COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1649

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH F. DAUGHERTY, M.D., LICENSE NO. 22022, 1045 JACKSON ROAD, PARK HILLS, KENTUCKY 41011-1911

SECOND AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, and Joseph F. Daugherty, M.D. ("the licensee"), and based upon the licensee's request to resume prescribing of certain controlled substances beyond 72-hours, hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER:**

STIPULATIONS OF FACT

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

1. At all relevant times, Joseph F. Daugherty, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's specialty is internal medicine.
3. On July 11, 2012, the State Medical Board of Ohio (hereafter "the Ohio Board") issued a notice of intent to take action against the licensee's Ohio medical license, in Case No. 12-CRF-058, alleging,

> From on or about August 2010 to the present, you undertook the care of Patients 1-6.... In regards to Patients 1-6, you failed to appropriately physically examine patients and diagnose medical conditions and/or document appropriate physical examination of patients and diagnosing of medical conditions before prescribing Schedule II controlled substances.

4. On December 12, 2012, the licensee entered into a Consent Agreement with the Ohio Board resolving Case No. 12-CRF-058, in which the licensee "...admits to the factual and legal allegations contained in the July 2012 Notice, a copy of which is attached hereto and incorporated herein as Exhibit A." Under the terms of the Consent Agreement, the licensee's Ohio medical license is suspended "for an indefinite period, but not less than 90 days." The Consent Agreement sets out specific conditions for reinstatement and specific terms of probation to be implemented if and when his Ohio license is reinstated.
5. By letter dated December 24, 2012, the licensee notified this Board of the entry and terms of the Ohio Consent Agreement, as required by that Agreement.
6. On March 14, 2013, the parties entered into an Agreed Order of Suspension and Probation, as required by 201 KAR 9:081, Section 9(4)(c). Condition 2b of that Agreed Order specified, in part, "...Once the Panel receives written verification that the Ohio Board has reinstated his Ohio license, the Panel or its Chair will promptly enter into an Amended Agreed Order of Probation with the licensee to reinstate his Kentucky license."
7. In April 2013, after the Board has received written verification that the Ohio Board reinstated the licensee's Ohio license, effective March 13, 2013, the Panel Chair approved the licensee to practice at Daugherty Medical Group in Florence, KY, Bellevue, KY and Cincinnati, Ohio, pursuant to terms and conditions set forth in an Amended Agreed Order of Probation. Revisions of the licensee's practice hours at his offices located in Kentucky were further made pursuant to terms and

conditions set forth in a second and then a Third Amended Agreed Order of Probation.

8. An investigation into the licensee's prescribing practices in Kentucky was initiated after the Kenton County Coroner reported to the Board that one of the licensee's patients, Patient A, had died of an overdose and that it appeared that the patient had been going to multiple doctors.

9. At the Board's request, the Office of Inspector General Division of Audits and Investigations ("OIG"), analyzed the licensee's prescribing patterns and noted the following concerns:

    - long-term use of one or more controlled substances;
    - combinations of controlled substances favored by persons who abuse or divert controlled substances;
    - family members obtaining the same or similar medications;
    - young patients receiving high doses of narcotics

    OIG referred fifteen (15) patient names (including Patient A) illustrative of these concerns for further review.

10. In or about December 2013, a Board consultant reviewed the licensee's records and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices; committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance and gross negligence; prescribed or dispensed medications in such amounts that he knew or had reason to know that the amounts were excessive under accepted and prevailing medical practice standards; and that his practice constitutes a danger to the health, welfare and safety of his patients and the public. The consultant stated, in part,

> ... in reviewing his capabilities of proper diagnosis, I feel that he fell short primarily as it relates to generally incomplete evaluations. Rarely was a complete physical exam done at the initiation of treatment ... As well, during routine and monthly visits evaluations were incomplete... Physical exams were rarely done. Laboratory follow-up was inadequate as it related either to ongoing medical problems or specifics for medication use. During these visits, Dr. Daugherty would fail to recognize signs and symptoms, especially related to current prescription medicine misuse, past histories of medication use, past history of addiction, and current use of substances including alcohol. Commentaries and notifications about patients overusing medications, selling medications, losing medications were not addressed. Drug screens inappropriate for prescriptions provided were not acted upon. Behaviors typically associated with mediation misuse and addiction was not acted upon.
> ...
> ...
> A major concern relates to the prescribing of controlled substances. All patients had some opioid prescription ... these prescriptions were for non-cancer pain, and associated diagnostics rarely support the need for choric opioid therapy. As well, these prescriptions were utilized with patients with identified addiction issues, and if not an identified addiction, used in patients with obvious addictive behaviors. Dr. Daugherty failed to intervene when these behaviors presented.
> ...

(The consultant's report is attached and incorporated herein.)

11. On or about January 24, 2014, the licensee responded, through counsel, to the Board consultant's report, stating in part that

> ... As the Board is aware, Dr. Daugherty entered into a Consent Decree with the Ohio Medical Board in December 2012. The grounds for discipline in Ohio are similar to the deficiencies found by the consultant. In addition, many of the chart entries reviewed by the consultant overlap in time with the six charts at issue in the Ohio action (2012-2012). Likewise, most of the chart entries reviewed by the consultant predate remedial steps taken by Dr. Daugherty to address the similar issues in Ohio...

12. On or about April 17, 2014, the Panel reviewed the above information and chose to defer action pending another consultant review.

13. On or about May 6, 2014, at the Board's request, the Office of Inspector General Division of Audits and Investigations ("OIG"), analyzed the licensee's prescribing patterns and noted the following concerns:

- long-term use of one or more controlled substances;
- combinations of controlled substances favored by persons who abuse or divert controlled substances;
- patients traveling long distances to obtain medications;
- family members obtaining the same or similar medications;
- young patients receiving high doses of narcotics

OIG referred fourteen (14) patient names illustrative of these concerns for further review.

14. On or about September 2014, a Board consultant reviewed the licensee's records and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices; committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice; prescribed or dispensed medications in such amounts that he knew or had reason to know that the amounts were excessive under accepted and prevailing medical practice standards; and that his practice constitutes a danger to the health, welfare and safety of his patients and the public. The consultant stated, in part,

> ... A major concern in my view was chart documentation and decision making by Dr. Daugherty. ... [D]ocumentation on progress notes was poor and inadequate. Histories were incomplete, did often contain some social identifiers, did on occasion identify new acute problems presented, but regularly did not discuss primary and relevant problems for the specific visit.
>
> ... in this population, including patients with chronic pain, other chronic medical problems, co-morbid psychiatric disease, no attention was paid to musculoskeletal findings nor to mental status exams in

particular and other physical findings pertinent to presenting problems and as well to identified treatment.

Diagnostic were basically limited to drug screens but there was no comment as to diagnostics completed relevant top pain issues and other chronic problems. Even with obtained drug screens findings were often overlooked, not addressed and even ignored resulting in inadequate patient care.

Patient assessments were frequently missing and/or incomplete. Regularly only pain was addressed. Failure to fully evaluate the patient with proper history, exam and diagnostics would lead to the inadequacy of properly assessing a medical presentation. It identifies a lack of involvement with patients that would lead to inaccurate diagnosis. It identifies lack of thought process in considering patient needs.

Plans were similarly lacking except for medications prescribed. ...

...

Information from KASPER report review was also problematic. Evident were a large number of patients with prescriptions for varied controlled substances including opiates, benzodiazepines, stimulants. Extended release and immediate release opiates were prescribed concomitantly in many situations. ... [H]igh dose opiates combined with acetaminophen could have resulted in acetaminophen toxicity and necessitate more caution. Apparent was long-term use of opiates by many patients. Some patients were afforded refills on prescriptions and not seen monthly for new prescriptions as is the usual standard.

Buprenorphine products were prescribed by Dr. Daugherty. Noticeable were prescriptions for 24 mgs per day, within normal prescribing, but outside what is now recognized as an excessive dose for most patients. Buprenorphine was provided as the mono product frequently, typically reserved for pregnancy or allergy (which is rare). Patients obtaining prescriptions for buprenorphine were irregular in filling these suggesting inconsistent care in the office. On the other hand some patients were afforded refills of buprenorphine apparently without office visits not the accepted standard. Buprenorphine prescriptions were provided along with benzodiazepine prescriptions, something very unusual, classically contraindicated and dangerous in a population with a diagnosis of addiction (which these patients presumably had). Prescriptions were also combined with stimulants again generally contraindicated in a population with addiction diagnosis without psychiatric input and psychological testing.

> Concerns about polypharmacy exist as seen with Kasper review as well as chart review. Combinations of opiates were regularly seen with benzodiazepines and then muscle relaxants (flexeril and zanaflex), anticonvulsants (gabapentin) and other psychotropics potentially leading to toxicity. It is important to note that these are medications often misused and abused in addiction. Other findings including drug screens that were inconsistent for the patient (absent prescribed medication, illicit substances present) and HCV positivity raise concerns that some of these patients had a primary diagnosis of addiction that was missed and then improperly and dangerously treated with controlled substances.
>
> Lastly and difficult to determine with a limited chart review, was finding adequate justification for treating these patients with opioids for noncancer pain and treating them long term with high dose.
> ...

(The consultant's report is attached and incorporated herein.)

15. On or about November 12, 2014, the licensee responded, through counsel, to the Board consultant's report, stating in part that

> ... Clearly, Dr. Daugherty is disappointed that the consultant does not discern the rationale for his decisions related to diagnosis and treatment from the patient charts under review. Whereas the rationale may not be evident in his charting, Dr. Daugherty's medical decision-making is grounded in sound medical knowledge and reasoning. With that said, Dr. Daugherty understands that it is his responsibility to clearly document the information that he relies upon in caring for patients, and that it is problematic if the reviewer cannot discern this information. ...

16. On or about November 16, 2014, the Board consultant reviewed the licensee's response and stated that he did not change his opinions as stated in his original review and, in fact, had become "more concerned that there may be a need for more immediacy in action" because the licensee's "comments, justifications and rationalizations suggest truly a failure to recognize and accept that his own practice is dangerous and veers significantly from current standards."

17. On March 19, 2015, the Board's Inquiry Panel A reviewed the investigation and the licensee appeared with counsel and was heard by the Panel before it deliberated. The Panel and the licensee agree to enter into an Agreed Order, in lieu of the issuance of a Complaint and Emergency Order of Suspension, pursuant to which the licensee agreed not to practice of medicine unless and until approved to do so by the Panel; to schedule, submit and complete a CPEP clinical skills assessment; to obtain a CPEP Educational Intervention Plan, if so recommended by CPEP; and to reimburse the costs of the investigation ($2,375) within 6 months.

18. On or about April 20-21, 2015, the licensee participated in a clinical skills assessment in the specialties of internal medicine (outpatient) and pain management. Overall, CPEP noted

> During this Assessment, Dr. Daugherty demonstrated a marginal fund of knowledge in outpatient internal medicine topics with important deficiencies in all areas covered. Dr. Daugherty … demonstrated an acceptable fund of knowledge in pain management with multiple gaps, including opioid pharmacology and monitoring of patients prescribed chronic opioid medications. His clinical judgment and reasoning were generally inadequate and his patient care as documented in charts submitted for review was inadequate, overall. His documentation in actual patient charts was poor; his documentation of the Simulated Patient (SP) encounters was marginal with need for improvement. Dr. Daugherty's communication skills were poor with SPs; his communication with peers was generally professional, but he exhibited poor eye contact. …
>
> …
>
> … CPEP has concerns about Dr. Daugherty's application of knowledge given that in the past three years he participated in 47 hours of continuing medical education (CME) on pain management topics and 52.8 hours of CME on controlled substance prescribing yet still has significant deficiencies in these areas. ….

CPEP recommended that the licensee participate in a structured education program, to include (1) point-of-care supervision by a preceptor in pain management

(initially this preceptor would review each and every patient with Dr. Daugherty prior to the patient's discharge from an outpatient setting) and (2) an internal medicine preceptor (who would initially review all of Dr. Daugherty's charts within 48-hours of the patient encounter).

19. In or around September 2015, CPEP developed the recommended Educational Intervention Plan for the licensee.

20. On or about October 15, 2015, the licensee submitted reimbursement of the Board's prior investigation in the amount of $2,375 and the Panel chose to allow the licensee to resume the practice of medicine pursuant to terms and conditions set forth in an Amended Agreed Order, which required that

    - The licensee successfully complete the CPEP Educational Plan as directed by CPEP;
    - He maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized and shall provide for at least two (2) favorable consultant reviews of the log and relevant records by Board agents before the order may be terminated;
    - He fully comply with the provisions of 201 KAR 9:260, Professional Standards for Prescribing or Dispensing Controlled Substances and the professional standards applicable to the licensee's specialty; and
    - He only prescribe, dispense, or otherwise professionally utilize controlled substances to patients when medically necessary, for up to and no more than a 72-hour period and only for an acute medical condition.

21. During the first progress reporting of his CPEP Educational Plan, CPEP noted that the quality and thoroughness of the licensee's charting showed some improvement. However, neither CPEP nor the preceptor were able to assess the licensee's clinical decision making in regard to prescribing because he had not prescribed any controlled substances for the permitted 72-hour periods.

22. In April 2016, the licensee expressed a desire to become a suboxone prescriber and to practice as a hospitalist, practice areas that were not part of his CPEP assessment and not part of his education plan. To do so, he requested that the Panel modify the Amended Agreed Order to allow him to prescribe for more than a 72-hour period. In August 2016, the Panel denied his request and directed him to continue in his CPEP education plan and directed that if he should desire to practice within another specialty, to first obtain a clinical skills assessment in that specialty(ies).
23. In October 2016, the State Medical Board of Ohio permanently revoked the licensee's license to practice in that state, based in part on the licensure restrictions imposed in Kentucky. Although the licensee appealed the Ohio board's action, it was affirmed after judicial review.
24. In October 2017, the licensee completed his CPEP educational plan activities and then participated in a post-education evaluation which revealed that although he demonstrated overall improvement in knowledge of internal medicine topics, with some remaining gaps, the licensee demonstrated significant persistent gaps in knowledge of chronic pain management, especially of opioids; the licensee's judgment and reasoning were variable but inadequate in terms of data gathering, formulating differential diagnoses and in issues pertaining to opioid prescribing; and the licensee's documentation deficiencies persisted after completion of the education plan (despite some improvement while under monitoring of the plan).
25. CPEP recommended that the licensee not treat chronic pain unless and until he completes a formal training program, such as a pain management fellowship and that he engage in a formal education plan addendum in the area of internal medicine

to address ongoing deficiencies. According to CPEP, the licensee should not resume any prescribing of controlled substances unless he can be monitored and reviewed.

26. At CPEP's recommendation, the licensee enrolled in an internal medicine addendum. He has not enrolled in a pain management fellowship.

27. On or about October 18, 2018, the licensee requested the 72-hour prescribing restriction be terminated or at least modified to allow him to resume prescribing of certain scheduled controlled substances for certain conditions. The Panel granted his request, in part, pursuant to the terms and conditions set forth in this Second Amended Agreed Order.

STIPULATED CONCLUSIONS OF LAW

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

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

2. While the licensee denies any wrongdoing, he acknowledges that, based upon the Stipulations of Fact, the Hearing Panel could conclude that he has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4), and 311.595(13). Accordingly, there are legal grounds for the parties to enter into this Second Amended Agreed Order.

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 practice medicine by entering into an informal resolution such as this Second Amended Agreed Order.

SECOND AMENDED AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the licensee's request to resume prescribing of certain controlled substances beyond 72-hours, the parties hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER** ("Order"):

1. The license to practice medicine in the Commonwealth of Kentucky held by JOSEPH F. DAUGHERTY, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;

2. During the effective period of this Agreed Order, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION until further order of the Board:

    a. The licensee SHALL comply with and SUCCESSFULLY complete all requirements of the Educational Intervention Plan Addendum developed for him by CPEP, at his expense and as directed by CPEP;

        i. The licensee SHALL comply with all directives of CPEP to execute and complete the Educational Intervention Plan Addendum and any failure to comply with the directives of CPEP shall constitute a violation of this Order and shall render the licensee's practice of medicine an immediate danger to the health, welfare and safety of patients and the public;

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

        iii. 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 Addendum;

    b. Except as provided in subparagraph i below, the licensee SHALL ONLY prescribe, dispense, or otherwise professionally utilize controlled

substances to patients when medically necessary, for up to and no more than a 72-hour period and only for an acute medical condition;

i. The licensee may prescribe Schedule IV and Schedule V controlled substances for the treatment of chronic neuropathic pain or diabetic neuropathy;

c. The licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed. 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 should 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 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 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 any request to modify or terminate this Order;

d. The licensee SHALL fully comply with the provisions of 201 KAR 9:260, Professional Standards for Prescribing or Dispensing Controlled Substances and the professional standards applicable to the licensee's specialty; and

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

3. The licensee expressly understands and agrees that if he should violate any term or condition of this Order, 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 Order, 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 Order.

4. The licensee expressly understands and agrees that any violation of the terms of this Order 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.

SO AGREED on this 30th day of October, 2018.

FOR THE LICENSEE:

JOSEPH F. DAUGHERTY, M.D.

DAVID A. TREVEY, ESQ.
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

DALE E. TONEY, M.D.
CHAIR, INQUIRY PANEL A

LEANNE K. DIAKOV
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Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
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December 1, 2013

Jon Marshall
Kentucky Board of Medical Licensure
310 Whittington Pkwy., Ste. 1B
Louisville, KY 40222

Re: Consultation on Joseph Daugherty, M.D.

Dear Mr. Marshall:

I have reviewed the following materials:

1. Grievance filed by Kenton County Coroner, Dr. David Suetholz
2. KASPER report from Paula York, Office of Inspector General
3. Investigative report
4. Dr. Daugherty's response, through counsel, with short summaries
5. KASPER report on Dr. Daugherty from 06/01/2011 to 05/17/2013
6. Fifteen medical files on patients of Dr. Daugherty

In response to your questions:

1. Yes, the named physician engaged in conduct, which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.
2. Yes, the named physician committed a serious act, or a pattern of acts, during the course of the physician's medical practice which under the intended circumstances would be deemed to be gross incompetence, gross ignorance, and gross negligence.
3. Yes, the physician's practice constitutes danger to the health, welfare and safety of the physician's patients and general public.

In regard to prescribing:

1. No, the named physician did not prescribe or dispense medications with the intent or knowledge that the medication would be used, or is likely to be used, other than medicinally or other than for an accepted therapeutic purpose.

2. No, the named physician did not prescribe or dispense medications for the licensee's personal use, or for the use of his immediate family, when the licensee knew or had reason to know that an abuse of controlled substances was occurring or may result from such practice.
3. Yes, the named physician did prescribe or dispense medications in such amounts that the licensee knew or had reason to know under the intended circumstances that set amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards.
4. Yes, the named physician did engage in conduct which departs from, or fails to conform to, the standards of acceptable of prevailing medical practice within the Commonwealth of Kentucky.
5. Yes, the named physician committed a serious act, or pattern of acts, during the course of his medical practice, which under the intended circumstances, would be deemed to be gross incompetence, gross ignorance, and gross negligence.

In reviewing the case files provided, I found that Dr. Daugherty did see his patients regularly, usually monthly. Problem list and medication list were compiled (although some omissions were apparent regarding active problems and medications). He did obtain KASPERs. He obtained controlled substance consents but, interestingly, most of these were dated either December, 2012 or January, 2013. Enclosed in charts were copies of prescriptions but these appeared to be only for the more recent visits and, otherwise, prescription logs were not a part of the record. On occasion, he did use brief screening tools for addiction. Drugs screens were obtained regularly. And, on occasion, he sought referrals for more complex problems such as pain, orthopaedics, hand surgery, physical therapy, chiropractor, and mental health.

However, in reviewing his capabilities of proper diagnosis, I feel that he fell short primarily as it relates to generally incomplete evaluations. Rarely was a complete physical exam done at the initiation of treatment, an exam which would include a full history including past medical history, past psychiatric history, medication and substance use history, social history, review of systems, and physical examination. As well, during routine and monthly visits evaluations were incomplete. Histories were either absent, limited, or just on the basis of a patient's completed questionnaire. Physical exams were rarely done. Laboratory follow-up was inadequate as it related either to ongoing medical problems or specifics for medication use. During these visits, Dr. Daugherty would fail to recognize signs and symptoms, especially related to current prescription medicine misuse, past histories of medication use, past history of addiction, and current use of substances including alcohol. Commentaries and notifications about patients overusing medications, selling medications, losing medications were not addressed. Drug screens inappropriate for prescriptions provided were not acted upon. Behaviors typically associated with medication misuse and addiction was not acted upon. Added documentation using a variety of diagnostics was either not obtained in order to obtain proper diagnosis and treatment plan, or obtained and not heeded. Consultations were requested, occasionally obtained, but often without follow-through, leading to inadequate diagnosis. The fact that many of these patients presented to Dr. Daugherty with already identified diagnoses and prescriptions for controlled substances does not justify his continuing this treatment plan without reevaluation.

Treatment for these patients failed to address the myriad of problems that existed. All patients were seen for pain or addiction but did have associated medical issues. These medical issues were followed irregularly with inadequate exams that would supplement any patient history provided, and with irregular laboratory screening to monitor these medication problems and medication use. Patients were poorly monitored especially with regard to their behavior, leading to poor treatment.

A major concern relates to the prescribing of controlled substances. All patients had some opioid prescription and, again, if a new patient to Dr. Daugherty, was something that may have been

initiated by a preceding physician. However, these prescriptions for opioids were for non-cancer pain, and associated diagnostics rarely support the need for chronic opioid therapy. As well, these prescriptions were utilized with patients with identified addiction issues, and if not an identified addiction, used in patients with obvious addictive behaviors. Dr. Daugherty failed to intervene when these behaviors presented.

Except for some prescriptions for methadone, most of the opioids were an immediate release formulation and at relatively high doses. This kind of prescribing leads to more frequent misuse and should have been accompanied by a transition to extended release formulations.

Many of the patients were treated for a supposed diagnosis of attention deficit disorder with psychostimulants. None of these diagnoses were well established, as there was no psychological testing or consultation. Again, these stimulants were mostly an immediate release formulation rather than extended release formulation and much more prone to misuse. Many of these prescriptions were provided for the same patients who had identified addictive disorder or behaviors associated with addiction and would, therefore, be considered generally contraindicated.

There were frequent prescriptions for benzodiazepine, always in combination with a variety of other medications including opioids, psychotropics, muscle relaxers, and anticonvulsives potentially leading to toxicity. They were used in patients with comorbid conditions such as COPD, obstructive sleep apnea, as well as addiction, leading to the potential for additional toxicity. The resultant polypharmacy was not so much an issue as to the numbers of pills per prescriptions, but more related to the combinations and utilizations of immediate release formulations.

Lastly, the high dose of opioids led to the potential for high doses of acetaminophen on a daily basis in many of these patients.

Another element in poor prescribing in the addiction population was identified by KASPER reports, which showed prescriptions for buprenorphine in a mono form (that is without naloxone) a form only utilized in exceptional circumstances as it leads to potential misuse. Prescribed frequently for these patients taking buprenorphine were benzodiazepine, again, generally contraindicated in the addiction population.

Records could be summarized as inadequate as history obtained from the patient was limited to often nonexistent and exams were generally nonexistent. Dr. Daugherty failed to provide any general assessment on a visit-by-visit basis in order to summarize the course of treatment, the patients' current status, or give support to any changes that might be made to the treatment plan. As well, treatment plans were quite limited in that they usually just identified medication prescriptions and on occasion diagnostics and suggestions for consultation.

In summary, I feel that Dr. Daugherty misdiagnosed and/or over-diagnosed, under-treated medical issues, over-treated pain issues, over-prescribed a combination of dangerous medications to an at risk population and was therefore a danger to his patients as well as to the community.

Respectfully,

Mark S. Jornisch, M.D.

MSJ/ked
400072/30526

September 26, 2014

Re. Dr. Joseph Daugherty

Mr. Marshall:
I have completed my review of information provided for Dr. John Daugherty. This includes:

Grievance filed by Kenton County coroner, Dr. David Suetholz
Kasper review report from Paula York, OIG dated 5/6/14
Dr. Daugherty's response, thru counsel, with chart summaries
Kasper report on Dr. Daugherty from 4/28/13-4/28/14
14 medical files on patients of Dr. Daugherty

As a second review I have as requested only included comments from records since 10/1/13. My conclusions are as follows:
1.Yes this physician has engaged in conduct, which departs from or fails to conform to the standards of acceptable medical practice within the Commonwealth of Kentucky.
2. Yes this physician has committed a serious act, or a pattern of acts, during the course of the physician's medical practice, which under the attendant circumstances would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice.
3. Yes, this physician's practice does constitute a danger to the health, welfare, and safety of the physician's patients or the general public.

Re. prescribing:
1. No, the physician did not prescribe or dispense medication with the intent or knowledge that the medication would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose.
2. No, the physician did not prescribe or dispense medication for the licensee's personal use or for the use of his immediate family when the licensee knew or had reason to know that an abuse of controlled substances was occurring, or may result from such practice.
3. Yes, the physician prescribed or dispensed medication in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amount so prescribed or dispensed was excessive under accepted and prevailing medical practice standards.
4. Yes, the physician did engage in conduct, which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky
5. Yes the physician did commit a serious act, or a pattern of acts, during the course of the physician's medical practice which under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice.

A major concern in my view was chart documentation and decision making by Dr. Daugherty. Charts in general were orderly and did have progress notes denoting patient visits. Problem lists were provided but not consistently up to date. Medication lists were available and prominent. Kasper reports were included as part of the chart. Consent forms were not up to date as none appeared to be done since the identified initiation of this review 10/1/13. Drug screens were completed routinely.

However, and consistently, documentation on progress notes was poor and inadequate. Histories were incomplete, did often contain some social identifiers, did on occasion identify new acute problems presented, but regularly did not discuss primary and relevant problems for the specific visit.

Exams did regularly include vital signs. They also (but often absent) had notations re. respiratory and cardiovascular exams. However these were very nonspecific and did not identify any other (positive or negative) findings in his patients. In this population including patients with chronic pain, other chronic medical problems, co-morbid psychiatric disease, no attention was paid to musculoskeletal findings nor to mental status exams in particular and other physical findings pertinent to presenting problems and as well to identified treatment.

Diagnostic were basically limited to drug screens but there was no comment as to diagnostics completed relevant to pain issues and other chronic problems. Even with obtained drug screens findings were often overlooked, not addressed, and even ignored resulting in inadequate patient care.

Patient assessments were frequently missing and/or incomplete. Regularly only pain was addressed. Failure to fully evaluate the patient with proper history, exam and diagnostics would lead to the inadequacy of properly assessing a medical presentation. It identifies a lack of involvement with patients that would lead to inaccurate diagnosis. It identifies lack of thought process in considering patient needs.

Plans were similarly lacking except for medications prescribed. As previously noted, failure to fully assess patients with history, exam and diagnostics would lead to the inability to adequately formulate plans and care for the entire patient. Referrals were alluded to but there was no comment or inclusion in patient care from documentation seen

Utilization from other resources especially mental health (counseling and psychiatry), addiction services, complementary and alternative treatment was rare. Even interventions as simple as diet and exercise were absent and need to be part of especially pain management as well as other chronic medical problems.

Prescribing falls into the same category. In order to properly prescribe and then assess benefit and potential toxicity, enough information needed to be gathered

through history, exam and diagnostics and then thought into assessment. That patients saw benefit from treatment could not be gleaned from Dr. Daugherty's documentation. That patients were not being harmed could also not be determined.

Information from Kasper report review was also problematic. Evident were a large number of patients with prescriptions for varied controlled substances including opiates, benzodiazepines, stimulants. Extended release and immediate release opiates were prescribed concomitantly in many situations. Dose, dosing interval, pharmacies were not obviously a problem. However high dose opiates combined with acetaminophen could have resulted in acetaminophen toxicity and necessitate more caution. Apparent was long term use of opiates by many patients. Some patients were afforded refills on prescriptions, and not seen monthly for new prescriptions as is the usual standard.

Buprenorphine products were prescribed by Dr. Daugherty. Noticeable were prescriptions for 24 mgs. per day, within normal prescribing, but outside what is now recognized as an excessive dose (16 mgs. maximum) for most patients. Buprenorphine was provided as the mono product (without naloxone) frequently, typically reserved for pregnancy or allergy (which is rare). Patients obtaining prescriptions for buprenorphine were irregular in filing these suggesting inconsistent care in the office. On the other hand some patients were afforded refills of buprenorphine apparently without office visits not the accepted standard. Buprenorphine prescriptions were provided along with benzodiazepine prescriptions, something very unusual, classically contraindicated and dangerous in a population with a diagnosis of addiction (which these patients presumably had). Prescriptions were also combined with stimulants again generally contraindicated in a population with addiction diagnosis without psychiatric input and psychological testing.

Concerns about polypharmacy exist as seen with Kasper review as well as chart review. Combinations of opiates were regularly seen with benzodiazepines and then muscle relaxants (flexeril and zanaflex), anticonvulsants (gabapentin), and other psychotropics potentially leading to toxicity. It is important to note that these are medications often misused and abused in addiction. Other findings including drug screens that were inconsistent for the patient (absent prescribed medication, illicit substances present), and HCV positivity raise concerns that some of these patient had a primary diagnosis of addiction that was missed and then improperly and dangerously treated with controlled substances.

Lastly and difficult to determine with a limited chart review, was finding adequate justification for treating these patients with opioids for noncancer pain and treating them long term with high dose.

Patients reviewed were admittedly complex but resources are available to help with treatment decisions. Because these patients were 'given' to Dr. Daugherty, were in pain, had co-morbid conditions is poor justification for continuing patterns of


treatment that were dangerous and potentially harmful. Due diligence is necessary in obtaining complete patient evaluations including other health care provider consultations to make the best decisions possible.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1649

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH F. DAUGHERTY, M.D., LICENSE NO. 22022, 1045 JACKSON ROAD, PARK HILLS, KENTUCKY 41011-1911

AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, and Joseph F. Daugherty, M.D. ("the licensee"), and based upon the licensee's request to resume the practice of medicine, hereby ENTER INTO the following **AMENDED AGREED ORDER**:

STIPULATIONS OF FACT

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

1. At all relevant times, Joseph F. Daugherty, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's specialty is internal medicine.
3. On July 11, 2012, the State Medical Board of Ohio (hereafter "the Ohio Board") issued a notice of intent to take action against the licensee's Ohio medical license, in Case No. 12-CRF-058, alleging,

> From on or about August 2010 to the present, you undertook the care of Patients 1-6.... In regards to Patients 1-6, you failed to appropriately physically examine patients and diagnose medical conditions and/or document appropriate physical examination of patients and diagnosing of medical conditions before prescribing Schedule II controlled substances.

4. On December 12, 2012, the licensee entered into a Consent Agreement with the Ohio Board resolving Case No. 12-CRF-058, in which the licensee "...admits to

the factual and legal allegations contained in the July 2012 Notice, a copy of which is attached hereto and incorporated herein as Exhibit A." Under the terms of the Consent Agreement, the licensee's Ohio medical license is suspended "for an indefinite period, but not less than 90 days." The Consent Agreement sets out specific conditions for reinstatement and specific terms of probation to be implemented if and when his Ohio license is reinstated.

5. By letter dated December 24, 2012, the licensee notified this Board of the entry and terms of the Ohio Consent Agreement, as required by that Agreement.
6. On March 14, 2013, the parties entered into an Agreed Order of Suspension and Probation, as required by 201 KAR 9:081, Section 9(4)(c). Condition 2b of that Agreed Order specified, in part, "...Once the Panel receives written verification that the Ohio Board has reinstated his Ohio license, the Panel or its Chair will promptly enter into an Amended Agreed Order of Probation with the licensee to reinstate his Kentucky license."
7. In April 2013, after the Board has received written verification that the Ohio Board reinstated the licensee's Ohio license, effective March 13, 2013, the Panel Chair approved the licensee to practice at Daugherty Medical Group in Florence, KY, Bellevue, KY and Cincinnati, Ohio, pursuant to terms and conditions set forth in an Amended Agreed Order of Probation. Revisions of the licensee's practice hours at his offices located in Kentucky were further made pursuant to terms and conditions set forth in a second and then a Third Amended Agreed Order of Probation.

8. An investigation into the licensee's prescribing practices in Kentucky was initiated after the Kenton County Coroner reported to the Board that one of the licensee's patients, Patient A, had died of an overdose and that it appeared that the patient had been going to multiple doctors.

9. At the Board's request, the Office of Inspector General Division of Audits and Investigations ("OIG"), analyzed the licensee's prescribing patterns and noted the following concerns:

    - long-term use of one or more controlled substances;
    - combinations of controlled substances favored by persons who abuse or divert controlled substances;
    - family members obtaining the same or similar medications;
    - young patients receiving high doses of narcotics

    OIG referred fifteen (15) patient names (including Patient A) illustrative of these concerns for further review.

10. In or about December 2013, a Board consultant reviewed the licensee's records and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices; committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance and gross negligence; prescribed or dispensed medications in such amounts that he knew or had reason to know that the amounts were excessive under accepted and prevailing medical practice standards; and that his practice constitutes a danger to the health, welfare and safety of his patients and the public. The consultant stated, in part,

    > ... in reviewing his capabilities of proper diagnosis, I feel that he fell short primarily as it relates to generally incomplete evaluations.

> Rarely was a complete physical exam done at the initiation of treatment … As well, during routine and monthly visits evaluations were incomplete… Physical exams were rarely done. Laboratory follow-up was inadequate as it related either to ongoing medical problems or specifics for medication use. During these visits, Dr. Daugherty would fail to recognize signs and symptoms, especially related to current prescription medicine misuse, past histories of medication use, past history of addiction, and current use of substances including alcohol. Commentaries and notifications about patients overusing medications, selling medications, losing medications were not addressed. Drug screens inappropriate for prescriptions provided were not acted upon. Behaviors typically associated with mediation misuse and addiction was not acted upon.
> …
> …
> A major concern relates to the prescribing of controlled substances. All patients had some opioid prescription … these prescriptions were for non-cancer pain, and associated diagnostics rarely support the need for choric opioid therapy. As well, these prescriptions were utilized with patients with identified addiction issues, and if not an identified addiction, used in patients with obvious addictive behaviors. Dr. Daugherty failed to intervene when these behaviors presented.
> …

(The consultant's report is attached and incorporated herein.)

11. On or about January 24, 2014, the licensee responded, through counsel, to the Board consultant's report, stating in part that

> … As the Board is aware, Dr. Daugherty entered into a Consent Decree with the Ohio Medical Board in December 2012. The grounds for discipline in Ohio are similar to the deficiencies found by the consultant. In addition, many of the chart entries reviewed by the consultant overlap in time with the six charts at issue in the Ohio action (2012-2012). Likewise, most of the chart entries reviewed by the consultant predate remedial steps taken by Dr. Daugherty to address the similar issues in Ohio…

12. On or about April 17, 2014, the Panel reviewed the above information and chose to defer action pending another consultant review.

13. On or about May 6, 2014, at the Board's request, the Office of Inspector General Division of Audits and Investigations ("OIG"), analyzed the licensee's prescribing patterns and noted the following concerns:

- long-term use of one or more controlled substances;
- combinations of controlled substances favored by persons who abuse or divert controlled substances;
- patients traveling long distances to obtain medications;
- family members obtaining the same or similar medications;
- young patients receiving high doses of narcotics

OIG referred fourteen (14) patient names illustrative of these concerns for further review.

14. On or about September 2014, a Board consultant reviewed the licensee's records and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices; committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice; prescribed or dispensed medications in such amounts that he knew or had reason to know that the amounts were excessive under accepted and prevailing medical practice standards; and that his practice constitutes a danger to the health, welfare and safety of his patients and the public. The consultant stated, in part,

> ... A major concern in my view was chart documentation and decision making by Dr. Daugherty. ... [D]ocumentation on progress notes was poor and inadequate. Histories were incomplete, did often contain some social identifiers, did on occasion identify new acute problems presented, but regularly did not discuss primary and relevant problems for the specific visit.
>
> ... in this population, including patients with chronic pain, other chronic medical problems, co-morbid psychiatric disease, no

attention was paid to musculoskeletal findings nor to mental status exams in particular and other physical findings pertinent to presenting problems and as well to identified treatment.

Diagnostic were basically limited to drug screens but there was no comment as to diagnostics completed relevant top pain issues and other chronic problems. Even with obtained drug screens findings were often overlooked, not addressed and even ignored resulting in inadequate patient care.

Patient assessments were frequently missing and/or incomplete. Regularly only pain was addressed. Failure to fully evaluate the patient with proper history, exam and diagnostics would lead to the inadequacy of properly assessing a medical presentation. It identifies a lack of involvement with patients that would lead to inaccurate diagnosis. It identifies lack of thought process in considering patient needs.

Plans were similarly lacking except for medications prescribed. …

…

Information from KASPER report review was also problematic. Evident were a large number of patients with prescriptions for varied controlled substances including opiates, benzodiazepines, stimulants. Extended release and immediate release opiates were prescribed concomitantly in many situations. … [H]igh dose opiates combined with acetaminophen could have resulted in acetaminophen toxicity and necessitate more caution. Apparent was long-term use of opiates by many patients. Some patients were afforded refills on prescriptions and not seen monthly for new prescriptions as is the usual standard.

Buprenorphine products were prescribed by Dr. Daugherty. Noticeable were prescriptions for 24 mgs per day, within normal prescribing, but outside what is now recognized as an excessive dose for most patients. Buprenorphine was provided as the mono product frequently, typically reserved for pregnancy or allergy (which is rare). Patients obtaining prescriptions for buprenorphine were irregular in filling these suggesting inconsistent care in the office. On the other hand some patients were afforded refills of buprenorphine apparently without office visits not the accepted standard. Buprenorphine prescriptions were provided along with benzodiazepine prescriptions, something very unusual, classically contraindicated and dangerous in a population with a diagnosis of addiction (which these patients presumably had). Prescriptions were also combined with stimulants again generally contraindicated in a

> population with addiction diagnosis without psychiatric input and psychological testing.
>
> Concerns about polypharmacy exist as seen with Kasper review as well as chart review. Combinations of opiates were regularly seen with benzodiazepines and then muscle relaxants (flexeril and zanaflex), anticonvulsants (gabapentin) and other psychotropics potentially leading to toxicity. It is important to note that these are medications often misused and abused in addiction. Other findings including drug screens that were inconsistent for the patient (absent prescribed medication, illicit substances present) and HCV positivity raise concerns that some of these patients had a primary diagnosis of addiction that was missed and then improperly and dangerously treated with controlled substances.
>
> Lastly and difficult to determine with a limited chart review, was finding adequate justification for treating these patients with opioids for noncancer pain and treating them long term with high dose.
> ...

(The consultant's report is attached and incorporated herein.)

15. On or about November 12, 2014, the licensee responded, through counsel, to the Board consultant's report, stating in part that

> ... Clearly, Dr. Daugherty is disappointed that the consultant does not discern the rationale for his decisions related to diagnosis and treatment from the patient charts under review. Whereas the rationale may not be evident in his charting, Dr. Daugherty's medical decision-making is grounded in sound medical knowledge and reasoning. With that said, Dr. Daugherty understands that it is his responsibility to clearly document the information that he relies upon in caring for patients, and that it is problematic if the reviewer cannot discern this information. ...

16. On or about November 16, 2014, the Board consultant reviewed the licensee's response and stated that he did not change his opinions as stated in his original review and, in fact, had become "more concerned that there may be a need for more immediacy in action" because the licensee's "comments, justifications and

rationalizations suggest truly a failure to recognize and accept that his own practice is dangerous and veers significantly from current standards."

17. On March 19, 2015, the Board's Inquiry Panel A reviewed the investigation and the licensee appeared with counsel and was heard by the Panel before it deliberated. The Panel and the licensee agree to enter into an Agreed Order, in lieu of the issuance of a Complaint and Emergency Order of Suspension, pursuant to which the licensee agreed not to practice of medicine unless and until approved to do so by the Panel; to schedule, submit and complete a CPEP clinical skills assessment; to obtain a CPEP Educational Intervention Plan, if so recommended by CPEP; and to reimburse the costs of the investigation ($2,375) within 6 months.

18. On or about April 20-21, 2015, the licensee participated in a clinical skills assessment in the specialties of internal medicine (outpatient) and pain management. Overall, CPEP noted

> During this Assessment, Dr. Daugherty demonstrated a marginal fund of knowledge in outpatient internal medicine topics with important deficiencies in all areas covered. Dr. Daugherty … demonstrated an acceptable fund of knowledge in pain management with multiple gaps, including opioid pharmacology and monitoring of patients prescribed chronic opioid medications. His clinical judgment and reasoning were generally inadequate and his patient care as documented in charts submitted for review was inadequate, overall. His documentation in actual patient charts was poor; his documentation of the Simulated Patient (SP) encounters was marginal with need for improvement. Dr. Daugherty's communication skills were poor with SPs; his communication with peers was generally professional, but he exhibited poor eye contact. …
>
> …
>
> … CPEP has concerns about Dr. Daugherty's application of knowledge given that in the past three years he participated in 47 hours of continuing medical education (CME) on pain management topics

> and 52.8 hours of CME on controlled substance prescribing yet still has significant deficiencies in these areas. ....

CPEP recommended that the licensee participate in a structured education program, to include (1) point-of-care supervision by a preceptor in pain management (initially this preceptor would review each and every patient with Dr. Daugherty prior to the patient's discharge from an outpatient setting) and (2) an internal medicine preceptor (who would initially review all of Dr. Daugherty's charts within 48-hours of the patient encounter).

19. In or around September 2015, CPEP developed the recommended Educational Intervention Plan for the licensee.

20. On or about October 15, 2015, the licensee submitted reimbursement of the Board's prior investigation in the amount of $2,375 and the Panel chose to allow the licensee to resume the practice of medicine pursuant to terms and conditions set forth in this Amended Agreed Order.

STIPULATED CONCLUSIONS OF LAW

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

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

2. While the licensee denies any wrongdoing, he acknowledges that, based upon the Stipulations of Fact, the Hearing Panel could conclude that he has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4), and 311.595(13). Accordingly, there are legal grounds for the parties to enter into this Amended Agreed Order.

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 by entering into an informal resolution such as this Amended Agreed Order.

AMENDED AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the licensee's request to resume the practice of medicine, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER** ("Order"):

1. The license to practice medicine in the Commonwealth of Kentucky held by JOSEPH F. DAUGHERTY, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;
2. During the effective period of this Agreed Order, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION until further order of the Board:
    a. The licensee SHALL comply with and SUCCESSFULLY complete all requirements of the Educational Intervention Plan developed for him by CPEP in September 2015, a copy of which is attached hereto, at his expense and as directed by CPEP;
        i. The licensee SHALL comply with all directives of CPEP to execute and complete the Educational Intervention Plan and any failure to comply with the directives of CPEP shall constitute a violation of this Order and shall render the licensee's practice of medicine an immediate danger to the health, welfare and safety of patients and the public;

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

iii. 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;

b. The licensee SHALL ONLY prescribe, dispense, or otherwise professionally utilize controlled substances to patients when medically necessary, for up to and no more than a 72-hour period and only for an acute medical condition;

c. The licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed. 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 should 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 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 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 term/condition;

d. The licensee SHALL fully comply with the provisions of 201 KAR 9:260, Professional Standards for Prescribing or Dispensing Controlled Substances and the professional standards applicable to the licensee's specialty; and

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

3. The licensee expressly understands and agrees that if he should violate any term or condition of this Order, 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 Order, 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 Order.

6. The licensee expressly understands and agrees that any violation of the terms of this Order 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.

SO AGREED on this 19th day of October, 2015.

FOR THE LICENSEE:

JOSEPH F. DAUGHERTY, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

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

LEANNE K. DIAKOV
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

December 1, 2013

Jon Marshall
Kentucky Board of Medical Licensure
310 Whittington Pkwy., Ste. 1B
Louisville, KY 40222

Re: Consultation on Joseph Daugherty, M.D.

Dear Mr. Marshall:

I have reviewed the following materials:

1. Grievance filed by Kenton County Coroner, Dr. David Suetholz
2. KASPER report from Paula York, Office of Inspector General
3. Investigative report
4. Dr. Daugherty's response, through counsel, with short summaries
5. KASPER report on Dr. Daugherty from 06/01/2011 to 05/17/2013
6. Fifteen medical files on patients of Dr. Daugherty

In response to your questions:

1. Yes, the named physician engaged in conduct, which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.
2. Yes, the named physician committed a serious act, or a pattern of acts, during the course of the physician's medical practice which under the intended circumstances would be deemed to be gross incompetence, gross ignorance, and gross negligence.
3. Yes, the physician's practice constitutes danger to the health, welfare and safety of the physician's patients and general public.

In regard to prescribing:

1. No, the named physician did not prescribe or dispense medications with the intent or knowledge that the medication would be used, or is likely to be used, other than medicinally or other than for an accepted therapeutic purpose.

2. No, the named physician did not prescribe or dispense medications for the licensee's personal use, or for the use of his immediate family, when the licensee knew or had reason to know that an abuse of controlled substances was occurring or may result from such practice.
3. Yes, the named physician did prescribe or dispense medications in such amounts that the licensee knew or had reason to know under the intended circumstances that set amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards.
4. Yes, the named physician did engage in conduct which departs from, or fails to conform to, the standards of acceptable of prevailing medical practice within the Commonwealth of Kentucky.
5. Yes, the named physician committed a serious act, or pattern of acts, during the course of his medical practice, which under the intended circumstances, would be deemed to be gross incompetence, gross ignorance, and gross negligence.

In reviewing the case files provided, I found that Dr. Daugherty did see his patients regularly, usually monthly. Problem list and medication list were compiled (although some omissions were apparent regarding active problems and medications). He did obtain KASPERs. He obtained controlled substance consents but, interestingly, most of these were dated either December, 2012 or January, 2013. Enclosed in charts were copies of prescriptions but these appeared to be only for the more recent visits and, otherwise, prescription logs were not a part of the record. On occasion, he did use brief screening tools for addiction. Drugs screens were obtained regularly. And, on occasion, he sought referrals for more complex problems such as pain, orthopaedics, hand surgery, physical therapy, chiropractor, and mental health.

However, in reviewing his capabilities of proper diagnosis, I feel that he fell short primarily as it relates to generally incomplete evaluations. Rarely was a complete physical exam done at the initiation of treatment, an exam which would include a full history including past medical history, past psychiatric history, medication and substance use history, social history, review of systems, and physical examination. As well, during routine and monthly visits evaluations were incomplete. Histories were either absent, limited, or just on the basis of a patient's completed questionnaire. Physical exams were rarely done. Laboratory follow-up was inadequate as it related either to ongoing medical problems or specifics for medication use. During these visits, Dr. Daugherty would fail to recognize signs and symptoms, especially related to current prescription medicine misuse, past histories of medication use, past history of addiction, and current use of substances including alcohol. Commentaries and notifications about patients overusing medications, selling medications, losing medications were not addressed. Drug screens inappropriate for prescriptions provided were not acted upon. Behaviors typically associated with medication misuse and addiction was not acted upon. Added documentation using a variety of diagnostics was either not obtained in order to obtain proper diagnosis and treatment plan, or obtained and not heeded. Consultations were requested, occasionally obtained, but often without follow-through, leading to inadequate diagnosis. The fact that many of these patients presented to Dr. Daugherty with already identified diagnoses and prescriptions for controlled substances does not justify his continuing this treatment plan without reevaluation.

Treatment for these patients failed to address the myriad of problems that existed. All patients were seen for pain or addiction but did have associated medical issues. These medical issues were followed irregularly with inadequate exams that would supplement any patient history provided, and with irregular laboratory screening to monitor these medication problems and medication use. Patients were poorly monitored especially with regard to their behavior, leading to poor treatment.

A major concern relates to the prescribing of controlled substances. All patients had some opioid prescription and, again, if a new patient to Dr. Daugherty, was something that may have been

initiated by a preceding physician. However, these prescriptions for opioids were for non-cancer pain, and associated diagnostics rarely support the need for chronic opioid therapy. As well, these prescriptions were utilized with patients with identified addiction issues, and if not an identified addiction, used in patients with obvious addictive behaviors. Dr. Daugherty failed to intervene when these behaviors presented.

Except for some prescriptions for methadone, most of the opioids were an immediate release formulation and at relatively high doses. This kind of prescribing leads to more frequent misuse and should have been accompanied by a transition to extended release formulations.

Many of the patients were treated for a supposed diagnosis of attention deficit disorder with psychostimulants. None of these diagnoses were well established, as there was no psychological testing or consultation. Again, these stimulants were mostly an immediate release formulation rather than extended release formulation and much more prone to misuse. Many of these prescriptions were provided for the same patients who had identified addictive disorder or behaviors associated with addiction and would, therefore, be considered generally contraindicated.

There were frequent prescriptions for benzodiazepine, always in combination with a variety of other medications including opioids, psychotropics, muscle relaxers, and anticonvulsives potentially leading to toxicity. They were used in patients with comorbid conditions such as COPD, obstructive sleep apnea, as well as addiction, leading to the potential for additional toxicity. The resultant polypharmacy was not so much an issue as to the numbers of pills per prescriptions, but more related to the combinations and utilizations of immediate release formulations.

Lastly, the high dose of opioids led to the potential for high doses of acetaminophen on a daily basis in many of these patients.

Another element in poor prescribing in the addiction population was identified by KASPER reports, which showed prescriptions for buprenorphine in a mono form (that is without naloxone) a form only utilized in exceptional circumstances as it leads to potential misuse. Prescribed frequently for these patients taking buprenorphine were benzodiazepine, again, generally contraindicated in the addiction population.

Records could be summarized as inadequate as history obtained from the patient was limited to often nonexistent and exams were generally nonexistent. Dr. Daugherty failed to provide any general assessment on a visit-by-visit basis in order to summarize the course of treatment, the patients' current status, or give support to any changes that might be made to the treatment plan. As well, treatment plans were quite limited in that they usually just identified medication prescriptions and on occasion diagnostics and suggestions for consultation.

In summary, I feel that Dr. Daugherty misdiagnosed and/or over-diagnosed, under-treated medical issues, over-treated pain issues, over-prescribed a combination of dangerous medications to an at risk population and was therefore a danger to his patients as well as to the community.

Respectfully,

Mark S. Jorrisch, M.D.

MSJ/ked
400072/30526

September 26, 2014

Re. Dr. Joseph Daugherty

Mr. Marshall:
I have completed my review of information provided for Dr. John Daugherty. This includes:

Grievance filed by Kenton County coroner, Dr. David Suetholz
Kasper review report from Paula York, OIG dated 5/6/14
Dr. Daugherty's response, thru counsel, with chart summaries
Kasper report on Dr. Daugherty from 4/28/13-4/28/14
14 medical files on patients of Dr. Daugherty

As a second review I have as requested only included comments from records since 10/1/13. My conclusions are as follows:
1.Yes this physician has engaged in conduct, which departs from or fails to conform to the standards of acceptable medical practice within the Commonwealth of Kentucky.
2. Yes this physician has committed a serious act, or a pattern of acts, during the course of the physician's medical practice, which under the attendant circumstances would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice.
3. Yes, this physician's practice does constitute a danger to the health, welfare, and safety of the physician's patients or the general public.

Re. prescribing:
1. No, the physician did not prescribe or dispense medication with the intent or knowledge that the medication would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose.
2. No, the physician did not prescribe or dispense medication for the licensee's personal use or for the use of his immediate family when the licensee knew or had reason to know that an abuse of controlled substances was occurring, or may result from such practice.
3. Yes, the physician prescribed or dispensed medication in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amount so prescribed or dispensed was excessive under accepted and prevailing medical practice standards.
4. Yes, the physician did engage in conduct, which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky
5. Yes the physician did commit a serious act, or a pattern of acts, during the course of the physician's medical practice which under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice.

A major concern in my view was chart documentation and decision making by Dr. Daugherty. Charts in general were orderly and did have progress notes denoting patient visits. Problem lists were provided but not consistently up to date. Medication lists were available and prominent. Kasper reports were included as part of the chart. Consent forms were not up to date as none appeared to be done since the identified initiation of this review 10/1/13. Drug screens were completed routinely.

However, and consistently, documentation on progress notes was poor and inadequate. Histories were incomplete, did often contain some social identifiers, did on occasion identify new acute problems presented, but regularly did not discuss primary and relevant problems for the specific visit.

Exams did regularly include vital signs. They also (but often absent) had notations re. respiratory and cardiovascular exams. However these were very nonspecific and did not identify any other (positive or negative) findings in his patients. In this population including patients with chronic pain, other chronic medical problems, co-morbid psychiatric disease, no attention was paid to musculoskeletal findings nor to mental status exams in particular and other physical findings pertinent to presenting problems and as well to identified treatment.

Diagnostic were basically limited to drug screens but there was no comment as to diagnostics completed relevant to pain issues and other chronic problems. Even with obtained drug screens findings were often overlooked, not addressed, and even ignored resulting in inadequate patient care.

Patient assessments were frequently missing and/or incomplete. Regularly only pain was addressed. Failure to fully evaluate the patient with proper history, exam and diagnostics would lead to the inadequacy of properly assessing a medical presentation. It identifies a lack of involvement with patients that would lead to inaccurate diagnosis. It identifies lack of thought process in considering patient needs.

Plans were similarly lacking except for medications prescribed. As previously noted, failure to fully assess patients with history, exam and diagnostics would lead to the inability to adequately formulate plans and care for the entire patient. Referrals were alluded to but there was no comment or inclusion in patient care from documentation seen

Utilization from other resources especially mental health (counseling and psychiatry), addiction services, complementary and alternative treatment was rare. Even interventions as simple as diet and exercise were absent and need to be part of especially pain management as well as other chronic medical problems.

Prescribing falls into the same category. In order to properly prescribe and then assess benefit and potential toxicity, enough information needed to be gathered

through history, exam and diagnostics and then thought into assessment. That patients saw benefit from treatment could not be gleaned from Dr. Daugherty's documentation. That patients were not being harmed could also not be determined.

Information from Kasper report review was also problematic. Evident were a large number of patients with prescriptions for varied controlled substances including opiates, benzodiazepines, stimulants. Extended release and immediate release opiates were prescribed concomitantly in many situations. Dose, dosing interval, pharmacies were not obviously a problem. However high dose opiates combined with acetaminophen could have resulted in acetaminophen toxicity and necessitate more caution. Apparent was long term use of opiates by many patients. Some patients were afforded refills on prescriptions, and not seen monthly for new prescriptions as is the usual standard.

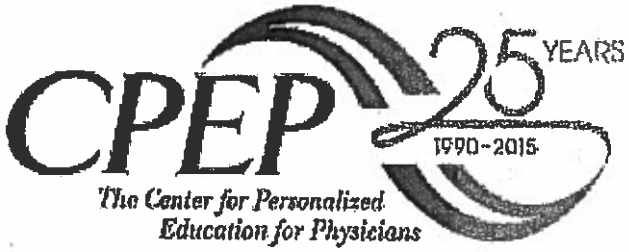
Buprenorphine products were prescribed by Dr. Daugherty. Noticeable were prescriptions for 24 mgs. per day, within normal prescribing, but outside what is now recognized as an excessive dose (16 mgs. maximum) for most patients. Buprenorphine was provided as the mono product (without naloxone) frequently, typically reserved for pregnancy or allergy (which is rare). Patients obtaining prescriptions for buprenorphine were irregular in filing these suggesting inconsistent care in the office. On the other hand some patients were afforded refills of buprenorphine apparently without office visits not the accepted standard. Buprenorphine prescriptions were provided along with benzodiazepine prescriptions, something very unusual, classically contraindicated and dangerous in a population with a diagnosis of addiction (which these patients presumably had). Prescriptions were also combined with stimulants again generally contraindicated in a population with addiction diagnosis without psychiatric input and psychological testing.

Concerns about polypharmacy exist as seen with Kasper review as well as chart review. Combinations of opiates were regularly seen with benzodiazepines and then muscle relaxants (flexeril and zanaflex), anticonvulsants (gabapentin), and other psychotropics potentially leading to toxicity. It is important to note that these are medications often misused and abused in addiction. Other findings including drug screens that were inconsistent for the patient (absent prescribed medication, illicit substances present), and HCV positivity raise concerns that some of these patient had a primary diagnosis of addiction that was missed and then improperly and dangerously treated with controlled substances.

Lastly and difficult to determine with a limited chart review, was finding adequate justification for treating these patients with opioids for noncancer pain and treating them long term with high dose.

Patients reviewed were admittedly complex but resources are available to help with treatment decisions. Because these patients were 'given' to Dr. Daugherty, were in pain, had co-morbid conditions is poor justification for continuing patterns of

treatment that were dangerous and potentially harmful. Due diligence is necessary in obtaining complete patient evaluations including other health care provider consultations to make the best decisions possible.



EDUCATIONAL INTERVENTION PROGRAM

EDUCATION PLAN

Developed September 2015

for

Joseph F. Daugherty, M.D.

NATIONALLY RECOGNIZED ▪ PROVEN LEADER ▪ TRUSTED RESOURCE

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EDUCATION PLAN

OVERVIEW

APPENDICES

I. INTRODUCTION

According to the Kentucky Medical Board of Licensure's Agreed Order dated April 7, 2015, Joseph F. Daugherty, M.D., was ordered to complete a clinical skills Assessment and any subsequent recommended education plan with CPEP. In April 2015, Dr. Daugherty completed an Assessment, which identified areas of educational need. The development of this Education Plan (Plan) was based on those needs. The Plan was also based on data gathered by CPEP and information obtained from Dr. Daugherty. The purpose of this Plan is to provide a framework in which Dr. Daugherty can address his educational needs.

A glossary of Educational Intervention terms is enclosed.

FOCUS OF PLAN

This Plan addresses Dr. Daugherty's practice of outpatient internal medicine as well as pain management, including treatment with Suboxone. If areas of educational need other than those addressed in this Plan are identified while Dr. Daugherty is participating in the Plan, CPEP will notify the referring organization and Dr. Daugherty and determine if the educational needs can be addressed within the context of this Plan.

Important to note:

- Prior to his Assessment, Dr. Daugherty reported to CPEP that he did not consider himself to be a pain management specialist. However, review of documents provided prior to the Assessment showed that Dr. Daugherty had previously been classified as a pain management specialist by the state of Ohio. Based on his reported percentage of patients in his practice for whom he prescribes chronic opioid medications, CPEP would also consider Dr. Daugherty a pain management specialist. Dr. Daugherty's Assessment included evaluation of his pain management care by pain management specialists.

- Dr. Daugherty reported in August 2015 that he will not be resuming the care of chronic pain patients.
  - Although Dr. Daugherty does not intend to resume caring for chronic pain patients, it will be appropriate for him to participate in self-study to address the Medical Knowledge educational needs pertaining to pain management, identified on pages 11-12 of the Assessment Report, so that he is adequately knowledgeable about these topics and when to refer patients for treatment of such conditions.

- Dr. Daugherty also reported in August 2015 that he would like to resume inpatient care; however, this was not addressed during his Assessment. Therefore, should he wish to pursue inpatient care, additional Assessment activities may need to be conducted. This Plan is specific to internal medicine in the outpatient setting only.

LIMITATIONS

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

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

- Pain Management: Address his more immediate educational needs by initially reviewing each patient prescribed controlled substances with the Preceptor prior to patient discharge

from the outpatient setting. He will then progress through decreasing levels of supervision and ultimately see patients independently/unsupervised;
  - Dr. Daugherty will also maintain a controlled substances prescribing log;
- Internal Medicine: Address his more immediate educational needs by initially reviewing all internal medicine patients with the Preceptor within a 48-hour period of time;
- Retrospectively review charts with the Preceptor of patients for whom Dr. Daugherty 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. Daugherty (see *Section V*). The Associate Medical Director will regularly communicate with and provide ongoing feedback and coaching to Dr. Daugherty and the Preceptor with regard to Dr. Daugherty's progress.

II. LEARNING GOALS

A. Medical Knowledge

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

Internal Medicine

1. Comprehensive review of internal medicine;*
2. Routine health maintenance:
   a. Familiarization with United States Preventive Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP) recommendations;
   b. Cervical Cancer:**
      1) Role and use of human papillomavirus (HPV) testing;
      2) Cervical cancer screening: initiation, frequency, cessation;
   c. Breast cancer screening: frequency, prevalence of false-positive findings;
   d. Prostate cancer screening: recommendations, controversies, lead time bias;
   e. Colorectal cancer screening recommendations: initiation of colonoscopy screening, frequency;
   f. Immunizations:**
      1) Pneumovax: indications for booster and timing of the booster dose;
      2) Zostavax: efficacy, indication, type of vaccine;
   g. Lack of indication for regular annual ECG in asymptomatic patients;

3. Cardiology:
   a. ECG interpretation including review of rhythms and patterns suggestive of ischemia and infarction;*
   b. CHADS-2 Score for anticoagulation decision-making in atrial fibrillation;
   c. Blood pressure goals in elderly patients;
   d. Xarelto: risks, contraindications, renal dosing;
   e. Lipid management: new recommendations, including risk factors;
   f. Lack of evidence for screening exercise treadmill tests, especially in female patients;
4. Pulmonology:
   a. Pulmonary embolism:**
      1) Risk factors for pulmonary embolism;
      2) D-dimer testing: predictive value;
      3) Wells score;
      4) Preferred imaging for diagnosis of pulmonary embolism;
   b. Treatment of exercise-induced asthma;
   c. Methods of smoking cessation;
   d. Causes of restrictive lung disease;
   e. Pneumonia severity index to determine which patients should be admitted with pneumonia;
5. Neurology:
   a. Causes and evaluation of dizziness;
   b. Evaluation of left arm pain and numbness;
   c. Role and use of the mini-mental status examination (MMSE) scoring for memory loss;
   d. Evaluation of possible dementia, including but not limited to, vitamin B12 level;
6. Nephrology/Urology:
   a. Monitoring for hyperkalemia when starting an ACE inhibitor in a patient with chronic kidney disease;
   b. Preferred imaging for diagnosis of nephrolithiasis;
   c. Treatment of renal stones with Flomax;
   d. Medication options for urge incontinence and side effects;
7. Hematology:
   a. C-reactive protein (CRP): indications for testing;
   b. Indications for MMA testing;
   c. Use of oral B12 to treat B12 deficiency;
   d. Liver disease as a cause of thrombocytopenia;
   e. Essential thrombocytosis;
8. Endocrinology:
   a. Preventive screening in diabetic patients, including but not limited to retinal exam and foot exam;
   b. Hyperaldosteronism: symptoms, diagnosis;
9. Miscellaneous:
   a. Diagnosis and management of acute sinusitis and acute bronchitis;
   b. Role of intranasal corticosteroids in treatment of allergic rhinitis;
   c. Lab findings such as low mean corpuscular volume in celiac disease.

Pain Management

1. Low-back pain:
   a. Components of physical examination for low-back pain, including but not limited to motor function, sensory function, vascular, deep tendon reflexes, provocative tests;
   b. Indications for CT imaging in musculoskeletal complaints;
   c. Indications for MRI in musculoskeletal complaints;
   d. Spondylolisthesis;
   e. Spinal stenosis;
   f. Indications for epidural steroid injections and facet blocks;
2. Neuropathic pain:
   a. Different types of peripheral neuropathy;
   b. How to make diagnosis of neuropathy;
   c. Neurontin: side effects;
3. Opioid medications:
   a. Equianalgesic dose conversion from morphine to methadone;
   b. Commonly prescribed medications that can cause QT prolongation;
   c. Concerning drug-drug interactions with methadone;
   d. Risk of addiction with long-acting versus short-acting opioids;
   e. Risk of overdose death associated with higher morphine milligram equivalents;
   f. Indications for discontinuing opioids in patients who have been prescribed chronic opioids, including opioid induced hyperalgesia;
   g. Risks of prescribing benzodiazepines concomitantly with opioid medications;
4. Monitoring of patients being prescribed chronic opioid medications:
   a. Recommended components of controlled substance agreement;
   b. Management of aberrant behaviors such as lost prescriptions or running out of medications early;
5. Addiction medicine, including but not limited to:
   a. Suboxone induction:
      1) Decision-making on dosing of Suboxone;
      2) Recommendations for use of the clinical opioid withdrawal scale (COWS) and how to use it;
      3) Management of comorbid psychiatric conditions, including but not limited to depression and anxiety;
   b. Naltrexone: indications, side effects;
   c. Vivitrol: indications, side effects.

*Topic summary not required.
**Subtopics may be combined into one summary; two references required.
(See III.C 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 gather information in an organized and complete fashion;
2. Structured formulation of differential diagnoses;
3. Appropriate evaluation of high-acuity conditions such as chest pain;
4. Appropriate use of consultants such as physical therapy and mental health providers in chronic pain patients;
5. Application of knowledge of monitoring chronic pain patients to actual practice;
6. Appropriate prescribing of controlled substances;
7. Evidence-based practice;
8. Avoidance of iatrogenesis when prescribing of controlled substances in combination (opioids with benzodiazepines);
9. Provide appropriate patient informed consent for patients on among other relevant issues, risk of overdose death when prescribed high morphine equivalent dosages of opioids;
10. Treatment planning – beginning to end;
11. Justification for testing.

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 medication lists and allergy notations that clearly show which medications are current;
2. Clear chronic problem lists;
3. Controlled substance agreements in patients that is relevant;
4. Health maintenance and chronic disease (such as diabetes) flow sheets;
5. Documentation that test results have been reviewed and how and when patients are notified of findings;
6. Consider use of a template that allows adequate room for subjective and objective note components;
7. Adequately detailed history of present illness;
8. Documentation of pertinent positive and negative review of systems;
9. Record of illicit substance use;
10. Appropriately detailed musculoskeletal and neurological examination findings;
11. Notation of differential diagnosis;
12. Documentation of clinical thinking;
13. Record of patient education;
14. Treatment plans that address all conditions;
15. Consistent documentation of follow-up plans.

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. Appropriate quantity of CME relevant to internal medicine;
2. Expanded use of medical content resources, including but not limited to Internet-based resources;
3. If not already in place, consider implementation of a system to allow easy access to information about his patient population for practice improvement opportunities.

E. Physician-Patient Communication Skills

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

1. Improved eye contact;
2. Use of open-ended questions;
3. Establishment of rapport;
4. Use of techniques to demonstrate empathy, including but not limited to, acknowledgement of patient pain and discomfort;
5. Use of transitional statements to signal changes in focus;
6. Use of active listening and increased focus on patient complaints;
7. Provide consistently detailed patient education, including discussion of medication side effects.

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. Daugherty 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

The list of Medical Knowledge topics is extensive; therefore, it will be essential that Dr. Daugherty 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. Daugherty 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. If Dr. Daugherty identifies a course(s) other than those recommended below, he must submit a brochure at least 60 days prior to the course date if the course is date specific.

A. Courses

Dr. Daugherty will:

1. Complete a comprehensive review course, such as the Medical Knowledge Self-Assessment Program (MKSAP) offered by the American College of Physicians. Information can be found at http://www.acponline.org;
2. Attend a medical record keeping seminar within the first two quarters of participation in the Education Plan. If ongoing documentation deficiencies are identified, the Associate Medical Director will make further recommendations. Dr. Daugherty should submit the following to CPEP:
   a. Course brochure within 30 days of signing the Plan for approval;
   b. Certificate of attendance upon completion.
3. Identify and complete a controlled substance prescribing course, approved by the Associate Medical Director prior to enrollment, such as *Prescribing Controlled Drugs*, www.cme.vanderbilt.edu/;
4. Identify and complete a pain management course, approved by the Associate Medical Director prior to enrollment, such as: *Essential Tools for Treating the Patient in Pain*, www.painmed.org/;

   Other course options can be found at:
   http://www.mbp.state.md.us/forms/drug_control_cme_chart.pdf

It will be important for Dr. Daugherty to complete the above-listed courses early in his participation in the Plan rather than later so that he has time to integrate newly learned skills and sufficiently demonstrate his maintenance improvements in charts reviewed.

B. Electrocardiogram Interpretation Activities

Important to note:

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

Dr. Daugherty 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. Daugherty transitioning to independently interpreting ECGs.

C. Evidence-Based Self-Study

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

D. Case-Based Activities

Dr. Daugherty 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:
   http://www.clevelandclinicmeded.com
   www.clinicalcases.org

E. Practice-based Learning

Dr. Daugherty will:

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

F. Systems-based Practice

Dr. Daugherty 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

G. Internet-Based Medical Information Resources

Dr. Daugherty will:

1. Utilize electronic resources at the point of care, such as a handheld device and/or 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.

H. Communication

Dr. Daugherty 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. Choose one of the following (a or b) to complete:
   a. Attend a physician-patient communication course with simulated patient encounters and immediate coaching and feedback. The Associate Medical Director must approve the workshop. A certificate of completion would be submitted to CPEP;
   b. Periodically record (videotape or digital recording) patient encounters and submit the recordings to CPEP to be reviewed by CPEP's communication specialist and receive feedback that he would incorporate for improvements. *Dr. Daugherty would need to have written permission from each patient and each patient must be aware that the recording would be reviewed by CPEP*;
3. After completion of number 2 above, submit to CPEP completed patient questionnaires addressing Dr. Daugherty's communication skills.
   a. The questionnaire and more direction will be provided by CPEP.

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MODULE B
PATIENT CARE ENHANCEMENT

During the activities described in this Module the Preceptor will provide feedback to Dr. Daugherty with regard to improvements in all areas of the Learning Goals. The Preceptor will coach Dr. Daugherty 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 Experiences.
- Once initiated, Preceptor Meetings and chart reviews will continue for the duration of the Plan.

A. Point of Care Experiences – Outpatient Setting and Prescribing

Outpatient Setting

During this experience:

1. Intensive Internal Medicine Chart Review:
   a. For a brief period of time to be determined by the Preceptor and Associate Medical Director, the Preceptor will review all charts within a 48-hour period of time to determine whether adequate information was obtained and whether evaluations and treatment plans were sufficient;
   b. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
2. Consultation:
   a. Dr. Daugherty will manage patients with immediate physician consultation available if needed for approximately one month;*
   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. After seeing patients for three weeks, submit six charts to the Associate Medical Director for review to evaluate Dr. Daugherty's readiness to progress to the Precepted Education Experience addressing outpatient care;
   d. 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 above;
3. Conclusion:
   a. Prior to completion of the above chart reviews, Dr. Daugherty will:
      1) Ensure that the Preceptor speaks with the Associate Medical Director regarding his/her recommendation that this review conclude;

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. Daugherty would receive educational benefit from extending the experience.

**If Dr. Daugherty'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.

Prescribing

If Dr. Daugherty resumes prescribing controlled substances, including but not limited to opioid medications, Suboxone and benzodiazepines, he will:

1. Concurrent Review:
   a. For a period of time to be determined by the Preceptor* and Associate Medical Director, Dr. Daugherty will discuss all patients for whom he is prescribing controlled substances with the Preceptor *prior to the patient leaving the office* to discuss patient evaluation, assessment for risk of abuse/addiction, screening for aberrant behaviors, and potential drug-drug interactions.
2. Subsequently:
   a. For a period of time to be determined by the Preceptor* and Associate Medical Director, Dr. Daugherty will retrospectively review with the Preceptor *all the records* for patients who are prescribed controlled substances *as well as any other medications that are prone to addiction, abuse or diversion.*
3. Controlled Substances Prescribing Log:
   a. Throughout the duration of the Plan, Dr. Daugherty will maintain a controlled substances prescribing log for Preceptor and CPEP review.

*If Dr. Daugherty resumes prescribing of controlled substances, he may need to select a second educational Preceptor if the internal medicine Preceptor does not routinely prescribe controlled substances and manage chronic pain or treat patients with Suboxone.

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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. Daugherty'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 Experiences, Dr. Daugherty will:

1. Meet with the Preceptor(s) weekly for a period to be determined by the Associate Medical Director and then 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. Daugherty provided independent/unsupervised care. Charts as described below should address the Plan Learning Goals as much as possible.

During the Precepted Education, Dr. Daugherty will:

1. Retrospective Chart Reviews:
   a. Submit to the Preceptor for review no fewer than 24 redacted* charts per month (six charts per weekly meeting and 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. Daugherty's practice.**

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. Daugherty 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 internal medicine and pain management 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. Daugherty 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. Daugherty'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. Daugherty will sign and return the Plan to CPEP by September 25, 2015. He will then:
   a. Initiate 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. Daugherty has not already done so;
      1) The Preceptor must be board certified in the same specialty and have a practice similar to Dr. Daugherty'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. By November 1, 2015, Dr. Daugherty will 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. Daugherty 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. Daugherty 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) Controlled Substances Prescribing Log;
      3) Preceptor Report forms completed by the Preceptor;
      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. 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. Daugherty 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. Daugherty and to other entities for which Dr. Daugherty has provided authorization. The Progress Reports will capture Dr. Daugherty'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. Daugherty 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. Daugherty's scope of practice. (See Section 5.1(e) of the CPEP *Educational Intervention Participation Agreement* for more information.)

- Dr. Daugherty will schedule the Evaluation no sooner than two months, and no later than four months, following notification from CPEP that he 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.

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- 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. Daugherty does not engage in this Plan by September 21, 2016, CPEP may require completion of additional Assessment activities to ensure that Dr. Daugherty's current educational needs are addressed.

SIGNATURES

Joseph F. Daugherty, M.D. — Date: 9.17.15

Daniel J. Shamburek, M.D.
Associate Medical Director — Date: 9/28/15

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

Joseph F. Daugherty, M.D.

Dr. Daugherty provided the following information to CPEP in March 2015. He should notify CPEP of any changes to his profile while participating in the Plan.

Specialty

Internal Medicine

Licensure

Licensing State	Status
Kentucky	Active with restrictions
Ohio	Active with restrictions

Practice Setting

Outpatient

Practice Profile: To Be Determined

Previously: Dr. Daugherty worked five days per week, saw approximately 24 patients per day in the office, did not treat patients in the hospital setting, and did not take call.

Volume of patients per day:
Number of days worked per week:
Number of patients admitted per month:
Census of inpatients per month: N/A
Number of days on-call per month:

Commonly Encountered Diagnoses:
Previously: Diabetes, hypertension, back pain, neuropathy, arthritis, sinusitis, bronchitis, obesity, anxiety, depression, bipolar, attention deficit disorder, hepatitis C, hypothyroidism, congestive heart failure, edema, hyperuricemia, headache

Outpatient Procedures: Previously: N/A

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 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 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 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 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. 1649

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH F. DAUGHERTY, M.D., LICENSE NO. 22022, 1045 JACKSON ROAD, PARK HILLS, KENTUCKY 41011-1911

AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, and Joseph F. Daugherty, M.D. ("the licensee"), and, based upon their mutual desire to fully and finally resolve this pending grievance without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER**:

STIPULATIONS OF FACT

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

1. At all relevant times, Joseph F. Daugherty, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's specialty is internal medicine.
3. On July 11, 2012, the State Medical Board of Ohio (hereafter "the Ohio Board") issued a notice of intent to take action against the licensee's Ohio medical license, in Case No. 12-CRF-058, alleging,

> From on or about August 2010 to the present, you undertook the care of Patients 1-6.... In regards to Patients 1-6, you failed to appropriately physically examine patients and diagnose medical conditions and/or document appropriate physical examination of patients and diagnosing of medical conditions before prescribing Schedule II controlled substances.

4. On December 12, 2012, the licensee entered into a Consent Agreement with the Ohio Board resolving Case No. 12-CRF-058, in which the licensee "...admits to

the factual and legal allegations contained in the July 2012 Notice, a copy of which is attached hereto and incorporated herein as Exhibit A." Under the terms of the Consent Agreement, the licensee's Ohio medical license is suspended "for an indefinite period, but not less than 90 days." The Consent Agreement sets out specific conditions for reinstatement and specific terms of probation to be implemented if and when his Ohio license is reinstated.

5. By letter dated December 24, 2012, the licensee notified this Board of the entry and terms of the Ohio Consent Agreement, as required by that Agreement.
6. On March 14, 2013, the parties entered into an Agreed Order of Suspension and Probation, as required by 201 KAR 9:081, Section 9(4)(c). Condition 2b of that Agreed Order specified, in part, "...Once the Panel receives written verification that the Ohio Board has reinstated his Ohio license, the Panel or its Chair will promptly enter into an Amended Agreed Order of Probation with the licensee to reinstate his Kentucky license."
7. In April 2013, after the Board has received written verification that the Ohio Board reinstated the licensee's Ohio license, effective March 13, 2013, the Panel Chair approved the licensee to practice at Daugherty Medical Group in Florence, KY, Bellevue, KY and Cincinnati, Ohio, pursuant to terms and conditions set forth in an Amended Agreed Order of Probation. Revisions of the licensee's practice hours at his offices located in Kentucky were further made pursuant to terms and conditions set forth in a second and then a Third Amended Agreed Order of Probation.

8. An investigation into the licensee's prescribing practices in Kentucky was initiated after the Kenton County Coroner reported to the Board that one of the licensee's patients, Patient A, had died of an overdose and that it appeared that the patient had been going to multiple doctors.

9. At the Board's request, the Office of Inspector General Division of Audits and Investigations ("OIG"), analyzed the licensee's prescribing patterns and noted the following concerns:

    - long-term use of one or more controlled substances;
    - combinations of controlled substances favored by persons who abuse or divert controlled substances;
    - family members obtaining the same or similar medications;
    - young patients receiving high doses of narcotics

    OIG referred fifteen (15) patient names (including Patient A) illustrative of these concerns for further review.

10. In or about December 2013, a Board consultant reviewed the licensee's records and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices; committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance and gross negligence; prescribed or dispensed medications in such amounts that he knew or had reason to know that the amounts were excessive under accepted and prevailing medical practice standards; and that his practice constitutes a danger to the health, welfare and safety of his patients and the public. The consultant stated, in part,

    > ... in reviewing his capabilities of proper diagnosis, I feel that he fell short primarily as it relates to generally incomplete evaluations.

> Rarely was a complete physical exam done at the initiation of treatment … As well, during routine and monthly visits evaluations were incomplete… Physical exams were rarely done. Laboratory follow-up was inadequate as it related either to ongoing medical problems or specifics for medication use. During these visits, Dr. Daugherty would fail to recognize signs and symptoms, especially related to current prescription medicine misuse, past histories of medication use, past history of addiction, and current use of substances including alcohol. Commentaries and notifications about patients overusing medications, selling medications, losing medications were not addressed. Drug screens inappropriate for prescriptions provided were not acted upon. Behaviors typically associated with mediation misuse and addiction was not acted upon.
> …
> …
> A major concern relates to the prescribing of controlled substances. All patients had some opioid prescription … these prescriptions were for non-cancer pain, and associated diagnostics rarely support the need for choric opioid therapy. As well, these prescriptions were utilized with patients with identified addiction issues, and if not an identified addiction, used in patients with obvious addictive behaviors. Dr. Daugherty failed to intervene when these behaviors presented.
> …

(The consultant's report is attached and incorporated herein.)

11. On or about January 24, 2014, the licensee responded, through counsel, to the Board consultant's report, stating in part that

> … As the Board is aware, Dr. Daugherty entered into a Consent Decree with the Ohio Medical Board in December 2012. The grounds for discipline in Ohio are similar to the deficiencies found by the consultant. In addition, many of the chart entries reviewed by the consultant overlap in time with the six charts at issue in the Ohio action (2012-2012). Likewise, most of the chart entries reviewed by the consultant predate remedial steps taken by Dr. Daugherty to address the similar issues in Ohio…

12. On or about April 17, 2014, the Panel reviewed the above information and chose to defer action pending another consultant review.

13. On or about May 6, 2014, at the Board's request, the Office of Inspector General Division of Audits and Investigations ("OIG"), analyzed the licensee's prescribing patterns and noted the following concerns:

- long-term use of one or more controlled substances;
- combinations of controlled substances favored by persons who abuse or divert controlled substances;
- patients traveling long distances to obtain medications;
- family members obtaining the same or similar medications;
- young patients receiving high doses of narcotics

OIG referred fourteen (14) patient names illustrative of these concerns for further review.

14. On or about September 2014, a Board consultant reviewed the licensee's records and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices; committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice; prescribed or dispensed medications in such amounts that he knew or had reason to know that the amounts were excessive under accepted and prevailing medical practice standards; and that his practice constitutes a danger to the health, welfare and safety of his patients and the public. The consultant stated, in part,

> ... A major concern in my view was chart documentation and decision making by Dr. Daugherty. ... [D]ocumentation on progress notes was poor and inadequate. Histories were incomplete, did often contain some social identifiers, did on occasion identify new acute problems presented, but regularly did not discuss primary and relevant problems for the specific visit.
>
> ... in this population, including patients with chronic pain, other chronic medical problems, co-morbid psychiatric disease, no

attention was paid to musculoskeletal findings nor to mental status exams in particular and other physical findings pertinent to presenting problems and as well to identified treatment.

Diagnostic were basically limited to drug screens but there was no comment as to diagnostics completed relevant top pain issues and other chronic problems. Even with obtained drug screens findings were often overlooked, not addressed and even ignored resulting in inadequate patient care.

Patient assessments were frequently missing and/or incomplete. Regularly only pain was addressed. Failure to fully evaluate the patient with proper history, exam and diagnostics would lead to the inadequacy of properly assessing a medical presentation. It identifies a lack of involvement with patients that would lead to inaccurate diagnosis. It identifies lack of thought process in considering patient needs.

Plans were similarly lacking except for medications prescribed. …
…
Information from KASPER report review was also problematic. Evident were a large number of patients with prescriptions for varied controlled substances including opiates, benzodiazepines, stimulants. Extended release and immediate release opiates were prescribed concomitantly in many situations. … [H]igh dose opiates combined with acetaminophen could have resulted in acetaminophen toxicity and necessitate more caution. Apparent was long-term use of opiates by many patients. Some patients were afforded refills on prescriptions and not seen monthly for new prescriptions as is the usual standard.

Buprenorphine products were prescribed by Dr. Daugherty. Noticeable were prescriptions for 24 mgs per day, within normal prescribing, but outside what is now recognized as an excessive dose for most patients. Buprenorphine was provided as the mono product frequently, typically reserved for pregnancy or allergy (which is rare). Patients obtaining prescriptions for buprenorphine were irregular in filling these suggesting inconsistent care in the office. On the other hand some patients were afforded refills of buprenorphine apparently without office visits not the accepted standard. Buprenorphine prescriptions were provided along with benzodiazepine prescriptions, something very unusual, classically contraindicated and dangerous in a population with a diagnosis of addiction (which these patients presumably had). Prescriptions were also combined with stimulants again generally contraindicated in a

> population with addiction diagnosis without psychiatric input and psychological testing.
>
> Concerns about polypharmacy exist as seen with Kasper review as well as chart review. Combinations of opiates were regularly seen with benzodiazepines and then muscle relaxants (flexeril and zanaflex), anticonvulsants (gabapentin) and other psychotropics potentially leading to toxicity. It is important to note that these are medications often misused and abused in addiction. Other findings including drug screens that were inconsistent for the patient (absent prescribed medication, illicit substances present) and HCV positivity raise concerns that some of these patients had a primary diagnosis of addiction that was missed and then improperly and dangerously treated with controlled substances.
>
> Lastly and difficult to determine with a limited chart review, was finding adequate justification for treating these patients with opioids for noncancer pain and treating them long term with high dose.
> ...

(The consultant's report is attached and incorporated herein.)

15. On or about November 12, 2014, the licensee responded, through counsel, to the Board consultant's report, stating in part that

> ... Clearly, Dr. Daugherty is disappointed that the consultant does not discern the rationale for his decisions related to diagnosis and treatment from the patient charts under review. Whereas the rationale may not be evident in his charting, Dr. Daugherty's medical decision-making is grounded in sound medical knowledge and reasoning. With that said, Dr. Daugherty understands that it is his responsibility to clearly document the information that he relies upon in caring for patients, and that it is problematic if the reviewer cannot discern this information. ...

16. On or about November 16, 2014, the Board consultant reviewed the licensee's response and stated that he did not change his opinions as stated in his original review and, in fact, had become "more concerned that there may be a need for more immediacy in action" because the licensee's "comments, justifications and

rationalizations suggest truly a failure to recognize and accept that his own practice is dangerous and veers significantly from current standards."

17. On March 19, 2015, the Board's Inquiry Panel A reviewed the investigation and the licensee appeared with counsel and was heard by the Panel before it deliberated. The Panel and the licensee agree to enter into this Agreed Order, in lieu of the issuance of a Complaint and Emergency Order of Suspension.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. While the licensee denies any wrongdoing, he acknowledges that, based upon the Stipulations of Fact, the Hearing Panel could conclude that he has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.
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.

AGREED ORDER

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:**

1. The license to practice medicine in the Commonwealth of Kentucky held by JOSEPH F. DAUGHERTY, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;

2. During the effective period of this Agreed Order, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION until further order of the Board:

    a. The licensee SHALL NOT perform any act within the Commonwealth of Kentucky that constitutes the "practice of medicine," 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;

    b. Within twenty (20) days of the filing of this Agreed Order, the licensee SHALL contact the Center for Personalized Education for Physicians ("CPEP"), 720 South Colorado Boulevard, Suite 1100-N, Denver, Colorado 80246, Tel. (303) 577-3232 Fax: (303) 577-3241, to schedule a clinical skills assessment for the earliest dates available to both CPEP and the licensee;

        i. Both parties may provide relevant information to CPEP for consideration as part of the clinical skills assessment. In order to permit the Board to provide such relevant information, the licensee SHALL immediately notify the Board's Legal Department of the assessment dates once the assessment is scheduled;

        ii. The licensee SHALL travel to CPEP and complete the assessment as scheduled, at his expense;

        iii. The licensee expressly understands and agrees that CPEP will issue its final Assessment Report, in accordance with its internal policies;

iv. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of the Assessment Report to the Board's Legal Department promptly after its completion;

v. If the Assessment Report recommends development of an Educational Plan, the licensee SHALL take all necessary steps to arrange for CPEP to immediately develop such a plan, at the licensee's expense, so that the proposed Educational Plan may be presented to the Panel for review along with the Assessment Report;

vi. The licensee expressly understands and agrees that if the CPEP Assessment Report recommends that the licensee retrain in a residency or residency-like setting, 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 approved to do so by the Panel;

vii. If the CPEP Assessment Report recommends that the licensee retrain in a residency or residency-like setting, the Panel shall neither modify nor terminate this Agreed Order unless and until he completes a residency or residency-like program and obtains a CPEP clinical skills assessment demonstrating that he is competent to engage in the "practice of medicine or osteopathy" without additional education;

c. The licensee SHALL pay the costs of the investigation in the amount of $2,375.00 within six (6) months from the date of entry of this Agreed Order; and

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

3. The licensee expressly understands and agrees that the Panel will not consider a request to resume the practice of medicine unless and until he has ensured that CPEP has provided copies of its assessment and education plan, if so recommended, to the Panel for review.

4. The licensee expressly understands and agrees that if the Panel should grant the licensee's request to resume the practice of medicine in the future, it will do so by an Amended Agreed Order, which shall incorporate the terms of the Third Amended Agreed Order of Probation (Case No. 1463), filed November 6, 2013, and at least require that:

    a. The licensee shall successfully complete the CPEP Educational Plan, if one has been recommended and developed, at his expense and as directed by CPEP;

    b. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized and shall provide for at least two (2) favorable consultant reviews of the log and relevant records by Board agents before the order may be terminated;

    c. The licensee fully comply with the provisions of 201 KAR 9:260, Professional Standards for Prescribing or Dispensing Controlled Substances and the professional standards applicable to the licensee's specialty; and

    d. Any other conditions deemed necessary by the Panel or Panel Chair at that time.

5. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order, 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, 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 Agreed

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.

6. The licensee understands and agrees that any violation of the terms of this Agreed Order 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.

SO AGREED on this 7th day of April, 2015.

FOR THE LICENSEE:

JOSEPH F. DAUGHERTY, M.D.

BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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

LEANNE K. DIAKOV
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

December 1, 2013

Jon Marshall
Kentucky Board of Medical Licensure
310 Whittington Pkwy., Ste. 1B
Louisville, KY 40222

Re: Consultation on Joseph Daugherty, M.D.

Dear Mr. Marshall:

I have reviewed the following materials:

1. Grievance filed by Kenton County Coroner, Dr. David Suetholz
2. KASPER report from Paula York, Office of Inspector General
3. Investigative report
4. Dr. Daugherty's response, through counsel, with short summaries
5. KASPER report on Dr. Daugherty from 06/01/2011 to 05/17/2013
6. Fifteen medical files on patients of Dr. Daugherty

In response to your questions:

1. Yes, the named physician engaged in conduct, which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.
2. Yes, the named physician committed a serious act, or a pattern of acts, during the course of the physician's medical practice which under the intended circumstances would be deemed to be gross incompetence, gross ignorance, and gross negligence.
3. Yes, the physician's practice constitutes danger to the health, welfare and safety of the physician's patients and general public.

In regard to prescribing:

1. No, the named physician did not prescribe or dispense medications with the intent or knowledge that the medication would be used, or is likely to be used, other than medicinally or other than for an accepted therapeutic purpose.

2. No, the named physician did not prescribe or dispense medications for the licensee's personal use, or for the use of his immediate family, when the licensee knew or had reason to know that an abuse of controlled substances was occurring or may result from such practice.
3. Yes, the named physician did prescribe or dispense medications in such amounts that the licensee knew or had reason to know under the intended circumstances that set amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards.
4. Yes, the named physician did engage in conduct which departs from, or fails to conform to, the standards of acceptable of prevailing medical practice within the Commonwealth of Kentucky.
5. Yes, the named physician committed a serious act, or pattern of acts, during the course of his medical practice, which under the intended circumstances, would be deemed to be gross incompetence, gross ignorance, and gross negligence.

In reviewing the case files provided, I found that Dr. Daugherty did see his patients regularly, usually monthly. Problem list and medication list were compiled (although some omissions were apparent regarding active problems and medications). He did obtain KASPERs. He obtained controlled substance consents but, interestingly, most of these were dated either December, 2012 or January, 2013. Enclosed in charts were copies of prescriptions but these appeared to be only for the more recent visits and, otherwise, prescription logs were not a part of the record. On occasion, he did use brief screening tools for addiction. Drugs screens were obtained regularly. And, on occasion, he sought referrals for more complex problems such as pain, orthopaedics, hand surgery, physical therapy, chiropractor, and mental health.

However, in reviewing his capabilities of proper diagnosis, I feel that he fell short primarily as it relates to generally incomplete evaluations. Rarely was a complete physical exam done at the initiation of treatment, an exam which would include a full history including past medical history, past psychiatric history, medication and substance use history, social history, review of systems, and physical examination. As well, during routine and monthly visits evaluations were incomplete. Histories were either absent, limited, or just on the basis of a patient's completed questionnaire. Physical exams were rarely done. Laboratory follow-up was inadequate as it related either to ongoing medical problems or specifics for medication use. During these visits, Dr. Daugherty would fail to recognize signs and symptoms, especially related to current prescription medicine misuse, past histories of medication use, past history of addiction, and current use of substances including alcohol. Commentaries and notifications about patients overusing medications, selling medications, losing medications were not addressed. Drug screens inappropriate for prescriptions provided were not acted upon. Behaviors typically associated with medication misuse and addiction was not acted upon. Added documentation using a variety of diagnostics was either not obtained in order to obtain proper diagnosis and treatment plan, or obtained and not heeded. Consultations were requested, occasionally obtained, but often without follow-through, leading to inadequate diagnosis. The fact that many of these patients presented to Dr. Daugherty with already identified diagnoses and prescriptions for controlled substances does not justify his continuing this treatment plan without reevaluation.

Treatment for these patients failed to address the myriad of problems that existed. All patients were seen for pain or addiction but did have associated medical issues. These medical issues were followed irregularly with inadequate exams that would supplement any patient history provided, and with irregular laboratory screening to monitor these medication problems and medication use. Patients were poorly monitored especially with regard to their behavior, leading to poor treatment.

A major concern relates to the prescribing of controlled substances. All patients had some opioid prescription and, again, if a new patient to Dr. Daugherty, was something that may have been

initiated by a preceding physician. However, these prescriptions for opioids were for non-cancer pain, and associated diagnostics rarely support the need for chronic opioid therapy. As well, these prescriptions were utilized with patients with identified addiction issues, and if not an identified addiction, used in patients with obvious addictive behaviors. Dr. Daugherty failed to intervene when these behaviors presented.

Except for some prescriptions for methadone, most of the opioids were an immediate release formulation and at relatively high doses. This kind of prescribing leads to more frequent misuse and should have been accompanied by a transition to extended release formulations.

Many of the patients were treated for a supposed diagnosis of attention deficit disorder with psychostimulants. None of these diagnoses were well established, as there was no psychological testing or consultation. Again, these stimulants were mostly an immediate release formulation rather than extended release formulation and much more prone to misuse. Many of these prescriptions were provided for the same patients who had identified addictive disorder or behaviors associated with addiction and would, therefore, be considered generally contraindicated.

There were frequent prescriptions for benzodiazepine, always in combination with a variety of other medications including opioids, psychotropics, muscle relaxers, and anticonvulsives potentially leading to toxicity. They were used in patients with comorbid conditions such as COPD, obstructive sleep apnea, as well as addiction, leading to the potential for additional toxicity. The resultant polypharmacy was not so much an issue as to the numbers of pills per prescriptions, but more related to the combinations and utilizations of immediate release formulations.

Lastly, the high dose of opioids led to the potential for high doses of acetaminophen on a daily basis in many of these patients.

Another element in poor prescribing in the addiction population was identified by KASPER reports, which showed prescriptions for buprenorphine in a mono form (that is without naloxone) a form only utilized in exceptional circumstances as it leads to potential misuse. Prescribed frequently for these patients taking buprenorphine were benzodiazepine, again, generally contraindicated in the addiction population.

Records could be summarized as inadequate as history obtained from the patient was limited to often nonexistent and exams were generally nonexistent. Dr. Daugherty failed to provide any general assessment on a visit-by-visit basis in order to summarize the course of treatment, the patients' current status, or give support to any changes that might be made to the treatment plan. As well, treatment plans were quite limited in that they usually just identified medication prescriptions and on occasion diagnostics and suggestions for consultation.

In summary, I feel that Dr. Daugherty misdiagnosed and/or over-diagnosed, under-treated medical issues, over-treated pain issues, over-prescribed a combination of dangerous medications to an at risk population and was therefore a danger to his patients as well as to the community.

Respectfully,

Mark S. Jorrisch, M.D.

MSJ/ked
400072/30526

September 26, 2014

Re. Dr. Joseph Daugherty

Mr. Marshall:
I have completed my review of information provided for Dr. John Daugherty. This includes:

Grievance filed by Kenton County coroner, Dr. David Suetholz
Kasper review report from Paula York, OIG dated 5/6/14
Dr. Daugherty's response, thru counsel, with chart summaries
Kasper report on Dr. Daugherty from 4/28/13-4/28/14
14 medical files on patients of Dr. Daugherty

As a second review I have as requested only included comments from records since 10/1/13. My conclusions are as follows:
1.Yes this physician has engaged in conduct, which departs from or fails to conform to the standards of acceptable medical practice within the Commonwealth of Kentucky.
2. Yes this physician has committed a serious act, or a pattern of acts, during the course of the physician's medical practice, which under the attendant circumstances would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice.
3. Yes, this physician's practice does constitute a danger to the health, welfare, and safety of the physician's patients or the general public.

Re. prescribing:
1. No, the physician did not prescribe or dispense medication with the intent or knowledge that the medication would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose.
2. No, the physician did not prescribe or dispense medication for the licensee's personal use or for the use of his immediate family when the licensee knew or had reason to know that an abuse of controlled substances was occurring, or may result from such practice.
3. Yes, the physician prescribed or dispensed medication in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amount so prescribed or dispensed was excessive under accepted and prevailing medical practice standards.
4. Yes, the physician did engage in conduct, which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky
5. Yes the physician did commit a serious act, or a pattern of acts, during the course of the physician's medical practice which under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice.

A major concern in my view was chart documentation and decision making by Dr. Daugherty. Charts in general were orderly and did have progress notes denoting patient visits. Problem lists were provided but not consistently up to date. Medication lists were available and prominent. Kasper reports were included as part of the chart. Consent forms were not up to date as none appeared to be done since the identified initiation of this review 10/1/13. Drug screens were completed routinely.

However, and consistently, documentation on progress notes was poor and inadequate. Histories were incomplete, did often contain some social identifiers, did on occasion identify new acute problems presented, but regularly did not discuss primary and relevant problems for the specific visit.

Exams did regularly include vital signs. They also (but often absent) had notations re. respiratory and cardiovascular exams. However these were very nonspecific and did not identify any other (positive or negative) findings in his patients. In this population including patients with chronic pain, other chronic medical problems, co-morbid psychiatric disease, no attention was paid to musculoskeletal findings nor to mental status exams in particular and other physical findings pertinent to presenting problems and as well to identified treatment.

Diagnostic were basically limited to drug screens but there was no comment as to diagnostics completed relevant to pain issues and other chronic problems. Even with obtained drug screens findings were often overlooked, not addressed, and even ignored resulting in inadequate patient care.

Patient assessments were frequently missing and/or incomplete. Regularly only pain was addressed. Failure to fully evaluate the patient with proper history, exam and diagnostics would lead to the inadequacy of properly assessing a medical presentation. It identifies a lack of involvement with patients that would lead to inaccurate diagnosis. It identifies lack of thought process in considering patient needs.

Plans were similarly lacking except for medications prescribed. As previously noted, failure to fully assess patients with history, exam and diagnostics would lead to the inability to adequately formulate plans and care for the entire patient. Referrals were alluded to but there was no comment or inclusion in patient care from documentation seen

Utilization from other resources especially mental health (counseling and psychiatry), addiction services, complementary and alternative treatment was rare. Even interventions as simple as diet and exercise were absent and need to be part of especially pain management as well as other chronic medical problems.

Prescribing falls into the same category. In order to properly prescribe and then assess benefit and potential toxicity, enough information needed to be gathered

through history, exam and diagnostics and then thought into assessment. That patients saw benefit from treatment could not be gleaned from Dr. Daugherty's documentation. That patients were not being harmed could also not be determined.

Information from Kasper report review was also problematic. Evident were a large number of patients with prescriptions for varied controlled substances including opiates, benzodiazepines, stimulants. Extended release and immediate release opiates were prescribed concomitantly in many situations. Dose, dosing interval, pharmacies were not obviously a problem. However high dose opiates combined with acetaminophen could have resulted in acetaminophen toxicity and necessitate more caution. Apparent was long term use of opiates by many patients. Some patients were afforded refills on prescriptions, and not seen monthly for new prescriptions as is the usual standard.

Buprenorphine products were prescribed by Dr. Daugherty. Noticeable were prescriptions for 24 mgs. per day, within normal prescribing, but outside what is now recognized as an excessive dose (16 mgs. maximum) for most patients. Buprenorphine was provided as the mono product (without naloxone) frequently, typically reserved for pregnancy or allergy (which is rare). Patients obtaining prescriptions for buprenorphine were irregular in filing these suggesting inconsistent care in the office. On the other hand some patients were afforded refills of buprenorphine apparently without office visits not the accepted standard. Buprenorphine prescriptions were provided along with benzodiazepine prescriptions, something very unusual, classically contraindicated and dangerous in a population with a diagnosis of addiction (which these patients presumably had). Prescriptions were also combined with stimulants again generally contraindicated in a population with addiction diagnosis without psychiatric input and psychological testing.

Concerns about polypharmacy exist as seen with Kasper review as well as chart review. Combinations of opiates were regularly seen with benzodiazepines and then muscle relaxants (flexeril and zanaflex), anticonvulsants (gabapentin), and other psychotropics potentially leading to toxicity. It is important to note that these are medications often misused and abused in addiction. Other findings including drug screens that were inconsistent for the patient (absent prescribed medication, illicit substances present), and HCV positivity raise concerns that some of these patient had a primary diagnosis of addiction that was missed and then improperly and dangerously treated with controlled substances.

Lastly and difficult to determine with a limited chart review, was finding adequate justification for treating these patients with opioids for noncancer pain and treating them long term with high dose.

Patients reviewed were admittedly complex but resources are available to help with treatment decisions. Because these patients were 'given' to Dr. Daugherty, were in pain, had co-morbid conditions is poor justification for continuing patterns of

treatment that were dangerous and potentially harmful. Due diligence is necessary in obtaining complete patient evaluations including other health care provider consultations to make the best decisions possible.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1463

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH F. DAUGHERTY, III, M.D., LICENSE NO. 22022, 1045 JACKSON ROAD, PARK HILLS, KENTUCKY 41011

THIRD AMENDED AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through the Chair of its Inquiry Panel A, and Joseph F. Daugherty, III, M.D. ("the licensee"), and, based upon the Panel Chair's approval the licensee's recent practice location request, hereby ENTER INTO the following **THIRD AMENDED AGREED ORDER OF PROBATION**:

STIPULATIONS OF FACT

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

1. At all relevant times, Joseph F. Daugherty, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Internal Medicine.
3. On July 11, 2012, the State Medical Board of Ohio (hereafter "the Ohio Board") issued a notice of intent to take action against the licensee's Ohio medical license, in Case No. 12-CRF-058, alleging,

   > From on or about August 2010 to the present, you undertook the care of Patients 1-6.... In regards to Patients 1-6, you failed to appropriately physically examine patients and diagnose medical conditions and/or document appropriate physical examination of patients and diagnosing of medical conditions before prescribing Schedule II controlled substances.

4. On December 12, 2012, the licensee entered into a Consent Agreement with the Ohio Board resolving Case No. 12-CRF-058, in which the licensee "...admits to the factual and legal allegations contained in the July 2012 Notice, a copy of which is attached hereto and incorporated herein as Exhibit A." Under the terms of the Consent Agreement, the licensee's Ohio medical license is suspended "for an indefinite period, but not less than 90 days." The Consent Agreement sets out specific conditions for reinstatement and specific terms of probation to be implemented if and when his Ohio license is reinstated.
5. By letter dated December 24, 2012, the licensee notified this Board of the entry and terms of the Ohio Consent Agreement, as required by that Agreement.
6. On March 14, 2013, the parties entered into an Agreed Order of Suspension and Probation, as required by 201 KAR 9:081, Section 9(4)(c). Condition 2b of that Agreed Order specified, in part, "...Once the Panel receives written verification that the Ohio Board has reinstated his Ohio license, the Panel or its Chair will promptly enter into an Amended Agreed Order of Probation with the licensee to reinstate his Kentucky license."
7. The Board has received written verification that the Ohio Board reinstated the licensee's Ohio license effective March 13, 2013.
8. In April 2013, the Panel Chair approved the licensee to practice at Daugherty Medical Group in Florence, KY, Bellevue, KY and Cincinnati, Ohio, pursuant to terms and conditions set forth in the Amended Agreed Order of Probation filed April 11, 2013.

9. In September 2013, the Panel Chair approved the revisions of the licensee's practice hours at his offices located in Kentucky, pursuant to terms and conditions set forth in the Second Amended Agreed Order of Probation filed of record September 19, 2013.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's medical 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(17) and (9), as illustrated by KRS 311.597(4). Accordingly, there were legal grounds for the parties to enter into the Agreed Order of Suspension and Probation. Those grounds continue to provide a legal basis for this Third Amended Agreed Order of Probation.
3. 201 KAR 9:081, Section 9(4)(c) provides,

   If a licensee has had disciplinary action taken against or sanctions imposed upon the licensee's license to practice medicine or osteopathy in any state, the appropriate panel:
   1a. Shall, at a minimum, impose the same substantive sanctions as a disciplinary sanction against the licensee's Kentucky license; and,
   b. May take any appropriate additional disciplinary action against the licensee, or
   2. Shall, or in lieu of the minimum sanction, the panel may revoke the license based upon the facts available to the panel at the time of action.
4. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally address the licensee's new request for a revision in practice hours at his Kentucky location without an evidentiary hearing by entering into an informal resolution such as this Third Amended Agreed Order of Probation.

THIRD AMENDED AGREED ORDER OF PROBATION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the Panel Chair's approval of the licensee's request for a revision in practice hours at his Kentucky location, the parties hereby ENTER INTO the following **THIRD AMENDED AGREED ORDER OF PROBATION:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Joseph F. Daugherty, III, M.D., SHALL BE SUBJECT to this Third Amended Agreed Order of Probation for the remainder of the original period of five (5) years, ending on March 13, 2018.
2. The licensee's Kentucky license is hereby CONTINUED ON PROBATION for the remainder of the five (5) period of the original Agreed Order, SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS, which are effective immediately upon the date of filing of this Third Amended Agreed Order and continue until March 13, 2018 or further Order of the Panel:
    a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine," 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.

b. 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.

c. The licensee is approved to practice medicine, during scheduled office hours, at the following location: 11 Spiral Drive, Florence, Kentucky 41042 (Mondays 8:30 a.m – 9:00 p.m.; Tuesdays 9:00 a.m. – 7:00 p.m.; Wednesdays 9:00 a.m. – 5:30 p.m.; Thursdays 9:00 a.m. – 7:00 p.m.; and Fridays 8:30 a.m. – 5:30 p.m.).

d. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions

should be maintained in the following manner: 1) patient; 2) chart; and 3) log.

e. 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.

f. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Third 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 Third Amended Agreed Order of Probation.

g. The licensee understands and agrees that at least one favorable consultant review must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Third Amended Agreed Order of Probation.

h. 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 Third 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 Third 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 Third Amended Agreed Order of Probation 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 Third Amended Agreed Order of Probation.

4. The licensee understands and agrees that any violation of the terms of this Third 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 without a license.

SO AGREED on this 1st day of Nov, 2013.

FOR THE LICENSEE:

JOSEPH F. DAUGHERTY, III, M.D.

Mary K Molloy

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

C. William Briscoe MD.

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

C. Lloyd Vest II

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1463

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH F. DAUGHERTY, III, M.D., LICENSE NO. 22022, 1045 JACKSON ROAD, PARK HILLS, KENTUCKY 41011

SECOND AMENDED AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through the Chair of its Inquiry Panel A, and Joseph F. Daugherty, III, M.D. ("the licensee"), and, based upon the Panel Chair's approval the licensee's recent practice location request, 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, Joseph F. Daugherty, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Internal Medicine.
3. On July 11, 2012, the State Medical Board of Ohio (hereafter "the Ohio Board") issued a notice of intent to take action against the licensee's Ohio medical license, in Case No. 12-CRF-058, alleging,

   > From on or about August 2010 to the present, you undertook the care of Patients 1-6.... In regards to Patients 1-6, you failed to appropriately physically examine patients and diagnose medical conditions and/or document appropriate physical examination of patients and diagnosing of medical conditions before prescribing Schedule II controlled substances.

4. On December 12, 2012, the licensee entered into a Consent Agreement with the Ohio Board resolving Case No. 12-CRF-058, in which the licensee "...admits to the factual and legal allegations contained in the July 2012 Notice, a copy of which is attached hereto and incorporated herein as Exhibit A." Under the terms of the Consent Agreement, the licensee's Ohio medical license is suspended "for an indefinite period, but not less than 90 days." The Consent Agreement sets out specific conditions for reinstatement and specific terms of probation to be implemented if and when his Ohio license is reinstated.
5. By letter dated December 24, 2012, the licensee notified this Board of the entry and terms of the Ohio Consent Agreement, as required by that Agreement.
6. On March 14, 2013, the parties entered into an Agreed Order of Suspension and Probation, as required by 201 KAR 9:081, Section 9(4)(c). Condition 2b of that Agreed Order specified, in part, "...Once the Panel receives written verification that the Ohio Board has reinstated his Ohio license, the Panel or its Chair will promptly enter into an Amended Agreed Order of Probation with the licensee to reinstate his Kentucky license."
7. The Board has received written verification that the Ohio Board reinstated the licensee's Ohio license effective March 13, 2013.
8. In April 2013, the Panel Chair approved the licensee to practice at Daugherty Medical Group in Florence, KY, Bellevue, KY and Cincinnati, Ohio, pursuant to terms and conditions set forth in the Amended Agreed Order of Probation filed April 11, 2013.

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 medical 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(17) and (9), as illustrated by KRS 311.597(4). Accordingly, there were legal grounds for the parties to enter into the Agreed Order of Suspension and Probation. Those grounds continue to provide a legal basis for this Second Amended Agreed Order of Probation.
3. 201 KAR 9:081, Section 9(4)(c) provides,

   > If a licensee has had disciplinary action taken against or sanctions imposed upon the licensee's license to practice medicine or osteopathy in any state, the appropriate panel:
   > 1a. Shall, at a minimum, impose the same substantive sanctions as a disciplinary sanction against the licensee's Kentucky license; and,
   > b. May take any appropriate additional disciplinary action against the licensee, or
   > 2. Shall, or in lieu of the minimum sanction, the panel may revoke the license based upon the facts available to the panel at the time of action.

4. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally address the licensee's new request for practice location approval without an evidentiary hearing 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 Panel Chair's approval of the licensee's new practice location

request, the parties hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER OF PROBATION:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Joseph F. Daugherty, III, M.D., SHALL BE SUBJECT to this Second Amended Agreed Order of Probation for the remainder of the original period of five (5) years, ending on March 13, 2018.
2. The licensee's Kentucky license is hereby CONTINUED ON PROBATION for the remainder of the five (5) period of the original Agreed Order, SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS, which are effective immediately upon the date of filing of this Second Amended Agreed Order and continue until March 13, 2018 or further Order of the Panel:
    a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine," 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.

b. 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.

c. The licensee is approved to practice medicine, during scheduled office hours, at the following locations: 11 Spiral Drive, Florence, Kentucky 41042 (Monday evenings 6:00 p.m. – 9:00 p.m.; Tuesdays and Thursdays 9:00 a.m. – 7:00 p.m.); and at 103 Landmark Drive, Suite 250, Bellevue, Kentucky 41073 (Mondays 8:30 a.m. – 5:00 p.m., Wednesdays 9:00 a.m. – 5:30 p.m. and Fridays 8:30 a.m. – 5:30 p.m.).

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

e. 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.

f. 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.

g. The licensee understands and agrees that at least one favorable consultant review 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.

h. 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 Second Amended Agreed Order of Probation 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 without a license.

SO AGREED on this 18th day of Sept, 2013.

FOR THE LICENSEE:

JOSEPH F. DAUGHERTY, III, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

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

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1463

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH F. DAUGHERTY, III, M.D., LICENSE NO. 22022, 1045 JACKSON ROAD, PARK HILLS, KENTUCKY 41011

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 Joseph F. Daugherty, III, M.D. ("the licensee"), and, based upon the Panel Chair's desire to approve the licensee's practice location request, 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, Joseph F. Daugherty, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Internal Medicine.
3. On July 11, 2012, the State Medical Board of Ohio (hereafter "the Ohio Board") issued a notice of intent to take action against the licensee's Ohio medical license, in Case No. 12-CRF-058, alleging,

   From on or about August 2010 to the present, you undertook the care of Patients 1-6.... In regards to Patients 1-6, you failed to appropriately physically examine patients and diagnose medical conditions and/or document appropriate physical examination of patients and diagnosing of medical conditions before prescribing Schedule II controlled substances.

4. On December 12, 2012, the licensee entered into a Consent Agreement with the Ohio Board resolving Case No. 12-CRF-058, in which the licensee "...admits to the factual and legal allegations contained in the July 2012 Notice, a copy of which is attached hereto and incorporated herein as Exhibit A." Under the terms of the Consent Agreement, the licensee's Ohio medical license is suspended "for an indefinite period, but not less than 90 days." The Consent Agreement sets out specific conditions for reinstatement and specific terms of probation to be implemented if and when his Ohio license is reinstated.

5. By letter dated December 24, 2012, the licensee notified this Board of the entry and terms of the Ohio Consent Agreement, as required by that Agreement.

6. On March 14, 2013, the parties entered into an Agreed Order of Suspension and Probation, as required by 201 KAR 9:081, Section 9(4)(c). Condition 2b of that Agreed Order specified, in part, "...Once the Panel receives written verification that the Ohio Board has reinstated his Ohio license, the Panel or its Chair will promptly enter into an Amended Agreed Order of Probation with the licensee to reinstate his Kentucky license."

7. The Board has received written verification that the Ohio Board reinstated the licensee's Ohio license effective March 13, 2013.

8. In April 2013, the Panel Chair approved the licensee to practice at Daugherty Medical Group in Florence, KY, Bellevue, KY and Cincinnati, Ohio, pursuant to terms and conditions set forth in this Amended Agreed Order of Probation.

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 medical 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(17) and (9), as illustrated by KRS 311.597(4). Accordingly, there were legal grounds for the parties to enter into the Agreed Order of Suspension and Probation. Those grounds continue to provide a legal basis for this Agreed Order.
3. 201 KAR 9:081, Section 9(4)(c) provides,

   > If a licensee has had disciplinary action taken against or sanctions imposed upon the licensee's license to practice medicine or osteopathy in any state, the appropriate panel:
   > 1a. Shall, at a minimum, impose the same substantive sanctions as a disciplinary sanction against the licensee's Kentucky license; and,
   > b. May take any appropriate additional disciplinary action against the licensee, or
   > 2. Shall, or in lieu of the minimum sanction, the panel may revoke the license based upon the facts available to the panel at the time of action.

4. 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 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 Panel Chair's desire to approve the licensee's practice location

request, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER OF PROBATION:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Joseph F. Daugherty, III, M.D., SHALL BE SUBJECT to this Amended Agreed Order of Probation for the remainder of the original period of five (5) years, ending on March 13, 2018.
2. The period of suspension imposed by the March 14, 2013 Agreed Order of Suspension and Probation was **TERMINATED**, effective immediately upon the filing of the Agreed Order Terminating Suspension; Agreed Order of Probation filed of record April 1, 2013;
3. The licensee's Kentucky license is hereby PLACED ON PROBATION for the remainder of the five (5) period of the original Agreed Order, SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS, which are effective immediately upon the date of filing of this Amended Agreed Order and continue until March 13, 2018 or further Order of the Panel:
    a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine," 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.

b. 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.

c. The licensee is approved to practice medicine, during normal office hours, at the following locations: 11 Spiral Drive, Florence, Kentucky 41042 (Monday evenings 6:00 p.m. – 8:00 p.m.; Tuesdays and Thursdays 9:00 a.m. – 6:00 p.m.); 103 Landmark Drive, Suite 250, Bellevue, Kentucky 41073 (Mondays 8:30 a.m. – 4:00 p.m., Wednesdays 1:00 p.m. – 4:30 p.m. and Fridays 8:30 a.m. – 4:15 p.m.); and 2230 Auburn Avenue, Cincinnati, Ohio 45219 (Wednesdays 9:00 a.m. – 12:00 noon).

d. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed,

when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log.

e. 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.

f. 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.

g. The licensee understands and agrees that at least one favorable consultant review 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.

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

4. The licensee expressly agrees that if he should violate any term or condition of the 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 Amended Agreed Order of Probation 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.

5. 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 without a license.

SO AGREED on this 9th day of April, 2013.

FOR THE LICENSEE:

JOSEPH F. DAUGHERTY, III, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

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

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1463

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH F. DAUGHERTY, III, M.D., LICENSE NO. 22022, 1045 JACKSON ROAD, PARK HILLS, KENTUCKY 41011

AGREED ORDER TERMINATING SUSPENSION; AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, and Joseph F. Daugherty, III, M.D. ("the licensee"), and, based upon the termination of his suspension by the Ohio State Board of Medicine, hereby ENTER INTO the following **AGREED ORDER TERMINATING SUSPENSION; AGREED ORDER OF PROBATION**:

STIPULATIONS OF FACT

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

1. At all relevant times, Joseph F. Daugherty, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Internal Medicine.
3. On July 11, 2012, the State Medical Board of Ohio (hereafter "the Ohio Board") issued a notice of intent to take action against the licensee's Ohio medical license, in Case No. 12-CRF-058, alleging,

   > From on or about August 2010 to the present, you undertook the care of Patients 1-6.... In regards to Patients 1-6, you failed to appropriately physically examine patients and diagnose medical conditions and/or document appropriate physical examination of patients and diagnosing of medical conditions before prescribing Schedule II controlled substances.

4. On December 12, 2012, the licensee entered into a Consent Agreement with the Ohio Board resolving Case No. 12-CRF-058, in which the licensee "...admits to the factual and legal allegations contained in the July 2012 Notice, a copy of which is attached hereto and incorporated herein as Exhibit A." Under the terms of the Consent Agreement, the licensee's Ohio medical license is suspended "for an indefinite period, but not less than 90 days." The Consent Agreement sets out specific conditions for reinstatement and specific terms of probation to be implemented if and when his Ohio license is reinstated.
5. By letter dated December 24, 2012, the licensee notified this Board of the entry and terms of the Ohio Consent Agreement, as required by that Agreement.
6. On March 14, 2013, the parties entered into an Agreed Order of Suspension and Probation, as required by 201 KAR 9:081, Section 9(4)(c). Condition 2b of that Agreed Order specified, in part, "...Once the Panel receives written verification that the Ohio Board has reinstated his Ohio license, the Panel or its Chair will promptly enter into an Amended Agreed Order of Probation with the licensee to reinstate his Kentucky license."
7. The Board has received written verification that the Ohio Board reinstated the licensee's Ohio license effective March 13, 2013.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's medical 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(17) and (9), as illustrated by KRS 311.597(4). Accordingly, there were legal grounds for the parties to enter into the Agreed Order of Suspension and Probation. Those grounds continue to provide a legal basis for this Agreed Order.

3. 201 KAR 9:081, Section 9(4)(c) provides,

> If a licensee has had disciplinary action taken against or sanctions imposed upon the licensee's license to practice medicine or osteopathy in any state, the appropriate panel:
> 1a. Shall, at a minimum, impose the same substantive sanctions as a disciplinary sanction against the licensee's Kentucky license; and,
> b. May take any appropriate additional disciplinary action against the licensee, or
> 2. Shall, or in lieu of the minimum sanction, the panel may revoke the license based upon the facts available to the panel at the time of action.

4. 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 Terminating Suspension; Agreed Order of Probation.

AGREED ORDER TERMINATING SUSPENSION; AGREED ORDER OF PROBATION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the termination of the licensee's suspension by the Ohio State Board of Medicine, the parties hereby ENTER INTO the following **AGREED ORDER TERMINATING SUSPENSION; AGREED ORDER OF PROBATION:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Joseph F. Daugherty, III, M.D., SHALL BE SUBJECT to this Agreed Order

Terminating Suspension; Agreed Order of Probation for the remainder of the original period of five (5) years, ending on March 13, 2018.

2. The period of suspension imposed by the March 14, 2013 Agreed Order of Suspension and Probation is hereby **TERMINATED**, effective immediately upon the date of filing of this Agreed Order;

3. The licensee's Kentucky license is hereby PLACED ON PROBATION for the remainder of the five (5) period of the original Agreed Order, SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS, which are effective immediately upon the date of filing of this Agreed Order and continue until March 13, 2018 or further Order of the Panel:

    a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine," 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.

b. 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.

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

d. 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.

e. 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.

f. The licensee understands and agrees that at least one favorable consultant review 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.

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

4. The licensee expressly agrees that if he should violate any term or condition of the 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 Agreed Order of Probation 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.

5. 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 without a license.

SO AGREED on this 21 day of March, 2013.

FOR THE LICENSEE:

Joseph F. Daugherty III MD
JOSEPH F. DAUGHERTY, III, M.D.

Mary K. Mallory
COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

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

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1463

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOSEPH F. DAUGHERTY, III, M.D., LICENSE NO. 22022, 1045 JACKSON ROAD, PARK HILLS, KENTUCKY 41011

AGREED ORDER OF SUSPENSION AND PROBATION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, and Joseph F. Daugherty, III, M.D. ("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 SUSPENSION AND PROBATION**:

STIPULATIONS OF FACT

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

1. At all relevant times, Joseph F. Daugherty, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Internal Medicine.
3. On July 11, 2012, the State Medical Board of Ohio (hereafter "the Ohio Board") issued a notice of intent to take action against the licensee's Ohio medical license, in Case No. 12-CRF-058, alleging,

   > From on or about August 2010 to the present, you undertook the care of Patients 1-6.... In regards to Patients 1-6, you failed to appropriately physically examine patients and diagnose medical conditions and/or document appropriate physical examination of patients and diagnosing of medical conditions before prescribing Schedule II controlled substances.

4. On December 12, 2012, the licensee entered into a Consent Agreement with the Ohio Board resolving Case No. 12-CRF-058, in which the licensee "...admits to the factual and legal allegations contained in the July 2012 Notice, a copy of which is attached hereto and incorporated herein as Exhibit A." Under the terms of the Consent Agreement, the licensee's Ohio medical license is suspended "for an indefinite period, but not less than 90 days." The Consent Agreement sets out specific conditions for reinstatement and specific terms of probation to be implemented if and when his Ohio license is reinstated.
5. By letter dated December 24, 2012, the licensee notified this Board of the entry and terms of the Ohio Consent Agreement, as required by that Agreement.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's medical 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(17) and (9), as illustrated by KRS 311.597(4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Suspension and Probation.
3. 201 KAR 9:081, Section 9(4)(c) provides,

> If a licensee has had disciplinary action taken against or sanctions imposed upon the licensee's license to practice medicine or osteopathy in any state, the appropriate panel:
> 1a. Shall, at a minimum, impose the same substantive sanctions as a disciplinary sanction against the licensee's Kentucky license; and,
> b. May take any appropriate additional disciplinary action against the licensee, or

2. Shall, or in lieu of the minimum sanction, the panel may revoke the license based upon the facts available to the panel at the time of action.

4. 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 Suspension and Probation.

AGREED ORDER OF SUSPENSION AND PROBATION

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 SUSPENSION AND PROBATION:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Joseph F. Daugherty, III, M.D., SHALL BE SUBJECT to this Agreed Order of Suspension and Probation for a period of five (5) years from the date of filing of the Agreed Order.
2. During the effective period of this Agreed Order, the licensee's medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:
    a. The licensee's Kentucky medical license is hereby SUSPENDED until further Order of the Panel or the expiration of this Agreed Order, with that suspension becoming effective immediately upon the date of filing of this Agreed Order of Suspension and Probation;
    b. The Panel will not terminate that suspension until the licensee's Ohio license is reinstated by the Ohio Board. Once the Panel receives written verification that the Ohio Board has reinstated his Ohio license, the Panel

or its Chair will promptly enter into an Amended Agreed Order of Probation with the licensee to reinstate his Kentucky license;

c. If, and when, the licensee's Kentucky medical license is reinstated, it SHALL BE PLACED ON PROBATION for the remainder of the five (5) period of this Agreed Order, SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

1. The licensee SHALL NOT perform any act which would constitute the "practice of medicine," 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.

2. 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.

3. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log.
4. 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.
5. 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.

6. The licensee understands and agrees that at least one favorable consultant review 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.
7. 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 the Agreed Order of Suspension and 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 Suspension and 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 Agreed Order of Suspension and Probation 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 Suspension and Probation.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order of Suspension and 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 6 day of March, 2013.

FOR THE LICENSEE:

JOSEPH F. DAUGHERTY, III, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

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

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