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

EMERGENCY ORDER OF RESTRICTION

On April 20, 2023, the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, considered allegations that the licensee improperly prescribed controlled substances. The Panel reviewed the following information: a panel memorandum prepared by Stephen Manley, Medical Investigator, dated March 20, 2023; a Grievance, dated September 27, 2022; Licensee's Response to Grievance, dated October 24, 2022; Board Consultant's Findings, dated December 22, 2022; Licensee's Response to Consultant Review, dated February 20, 2023; and Board Consultant's Final Response Licensee's Response, dated March 1, 2023. The licensee was given notice and appeared before and was heard by the Panel before it chose to issue this emergency order.

Having considered this information and being sufficiently advised, Inquiry Panel A enters the following EMERGENCY ORDER OF RESTRICTION, in accordance with KRS 311.852(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available, Inquiry Panel A concludes there is probable cause to make the following Findings of Fact, which support this Emergency Order of Restriction:

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.
>
> [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.

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 mis-using 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.

[...]

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.
>
> [...]
>
> 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.
> >
> > 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. 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.

6. 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.

7. 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.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available, Inquiry Panel A finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Restriction:

1. The licensee's Kentucky license to practice as a Physician Assistant is subject to regulation and discipline by this Board.
2. KRS 311.852(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician assistant's license at any time an inquiry panel has probable cause to believe that a) the physician assistant has violated the terms of an order placing him or her on probation; or b) a physician assistant's practice constitutes a danger to the health, welfare and safety of his or her patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.850(1)(n), (p), and (s).
4. Inquiry Panel A concludes there is probable cause to believe this licensee's practice constitutes a danger to the health, welfare and safety of her patients or the general public.
5. The Board may draw logical and reasonable inferences about a licensee's practice by considering certain facts about a licensee's practice. If there is proof that a licensee has violated a provision of the Kentucky Physician Assistant Statutes in one set of circumstances, the Board may infer that the licensee will similarly violate the Kentucky Physician Assistant Statutes when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a licensee's practice presents representative proof of the nature of that licensee's practice in general. Accordingly, probable cause to believe that the licensee has committed certain

violations in the recent past presents probable cause to believe that the licensee will commit similar violations in the near future, during the course of the licensee's physician assistant practice.

6. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. *Barry v. Barchi*, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); *FDIC v. Mallen*, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and *Gilbert v. Homar*, 520 U.S. 924 (1997), 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of her right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF RESTRICTION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel A hereby ORDERS that the license to practice as a physician assistant in the Commonwealth of Kentucky held by Julie A. Salisbury, P.A.-C, is RESTRICTED and Ms. Salisbury is prohibited from prescribing, dispensing, or otherwise professionally utilizing controlled substances until the Board's Hearing Panel has finally resolved the Complaint or until such further Order of the Board.

Inquiry Panel A further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

SO ORDERED this 18th day of May, 2023.

W. Saleem.

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

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Restriction was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; 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, 2429 Parrish Ave., Owensboro, Kentucky 42301 (Julie.run@hotmail.com) and to her counsel, John David Meyer, Meyer & Meyer, LLP, 100 E. Veterans Boulevard, Owensboro, KY 42303 (jdmeyerlaw@bellsouth.net) on this 18th day of May, 2023.

Nicole C. K

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