

FILED OF RECORD

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1476

DEC 19 2013

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY THOMAS A. SMITH, M.D., LICENSE NO. 26421, 96 WALKER HILL, STAFFORDSVILLE, KENTUCKY 41256

AMENDED AGREED ORDER OF PERMANENT RESTRICTION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Thomas A. Smith, M.D. (hereafter "the licensee"), and, following its review of the CPEP assessment conducted pursuant to the original Agreed Order, hereby ENTER INTO the following **AMENDED AGREED ORDER OF PERMANENT RESTRICTION**:

STIPULATIONS OF FACT

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

1. At all relevant times, Thomas A. Smith, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Family Medicine.
3. On July 24, 2003, the licensee resolved an investigation into his prescribing practices by entering into an Agreed Order in Board Case No. 887. Under the terms of that Agreed Order, the licensee was required to successfully complete an approved prescribing course and an approved documentation program. He was also required to maintain a controlled substances log and submit his log and records for reviews by a Board consultant.

4. The Office of Inspector General (OIG) received an anonymous grievance alleging that there were groups of people waiting in the licensee's parking lot to get controlled substances, acting intoxicated and trading unknown items in the parking lot. After receiving this complaint, OIG reviewed the licensee's prescribing practices and reported that certain patient records should be reviewed by the Board based upon age, distance traveled, addictive drug combinations, and polypharmacy. 12 patients were identified for review.
5. The Board obtained 15 patient records and provided them to a Board consultant for review. The consultant provided a written report that included the following findings and conclusions,

1. Initial Evaluation:

... The problems in initial evaluation of patients included failure to list or mention current medications, even prior medications that the patient had taken. In a few cases there were KASPERS showing recent medications, but I can't remember any early ones that revealed patient taking narcotics. There generally seemed to be no mention of tests or scans that revealed the extent of the problem. In the old part of the records, some scans were noted but these often were not even specifically mentioned in the evaluation of the patient. One patient even got narcotics for a condition (pain in back) not even mentioned in the complaints. Another given medication based on what the patient and wife said. There was often no clear pathway from history on to physical on to assessment that gave a clear picture why patient was started on the dosage of medication he or she got. The patient may well have needed the medication at that dosage, but it was very difficult to tell from the information provided.

2. Medical Records:

It was difficult to follow or tell from the records what was happening to the patient at any specified time. The records were voluminous, but repetitious, duplicated, like "rubber stamped". One case, a workman's compensation injury involved a patient, Patient A. It was being reviewed by a couple of physicians who noted it was difficult to tell if a particular medicine was justified because of computer generated repetitious records and basic duplications. They noted that nothing changed from visit to visit and couldn't understand why the patient even had to be seen monthly. Both the history and

physical exams were repetitious, often for **4 or 5 years**. One common part of the physical, the back exam, remained the same for years. The medicine dosage changed, but the exam did not. It was difficult to tell what was going on with the patient at any given time. Another example was the plan saying "needs pain clinic appointment and get MRI"; **for years!** Sometimes statement in the notes mentioned need to schedule a test which had already been done 1-2 years prior. Basically indicating that not much attention was paid to what was going on, just computer generated records, often unchanged from visit to visit.

3. Medication:

As mentioned, medications were often initiated without revealing prior or current medications. At times medication was started at a moderately high level such as Lorcet 10mg or Oxycodone 10 mg 4 times daily. There was no mention why smaller dosed could not be initiated and increased if needed. Starting at a moderately high level obviously means increases in dosages are going to result in patient taking high dosages.

Narcotics and other controlled medications were increased, or in some cases initiated, without any **rationale** or **notation** in the chart as to why being done. One could see from the notation of "medicine given today", what was being prescribed, but no discussion why. Patients' response to medications rarely discussed. It was noted in the subjective for long time that pain was "bad and worsening" in one chart despite being maintained on rather large dosages of medication.

In some instances, not often, narcotics were reduced briefly, never weaned. Soma was used with Valium 10 mg in a few patients, or Soma with another tranquilizer. Since Soma is an anti-anxiety medication with some muscle relaxing affect, would appear to be double dosing the patient with tranquilizer, plus having narcotics on board.

As seen from the worksheets some patients were on quite high levels of oxycodone, even up to **120 to 150 mg** per day, quite a dosage for primary care physicians and thus diverting requiring close monitoring, especially for compliance in not diverting medicine. One area where the chart was helpful was the medication and very helpful to follow current narcotic and other controlled medications. Patients, however, should be started on the smallest amount of medication (dosage) initially that might have some affect, not large amounts **initially**.

4. Compliance Monitoring:

A KASPER from 6/2011 to 6/2012 was done by Dr. Smith and sent with each chart. Most charts had at least one KASPER before and generally (few exceptions) showed they were obtaining medication just from him.

Urine drug screening (UDS) was done on most charts, some having 5 or 6 over the years. Unfortunately, with one exception, every chart had at least one

and as many as 5 (Patient B) inappropriate (non-compliant) drug tests. Mainly medications prescribed not present, but some with medications present not prescribed. Unfortunately, Dr. Smith did not mention this in any chart progress note, nor were they repeated. In his summary to the Board, he discussed the last UDS' that were performed on the patients and **only 2** were compliant with one of those having inappropriate tests prior. The other complaint test was on Patient C who had just had his Lortab stopped after the Board's inquiry. He had not had a test prior. He was taking Lortab before for "conversion reaction"; no way to be sure patients were not diverting drugs because of the non-compliant tests.

5. Consults:

Some patients had pain consults in the past. However, it certainly appeared at least 5 or 6 patients in the reviews needed to see pain physicians, even just for opinion and help with medications management. Even those who had seen a pain physician in the past could have been re-evaluated at intervals. Dr. Smith's notes in several patients' charts mentioned seeing a pain physician, **repeatedly**, but he didn't follow through. This is especially true when patients are taking rather high dosages of narcotics.

Over half of cases appeared to have depression and almost all had anxiety. Psychiatric evaluation appeared to be needed to help manage some patients, but rarely done...a few cases that was perhaps their **primary** problem.

Also seemingly rare was orthopedic consults, especially in several patients where just an opinion or consult may well have reduced their need for high dosage of narcotics.

6. General Medical Care:

Most of the patients had some sort of medical problems, e.g. Diabetes, hypertension, elevated lipids, obesity, etc. Several patients were prescribed Adipex for weight loss. In one case, patient appeared to be taking 4 per day for a few months. Either that or was diverting drugs. Could not understand why patients were usually started 1 ½ to 2 per day, instead of **just one daily initially** to see how he or she did. One patient told him in her initial evaluation "it helped her nerves" and was given the Adipex, not appropriate for that complaint.

Blood pressure in a couple of patients was a problem. Especially in one patient where it was elevated over 75% of the time. There was no mention of attacking this in the chart but was on blood pressure medicines, just not mentioning increasing dosages, etc.

Labs were done on most of the patients that were appropriate; however there was never any mention of **results** of any of the labs in the physician's medical records, nor plan for treatment of such. (E.g. diet, particular medication, lifestyle changes, etc.) – Often the medication list showed medicines for the particular problem, but not much information available on

how was doing, etc. One has to go through the labs in the chart to see if any progress made, or to see what the patient's medical problem and severity of it is. Weight Loss with the Adipex was not often appearing to be effective, but yet still getting the medications. More attention was directed to pain control treatment than anything else.

In summary, more thorough initial evaluation to include all scans, x-rays or blood work pertinent to the problem (pain or medical) is needed. This includes thorough history to include prior medications that lead up to current medications patient is taking. Prior tests should be discussed and copies of scans, x-rays, etc., made a part of record. After initial evaluation, patient should be started on **smallest dosage possible** or narcotics to control symptoms and establish what the goals are and if being met. Especially it should be noted in the chart **why** medicine is being increased instead of just putting it in the list prescribed medicines.

Some evidence should be present on each visit that patient was examined and "rubber stamping" the exams stopped. Compliance monitoring, primarily UDS appeared to be useless, as **never** addressed. Therefore it appears patients could easily be diverting drugs or abusing them.

Consults should be considered and done more often, especially considering the dosage of medication the patients are prescribed.

Dr. Smith could reduce the volume of paperwork by 75% and have 100% more information if various problems were addressed. It was difficult to justify, or understand why so many patients were being seen every 2 weeks, when nothing was changed over long periods of times, in some cases 1-2 years. The charts had 2 sets of chief complaints, 2 subjectives that often were repetitious for months or years. Past medical histories or review of systems never elaborated on the positives. Example – often had history (+) depression without any elaboration of degree of depression, prior meds, prior psychiatric care, etc. This generally applied to most all of+ ROS and+ MH, with no elaboration.

6. By letter dated August 31, 2012, the licensee and his attorney filed the following response to the consultant's findings, contesting many of his findings and conclusions.

1. Initial Evaluation:

Medinotes EMR had ongoing list of current medications for each patient easily accessible by tab. Also, we had a list in the SOAP note labeled USUAL PATIENT MEDICATIONS which we always attempted to keep updated, assisted by the electronic medical record insert, which was inserted at that location and opened into the medication list in the program when clicked on.

All Kaspers were not sent with the charts. Some older ones in storage charts on patients with us many years.

These are all information readily available in the chart.

2. Medical Records:

We use every method we can to track the patient and to keep their information accessible and organized. The flow of the care can be followed easily. In a sense, however, with transition to a new EMR; with partial paper and partial paperless charts; with two hospitals to attend; and with information hidden in many places in the electronic records accessible by simply clicking on a tab, you just have to know where to look. There is a learning curve on any EMR, and all the bells and whistles can be daunting. However, with training on the major sources of information on the patient most physicians placed in front of my EMR could care for the patient. The staff could print the progress notes if necessary, or give a pointer or two on our program.

We do not have any trouble knowing what is going on with the patient at any given time. We try to keep up with and record everything. Again, the templates are just a tool we use to try to care for the patient and we do not view them as gratuitous just to "fill in a chart."

The template is a framework to hang new data on. That does not mean the other is not done, but I do not change it if there is nothing new found or if the patient's condition is not changed in a given area. Some patients seen for years are the same every time you see the, sometimes for a long time. That does not mean we do not evaluate the patient and try to keep up with their care. Some insurer's like worker's compensation, will not pay for us to care for any but the one problem. If any other care is given the patient, we generally have to do that under another insurance or for free.

3. Medication:

Most of my patients are on disability ordered by the court for various reasons, and may have high levels of pain. Many of them have back problems. Many of the patients that come to me have already been on pain medicine and/or other controlled substances for years prior to ever coming to me. Many have been to pain clinic(s) already, as well as neurosurgeons.

4. Compliance Monitoring:

I have obtained Kaspers on all patients on controlled substances for approximately a decade, from the first moment they were available to the doctors. I currently follow all HB1 guidelines for obtaining Kaspers, and even more often PRN. I have often obtained these from West Virginia as well, and occasionally from Ohio, although it is a more difficult process there.

I sign the results of all labs and have a special mark when they are to be filled. Others are left loose in the chart (most recent) in order to go over with the patient. So I try always to be aware of what has been done and try to go over it on subsequent visits with the patients. In the past, I chiefly checked for extraneous medications or substances in the urine.

5. Consults:

The patients were often requested to go to pain clinic to no avail; sometimes due to finances, sometimes due to insurance refusal to authorize, sometimes due to lack of travel expenses, sometimes due to fear of injections, sometimes due to having already been and not wanting to ever go back.

6. General Medical Care:

I am always mindful to address these as much as possible. Healthcare prevention is covered in most of the patient's visits to one degree or another and tests or other appropriate measures/mediations are ordered. Most of my patients have many medical problems, often very severe. I deal with a low income stratum, most of whom are on welfare or disability. I have many uninsured patients as well. Many of my patients are derived from on-call service at the two local hospitals, and often have advanced intractable disease. The rates of diabetes, hypertension, heart disease, smoking related ailments, mental illness, morbid obesity, etc. are astronomical in this impoverished area of Appalachia, especially in the poor.

My first goal for patients is 140/90 as I explain to them, then second goal 130/80 if feasible and tolerated to reach the cardiological societies preferences. This is not always possible in some patients, or reasonable for various reasons. I do have a historical record for patients' vitals available in the EMR for graphing or printing and refer often to that to monitor how the patient has been doing on an average, rather than any one single measurement.

All labs are reviewed and signed off on. TAS means I have reviewed the lab and may want to follow further with the patient and these are left in the chart loose for next visit. Capital "S," often made large, means I have reviewed the labs and/or dealt with them and they can be filed. I often write notes on abnormal to my nurse or give verbal order that patient needs to "SEE M.D." or "SEE M.D. STAT" for the nurse to get that patient into clinic. All abnormal labs are dealt with and most of the time the instructions or treatment are written beside the abnormal lab(s) on the lab report before filing or giving to the nurse to proceed with others. Often dietary changes/sheets are ordered on the right hand corner of the encounter forms, to be done by staff, who knows to follow these instructions. The same is done for referrals, prostheses, medical tests to be arranged, and further labs or tests. The patient labs have NEVER been ignored.

ALL abnormal labs and tests are COMPARED to the last labs or tests, just as one would do in a hospital. Most of our charts have filing tabs listed "Lab," "X-ray," etc. to keep organized. The labs, and all other data are filed as in any chart in reverse order, so all data can be immediately viewed and compared chronologically with ease. With 5--10 medical problems, changes in medications and treatments sometimes are rapid fire and not listed in the SOAP note, but the medications that are active and a complete list of medications are available immediately on a drop-down in the EMR, and all notes are preserved showing any changes made in that visit, and a complete list of ALL medications prescribed and date is available in the E-scribe listing all dates and prescriptions, as well as in the

program. The list of controlled substances at the bottom of all chart visit notes is kept so that any changes made easily visible if patient is on controlled substances.

If patients are seen every month or every two weeks, it is chiefly from trying to follow the previous KBML dictum to "see the patients (on controlled substances) often and give them small amounts." I have tried multiple variations but giving refills always seemed to exacerbate overuse because the patients would somehow always manage to find a pharmacy to give them the refills early.

I am always keenly on the alert for patients with depression and treat a great number with medications for that disorder, either for primary depressive disorders or secondary, such as to pain, etc. I always approach the patient for antidepressant if they appear to need such. Many turn antidepressants down. Many ask for benzodiazepines for depression, which is refused, as is a depressant.

7. Pursuant to the original Agreed Order of Permanent Restriction, the licensee completed a clinical skills assessment by the Center for Personalized Education for Physicians (CPEP) on June 13-14, 2013. Relevant findings and conclusions from that assessment include:

...Dr. Smith is permanently restricted from prescribing, dispensing or otherwise using controlled substances for the remainder of his medical practice.

...

Note: Based on the restriction described above, chronic pain management and prescribing of chronic controlled substances (including opioids) were not evaluated as part of this Assessment. Acute (short term) controlled substance prescribing, as might be relevant in a hospital setting, was evaluated.

...

B. Assessment Findings

During this Assessment, Dr. Smith demonstrated medical knowledge that was variable, lacking depth or currency in many areas. His clinical judgment and reasoning were also variable, and were concerning in certain respects, including organization and information gathering. Dr. Smith's communication skills were minimally adequate with Simulated Patients (SPs); his communication with peers was professional but unfocused. His documentation in the patient chart was inadequate; his documentation of the SP encounters was marginally adequate with a need for improvement.

...

Review of Dr. Smith's health information revealed that he has a health condition(s) that, if not well controlled, could impact the practice of medicine. The documenting physician opined that Dr. Smith "is capable of engaging in full-time practice from the medical point of view." However, the physician did not specifically address the status of this condition, and does not appear to be the treating physician for this condition.

Dr. Smith's cognitive function screen summary scores were in the normal range. However, analyses of specific subtest performances raised some concerns about his memory and reaction time.

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1. Medical Knowledge

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Dr. Smith's knowledge of current recommendations for routine health screening was poor. Gaps in his knowledge of pharmacology were evident in several discussions.

The consultants found that Dr. Smith did not convey good understanding or recollection of the pathophysiology of common conditions such as hypertension, diabetes, and heart disease. He did not convey familiarity with currently available, evidence-based tools for clinical decision-making, such as those available to assist in determining whether hospitalization for a patient with pneumonia would be appropriate.

The discussion above provides some examples of the educational needs identified during the clinical interviews. The list below includes these and other needs that were identified during the Assessment. As discussed further in *Section C.2. Interprofessional Communication Skills*, some communication issues limited the content that the consultants were able to cover during these interviews.

2. Clinical Judgment and Reasoning

Dr. Smith's clinical judgment and reasoning, as demonstrated during this Assessment, were variable, and were concerning in certain respects, including organization and information gathering.

During discussions, Dr. Smith did not demonstrate a structured approach to the clinical cases. It appeared that he had difficulty asking relevant questions to gather useful information in the hypothetical cases and was struggling to find the parts of the history and exam that were pertinent to the diagnosis and treatment. This was substantiated by Dr. Smith's actual patient records, where the consultants found limited information recorded in the subjective sections, though the objective sections were more complete.

In some of the hypothetical case discussions, Dr. Smith prematurely anchored on an incorrect diagnosis, or prematurely and illogically dismissed the actual diagnosis. Examples of instances in which he dismissed the correct diagnoses when provided with fairly classic presentations included cases of rheumatoid arthritis (RA) and idiopathic thrombocytopenic purpura (ITP). It is possible that knowledge or experience gaps contributed to this.

Dr. Smith's formulation of differential diagnoses was adequate in many instances. However, his lists were not sufficiently structured to prevent him from omitting important diagnostic considerations, such as pneumonia and pneumothorax for chest pain. Similar organizational issues may have interfered with his ability to provide comprehensive responses to other questions, such as risk factors for stroke, for which he omitted smoking and diabetes.

...
One consultant raised concerns about Dr. Smith's understanding of his own limitations. The consultant opined that, based on the quantity of incorrect responses provided by Dr. Smith, he either is not aware of his own knowledge gaps, or has difficulty in admitting when he is not knowledgeable on a subject.

...Because the Board may consider allowing Dr. Smith to prescribe controlled substances in the inpatient setting, shorter-term prescribing and administration of controlled substances, as might be relevant in the inpatient setting, was assessed. A consultant opined that Dr. Smith adequately discussed considerations of prescribing a benzodiazepine in an elderly patient with COPD and seemed adequately attentive to non-psychiatric causes of anxiety. However, his prescribing was criticized for two of his outpatients. In one case he prescribed Valium for sleep to a patient with a history of alcoholism and Wernicke encephalopathy. In another, he prescribed large doses of chronic opiates to an extremely obese patient with obstructive sleep apnea, thus risking apnea and respiratory depression. While both of these comments pertained to outpatients, CPEP believes that the concepts involved and criticism can be extrapolated to apply to the inpatient setting as well.

The consultants had difficulty providing comments on Dr. Smith's overall decision-making, clinical thinking, and quality of care in practice, primarily due to documentation deficiencies. One consultant found that Dr. Smith's plans were "incomprehensible," thus making it very difficult to judge quality of care. Due to limited information in the subjective, assessment, and plan sections, the consultants found it difficult to follow clinical reasoning; the plans sometimes did not relate to the other information in the note. There were a few specific concerns that were raised. For example, a consultant noted that Dr. Smith documented that the blood pressure of a 61 year-old male with hypertension was uncontrolled, yet there were no changes to the management plan to address this. Another consultant observed that, while Dr. Smith seemed aware of preventive guidelines for monitoring of diabetics, based on discussion, chart review did not reflect that he was applying that knowledge in practice.

...

3. Patient Care Documentation

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Despite the use of electronic documentation, it was difficult to find desired information in the records. Some information that would be expected in list format was charted in paragraph format with back slashes used to separate list

items, making it difficult to quickly review these lists for important information. There were several instances in which the chart notes merely referred to another location in the chart to reference a lab or treatment, rather than simply providing the result and plan; while there were times that doing so was the most efficient way to document, it was done to an extent in these notes that it interfered with their usefulness....

...

In summary, Dr. Smith's patient care documentation was inadequate. All three consultants indicated that they would not be able to easily assume care for these patients on the basis of these records.

8. Following completion of the CPEP assessment, the licensee arranged for CPEP to prepare an Educational Intervention Program Education Plan. That Plan was issued by CPEP in October 2013. It is attached to this Amended Agreed Order of Permanent Restriction and is fully incorporated by reference.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's Kentucky 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(9), as illustrated by KRS 311.597(1), (3) and (4). Accordingly, there were legal grounds for the parties to enter into the Agreed Order of Permanent Restriction. Those legal grounds also provide a legal basis for the entry of this Amended Agreed Order of Permanent Restriction.
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 Amended Agreed Order of Permanent Restriction.

AMENDED AGREED ORDER OF PERMANENT RESTRICTION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the Panel's review of the CPEP assessment report, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER OF PERMANENT RESTRICTION**:

1. The license to practice medicine in the Commonwealth of Kentucky held by Thomas A. Smith, M.D., continues to be RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, continuing immediately upon the filing of this Order;
2. During the effective period of this Amended Agreed Order of Permanent Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:
 - a. The licensee SHALL NOT prescribe, dispense, or otherwise utilize controlled substances for the remainder of his medical practice. This is a permanent restriction that will remain in place for the remainder of the licensee's practice, and SHALL NOT be subject to reconsideration, modification, or termination, with the single exception of clarification set out in Condition 2g, infra. As an express consideration for the Panel's not revoking his license or requiring surrender of his license, the licensee expressly agrees that he will not file any request for reconsideration, modification, or termination and the Panel will not consider any request

for reconsideration, modification, or termination, but may consider the limited opportunity for clarification set out in Condition 2c, *infra*.

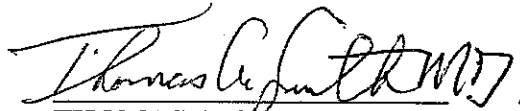
- b. The licensee SHALL successfully complete the CPEP Educational Intervention Program Education Plan, attached and fully incorporated by reference into this Amended Agreed Order of Indefinite Restriction, at his expense, and as directed by CPEP staff. If required by CPEP, the licensee SHALL ALSO successfully complete the CPEP Post-program Evaluation, at his expense, and as directed by CPEP staff.
- c. After the Education Plan has been fully completed and the Panel has received all relevant reports from CPEP, and if the licensee has made a specific request that the Panel do so, the Panel will determine whether the permanent restriction should be clarified in a manner that would permit the licensee to order the administration of controlled substances to his patients who are properly and currently admitted to a licensed hospital but no prescribing of controlled substances upon discharge.
- d. The licensee SHALL pay the costs of the investigation in the amount of \$6,000.00 within sixty (60) months from entry of the original Agreed Order of Permanent Restriction, paying at least \$1,200 during each 12 month period following the date of filing of the original Agreed Order of Permanent Restriction;
- e. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Amended Agreed Order of Permanent Restriction, 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 Permanent Restriction, 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 Permanent Restriction 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 Permanent Restriction.
4. The licensee understands and agrees that any violation of the terms of this Amended Agreed Order of Permanent Restriction 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 4 day of December 2013.

FOR THE LICENSEE:



THOMAS A. SMITH, M.D.

COUNSEL FOR THE LICENSEE
(If Applicable)

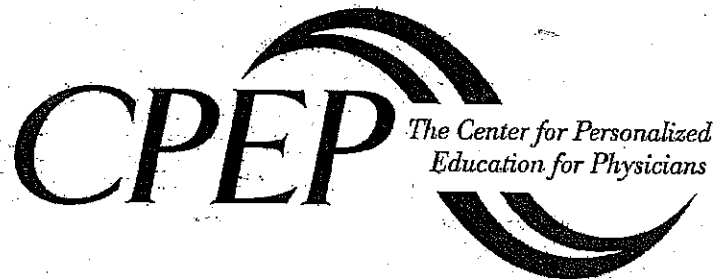
FOR THE BOARD:



RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B



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EDUCATIONAL INTERVENTION PROGRAM

EDUCATION PLAN

Developed October 2013

for

Thomas A. Smith, M.D.

NATIONALLY RECOGNIZED ■ PROVEN LEADER ■ TRUSTED RESOURCE

**7351 Lowry Boulevard, Suite 100
Denver, Colorado 80230
Phone: 303-577-3232
Fax: 303-577-3241
www.cpepdoc.org**

EDUCATION PLAN

OVERVIEW

- Section I Introduction and Plan Design
- Section II Individual Learning Goals
- Specific areas of educational need
- Section III Performance Objectives (Modules A and B)
- Self-study, CME, Preceptor Meetings
- Section IV Initiation of the Plan and Preceptor Approval
- Determining the start of activities
 - Education Notebook
 - Preceptor Approval Process
- Section V Participation and Monitoring
- Participation Expectations
 - Evaluation Process
- Section VI Duration

APPENDICES

- Appendix A Practice Profile
- Appendix B Federal Regulations of Privacy of Individually Identifiable Health Information
- Appendix C Glossary and Educational Terms

I. INTRODUCTION

According to the Kentucky Board of Medical Licensure's (Board's) public Agreed Order of Permanent Restrictions (Order) dated April 10, 2013, Thomas A. Smith, M.D. was ordered to complete a clinical skills Assessment and any subsequent recommended education plan with CPEP. The Order permanently restricts Dr. Smith from prescribing, dispensing, or otherwise using controlled substances for the remainder of his medical practice. The Order allows for the Board to determine whether, after review of the CPEP Assessment Report and Education Plan, the restriction should be clarified to allow for administration of controlled substances to patients during admission to a licensed hospital.

Previously, the Board issued a public Agreed Order in July 2003 involving prescribing controlled substances and antibiotics, polypharmacy, and patient care. Dr. Smith was ordered to complete a prescribing course and a documentation course at that time

In June 2013, Dr. Smith 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. Smith. The purpose of this Plan is to provide a framework in which Dr. Smith can address his educational needs.

Notes:

- Based on the restrictions described above, chronic pain management and prescribing of chronic controlled substances (including opioids) were not evaluated as part of his Assessment. Acute (short term) controlled substance prescribing, as might be relevant in a hospital setting, was evaluated.
- If Dr. Smith's restriction from prescribing controlled substances is lifted, this educational experience will include attention to prescribing of controlled substances in the inpatient setting.

A glossary of Educational Intervention terms is enclosed.

FOCUS OF PLAN

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

HEALTH CONSIDERATIONS

As stated in the Assessment Report, review of Dr. Smith's health information revealed that he has a health condition(s) that, if not well controlled, could impact the practice of medicine. The documenting physician opined that Dr. Smith "is capable of engaging in full-time practice from the medical point of view." However, the physician did not specifically address the status of this condition, and does not appear to be the treating physician for this condition. Dr. Smith informed CPEP that the Board is aware of his health condition, and that he is seen by the Kentucky Physician Health Foundation.

LIMITATIONS

- CPEP cannot guarantee that a Preceptor and/or an appropriate setting can be identified to address this Plan.
- CPEP does not monitor participants' health issues. CPEP will contact the participant and/or the referring organization if concerns arise indicating that health issues may be impacting the participant's ability to complete the Plan activities.

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.

HOSPITAL PRIVILEGES

Dr. Smith will need to be able to see patients in the inpatient setting to address all of the Learning Goals described in this Plan. *It is the participant's responsibility* to ensure that he adheres to applicable credentialing requirements for the institution in which the Plan activities occur.

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. Smith'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. Smith 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. 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. Smith (see *Section V*). The Associate Medical Director will regularly communicate with and provide ongoing feedback and coaching to Dr. Smith and the Preceptor with regard to Dr. Smith's progress.

II. LEARNING GOALS

A. Medical Knowledge

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

1. General review of family medicine;*
2. Pathophysiology: hypertension, diabetes, heart disease;
3. Evidence-based decision-making tools;
4. Routine health screening guidelines for adults: cancer screening; blood tests and indications;
5. Neurology and Psychiatry:**
 - a. Differentiating between transient ischemic attack (TIA) and cerebral vascular accident (CVA);
 - b. Evaluation and management of CVA with thrombolytics (including window of opportunity for thrombolytics);
 - c. Evaluation of dementia and depression in the elderly;
6. Cardiology:
 - a. Definition of stage two hypertension;*
 - b. Treatment of hypertension: knowledge of the broad variety of medication classes available, side effects, and contraindications of antihypertensives; when to initiate medication; evaluation of secondary hypertension;
 - c. Indications for and use of thrombolytics for myocardial infarction (MI);
7. Pulmonology:**
 - a. Criteria for hospitalization for pneumonia;
 - b. Indications for and use of thrombolytics for pulmonary embolism (PE);
 - c. Imaging of choice for PE;
8. Rheumatologic disorders:**
 - a. Rheumatoid arthritis;
 - b. Reiter's syndrome;
 - c. Lab testing for rheumatologic disorders;
9. Pharmacology:
 - a. Mechanism of action of and contraindications to triptans;
 - b. Heparin drip dosing for PE;
 - c. Dosing of Levaquin in renal-compromised patients;*
 - d. Side effects of medications used for benign prostatic hypertrophy (BPH) and incontinence;
 - e. Mechanism of action of metformin;
 - f. Indications for Epogen;

- g. Side effects of common antidepressants;
- h. Selecting appropriate benzodiazepines when needed in the elderly;
- 10. Urology:**
 - a. Imaging of choice for nephrolithiasis;
 - b. Management of renal stones;
- 11. Women's health:
 - a. Management and follow-up of abnormal Pap smears;
 - b. Family planning: methods, dosing, side effects;
 - c. Evaluation of abnormal vaginal bleeding in both pre- and postmenopausal women;
 - d. Treatment of post-partum depression in breastfeeding and non-breastfeeding women;
- 12. Endocrinology/diabetes:
 - a. Treatment of diabetes;
 - b. Indications for insulin and familiarity with newer forms of insulin;
- 13. Pediatrics:**
 - a. Current age-based guidelines on withholding antibiotic treatment in the treatment of otitis media for some children;
 - b. First-line antibiotic treatment of otitis media;
- 14. Additional topics:
 - a. Reye's syndrome;
 - b. Management options for acne.

*Topic summary not required.

**Subtopics may be combined into one summary; two references required.

(See III.B below for description of topic summaries.)

B. Clinical Judgment

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

1. Overall organization and structure in approach to clinical cases;
2. Avoidance of premature anchoring on or dismissal of diagnostic possibilities;
3. Ability to gather adequate clinical information;
4. Structured formulation of differential diagnoses;
5. Consistent ability to correctly assess acuity of illness;
6. Understanding of limitations;
7. Appropriate prescribing of controlled substances;
8. Application of knowledge in practice.

Note: The consultants did not believe that they achieved a thorough assessment of Dr. Smith's decision-making and quality of care due to documentation deficiencies. An ongoing assessment of clinical decision-making will be made during Dr. Smith's educational endeavors.

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. Optimize formatting of the notes – for example, use of lists rather than paragraph format for certain items such as review of systems or past medical history;
2. Adequate content in all sections (S/O/A/P) of the note so that the reader can understand what transpired during the patient encounter;
3. Internal consistency of notes (plans that correspond to the subjective and objective sections of the notes);
4. Adequately detailed discharge summaries that address all the diagnoses treated during the patient's hospitalization and inclusion of only pertinent tests and studies and studies pending at the time of discharge;
5. Clear documentation that patients had been made aware of abnormal results and of plans to address abnormal labs;
6. Include the specifics of medication allergic reactions;
7. Maintain distinction between historical and objective sections;
8. Clarity in the recording of assessments and plan sections.

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. Identification of more reliable and structured Internet resources for use at the point-of-care.

E. Physician-Patient Communication Skills

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

1. Identify strategies to minimize nervousness and anxiety during patient encounters;
2. Minimize the need for apologies;
3. Establish a clear agenda for the visit and set expectations;
4. Clearly convey the treatment plan;
5. Enhance communication before and during physical examinations;
6. Respect patients' need for personal space;
7. Increase the use of open-ended questioning;
8. Follow-up on information provided by the patient.

(The remainder of this page is intentionally blank.)

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. Smith 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 fourth month of beginning the Plan activities.
- Courses and/or CME activities should be completed no later than the fourth month of participation, unless specified otherwise.

Guideline

The list of Medical Knowledge topics is extensive; therefore, it will be essential that Dr. Smith develop a strategy that ensures he submits all topic/subtopic summaries within 6 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. Smith 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. Smith 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. He should receive approval of resources prior to incorporating those resources into his Plan activities.

A. Courses

Dr. Smith will:

1. Complete a comprehensive review course, such as The Core Content Family Medicine Review or the review course offered by American Academy of Family Medicine (AAFP). Information may be found at <http://www.corecontent.com/products.cfm> and <http://www.aafp.org>;

2. Attend a documentation 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. Smith 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. Complete a pain management course, such as the AMA online pain management series (12 modules) found at this link: <https://cme.ama-assn.org/Education.aspx>.

*If an approved course is not available within this timeframe, Dr. Smith should provide evidence of *enrollment* in the earliest available course within this time. It is important for Dr. Smith to attend the seminar early in his participation in the Plan so that he has time to integrate newly learned skills and sufficiently demonstrate his maintenance improvements in charts reviewed.

B. Evidence-Based Self-Study

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

1. Submit a brief paragraph, case based discussion, outline, or algorithm to summarize the major points learned;
 - a. In preparing the submission, Dr. Smith 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. Subscribe to *The Medical Letter* or *Prescriber's Letter* for current pharmacology review;
4. 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.;
5. Participate in self-study relevant to his practice for the duration of the Plan.

C. Practice-based Learning

Dr. Smith will:

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

D. Systems-based Practice

Dr. Smith 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

E. Computer-Based Medical Information Resources

Dr. Smith will:

1. If he does not already do so, utilize electronic resources at the point of care (in the inpatient and outpatient settings) 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.

F. Communication

Dr. Smith will:

1. Prior to the Preceptor observing patient encounters, read The Medical Interview by John L. Coulehan, M.D., and Marian R. Block, M.D., and discuss with the Preceptor;
2. Choose one of the following (a, b, or c) to complete:
 - a. Attend an individualized communication program with simulated patient encounters and immediate coaching and feedback. The Associate Medical Director must approve the program. A certificate of completion would be submitted to CPEP;
 - b. Obtain personalized communication training. The AMD must approve the training. A summary report of Dr. Smith's progress would be submitted within 30 days of completion of the training;
 - c. Receive Preceptor coaching and feedback as a result of 12 patient encounters observed by the Preceptor, at least three of which should be new patients.
3. After completion of number 2 above, submit to CPEP completed patient questionnaires addressing Dr. Smith's communication skills:
 - a. The questionnaire and more direction will be provided by CPEP.

MODULE B

PATIENT CARE ENHANCEMENT

During the activities described in this Module the Preceptor will provide feedback to Dr. Smith with regard to improvements in all areas of the Learning Goals. The Preceptor will coach Dr.

Smith 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.
- Once initiated, Preceptor Meetings and chart reviews will continue for the duration of the Plan.

A. FOCUSED PROFESSIONAL PRACTICE EXPERIENCE

To gain an understanding of Dr. Smith's organizational and communication skills, Dr. Smith will:

1. Manage patients under the direct observation and supervision of the Preceptor for *one day* in the outpatient setting *during the first week* of his participation in the Plan. This experience may be extended if it is determined that Dr. Smith would receive educational benefit from an extension;
2. Document the cases specifying the condition/diagnosis, procedure outcomes, and plan for each patient on the Case Log provided by CPEP.

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. Smith'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/her knowledge to actual patient care.

PRECEPTOR MEETINGS

Dr. Smith will:

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

Guideline

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

PRECEPTOR MEETING ACTIVITIES

Chart Review Objectives

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

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

During the Precepted Education, Dr. Smith will:

1. Retrospective Chart Reviews:
 - a. Submit to the Preceptor for review no fewer than 24 redacted* charts per month (12 charts per twice-monthly sessions);
 - 1) Cases should include inpatient and outpatient;
 - 2) The Preceptor may also specify cases to be reviewed;
 - 3) 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 also specify charts to be submitted;
 - c. Cases should be specifically relevant to the Plan as well as representative of the scope of Dr. Smith's practice, as much as possible;
2. Didactic Discussions and Coaching:
 - a. Clinical Judgment:
 - 1) With the Preceptor, discuss the Clinical Judgment Learning Goals and application of knowledge to patient care;
 - 2) Develop and discuss with the Preceptor systems (protocols, algorithms, and/or chart templates) or other strategies for organizing the clinical evaluation to ensure that the Clinical Judgment Learning Goals are addressed and that improvements are integrated into his daily patient care;
 - b. Documentation:
 - 1) Receive coaching from the Preceptor that addresses general documentation principles as well as the specific areas of need described in Learning Goal C, *Documentation*, including strategies and/or use of chart templates for improved documentation;
 - c. Medical Knowledge:
 - 1) Discuss with the Preceptor each topic and subtopic identified in Module A, including applicable and current evidence-based guidelines as available. Dr. Smith should also discuss his topic/subtopic summaries with the Preceptor;
 - d. Communication:
 - 1) Receive coaching and review reference materials described in the Plan related to communication skills;

3. Lifelong Learning:

a. Develop lifelong learning skills:

- 1) Discuss and develop a plan with the Preceptor for maintaining current standards in family medicine after conclusion of the Educational Intervention. Discuss the plan with the Associate Medical Director and demonstrate ongoing learning throughout the duration of the Plan. The plan should:
 - a) Incorporate computer-based resources;
 - b) Integrate evidence-based medicine resources;
 - c) Promote lifelong learning;
 - d) Include activities that address clinical decision-making;

b. CPEP recommends that Dr. Smith:

- 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. Smith'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. Smith will sign and return the Plan to CPEP by November 1, 2013. 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 Job Description* (attached) identify a Preceptor candidate if Dr. Smith has not already done so;
 - 1) The Preceptor must be board certified in the same specialty and have a practice similar to Dr. Smith's;
2. Provide a copy of the Plan, the attached *Preceptor Job Description* and 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 December 1, 2013, Dr. Smith 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. Smith 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 Job Description*. 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. Smith will:

1. Maintain Education 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;
2. Submit materials:
 - a. By the fifth of every month, submit:
 - 1) Education Logs;
 - 2) Preceptor Report forms completed by the Preceptor;
 - 3) 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 Focused Professional Practice Experience;
 - 2) Topic/subtopic summaries;
 - 3) CME certificates and/or other documentation of completed activities specified in the Plan (if applicable);
3. Submit Charts:
 - a. 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. Smith's appointment and hospital schedule;

4. Be responsible for his and his Preceptor's participation in the Plan activities and his educational progress;
5. 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. Smith and to other entities for which Dr. Smith has provided authorization. The Progress Reports will capture Dr. Smith'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. Smith 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. Smith's scope of practice. (See Section 5:1(e) of the CPEP *Educational Intervention Participation Agreement* for more information.)

- Dr. Smith 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

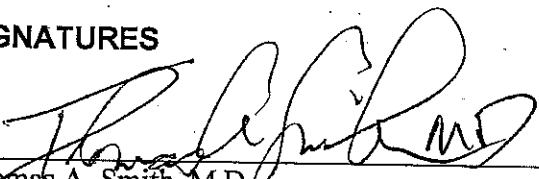
Most participants complete an Education Plan in approximately 12-18 months. The actual duration varies depending on many factors including the scope of educational needs identified.

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.
- 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. Smith does not engage in this Plan by November 14, 2014, CPEP may require completion of additional Assessment activities to ensure that Dr. Smith's current educational needs are addressed.

SIGNATURES



Thomas A. Smith, M.D.

12/3/13

Date

Patricia Kelly, M.D.
Associate Medical Director

Date

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

APR 11 2013

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1476

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY THOMAS A. SMITH, M.D., LICENSE NO. 26421, 96 WALKER HILL, STAFFORDSVILLE, KENTUCKY 41256

AGREED ORDER OF PERMANENT RESTRICTION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Thomas A. Smith, M.D. (hereafter "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 PERMANENT RESTRICTION:

STIPULATIONS OF FACT

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

1. At all relevant times, Thomas A. Smith, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Family Medicine.
3. On July 24, 2003, the licensee resolved an investigation into his prescribing practices by entering into an Agreed Order in Board Case No. 887. Under the terms of that Agreed Order, the licensee was required to successfully complete an approved prescribing course and an approved documentation program. He was also required to maintain a controlled substances log and submit his log and records for reviews by a Board consultant.

4. The Office of Inspector General (OIG) received an anonymous grievance alleging that there were groups of people waiting the licensee's parking lot to get controlled substances, acting intoxicated and trading unknown items in the parking lot. After receiving this complaint, OIG reviewed the licensee's prescribing practices and reported that certain patient records should be reviewed by the Board based upon age, distance traveled, addictive drug combinations, and polypharmacy. 12 patients were identified for review.

5. The Board obtained 15 patient records and provided them to a Board consultant for review. The consultant provided a written report that included the following findings and conclusions,

1. Initial Evaluation:

... The problems in initial evaluation of patients included failure to list or mention current medications, even prior medications that the patient had taken. In a few cases there were KASPERS showing recent medications, but I can't remember any early ones that revealed patient taking narcotics. There generally seemed to be no mention of tests or scans that revealed the extent of the problem. In the old part of the records, some scans were noted but these often were not even specifically mentioned in the evaluation of the patient. One patient even got narcotics for a condition (pain in back) not even mentioned in the complaints. Another given medication based on what the patient and wife said. There was often no clear pathway from history on to physical on to assessment that gave a clear picture why patient was started on the dosage of medication he or she got. The patient may well have needed the medication at that dosage, but it was very difficult to tell from the information provided.

2. Medical Records:

It was difficult to follow or tell from the records what was happening to the patient at any specified time. The records were voluminous, but repetitious, duplicated, like "rubber stamped". One case, a workman's compensation injury involved a patient, Patient A. It was being reviewed by a couple of physicians who noted it was difficult to tell if a particular medicine was justified because of computer generated repetitious records and basic duplications. They noted that nothing changed from visit to visit and couldn't understand why the patient even had to be seen monthly. Both the history and

physical exams were repetitious, often for 4 or 5 years. One common part of the physical, the back exam, remained the same for years. The medicine dosage changed, but the exam did not. It was difficult to tell what was going on with the patient at any given time. Another example was the plan saying "needs pain clinic appointment and get MRI"; for years! Sometimes statement in the notes mentioned need to schedule a test which had already been done 1-2 years prior. Basically indicating that not much attention was paid to what was going on, just computer generated records, often unchanged from visit to visit.

3. Medication:

As mentioned, medications were often initiated without revealing prior or current medications. At times medication was started at a moderately high level such as Lorcet 10mg or Oxycodone 10 m 4 times daily. There was no mention why smaller dosed could not be initiated and increased if needed. Starting at a moderately high level obviously means increases in dosages are going to result in taking high dosages.

Narcotics and other controlled medications were increased, or in some cases initiated, without any **rationale** or **notation** in the chart as to why being done. One could see from the notation of "medicine given today", what was being prescribed, but no discussion why. Patients' response to medications rarely discussed. It was noted in the subjective for long time that pain was "bad and worsening" in one chart despite being maintained on rather large dosages of medication.

In some instances, not often, narcotics were reduced briefly, never weaned.

Soma was used with Valium 10 mg in a few patients, or Soma with another tranquilizer. Since Soma is an anti-anxiety medication with some muscle relaxing affect, would appear to be double dosing the patient with tranquilizer, plus having narcotics on board.

As seen from the worksheets some patients were on quite high levels of oxycodone, even up to **120 to 150 mg** per day, quite a dosage for primary care physicians and thus diverting requiring close monitoring, especially for compliance in not diverting medicine. One area where the chart was helpful was the medication and very helpful to follow current narcotic and other controlled medications. Patients, however, should be started on the smallest amount of medication (dosage) initially that might have some affect, not large amounts **initially**.

4. Compliance Monitoring:

A KASPER from 6/2011 to 6/2012 was done by Dr. Smith and sent with each chart. Most charts had at least one KASPER before and generally (few exceptions) showed they were obtaining medication just from him.

Urine drug screening (UDS) was done on most charts, some having 5 or 6 over the years. Unfortunately, with one exception, every chart had at least one

and as many as 5 (Patient B) inappropriate (non-compliant) drug tests. Mainly medications prescribed not present, but some with medications present not prescribed. Unfortunately, Dr. Smith did not mention this in any chart progress note, nor were they repeated. In his summary to the Board, he discussed the last UDS' that were performed on the patients and **only 2** were compliant with one of those having inappropriate tests prior. The other complaint test was on Patient C who had just had his Lortab stopped after the Board's inquiry. He had not had a test prior. He was taking Lortab before for "conversion reaction"; no way to be sure patients were not diverting drugs because of the non-compliant tests.

5. Consults:

Some patients had pain consults in the past. However, it certainly appeared at least 5 or 6 patients in the reviews needed to see pain physicians, even just for opinion and help with medications management. Even those who had seen a pain physician in the past could have been re-evaluated at intervals. Dr. Smith's notes in several patients' charts mentioned seeing a pain physician, **repeatedly**, but he didn't follow through. This is especially true when patients are taking rather high dosages of narcotics.

Over half of cases appeared to have depression and almost all had anxiety. Psychiatric evaluation appeared to be needed to help manage some patients, but rarely done... a few cases that was perhaps their **primary** problem.

Also seemingly rare was orthopedic consults, especially in several patients where just an opinion or consult may well have reduced their need for high dosage of narcotics.

6. General Medical Care:

Most of the patients had some sort of medical problems, e.g. Diabetes, hypertension, elevated lipids, obesity, etc. Several patients were prescribed Adipex for weight loss. In one case, patient appeared to be taking 4 per day for a few months. Either that or was diverting drugs. Could not understand why patients were usually started 1 ½ to 2 per day, instead of **just one daily initially** to see how he or she did. One patient told him in her initial evaluation "it helped her nerves" and was given the Adipex, not appropriate for that complaint.

Blood pressure in a couple of patients was a problem. Especially in one patient where it was elevated over 75% of the time. There was no mention of attacking this in the chart but was on blood pressure medicines, just not mentioning increasing dosages, etc.

Labs were done on most of the patients that were appropriate; however there was never any mention of **results** of any of the labs in the physician's medical records, nor plan for treatment of such. (E.g. diet, particular medication, lifestyle changes, etc.) – Often the medication list showed medicines for the particular problem, but not much information available on

how was doing, etc. One has to go through the labs in the chart to see if any progress made, or to see what the patient's medical problem and severity of it is. Weight Loss with the Adipex was not often appearing to be effective, but yet still getting the medications. More attention was directed to pain control treatment than anything else.

In summary, more thorough initial evaluation to include all scans, x-rays or blood work pertinent to the problem (pain or medical) is needed. This includes thorough history to include prior medications that lead up to current medications patient is taking. Prior tests should be discussed and copies of scans, x-rays, etc., made a part of record. After initial evaluation, patient should be started on **smallest dosage possible** or narcotics to control symptoms and establish what the goals are and if being met. Especially it should be noted in the chart **why** medicine is being increased instead of just putting it in the list prescribed medicines.

Some evidence should be present on each visit that patient was examined and "rubber stamping" the exams stopped. Compliance monitoring, primarily UDS appeared to be useless, as **never** addressed. Therefore it appears patients could easily be diverting drugs or abusing them.

Consults should be considered and done more often, especially considering the dosage of medication the patients are prescribed.

Dr. Smith could reduce the volume of paperwork by 75% and have 100% more information if various problems were addressed. It was difficult to justify, or understand why so many patients were being seen every 2 weeks, when nothing was changed over long periods of times, in some cases 1-2 years. The charts had 2 sets of chief complaints, 2 subjectives that often were repetitious for months or years. Past medical histories or review of systems never elaborated on the positives. Example – often had history (+) depression without any elaboration of degree of depression, prior meds, prior psychiatric care, etc. This generally applied to most all of + ROS and + MH, with no elaboration.

6. By letter dated August 31, 2013, the licensee and his attorney filed the following response to the consultant's findings, contesting many of his findings and conclusions.

1. Initial Evaluation:

Medinotes EMR had ongoing list of current medications for each patient easily accessible by tab. Also, we had a list in the SOAP note labeled USUAL PATIENT MEDICATIONS which we always attempted to keep updated, assisted by the electronic medical record insert, which was inserted at that location and opened into the medication list in the program when clicked on.

All Kaspers were not sent with the charts. Some older ones in storage charts on patients with us many years.

These are all information readily available in the chart.

2. Medical Records:

We use every method we can to track the patient and to keep their information accessible and organized. The flow of the care can be followed easily. In a sense, however, with transition to a new EMR; with partial paper and partial paperless charts; with two hospitals to attend; and with information hidden in many places in the electronic records accessible by simply clicking on a tab, you just have to know where to look. There is a learning curve on any EMR, and all the bells and whistles can be daunting. However, with training on the major sources of information on the patient most physicians placed in front of my EMR could care for the patient. The staff could print the progress notes if necessary, or give a pointer or two on our program.

We do not have any trouble knowing what is going on with the patient at any given time. We try to keep up with and record everything. Again, the templates are just a tool we use to try to care for the patient and we do not view them as gratuitous just to "fill in a chart."

The template is a framework to hang new data on. That does not mean the other is not done, but I do not change it if there is nothing new found or if the patient's condition is not changed in a given area. Some patients seen for years are the same every time you see the, sometimes for a long time. That does not mean we do not evaluate the patient and try to keep up with their care. Some insurer's like worker's compensation, will not pay for us to care for any but the one problem. If any other care is given the patient, we generally have to do that under another insurance or for free.

3. Medication:

Most of my patients are on disability ordered by the court for various reasons, and may have high levels of pain. Many of them have back problems. Many of the patients that come to me have already been on pain medicine and/or other controlled substances for years prior to ever coming to me. Many have been to pain clinic(s) already, as well as neurosurgeons.

4. Compliance Monitoring:

I have obtained Kaspers on all patients on controlled substances for approximately a decade, from the first moment they were available to the doctors. I currently follow all HB1 guidelines for obtaining Kaspers, and even more often PRN. I have often obtained these from West Virginia as well, and occasionally from Ohio, although it is a more difficult process there.

I sign the results of all labs and have a special mark when they are to be filled. Others are left loose in the chart (most recent) in order to go over with the patient. So I try always to be aware of what has been done and try to go over it on subsequent visits with the patients. In the past, I chiefly checked for extraneous medications or substances in the urine.

5. Consults:

The patients were often requested to go to pain clinic to no avail; sometimes due to finances, sometimes due to insurance refusal to authorize, sometimes due to lack of travel expenses, sometimes due to fear of injections, sometimes due to having already been and not wanting to ever go back.

6. General Medical Care:

I am always mindful to address these as much as possible. Healthcare prevention is covered in most of the patient's visits to one degree or another and tests or other appropriate measures/mediations are ordered. Most of my patients have many medical problems, often very severe. I deal with a low income stratum, most of whom are on welfare or disability. I have many uninsured patients as well. Many of my patients are derived from on-call service at the two local hospitals, and often have advanced intractable disease. The rates of diabetes, hypertension, heart disease, smoking related ailments, mental illness, morbid obesity, etc. are astronomical in this impoverished area of Appalachia, especially in the poor.

My first goal for patients is 140/90 as I explain to them, then second goal 130/80 if feasible and tolerated to reach the cardiological societies preferences. This is not always possible in some patients, or reasonable for various reasons. I do have a historical record for patients' vitals available in the EMR for graphing or printing and refer often to that to monitor how the patient has been doing on an average, rather than any one single measurement.

All labs are reviewed and signed off on. TAS means I have reviewed the lab and may want to follow further with the patient and these are left in the chart loose for next visit. Capital "S," often made large, means I have reviewed the labs and/or dealt with them and they can be filed. I often write notes on abnormal to my nurse or give verbal order that patient needs to "SEE M.D." or "SEE M.D. STAT" for the nurse to get that patient into clinic. All abnormal labs are dealt with and most of the time the instructions or treatment are written beside the abnormal lab(s) on the lab report before filing or giving to the nurse to proceed with others. Often dietary changes/sheets are ordered on the right hand corner of the encounter forms, to be done by staff, who knows to follow these instructions. The same is done for referrals, prostheses, medical tests to be arranged, and further labs or tests. The patient labs have NEVER been ignored.

ALL abnormal labs and tests are COMPARED to the last labs or tests, just as one would do in a hospital. Most of our charts have filing tabs listed "Lab," "X-ray," etc. to keep organized. The labs, and all other data are filed as in any chart in reverse order, so all data can be immediately viewed and compared chronologically with ease. With 5--10 medical problems, changes in medications and treatments sometimes are rapid fire and not listed in the SOAP note, but the medications that are active and a complete list of medications are available immediately on a drop-down in the EMR, and all notes are preserved showing any changes made in that visit, and a complete list of ALL medications prescribed and date is available in the E-scribe listing all dates and prescriptions, as well as in the

program. The list of controlled substances at the bottom of all chart visit notes is kept so that any changes made easily visible if patient is on controlled substances.

If patients are seen every month or every two weeks, it is chiefly from trying to follow the previous KBML dictum to "see the patients (on controlled substances) often and give them small amounts." I have tried multiple variations but giving refills always seemed to exacerbate overuse because the patients would somehow always manage to find a pharmacy to give them the refills early.

I am always keenly on the alert for patients with depression and treat a great number with medications for that disorder, either for primary depressive disorders or secondary, such as to pain, etc. I always approach the patient for antidepressant if they appear to need such. Many turn antidepressants down. Many ask for benzodiazepines for depression, which is refused, as is a depressant.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's Kentucky 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(9), as illustrated by KRS 311.597(1), (3) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Permanent Restriction.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending investigation without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Permanent Restriction.

AGREED ORDER OF PERMANENT RESTRICTION

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 PERMANENT RESTRICTION:

1. The license to practice medicine in the Commonwealth of Kentucky held by Thomas A. Smith, 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 of Permanent Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:
 - a. The licensee SHALL NOT prescribe, dispense, or otherwise utilize controlled substances for the remainder of his medical practice. This is a permanent restriction that will remain in place for the remainder of the licensee's practice, and SHALL NOT be subject to reconsideration, modification, or termination, with the single exception of clarification set out in Condition 2g, infra. As an express consideration for the Panel's not revoking his license or requiring surrender of his license, the licensee expressly agrees that he will not file any request for reconsideration, modification, or termination and the Panel will not consider any request for reconsideration, modification, or termination, but may consider the limited opportunity for clarification set out in Condition 2g, infra.
 - b. Within twenty (20) days of the filing of this Agreed Order, the licensee shall contact Center for Personalized Education for Physicians ("CPEP"), 7351 Lowry Boulevard, Suite 100, Denver Colorado 80230 (303) 577-

3232 Fax: (303) 577-3241, to schedule a clinical skills assessment for the earliest dates available to both CPEP and the licensee;

- c. 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;
- d. The licensee shall travel to CPEP and complete the assessment as scheduled, at his/her expense;
- e. Both parties will be provided a copy of the Assessment Report for their review. The licensee shall complete any necessary waiver/release so that the Board may receive a copy of the Assessment Report for review;
- f. 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;
- g. After reviewing the CPEP Assessment Report and Educational Plan, if recommended, the Panel may impose additional conditions to address deficiencies or practice problems identified in those documents, including but not limited to, a requirement that the licensee successfully complete the Educational Plan and any Post-Education Evaluation, if recommended, at his expense and as directed by CPEP staff. After

reviewing the CPEP Assessment Report and Educational Plan, and if the licensee has made a specific request that the Panel do so, the Panel will determine whether the permanent restriction should be clarified in a manner that would permit the licensee to order the administration of controlled substances to his patients who are properly and currently admitted to a licensed hospital but no prescribing of controlled substances upon discharge.

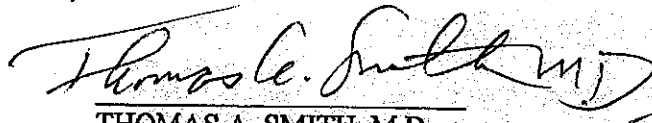
- h. The licensee SHALL pay the costs of the investigation in the amount of \$6,000.00 within sixty (60) months from entry of this Agreed Order of Permanent Restriction, paying at least \$1,200 during each 12 month period following the date of filing of this Agreed Order of Permanent Restriction;
 - i. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.
3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Permanent Restriction, 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 Permanent Restriction, 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 Permanent Restriction 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 Permanent Restriction.

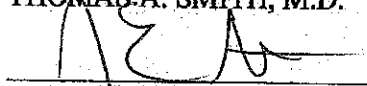
4. The licensee understands and agrees that any violation of the terms of this Agreed Order of Permanent Restriction would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 10 day of April, 2013.

FOR THE LICENSEE:

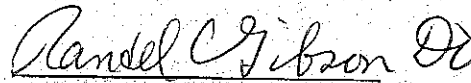


THOMAS A. SMITH, M.D.

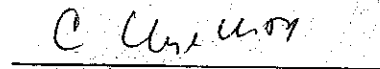


JAMES E. SMITH
COUNSEL FOR THE LICENSEE

FOR THE BOARD:



RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B



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

FILED OF RECORD

JUL 24 2003

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 887

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY THOMAS A. SMITH, M.D., LICENSE NO. ~~01067~~, 713
WEST BROADWAY AVENUE, PAINTSVILLE, KENTUCKY 41240 ²⁶⁴²¹

AGREED ORDER

Comes now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Thomas A. Smith, M.D., and, based upon their mutual desire to fully and finally resolve a pending grievance without evidentiary proceedings, 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, Thomas A. Smith, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Family Practice.
3. In September 2000, the Board received a grievance from the Office of the Attorney General, Medicaid Fraud and Abuse Division regarding the licensee. After an investigation and review of thirty-two (32) patient charts by their consultant into the billing practices of the licensee, the matter was referred to the Board to review the appropriateness of the licensee's prescribing of controlled substances.

4. The Consultant for the Medicaid Fraud and Abuse Division reviewed thirty-two (32) patient charts and concluded that the licensee's prescribing practices were inappropriate. In the Consultant's summary, she opined:

"The physician prescribes narcotics with insufficient information and for inappropriate periods of time. He provides inadequate information to the patients concerning the proper use, effects and interactions of the drugs he prescribes. He employs a particularly dangerous form of polypharmacy and appears to have no insight regarding the harmful effects on his patients.

This physician clearly has difficulty setting limits with patients. A pattern of behavior exists that could be said to just miss being abusive while facilitating abusive behavior on the part of certain patients. In other words, the physician misses being abusive in the individual case by cloaking his actions in a sort of studied gullibility, though he is patently aware that drug seekers and drug abusers will take advantage of this posture.

It is the strong opinion of this reviewer that the physician needs remedial education on these issues."

5. In addition to the concerns expressed by the Consultant of the licensee's prescribing pattern of unrestrained polypharmacy and failure to adequately alert patients of drug interactions, the Consultant finds that the licensee prescribes controlled substances on a short-term and long-term basis without reasonable justification. The Consultant notes that the licensee "regularly documents encouraging patients to minimize their reliance on narcotics, and regularly admonishes them that he will not provide 'extra' doses of narcotics. However, as he routinely does prescribe extra doses these cautions are somewhat disingenuous." The Consultant points out that despite the licensee's awareness of the interaction between Lorcet and Soma and its addictive potential, he frequently prescribes the two drugs in tandem. Although the licensee utilizes drug screens

for patients on long-term narcotics, the Consultant noted that the licensee will ignore obvious red flags.

6. The Consultant also raised concern with the licensee's lack of thorough medical evaluations. The Consultant stated as follows:

"It is not only the patients with pain that are slighted in respect to a thorough medical evaluation. There are a number of other symptoms or problems, which appear to elicit an automatic response (prescription), without due inquiry and investigation on the part of the physician. Most psychiatric complaints and symptoms appear to fall into this category. The physician takes it upon himself to treat psychiatric complaints, sometimes of a severe recurring variety (major depression, bipolar disorder), although he does not have the habit of doing a good psychiatric evaluation of patients and generally seems to prescribe on a hit-or-miss basis, with little or no counseling or therapeutic interaction documented."

7. In June 2002, a Consultant for the Board reviewed a number of patient charts. These charts included a number of charts reviewed by the Medicaid Consultant and a number of new charts obtained as part of the Board's investigation. The Board Consultant concluded that the licensee does not fully meet the accepted standards of medical practice in the areas of medical records documentation and prescribing of medication. Due to the licensee's departure from the standard of care, the Board Consultant expresses the opinion that the licensee has not provided optimum or minimal care for many of his patients. The Board consultant found the licensee's practice to bring a discredit on the profession as a whole, and in some instances constitute a hazard to his patients. The Board Consultant states that despite the licensee's "errors of omission and commission, it is apparent that he wishes to provide a service to the patients who come to him. If that compassion, and the basic knowledge he obviously possesses could be channeled in the right direction, it is my belief that he can be a valuable asset to

his community. Remedial education is certainly a viable resource to direct his talents if he is amenable to it.”

8. In the area of medical records documentation, the Board consultant found problems with the licensee’s failure to obtain prior records to substantiate or expand upon the patient’s version of his/her complaint. Despite the lack of verifying records or diagnostic studies, the licensee was noted to have prescribed various narcotics, a controlled substance muscle relaxant, and controlled substance tranquilizers from day one.
9. The Board Consultant raises concern over the licensee’s prescribing practices of controlled substances. The Consultant notes that medications are continued indefinitely in most patients, without documentation of the response to the medication, the functional capacity of the patient, or documented attempts to provide different or better drugs or other treatment modalities for them. The Board Consultant also found the licensee was merely “paying lip service” to his concern about patients becoming addicted to or abusing drugs, as he failed to follow through on warnings to patients about limiting their prescriptions. In one patient, the Board Consultant found that the licensee continued to prescribe narcotics and Soma to the patient after the patient was dismissed from the licensee’s practice when a KAPSER revealed the patient was obtaining drugs from other sources.
10. The Board Consultant found that the licensee’s prescribing of non-controlled substances was not always rational and justified. The Consultant found the

prescribing of antibiotics was done without any evidence of symptoms or diagnosis to justify the prescription.

11. On September 20, 2002, the licensee provided a written response to the grievance and consultant reports. The licensee indicated that he was first alerted to a problem of his practice being an "easy target" for drug seekers in September 1999 by Doug Wilson, former Medical Investigator. The licensee reports that he took steps to remedy the situation immediately and has since 1999 attempted to avoid any breeches of appropriate prescribing practices. In response to the grievance, the licensee states as follows:

"I have reviewed the examiners' reports in depth, and note that nearly all of the criticisms come from the period prior to three years ago. It was not then, and never, my intent to attract any abusers to my practice. It was never my intent to prescribe controlled substances for any purpose other than to relieve pain and suffering. It was never my intent to be manipulated. It certainly was never my intent to prescribe controlled substances for profit. I tried diligently to work on, and tried to get all patients to work on their health problems, not just pain control."

12. The licensee explains that he has reviewed the Consultants' concerns and is addressing those concerns. The licensee states that he is taking steps to keep his charts better organized, including a paper medicine flow sheet. The licensee is reviewing prescribing practices of controlled substances and antibiotics. He is also reviewing drug interactions and addressing these interactions and potential side effects with patients.
13. In October 2002, the Panel requested the licensee to enter into an Agreed Order of Indefinite Restriction. Under the terms of the proposed Agreed Order of Indefinite Restriction, the licensee would not prescribe controlled substances, would attend the Center for Personalized Education for Physicians (CPEP) for a

clinical skills evaluation and would attend the University of Kentucky's mini-residency on "The Use and Prescribing of Controlled Substances" or an equivalent course previously approved by the Board. After consultation with his attorney, the licensee submitted a detailed response to the Board Consultant's initial evaluation through his attorney on February 7, 2003. The licensee's detailed response elaborated on his September 2002 response. The licensee's response was submitted to the Board Consultant.

14. On March 21, 2003, the Board Consultant issued a second report based upon the licensee's February 2003 response. The Board Consultant reported as follows:

"I have reviewed the opinion that I submitted in regard to the grievance against Dr. Smith. Of the 14 records that I reviewed and offered an opinion about, six (6) covered service prior to September 1999 (9/99), four (4) were treated both before and after (9/99), two (2) covered service after (9/99), and in two (2) dates were not identified in my opinion summary. Of the 14 cases reported by me, only nine (9) were included in Dr. Smith's comments covering 37 of his patients.

During my initial review I did not focus on particular time periods, but looked for a pattern or patterns of practice which would lead to an opinion. After reviewing my individual patient summaries in the submitted opinion I found that indeed the patterns of practice, particularly prescribing habits, that evoked the greatest criticism occurred prior to 9/99. After that date little fault was found in managing patients received prescriptions for controlled substances but more with the quality and utility of his medical records.

15. The Panel reconsidered the licensee's case at a special meeting on June 26, 2003.

Based upon the additional information provided by the licensee and the Board Consultant, the Panel voted to request the licensee to enter into an Agreed Order under the terms stated herein.

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. Based upon the information in the Stipulations of Fact, there is evidence that the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by 311.597(4). Accordingly, there are legal bases for disciplinary action against his Kentucky medical license.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve the pending grievance through 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 the pending grievance without an evidentiary proceeding, the parties hereby ENTER INTO the following

AGREED ORDER:

1. During the effective period of this Agreed Order, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:
 - a. The licensee SHALL successfully complete the University of Kentucky's mini-residency on "The Use and Prescribing of Controlled Substances" or an equivalent course previously approved by the Board;

- b. The licensee shall maintain a "controlled substance log," for each instance in which the licensee prescribes, dispenses or otherwise professionally utilizes controlled substances. The "controlled substances log" must include date, patient name, patient complaint, medication prescribed, when it was last prescribed/dispensed/utilized 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. Dispensing information should be maintained in the patient chart and the log;
- c. Upon request, the licensee shall make the "controlled substances log" and/or all relevant patient charts available for review, by the Board's agents and/or Board consultants;
- d. The licensee SHALL routinely request and appropriately utilize KASPER reports for all patients for whom he has prescribed controlled substances;
- e. Within twenty (20) days of the filing of this Agreed Order, the licensee SHALL make all necessary arrangements to enroll in the Documentation Seminar at the Center for Personalized Education for Physicians (CPEP), Aurora, Colorado, at the earliest time. The licensee shall complete all CPEP courses at his expense;
- f. The licensee SHALL provide written verification that he has successfully completed CPEP's Documentation Seminar and has enrolled in the 6-month Post-Program;


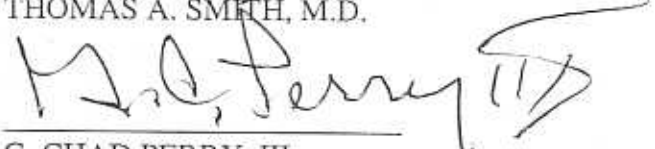
- g. The licensee SHALL provide written verification that he has successfully completed the 6-month CPEP Post-Program, at his expense, following his completion of the Documentation Course;
 - h. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations from the Documentation Course and Post-Program to the Board's Legal Department promptly after its completion;
 - i. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.
2. 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 or the Panel is authorized by law to enter an Emergency Order of Suspension or Emergency Order of Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation by the Board's General Counsel or Assistant General Counsel. If the Panel Chair or Panel 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.


3. The licensee understands and agrees that any violation of this Agreed Order may serve as the basis for disciplinary action pursuant to KRS 311.595(13), including revocation of his Kentucky medical license.

SO AGREED on this 16th day of July 2003.

FOR THE LICENSEE:


THOMAS A. SMITH, M.D.

G. CHAD PERRY, III
COUNSEL FOR THE LICENSEE

FOR THE BOARD:


PRESTON P. NUNNELLEY, M.D.
CHAIR, INQUIRY PANEL B


L. CHAD ELDER
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