COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1528

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY ANTHONY A. DeGUZMAN, M.D., LICENSE NO. 31110, 309 BROADWAY STREET, PAINTSVILLE, KENTUCKY 41240

AGREED ORDER OF RETIREMENT

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, and Anthony A. DeGuzman, M.D., ("the licensee"), and, based upon their mutual desire to fully and finally resolve this matter and to allow the licensee to retire without further Board action, hereby ENTER INTO the following **AGREED ORDER OF RETIREMENT**:

STIPULATIONS OF FACT

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

1. At all relevant times, Anthony A. DeGuzman, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is family medicine.
3. On or about May 21, 2013, the Board received a grievance which alleged concerns about the licensee's prescribing of Oxycodone, Xanax and Soma.
4. On or about June 4, 2013, the Office of the Inspector General ("OIG"), Division of Audits and Investigations, received a grievance which alleged that there was a lot of traffic at the licensee's medical office, including vehicles with out-of-state license plates.

5. On or around June 4, 2013, OIG Investigator, Amanda Ward, R.Ph., reviewed and analyzed the licensee's KASPER records (for the period of June 1, 2012 through May 30, 2013) and noted several concerns, including:

    - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
    - Long-term use of one or more controlled substances;
    - Patients traveling long distances;
    - Over 700 prescriptions for Oxycodone-containing medications written by the licensee from June 1, 2012, to May 30, 2013, with over 200 of those being written since May 1, 2013

    Ms. Ward identified fifteen (15) of the licensee's patients with prescribing patterns reflective of these concerns and recommended further investigation by the Board.

6. On or about June 28, 2013, OIG reported that Patient A had died of an overdose of medications prescribed to him by the licensee. Patient A saw the licensee on or about June 25, 2013 and filled prescriptions on that same date for #60 Soma 350 mg, #90 Neurontin 600 mg, #30 Percocet 10, and #60 Oxycodone 30 mg.

7. In or around August 2013, a Board consultant reviewed the licensee's patient charts for Patient A and the fifteen (15) OIG-identified patients and concluded that the licensee departed from or failed to conform to acceptable and prevailing medical practices; and that he committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross negligence, as well as instances of gross ignorance, gross incompetence and malpractice. The consultant stated,

    > In my opinion, Dr. DeGuzman's patient care is below the minimum standard of medical care. He is primarily prescribing high potency narcotics and sedatives, in large quantities, and without proper justification or documentation. His medical license should be immediately suspended or restricted.

In summary, the consultant noted:

- The licensee's practice does not look like a typical Internal Medicine or Family Practice because the focus is on the prescribing of controlled substances and not on the management of chronic illnesses. Rather, it is a Pain Management practice, in which large dosages of highly addictive medications are prescribed.
- The licensee treats a younger population than what is usually seen in internal medicine practices.
- History portions of patient charts lacks pertinent details of previous illnesses, specifically:
    - Details on previous course of treatments
    - Details on previous medications received or how patient responded
- Reviews of Systems (ROS) are incomplete and very brief. A common ROS finding in his charts is "Anxiety" only.
- Follow up notes are pre-printed, very brief, and lacking detail about patient problems, goals or objectives.
- The licensee does not make referrals to specialists, such as Neurosurgeons, Orthopedic Surgeons, Psychiatrists, or Pain Management Clinics to receive a second opinion.
- Most patients are not subjected to urine drug screens, which is one of the tools to help physicians identify potential drug abuse or diversions. In some cases, the licensee obtained urine drug screens and continued to write controlled substances after patients tested positive for other substances.
- In the case of a patient with evidence of Chronic Liver Disease and history of alcohol abuse, the licensee continued to prescribe narcotics, when potential harm to the patient was very high.
- Although the licensee had KASPER in many patient charts, he did not demonstrate appropriate response to evidence of patients receiving controlled substances from other providers and in other cities.
- The licensee had imaging studies in many patient charts, but interpreted nearly any abnormality as justification for narcotic prescriptions. Instead, a physician should use a step-wise comprehensive approach, starting with non-narcotic medications and therapies and obtaining opinions from specialists. If those options are proven unable to provide the patient relief and functional improvement, then a physician should consider narcotics, starting with small doses for short periods of time.

8. On October 17, 2013, the Board's Inquiry Panel A reviewed the investigation and the licensee appeared before and was heard by the Panel before it deliberated. The Panel and the licensee agreed to enter into an Agreed Order of Indefinite Restriction, in lieu of the issuance of a Complaint and Emergency Order of Restriction, on November 12,

2013. Pursuant to the Agreed Order of Indefinite Restriction, the licensee became restricted from prescribing, dispensing or otherwise professionally utilizing controlled substances, agreed to submit to a clinical skills assessment at the Center for Personalized Education for Physicians ("CPEP"), and agreed to reimburse the Board's costs of $1,050.00 within six months.

9. On or about December 12-13, 2013, the licensee submitted to a clinical skills assessment at CPEP, to evaluate his practice of outpatient internal medicine and pain management. CPEP found that

> Dr. deGuzman demonstrated poor knowledge of chronic pain management. His knowledge of internal medicine was broad, but superficial. His clinical judgment and reasoning were poor. Dr. deGuzman's communication skills were poor with Simulated Patients (SPs) and professional with peers. His documentation in patient charts submitted for review was inadequate; his documentation of the SP encounters was marginally adequate.
> ...
> ... Dr. deGuzman's cognitive function screen results were below expectations.
>
> ...Based on Dr. deGuzman's neuropsychological screening test results, more extensive evaluation involving a comprehensive neuropsychological examination is recommended. ...
> ...
> Because of the extent of the deficiencies identified, CPEP believes that Dr. deGuzman should retrain in a fellowship or other formal educational setting. CPEP does not believe that Dr. deGuzman demonstrated the ability to practice independently in providing pain management care while attempting to remediate his clinical skills.
>
> While Dr. deGuzman demonstrated significant educational needs in outpatient internal medicine, CPEP opines that an attempt at supervised remedial education would be appropriate. ...

10. In or around May 2014, at the licensee's request, CPEP developed an Educational Intervention Plan in regard to his practice of outpatient internal medicine. The plan requires, in part, that the licensee practice with direct supervision of a Preceptor in

Point of Care activities for an indefinite period of time until he demonstrates competency to see patients independently/unsupervised.

11. On or about September 10, 2014, the licensee entered into an Amended Agreed Order of Indefinite Restriction, pursuant to which the licensee was

- Restricted to the practice of outpatient internal medicine;
- Prohibited from prescribing, dispensing, or otherwise professionally utilizing controlled substances unless and until approved to do so by the Panel;
- Required to identify and secure a CPEP-approved preceptor to directly supervise his practice of medicine;
- Required to actively seek a CPEP-approved preceptor and provide the Board with copies of all correspondence to and from potential preceptors in order to document his efforts, within ten (10) days of sending or receiving said correspondence;
- Required to engage CPEP's preceptor locator services and provide the Board with documentation to support that he has engaged those services;
- If after three (3) months, the licensee has not secured a CPEP-approved preceptor to directly supervise his practice of medicine, the licensee shall immediately cease the practice of medicine and shall not engage in any act which would constitute the "practice of medicine" as that term is defined by KRS 311.550(10) until approved to do so by the Panel;
- Within twenty (20) days, initiate the CPEP Educational Intervention Program (attached), as developed for him in May 2014;
- Required to successfully complete all requirements of that Educational Intervention Program, at his expense and as directed by CPEP;
- If deemed necessary and appropriate by CPEP, successfully complete the Post-Education Assessment, at his expense and as directed by CPEP;
- Required to take all necessary steps, including the execution of waivers and/or releases, to ensure that CPEP provides timely written reports to the Board outlining his compliance with the Educational Intervention; and
- Prohibited from further violating any provision of KRS 311.595 and/or 311.597.

12. On or about March 30, 2015, the licensee informed the Board that he was closing his medical practice and retiring from the practice of medicine.

STIPULATED CONCLUSIONS OF LAW

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

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(3) and (4), and (13). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Retirement.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter by entering into an informal resolution such as this Agreed Order of Retirement.

AGREED ORDER OF RETIREMENT

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this matter and to allow the licensee to retire without further Board action, the parties hereby ENTER INTO the following **AGREED ORDER OF RETIREMENT:**

1. In accordance with the licensee's stated intent, the license to practice medicine within the Commonwealth of Kentucky held by Anthony A. DeGuzman, M.D., is **RETIRED**, effective immediately upon the date of entry of this Agreed Order of Retirement and continuing for an indefinite period;

2. Beginning immediately and continuing throughout the indefinite period of this Agreed Order of Retirement, the licensee SHALL NOT perform any act, within the Commonwealth of Kentucky, which constitutes the "practice of medicine or osteopathy" as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction or any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities;

3. The licensee SHALL NOT petition the Board for reinstatement of his ability to again practice medicine in the Commonwealth of Kentucky, pursuant to KRS 311.607, prior to the expiration of two (2) years from entry of this Agreed Order of Retirement. Prior to petitioning for a license to again practice medicine, the licensee SHALL complete psychiatric and neuropsychological evaluations and a

Board-approved clinical skills assessment program, at his expense, and he SHALL satisfy to the Panel that he is of good moral character and both physically and mentally competent to resume the practice of medicine without undue risk or danger to patients or the public. The decision whether to allow the licensee to resume the practice of medicine in the Commonwealth of Kentucky lies within the sole discretion of the Panel and the licensee expressly agrees that, in the event that the Board should reinstate his ability to again practice medicine in the Commonwealth of Kentucky, it may require that he enter into an Agreed Order with the same terms and conditions set forth in the Amended Agreed Order of Indefinite Restriction, entered September 10, 2014, Case No. 1528, and any other terms and conditions which may be deemed appropriate by the Panel at that time;

4. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Retirement, 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 Retirement, 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 Retirement 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 Retirement; and

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

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

FOR THE LICENSEE:

ANTHONY A. DeGUZMAN, M.D.

[redacted] Nikant Vanka

COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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

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AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, and Anthony A. DeGuzman, M.D., ("the licensee"), and, based upon their mutual desire to fully and finally resolve this matter without an evidentiary hearing, hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION**:

STIPULATIONS OF FACT

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

1. At all relevant times, Anthony A. DeGuzman, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is family medicine.
3. On or about May 21, 2013, the Board received a grievance which alleged concerns about the licensee's prescribing of Oxycodone, Xanax and Soma.
4. On or about June 4, 2013, the Office of the Inspector General ("OIG"), Division of Audits and Investigations, received a grievance which alleged that there was a lot of traffic at the licensee's medical office, including vehicles with out-of-state license plates.

5. On or around June 4, 2013, OIG Investigator, Amanda Ward, R.Ph., reviewed and analyzed the licensee's KASPER records (for the period of June 1, 2012 through May 30, 2013) and noted several concerns, including:

    - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
    - Long-term use of one or more controlled substances;
    - Patients traveling long distances;
    - Over 700 prescriptions for Oxycodone-containing medications written by the licensee from June 1, 2012, to May 30, 2013, with over 200 of those being written since May 1, 2013

    Ms. Ward identified fifteen (15) of the licensee's patients with prescribing patterns reflective of these concerns and recommended further investigation by the Board.

6. On or about June 28, 2013, OIG reported that Patient A had died of an overdose of medications prescribed to him by the licensee. Patient A saw the licensee on or about June 25, 2013 and filled prescriptions on that same date for #60 Soma 350 mg, #90 Neurontin 600 mg, #30 Percocet 10, and #60 Oxycodone 30 mg.

7. In or around August 2013, a Board consultant reviewed the licensee's patient charts for Patient A and the fifteen (15) OIG-identified patients and concluded that the licensee departed from or failed to conform to acceptable and prevailing medical practices; and that he committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross negligence, as well as instances of gross ignorance, gross incompetence and malpractice. The consultant stated,

    > In my opinion, Dr. DeGuzman's patient care is below the minimum standard of medical care. He is primarily prescribing high potency narcotics and sedatives, in large quantities, and without proper justification or documentation. His medical license should be immediately suspended or restricted.

In summary, the consultant noted:

- The licensee's practice does not look like a typical Internal Medicine or Family Practice because the focus is on the prescribing of controlled substances and not on the management of chronic illnesses. Rather, it is a Pain Management practice, in which large dosages of highly addictive medications are prescribed.
- The licensee treats a younger population than what is usually seen in internal medicine practices.
- History portions of patient charts lacks pertinent details of previous illnesses, specifically:
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- Reviews of Systems (ROS) are incomplete and very brief. A common ROS finding in his charts is "Anxiety" only.
- Follow up notes are pre-printed, very brief, and lacking detail about patient problems, goals or objectives.
- The licensee does not make referrals to specialists, such as Neurosurgeons, Orthopedic Surgeons, Psychiatrists, or Pain Management Clinics to receive a second opinion.
- Most patients are not subjected to urine drug screens, which is one of the tools to help physicians identify potential drug abuse or diversions. In some cases, the licensee obtained urine drug screens and continued to write controlled substances after patients tested positive for other substances.
- In the case of a patient with evidence of Chronic Liver Disease and history of alcohol abuse, the licensee continued to prescribe narcotics, when potential harm to the patient was very high.
- Although the licensee had KASPER in many patient charts, he did not demonstrate appropriate response to evidence of patients receiving controlled substances from other providers and in other cities.
- The licensee had imaging studies in many patient charts, but interpreted nearly any abnormality as justification for narcotic prescriptions. Instead, a physician should use a step-wise comprehensive approach, starting with non-narcotic medications and therapies and obtaining opinions from specialists. If those options are proven unable to provide the patient relief and functional improvement, then a physician should consider narcotics, starting with small doses for short periods of time.

8. On October 17, 2013, the Board's Inquiry Panel A reviewed the investigation and the licensee appeared before and was heard by the Panel before it deliberated. The Panel and the licensee agreed to enter into this Agreed Order of Indefinite Restriction, in lieu of the issuance of a Complaint and Emergency Order of Restriction, on

November 12, 2013. Pursuant to the Agreed Order of Indefinite Restriction, the licensee became restricted from prescribing, dispensing or otherwise professionally utilizing controlled substances, agreed to submit to a clinical skills assessment at the Center for Personalized Education for Physicians ("CPEP"), and agreed to reimburse the Board's costs of $1,050.00 within six months.

9. On or about December 12-13, 2013, the licensee submitted to a clinical skills assessment at CPEP, to evaluate his practice of outpatient internal medicine and pain management. CPEP found that

> Dr. deGuzman demonstrated poor knowledge of chronic pain management. His knowledge of internal medicine was broad, but superficial. His clinical judgment and reasoning were poor. Dr. deGuzman's communication skills were poor with Simulated Patients (SPs) and professional with peers. His documentation in patient charts submitted for review was inadequate; his documentation of the SP encounters was marginally adequate.
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> ... Dr. deGuzman's cognitive function screen results were below expectations.
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> ...Based on Dr. deGuzman's neuropsychological screening test results, more extensive evaluation involving a comprehensive neuropsychological examination is recommended. ...
> ...
> Because of the extent of the deficiencies identified, CPEP believes that Dr. deGuzman should retrain in a fellowship or other formal educational setting. CPEP does not believe that Dr. deGuzman demonstrated the ability to practice independently in providing pain management care while attempting to remediate his clinical skills.
>
> While Dr. deGuzman demonstrated significant educational needs in outpatient internal medicine, CPEP opines that an attempt at supervised remedial education would be appropriate. ...

10. In or around May 2014, at the licensee's request, CPEP developed an Educational Intervention Plan in regard to his practice of outpatient internal medicine. The plan requires, in part, that the licensee practice with direct supervision of a Preceptor in

Point of Care activities for an indefinite period of time until he demonstrates competency to see patients independently/unsupervised.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Amended Agreed Order of Indefinite 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(3) and (4), and (13). Accordingly, there are legal grounds for the parties to enter into this Amended Agreed Order of Indefinite Restriction.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending grievance without an evidentiary hearing by entering into an informal resolution such as this Amended Agreed Order of Indefinite Restriction.

AMENDED AGREED ORDER OF INDEFINITE 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 matter without an evidentiary hearing, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Anthony A. DeGuzman, 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 Indefinite 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 professionally utilize controlled substances unless and until approved to do so by the Panel;

    b. The licensee SHALL ONLY engage in the practice of outpatient internal medicine;

    c. Within three (3) months of the filing of this Amended Agreed Order of Indefinite Restriction, the licensee SHALL have identified and secured a CPEP-approved preceptor to directly supervise his practice of medicine;

        i. The licensee SHALL actively seek a CPEP-approved preceptor and SHALL provide the Board with copies of all correspondence to and from potential preceptors in order to document his efforts, within ten (10) days of sending or receiving said correspondence;

        ii. The licensee SHALL engage CPEP's preceptor locator services and SHALL provide the Board with documentation to support that he has engaged those services;

        iii. If after three (3) months, the licensee has not secured a CPEP-approved preceptor to directly supervise his practice of medicine, the licensee SHALL immediately cease the practice of medicine and SHALL NOT engage in any act which would constitute the "practice of medicine" as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – until approved to do so by the Panel;

    d. Within twenty (20) days of the filing of this Amended Agreed Order of Indefinite Restriction, the licensee SHALL, at his expense, initiate the CPEP Educational Intervention Program (attached), as developed for him in May 2014;

i. The licensee SHALL successfully complete all requirements of that Educational Intervention Program, at his expense and as directed by CPEP;
ii. If deemed necessary and appropriate by CPEP, the licensee SHALL successfully complete the Post-Education Assessment, at his expense and as directed by CPEP;
iii. The licensee SHALL take all necessary steps, including the execution of waivers and/or releases, to ensure that CPEP provides timely written reports to the Board outlining his compliance with the Educational Intervention;

e. The licensee understands and agrees that if the Panel should allow the licensee to resume the professional utilization of controlled substances after completion of the above terms, it will do so by a Second Amended Agreed Order of Indefinite Restriction, which shall provide for the licensee to maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized and shall provide for periodic review of the log and relevant records by Board agents upon request, and any other conditions deemed necessary by the Panel at that time; and

f. 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 Indefinite 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 Indefinite Restriction, the Panel Chair is authorized by law to enter an Emergency Order of Suspension 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 Indefinite 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 Indefinite Restriction.

4. The licensee understands and agrees that any violation of the terms of this Amended Agreed Order of Indefinite 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 10th day of September, 2014.

FOR THE LICENSEE:

ANTHONY A. DeGUZMAN, M.D.

STEPHEN W. OWENS
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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

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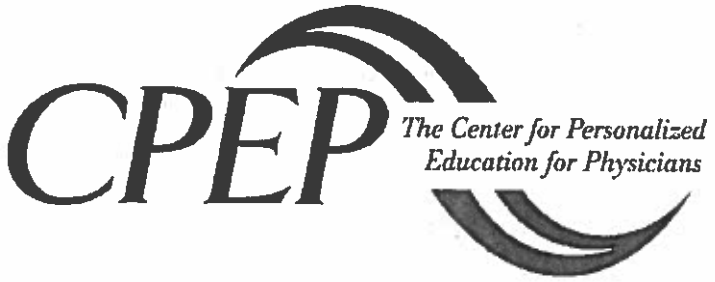

EDUCATIONAL INTERVENTION PROGRAM

EDUCATION PLAN

Developed May 2014

for

Anthony A. deGuzman, 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

APPENDICES

I. INTRODUCTION

According to the Kentucky Board of Medical Licensure's (Board's) Agreed Order of Indefinite Restriction (Order) dated November 12, 2013, Anthony A. deGuzman, M.D., was ordered to complete a clinical skills Assessment and comply with any resulting educational recommendations with CPEP. In December 2013, Dr. deGuzman 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. deGuzman. The purpose of this Plan is to provide a framework in which Dr. deGuzman can address his educational needs.

A glossary of Educational Intervention terms is enclosed.

FOCUS OF PLAN

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

Important to note:

- Dr. deGuzman's practice of pain management was also assessed. Because of the extent of the deficiencies identified, CPEP believes that Dr. deGuzman should retrain in a fellowship or other formal educational setting. CPEP does not believe that Dr. deGuzman demonstrated the ability to practice independently in providing pain management care while attempting to remediate his clinical skills. Therefore, pain management is not included in this Plan.
- Even if Dr. deGuzman does not plan to resume the management of chronic pain, following formal retraining, or prescribe opioids, the educational needs around prescribing should still be addressed as they pertain to prescribing other drugs with risks of addiction, abuse, and diversion.
- In accordance with the Board's Order, Dr. deGuzman "... shall not prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel."

LIMITATIONS

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

LICENSING

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

DESIGN

The individual Learning Goals described below in *Section II* were derived from the findings of the Assessment. This Plan was designed to address those Learning Goals through Medical Knowledge Enhancement and Patient Care Enhancement educational activities described in *Section III* as Modules A and B. Evaluation of Dr. deGuzman'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. deGuzman to begin the activities as soon as he has initiated the Plan. The recommended activities include:

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

B. Patient Care Enhancement (Module B)

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

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

C. Oversight

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

II. LEARNING GOALS

A. Medical Knowledge

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

Pain Management

1. Comprehensive understanding of the principles and practice of pain management and controlled substance prescribing, including but not limited to:
   a. Physiology of the different types of pain;
   b. Current ways to assess risk and screening tools to help identify those at risk for abuse or diversion;
   c. Role of the long-acting opioids;
   d. Spectrum of available opioids;
   e. Toxicology: Issues pertaining to opioid screening tests;
   f. Impact of comorbidities on opioid management.

Internal Medicine

1. Overall review in internal medicine;*
2. Routine health screening: vaccine recommendations;
3. Cardiology:
   a. Currently preferred biomarkers of MI;
   b. Indications for B-type natriuretic peptide (BNP) testing;
   c. ECG interpretation;*
4. Musculoskeletal:
   a. Full understanding of the physical findings in RA, including synovitis;
   b. Indications for imaging in back pain and imaging modality of choice;
5. Hematology:**
   a. Potential etiologies of anemia based on MCV and other testing;
   b. Hemolytic anemia;
6. Nephrology: normal GFR, estimating renal function/GFR based on serum creatinine;
7. Psychiatry: diagnostic criteria for depression;
8. Endocrinology:
   a. Diabetes:
      1) Initiation and management of insulin, including timing for sliding scale insulin administration;

2) Management of oral medications while initiating insulin;
3) Evaluation and diagnosis of diabetic neuropathy;
4) Appropriate screening for nephropathy;
5) Indications for screening ECGs in diabetics;

b. Thyroid disease:
1) Hypothyroidism:
a) Weight-based estimation of thyroid dosing;
b) Subclinical hypothyroidism;
c) Evaluation of hypothyroidism;
d) Indications for thyroid uptake scans;
2) Hyperthyroidism:
a) Subclinical hyperthyroidism;
b) Evaluation and causes of hyperthyroidism;

9. Infectious disease:**
a. Risk factors for MRSA and clinical scenarios in which MRSA should be considered;
b. Likely causative agents of cellulitis and abscesses;
10. Gastroenterology:**
a. Potential causes of elevated liver enzymes;
b. Evaluation of elevated liver function testing; testing for hepatitis.

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

B. Clinical Judgment

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

1. Ability to gather information in a logical, organized, and complete fashion;
2. Logical conclusions based on data;
3. Formulation of adequate differential diagnoses;
4. Appropriate diagnostic and treatment planning;
5. Appropriate controlled substance prescribing;
6. Appropriate overall management of patients seen for chronic pain, including controlled substance prescribing;
7. Avoidance of iatrogenesis, especially as it pertains to controlled substance prescribing.

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. Attention to legibility;
2. Avoidance of over-reliance on templated notes;

3. Consistent inclusion of all appropriate elements of a single-visit encounter note;
4. Consistent inclusion of adequate detail, including documentation of pain severity, location, radiation, and quality and presence or absence of "red flag" symptoms in patients with back or neck pain;
5. Appropriately thorough physical exams;
6. Documentation of effectiveness and adverse effects of prescribed therapy;
7. Documentation of clinical reasoning and discussion of differential diagnoses, when appropriate;
8. Complete documentation of prescriptions;
9. Evidence of consideration of the risks for drug abuse or diversion, including use of controlled substance agreements and documentation of urine drug testing and monitoring of the state-controlled substance prescription database;
10. Inclusion of problem lists;
11. Documentation that abnormal test results are reviewed and acted upon.

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. Consider increasing the amount of CME obtained through attendance at live CME conferences;
2. If not already in place, consider implementation of a system to allow easy access to information about his patient population for practice improvement opportunities.

E. Physician-Patient Communication Skills

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

1. Knocking prior to entering patient room;
2. Appropriate voice volume;
3. Establishment of rapport;
4. Use of open-ended questions;
5. Avoidance of excessive note-taking;
6. Demonstration of active listening and avoidance of repeating questions;
7. Use of the exam table for physical examinations;
8. Attention to patient discomfort;
9. Avoidance of excessive use of medical jargon.

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. deGuzman will:

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

Timelines

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

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

Guideline

The list of Medical Knowledge topics is extensive; therefore, it will be essential that Dr. deGuzman develop a strategy that ensures he submits all topic/subtopic summaries within six months of initiating the Plan so that he has ample time to demonstrate his application of new knowledge to his actual patient care during the Precepted Education component.

Associate Medical Director Approval of Resources

Dr. deGuzman 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. deGuzman 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. deGuzman will:

1. Complete a comprehensive review course in internal medicine, such as the Medical Knowledge Self-Assessment Program (MKSAP) offered by the American College of Physicians. Information can be found at http://www.acponline.org;
2. Attend a medical record keeping seminar within the first two quarters of participation in the Education Plan.* If ongoing documentation deficiencies are identified, the Associate Medical Director will make further recommendations. Dr. deGuzman should submit the following to CPEP:
   a. Course brochure within 30 days of signing the Plan for approval;
   b. Certificate of attendance upon completion.
      1) Subsequent to attending the seminar, or earlier, Dr. deGuzman will adopt a charting system that includes problem and medication lists, flow sheets, and controlled substance contracts;
3. Attend a CME course on prescribing, such as *Prescribing Controlled Drugs*, offered on various dates through the Vanderbilt Center for Professional Health, Nashville, Tennessee:
   http://www.mc.vanderbilt.edu/root/vumc.php?site=cph&doc=36613

*If an approved course is not available within this timeframe, Dr. deGuzman should provide evidence of *enrollment* in the earliest available course within this time.

Guideline

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

B. Electrocardiogram Interpretation Activities

Important to note:

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

Dr. deGuzman will:

1. Complete an ECG course, such as "12-Lead ECG Course" by Vernon R. Stanley, M.D., Ph.D., found online at: https://www.ecgcourse.com/;
2. Review at least 25 to 30 ECGs with the Preceptor;
3. Submit documentation of successful completion of an ECG course;
4. Document independent/unsupervised ECG reading and review as well as ECGs reviewed with the Preceptor on Education Logs.

C. Communication

Dr. deGuzman will:

1. 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 interactive communication workshop for physicians. The Associate Medical Director must approve the workshop. 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. deGuzman's progress would be submitted within 30 days of completion of the training;
   c. Periodically record (videotape or digital recording) patient encounters and submit the recordings to CPEP to be reviewed by CPEP's communication specialist and receive feedback that he would incorporate for improvements. Dr. deGuzman would need to have written permission from each patient and each patient must be aware that the recording would be reviewed by CPEP;
3. After completion of number 2 above, submit to CPEP completed patient questionnaires addressing Dr. deGuzman's communication skills.
   a. The questionnaire and more direction will be provided by CPEP.

D. Evidence-Based Self-Study

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

1. Submit a brief paragraph, case based discussion, outline, or algorithm to summarize the major points learned;
   a. In preparing the submission, Dr. deGuzman 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.

E. Case-Based Activities

Dr. deGuzman will:

1. Participate in case-based self-study activities, such as those offered online by the Cleveland Clinic Center for Continuing Education and *New England Journal of Medicine*:
   http://www.clevelandclinicmeded.com/
   www.nejm.org
   www.clinicalcases.org

F. Practice-based Learning

Dr. deGuzman will:

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

G. Systems-based Practice

Dr. deGuzman will:

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

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

H. Computer-Based Medical Information Resources

Dr. deGuzman will:

1. If he does not already do so, utilize electronic resources at the point of care, such as a handheld device and/or computer with access to the Internet. Software or web sites should assist with immediate access to up-to-date medical information relevant to medication prescribing and drug interactions, and patient care decisions, including formulating an adequate differential diagnosis, interpreting test results and evaluating treatment options.

MODULE B
PATIENT CARE ENHANCEMENT

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

Timeline

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

A. Point of Care Experience: Outpatient Care

During this experience Dr. deGuzman will:

1. Patient Volume:
   a. Limit his patient volume to ensure time to devote to each patient's data gathering and treatment planning;
2. End of Day Review:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, review each case with the Preceptor at the end of each day to determine if the exam and evaluation have been adequate and if the plan is appropriate;
   b. Document the cases specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP;
   c. Ensure that the Preceptor speaks with the Associate Medical Director prior to transitioning to the Onsite Consultation component;
3. Weekly Preceptor Meetings:
   a. Concurrent with initiating the End of Day Review, implement weekly PoC meetings to *review a selection of cases in more detail*;
4. Onsite Consultation:
   a. At the conclusion of the End of Day Review, manage patients with immediate physician consultation available if needed for approximately one month;*
   b. After seeing patients for three weeks, submit six charts to the Associate Medical Director for review to evaluate Dr. deGuzman's readiness to progress to the Precepted Education Experience;
   c. Document every case specifying the condition/diagnosis and treatment plan for each patient on the PoC Case Log provided by CPEP and submit the Case Log along with the charts mentioned immediately above;
5. Conclusion:
   a. At the completion of the above activities, Dr. deGuzman will:

1) Ensure that the Preceptor speaks with the Associate Medical Director and submits a written report documenting Dr. deGuzman's readiness to proceed to independent/unsupervised patient care in the outpatient setting;
2) Receive notification from the Associate Medical Director that the PoC Experience has been completed.

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

B. Point of Care Experience: Prescribing

If Dr. deGuzman is permitted by the Board to resume controlled substance prescribing in the context of an outpatient internal medicine practice, he will:

1. End of Day Review:
   a. For a period of time to be determined by the Preceptor and Associate Medical Director, review each patient prescribed controlled substances with the Preceptor at the end of each day to determine if the exam and evaluation have been adequate and if the plan is appropriate;
   b. Document the cases on the PoC Case Log provided by CPEP;
   c. Ensure that the Preceptor speaks with the Associate Medical Director prior to transitioning to a lesser degree of oversight.

C. 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. deGuzman's improvement with regard to the specific Plan Learning Goals. All meetings and activities will be documented on an Education Log provided by CPEP.

Guideline

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

PRECEPTOR MEETINGS

After completion of the outpatient PoC Experience, Dr. deGuzman 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. deGuzman provided independent/unsupervised care. Charts as described below should address the Plan Learning Goals as much as possible.

During the Precepted Education, Dr. deGuzman will:

1. Retrospective Chart Reviews:
   a. Submit to the Preceptor for review no fewer than 24 redacted* charts per month (12 charts per twice-monthly sessions);
      1) The Preceptor may specify cases to be reviewed;
      2) Redacted* copies of charts should be submitted to the Preceptor in time for the Preceptor to review them before the meetings;
   b. Submit to CPEP by the fifth of *every other* month (month to be determined), six of the 24 redacted* charts used in the Preceptor Meetings;
      1) The Associate Medical Director may specify charts to be submitted;
      2) If Dr. deGuzman resumes prescribing controlled substances, he will include a minimum of two charts of patients for whom he is prescribing with the every-other-month submissions to CPEP;
   c. Cases should be specifically relevant to the Plan as well as representative of the scope of Dr. deGuzman'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;
      3) The Preceptor should monitor Dr. deGuzman's patient volume and work schedule for the duration of the Preceptor Meetings to ensure that both are reasonable and do not hinder the quality of patient care provided;
   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. deGuzman should also discuss his topic/subtopic summaries with the Preceptor;

d. Communication:
   1) Receive coaching and review reference materials described in the Plan related to communication skills;

3. Lifelong Learning:
   a. Develop lifelong learning skills:
      1) Discuss and develop a plan with the Preceptor for maintaining current standards in internal medicine 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, such as case studies.
   b. CPEP encourages Dr. deGuzman to:
      1) Review and reflect on the status of his learning and improvements on an ongoing basis;
      2) Keep a learning journal on his reflections, including which activities were beneficial, or not beneficial, and why.

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

Guidelines

- During the Preceptor Meetings, the Preceptor should provide coaching and recommendations to the participant to ensure that improvements in all Learning Goals identified in the Plan are collectively and consistently applied to Dr. deGuzman'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. deGuzman will sign and return the Plan to CPEP by June 6, 2014. 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. deGuzman has not already done so;
      1) The Preceptor must be board certified in the same specialty and have a practice similar to Dr. deGuzman'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 July 7, 2014, Dr. deGuzman 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. deGuzman 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. deGuzman will:

1. Maintain Education and PoC Case Logs:

a. Education Logs should document all educational activities including Preceptor Meetings and the content of the Meetings, and those activities that are outside of the scope of the Plan but relevant to his practice;
b. PoC Case Logs should document PoC activities as previously described in Module B;

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

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

FORMATIVE EVALUATION

Evaluation of Educational Progress

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

Approximately every four months, Progress Reports will be generated and provided to Dr. deGuzman and to other entities for which Dr. deGuzman has provided authorization. The Progress Reports will capture Dr. deGuzman'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. deGuzman 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. deGuzman's scope of practice. (See Section 5.1(e) of the CPEP *Educational Intervention Participation Agreement* for more information.)

- Dr. deGuzman 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.

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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. deGuzman does not engage in this Plan by May 13, 2015, CPEP may require completion of additional Assessment activities to ensure that Dr. deGuzman's current educational needs are addressed.

SIGNATURES

Anthony A. deGuzman, M.D. Date: 9.4.2014

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.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1528

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY ANTHONY A. DeGUZMAN, M.D., LICENSE NO. 31110, 309 BROADWAY STREET, PAINTSVILLE, KENTUCKY 41240

AGREED ORDER OF INDEFINITE RESTRICTION

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

STIPULATIONS OF FACT

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

1. At all relevant times, Anthony A. DeGuzman, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is family medicine.
3. On or about May 21, 2013, the Board received a grievance which alleged concerns about the licensee's prescribing of Oxycodone, Xanax and Soma.
4. On or about June 4, 2013, the Office of the Inspector General ("OIG"), Division of Audits and Investigations, received a grievance which alleged that there was a lot of traffic at the licensee's medical office, including vehicles with out-of-state license plates.

5. On or around June 4, 2013, OIG Investigator, Amanda Ward, R.Ph., reviewed and analyzed the licensee's KASPER records (for the period of June 1, 2012 through May 30, 2013) and noted several concerns, including:

    - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
    - Long-term use of one or more controlled substances;
    - Patients traveling long distances;
    - Over 700 prescriptions for Oxycodone-containing medications written by the licensee from June 1, 2012, to May 30, 2013, with over 200 of those being written since May 1, 2013

    Ms. Ward identified fifteen (15) of the licensee's patients with prescribing patterns reflective of these concerns and recommended further investigation by the Board.

6. On or about June 28, 2013, OIG reported that Patient A had died of an overdose of medications prescribed to him by the licensee. Patient A saw the licensee on or about June 25, 2013 and filled prescriptions on that same date for #60 Soma 350 mg, #90 Neurontin 600 mg, #30 Percocet 10, and #60 Oxycodone 30 mg.

7. In or around August 2013, a Board consultant reviewed the licensee's patient charts for Patient A and the fifteen (15) OIG-identified patients and concluded that the licensee departed from or failed to conform to acceptable and prevailing medical practices; and that he committed a serious act or a pattern of acts during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross negligence, as well as instances of gross ignorance, gross incompetence and malpractice. The consultant stated,

    > In my opinion, Dr. DeGuzman's patient care is below the minimum standard of medical care. He is primarily prescribing high potency narcotics and sedatives, in large quantities, and without proper justification or documentation. His medical license should be immediately suspended or restricted.

In summary, the consultant noted:

- The licensee's practice does not look like a typical Internal Medicine or Family Practice because the focus is on the prescribing of controlled substances and not on the management of chronic illnesses. Rather, it is a Pain Management practice, in which large dosages of highly addictive medications are prescribed.
- The licensee treats a younger population than what is usually seen in internal medicine practices.
- History portions of patient charts lacks pertinent details of previous illnesses, specifically:
    - Details on previous course of treatments
    - Details on previous medications received or how patient responded
- Reviews of Systems (ROS) are incomplete and very brief. A common ROS finding in his charts is "Anxiety" only.
- Follow up notes are pre-printed, very brief, and lacking detail about patient problems, goals or objectives.
- The licensee does not make referrals to specialists, such as Neurosurgeons, Orthopedic Surgeons, Psychiatrists, or Pain Management Clinics to receive a second opinion.
- Most patients are not subjected to urine drug screens, which is one of the tools to help physicians identify potential drug abuse or diversions. In some cases, the licensee obtained urine drug screens and continued to write controlled substances after patients tested positive for other substances.
- In the case of a patient with evidence of Chronic Liver Disease and history of alcohol abuse, the licensee continued to prescribe narcotics, when potential harm to the patient was very high.
- Although the licensee had KASPER in many patient charts, he did not demonstrate appropriate response to evidence of patients receiving controlled substances from other providers and in other cities.
- The licensee had imaging studies in many patient charts, but interpreted nearly any abnormality as justification for narcotic prescriptions. Instead, a physician should use a step-wise comprehensive approach, starting with non-narcotic medications and therapies and obtaining opinions from specialists. If those options are proven unable to provide the patient relief and functional improvement, then a physician should consider narcotics, starting with small doses for short periods of time.

8. On October 17, 2013, the Board's Inquiry Panel A reviewed the investigation and the licensee appeared before and was heard by the Panel before it deliberated. The Panel and the licensee agreed to enter into this Agreed Order of Indefinite Restriction, in lieu of the issuance of a Complaint and Emergency Order of Restriction.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Indefinite 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(3) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Indefinite Restriction.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending grievance without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Indefinite Restriction.

AGREED ORDER OF INDEFINITE 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 grievance without an evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER OF INDEFINITE RESTRICTION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Anthony A. DeGuzman, 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 Indefinite 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 professionally utilize controlled substances unless and until approved to do so by the Panel;

b. Within twenty (20) days of the filing of this Agreed Order, the licensee SHALL contact the Center for Personalized Education for Physicians (CPEP), 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 expense;

e. The licensee SHALL complete any necessary waiver/release required to ensure that CPEP will provide a copy of the Assessment Report to the Board's Legal Department promptly upon its completion. CPEP will issue its final Assessment Report, in accordance with its internal policies;

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; and

g. The licensee understands and agrees that if the Panel should allow the licensee to resume the professional utilization of controlled substances after completion of the above terms, it will do so by an Amended Agreed Order of Indefinite Restriction, which shall provide for the licensee to maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized and shall provide for periodic review of the log and relevant records by Board agents upon request, and any other conditions deemed necessary by the Panel at that time;

h. Pursuant to KRS 311.565(1)(v), the licensee SHALL REIMBURSE the Board the costs of the proceedings in the amount of one-thousand five-

hundred dollars ($1,500.00), within six (6) months from entry of this Agreed Order of Indefinite Restriction; and

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 Indefinite 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 Indefinite 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 Indefinite 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 Indefinite Restriction.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order of Indefinite 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 12th day of November, 2013.

FOR THE LICENSEE:

ANTHONY A. DeGUZMAN, M.D.

STEPHEN W. OWENS
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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

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