FILED OF RECORD

JUL 20 2023

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. PA-50

IN RE: THE LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT IN THE COMMONWEALTH OF KENTUCKY HELD BY JULIE A. SALISBURY, P.A.-C., LICENSE NO. PA819, 2429 WEST PARRISH AVENUE, OWENSBORO, KENTUCKY 42301

AMENDED COMPLAINT

Comes now the Complainant, Chair of the Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel which met on April 20, 2023, states for its Amended Complaint against the licensee, Julie A. Salisbury, P.A.-C, as follows:

1. At all relevant times, Julie A. Salisbury, P.A.-C (the "licensee"), was licensed by the Board to practice as a Physician Assistant within the Commonwealth of Kentucky.
2. On or about September 27, 2022, the Board received a grievance from the mother of a patient who died from an overdose alleging:

> My son [Patient A] started seeing Dr. [sic] Salisbury in 2019 when he moved to Owensboro for rehab then into sober living. Dr. [sic] Salisbury started prescribing [Patient A] Klonopin .5mg 1 x day in September 2021. Dr. [sic] Salisbury knew [Patient A] was a addict. He was going to a suboxone clinic but prescribed him Klonpin [sic] anyways. She only conducted one drug test when she first prescribed it and never repeated one. In October 2021 she increased him to .5mg 2 x day. In November 2021 [Patient A] overdosed on Klonpin [sic] and Meth. She still continued to prescribe him Klonpin [sic]. In February 2022 she increased him again to .5mg 3 x day. [Patient A] overdosed and died June 12, 2022. His toxicology report showed his Klonopin levels was 64.1 ng/ml. This doctor prescribed my son a controlled substance knowing he was a addict. Even increased his amount after he overdosed on it.
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> [Patient A] was in the ICU on a ventilator in November. He almost died then. How can a dr legally prescribe a know [sic] addict a controlled substance and then increase his amount after he overdosed. I was listed on [Patient A's] medical records for information to be released to me when he died. I went to the office to get a copy of his records. They where [sic] going to give them to me. Till they asked how he died and I said he overdosed.

Then they refused to give me his records and told me to get a lawyer if I wanted them. So I had to go to Court and get appointed Administrator of his estate and request to Judge I needed medical records to get them.

3. On or about October 24, 2022, the licensee responded to the grievance. She explained:

> … I first saw [Patient A] at an Urgent Care I was working in and then followed up with him as a primary care patient in my primary care office. He presented with a history of depression and anxiety as well as a history of drug abuse. At the time I started seeing him, he was taking Prozac 40 mg once daily and Wellbutrin XL 150 mg once daily for depression and anxiety. His symptoms were fairly well-controlled with this treatment, however when I saw him in August of 2020, he had been struggling more with his anxiety. He had tried to donate plasma and his heart rate had been too high for him to donate on a couple of occasions which he contributed to his anxiety. He requested something to help with both the tachycardia and his anxiety and I started him on Buspirone 10 mg twice daily and Toprol XL 25 mg once daily. At his follow up in September, he informed me that the 10 mg Buspirone dose was causing him some side effects, so he had lowered the dose to ½ tablet (5 mg) twice daily instead and that was working well for him. He was also experiencing some difficulty sleeping and I started him on 6 mg of Doxepin nightly. At that point, I gave him 6 months' worth of refills and instructions to follow up or call if any problems with his medications.
>
> In April of 2021 I left the primary care office I was working in and moved to a new office location and started to see patients again in June. I had made every best attempt to reach my patients prior to moving including mailing a letter that I was moving offices and a follow up post card with the new location information once I had started seeing patients again. I first saw [Patient A] again in August of 2021 and he had run out of medications for a short period of time (the office I had left gave my patients 30 days' supply of medication). His anxiety had been problematic for him during this time and he was started back on Prozac, Wellbutrin XL, Buspirone and Toprol XL. He had stopped taking the Doxepin as he had not found it helpful.
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> On September 14, 2021, he returned with concerns about his anxiety and how it was affecting his work. … After a discussion about all the medications we had tried, including the higher dose of Buspirone he had not tolerated, I agreed to try him on a low dose of Klonopin 0.5 mg once daily as needed pending a clear urine drug screen. He signed a controlled substances agreement at that time, his drug screen came back clear and I sent in the medication once I reviewed the UDS. I had him follow up in 1 month and he was doing better with the Klonopin, but still having trouble making it through his entire work shift as he worked mostly nights. I increased his dose to twice daily at that office visit and again had him follow

up in 1 month. On November 16th he returned and was doing well with the twice daily dosing.

[...]

It was just recently, unfortunately after [Patient A's] passing, brought to my attention that sometime during the month of November 2021 [Patient A] was admitted to the hospital with an overdose of Methamphetamine, and Klonopin was also noted to be in his system. I was never made aware of this nor notified by the hospital or [Patient A]. ... I can assure you I would have never continued to prescribe [Patient A] a controlled substance of any sort had I known he had been using any illegal substances. I also do not give refills on benzodiazepines without the patient contacting the office to request a refill between office visits and I see them in person every 3 months once they are on a stable dose. [Patient A] called to request a refill on December 14th and again on January 14th and never once mentioned his hospital admission. I saw him again in person on February 15th and he again did not mention anything about his admission. He did admit to some new stressors going on at home and we discussed having him start seeing a counselor again as he had stopped doing so. I did increase his dose to three times daily at that office visit, again unknowing that he had been admitted or had used methamphetamine.

When he returned for his follow up in May, he was about to leave town to go out west with his grandmother and requested to have his Klonopin filled 4 days early so he wouldn't run out while out of town. I agreed to do so considering he had never asked for a prescription early, had always been compliant with office visits and I had no reason to suspect he would be misusing his medication which is also why I had not yet obtained another drug screen on [Patient A] since it only has to be done periodically unless there is reason to suspect misuse. [Patient A] was very excited about his trip during his visit, he had gone to Yellowstone with his grandmother the previous year and was looking forward to going again. Tragically that was the last office visit I had with [Patient A] as he overdosed again on June 12th and passed away. According to [Patient A's] mother, the level of Klonopin on his toxicology report was 64.1 ng/ml which falls well within the normal therapeutic range of 20-80 ng/ml which would indicate he was taking it as directed. I was not made aware of what substance [Patient A] actually overdosed on as I have never seen his full toxicology report or death certificate.

[...]

Much to my dislike, in February 2022 I inherited a large number of patients from a provider that left our office who were unknowingly to me on MULTIPLE controlled substances at very high doses and I have been contacted by the Suboxone clinic on a couple of them to try to taper them down or off one or more of their medications. I have been doing my best to work with them in making this happen. As a result of both this influx of

> patients and after having gone through this process with [Patient A], I have been referring almost every patient that is on a benzodiazepine out of our office and to behavioral health providers. Unfortunately, this is a process that takes time. I have also been getting drug screens on these new-to-me patients and have had many of them test positive for illegal substances.
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> [...]
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> In conclusion, this has been an eye-opening experience for me as I have always thought myself a responsible provider having only had one other grievance made against me (which was determined to be unfounded) in my 18 years as a provider. I am willing to face any consequences the Medical Board feels necessary if my actions in this case are deemed unprofessional or not meeting up to the Board's standards.

4. On or about December 22, 2022, a Board consultant completed a review of the patient's records. As a result, it is the consultant's opinion that the licensee's care of the patient was below the minimum standards, stating in part:

> [Patient A's] treatment at the local Suboxone clinic is not mentioned in the narrative portion of the charts provided; only in the Provider's response letter. The only mention of the patient's addiction history was "Crisis Stabilization Unit" under Past Medical History. Suboxone never appears on [Patient A's] chart medication lists.
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> One urine toxicology screen was obtained on 9/14/2021; the only place in the chart mentioning Suboxone was on the order form for that laboratory in the back of the chart of that date.
>
> No KASPER report on the Patient was requested by the Provider until 6/20/22, ten days after the Patient's death.
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> [...]
>
> With the information available, the record demonstrates negligence in history taking, initial and ongoing evaluation, and treatment, with lack of coordination of care with other providers and resources.
>
>> 1) History taking: no history of the Patient's substance abuse history, "rehab" (mentioned in the grievance), and ongoing treatment in the Suboxone clinic. In terms of Social History, pertinent negatives would include use of recreational substances, yet this is not indicated. Additionally, it is not part of the Providers template for care.
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>> 2) Evaluation: The symptoms of Anxiety Disorder can suggest other medical diagnoses, including hyperthyroidism, arrhythmias,

asthma, chronic obstructive pulmonary disease, certain medication use or withdrawal, and substance use or withdrawal.

Other than basic laboratories, requested on 7/24/2020 and 8/28/20 with no results in the provided charts for the Provider's or my review, no EKG or other evaluation was offered.

The Provider used no available standardized instruments widely employed in the care of patients with mental health needs, no evaluation of other underlying medical and psychosocial reasons for the patient's anxiety, depression, tachycardia and sleep disorders, and no ongoing urine toxicology screens in this patient whose addiction history was evidently known by the Provider, per her response letter to the Board.

3) Treatment: The Provider gave the patient Toprol XL for tachycardia, Doxepin for sleep, merely symptomatic treatments when no further evaluation, though warranted, was pursued. When the patient was refractory to the potent combination of antidepressants and anxiolytics prescribed, no further evaluation or distinct psychiatric referral was pursued.

4) Coordination of care: while a mention is made that the Patient had sought counseling on a few occasions, despite the fact that the Provider stated that she would not escalate the dose without further evaluation by "BH", she did escalate to the 3x daily dose. No behavioral health referral or evaluation is seen in the chart.

5. By her conduct, as detailed in the facts set forth in paragraph 4 above, the licensee violated several provisions established in 201 KAR 9:260, including:

    - Section 2(1 & 2);
    - Section 4(2); and
    - Section 7.

6. On or about February 20, 2023, the licensee responded to the consultant's report. She acknowledged many of her shortcomings, stating:

> I will admit, I immediately recognized upon reviewing his records prior to submitting them several of these shortcomings myself. I failed to get a KASPER report like I should have both initially and every 90 days. I also failed to include his history of opiate abuse on his past medical history as well as not listing Suboxone on his current medication list. I have no excuse for why this was not done. Although I knew this was part of his history, I did not have it in the forefront of his medical record like it should have been.

In addition, she explained that she has initiated several changes/improvements in her practice.

7. The Board consultant considered the licensee's response and stands by her original report, stating:

> We all want Providers to continue to practice only if they are supervised in an appropriate manner to avoid, as much as anyone can, tragedies such as this. I cannot at this time be sure that the Provider's practice has been transformed unless the Board makes certain that this has occurred and will continue as such.

8. On or about April 20, 2023, the licensee appeared before the Panel and reiterated much of what she said in her written responses. She also informed the Board that her practice location is not owned, managed or under the control of her supervising physician. Her supervising physician comes to her separate practice location every month or two and completes a random review of 10% of her charts.

9. By her conduct, the licensee has violated KRS 311.850(1)(n), (p), and (s). Accordingly, legal grounds exist for disciplinary action against her license to practice as a Physician Assistant in the Commonwealth of Kentucky.

10. The licensee is directed to respond to the allegations delineated in paragraph 5 of the Amended Complaint within thirty (30) days of service thereof and is further given notice that:

    (a) Her failure to respond may be taken as an admission of the charges; and

    (b) She may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in her defense.

11. NOTICE IS HEREBY GIVEN that a hearing on this Amended Complaint is scheduled for **November 1, 2 & 3, 2023**, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310

Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

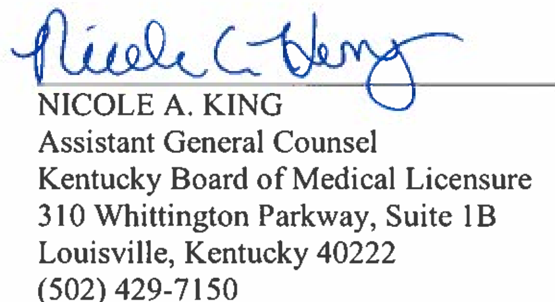
WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice as a Physician Assistant in the Commonwealth of Kentucky held by Julie A. Salisbury, P.A.-C.

This 20th day of July, 2023.

WAQAR A. SALEEM, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Amended Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellmann, Esq., Hearing Officer, 810 Hickman Hill Road, Frankfort, Kentucky 40601 and copies were mailed via certified mail return-receipt requested and via email to the licensee, Julie A. Salisbury, P.A.-C, License No. PA-50, 1919 Fawn Dr., Owensboro, Kentucky 42303 (Julie.run@hotmail.com) and to her counsel, Randall Strause, Esq. & Andrew J. Williams, Esq., Strause Law Group, PLLC, 804 Stone Creek Parkway, Suite One, Louisville, Kentucky 40223 (rstrause@strauselawgroup.com and awilliams@strauselawgroup.com) on this 20th day of July, 2023.



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