-EDUCATION EVALUATION (EVALUATION)

The Evaluation is a summative assessment that measures the maintenance of the improvements made by the participant as a result of progressing in and completing the Plan. The content of the Plan and the participant's scope of practice will be addressed during the Evaluation. The method of the Evaluation is similar to the Assessment process.

COMPLETION OF THE EDUCATIONAL INTERVENTION

- *Successful Completion:* The participant successfully completed the Plan Objectives and the summative evaluation). There are generally no or limited recommendations for further educational activities.
- *Insufficient Progress to Support Successful Completion of the Plan:* In the summative evaluation, the participant has not demonstrated sufficient achievement of one or more Learning Goals to successfully complete the Educational Intervention. Based on the areas of remaining educational need identified in the Post-Education Evaluation and on CPEP staff review of the prior Plan activities, CPEP may recommend:
  a. *Education Plan Addendum*: An extension of the Plan designed to address residual areas of need identified in the summative evaluation;
  b. *Maximum Educational Benefit:* Following completion of the Post-Education Evaluation, CPEP may determine that the participant has not demonstrated successful completion of the Plan and/or integration of improvements into daily patient care and would not benefit from further educational activities.

LIMITATIONS

- A CPEP Education Plan is not intended to provide the same rigor of training or depth of curriculum as a residency nor can it lead to eligibility for board certification. A residency program is provided through an accredited graduate medical education program.
- The Education Plan is not intended to provide proctoring, either for the purpose of gaining hospital privileges or to fulfill any other entities requirement for proctoring. Proctoring is an objective evaluation of a physician's clinical competence by a physician who represents and is responsible to the health care facility medical staff or another entity. A proctor does not teach or make recommendations for improved patient care.
- The Preceptor's role is not the same as a practice monitor, who is expected to focus on patient safety, evaluate the physician's practice, and report to an authoritative entity. The Preceptor should be able to focus only on the Education Plan. CPEP strongly recommends that the preceptor and the practice monitor not be the same individual.

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DESCRIPTION OF EDUCATIONAL ACTIVITIES

MEDICAL KNOWLEDGE ENHANCEMENT

Educational activities are recommended to improve medical knowledge. Some activities are topic specific while others are more broad. Topic-specific activities may include literature searches that acquaint and familiarize the participant with reliable and current information and resources. This activity often introduces the use of the Internet to participants as well as directs their attention to the need for ongoing professional development. The participant must identify appropriate literature resources and materials for reading and research. The participant will submit a written synopsis of articles and/or guidelines specific to the Plan. An acceptable synopsis will adequately describe how the participant can apply the information to his/her practice.

To meet the need for a broader review of medical knowledge, the Plan may recommend continuing medical education (CME) activities and/or courses. The Plan generally recommends online activities, but occasionally the Plan will recommend an onsite course. CME may also be recommended for certain topics or knowledge areas in which CME would provide a more optimal educational experience.

POINT OF CARE EDUCATIONAL EXPERIENCE (POC)

PoC education occurs at the moment of the patient encounter. PoC education can occur in the outpatient, inpatient, or surgical setting. CPEP's PoC experiences are designed to allow the Preceptor to observe, educate, and/or provide supervision as the participant is providing patient care or performing procedures. The length of time and the level of supervision are determined based on the participant's educational goals. Following are descriptions of the levels of supervision that may be included in a Plan:

A. Focused PoC Training

This is a finite educational experience, which generally lasts from one day up to four weeks. It is designed to provide focused training and an enriched educational experience in a particular skill, exposure to a particular disease, and/or a particular patient population. This experience may occur in a single block of time or may occur incrementally over an extended period, depending on the scheduling requirements of the preceptor and the facility. It may or may not be required to occur at the beginning of the Plan. The Focused PoC Training may address:

- Skills in the management of acute medical conditions (e.g., asthma, chest pain, pediatric emergencies);
- Skills in the management of a particular patient population (e.g., pediatrics, chronic pain patients);
- Procedural skills (e.g., endoscopy, casting, suturing, laparoscopy, intubation of the difficult airway).

B. Comprehensive PoC Experience

This educational experience is designed to provide preceptor oversight and training covering a broad spectrum of practice issues. Generally, this experience will be completed in a specified and continuous block of time at the beginning of the Plan. Examples of situations that may be appropriate for this experience include:

- A participant returning to practice after an extended absence;
- A participant returning to practice after prior revocation or suspension of licensure;
- The quantity or spectrum of the participant's educational needs is such that the participant would benefit from an intense one-on-one educational experience that would address immediate educational needs.

PoC Process

The PoC experience process is generally as follows.

1. Shadowing/Assisting: The participant observes and/or assists the Preceptor.
2. Direct Supervision: The Preceptor is physically present during the patient encounter or procedure conducted by the participant.
    a. In some instances, the Plan will specify that the participant received 100% supervision. The Plan will specify if this applies to all patient encounters or to patient encounters of a specific type (e.g., pediatric patients; laparoscopic procedures). In the specific areas requiring PoC supervision, CPEP recommends that the participant *not* provide patient care of this type outside of this PoC experience.
    b. If 100% supervision is *not* specified, the supervision would apply only in the context of the PoC activity. The participant would provide patient care outside of the PoC experience.
3. Onsite Consultation: The participant sees patients independent/unsupervisedly with onsite consultation. Consultation will occur as designated by the education plan.

PATIENT CARE ENHANCEMENT

Precepted education provides a longitudinal learning experience that occurs through regularly scheduled meetings with the Preceptor. The Precepted Education may occur concurrently with the PoC Experience. The meetings address the Plan's Learning Goals through didactic exercises, chart reviews, review of literature and appropriate Internet web sites, as well as case-based and hypothetical discussions. Precepted Education may include any or all of the following:

- *Initial observation:* The Preceptor may observe the participant in his/her practice setting to provide insight to the preceptor about the participant's practice and environment. (Generally four to eight hours of observation.)
- *Prospective chart review:* The Preceptor and the participant will discuss treatment and/or procedural plans, treatment alternatives, and procedure and patient selection.
- *Retrospective chart review:* The Preceptor reviews charts from prior patient encounters. Such reviews facilitate discussions that address medical knowledge, clinical judgment, application of knowledge, and documentation, as well as overall patient care.

FILED OF RECORD

APR 21 2016

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1461

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY WERNER GRENTZ, D.O., LICENSE NO. 02269, 2197 PINE BROCK ROAD, LONDON, KENTUCKY 40741

AMENDED AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, and Werner Grentz, D.O. ("the licensee"), and, and based upon the licensee's request for practice location approval, hereby ENTER INTO the following **AMENDED AGREED ORDER OF PROBATION:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Amended Agreed Order of Probation:

1. At all relevant times, Werner Grentz, D.O., was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is Family Medicine.
3. A release by Kerry B. Harvey, United States Attorney for the Eastern District of Kentucky, provided the following information about the licensee:

   The Internal Revenue Service (IRS) arrested the licensee on May 1, 2012. The licensee allegedly earned between $169,000 and $356,000 each of the years between 2005 and 2010, but failed to file tax returns for those years. The licensee practiced in hospitals and medical offices in London, Manchester, and Monticello, Kentucky and in Jellico, Tennessee.
   According to the indictment, which was returned on April 6 and unsealed on May 2, 2012, the licensee evaded taxes by providing one of his employers with an IRS form in which he falsely claimed that he was exempt from having federal income tax withheld from his earnings. He also allegedly had his earnings deposited into bank accounts of companies that he controlled in order to hide his income.

4. The federal grand jury for the Eastern District of Kentucky returned Indictment No. 6:12-CR-12-GFVT on April 6, 2012, under seal. The indictment charged the licensee with two (2) counts of violating 26 U.S.C. 7203, by failing to file income tax returns as required by law, and four (4) counts of violating 26 U.S.C. 7201, by attempting to conceal his income by certain transactions, all felonies.

5. On December 18, 2012, the licensee entered into a Plea Agreement with the United States, under which he agreed to plead guilty to Count 5 of the Indictment, in exchange for dismissal of Counts 1-4 and 6. The Plea Agreement specified the following factual bases for his plea to Count 5,

   In 2002, after he failed to file tax returns for several years, the IRS sent the licensee a letter to inform him that federal law contains criminal penalties for willfully failing to file tax returns. In 2007, agents told the licensee that he was under investigation.
   During 2009, the licensee worked as an independent physician contractor at a hospital in Jellico, TN, and at a medical office in London, KY. From that work, he received taxable income of $356,073. Although he owed a substantial amount of federal income tax based upon his taxable income, he failed to file an income tax return with the IRS on or before April 15, 2010, as required by law, or to pay the tax to the IRS.
   The licensee made affirmative attempts to evade and to defeat the tax by causing his compensation to be deposited into bank accounts that he had opened in the names of two shell companies and by withdrawing the deposited money from the accounts on the same day or within a few days after the compensation had been deposited into the accounts.

6. The licensee formally entered his plea to Count 5 in court on January 17, 2013. As part of his plea, the licensee acknowledged that he failed to pay $900,068 in taxes since 1999.

7. The licensee was incarcerated for approximately fourteen (14) months.

8. The licensee entered into an Agreed Order of Surrender on or about February 21, 2013.

9. In December 2014, counsel for the licensee requested to be placed on the Panel's February 2015 agenda regarding reinstatement of his osteopathic license.

10. Since he had not practiced osteopathy in over two (2) years, the licensee was advised at that time to obtain a clinical skills assessment from the Center for Personalized Education for Physicians ("CPEP").

11. On or about May 13-14, 2015, the licensee completed a CPEP clinical skills assessment. CPEP reported:

> During this Assessment, Dr. Grentz demonstrated a variable and, at times, outdated fund of knowledge in outpatient family medicine. His clinical judgment and reasoning, as demonstrated during this Assessment were inadequate, overall. His Simulated Patient (SP) documentation was adequate. His communication skills were adequate, with need for improvement, with SPs and professional with peers. Review of Dr. Grentz's health information revealed a report of unilateral vision deficit and hearing loss treated with amplification. If severe, these conditions may have the potential to impact the practice of medicine; the specific status of these conditions was not available in the information submitted. His cognitive function screen results were within normal limits.

12. In or around October 2015, CPEP developed an Educational Intervention Program ("Education Plan") to address the licensee's deficiencies in family medicine.

13. On or about February 18, 2016, the Panel reinstated the licensee's license to practice osteopathy pursuant to terms and conditions set forth in an Agreed Order of Probation filed of record on March 16, 2016.

14. In April 2016, by entry of this Amended Agreed Order of Probation, the licensee requested and was granted practice location approval to practice family medicine for approximately thirty-two (32) hours per week under the direct supervision of James Miller III, M.D. at 100 Jay Street, Suite 330 in Stanford, Kentucky.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Amended Agreed Order of Probation:

1. The licensee's osteopathic license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(4) and (10). Accordingly, there are legal grounds for the parties to enter into this Amended Agreed Order of Probation.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter and allow the licensee to resume the practice of medicine at an approved practice location by entering into an informal resolution such as this Amended Agreed Order of Probation.

AMENDED AGREED ORDER OF PROBATION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the licensee's request for practice location approval, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER OF PROBATION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by WERNER GRENTZ, D.O., is hereby reinstated and PLACED ON PROBATION FOR A PERIOD OF FIVE (5) YEARS, with the period of probation effective upon the filing of the previous Agreed Order of Probation on March 16, 2016.
2. During the effective period of this Amended Agreed Order of Probation, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine or osteopathy," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – unless and until the Panel or its Chair has approved, in writing, the practice location at which he will practice medicine. The decision whether to approve a particular practice location lies in the sole discretion of the Panel or its Chair. In determining whether to approve a particular practice location, the Panel or its Chair will particularly consider whether there will be appropriate supervision of the licensee, and may also consider the nature of the practice, including the licensee's proposed duties and hours to be worked. In approving such practice location, the Panel or its Chair may include specific conditions/restrictions to ensure patient safety;

    i. Once approved, the licensee SHALL NOT change practice locations without first obtaining written approval by the Panel or its Chair for such change. The parties agree that the Panel or its Chair may require additional conditions and/or restrictions as a condition of it granting approval for a new practice location;

    ii. The licensee is hereby approved to practice family medicine for approximately thirty-two (32) hours per week under the direct supervision of James Miller III, M.D. at **100 Jay Street, Suite 330 in Stanford, Kentucky.**

b. Beginning immediately, the licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized. The controlled substances log SHALL include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets SHALL be consecutively numbered, <u>legible</u> i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions SHALL be maintained in the following manner: 1) patient; 2) chart; and 3) log;

    i. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultants;
    ii. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Amended Agreed Order of Probation. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's

written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Amended Agreed Order of Probation;

iii. The licensee understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Amended Agreed Order of Probation;

c. The licensee SHALL comply with and SUCCESSFULLY complete all requirements of the Educational Intervention Plan developed by CPEP, at his expense and as directed by CPEP, a copy of which is attached;

i. The licensee understands and agrees that he SHALL be responsible for ensuring that his preceptor(s) comply with all directives and instructions of CPEP during the duration of the Educational Intervention Plan and he SHALL immediately report any noncompliance directly to CPEP;

ii. The licensee understands and agrees that any failure to comply with the directives and instructions of CPEP during the duration of the Educational Intervention Plan shall constitute a violation of this Amended Agreed Order of Probation and shall be grounds for immediate suspension of his license to practice osteopathy in the Commonwealth of Kentucky;

iii. In the event that the licensee's CPEP Educational Intervention Plan should be come suspended for any reason, the licensee SHALL immediately cease the "practice of medicine or osteopathy," as that term is defined in KRS 311.550(10), until further order of the Panel. His failure to do so, shall constitute a violation of this Amended Agreed Order of Probation and shall be grounds for immediate suspension of his license to practice medicine/osteopathy in the Commonwealth of Kentucky;

iv. If deemed necessary and appropriate by CPEP, the licensee SHALL SUCCESSFULLY COMPLETE the Post-Education Assessment, at his expense and as directed by CPEP;

v. The licensee SHALL TAKE ALL NECESSARY STEPS, including the execution of waivers and/or releases, to ensure that CPEP provides timely written reports to the Board outlining his compliance with the Educational Intervention Plan; and

d. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Amended Agreed Order of Probation, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Amended Agreed Order of Probation, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Amended Agreed Order of Probation.

4. The licensee understands and agrees that any violation of the terms of this Amended Agreed Order of Probation would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13) and may provide a legal basis for criminal prosecution for practicing medicine without a license.

SO AGREED on this 21st day of April, 2016.

FOR THE LICENSEE:

W. Grentz D.O.

WERNER GRENTZ, D.O.

All Rights Reserved

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

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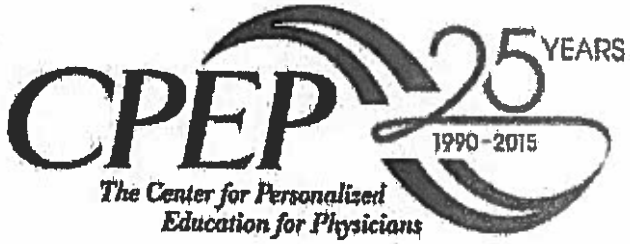

EDUCATIONAL INTERVENTION PROGRAM

EDUCATION PLAN

Developed October 2015

for

Werner Grentz, D.O.

NATIONALLY RECOGNIZED ▪ PROVEN LEADER ▪ TRUSTED RESOURCE

720 S. Colorado Boulevard, Suite 1100-N
Denver, Colorado 80246
Phone: 303-577-3232
Fax: 303-577-3241
www.cpepdoc.org

EDUCATION PLAN

OVERVIEW

APPENDICES

I. INTRODUCTION

According to the Kentucky Board of Medical Licensure's Agreed Order of Surrender dated February 21, 2013, Werner Grentz, D.O., may not petition for reinstatement of his license to practice osteopathy for a minimum of two years. Dr. Grentz completed a clinical skills Assessment in May 2015 as part of the process to reinstate his license. The Assessment identified areas of educational need. The development of this Education Plan (Plan) was based on those needs. The purpose of this Plan is to provide a framework in which Dr. Grentz can address his educational needs.

A glossary of Educational Intervention terms is enclosed.

FOCUS OF PLAN

This Plan addresses Dr. Grentz's practice of outpatient family medicine. If areas of educational need other than those addressed in this Plan are identified while Dr. Grentz is participating in the Plan, CPEP will notify the referring organization and Dr. Grentz and determine if the educational needs can be addressed within the context of this Plan.

LIMITATIONS

CPEP cannot guarantee that a Preceptor and/or an appropriate setting can be identified to address this Plan.

HEALTH CONSIDERATIONS

Dr. Grentz should continue to have his vision and hearing periodically monitored by his physicians. He should consider an evaluation by a physician health program in order to assess whether these conditions are severe enough to impact practice and what, if any, accommodations might be necessary.

Any requests for modifications of this Plan should be submitted to CPEP. CPEP will make reasonable efforts to meet the educational needs of Dr. Grentz and assist in reasonable accommodations but reserves the right to terminate the Educational Intervention if accommodations cannot be made.

LICENSING

Because CPEP Education plans are practice-based, physician-participants must have a medical license in order to complete a Plan. Some activities, such as self-study, may be completed without a medical license. *It is the participant's responsibility* to ensure that he/she practices within the parameters of his licensure status.

DESIGN

The individual Learning Goals described below in *Section II* were derived from the findings of the Assessment. This Plan was designed to address those Learning Goals through Medical Knowledge Enhancement and Patient Care Enhancement educational activities described in *Section III* as

Modules A and B. Evaluation of Dr. Grentz's progress and oversight of his participation will be provided by the CPEP Associate Medical Director. The Plan is designed around continuous and timely participation so that maximum educational benefit is received and ongoing progress is made. Following is more detailed information about the Modules and the Associate Medical Director oversight.

Note: The requirements of this Plan are not intended to supersede or exclude any requirements specific to his employer, credentialing, or licensure regulations. However, some activities may be applicable to both the Plan and such requirements.

A. Medical Knowledge Enhancement (Module A)

The Medical Knowledge Enhancement Learning Goals are addressed independently by the participant as well as through discussions with the Preceptor. The activities are designed to improve the participant's medical knowledge specific to the Learning Goals. Other improvements are generally realized as a result of the activities. A Preceptor is not needed to begin the activities described in Module A. CPEP encourages Dr. Grentz to begin the activities as soon as he has initiated the Plan. The recommended activities include:

- Independent/unsupervised self-study;
- Evidence-based research;
- Continuing medical education activities and/or courses.

B. Patient Care Enhancement (Module B)

Dr. Grentz will work with a Preceptor who has a practice similar to his. He will participate in Point of Care (PoC) activities as described below. Subsequently, Dr. Grentz will participate in a longitudinal learning experience that is reliant on regularly scheduled Preceptor Meetings. The PoC Experience will be completed prior to Dr. Grentz seeing patients independently/unsupervised as described in *Module B*. During these experiences, Dr. Grentz will:

- Address his more immediate educational needs by initially seeing patients with direct supervision. He will then progress through decreasing levels of supervision and ultimately see patients independently/unsupervised;
- Retrospectively review charts with the Preceptor of patients for whom Dr. Grentz provided independent/unsupervised care;
- Receive one-on-one coaching and constructive feedback with regard to medical knowledge, clinical judgment and documentation, particularly with regard to those areas identified in the Plan Learning Goals (see *Section II*);
- Discuss and reinforce new information and skills gained for full integration into daily patient care;
- Appreciate the value of lifelong learning, peer relationships, and self-assessment to the quality of patient care.

C. Oversight

The Associate Medical Director oversight includes Preceptor training, consideration of the feedback provided by the Preceptor and review of educational materials submitted by Dr. Grentz (see *Section V*). The Associate Medical Director will regularly communicate with and provide ongoing feedback and coaching to Dr. Grentz and the Preceptor with regard to Dr. Grentz's progress.

II. LEARNING GOALS

A. Medical Knowledge

To improve evidenced-based medical knowledge including, but not limited to, the following areas:

1. Comprehensive review of outpatient family medicine;*
2. Routine Health Screening:
   a. Evidence-based guidelines, such as those from the USPSTF;
   b. Guidelines for screening for STDs;
   c. Adult cancer screening recommendations: breast, prostate, cervical, and colorectal cancer;
   d. Pediatric and adult immunizations, including indications for pneumonia, hepatitis A/B, pertussis, tetanus, influenza, and herpes zoster vaccines;
   e. Guidelines for lipid management;
   f. Smoking cessation counseling;
   g. Assessment of hearing, vision, dementia screening, and of falls risk in the elderly;
   h. Screening for diabetes;
   i. Guidelines for lipid management;
3. Cardiovascular diseases:
   a. ECG interpretation;*
   b. Current guidelines (JNC 8) for hypertension management;
4. Pediatrics:
   a. Medications to avoid in young children;
5. Hematology:
   a. Assessment and management of anemias;
   b. Methods of lowering the INR in patients on warfarin;
6. Pain management:
   a. Safety aspects of narcotics;
7. Pulmonary medicine:
   a. Assessment for respiratory distress in children;
   b. Evaluation and treatment for DVT/PE and anticoagulation management, including novel oral anticoagulants;
   c. Management of COPD;
8. Gastroenterology:
   a. Evaluation and treatment of hemorrhoids;
   b. Evaluation and management of gastroesophageal reflux disease (GERD), including lifestyle interventions;

9. Endocrinology:
   a. Diagnosis and management of diabetes, including newer diabetes medications and indications for ACE inhibitors;
   b. Evaluation and management of thyroid disorders, including medication adjustment and timing of laboratory studies to assess efficacy of change in dosage of thyroid hormone supplement;
10. Neurology:
   a. Evaluation, risk stratification, and management of dementia;
   b. Stroke:**
      1) Evaluation and management of acute stroke;
      2) Recommendations for secondary prevention;
11. Infectious diseases:
   a. Evaluation and management of diabetic leg infections;
   b. Atypical pneumonia including potential causes, evaluation, and management;
   c. Evaluation and management of septic shock;
12. Nephrology:
   a. Potential causes of acute kidney injury;
   b. Evaluation and management of rhabdomyolysis and renal failure;
   c. Medication adjustments for kidney disease;
13. Urology:
   a. Evaluation and management of urinary incontinence;
14. Women's health:
   a. Recognizing potential pregnancy;
   b. Evaluation and management of post-menopausal bleeding;
   c. Indications for human papillomavirus (HPV) testing.

*Topic summary not required.
**Subtopics may be combined into one summary; two references required.
(See III.B below for description of topic summaries.)

B. Clinical Judgment

To *consistently* demonstrate appropriate clinical judgment in the areas that include, but are not limited to, the following:

1. Ability to consistently gather adequate clinical information;
2. Avoidance of premature diagnostic closure;
3. Structured and thorough formulation of differential diagnoses;
4. Ability to correctly assess acuity of illness and make appropriate plans;
5. Evidence-based approach to practice;
6. Avoidance of iatrogenic injury;
7. Treatment planning: attention to lifestyle modifications.

C. Documentation

The participant will learn principles of documentation that are based on recommendations and requirements of nationally recognized organizations such as the Joint Commission and Centers for Medicare and Medicaid Services (CMS) and recommendations of national specialty societies and will *consistently* demonstrate appropriate patient care documentation that includes, but is not limited to, the following:

1. Documentation of patient education.

Guideline

Adequate documentation requires inclusion of sufficient detail in visit notes such that the notes "stand alone" and determination of the level of care provided does not require verbal input from the documenting physician to be fully understood. Ultimately, adequate documentation includes chart organization and systems tools that allow another physician to easily assume care of a patient.

D. Practice-based Learning

1. Increased participation in CME activities;
2. Consider the use of evidence-based, medical content Internet-based resources.

E. Physician-Patient Communication Skills

To *consistently* demonstrate appropriate communication skills in the areas that include, but are not limited to, the following:

1. Continuing education on creating a more positive initial impression and providing more in-depth education on diagnoses and treatment plans.

III. PERFORMANCE OBJECTIVES

Performance Objectives are specific educational activities that provide focused learning experiences designed to assist the participant with achievement of the Learning Goals (*Section II*). The participant will integrate newly learned information into his daily practice and demonstrate long-term improved patient care during Module B Activities.

MODULE A
MEDICAL KNOWLEDGE ENHANCEMENT

Module A activities do not require approval of a Preceptor to initiate. Dr. Grentz will:

- Document all activities, including ongoing case-based activities, continuing medical education activities (CME) and self-study on an Education Log provided by CPEP;
- Participate in self-study activities during participation in the Plan that demonstrate lifelong learning skills;
- Submit certificates of completion for any courses, if applicable.

Timelines

The timelines below are recommended to maximize participation in the Plan.

- Independent/unsupervised activities, such as self-study, should be initiated immediately once the Plan has been signed.
- Topic/subtopic summaries should be completed by the sixth month of beginning the Plan activities.
- Courses and/or CME activities should be completed no later than the fourth month of participation.

Guideline

It will be important that Dr. Grentz develop a strategy that ensures he submits all topic/subtopic summaries within six months of initiating the Plan so that he has ample time to demonstrate his application of new knowledge to his actual patient care during the Precepted Education component.

Associate Medical Director Approval of Resources

Dr. Grentz may identify resources other than those mentioned below; however, the Associate Medical Director must approve those resources in order for the activities to be applicable to the Plan. He should receive approval of resources prior to incorporating those resources into his Plan activities.

A. Courses

Dr. Grentz will:

1. Complete a comprehensive review course, such as *The Core Content Review of Family Medicine* or the review course offered by American Academy of Family Medicine (AAFP). Information may be found at: http://www.corecontent.com/products.cfm and http://www.aafp.org
2. The Associate Medical Director will monitor Dr. Grentz's documentation skills to determine if he would benefit from participating in a documentation course. If such a recommendation is made more information would be provided to Dr. Grentz at that time.

B. Evidence-Based Self-Study

The purpose of this module is to demonstrate self-directed learning and to create educational resources for reference. Dr. Grentz will:

1. *For each of the topics and subtopics* listed in the Medical Knowledge Enhancement Learning Goals (except for those indicated with asterisks), submit a brief paragraph, case based discussion, outline, or algorithm to summarize the major points learned;
   a. In preparing the submission, Dr. Grentz will use *at least two resources for each of the topics and subtopics* listed in the Medical Knowledge Enhancement Learning Goals (except for those indicated with asterisks). The submission should explain the applicability of knowledge to his practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale;

1) Appropriate resources are current, peer-reviewed, evidence-based medical references. Notes from a pertinent conference may be utilized with prior Associate Medical Director approval;
   a) CPEP will provide an Education Notebook upon initiation of the Plan. (Refer to *Section IV.A.1.b* below. It will contain information about resources, such as: http://www.dartmouth.edu/~biomed/resources.htmld/guides/FindingGoodAnswers.pdf.)

2. Identify and become familiar with the resources for current guidelines relevant to the Medical Knowledge Learning Goals;
   a. Document and submit appropriate clinical guideline resources on an Education Log;
3. Regularly review *The Medical Letter*, *Prescriber's Letter* or other prescribing periodical (with the Associate Medical Director's approval) for current pharmacology review;
   a. Document this review in the self-study section of the Education Log;
4. Read Chapters 1-11 of Learning Clinical Reasoning, Second Edition by Jerome P. Kassirer, M.D., John B. Wong, M.D., and Richard I. Kopelman, M.D., and discuss with the Preceptor;
   a. Document reading and discussions on Education Logs;
5. If applicable and as needed, read Procedures for Primary Care, by John L. Pfenninger, M.D., FAAFP; Michael Tuggy, M.D.; Grant C. Fowler, M.D. and Jorge Garcia, M.D. and document reading on an Education Log;
6. Participate in self-study relevant to his practice for the duration of the Plan.

C. Electrocardiogram Interpretation Activities

Important to note:

- Dr. Grentz should not be responsible for ECG interpretation (without over-reading) prior to demonstrating competence to his Preceptor.

Dr. Grentz will:

1. Read the textbook Clinical Electrocardiography: A Simplified Approach by Ary L. Goldberger, or other approved resource, and review with the Preceptor;
2. Review at least 25 to 30 ECGs using resources such as:
   a. "Alan E. Lindsay ECG Learning Center" on the University of Utah School of Medicine website located at http://ecg.utah.edu/introduction
   b. http://www.ecg-interpretation.blogspot.com/
3. Document independent/unsupervised ECG reading and review as well as ECGs reviewed with the Preceptor on Education Logs;
4. Ensure that the Preceptor speaks with the Associate Medical Director prior to Dr. Grentz independently reading and interpreting ECGs.

D. Communication

Dr. Grentz will:

1. Read pertinent chapters of the Field Guide to the Difficult Patient Interview by Frederic W. Platt, M.D., and Geoffrey H. Gordon, M.D., and discuss with the Preceptor;
   a. Document chapters read on an Education Log;

b. The Preceptor and Associate Medical Director may assign particular chapters;
2. At a time to be determined by the Associate Medical Director, submit to CPEP completed patient questionnaires addressing his communication skills.
   a. The questionnaire and more direction will be provided by CPEP.

E. Case-Based Activities

Dr. Grentz will:

1. Review cases in chapters 12-22 of Learning Clinical Reasoning, Second Edition that illustrate concepts applicable to identified needs;
   a. Document this review in the self-study section of the Education Log;
2. Pursue case-based learning through resources such as:
   www.aafp.org
   www.clinicalcases.org

F. Practice-based Learning

Dr. Grentz will:

1. Review current peer-reviewed, evidence-based medical literature pertinent to family medicine throughout the duration of the Plan;
2. Utilize appropriate Internet web sites and other medical resources.

G. Systems-based Practice

Dr. Grentz will:

1. Discuss with the Preceptor ways to augment his awareness of systems-based practice such as:
   a. Familiarity with different types of medical practice and delivery systems;
   b. Awareness of resources for patients and ways to help patients work within that system;
   c. Understanding of issues within the medical system which contribute to and reduce medical error;
   d. Understanding of cost effective resource allocation and appropriate prescribing patterns to that end;
   e. Participating in interdisciplinary teams as appropriate.

Core competencies which have been adopted by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education can be found here:
http://www.abms.org/maintenance_of_certification/MOC_competencies.aspx

H. Internet-Based Medical Information Resources

Dr. Grentz will:

1. Utilize electronic resources at the point of care, such as a computer with access to the Internet. Software or web sites should assist with immediate access to up-to-date medical information relevant to medication prescribing and drug interactions, and patient care decisions, including formulating an adequate differential diagnosis, interpreting test results and evaluating treatment options.

MODULE B
PATIENT CARE ENHANCEMENT

During the activities described in this Module the Preceptor will provide feedback to Dr. Grentz with regard to improvements in all areas of the Learning Goals. The Preceptor will coach Dr. Grentz to integrate improved knowledge, decision-making and documentation into daily patient care. All meetings and activities will be documented on an Education Log provided by CPEP.

Timeline

- See *Section IV* for complete time frames for the Preceptor approval process and initiation of Preceptor Meetings and the Point of Care Experience.
- Once initiated, Preceptor Meetings and chart reviews will continue for the duration of the Plan.

A. Point of Care Experience

During this experience, Dr. Grentz will:

1. Shadow:
   a. To become acquainted with the office setting, shadow the Preceptor for approximately one-half day;
   b. Discuss each case including diagnosis, management options and expected outcomes;
2. Supervision:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, manage patients with 100% direct supervision;
      1) Direct supervision is defined as side-by-side observation of the patient encounter by the Preceptor;
   b. Discuss each case including management options and expected outcomes;
   c. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
   d. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *Concurrent Case Review*;
3. Concurrent Case Review:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, review each case with the Preceptor prior to releasing the patient to determine if the exam and evaluation have been adequate and if the plan is appropriate;
   b. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
   c. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *End of Day Review*;
4. End of Day Review:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, review all patients at the end of each day with the Preceptor;
   b. Discuss each case including management options and expected outcomes;

c. Have each note for the above patient encounters reviewed for completeness and overall quality by the Preceptor when the note is completed or when the dictations are available, and receive feedback on the documentation of the patient visit;
d. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
e. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *Consultation*;

5. Consultation:
   a. Manage patients with immediate physician consultation available if needed for approximately one month;*
      1) The onsite physician may be someone other than the Preceptor, but should be someone approved by the Associate Medical Director;
   b. Implement weekly PoC meetings. During these meetings:
      1) Retrospectively review each case and outcome with the Preceptor;**
      2) Have each note for the above patient encounters reviewed for completeness and overall quality by the Preceptor and receive feedback on management and documentation of the patient visit;
   c. Document every case specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP and submit the Case Log along with the charts mentioned immediately below;
   d. After seeing patients for three weeks, submit six charts to the Associate Medical Director for review to evaluate Dr. Grentz's readiness to progress to the Precepted Education Experience;
6. Conclusion:
   a. At the completion of the above activities, Dr. Grentz will:
      1) Ensure that the Preceptor speaks with the Associate Medical Director and submits a written report documenting Dr. Grentz's readiness to proceed to independent/ unsupervised patient care;
      2) Receive notification from the Associate Medical Director that the PoC Experience has been completed.

*One month is an estimated timeframe and may be lengthened if it is determined that Dr. Grentz would receive educational benefit from extending the experience.

**If Dr. Grentz's patient volume is too large to allow review of each case, he and the Preceptor should review no fewer than six cases per weekly meetings that are relevant to his Plan Learning Goals as much as possible.

B. PRECEPTED EDUCATION

It will be important that the Preceptor Meetings and activities are thorough and that the Preceptor provides objective feedback sufficient to support Dr. Grentz's improvement with regard to the specific Plan Learning Goals. All meetings and activities will be documented on an Education Log provided by CPEP.

Guideline
Having knowledge is distinct from applying knowledge. It is essential that, when reviewing charts, the Preceptor determine whether or not the participant *applied* his knowledge to actual patient care.

PRECEPTOR MEETINGS
After completion of the PoC Experience, Dr. Grentz will:

1. Meet with the Preceptor twice monthly for the duration of the Plan. To provide a quality learning experience, CPEP recommends that each meeting be a minimum of two hours;
2. With the Preceptor and in conjunction with the activities described below in *Preceptor Meeting Activities*, utilize the following to address the Learning Goals:
   a. Chart review and case-based discussions;
   b. Hypothetical case discussions;
   c. Topic discussions;
   d. Current medical literature reviews;
   e. Utilization of appropriate Internet web sites and other medical resources.

Guideline
Although impromptu collegial discussions may occur outside of Preceptor Meetings, such discussions are separate from the Preceptor Meeting requirement.

PRECEPTOR MEETING ACTIVITIES

Chart Review Objectives

Charts are the primary method of evaluating the participant's application of knowledge and clinical judgment and reasoning. Therefore, charts submitted to the Preceptor and the Associate Medical Director as described below should demonstrate the participant's integration of feedback and information learned as a result of completing Module A activities. Submitted charts should reflect consistent improvements in overall patient care.

Charts reviewed during Preceptor Meetings will be those of patients for whom Dr. Grentz provided independent/unsupervised care. Charts as described below should address the Plan Learning Goals as much as possible.

During the Precepted Education, Dr. Grentz will:

1. Retrospective Chart Reviews:
   a. Submit to the Preceptor for review no fewer than 24 redacted* charts per month (12 charts per twice-monthly sessions);
      1) The Preceptor may specify cases to be reviewed;
      2) Redacted* copies of charts should be submitted to the Preceptor in time for the Preceptor to review them before the meetings;
   b. Submit to CPEP by the fifth of *every other* month (month to be determined), six of the 24 redacted* charts used in the Preceptor Meetings;
      1) The Associate Medical Director may specify charts to be submitted;

c. **Cases should be specifically relevant to the Plan as well as representative of the scope of Dr. Grentz's practice, as much as possible.**

2. Didactic Discussions and Coaching:
   a. Clinical Judgment:
      1) With the Preceptor, discuss the Clinical Judgment Learning Goals and application of knowledge to patient care;
      2) Develop and discuss with the Preceptor systems (protocols, algorithms, and/or chart templates) or other strategies for organizing the clinical evaluation to ensure that the Clinical Judgment Learning Goals are addressed and that improvements are integrated into his daily patient care;
   b. Documentation:
      1) Receive coaching from the Preceptor that addresses general documentation principles as well as the specific areas of need described in Learning Goal C, *Documentation*, including strategies and/or use of chart templates for improved documentation;
   c. Medical Knowledge:
      1) Discuss with the Preceptor each topic and subtopic identified in Module A, including applicable and current evidence-based guidelines as available. Dr. Grentz should also discuss his topic/subtopic summaries with the Preceptor;
   d. Communication:
      1) Receive coaching and review reference materials described in the Plan related to communication skills;
3. Lifelong Learning:
   a. Develop lifelong learning skills:
      1) Discuss and develop a plan with the Preceptor for maintaining current standards in family medicine after conclusion of the Educational Intervention. Discuss the plan with the Associate Medical Director and demonstrate ongoing learning throughout the duration of the Plan. The plan should:
         a) Incorporate Internet-based resources;
         b) Integrate evidence-based medicine resources;
         c) Promote lifelong learning;
         d) Include activities that address clinical decision-making, such as case studies.
   b. CPEP encourages Dr. Grentz to:
      1) Review and reflect on the status of his learning and improvements on an ongoing basis;
      2) Keep a learning journal on his reflections, including which activities were beneficial, or not beneficial, and why.

** Refer to Appendix B, Privacy of Individually Identifiable Health Information*

Guidelines

- During the Preceptor Meetings, the Preceptor should provide coaching and recommendations to the participant to ensure that improvements in all Learning Goals

identified in the Plan are collectively and consistently applied to Dr. Grentz's actual patient care.

- The participant's progress will be determined based on the achievement of the Learning Goals and in consideration with generally accepted standards of care. The constraints of a physician's practice circumstances, such as the availability of local medical resources, are taken into consideration when reviewing a physician's actual practices.

IV. INITIATING THE PLAN

A. Determining the Start Date and Beginning Educational Activities

1. Dr. Grentz will sign and return the Plan to CPEP by November 6, 2015. He will then:
   a. Initiate the self-study components of the Plan the first day of the month following CPEP's receipt of the signed Plan;
   b. Receive an Education Notebook from CPEP with directions, Education Logs, resources, and other information to complete the educational activities;
   c. Initiate and document self-study activities and course participation;
   d. *After reviewing* the Preceptor qualifications described in the *Preceptor Overview and Agreement,* identify a Preceptor candidate if Dr. Grentz has not already done so;
      1) The Preceptor must be board certified in the same specialty and have a practice similar to Dr. Grentz's;
2. Provide a copy of the Plan, *Preceptor Overview and Agreement,* Confidentiality Statement, and a copy of the Assessment Report to the proposed Preceptor so that the approval process, as described below, can progress accordingly.

B. Preceptor Approval

1. Dr. Grentz will, *within 30 days of licensure reinstatement,* submit to CPEP:
   a. The proposed Preceptor curriculum vitae (CV) including the Preceptor name and contact information;
   b. Signed CPEP Authorization to Release/Receive Information form authorizing CPEP to communicate with the Preceptor;
      1) A telephone call with the Preceptor and the Associate Medical Director will then be scheduled as part of the approval process;
      2) The participant will be notified of the approval;
2. Upon notification of approval, Dr. Grentz will begin meeting regularly with the Preceptor. He should document meetings on an Education Log.

Guideline

For the participant's educational benefit, the Preceptor must meet the qualifications as described in the *Preceptor Overview and Agreement.* Additionally, CPEP must approve the Preceptor in order for any precepted activities to be applicable to the Plan.

V. PARTICIPATION AND MONITORING

Consistent participation in educational activities, including regular and timely submission of materials and participation in scheduled CPEP conference calls, enhances the educational experience. Such participation may also impact the duration of the Plan. Because the Associate Medical Director must be able to evaluate the participant's ongoing progress and provide timely and pertinent feedback, Dr. Grentz will:

1. Maintain Education and PoC Case Logs:
   a. Education Logs should document all educational activities including Preceptor Meetings and the content of the Meetings, and those activities that are outside of the scope of the Plan but relevant to his practice;
   b. PoC Case Logs should document PoC activities as previously described in Module B;
2. Submit materials:
   a. By the fifth of every month, submit:
      1) Education Logs;
      2) Preceptor Report forms completed by the Preceptor;
      3) Controlled Substances Log, if applicable;
      4) Other materials relevant to the Plan or as requested by the Associate Medical Director;
   b. By the fifth of every month and until the following has been completed, submit:
      1) Case Logs for the PoC activities;
      2) Topic/subtopic summaries;
      3) CME certificates and/or other documentation of completed activities specified in the Plan (if applicable);
3. Submit Charts:
   a. Either monthly or every other month, as directed by CPEP, submit charts,** as described in Module B. Charts must be complete and if possible, include one year of patient care and include the Preceptor's written comments either on or with the copies of the charts. More information will be provided when the Plan is initiated;
   b. At the request of the Associate Medical Director, submit randomly selected charts for review from Dr. Grentz's appointment schedule;
4. Communication:
   a. Participate in calls with CPEP as requested;
   b. Respond to emails or letters from CPEP in a timely fashion;
5. Be responsible for his and his Preceptor's participation in the Plan activities and his educational progress;
6. Demonstrate maintenance of improvements for all Learning Goals prior to conclusion of the Patient Care Enhancement activities.

**See *Module B, Retrospective Chart Review* to determine if charts should be submitted monthly or every other month

FORMATIVE EVALUATION
Evaluation of Educational Progress

Ongoing progress is measured using formative evaluation tools such as regular chart reviews, review of topic/subtopic summaries, participant and Preceptor discussions with the Associate Medical Director, and written Preceptor Reports.

Approximately every four months, Progress Reports will be generated and provided to Dr. Grentz and to other entities for which Dr. Grentz has provided authorization. The Progress Reports will capture Dr. Grentz's progress as demonstrated during Formative Evaluations conducted during that reporting period.

SUMMATIVE EVALUATION
Post-Education Evaluation

Following the completion of the Plan activities, Dr. Grentz will participate in a Post-Education Evaluation (Evaluation) to demonstrate that he achieved the Learning Goals and successfully completed the Educational Intervention. The Evaluation will be focused on the areas identified as Learning Goals in the Plan and will consider Dr. Grentz's scope of practice. (See Section 5.1(e) of the CPEP *Educational Intervention Participation Agreement* for more information.)

- Dr. Grentz will schedule the Evaluation no sooner than two months, and no later than four months, following notification from CPEP that he/she has completed the Plan activities.

VI. ESTIMATED DURATION

Plan Learning Goals and Performance Objectives
Most participants complete an Education Plan in approximately 12-18 months. The actual duration varies depending on many factors including the scope of educational needs identified.

CONDITIONS
- Modifying an approach to overall patient care, specifically application of knowledge, clinical judgment and documentation may be challenging. Additionally, certain aspects of the Plan cannot be predicted, such as spectrum of patients and cases presented, as well as the participant's dedication to the educational activities. Therefore, the duration of the Plan can only be estimated.
- CPEP reserves the right to change the content and/or duration of the Education Plan.
- CPEP is not responsible for ensuring that the participant obtains any required privileges or credentials while participating in the Education Plan; this is the responsibility of the participant.

- Once the participant has completed the Education Plan and/or has been authorized to complete the Post-Education Evaluation, CPEP is no longer reviewing charts or providing educational services to the participant.
- If Dr. Grentz does not engage in this Plan by October 14, 2016, CPEP may require completion of additional Assessment activities to ensure that Dr. Grentz's current educational needs are addressed.

SIGNATURES

_____ _____
Werner Grentz, D.O. Date

_____ _____
Abigail C. Anderson, M.D. Date
Associate Medical Director

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Preceptor candidates.

APPENDIX A
Prospective Practice Profile

Werner Grentz, D.O.

Dr. Grentz should notify CPEP of updates and changes to his profile while participating in the Plan.

Specialty

Family Medicine

Licensure

Licensing State	Status
KY	Surrendered

Practice Setting

Outpatient

Practice Profile – To Be Determined

Volume of patients per day:
Number of days worked per week:
Number of patients admitted per month:
Census of inpatients per month: approximately
Number of days on-call per month:
Number of patients in SNF:

Commonly Encountered Diagnoses

Inpatient Procedures:
Outpatient Procedures:

(The remainder of this page is intentionally blank.)

APPENDIX B

[Code of Federal Regulations]
[Title 45, Volume 1]
[Revised as of October 1, 2002]
From the U.S. Government Printing Office via GPO Access
[CITE: 45CFR164.514]

TITLE 45--PUBLIC WELFARE AND HUMAN SERVICES

PART 164--SECURITY AND PRIVACY

Subpart E--Privacy of Individually Identifiable Health Information

Sec. 164.514 Other requirements relating to uses and disclosures of protected health information.

(a) Standard: de-identification of protected health information. Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

(b) Implementation specifications: requirements for de-identification of protected health information. A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

(i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination; or

(2)(i) The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates

(including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;
(E) Fax numbers;
(F) Electronic mail addresses;
(G) Social security numbers;
(H) Medical record numbers;
(I) Health plan beneficiary numbers;
(J) Account numbers;
(K) Certificate/license numbers;
(L) Vehicle identifiers and serial numbers, including license plate numbers;
(M) Device identifiers and serial numbers;
(N) Web Universal Resource Locators (URLs);
(O) Internet Protocol (IP) address numbers;
(P) Biometric identifiers, including finger and voice prints;
(Q) Full face photographic images and any comparable images; and
(R) Any other unique identifying number, characteristic, or code; and

(ii) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

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Werner Grentz, D.O.

APPENDIX C

CPEP GLOSSARY AND DESCRIPTION OF EDUCATIONAL PROCESS

EDUCATIONAL INTERVENTION

The Educational Intervention describes the entire educational program, which includes the development and monitoring of the Education Plan and services provided by CPEP, such as progress reports, ongoing support to the participant, and the Post-Education Evaluation.

EDUCATION PLAN

A CPEP Education Plan (Plan) is an individualized structured educational process based on the findings of the Assessment (see below). Because CPEP Plans are personalized, each Plan contains requirements that are specific to the needs of the participant for whom the Plan was developed. Requirements, such as the type of educational activity, the intensity or duration of an activity, or the level of supervision, will vary per Plan. Requirements may also be modified as the participant's needs evolve over time. The Plan typically concludes with a Post-Education Evaluation (Evaluation) so that the participant can objectively demonstrate that the Goals of the Plan have been achieved.

ASSESSMENT

The Assessment is designed to evaluate the participant through use of specialty-specific, individualized testing tools. An Associate Medical Director oversees the Assessment and attends clinical interviews to ensure that the process is reflective of the participant's practice specialty and takes into account any noted reason for referral. Results from the participant's performance in each assessment modality are incorporated into an Assessment Report. The Assessment Report reflects the effort and analysis of CPEP's Medical Director, Associate Medical Director, and administrative staff.

ASSOCIATE MEDICAL DIRECTOR

The CPEP Associate Medical Director (AMD) is a qualified physician who oversees the participant's educational progress and compliance during the Plan. The AMD also provides training to and communicates with the Preceptor (see below).

EDUCATIONAL PRECEPTOR (PRECEPTOR)

A Preceptor is a qualified physician who is approved by CPEP, and the referring organization if applicable. The Preceptor's main function is educational. He/She is expected to teach, provide educational guidance, and evaluate the participant's educational progress. The Preceptor provides one-on-one education, incorporates case reviews and discussions into the meetings, and may provide supervision (see below) during patient encounters or procedures as directed in the Plan. A secondary Preceptor may be identified to address specific/specialty areas (e.g., cardiology, pharmacology) or to address the unique needs of a participant.

LEARNING GOALS

A Learning Goal describes the measurable areas of knowledge, skills, and/or concepts that a participant will gain by completing the described educational activities. Learning Goals are developed based on the findings of the Assessment. At the request of a referring organization or the participant, other goals may also be included.

PERFORMANCE OBJECTIVES/EDUCATIONAL ACTIVITIES

Performance Objectives specify the educational activities that are recommended to achieve the Learning Goals. Appropriate completion of the activities demonstrates that the information/skills/concepts have been addressed by the participant's utilization of the defined strategies or learning tools. See *Description of Educational Activities.*

EVALUATION METHODS

CPEP incorporates both formative and summative evaluations:

- A formative evaluation occurs during the educational program to assess initial and ongoing learning as the educational experience progresses, i.e., AMD and Preceptor discussions, topic/subtopic summaries, chart reviews, etc.
- A summative evaluation focuses on the outcomes and impact of the learning experience at the completion of an educational program, i.e., Post-Education Evaluation.

PARTICIPATION/COMPLIANCE

The CPEP staff and AMD monitor the participant's participation/compliance with the Plan. Participants must regularly participate in acceptable educational activities as directed by the Plan and submit materials within the timeframes established by CPEP. The participant must also demonstrate progress toward attainment of the Learning Goals. Inappropriate participation/noncompliance will be reported to the referring agency. If a participant is not participating or progressing appropriately, the Plan may be placed in one of the following categories:

- *Hold:* Occasionally, CPEP, in conjunction with the referring organization, may allow a participant to postpone, or place educational activities on hold, for a predetermined period of time (typically one to three months). Generally the hold status is offered to allow the participant the opportunity to address personal or professional issues that would prevent him/her from appropriately focusing on educational activities. A postponement of educational activities is not recommended, and should be limited to a one-time occurrence.
- *Suspension:* CPEP may suspend the participant's Education Plan if it is determined that the participant has:
  - Participated in inappropriate or minimal educational activity;
  - Failed to provide documentation of educational activities,
  - Failed to respond to CPEP requests or direction;
  - Not benefited from participation in the Plan.

It may be possible for the participant to reengage in educational services.

COMPLETION OF THE PERFORMANCE OBJECTIVES

Completion of Performance Objectives with approval to participate in a Post-Educational Evaluation: Overall, formative evaluations indicate that the participant completed the Performance Objectives by adequately demonstrating appropriate gains in knowledge/skills to achieve the Learning Goals. The participant will be advised to schedule a Post-Education Evaluation.

- *Incomplete Performance Objectives:* The participant has made insufficient progress toward completion of Performance Objectives or toward achievement of the Learning Goals. Based on the areas of remaining educational need and CPEP staff review of the participant's activities, CPEP will provide recommendations that may include the following:
  a. *Termination due to Maximum Educational Benefit:* While the participant may have made progress in the Plan, he/she has not demonstrated successful completion in one or more of the Plan's Goals or Objectives. Prior improvements may not have been maintained and/or regression in the educational process was demonstrated. CPEP determined that there would be little or no benefit for the participant to continue with an educational program at that time.
  b. *Termination due to Non-Compliance:* The participant has violated or would not comply with the CPEP Participation Agreement and/or the Education Plan such that an appropriate working relationship with the participant is not possible. Future CPEP services would not be available to the participant.

POST-EDUCATION EVALUATION (EVALUATION)

The Evaluation is a summative assessment that measures the maintenance of the improvements made by the participant as a result of progressing in and completing the Plan. The content of the Plan and the participant's scope of practice will be addressed during the Evaluation. The method of the Evaluation is similar to the Assessment process.

COMPLETION OF THE EDUCATIONAL INTERVENTION

- *Successful Completion:* The participant successfully completed the Plan Objectives and the summative evaluation). There are generally no or limited recommendations for further educational activities.
- *Insufficient Progress to Support Successful Completion of the Plan:* In the summative evaluation, the participant has not demonstrated sufficient achievement of one or more Learning Goals to successfully complete the Educational Intervention. Based on the areas of remaining educational need identified in the Post-Education Evaluation and on CPEP staff review of the prior Plan activities, CPEP may recommend:
  a. *Education Plan Addendum*: An extension of the Plan designed to address residual areas of need identified in the summative evaluation;
  b. *Maximum Educational Benefit:* Following completion of the Post-Education Evaluation, CPEP may determine that the participant has not demonstrated successful completion of the Plan and/or integration of improvements into daily patient care and would not benefit from further educational activities.

LIMITATIONS

- A CPEP Education Plan is not intended to provide the same rigor of training or depth of curriculum as a residency nor can it lead to eligibility for board certification. A residency program is provided through an accredited graduate medical education program.
- The Education Plan is not intended to provide proctoring, either for the purpose of gaining hospital privileges or to fulfill any other entities requirement for proctoring. Proctoring is an objective evaluation of a physician's clinical competence by a physician who represents and is responsible to the health care facility medical staff or another entity. A proctor does not teach or make recommendations for improved patient care.
- The Preceptor's role is not the same as a practice monitor, who is expected to focus on patient safety, evaluate the physician's practice, and report to an authoritative entity. The Preceptor should be able to focus only on the Education Plan. CPEP strongly recommends that the preceptor and the practice monitor not be the same individual.

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DESCRIPTION OF EDUCATIONAL ACTIVITIES

MEDICAL KNOWLEDGE ENHANCEMENT

Educational activities are recommended to improve medical knowledge. Some activities are topic specific while others are more broad. Topic-specific activities may include literature searches that acquaint and familiarize the participant with reliable and current information and resources. This activity often introduces the use of the Internet to participants as well as directs their attention to the need for ongoing professional development. The participant must identify appropriate literature resources and materials for reading and research. The participant will submit a written synopsis of articles and/or guidelines specific to the Plan. An acceptable synopsis will adequately describe how the participant can apply the information to his/her practice.

To meet the need for a broader review of medical knowledge, the Plan may recommend continuing medical education (CME) activities and/or courses. The Plan generally recommends online activities, but occasionally the Plan will recommend an onsite course. CME may also be recommended for certain topics or knowledge areas in which CME would provide a more optimal educational experience.

POINT OF CARE EDUCATIONAL EXPERIENCE (POC)

PoC education occurs at the moment of the patient encounter. PoC education can occur in the outpatient, inpatient, or surgical setting. CPEP's PoC experiences are designed to allow the Preceptor to observe, educate, and/or provide supervision as the participant is providing patient care or performing procedures. The length of time and the level of supervision are determined based on the participant's educational goals. Following are descriptions of the levels of supervision that may be included in a Plan:

A. Focused PoC Training

This is a finite educational experience, which generally lasts from one day up to four weeks. It is designed to provide focused training and an enriched educational experience in a particular skill, exposure to a particular disease, and/or a particular patient population. This experience may occur in a single block of time or may occur incrementally over an extended period, depending on the scheduling requirements of the preceptor and the facility. It may or may not be required to occur at the beginning of the Plan. The Focused PoC Training may address:

- Skills in the management of acute medical conditions (e.g., asthma, chest pain, pediatric emergencies);
- Skills in the management of a particular patient population (e.g., pediatrics, chronic pain patients);
- Procedural skills (e.g., endoscopy, casting, suturing, laparoscopy, intubation of the difficult airway).

B. Comprehensive PoC Experience

This educational experience is designed to provide preceptor oversight and training covering a broad spectrum of practice issues. Generally, this experience will be completed in a specified and continuous block of time at the beginning of the Plan. Examples of situations that may be appropriate for this experience include:

- A participant returning to practice after an extended absence;
- A participant returning to practice after prior revocation or suspension of licensure;
- The quantity or spectrum of the participant's educational needs is such that the participant would benefit from an intense one-on-one educational experience that would address immediate educational needs.

PoC Process

The PoC experience process is generally as follows.

1. Shadowing/Assisting: The participant observes and/or assists the Preceptor.
2. Direct Supervision: The Preceptor is physically present during the patient encounter or procedure conducted by the participant.
    a. In some instances, the Plan will specify that the participant received 100% supervision. The Plan will specify if this applies to all patient encounters or to patient encounters of a specific type (e.g., pediatric patients; laparoscopic procedures). In the specific areas requiring PoC supervision, CPEP recommends that the participant *not* provide patient care of this type outside of this PoC experience.
    b. If 100% supervision is *not* specified, the supervision would apply only in the context of the PoC activity. The participant would provide patient care outside of the PoC experience.
3. Onsite Consultation: The participant sees patients independent/unsupervisedly with onsite consultation. Consultation will occur as designated by the education plan.

PATIENT CARE ENHANCEMENT

Precepted education provides a longitudinal learning experience that occurs through regularly scheduled meetings with the Preceptor. The Precepted Education may occur concurrently with the PoC Experience. The meetings address the Plan's Learning Goals through didactic exercises, chart reviews, review of literature and appropriate Internet web sites, as well as case-based and hypothetical discussions. Precepted Education may include any or all of the following:

- *Initial observation:* The Preceptor may observe the participant in his/her practice setting to provide insight to the preceptor about the participant's practice and environment. (Generally four to eight hours of observation.)
- *Prospective chart review:* The Preceptor and the participant will discuss treatment and/or procedural plans, treatment alternatives, and procedure and patient selection.
- *Retrospective chart review:* The Preceptor reviews charts from prior patient encounters. Such reviews facilitate discussions that address medical knowledge, clinical judgment, application of knowledge, and documentation, as well as overall patient care.

FILED OF RECORD

MAR 16 2016

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1461

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY WERNER GRENTZ, D.O., LICENSE NO. 02269, 2197 PINE BROCK ROAD, LONDON, KENTUCKY 40741

AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, and Werner Grentz, D.O. ("the licensee"), and, based upon the licensee's request to reinstate his license to practice osteopathy in the Commonwealth of Kentucky, hereby ENTER INTO the following **AGREED ORDER OF PROBATION:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Probation:

1. At all relevant times, Werner Grentz, D.O., was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is Family Medicine.
3. A release by Kerry B. Harvey, United States Attorney for the Eastern District of Kentucky, provided the following information about the licensee:

   The Internal Revenue Service (IRS) arrested the licensee on May 1, 2012. The licensee allegedly earned between $169,000 and $356,000 each of the years between 2005 and 2010, but failed to file tax returns for those years. The licensee practiced in hospitals and medical offices in London, Manchester, and Monticello, Kentucky and in Jellico, Tennessee.
   According to the indictment, which was returned on April 6 and unsealed on May 2, 2012, the licensee evaded taxes by providing one of his employers with an IRS form in which he falsely claimed that he was exempt from having federal income tax withheld from his earnings. He also allegedly had his earnings deposited into bank accounts of companies that he controlled in order to hide his income.

4. The federal grand jury for the Eastern District of Kentucky returned Indictment No. 6:12-CR-12-GFVT on April 6, 2012, under seal. The indictment charged the licensee with two (2) counts of violating 26 U.S.C. 7203, by failing to file income tax returns as required by law, and four (4) counts of violating 26 U.S.C. 7201, by attempting to conceal his income by certain transactions, all felonies.

5. On December 18, 2012, the licensee entered into a Plea Agreement with the United States, under which he agreed to plead guilty to Count 5 of the Indictment, in exchange for dismissal of Counts 1-4 and 6. The Plea Agreement specified the following factual bases for his plea to Count 5,

   In 2002, after he failed to file tax returns for several years, the IRS sent the licensee a letter to inform him that federal law contains criminal penalties for willfully failing to file tax returns. In 2007, agents told the licensee that he was under investigation.
   During 2009, the licensee worked as an independent physician contractor at a hospital in Jellico, TN, and at a medical office in London, KY. From that work, he received taxable income of $356,073. Although he owed a substantial amount of federal income tax based upon his taxable income, he failed to file an income tax return with the IRS on or before April 15, 2010, as required by law, or to pay the tax to the IRS.
   The licensee made affirmative attempts to evade and to defeat the tax by causing his compensation to be deposited into bank accounts that he had opened in the names of two shell companies and by withdrawing the deposited money from the accounts on the same day or within a few days after the compensation had been deposited into the accounts.

6. The licensee formally entered his plea to Count 5 in court on January 17, 2013. As part of his plea, the licensee acknowledged that he failed to pay $900,068 in taxes since 1999.

7. The licensee was incarcerated for approximately fourteen (14) months.

8. The licensee entered into an Agreed Order of Surrender on or about February 21, 2013.

9. In December 2014, counsel for the licensee requested to be placed on the Panel's February 2015 agenda regarding reinstatement of his osteopathic license.

10. Since he had not practiced osteopathy in over two (2) years, the licensee was advised at that time to obtain a clinical skills assessment from the Center for Personalized Education for Physicians ("CPEP").

11. On or about May 13-14, 2015, the licensee completed a CPEP clinical skills assessment. CPEP reported:

> During this Assessment, Dr. Grentz demonstrated a variable and, at times, outdated fund of knowledge in outpatient family medicine. His clinical judgment and reasoning, as demonstrated during this Assessment were inadequate, overall. His Simulated Patient (SP) documentation was adequate. His communication skills were adequate, with need for improvement, with SPs and professional with peers. Review of Dr. Grentz's health information revealed a report of unilateral vision deficit and hearing loss treated with amplification. If severe, these conditions may have the potential to impact the practice of medicine; the specific status of these conditions was not available in the information submitted. His cognitive function screen results were within normal limits.

12. In or around October 2015, CPEP developed an Educational Intervention Program ("Education Plan") to address the licensee's deficiencies in family medicine.

13. On or about February 18, 2016, the Panel reinstated the licensee's license to practice osteopathy pursuant to terms and conditions set forth in this Agreed Order of Probation.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Probation:

1. The licensee's osteopathic license is subject to regulation and discipline by the Board.

2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(4) and (10). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Probation.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter and allow the licensee to resume the practice of osteopathy in the Commonwealth of Kentucky by entering into an informal resolution such as this Agreed Order of Probation.

AGREED ORDER OF PROBATION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the licensee's request to reinstate his license to practice osteopathy in the Commonwealth of Kentucky, the parties hereby ENTER INTO the following **AGREED ORDER OF PROBATION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by WERNER GRENTZ, D.O., is hereby reinstated and PLACED ON PROBATION FOR A PERIOD OF FIVE (5) YEARS, with that period of probation to become effective immediately upon the filing of this Agreed Order of Probation.
2. During the effective period of this Agreed Order of Probation, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

    a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine or osteopathy," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – unless and until the Panel or its Chair has approved, in writing, the practice location at which he will practice medicine. The decision whether to approve a particular practice location lies in the sole discretion of the Panel or its Chair. In determining

whether to approve a particular practice location, the Panel or its Chair will particularly consider whether there will be appropriate supervision of the licensee, and may also consider the nature of the practice, including the licensee's proposed duties and hours to be worked. In approving such practice location, the Panel or its Chair may include specific conditions/restrictions to ensure patient safety. Once approved, the licensee SHALL NOT change practice locations without first obtaining written approval by the Panel or its Chair for such change. The parties agree that the Panel or its Chair may require additional conditions and/or restrictions as a condition of it granting approval for a new practice location;

b. Beginning immediately, the licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized. The controlled substances log SHALL include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets SHALL be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions SHALL be maintained in the following manner: 1) patient; 2) chart; and 3) log;

    i. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultants;
    ii. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Amended Agreed Order. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Amended Agreed Order;
    iii. The licensee understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Agreed Order of Probation;

c. The licensee SHALL comply with and SUCCESSFULLY complete all requirements of the Educational Intervention Plan developed by CPEP, at his expense and as directed by CPEP, a copy of which is attached;

    i. The licensee understands and agrees that he SHALL be responsible for ensuring that his preceptor(s) comply with all directives and

instructions of CPEP during the duration of the Educational Intervention Plan and he SHALL immediately report any noncompliance directly to CPEP;

ii. The licensee understands and agrees that any failure to comply with the directives and instructions of CPEP during the duration of the Educational Intervention Plan shall constitute a violation of this Agreed Order and shall be grounds for immediate suspension of his license to practice osteopathy in the Commonwealth of Kentucky;

iii. In the event that the licensee's CPEP Educational Intervention Plan should be come suspended for any reason, the licensee SHALL immediately cease the "practice of medicine or osteopathy," as that term is defined in KRS 311.550(10), until further order of the Panel. His failure to do so, shall constitute a violation of this Agreed Order and shall be grounds for immediate suspension of his license to practice medicine/osteopathy in the Commonwealth of Kentucky;

iv. If deemed necessary and appropriate by CPEP, the licensee SHALL SUCCESSFULLY COMPLETE the Post-Education Assessment, at his expense and as directed by CPEP;

v. The licensee SHALL TAKE ALL NECESSARY STEPS, including the execution of waivers and/or releases, to ensure that CPEP provides timely written reports to the Board outlining his compliance with the Educational Intervention Plan; and

d. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Probation, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order of Probation, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a

violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Probation.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order of Probation would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13) and may provide a legal basis for criminal prosecution for practicing medicine without a license.

SO AGREED on this 9th day of March, 2016.

FOR THE LICENSEE:

W. Grentz D.O.

WERNER GRENTZ, D.O.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

C. William Briscoe MD

C. WILLIAM BRISCOE, M.D.
CHAIR, INQUIRY PANEL A

Sara Farmer

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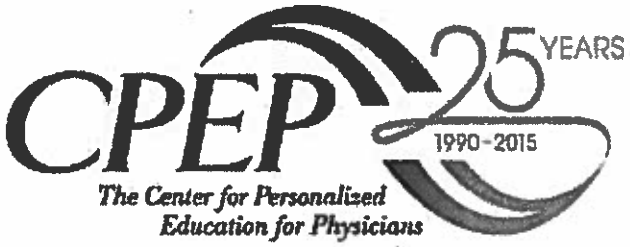

EDUCATIONAL INTERVENTION PROGRAM

EDUCATION PLAN

Developed October 2015

for

Werner Grentz, D.O.

NATIONALLY RECOGNIZED ▪ PROVEN LEADER ▪ TRUSTED RESOURCE

720 S. Colorado Boulevard, Suite 1100-N
Denver, Colorado 80246
Phone: 303-577-3232
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EDUCATION PLAN

OVERVIEW

APPENDICES

I. INTRODUCTION

According to the Kentucky Board of Medical Licensure's Agreed Order of Surrender dated February 21, 2013, Werner Grentz, D.O., may not petition for reinstatement of his license to practice osteopathy for a minimum of two years. Dr. Grentz completed a clinical skills Assessment in May 2015 as part of the process to reinstate his license. The Assessment identified areas of educational need. The development of this Education Plan (Plan) was based on those needs. The purpose of this Plan is to provide a framework in which Dr. Grentz can address his educational needs.

A glossary of Educational Intervention terms is enclosed.

FOCUS OF PLAN

This Plan addresses Dr. Grentz's practice of outpatient family medicine. If areas of educational need other than those addressed in this Plan are identified while Dr. Grentz is participating in the Plan, CPEP will notify the referring organization and Dr. Grentz and determine if the educational needs can be addressed within the context of this Plan.

LIMITATIONS

CPEP cannot guarantee that a Preceptor and/or an appropriate setting can be identified to address this Plan.

HEALTH CONSIDERATIONS

Dr. Grentz should continue to have his vision and hearing periodically monitored by his physicians. He should consider an evaluation by a physician health program in order to assess whether these conditions are severe enough to impact practice and what, if any, accommodations might be necessary.

Any requests for modifications of this Plan should be submitted to CPEP. CPEP will make reasonable efforts to meet the educational needs of Dr. Grentz and assist in reasonable accommodations but reserves the right to terminate the Educational Intervention if accommodations cannot be made.

LICENSING

Because CPEP Education plans are practice-based, physician-participants must have a medical license in order to complete a Plan. Some activities, such as self-study, may be completed without a medical license. *It is the participant's responsibility* to ensure that he/she practices within the parameters of his licensure status.

DESIGN

The individual Learning Goals described below in *Section II* were derived from the findings of the Assessment. This Plan was designed to address those Learning Goals through Medical Knowledge Enhancement and Patient Care Enhancement educational activities described in *Section III* as

Modules A and B. Evaluation of Dr. Grentz's progress and oversight of his participation will be provided by the CPEP Associate Medical Director. The Plan is designed around continuous and timely participation so that maximum educational benefit is received and ongoing progress is made. Following is more detailed information about the Modules and the Associate Medical Director oversight.

Note: The requirements of this Plan are not intended to supersede or exclude any requirements specific to his employer, credentialing, or licensure regulations. However, some activities may be applicable to both the Plan and such requirements.

A. Medical Knowledge Enhancement (Module A)

The Medical Knowledge Enhancement Learning Goals are addressed independently by the participant as well as through discussions with the Preceptor. The activities are designed to improve the participant's medical knowledge specific to the Learning Goals. Other improvements are generally realized as a result of the activities. A Preceptor is not needed to begin the activities described in Module A. CPEP encourages Dr. Grentz to begin the activities as soon as he has initiated the Plan. The recommended activities include:

- Independent/unsupervised self-study;
- Evidence-based research;
- Continuing medical education activities and/or courses.

B. Patient Care Enhancement (Module B)

Dr. Grentz will work with a Preceptor who has a practice similar to his. He will participate in Point of Care (PoC) activities as described below. Subsequently, Dr. Grentz will participate in a longitudinal learning experience that is reliant on regularly scheduled Preceptor Meetings. The PoC Experience will be completed prior to Dr. Grentz seeing patients independently/unsupervised as described in *Module B*. During these experiences, Dr. Grentz will:

- Address his more immediate educational needs by initially seeing patients with direct supervision. He will then progress through decreasing levels of supervision and ultimately see patients independently/unsupervised;
- Retrospectively review charts with the Preceptor of patients for whom Dr. Grentz provided independent/unsupervised care;
- Receive one-on-one coaching and constructive feedback with regard to medical knowledge, clinical judgment and documentation, particularly with regard to those areas identified in the Plan Learning Goals (see *Section II*);
- Discuss and reinforce new information and skills gained for full integration into daily patient care;
- Appreciate the value of lifelong learning, peer relationships, and self-assessment to the quality of patient care.

C. Oversight

The Associate Medical Director oversight includes Preceptor training, consideration of the feedback provided by the Preceptor and review of educational materials submitted by Dr. Grentz (see *Section V*). The Associate Medical Director will regularly communicate with and provide ongoing feedback and coaching to Dr. Grentz and the Preceptor with regard to Dr. Grentz's progress.

II. LEARNING GOALS

A. Medical Knowledge

To improve evidenced-based medical knowledge including, but not limited to, the following areas:

1. Comprehensive review of outpatient family medicine;*
2. Routine Health Screening:
   a. Evidence-based guidelines, such as those from the USPSTF;
   b. Guidelines for screening for STDs;
   c. Adult cancer screening recommendations: breast, prostate, cervical, and colorectal cancer;
   d. Pediatric and adult immunizations, including indications for pneumonia, hepatitis A/B, pertussis, tetanus, influenza, and herpes zoster vaccines;
   e. Guidelines for lipid management;
   f. Smoking cessation counseling;
   g. Assessment of hearing, vision, dementia screening, and of falls risk in the elderly;
   h. Screening for diabetes;
   i. Guidelines for lipid management;
3. Cardiovascular diseases:
   a. ECG interpretation;*
   b. Current guidelines (JNC 8) for hypertension management;
4. Pediatrics:
   a. Medications to avoid in young children;
5. Hematology:
   a. Assessment and management of anemias;
   b. Methods of lowering the INR in patients on warfarin;
6. Pain management:
   a. Safety aspects of narcotics;
7. Pulmonary medicine:
   a. Assessment for respiratory distress in children;
   b. Evaluation and treatment for DVT/PE and anticoagulation management, including novel oral anticoagulants;
   c. Management of COPD;
8. Gastroenterology:
   a. Evaluation and treatment of hemorrhoids;
   b. Evaluation and management of gastroesophageal reflux disease (GERD), including lifestyle interventions;

9. Endocrinology:
   a. Diagnosis and management of diabetes, including newer diabetes medications and indications for ACE inhibitors;
   b. Evaluation and management of thyroid disorders, including medication adjustment and timing of laboratory studies to assess efficacy of change in dosage of thyroid hormone supplement;
10. Neurology:
   a. Evaluation, risk stratification, and management of dementia;
   b. Stroke:**
      1) Evaluation and management of acute stroke;
      2) Recommendations for secondary prevention;
11. Infectious diseases:
   a. Evaluation and management of diabetic leg infections;
   b. Atypical pneumonia including potential causes, evaluation, and management;
   c. Evaluation and management of septic shock;
12. Nephrology:
   a. Potential causes of acute kidney injury;
   b. Evaluation and management of rhabdomyolysis and renal failure;
   c. Medication adjustments for kidney disease;
13. Urology:
   a. Evaluation and management of urinary incontinence;
14. Women's health:
   a. Recognizing potential pregnancy;
   b. Evaluation and management of post-menopausal bleeding;
   c. Indications for human papillomavirus (HPV) testing.

*Topic summary not required.
**Subtopics may be combined into one summary; two references required.
(See III.B below for description of topic summaries.)

B. Clinical Judgment

To *consistently* demonstrate appropriate clinical judgment in the areas that include, but are not limited to, the following:

1. Ability to consistently gather adequate clinical information;
2. Avoidance of premature diagnostic closure;
3. Structured and thorough formulation of differential diagnoses;
4. Ability to correctly assess acuity of illness and make appropriate plans;
5. Evidence-based approach to practice;
6. Avoidance of iatrogenic injury;
7. Treatment planning: attention to lifestyle modifications.

C. Documentation

The participant will learn principles of documentation that are based on recommendations and requirements of nationally recognized organizations such as the Joint Commission and Centers for Medicare and Medicaid Services (CMS) and recommendations of national specialty societies and will *consistently* demonstrate appropriate patient care documentation that includes, but is not limited to, the following:

1. Documentation of patient education.

Guideline

Adequate documentation requires inclusion of sufficient detail in visit notes such that the notes "stand alone" and determination of the level of care provided does not require verbal input from the documenting physician to be fully understood. Ultimately, adequate documentation includes chart organization and systems tools that allow another physician to easily assume care of a patient.

D. Practice-based Learning

1. Increased participation in CME activities;
2. Consider the use of evidence-based, medical content Internet-based resources.

E. Physician-Patient Communication Skills

To *consistently* demonstrate appropriate communication skills in the areas that include, but are not limited to, the following:

1. Continuing education on creating a more positive initial impression and providing more in-depth education on diagnoses and treatment plans.

III. PERFORMANCE OBJECTIVES

Performance Objectives are specific educational activities that provide focused learning experiences designed to assist the participant with achievement of the Learning Goals (*Section II*). The participant will integrate newly learned information into his daily practice and demonstrate long-term improved patient care during Module B Activities.

MODULE A
MEDICAL KNOWLEDGE ENHANCEMENT

Module A activities do not require approval of a Preceptor to initiate. Dr. Grentz will:

- Document all activities, including ongoing case-based activities, continuing medical education activities (CME) and self-study on an Education Log provided by CPEP;
- Participate in self-study activities during participation in the Plan that demonstrate lifelong learning skills;
- Submit certificates of completion for any courses, if applicable.

Timelines

The timelines below are recommended to maximize participation in the Plan.

- Independent/unsupervised activities, such as self-study, should be initiated immediately once the Plan has been signed.
- Topic/subtopic summaries should be completed by the sixth month of beginning the Plan activities.
- Courses and/or CME activities should be completed no later than the fourth month of participation.

Guideline

It will be important that Dr. Grentz develop a strategy that ensures he submits all topic/subtopic summaries within six months of initiating the Plan so that he has ample time to demonstrate his application of new knowledge to his actual patient care during the Precepted Education component.

Associate Medical Director Approval of Resources

Dr. Grentz may identify resources other than those mentioned below; however, the Associate Medical Director must approve those resources in order for the activities to be applicable to the Plan. He should receive approval of resources prior to incorporating those resources into his Plan activities.

A. Courses

Dr. Grentz will:

1. Complete a comprehensive review course, such as *The Core Content Review of Family Medicine* or the review course offered by American Academy of Family Medicine (AAFP). Information may be found at: http://www.corecontent.com/products.cfm and http://www.aafp.org
2. The Associate Medical Director will monitor Dr. Grentz's documentation skills to determine if he would benefit from participating in a documentation course. If such a recommendation is made more information would be provided to Dr. Grentz at that time.

B. Evidence-Based Self-Study

The purpose of this module is to demonstrate self-directed learning and to create educational resources for reference. Dr. Grentz will:

1. *For each of the topics and subtopics* listed in the Medical Knowledge Enhancement Learning Goals (except for those indicated with asterisks), submit a brief paragraph, case based discussion, outline, or algorithm to summarize the major points learned;
   a. In preparing the submission, Dr. Grentz will use *at least two resources for each of the topics and subtopics* listed in the Medical Knowledge Enhancement Learning Goals (except for those indicated with asterisks). The submission should explain the applicability of knowledge to his practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale;

1) Appropriate resources are current, peer-reviewed, evidence-based medical references. Notes from a pertinent conference may be utilized with prior Associate Medical Director approval;
   a) CPEP will provide an Education Notebook upon initiation of the Plan. (Refer to *Section IV.A.1.b* below. It will contain information about resources, such as: http://www.dartmouth.edu/~biomed/resources.htmld/guides/FindingGoodAnswers.pdf.)

2. Identify and become familiar with the resources for current guidelines relevant to the Medical Knowledge Learning Goals;
   a. Document and submit appropriate clinical guideline resources on an Education Log;
3. Regularly review *The Medical Letter*, *Prescriber's Letter* or other prescribing periodical (with the Associate Medical Director's approval) for current pharmacology review;
   a. Document this review in the self-study section of the Education Log;
4. Read Chapters 1-11 of Learning Clinical Reasoning, Second Edition by Jerome P. Kassirer, M.D., John B. Wong, M.D., and Richard I. Kopelman, M.D., and discuss with the Preceptor;
   a. Document reading and discussions on Education Logs;
5. If applicable and as needed, read Procedures for Primary Care, by John L. Pfenninger, M.D., FAAFP; Michael Tuggy, M.D.; Grant C. Fowler, M.D. and Jorge Garcia, M.D. and document reading on an Education Log;
6. Participate in self-study relevant to his practice for the duration of the Plan.

C. Electrocardiogram Interpretation Activities

Important to note:

- Dr. Grentz should not be responsible for ECG interpretation (without over-reading) prior to demonstrating competence to his Preceptor.

Dr. Grentz will:

1. Read the textbook Clinical Electrocardiography: A Simplified Approach by Ary L. Goldberger, or other approved resource, and review with the Preceptor;
2. Review at least 25 to 30 ECGs using resources such as:
   a. "Alan E. Lindsay ECG Learning Center" on the University of Utah School of Medicine website located at http://ecg.utah.edu/introduction
   b. http://www.ecg-interpretation.blogspot.com/
3. Document independent/unsupervised ECG reading and review as well as ECGs reviewed with the Preceptor on Education Logs;
4. Ensure that the Preceptor speaks with the Associate Medical Director prior to Dr. Grentz independently reading and interpreting ECGs.

D. Communication

Dr. Grentz will:

1. Read pertinent chapters of the Field Guide to the Difficult Patient Interview by Frederic W. Platt, M.D., and Geoffrey H. Gordon, M.D., and discuss with the Preceptor;
   a. Document chapters read on an Education Log;

b. The Preceptor and Associate Medical Director may assign particular chapters;
2. At a time to be determined by the Associate Medical Director, submit to CPEP completed patient questionnaires addressing his communication skills.
   a. The questionnaire and more direction will be provided by CPEP.

E. Case-Based Activities

Dr. Grentz will:

1. Review cases in chapters 12-22 of Learning Clinical Reasoning, Second Edition that illustrate concepts applicable to identified needs;
   a. Document this review in the self-study section of the Education Log;
2. Pursue case-based learning through resources such as:
   www.aafp.org
   www.clinicalcases.org

F. Practice-based Learning

Dr. Grentz will:

1. Review current peer-reviewed, evidence-based medical literature pertinent to family medicine throughout the duration of the Plan;
2. Utilize appropriate Internet web sites and other medical resources.

G. Systems-based Practice

Dr. Grentz will:

1. Discuss with the Preceptor ways to augment his awareness of systems-based practice such as:
   a. Familiarity with different types of medical practice and delivery systems;
   b. Awareness of resources for patients and ways to help patients work within that system;
   c. Understanding of issues within the medical system which contribute to and reduce medical error;
   d. Understanding of cost effective resource allocation and appropriate prescribing patterns to that end;
   e. Participating in interdisciplinary teams as appropriate.

Core competencies which have been adopted by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education can be found here:
http://www.abms.org/maintenance_of_certification/MOC_competencies.aspx

H. Internet-Based Medical Information Resources

Dr. Grentz will:

1. Utilize electronic resources at the point of care, such as a computer with access to the Internet. Software or web sites should assist with immediate access to up-to-date medical information relevant to medication prescribing and drug interactions, and patient care decisions, including formulating an adequate differential diagnosis, interpreting test results and evaluating treatment options.

MODULE B
PATIENT CARE ENHANCEMENT

During the activities described in this Module the Preceptor will provide feedback to Dr. Grentz with regard to improvements in all areas of the Learning Goals. The Preceptor will coach Dr. Grentz to integrate improved knowledge, decision-making and documentation into daily patient care. All meetings and activities will be documented on an Education Log provided by CPEP.

Timeline

- See *Section IV* for complete time frames for the Preceptor approval process and initiation of Preceptor Meetings and the Point of Care Experience.
- Once initiated, Preceptor Meetings and chart reviews will continue for the duration of the Plan.

A. Point of Care Experience

During this experience, Dr. Grentz will:

1. Shadow:
   a. To become acquainted with the office setting, shadow the Preceptor for approximately one-half day;
   b. Discuss each case including diagnosis, management options and expected outcomes;
2. Supervision:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, manage patients with 100% direct supervision;
      1) Direct supervision is defined as side-by-side observation of the patient encounter by the Preceptor;
   b. Discuss each case including management options and expected outcomes;
   c. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
   d. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *Concurrent Case Review*;
3. Concurrent Case Review:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, review each case with the Preceptor prior to releasing the patient to determine if the exam and evaluation have been adequate and if the plan is appropriate;
   b. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
   c. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *End of Day Review*;
4. End of Day Review:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, review all patients at the end of each day with the Preceptor;
   b. Discuss each case including management options and expected outcomes;

c. Have each note for the above patient encounters reviewed for completeness and overall quality by the Preceptor when the note is completed or when the dictations are available, and receive feedback on the documentation of the patient visit;
d. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
e. Ensure that the Preceptor communicates with the Associate Medical Director about his readiness to transition to *Consultation*;

5. Consultation:
   a. Manage patients with immediate physician consultation available if needed for approximately one month;*
      1) The onsite physician may be someone other than the Preceptor, but should be someone approved by the Associate Medical Director;
   b. Implement weekly PoC meetings. During these meetings:
      1) Retrospectively review each case and outcome with the Preceptor;**
      2) Have each note for the above patient encounters reviewed for completeness and overall quality by the Preceptor and receive feedback on management and documentation of the patient visit;
   c. Document every case specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP and submit the Case Log along with the charts mentioned immediately below;
   d. After seeing patients for three weeks, submit six charts to the Associate Medical Director for review to evaluate Dr. Grentz's readiness to progress to the Precepted Education Experience;
6. Conclusion:
   a. At the completion of the above activities, Dr. Grentz will:
      1) Ensure that the Preceptor speaks with the Associate Medical Director and submits a written report documenting Dr. Grentz's readiness to proceed to independent/ unsupervised patient care;
      2) Receive notification from the Associate Medical Director that the PoC Experience has been completed.

*One month is an estimated timeframe and may be lengthened if it is determined that Dr. Grentz would receive educational benefit from extending the experience.

**If Dr. Grentz's patient volume is too large to allow review of each case, he and the Preceptor should review no fewer than six cases per weekly meetings that are relevant to his Plan Learning Goals as much as possible.

B. PRECEPTED EDUCATION

It will be important that the Preceptor Meetings and activities are thorough and that the Preceptor provides objective feedback sufficient to support Dr. Grentz's improvement with regard to the specific Plan Learning Goals. All meetings and activities will be documented on an Education Log provided by CPEP.

Guideline
Having knowledge is distinct from applying knowledge. It is essential that, when reviewing charts, the Preceptor determine whether or not the participant *applied* his knowledge to actual patient care.

PRECEPTOR MEETINGS
After completion of the PoC Experience, Dr. Grentz will:

1. Meet with the Preceptor twice monthly for the duration of the Plan. To provide a quality learning experience, CPEP recommends that each meeting be a minimum of two hours;
2. With the Preceptor and in conjunction with the activities described below in *Preceptor Meeting Activities*, utilize the following to address the Learning Goals:
   a. Chart review and case-based discussions;
   b. Hypothetical case discussions;
   c. Topic discussions;
   d. Current medical literature reviews;
   e. Utilization of appropriate Internet web sites and other medical resources.

Guideline
Although impromptu collegial discussions may occur outside of Preceptor Meetings, such discussions are separate from the Preceptor Meeting requirement.

PRECEPTOR MEETING ACTIVITIES

Chart Review Objectives

Charts are the primary method of evaluating the participant's application of knowledge and clinical judgment and reasoning. Therefore, charts submitted to the Preceptor and the Associate Medical Director as described below should demonstrate the participant's integration of feedback and information learned as a result of completing Module A activities. Submitted charts should reflect consistent improvements in overall patient care.

Charts reviewed during Preceptor Meetings will be those of patients for whom Dr. Grentz provided independent/unsupervised care. Charts as described below should address the Plan Learning Goals as much as possible.

During the Precepted Education, Dr. Grentz will:

1. Retrospective Chart Reviews:
   a. Submit to the Preceptor for review no fewer than 24 redacted* charts per month (12 charts per twice-monthly sessions);
      1) The Preceptor may specify cases to be reviewed;
      2) Redacted* copies of charts should be submitted to the Preceptor in time for the Preceptor to review them before the meetings;
   b. Submit to CPEP by the fifth of *every other* month (month to be determined), six of the 24 redacted* charts used in the Preceptor Meetings;
      1) The Associate Medical Director may specify charts to be submitted;

c. **Cases should be specifically relevant to the Plan as well as representative of the scope of Dr. Grentz's practice, as much as possible.**

2. Didactic Discussions and Coaching:
   a. Clinical Judgment:
      1) With the Preceptor, discuss the Clinical Judgment Learning Goals and application of knowledge to patient care;
      2) Develop and discuss with the Preceptor systems (protocols, algorithms, and/or chart templates) or other strategies for organizing the clinical evaluation to ensure that the Clinical Judgment Learning Goals are addressed and that improvements are integrated into his daily patient care;
   b. Documentation:
      1) Receive coaching from the Preceptor that addresses general documentation principles as well as the specific areas of need described in Learning Goal C, *Documentation*, including strategies and/or use of chart templates for improved documentation;
   c. Medical Knowledge:
      1) Discuss with the Preceptor each topic and subtopic identified in Module A, including applicable and current evidence-based guidelines as available. Dr. Grentz should also discuss his topic/subtopic summaries with the Preceptor;
   d. Communication:
      1) Receive coaching and review reference materials described in the Plan related to communication skills;
3. Lifelong Learning:
   a. Develop lifelong learning skills:
      1) Discuss and develop a plan with the Preceptor for maintaining current standards in family medicine after conclusion of the Educational Intervention. Discuss the plan with the Associate Medical Director and demonstrate ongoing learning throughout the duration of the Plan. The plan should:
         a) Incorporate Internet-based resources;
         b) Integrate evidence-based medicine resources;
         c) Promote lifelong learning;
         d) Include activities that address clinical decision-making, such as case studies.
   b. CPEP encourages Dr. Grentz to:
      1) Review and reflect on the status of his learning and improvements on an ongoing basis;
      2) Keep a learning journal on his reflections, including which activities were beneficial, or not beneficial, and why.

** Refer to Appendix B, Privacy of Individually Identifiable Health Information*

Guidelines

- During the Preceptor Meetings, the Preceptor should provide coaching and recommendations to the participant to ensure that improvements in all Learning Goals

identified in the Plan are collectively and consistently applied to Dr. Grentz's actual patient care.

- The participant's progress will be determined based on the achievement of the Learning Goals and in consideration with generally accepted standards of care. The constraints of a physician's practice circumstances, such as the availability of local medical resources, are taken into consideration when reviewing a physician's actual practices.

IV. INITIATING THE PLAN

A. Determining the Start Date and Beginning Educational Activities

1. Dr. Grentz will sign and return the Plan to CPEP by November 6, 2015. He will then:
   a. Initiate the self-study components of the Plan the first day of the month following CPEP's receipt of the signed Plan;
   b. Receive an Education Notebook from CPEP with directions, Education Logs, resources, and other information to complete the educational activities;
   c. Initiate and document self-study activities and course participation;
   d. *After reviewing* the Preceptor qualifications described in the *Preceptor Overview and Agreement,* identify a Preceptor candidate if Dr. Grentz has not already done so;
      1) The Preceptor must be board certified in the same specialty and have a practice similar to Dr. Grentz's;
2. Provide a copy of the Plan, *Preceptor Overview and Agreement,* Confidentiality Statement, and a copy of the Assessment Report to the proposed Preceptor so that the approval process, as described below, can progress accordingly.

B. Preceptor Approval

1. Dr. Grentz will, *within 30 days of licensure reinstatement,* submit to CPEP:
   a. The proposed Preceptor curriculum vitae (CV) including the Preceptor name and contact information;
   b. Signed CPEP Authorization to Release/Receive Information form authorizing CPEP to communicate with the Preceptor;
      1) A telephone call with the Preceptor and the Associate Medical Director will then be scheduled as part of the approval process;
      2) The participant will be notified of the approval;
2. Upon notification of approval, Dr. Grentz will begin meeting regularly with the Preceptor. He should document meetings on an Education Log.

Guideline

For the participant's educational benefit, the Preceptor must meet the qualifications as described in the *Preceptor Overview and Agreement.* Additionally, CPEP must approve the Preceptor in order for any precepted activities to be applicable to the Plan.

V. PARTICIPATION AND MONITORING

Consistent participation in educational activities, including regular and timely submission of materials and participation in scheduled CPEP conference calls, enhances the educational experience. Such participation may also impact the duration of the Plan. Because the Associate Medical Director must be able to evaluate the participant's ongoing progress and provide timely and pertinent feedback, Dr. Grentz will:

1. Maintain Education and PoC Case Logs:
   a. Education Logs should document all educational activities including Preceptor Meetings and the content of the Meetings, and those activities that are outside of the scope of the Plan but relevant to his practice;
   b. PoC Case Logs should document PoC activities as previously described in Module B;
2. Submit materials:
   a. By the fifth of every month, submit:
      1) Education Logs;
      2) Preceptor Report forms completed by the Preceptor;
      3) Controlled Substances Log, if applicable;
      4) Other materials relevant to the Plan or as requested by the Associate Medical Director;
   b. By the fifth of every month and until the following has been completed, submit:
      1) Case Logs for the PoC activities;
      2) Topic/subtopic summaries;
      3) CME certificates and/or other documentation of completed activities specified in the Plan (if applicable);
3. Submit Charts:
   a. Either monthly or every other month, as directed by CPEP, submit charts,** as described in Module B. Charts must be complete and if possible, include one year of patient care and include the Preceptor's written comments either on or with the copies of the charts. More information will be provided when the Plan is initiated;
   b. At the request of the Associate Medical Director, submit randomly selected charts for review from Dr. Grentz's appointment schedule;
4. Communication:
   a. Participate in calls with CPEP as requested;
   b. Respond to emails or letters from CPEP in a timely fashion;
5. Be responsible for his and his Preceptor's participation in the Plan activities and his educational progress;
6. Demonstrate maintenance of improvements for all Learning Goals prior to conclusion of the Patient Care Enhancement activities.

**See *Module B, Retrospective Chart Review* to determine if charts should be submitted monthly or every other month

FORMATIVE EVALUATION
Evaluation of Educational Progress

Ongoing progress is measured using formative evaluation tools such as regular chart reviews, review of topic/subtopic summaries, participant and Preceptor discussions with the Associate Medical Director, and written Preceptor Reports.

Approximately every four months, Progress Reports will be generated and provided to Dr. Grentz and to other entities for which Dr. Grentz has provided authorization. The Progress Reports will capture Dr. Grentz's progress as demonstrated during Formative Evaluations conducted during that reporting period.

SUMMATIVE EVALUATION
Post-Education Evaluation

Following the completion of the Plan activities, Dr. Grentz will participate in a Post-Education Evaluation (Evaluation) to demonstrate that he achieved the Learning Goals and successfully completed the Educational Intervention. The Evaluation will be focused on the areas identified as Learning Goals in the Plan and will consider Dr. Grentz's scope of practice. (See Section 5.1(e) of the CPEP *Educational Intervention Participation Agreement* for more information.)

- Dr. Grentz will schedule the Evaluation no sooner than two months, and no later than four months, following notification from CPEP that he/she has completed the Plan activities.

VI. ESTIMATED DURATION

Plan Learning Goals and Performance Objectives
Most participants complete an Education Plan in approximately 12-18 months. The actual duration varies depending on many factors including the scope of educational needs identified.

CONDITIONS
- Modifying an approach to overall patient care, specifically application of knowledge, clinical judgment and documentation may be challenging. Additionally, certain aspects of the Plan cannot be predicted, such as spectrum of patients and cases presented, as well as the participant's dedication to the educational activities. Therefore, the duration of the Plan can only be estimated.
- CPEP reserves the right to change the content and/or duration of the Education Plan.
- CPEP is not responsible for ensuring that the participant obtains any required privileges or credentials while participating in the Education Plan; this is the responsibility of the participant.

- Once the participant has completed the Education Plan and/or has been authorized to complete the Post-Education Evaluation, CPEP is no longer reviewing charts or providing educational services to the participant.
- If Dr. Grentz does not engage in this Plan by October 14, 2016, CPEP may require completion of additional Assessment activities to ensure that Dr. Grentz's current educational needs are addressed.

SIGNATURES

Werner Grentz, D.O. Date

Abigail C. Anderson, M.D. Date
Associate Medical Director

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Preceptor candidates.

APPENDIX A
Prospective Practice Profile

Werner Grentz, D.O.

Dr. Grentz should notify CPEP of updates and changes to his profile while participating in the Plan.

Specialty

Family Medicine

Licensure

Licensing State	Status
KY	Surrendered

Practice Setting

Outpatient

Practice Profile – To Be Determined

Volume of patients per day:
Number of days worked per week:
Number of patients admitted per month:
Census of inpatients per month: approximately
Number of days on-call per month:
Number of patients in SNF:

Commonly Encountered Diagnoses

Inpatient Procedures:
Outpatient Procedures:

(The remainder of this page is intentionally blank.)

APPENDIX B

[Code of Federal Regulations]
[Title 45, Volume 1]
[Revised as of October 1, 2002]
From the U.S. Government Printing Office via GPO Access
[CITE: 45CFR164.514]

TITLE 45--PUBLIC WELFARE AND HUMAN SERVICES

PART 164--SECURITY AND PRIVACY

Subpart E--Privacy of Individually Identifiable Health Information

Sec. 164.514 Other requirements relating to uses and disclosures of protected health information.

(a) Standard: de-identification of protected health information. Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

(b) Implementation specifications: requirements for de-identification of protected health information. A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

(i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination; or

(2)(i) The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates

(including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;
(E) Fax numbers;
(F) Electronic mail addresses;
(G) Social security numbers;
(H) Medical record numbers;
(I) Health plan beneficiary numbers;
(J) Account numbers;
(K) Certificate/license numbers;
(L) Vehicle identifiers and serial numbers, including license plate numbers;
(M) Device identifiers and serial numbers;
(N) Web Universal Resource Locators (URLs);
(O) Internet Protocol (IP) address numbers;
(P) Biometric identifiers, including finger and voice prints;
(Q) Full face photographic images and any comparable images; and
(R) Any other unique identifying number, characteristic, or code; and

(ii) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

(The remainder of this page is intentionally blank.)

Werner Grentz, D.O.

APPENDIX C

CPEP GLOSSARY AND DESCRIPTION OF EDUCATIONAL PROCESS

EDUCATIONAL INTERVENTION

The Educational Intervention describes the entire educational program, which includes the development and monitoring of the Education Plan and services provided by CPEP, such as progress reports, ongoing support to the participant, and the Post-Education Evaluation.

EDUCATION PLAN

A CPEP Education Plan (Plan) is an individualized structured educational process based on the findings of the Assessment (see below). Because CPEP Plans are personalized, each Plan contains requirements that are specific to the needs of the participant for whom the Plan was developed. Requirements, such as the type of educational activity, the intensity or duration of an activity, or the level of supervision, will vary per Plan. Requirements may also be modified as the participant's needs evolve over time. The Plan typically concludes with a Post-Education Evaluation (Evaluation) so that the participant can objectively demonstrate that the Goals of the Plan have been achieved.

ASSESSMENT

The Assessment is designed to evaluate the participant through use of specialty-specific, individualized testing tools. An Associate Medical Director oversees the Assessment and attends clinical interviews to ensure that the process is reflective of the participant's practice specialty and takes into account any noted reason for referral. Results from the participant's performance in each assessment modality are incorporated into an Assessment Report. The Assessment Report reflects the effort and analysis of CPEP's Medical Director, Associate Medical Director, and administrative staff.

ASSOCIATE MEDICAL DIRECTOR

The CPEP Associate Medical Director (AMD) is a qualified physician who oversees the participant's educational progress and compliance during the Plan. The AMD also provides training to and communicates with the Preceptor (see below).

EDUCATIONAL PRECEPTOR (PRECEPTOR)

A Preceptor is a qualified physician who is approved by CPEP, and the referring organization if applicable. The Preceptor's main function is educational. He/She is expected to teach, provide educational guidance, and evaluate the participant's educational progress. The Preceptor provides one-on-one education, incorporates case reviews and discussions into the meetings, and may provide supervision (see below) during patient encounters or procedures as directed in the Plan. A secondary Preceptor may be identified to address specific/specialty areas (e.g., cardiology, pharmacology) or to address the unique needs of a participant.

LEARNING GOALS

A Learning Goal describes the measurable areas of knowledge, skills, and/or concepts that a participant will gain by completing the described educational activities. Learning Goals are developed based on the findings of the Assessment. At the request of a referring organization or the participant, other goals may also be included.

PERFORMANCE OBJECTIVES/EDUCATIONAL ACTIVITIES

Performance Objectives specify the educational activities that are recommended to achieve the Learning Goals. Appropriate completion of the activities demonstrates that the information/skills/concepts have been addressed by the participant's utilization of the defined strategies or learning tools. See *Description of Educational Activities.*

EVALUATION METHODS

CPEP incorporates both formative and summative evaluations:

- A formative evaluation occurs during the educational program to assess initial and ongoing learning as the educational experience progresses, i.e., AMD and Preceptor discussions, topic/subtopic summaries, chart reviews, etc.
- A summative evaluation focuses on the outcomes and impact of the learning experience at the completion of an educational program, i.e., Post-Education Evaluation.

PARTICIPATION/COMPLIANCE

The CPEP staff and AMD monitor the participant's participation/compliance with the Plan. Participants must regularly participate in acceptable educational activities as directed by the Plan and submit materials within the timeframes established by CPEP. The participant must also demonstrate progress toward attainment of the Learning Goals. Inappropriate participation/noncompliance will be reported to the referring agency. If a participant is not participating or progressing appropriately, the Plan may be placed in one of the following categories:

- *Hold:* Occasionally, CPEP, in conjunction with the referring organization, may allow a participant to postpone, or place educational activities on hold, for a predetermined period of time (typically one to three months). Generally the hold status is offered to allow the participant the opportunity to address personal or professional issues that would prevent him/her from appropriately focusing on educational activities. A postponement of educational activities is not recommended, and should be limited to a one-time occurrence.
- *Suspension:* CPEP may suspend the participant's Education Plan if it is determined that the participant has:
  - Participated in inappropriate or minimal educational activity;
  - Failed to provide documentation of educational activities,
  - Failed to respond to CPEP requests or direction;
  - Not benefited from participation in the Plan.

It may be possible for the participant to reengage in educational services.

COMPLETION OF THE PERFORMANCE OBJECTIVES

Completion of Performance Objectives with approval to participate in a Post-Educational Evaluation: Overall, formative evaluations indicate that the participant completed the Performance Objectives by adequately demonstrating appropriate gains in knowledge/skills to achieve the Learning Goals. The participant will be advised to schedule a Post-Education Evaluation.

- *Incomplete Performance Objectives:* The participant has made insufficient progress toward completion of Performance Objectives or toward achievement of the Learning Goals. Based on the areas of remaining educational need and CPEP staff review of the participant's activities, CPEP will provide recommendations that may include the following:
  a. *Termination due to Maximum Educational Benefit:* While the participant may have made progress in the Plan, he/she has not demonstrated successful completion in one or more of the Plan's Goals or Objectives. Prior improvements may not have been maintained and/or regression in the educational process was demonstrated. CPEP determined that there would be little or no benefit for the participant to continue with an educational program at that time.
  b. *Termination due to Non-Compliance:* The participant has violated or would not comply with the CPEP Participation Agreement and/or the Education Plan such that an appropriate working relationship with the participant is not possible. Future CPEP services would not be available to the participant.

POST-EDUCATION EVALUATION (EVALUATION)

The Evaluation is a summative assessment that measures the maintenance of the improvements made by the participant as a result of progressing in and completing the Plan. The content of the Plan and the participant's scope of practice will be addressed during the Evaluation. The method of the Evaluation is similar to the Assessment process.

COMPLETION OF THE EDUCATIONAL INTERVENTION

- *Successful Completion:* The participant successfully completed the Plan Objectives and the summative evaluation). There are generally no or limited recommendations for further educational activities.
- *Insufficient Progress to Support Successful Completion of the Plan:* In the summative evaluation, the participant has not demonstrated sufficient achievement of one or more Learning Goals to successfully complete the Educational Intervention. Based on the areas of remaining educational need identified in the Post-Education Evaluation and on CPEP staff review of the prior Plan activities, CPEP may recommend:
  a. *Education Plan Addendum*: An extension of the Plan designed to address residual areas of need identified in the summative evaluation;
  b. *Maximum Educational Benefit:* Following completion of the Post-Education Evaluation, CPEP may determine that the participant has not demonstrated successful completion of the Plan and/or integration of improvements into daily patient care and would not benefit from further educational activities.

LIMITATIONS

- A CPEP Education Plan is not intended to provide the same rigor of training or depth of curriculum as a residency nor can it lead to eligibility for board certification. A residency program is provided through an accredited graduate medical education program.
- The Education Plan is not intended to provide proctoring, either for the purpose of gaining hospital privileges or to fulfill any other entities requirement for proctoring. Proctoring is an objective evaluation of a physician's clinical competence by a physician who represents and is responsible to the health care facility medical staff or another entity. A proctor does not teach or make recommendations for improved patient care.
- The Preceptor's role is not the same as a practice monitor, who is expected to focus on patient safety, evaluate the physician's practice, and report to an authoritative entity. The Preceptor should be able to focus only on the Education Plan. CPEP strongly recommends that the preceptor and the practice monitor not be the same individual.

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DESCRIPTION OF EDUCATIONAL ACTIVITIES

MEDICAL KNOWLEDGE ENHANCEMENT

Educational activities are recommended to improve medical knowledge. Some activities are topic specific while others are more broad. Topic-specific activities may include literature searches that acquaint and familiarize the participant with reliable and current information and resources. This activity often introduces the use of the Internet to participants as well as directs their attention to the need for ongoing professional development. The participant must identify appropriate literature resources and materials for reading and research. The participant will submit a written synopsis of articles and/or guidelines specific to the Plan. An acceptable synopsis will adequately describe how the participant can apply the information to his/her practice.

To meet the need for a broader review of medical knowledge, the Plan may recommend continuing medical education (CME) activities and/or courses. The Plan generally recommends online activities, but occasionally the Plan will recommend an onsite course. CME may also be recommended for certain topics or knowledge areas in which CME would provide a more optimal educational experience.

POINT OF CARE EDUCATIONAL EXPERIENCE (POC)

PoC education occurs at the moment of the patient encounter. PoC education can occur in the outpatient, inpatient, or surgical setting. CPEP's PoC experiences are designed to allow the Preceptor to observe, educate, and/or provide supervision as the participant is providing patient care or performing procedures. The length of time and the level of supervision are determined based on the participant's educational goals. Following are descriptions of the levels of supervision that may be included in a Plan:

A. Focused PoC Training

This is a finite educational experience, which generally lasts from one day up to four weeks. It is designed to provide focused training and an enriched educational experience in a particular skill, exposure to a particular disease, and/or a particular patient population. This experience may occur in a single block of time or may occur incrementally over an extended period, depending on the scheduling requirements of the preceptor and the facility. It may or may not be required to occur at the beginning of the Plan. The Focused PoC Training may address:

- Skills in the management of acute medical conditions (e.g., asthma, chest pain, pediatric emergencies);
- Skills in the management of a particular patient population (e.g., pediatrics, chronic pain patients);
- Procedural skills (e.g., endoscopy, casting, suturing, laparoscopy, intubation of the difficult airway).

B. Comprehensive PoC Experience

This educational experience is designed to provide preceptor oversight and training covering a broad spectrum of practice issues. Generally, this experience will be completed in a specified and continuous block of time at the beginning of the Plan. Examples of situations that may be appropriate for this experience include:

- A participant returning to practice after an extended absence;
- A participant returning to practice after prior revocation or suspension of licensure;
- The quantity or spectrum of the participant's educational needs is such that the participant would benefit from an intense one-on-one educational experience that would address immediate educational needs.

PoC Process

The PoC experience process is generally as follows.

1. Shadowing/Assisting: The participant observes and/or assists the Preceptor.
2. Direct Supervision: The Preceptor is physically present during the patient encounter or procedure conducted by the participant.
    a. In some instances, the Plan will specify that the participant received 100% supervision. The Plan will specify if this applies to all patient encounters or to patient encounters of a specific type (e.g., pediatric patients; laparoscopic procedures). In the specific areas requiring PoC supervision, CPEP recommends that the participant *not* provide patient care of this type outside of this PoC experience.
    b. If 100% supervision is *not* specified, the supervision would apply only in the context of the PoC activity. The participant would provide patient care outside of the PoC experience.
3. Onsite Consultation: The participant sees patients independent/unsupervisedly with onsite consultation. Consultation will occur as designated by the education plan.

PATIENT CARE ENHANCEMENT

Precepted education provides a longitudinal learning experience that occurs through regularly scheduled meetings with the Preceptor. The Precepted Education may occur concurrently with the PoC Experience. The meetings address the Plan's Learning Goals through didactic exercises, chart reviews, review of literature and appropriate Internet web sites, as well as case-based and hypothetical discussions. Precepted Education may include any or all of the following:

- *Initial observation:* The Preceptor may observe the participant in his/her practice setting to provide insight to the preceptor about the participant's practice and environment. (Generally four to eight hours of observation.)
- *Prospective chart review:* The Preceptor and the participant will discuss treatment and/or procedural plans, treatment alternatives, and procedure and patient selection.
- *Retrospective chart review:* The Preceptor reviews charts from prior patient encounters. Such reviews facilitate discussions that address medical knowledge, clinical judgment, application of knowledge, and documentation, as well as overall patient care.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1461

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY WERNER GRENTZ, D.O., 2197 PINE BROCK ROAD, LONDON, KENTUCKY 40741

AGREED ORDER OF SURRENDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, and Werner Grentz, D.O. ("the licensee"), and, based upon their mutual desire to fully and finally resolve this pending investigation without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER OF SURRENDER**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Surrender:

1. At all relevant times, Werner Grentz, D.O., was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is Family Medicine.
3. A release by Kerry B. Harvey, United States Attorney for the Eastern District of Kentucky, provided the following information about the licensee:

   The Internal Revenue Service (IRS) arrested the licensee on May 1, 2012. The licensee allegedly earned between $169,000 and $356,000 each of the years between 2005 and 2010, but failed to file tax returns for those years. The licensee practiced in hospitals and medical offices in London, Manchester, and Monticello, Kentucky and in Jellico, Tennessee.
   According to the indictment, which was returned on April 6 and unsealed on May 2, 2012, the licensee evaded taxes by providing one of his employers with an IRS form in which he falsely claimed that he was exempt from having federal income tax withheld from his earnings. He also allegedly had his earnings deposited into bank accounts of companies that he controlled in order to hide his income.

4. The federal grand jury for the Eastern District of Kentucky returned Indictment No. 6:12-CR-12-GFVT on April 6, 2012, under seal. The indictment charged the licensee with two (2) counts of violating 26 U.S.C. 7203, by failing to file income tax returns as required by law, and four (4) counts of violating 26 U.S.C. 7201, by attempting to conceal his income by certain transactions, all felonies.

5. On December 18, 2012, the licensee entered into a Plea Agreement with the United States, under which he agreed to plead guilty to Count 5 of the Indictment, in exchange for dismissal of Counts 1-4 and 6. The Plea Agreement specified the following factual bases for his plea to Count 5,

   In 2002, after he failed to file tax returns for several years, the IRS sent the licensee a letter to inform him that federal law contains criminal penalties for willfully failing to file tax returns. In 2007, agents told the licensee that he was under investigation.
   During 2009, the licensee worked as an independent physician contractor at a hospital in Jellico, TN, and at a medical office in London, KY. From that work, he received taxable income of $356,073. Although he owed a substantial amount of federal income tax based upon his taxable income, he failed to file an income tax return with the IRS on or before April 15, 2010, as required by law, or to pay the tax to the IRS.
   The licensee made affirmative attempts to evade and to defeat the tax by causing his compensation to be deposited into bank accounts that he had opened in the names of two shell companies and by withdrawing the deposited money from the accounts on the same day or within a few days after the compensation had been deposited into the accounts.

6. The licensee formally entered his plea to Count 5 in court on January 17, 2013. As part of his plea, the licensee acknowledged that he failed to pay $900,068 in taxes since 1999. He is scheduled for formal sentencing on May 16, 2013 and faces a maximum sentence of five (5) years in prison.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Surrender:

1. The licensee's osteopathic license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(4) and (10). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Surrender.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending investigation without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Surrender.

AGREED ORDER OF SURRENDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this pending investigation without an evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER OF SURRENDER:**

1. The licensee SHALL SURRENDER his license to practice osteopathy within the Commonwealth of Kentucky, with that surrender to become effective immediately upon the date of filing of this Agreed Order of Surrender and continuing for an indefinite period.
2. During the effective period of this Agreed Order of Surrender, the licensee SHALL NOT perform any act within the Commonwealth of Kentucky which would constitute the "practice of medicine or osteopathy," as that term is defined

by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities," unless and until approved to do so by the Panel, in response to a properly filed petition for reinstatement.

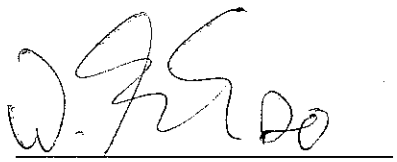
3. The licensee SHALL NOT petition for reinstatement of his license to practice osteopathy for a minimum period of two (2) years from the date of filing of this Agreed Order of Surrender. The parties understand and agree that the provisions of KRS 311.607, SHALL apply to any petition for reinstatement filed by the licensee. The licensee understands and agrees that, if he should file a petition for reinstatement, the Panel may require him to successfully complete an assessment(s) or evaluation(s), at his expense, to assist the Panel in their determination regarding the petition. The licensee also understands and agrees that the decision whether to grant such a petition for reinstatement lies within the sole discretion of the Panel.
4. The licensee SHALL NOT violate any provisions of KRS 311.595 and/or 311.597.
5. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Surrender, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order of Surrender, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a

violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Surrender.

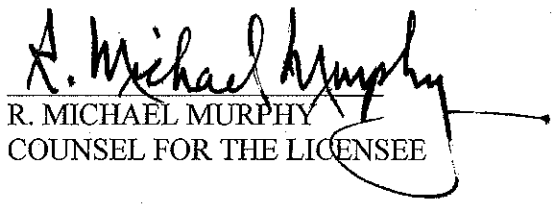
6. The licensee understands and agrees that any violation of the terms of this Agreed Order of Surrender would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13) and may provide a legal basis for criminal prosecution for practicing medicine without a license.

SO AGREED on this ____ day of _____, 2013.

FOR THE LICENSEE:



WERNER GRENTZ, D.O.



R. MICHAEL MURPHY
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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