COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2128

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY WILLIAM K. VINCENT, M.D., LICENSE NO. 36099, 222 PHILLIP STONE WAY, CENTRAL CITY, KENTUCKY 42330

FINAL ORDER OF REVOCATION

Pursuant to KRS 311.591(7) and KRS 13B.120, at its meeting on November 21, 2024, the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Hearing Panel B, took up this matter for final action. Hearing Panel B considered a memorandum, dated November 1, 2024; the Complaint, filed October 24, 2023; the Emergency Order of Restriction, filed October 24, 2023; the Final Order Overturning Emergency Order of Restriction, filed December 22, 2023; the Findings of Fact, Conclusions of Law and Recommended Order, dated October 15, 2024; the Board's Exceptions, filed October 30, 2024; and the licensee's Exceptions, filed October 30, 2024.

Having considered all the information available and being sufficiently advised, pursuant to KRS 13B.120(2), Hearing Panel B hereby MODIFIES, IN PART, the Hearing Officer's recommended order as follows:

> The following fact should be added to the Findings of Fact: "Dr. Vincent failed to incorporate abnormal KASPER findings into appropriate clinical reasoning to support the continuation or modification of treatment and failed to accurately document the same in the patient record, as required by 201 KAR 9:270, Section 2(4)(e)(5)(a). *See* for example, Exhibit 1, marked pp. 1790 and 1801."
>
> Conclusions of Law ¶ 5 is modified to reflect a reference to Dr. Vincent rather than Dr. Hardison.
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> Conclusions of Law ¶ 30 is modified to read: "Based upon Dr. Vincent's prescribing practices for buprenorphine, stimulants, gabapentin and benzodiazepines, the preponderance of the evidence supports the

conclusion that Dr. Vincent violated KRS 311.595(9), as illustrated by KRS 311.597(4)."

Except for the identified modifications, Hearing Panel B hereby ACCEPTS AND ADOPTS all other findings of fact and conclusions of law from the hearing officer and incorporates them by reference into this Order. (Attachment)

The Panel explains the modification as follows: The Hearing Officer included a finding of fact in Dr. Hardison's case (Case No. 2127) that Dr. Hardison failed to incorporate abnormal KASPER findings into appropriate clinical reasoning to support the continuation or modification of treatment and failed to accurately document the same in the patient record. Hardison, Case No. 2127, Findings of Fact, Conclusions of Law and Recommended Order, ¶167. The same factual scenario is found in Dr. Vincent's case. *See* Vincent Exhibit 1, pp. 1790 and 1801. Conclusions of Law ¶¶ 5 and 30 are amended to fix typographical errors. The conclusions of law pertain to the case against Dr. Vincent and are amended accordingly. Additionally, "gabapentin" was placed in the incorrect position and should be moved to the list of prescribed medications. It was one of the additional medications at issue throughout this case (*see* Final Order Overturning Emergency Order of Restriction).

Having considered all statutorily available sanctions and the nature of the violations in this case - including the licensee's violations of and dismissive attitude toward multiple Board's regulations, failures to exercise caution when prescribing highly addictive and frequently abused controlled substances, prescribing medically unnecessary and potentially lethal drugs, and a general disregard for basic standards of care that endangers patients and community health - the Hearing Panel has determined that revocation is the appropriate sanction. Accordingly, Hearing Panel B **ORDERS**:

1. The license to practice medicine held by William K. Vincent, M.D., is hereby REVOKED and he may not perform any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – in the Commonwealth of Kentucky;

2. The provisions of KRS 311.607 SHALL apply to any petition for reinstatement filed by the licensee; and

3. Pursuant to KRS 311.565(1)(v), the licensee SHALL REIMBURSE the costs of these proceedings in the amount of $49,034.00, prior to filing any petition for reinstatement of his license to practice medicine in the Commonwealth of Kentucky.

SO ORDERED on this 27th day of November 2024.

DALE E. TONEY, M.D.
CHAIR, HEARING PANEL B

CERTIFICATE OF SERVICE

I certify that the original of the foregoing Final Order of Revocation 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, first-class postage prepaid, to Thomas J. Hellmann, Esq., Hearing Officer, 810 Hickman Hill Road, Frankfort, Kentucky 40601; and copies were mailed, certified return-receipt requested, to the licensee William K. Vincent, M.D., License No. 36099, 222 Phillip Stone Way, Central City, Kentucky 42330 and his counsel, Lisa English Hinkle, Esq., Ed Monarch, Esq., and Katy Harvey, Esq., McBrayer, PLLC, 201 East Main Street, Suite 900, Lexington, Kentucky 40507 on this 27th day of November, 2024.

Nicole A. King
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 764-2615

EFFECTIVE DATE AND APPEAL RIGHTS

Pursuant to KRS 311.593(1) and 13B.120, this Order will be effective immediately on filing. It is the Panel's opinion that based upon sufficient reasonable cause, the health, welfare, and safety of Dr. Vincent's patients or the general public would be endangered by delay.

The licensee may appeal from this Order, pursuant to KRS 311.593 and 13B.140-.150, by filing a Petition for Judicial Review in Jefferson Circuit Court within thirty (30) days after this Order is mailed or delivered by personal service. Copies of the petition shall be served by the licensee upon the Board and its General Counsel or Assistant General Counsel. The Petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested, along with a copy of this Order.

COMMONWEALTH OF KENTUCKY
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FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED ORDER

On October 24, 2023, the Kentucky Board of Medical Licensure [hereinafter "the Board"] issued the *Complaint* charging William K. Vincent, M.D., with violating the three statutes governing the practice of medicine, KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12). Exhibit 1, Tab C, *Complaint*, Paragraph 16, page 8. [The citations to the *Complaint* will be to their numbered paragraphs and pages without reference to Exhibit 1, Tab C]. In this action the Board requests the hearing officer to find Dr. Vincent guilty of violating those statutes and to recommend the Board take any appropriate disciplinary action against his license for the violations, including revocation of his license to practice medicine.

On the same day that the Board issued the *Complaint*, the Board also issued the *Emergency Order of Restriction* ("*Emergency Order*") against Dr. Vincent's license to practice medicine based upon the same allegations contained in the *Complaint*. [Citations to the emergency order will also be to the document's numbered paragraphs and pages without reference to Exhibit 1, Tab B]. The *Emergency Order* restricted Dr. Vincent's license to practice medicine by prohibiting him 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." *Emergency Order*, page 10.

At the request of Dr. Vincent the undersigned hearing officer conducted an administrative hearing on the *Emergency Order*, and on December 22, 2023, he issued the *Final Order Overturning Emergency Order of Restrictions* ("*Final Order*"). He found pursuant to KRS 13B.125(3) and KRS 311.592(1), there was substantial evidence in the record to support the conclusion that Dr. Vincent engaged in conduct in violation of the Board's statutes as alleged in the *Emergency Order*. He also found, however, there was not substantial evidence in the record that Dr. Vincent's care and treatment of patients constituted an immediate danger to the health, safety, or welfare of patients or the general public. That determination was based largely upon the findings and opinions of the Board's expert, Dr. Mark Jorrisch, and upon Dr. Vincent's agreement not to prescribe certain controlled substances pending resolution of the allegations in the *Complaint*.

The hearing officer conducted the administrative hearing on the *Complaint* over eleven days in June 2024. Hon. Nicole A. King represented the Kentucky Board of Medical Licensure, and Hon. Lisa English Hinkle, Hon. Ed Monarch, and Hon. Katy Harvey represented Dr. Vincent, who also attended the hearing.

The hearing officer notes that the *Complaint* and *Emergency Order* issued in this action are similar to the *Complaint* and *Emergency Order* issued against Dr. Barry G. Hardison who worked in the same medical practice as Dr. Vincent. Although the factual allegations against the two physicians are not identical and involve different

patients for each physician, the substance of the alleged types of misconduct are similar in that they involved the same medical practice, the same prescribing practices, and the same alleged violations of the Board's statutes and regulations. In addition, Dr. Jorrisch served as the Board's consultant for both cases, and he reviewed the care and treatment at issue in both cases, arrived at substantially similar conclusions as to the deficiencies in the care and treatment of patients by both physicians, and drafted substantially similar reports for the physicians. The hearing officer further notes that Dr. Vincent and Dr. Hardison had similar and consistent approaches to the care of patients at issue in this action, had similar prescribing practices for the patients, and presented the same or similar defenses to the Board's allegations. In fact, the hearing officer found no disagreement between the physicians in their approach to patient care or inconsistencies between them with regard to the care that each provided to patients, which common defense was further supported by the fact the same counsel represented both physicians.

Due to the similarity of the charges against the two physicians and by agreement of the parties, the administrative hearing on the Board's *Complaint* against each physician was conducted jointly, and the record from the administrative hearings on the physicians' challenge to their respective *Emergency Orders* were incorporated by reference into the administrative hearing on the *Complaint* actions. Although there was substantial overlap in the exhibits admitted into evidence for the two physicians, they were not identical, and therefore, the parties utilized a separate numbering system for

the exhibits in each physician's case. Dr. Jorrisch reviewed on behalf of the Board the medical records for eighteen of Dr. Vincent's patients and sixteen of Dr. Hardison's.

After considering the evidence admitted at the administrative hearing and the arguments of counsel, the hearing officer finds the preponderance of the evidence supports the conclusion that Dr. Vincent violated KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12), in his care and treatment for sixteen of the eighteen patients. (Patient 3's care and treatment fell within the standard of care, and Patient 12 had not been treated by Dr. Vincent. Exhibit 1, marked pages 1726-1727, 1770.) For those violations the hearing officer recommends the Board take any appropriate action against Dr. Vincent's license to practice medicine. In support of that recommendation, the hearing officer submits the following Findings of Fact, Conclusions of Law, and Recommended Order:

FINDINGS OF FACT

1. On October 24, 2023, the Board issued the *Complaint* and *Emergency Order* that make identical factual allegations against Dr. Vincent to support violations of KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12). *Complaint*, pages 1-9; *Emergency Order*, pages 2-8.

2. By agreement of the parties at the administrative hearing in this action, the record of the administrative hearing on the *Emergency Order* was adopted and incorporated into the record of this action, and the hearing officer adopts and incorporates by reference into this recommendation the Findings of Fact and Conclusions of Law from the *Final Order* that he issued on the *Emergency Order*.

3. The allegations of misconduct against Dr. Vincent focused on his care and treatment of patients at "A New Start" ("ANS"), a medical practice in Central City, Kentucky, that specializes in the treatment of Opiate Use Disorder ("OUD"), Substance Use Disorder ("SUD"), and Stimulant Use Disorder ("StUD"). *Emergency Order*, pages 2-7; *Complaint*, pages 2-7; Exhibit 1, marked pages 1514-1522, 1696-1703, and 1707-1802."

4. The Board asserts that Dr. Vincent failed to follow the Board's statutes and regulations in his treatment and prescribing practices related to buprenorphine products for the treatment of OUD; with his prescribing practices related to benzodiazepines, such as Xanax and Klonopin, and other controlled substances, such as gabapentin; and with his prescribing of stimulants such as Adderall and Ritalin for StUD.

5. A physician is subject to discipline under KRS 311.595(9), as illustrated by KRS 311.597(4), if he engages in "conduct which is calculated or has the effect of bringing the medical profession into disrepute, including but not limited to any departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky . . . ."

6. Under KRS 311.595(12), a physician is subject to discipline if he has "violated or attempted to violate, directly or indirectly, or assisted in or abetted the violation of, or conspired to violate any provision or term of any medical practice act, including but not limited to the code of conduct promulgated by the board under KRS 311.601 or any other valid regulation of the board."

7. Since the Board has specific regulations governing the prescribing of controlled substances generally, and buprenorphine and amphetamines in particular, the hearing officer's review of the alleged statutory violations will necessarily focus on Dr. Vincent's prescribing practices related to those controlled substances and on his compliance with the above-cited statutes and the applicable regulations: 201 KAR 9:016, 201 KAR 9:260, and 201 KAR 9:270.

8. An analysis of whether Dr. Vincent's prescribing practices under 201 KAR 9:270 violates the "standards of acceptable and prevailing medical practices" in Kentucky under KRS 311.595(9), as illustrated by KRS 311.597(4), must begin with a consideration of Section 5 of the regulation, which states the "failure to comply with or a violation of the professional standards established in Sections 2, 3, and 4 of this administrative regulation shall constitute a 'departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky,' in violation of KRS 311.850(1)(p) and (s), KRS 311.595(12) and (9), as illustrative by KRS 311.597(4), . . . subjecting a licensee to sanctions authorized by KRS 311.595 and 311.850."

9. To the extent the licensee and his expert witnesses assert a violation of 201 KAR 9:270, Sections 2, 3, or 4, does not constitute a violation of the standards of acceptable and prevailing medical practice in Kentucky, in light of the provision of 201 KAR 9:270, Section 5, to the contrary, such assertions carry no weight.

10. The analysis of the propriety of the prescribing of Adderall and Ritalin to patients is governed by the provisions of 201 KAR 9:016, which states in Section 2 that

prior to prescribing an amphetamine a "licensee shall take into account" five factors, including the potential for abuse, dependence, misuse, and diversion of the prescribed stimulant.

11. Under 201 KAR 9:016, Section 3, the patient record "shall denote the diagnosis that justifies treatment with a Schedule II amphetamine" and the controlled substance "shall be used to treat only" six medical conditions, a single one of which is relevant to this action, "attention deficit/hyperactive disorder."

12. Pursuant to 201 KAR 9:016, Section 6(1), the "failure to comply with the requirements of this administrative regulation shall constitute dishonorable, unethical, or unprofessional conduct by a licensee, which is apt to deceive, defraud, or harm the public under KRS 311.595(9) and KRS 311.597."

13. Thus, to the extent the licensee and his expert witnesses assert a violation 201 KAR 9:016 does not constitute a violation of KRS 311.595(9) and KRS 311.597, in spite of the provision of the regulation to the contrary, such assertions carry no weight.

14. For the prescribing of any controlled substance in Kentucky the physician "shall comply" with the provisions of 201 KAR 9:260, which establishes "the standards of acceptable and prevailing medical practice for prescribing, dispensing, or administering a controlled substance" for the treatment of pain or other medical conditions. 201 KAR 9:260, Section 1(1).

15. The standards require that prior to prescribing the controlled substance the physician to "obtain and document all relevant information in a patient's medical record in a legible manner and in sufficient detail to enable the board to determine whether the

licensee is conforming to professional standards for prescribing controlled substances, which shall include, among other relevant information, the patient's medical history; physical or mental health examination; evaluations and consultations; treatment objectives; discussions of risks, benefits, and limitations of treatment; medications, including date, type, dosage, and quantity prescribed; and instructions and agreements. 201 KAR 9:260, Sections 2, 3, and 6.

16. To the extent the licensee and his expert witnesses assert a violation of the provisions of 201 KAR 9:260 does not constitute a departure from or failure to conform to the standards of acceptable and prevailing medical practice in Kentucky such assertions carry no weight.

17. Dr. Vincent graduated from University of Louisville School of Medicine in 1997 and practiced Family Medicine from May 2009 to October 2018. EV 1, 10:44 a.m.; Exhibit 1, marked page 1629. (The administrative hearing on the emergency order for Dr. Vincent was conducted over six days, and citations to the recordings of the emergency hearing for Dr. Vincent are represented by "EV" (Emergency Vincent) followed by a number representing the sequential day of the hearing and the time stamp on the video recording. The citations to the recording of the emergency hearing for Dr. Hardison's case will use a similar format but that hearing will be represented by "EH" (Emergency Hardison). Citations to the recordings of the combined administrative hearing on the Complaint actions will be represented by "CH" (Complaint Hearing) followed by a number representing the sequential day of the hearing and the time stamp on the recording.)

18. He practiced Family Medicine in his home county of Muhlenberg County, Kentucky, and as a result, he has known many of his patients for his whole life. EV 1, 10:46 a.m.

19. Dr. Vincent began working at ANS part-time in April 2014 and became Medical Director/Staff Physician in December 2015, and he has served in that role since that time. Exhibit 1, marked page 1629.

20. He was board certified in Family Medicine in 2000 and in Addictionology in 2018. Exhibit 1, marked page 1629.

21. Dr. Vincent's current medical specialty is addiction medicine, and the allegations of misconduct focus on the prescribing practices at ANS. Exhibit 1, marked page 1629.

22. The Board does not dispute that Dr. Vincent is qualified and authorized to prescribe, dispense, or administer buprenorphine and other controlled substances.

23. Dr. Vincent described substance use disorders as a significant problem in Muhlenberg County, with every person in the county touched by addiction in one form or another. EV 1, 10:48 a.m.

24. Dr. Vincent described his patient population as including patients who have addictions to opiates and benzodiazepines or opiates and stimulants, and some patients have become addicted after experimenting with drugs, while others have received legitimate prescriptions for opioids but get addicted. EV 1, 10:50-10:52 a.m.

25. Many patients have mental health issues in addition to their substance use issues and use controlled substances in an effort to improve their symptoms of

depression and anxiety, while others turn to controlled substances in response to trauma in their lives. EV 1, 10:50-10:52 a.m.

26. In addition, that patient population often have untreated health issues, pain, and cancer. EV 1, 11:12 a.m.

27. In addition, patients with substance use disorders are at higher risk for Hepatitis and HIV, and are often isolated from family members and children, have financial and legal issues, and have been previously incarcerated. EV 1, 11:04 a.m.

28. In a county with high poverty and a population that has limited access to medical care and resources, many people in the county are at risk for substance use issues, but such issues also make it difficult to access medical care. EV 1, 10:54-10:59.

29. It was clear from his testimony that Dr. Vincent has a genuine commitment to helping his patients and his county through his practice of medicine.

30. ANS employs in the medical practice at least twenty-five individuals in several different positions to assist with the care and treatment of patients, including Physician Assistants, four APRNs, Medication -Assisted Treatment Providers, Care Coordinators, seven to eight Case Managers, and twelve Peer Support Specialists. Exhibit 1, marked pages 1578-1597; EV 1, 10:03-10:05 a.m.

31. In addition, A New Start has a specific organizational chart and various policies and procedures for the treatment of OUD. Exhibit 1, marked pages 1599-1606.

32. Dr. Hardison opened ANS in Central City, Kentucky, for the treatment of those patients. EV 1, 9:59-10:01 a.m.

33. ANS is certified by the Commission on Accreditation of Rehabilitation Facilities for the treatment of SUD in combination with mental health services for those patients.

34. Thus, there's no dispute that A New Start is a legitimate, fully operational opioid treatment facility that is well respected in the local community. Exhibit 3, attached exhibits 8-12.

35. Suboxone is a combination of buprenorphine and naloxone that knocks opiates, such as heroin, off the receptors in the brain and block its effect, and the combined medication controls the cravings for an opiate while also decreasing the likelihood of abuse. EV 1, 9:29-9:31 a.m. and 11:38-11:42 a.m.

36. Subutex is known as a "mono product" that consists only of buprenorphine and while still blocking the receptors, it gives a partial euphoric effect, which gives it a higher potential for abuse and is subject to diversion, although it is not the drug of choice for persons with an OUD. EV 1, 11:41-11:42 a.m.; CH 1, 10:13 a.m.

37. Therefore, by regulation the mono product "shall not be prescribed" except in limited, specific circumstances, the most relevant of which for this action is "to a patient with demonstrated hypersensitivity to naloxone." 201 KAR 9:270, Section 2(2).

38. Sublocade is the injectable form of the mono product CH 2, 1:01-1:04 p.m.

39. Because Muhlenberg County is a poor community Dr. Hardison wanted to bring all aspects of patient care under one roof at ANS. EV 1, 10:00-10:01 a.m.

40. Thus, affiliated with ANS is the primary care practice, Care Now, that is located in the same building as ANS. EV 1, 10:05-10:06 a.m.

41. Care Now was established for patients of ANS in order that they may have a primary care facility available to treat their other healthcare needs, including mental health treatment. EV 1, 10:05-10:06 a.m.

42. The clinic has various policies and procedures in place for the treatment of patients with SUD and has a specific organizational chart and several categories of specialists to assist patients, including peer support specialists who have overcome addiction issues themselves, targeted case managers who assist patients with issues such as food assistance and housing, and a mental health nurse practitioner who addresses the mental health issues associated with a person's addiction. Exhibit 1, marked pages 1696-1703.

43. Although the Board's expert, Dr. Mark Jorrisch, found many deficiencies in Dr. Vincent's addiction medicine practice, he never suggested in his report or in his testimony at either the *Complaint* or emergency hearings for Dr. Hardison and Dr. Vincent that their medical practice was a "pill mill" in which patients are prescribed controlled substances with little regard for the their general health, actual medical conditions, and overall well-being. Exhibit 1, marked pages 1707-1714; EV 6, 9:26 a.m.

44. Thus, there is no dispute that ANS is a legitimate, fully operational opioid treatment facility which is reflected by the fact the facility is well respected by officials in the local community. CH 10, 1:45-2:00 p.m.; Exhibit 3, attached exhibits 8-13.

45. Fifty percent of patients at ANS are treated for opiate addiction and thirty percent for meth addiction. CH 5, 3:07 p.m.

46. At ANS Dr. Hardison and Dr. Vincent handle many patients with difficult and complex addiction issues. CH 7, 3:58 p.m.; CH 8, 2:40-2:42 p.m.; CH 10, 11:26 a.m.

47. The parties do not dispute that Dr. Vincent is qualified and authorized to prescribe, dispense, and administer buprenorphine, stimulant medications, and other controlled substances.

48. Dr. Vincent described addiction as a life-long disease that requires the physician to meet patients where they are and to measure success by meeting goals that are set for the patient, which can be as simple as harm reduction. EV 1, 11:19-11:21 a.m.

49. He tries to keep patients alive in spite of their continuing addiction in the hope that eventually "the light turns on" and they change behavior and begin a meaningful recover. EV 1, 11:21 a.m.

50. Thus, there's a general reluctance to kick out of the program non-complaint patients because they'll return to their previous behavior of addiction that is a pathway to their destruction. EV 1, 11:28-11:31 a.m.

51. Dr. Vincent and ANS came to the attention of the Board as a result of a grievance filed by a Social Services Clinician in the Department of Corrections who was concerned that Dr. Hardison and Dr. Vincent may be over prescribing controlled substances at ANS. Exhibit 1, marked page 1517.

52. At the Board's request, the Cabinet for Health and Family Services, Office of Inspector General, reviewed Dr. Vincent's KASPER records and identified eighteen patients whose records were consistent with the concerns for his prescribing practices

found by the Social Services Clinician. Exhibit 1, marked pages 1518-1522; CH 9, 1:02-1:20 p.m.

53. The Board obtained copies of medical records for eighteen patients from A New Start and provided them to the Board's consultant, Dr. Mark Jorrisch, who reviewed over 26,000 pages of records and found deviations from the standards of acceptable and prevailing medical practices in the care and treatment provided to sixteen of the patients. Exhibit 1, marked pages 1707-1802; EV 5, 11:52 a.m.

54. Dr. Jorrisch testified at the administrative hearing that unless stated otherwise in his testimony, the opinions he expressed in his report and in his testimony at the administrative hearing were based upon the standards of acceptable and prevailing medical practice in Kentucky at the time of the care provided by Dr. Vincent in this action. CH 3, 9:06 a.m.

55. Dr. Jorrisch testified at the hearing on the *Emergency Order* that the opinions expressed in his report went to Dr. Vincent's care and treatment alone. Exhibit 1, marked pages 1707-1802; EV 5, 2:38 p.m.

56. Dr. Jorrisch has been a consultant with the Board since 2005, and he was qualified as an expert in medicine generally and specifically in the prescribing of controlled substances and in the treatment and management of substance use disorders. CH III, 9:05 a.m. Exhibit 34.

57. In 1980 Dr. Jorrisch began practicing internal medicine, and he became certified in addiction medicine that same year. Exhibit 34; EV 5, 9:03 a.m.

58. He is the Medical Director of an opiate rehabilitation facility in Louisville, Kentucky, and has administered methadone through that facility since 1990. EV 5, 9:04-9:05 a.m.; Exhibit 34.

59. For the past eight years he has practiced exclusively in the field of addiction medicine, and he has prescribed Suboxone through his medical practice since 2018. EV 3, 9:03-9:06 a.m.; Exhibit 34.

60. Dr. Jorrisch testified he rarely prescribed controlled substances in his previous internal medicine practice, but he did so on occasion when a patient needed an opiate or a benzodiazepine, but only prescribed them for short periods of time. EV 3, 9:07 a.m.

61. Dr. Jorrisch and Dr. Vincent treat similar patient populations, and Dr. Jorrisch has practiced in a rural area. CH 3, 1:50 p.m.

62. For each patient whose care he reviewed Dr. Jorrisch prepared an "Expert Review Worksheet" provided by the Board to its consultants that generally addressed whether the diagnosis, treatment, and records for the patient met minimum standards, and he attached an extensive narrative for each patient explaining the basis for his opinions related to the three categories. Exhibit 1, marked pages 1707-1802.

63. Overall, Dr. Jorrisch estimated that he spent at least forty hours reviewing the medical records and other information provided by the Board and preparing his consultant report. EV 5, 9:10 a.m.; Exhibit 1, marked pages 1707-1802.

64. Dr. Jorrisch found no deviations from the standard of care for the person identified as Patient 3 or for Patient 12 who was not treated by Dr. Vincent, but for the

other sixteen patients, Dr. Jorrisch found deviations in the three categories for the majority of the patients. Exhibit 1, marked pages 1707-1802.

65. For nine patients the diagnosis was "below minimum standards;" for fourteen patients, treatment was "below minimum standards;" and for fourteen patients, the medical records were "below minimum standards." Id.

66. Dr. Jorrisch's "overall opinion" based upon the above-listed categories was that the care and treatment provided to two patients was "clearly within the minimum standards;" for four patients the care and treatment was "borderline;" and for the remaining twelve patients, the care and treatment was "clearly below minimum standards." Id.

67. Through his cover letter dated June 17, 2023, that accompanied the worksheets, Dr. Jorrisch provided a general summary of his findings, conclusions, and opinions regarding the care and treatment provided by Dr. Vincent based upon his review of the medical records from A New Start. Exhibit 1, marked pages 1707-1714.

68. Under the category of "Prescribing," Dr. Jorrisch found the medications Dr. Vincent prescribed were "excessive under accepted and prevailing medical practice standards." Id, marked page 1707.

69. Dr. Jorrisch also found under that category, as well as the categories in his cover letter of "Substandard Care" and "Medical Necessity," that Dr. Vincent "engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky" . . . and that his

medical practice "constitute[s] a danger to the health, welfare, and safety of the physician's patients and the general public." Id, marked pages 1707-1708.

70. In spite of Dr. Vincent's assertions to the contrary and studies that allegedly support the use of stimulants for treatment of StUD, Dr. Jorrisch stated, "treatment of Stimulant Use Disorder continues to be a purely behavioral approach albeit difficult and with limited success." Exhibit 1, marked pages 1709-1710.

71. The hearing officer notes that Dr. Jorrisch's opinion is consistent with the provisions of 201 KAR 9:016, Section 3(2).

72. Dr. Jorrisch identified several other specific practices that fell below the applicable standards, including failure to obtain a complete history or the patient's past medical records, or past treatment history for OUD; failure to follow the appropriate protocol to initiate treatment for an OUD; failure to set forth for all patient visits "the actual conclusion and plan of action, particularly for struggling patients;" failure to provide a complete history of present illness; failure to identify alcohol use by patients; failure to address drug screens that were inconsistent with the prescribed medications; failure to adequately address mental health concerns; and failure to address non-opiate related medical issues revealed through examination or testing. Id, marked pages 1709-1712.

73. Dr. Jorrisch also noted in the cover letter that his "critical concern" was "the prescribing habits and routines of Dr. Vincent" and the risks related to the prescribing of "potentially addicting substance" to "patients with a diagnosis of Substance Use Disorder." Id., marked page 1712.

74. Dr. Jorrisch summarized his findings and conclusions by stating, "Dr. Vincent's practice [is] definitely outside the standards for treatment in the Commonwealth of Kentucky, dangerous to his patients, and dangerous to the community. Major concerns exist for accurate evaluation of patients, for identification of active diagnoses, for documentation in the medical record and in prescribing." Id., marked page 1714.

75. Dr. Jorrisch noted that adequate documentation is especially critical in a medical practice such as Dr. Vincent's in which multiple providers can be treating the patient and reviewing the record of care. EV 6, 9:38-9:40 a.m.

76. In short, if care and treatment isn't documented, there's no way for others to be sure it happened. EV 5, 10:25 a.m.

77. In response to Dr. Jorrisch's report and the Board's allegations, Dr. Vincent provided through counsel several letters and a substantial amount of information in support of his medical practices. Exhibit 1A, attached exhibits 3, 5, 6, and 7.

78. In addition, Dr. Vincent provided opinions from two addiction medicine specialists, Dr. Roger Starner Jones and Dr. James Patrick Murphy, who found Dr. Vincent's practice of medicine to be within the applicable standards. Exhibit 1, marked pages 2188-2203.

79. Dr. James Murphy is board certified in addiction, anesthesiology, and pain management, and he testified at both the Emergency Hearing and the administrative hearing on the *Complaint* as an expert in addiction, anaesthesiology, and pain management. EV 1, 3:15 p.m. and 3:33 p.m.

80. He had spent approximately twenty hours reviewing the charts of the patients at issue in this action. EV 2, 11:12 a.m.

81. Dr. Murphy didn't recall seeing Jorrisch's response to his report and opinion. EV 2, 11:48 a.m.

82. Dr. Murphy, however, specifically agreed with Dr. Jorrisch's concern for inadequate documentation, stating that Dr. Vincent and his colleagues "in some instances [were] not documenting in a manner that could allow the KBML to readily understand their decision making processes," which is an acknowledgment of a violation of the Board's regulations. Exhibit 1, marked page 2202.

83. Dr. Murphy testified that clear documentation is always helpful and needs to be as clear as the provider can make it. CH 11, 10:13-10:14 a.m.

84. Dr. Vincent submitted his own written response to each of Dr. Jorrisch's Expert Review Worksheets but denied any violations to the Board's statutes and regulations. Exhibit 1, marked pages 2341-2358.

85. Dr. Jorrisch provided a fifteen page reply to the information provided by Dr. Vincent and concluded his reply by stating, "In summary, this report supports my original opinions re. Dr. William Kelly Vincent." Exhibit 1, marked pages 2600-2614.

86. At the administrative hearing on the emergency order Dr. Murphy testified that the care and treatment provided by Dr. Vincent for each patient was within the standard of care, and he found no deviation from the standard in Dr. Vincent's prescribing of buprenorphine, the prescribing of other controlled substances to patients

with substance use disorders, or in the treatment of other health issues faced by the patients. EV 1, 3:40-3:54 p.m.

87. Dr. Murphy also found that Dr. Vincent's care and treatment of the patients did not pose a danger to them. EV 1, 3:59 p.m.

88. Although Dr. Murphy highlighted what he considered to be some factual errors in Dr. Jorrisch's report, his testimony at the Emergency Hearing focused mainly on the difference between his and Dr. Jorrisch's professional opinions regarding whether Dr. Vincent's care and treatment met the standard for acceptable and prevailing medical practice.

89. At the administrative hearing on the *Complaint* Dr. Murphy testified that Dr. Vincent met the standards for acceptable and prevailing medical practice in Kentucky, and in his testimony he pointed out several instances in which Dr. Jorrisch made factual errors regarding the adequacy of the documentation in the records, especially those regarding the patients' vital signs, none of which affected the credibility of Dr. Jorrisch's opinions on whether Dr. Vincent met the standard of acceptable and prevailing medical practice in Kentucky. CH 11, 9:24 a.m.

90. The hearing officer notes that in spite of Dr. Jorrisch reviewing separate sets of patients for Dr. Hardison and Dr. Vincent, his findings and conclusions set forth in his multi-page cover letters to his reports for each physician are substantially identical both in form and content, and Dr. Jorrisch's opinions are substantially the same regarding violations of the applicable standards for the care each physician provided to the patients.

91. In spite of the similarities between the reports, the hearing officer finds based upon Dr. Jorrisch's testimony at the hearings on the *Emergency Order* and *Complaint*, he performed a rigorous and detailed review of each physician's care and treatment of his patients. The individual Expert Review Worksheets show similar deficiencies by the physicians in their care and treatment of their individual patients, which is not surprising to the extent the similarities are consistent with the "team approach" adopted by the practice for the care and treatment of patients with OUD, SUD, and StUD. Exhibit 1, marked page 1708.

92. In his cover letter to the Board Dr. Jorrisch concluded that Dr. Vincent violated "Prescribing" standards, rendered "Substandard Care," and violated standards related to "prescribing, management of medical records, patient evaluation and treatment," which conduct departed from or failed to conform to the standards of acceptable and prevailing medical practice in Kentucky. Exhibit 1, marked pages 1707-1708.

93. Dr. Jorrisch supported the conclusions in his cover letter by listing several pages of the types of deficiencies found in his review of Dr. Vincent's patient records. Exhibit 1, marked pages 1710-1714.

94. Those deficiencies included Dr. Vincent's failure to follow the standards for prescribing buprenorphine, treating patients with stimulants who had a diagnosis of a meth addiction, treating patients with benzodiazepines who had been diagnosed with a substance use disorder, and prescribing to patients with an OUD medications such as

promethazine, hydroxyzine, and gabapentin since those medications are often misused by such patients. Exhibit 1, marked page 1710-1714.

95. As for Dr. Vincent's practice of prescribing stimulants for the treatment of StUD, Dr. Jorrisch stated, "treatment of Stimulant Use Disorder continues to be a purely behavioral approach albeit difficult and with limited success." Exhibit 1, marked page 1710.

96. The hearing officer notes that Dr. Jorrisch's opinion is consistent with the provisions of 201 KAR 9:016, Section 3(2).

97. Dr. Jorrisch identified several other specific practices of Dr. Vincent that fell below the applicable standards of care, including his failure to record a clear history of past treatment and a History of Present Illness ("HPI") and his failure to obtain the patient's past medical records of treatment for an OUD. Exhibit 1, marked pages 1710.

98. Dr. Jorrisch noted that Dr. Vincent failed to address several patients' alcohol use even though it was identified in the patient notes, failed to address drugs with abnormal pH levels, and inappropriately relied upon "levels" of medication in drug screens to assess status of drug use. Exhibit 1, marked page 1711, 1757.

99. Dr. Vincent failed to address patients' various metabolic problems, did not address hematologic abnormalities, wrote prescriptions for unidentified problems or for problems that were not adequately evaluated, and failed to have close collaboration with other providers when necessary. Id.

100. Dr. Jorrisch found that Dr. Vincent failed to have adequate collaboration with the APRN for patients with significant mental health issues, including active

hallucinations, that required consideration of referrals to other mental health resources. Id.

101. Dr. Jorrisch also noted in the cover letter that his "critical concern" was "the prescribing habits and routines of Dr. Vincent" and the risks related to the prescribing of "potentially addicting substance" to "patients with a diagnosis of Substance Use Disorder." Id., marked page 1712.

102. Dr. Jorrisch summarized his findings and conclusions in his report by stating, "Dr. Vincent's practice [is] definitely outside the standards for treatment in the Commonwealth of Kentucky, dangerous to his patients, and dangerous to the community. Major concerns exist for accurate evaluation of patients, for identification of active diagnoses, for documentation in the medical record and in prescribing." Id., marked page 1714.

103. Many of the standards that Dr. Jorrisch found Dr. Vincent failed to meet in his medical practice are specifically required under the regulations governing the prescribing of controlled substances, stimulant medications, and buprenorphine.

104. In his individual report for each of the eighteen patients, Dr. Jorrisch set forth the specific findings that supported his general findings and conclusions in his cover letter that accompanied the Expert Review Worksheets. Exhibit 1, marked pages 1707-1802.

105. At the emergency hearing Dr. Jorrisch testified that as a result of Dr. Vincent's prescribing practices, he would not be surprised to learn that "something

happened" to a patient, explaining that although Dr. Vincent wasn't an immediate danger, his prescribing practices were dangerous. EV 6, 1:37 p.m.

106. At the administrative hearing on the *Complaint*, Dr. Jones, Dr. Murphy, and an additional expert witness, Dr. Molly Rutherford, testified on behalf of Dr. Vincent, and they agreed that his treatment of the patients at issue in this action fell within the standards of acceptable and prevailing medical practice in Kentucky and did not violate the Board's statutes and regulations.

107. Dr. Vincent testified at both the emergency hearing and the Complaint hearing about the care provided to the patients at issue, and Dr. Jorrisch also testified at both hearings and provided testimony regarding his review of the care and treatment for each of the eighteen patients.

108. Dr. Jorrisch's findings and conclusions for each patient are too extensive to review individually in this recommendation, but the hearing officer found in general Dr. Jorrisch's findings and opinions to be compelling and well supported by the record.

109. In contrast, the hearing officer did not find Dr. Vincent's or his experts' testimony to be as persuasive as Dr. Jorrisch's in light of Dr. Murphy's acknowledgment of shortcomings in Dr. Vincent's record keeping practices, Dr. Vincent's failure to challenge many of Dr. Jorrisch's factual findings in support of his opinions, and based upon the standards of acceptable and prevailing medical practice in Kentucky as established by the applicable regulations and through the experts' testimony.

110. To the extent that Dr. Vincent's expert witnesses assert he did not violate the standards of acceptable and prevailing medical practice in Kentucky in spite of his

clear and repeated violations of the provisions of 201 KAR 9:270, their opinions are not credible, especially considering Section 5 of the regulation that specifically states violations of Sections 2, 3, and 4 of the regulations "shall constitute a 'departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky" and shall constitute violations of KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12), which are the specific statutes cited by the Board in support of the *Complaint*.

111. The hearing officer notes that one section of Dr. Murphy's report is titled "Buprenorphine is Effective Pain Treatment." Exhibit 1, marked page 618.

112. Yet, 201 KAR 9:270, Section 2(1)(b), states that buprenorphine products shall not be prescribed for pain unless delivered in an FDA approved form and for an FDA approved purpose, and although Dr. Jorrisch testified that some formulations of buprenorphine are approved for the treatment of pain, he also testified that Suboxone, Subutex, and Sublocade are not approved for that purpose. CH 3, 9:24-9:25 a.m.

113. In addition, Dr. Murphy testified at the Emergency Hearing for Dr. Vincent that any deviation from the regulation he found in his review of the medical records were not violations of the standard of care because the deviations were consistent with the Treatment Improvement Protocol ("TIP") 63, published by the Substance Abuse and Mental Health Services Administration ("SAMHSA"). EV 2, 10:30 a.m.; Exhibit 8.

114. Thus, Dr. Murphy does not believe a physician is bound by the requirements of the Board's regulations if there is a competing authority, even with the

specific requirement that a physician explain in his medical record why he deviated from the regulation's standards. 201 KAR 9:270, Section 4(2).

115. Hence, to the extent Dr. Murphy or Dr. Vincent's other expert witnesses assert or suggest his prescribing practices have met the applicable standards in light of clear violations of the regulations, the obvious conclusion is the expert witnesses do not accept the Board's regulations as the governing standards for the prescribing of buprenorphine and other controlled substances. Therefore, their overall credibility is further undermined by such assertions, and their opinions carry little weight.

116. Pursuant to 201 KAR 9:270, Section 4(1) and(2), a physician is required to "obtain and document all relevant information in a patient's medical record in a legible manner and in sufficient detail to enable the board to determine whether the licensee is conforming to the professional standards for prescribing" buprenorphine, and if he is unable to obtain those records, the physician "shall document those circumstances in the patient's record." CH 3, 9:25-9:26 a.m.

117. To the extent Dr. Vincent or his expert witnesses assert or suggest a physician may ignore that requirement and others in the Board's regulation, or may ignore an established standard because the practice of addiction medicine is "evolving" or because the physician is acting in the best interest of the patient, such an approach has no basis in law and is contrary to the fundamental principle that a physician "shall" follow the Board's regulations. At the least and as required by the Board's regulations, the physician shall explain in his patient records, which Dr. Vincent failed to do, the

reason for his deviation from a standard and regulation, assuming such deviation may even be authorized by the language of the regulation itself.

118. To the extent that Dr. Vincent or his experts assert he acted in the best interests of the patient and within the standards of acceptable and prevailing medical practice by deviating from the requirements of a regulation, but he has not clearly stated in the patient record as required by the Board's regulations the reasons in support of the deviation from the standard, the physicians' assertions carry little weight. 201 KAR 9:270, Section 4(1) and(2).

119. At the administrative hearings on the emergency orders and on the *Complaints*, witnesses provided extensive and detailed testimony on the effects of opiates on the human body and on the evaluation and treatment process for prescribing buprenorphine to treat an OUD that was helpful in providing both the context for and an understanding of the violations at issue in this action.

120. Dr. Vincent provided during the administrative hearing on his *Emergency Order* relevant testimony regarding the operation of ANS and an opioids' effect on the body and how they interfere with its functioning.

121. Opioids, such as heroin, are a full agonist that binds to receptors in the brain to give a "reward" and cause persons to seek more of the drug for the effect produced. EV 1, 11:32-11:34 a.m.

122. Because a person builds a tolerance to the drug, requiring increasing amounts for the same effect and to prevent the person from going into withdrawal, large

amounts of opioids can cause respiratory suppression that results in death. EV 1, 11:34-11:36 a.m.

123. ANS treats OUD by substituting buprenorphine for heroin or other opioids the patient may be taking. EV 1, 11:32-11:34 a.m.

124. Buprenorphine occupies the same receptors in the brain as opioids, which prevents the person from going into withdrawal and reduces the craving for the drug. EV 1, 11:34 and 11:41 a.m.; EV 2, 11:35-11:38 a.m.

125. The standards for the prescribing of buprenorphine has been evolving in the medical community in an effort to allow increased access to the medication to treat an opioid addiction. EV 1, 11:42-11:45 a.m.

126. Suboxone has an advantage over methadone because it is generally a safer medication for the treatment of an OUD and does not have the side effect of respiratory suppression. EV 1, 11:56-11:58 a.m.

127. Methadone can be abused by opiate addicted patients and is susceptible to diversion, and therefore, it is also highly regulated. EV 1, 11:59 a.m.-12:01 p.m.

128. If a patient is switching from methadone to Suboxone, the person must not have taken methadone for at least seventy-two hours before induction since he can experience severe withdrawals if he still has methadone in his body. EV 3, 12:54-12:57 p.m.

129. Subutex contains only buprenorphine and is subject to diversion because it can be snorted and injected. See CH 3, 2:55 p.m.

130. The entire process for prescribing buprenorphine is strictly regulated by the provisions of 201 KAR 9:270.

131. In his reports for the individual patients and in his testimony reviewing the care for each patient, Dr. Jorrisch provided details related to Dr. Vincent's violations of the standards set forth in 201 KAR 9:270, Section 2(4) related to the induction process for prescribing buprenorphine and the maintenance of adequate records. Exhibit 1, marked pages 1707-1802.

132. In spite of the requirements of the regulation to obtain past medical records and in spite of the assertion that ANS had a standing order to obtain those records, at the administrative hearing on the *Complaint* Dr. Hardison testified that it was a "rare bird" for ANS to obtain a patient's past medical records. CH 1, 10:19-10:20 a.m.

133. In addition, Dr. Hardison testified, "I'm sure" that he hadn't documented every effort to obtain those records in spite of his requirement to do so pursuant to 201 KAR 9:270, Section 4, when prescribing buprenorphine, and the hearing officer will assume that Dr. Hardison's approach to obtaining and documenting efforts to past medical records was reflective of the general approach of all physicians in the practice. CH 1, 10:20 a.m.

134. Although testifying on behalf of the physicians, Dr. Jones stated he may have seen a few records from other clinics in the patients' files, but he couldn't recall seeing documentation regarding ANS's inability to get a patient's prior medical records. CH 8, 10:51 a.m.

135. In fact, Dr. Hardison was dismissive of the regulation's documentation requirement, stating that if the regulations required a physician to document the efforts to obtain a patient's past medical records, 99% of physicians didn't do it, which again the hearing officer finds to have been reflective of the general approach of the clinic and Dr. Vincent to obtain those records since it was not done on a regular basis. CH 1, 10:21 a.m.

136. Furthermore, Dr. Hardison testified that the clinic had "lots of protocols," and although he asserted it was important to follow them on each occasion, his failure to obtain the patient's medical records or to document those efforts showed that he and the other physicians either routinely ignored or failed to rigorously enforce the protocols for record keeping. CH 1, 10:21 a.m.

137. Thus, the preponderance of evidence supports the conclusion that Dr. Vincent failed to maintain documentation as required by 201 KAR 9:270, Section 2(4), and he failed to document that he made the requisite effort to obtain patients' prior medical records.

138. In applying the standards in the regulation on treating patients with buprenorphine, the treating physician must first identify the patient as either a new patient for treatment of an OUD or a patient who is continuing treatment. CH 3, 9:15 a.m.

139. The physician is also required to include in the medical records the HPI, which in many instances was inadequate due to the failure to include the person's

current status, which would necessitate another physician to review an entire three-page office note to understand the patient's status. CH 3, 1:36 p.m.

140. Every new patient at ANS was required to have a urine drug screen ("UDS") and an evaluation to determine whether the person was in withdrawal, was currently taking opioids or methadone, and was naive to buprenorphine. EV 3, 12:42-12:46 p.m.

141. Thus, the urine drug screen is performed for patient safety and to get baseline levels of opiates and other medications the patient is taking since some medications can stay in the body for weeks. EV 3, 12:59 p.m.

142. Although Dr. Vincent generally performed an appropriate initial UDS, significant and important information was often missing in the medical records related to those drug screens. Exhibit 1, marked page 1710-1711.

143. Dr. Vincent also failed to adequately address diluted UDS or drug screens with abnormal pH and failed to adequately address drug screens that showed the absence of prescribed medications or additional unprescribed controlled substances. Exhibit 1, marked page 1711. See also, Exhibit 1, marked pages 1752 and 1757 for patient examples.

144. As part of initial patient screening, the physician must obtain a COWS score to determine whether the patient is in withdrawal, but it was not clear if the COWS evaluation was performed or if the patient was in moderate or severe withdrawal. 201 KAR 9:270, Section 2(4)(c)(2); Exhibit 1, marked page 1710.

145. In addition to obtaining a COWS score, 201 KAR 9:270, Section 2(4)(c), requires the physician to recommend and observe in-office induction or record why in-office induction did not occur, shall initiate treatment with a dose not to exceed the equivalent of four milligrams of buprenorphine, and shall not exceed sixteen milligrams on the first day of treatment.

146. Dr. Jorrisch found that patients were routinely admitted and treated with 16 to 24 mg of buprenorphine on the first day which is outside of the Kentucky standards. Exhibit 1, marked page 1710. EV 5, 9:25-9:28 a.m.

147. If the patient is "naive" to Suboxone, in that they have no recent history of use of the medication, the induction must take place at ANS, but if the person is not naive, he can undertake the induction in his own home. EV 3, 12:42 p.m. and 12:49-12:53 p.m.

148. Pursuant to 201 KAR 9:270, Section 2(4)(c)(1)(b), the physician is required to record why in-office induction did not occur.

149. If the patient has been seen by another provider and does not have a lapse in treatment, the new provider "shall document that fact" and may treat the patient with buprenorphine without induction at the same or lesser dosage. 201 KAR 9:270, Section 4(d).

150. Dr. Jorrisch found, however, that Dr. Vincent's patient notes lacked "a clear indication of past treatment episodes, especially as it would necessitate differentiation of new patients, patients transitioning to a new prescriber, transfers, patients who have experienced past treatment with buprenorphine." Exhibit 1, marked page 1710.

151. Dr. Vincent also failed to comply with the requirements of the Board's regulations to document the initial dose given to a new patient, the escalation of the dosage, and the use of home inductions in place of office inductions. Exhibit 1, marked page 512; EV 5, 9:25-9:28 a.m. and 9:31 a.m.; 201 KAR 270, Section 2(4).

152. New patients or patients with a lapse in treatment with buprenorphine must initiate treatment at 4 mg and have their dosage escalated to no more than 16 mg the first day of treatment in accordance with 201 KAR 9:270, Section 4(c)(3). CH 3, 9:15-9:16 a.m.

153. The great majority of patients did not need a dose greater than 16 mg, and if patients are prescribed more, the medication, especially the mono product, can be sold which presents a safety issue for the community. EV 5, 9:31-9:33 a.m.

154. Thus, it was both inappropriate and contrary to the provisions of 201 KAR 9:270 to initiate a new patient at 16 mg or greater of buprenorphine, especially in light of the regulation's requirement to document the need to go beyond the requirements of the regulation. CH 3, 9:15 a.m.; EV 5, 9:31-9:33 a.m.; 201 KAR 9:270, Section 4(2).

155. If the physician can document through medical records, drug screens, and KASPER reports that the patient is not naive to buprenorphine or has not had a lapse in treatment, the patient can be started at the dosage the patient had been taking with the previous provider. CH 3, 9:15-9:17 a.m.

156. The physician, however, cannot simply rely upon the patient's assertion that he has been in a suboxone treatment program to justify classifying a patient as anything but a new patient and must start him at 4 mg and escalate to no more than 16

mg of buprenorphine on the first day in accordance with the requirements of the regulation. CH 3, 9:15-9:16 a.m.

157. A patient "simply identifying familiarity with buprenorphine does not justify admission without induction and at higher doses." Exhibit 1, marked page 512; CH 3, 9:16 a.m.

158. After induction, the physician may increase a patient's buprenorphine beyond 16 mg in the appropriate circumstances. CH 3, 9:17 a.m.

159. Dr. Vincent's process for getting to 16 mg of buprenorphine without clear rationale on the first day of treatment was inappropriate. EV 5, 9:27 a.m.; Exhibit 1, marked page 1710.

160. Because of the potential for abuse of the mono product, Subutex, a physician "shall not" prescribe it unless the patient has a "demonstrated hypersensitivity to naloxone" or other specific medical conditions not applicable to the patients in this action. 201 KAR 9:270, Section 2(2)(b). CH 1, 10:13 a.m.; CH 2, 1:32-1:34 p.m.; 201 KAR 9:270, Section 2(2).

161. Dr. Vincent had inadequate justification for the use of the mono product in place of Suboxone, and he continued the mono product after patients tested positive for naloxone without clear reasoning for continuing. Exhibit 1, marked page 1710, 1747, 1775, 1780, 1783.

162. Patient 7 was kept on the mono product in spite of three UDS in a row that were positive for naloxone. CH 6, 4:29-4:30 p.m.

163. Patient 13 was placed on the mono product as the result of alleged headaches, but with that change in the treatment plan, Dr. Vincent should have documented, but did not, the effects on the patient's condition from that change. CH 4, 1:41-1:42 p.m.

164. Dr. Vincent prescribed Patient 14 the mono product without a clear indication in the patient record why the change was made, although it possibly could have been due to interference with the patient's cancer treatment, but that was never documented. CH4, 1:59-2:00 p.m.

165. At the administrative hearing Dr. Vincent's counsel suggested that the switch to the mono product may have been because Patient 14 was receiving chemotherapy for cancer treatment, but that potential reasoning was absent from Dr. Vincent's patient notes, which left the reviewing physician to speculate for a reason why Dr. Vincent may have switched to or continued with the mono product, which is contrary to the requirements of 201 KAR 9:270, Section 4. CH 4, 1:57-1:58 p.m.

166. Dr. Jorrisch stated that if another physician who was treating Patient 14 with opiates for pain also prescribed medications with naloxone, which would interfere with pain management, that would be "very bad practice." CH 4, 2:00-2:01 p.m.

167. In addition, Patient 14's later UDS tested positive for naloxone, which suggested the patient did not have an allergy to suboxone, but Dr. Vincent's patient notes don't address that fact or the reasons for continuing to prescribe the mono product. CH 4, 2:01 p.m.

168. Dr. Vincent prescribed Patient 15 with the mono product due to severe headaches, but the patient's headaches predated the treatment with suboxone and are more associated with buprenorphine than with naloxone, which necessitated further investigation by Dr. Vincent before prescribing the more dangerous mono product. Exhibit 21, marked page 22532; EV 6, 10:08 a.m.; CH 4, 2:14-2:16 p.m.; 2:22 p.m.

169. Patient 16 was the wife of Patient 15, and she was also prescribed the mono product also due to headaches (migraines). CH 9, 1:22 p.m.; Exhibit 1, marked page 1730; Exhibit 22, marked page 23581.

170. The standard of care required the physician to obtain the patient's medical records from the previous provider before issuing the second or third prescription for the mono product to verify the truthfulness of the patient's assertion of an allergic reaction to naloxone. CH 3, 2:50-2:51 p.m.

171. Dr. Vincent's patient records do not show or suggest he made the requisite effort to comply with that requirement.

172. In spite of Dr. Vincent having several patients who were allegedly allergic to naloxone, Dr. Jones testified he has never seen a patient with a naloxone allergy, describing the occurrence as "vanishingly rare." CH 8, 10:49 a.m. and 10:56 a.m.

173. Due to the requirements of the Board's regulation, Dr. Jones stated he expected a physician to state his clinical reasoning for continuing the mono product for a patient, stating a physician cannot simply take a patient's word on an allergy because of the risk of diversion. CH 8, 10:53-10:54 a.m.

174. Despite those requirements, however, Dr. Jones did not see that reasoning in Dr. Vincent's medical records. CH 8, 10:57 a.m.

175. Hence, Dr. Vincent failed to comply with the requirements of the regulation for prescribing the mono product, failed to document its necessity, and failed to take into account in his prescribing the possibility his patients may be diverting the mono product and taking the buprenorphine/naloxone product in its place.

176. An initial dose of buprenorphine at 16 mg and above can precipitate withdrawal, which is unsafe, and dose escalation by the physician beyond 16 mg on the first day is excessive. CH 1, 10:25 and 10:27 a.m. CH 3, 9:16 a.m.

177. The treating physician has to be aware that a patient is unlikely to have withdrawal at 16 mg of buprenorphine and that other interventions are appropriate over increasing buprenorphine, especially in patients who may be looking for the same effect they received from street drugs. CH 3, 10:15 a.m.

178. The escalation of buprenorphine to and above 16 mg must be done in a measured and safe way and must be supported in the record, which Dr. Jorrisch did not see in Dr. Vincent's records. EV 5, 9:28 a.m.; CH 3, 915-9:16 a.m. and 10:15-10:17 a.m.

179. Another concern for escalating Buprenorphine above 16 mg is the possibility that the patient may seek to divert any excess medication, and although Dr. Jorrisch recognized that some patients may benefit from a higher dose, that need must be documented, which he didn't see in the medical records. CH 3, 10:15-10:17 a.m.

180. The patient records showed that Dr. Vincent initiated and/or continued treatment of some patients with buprenorphine at 16 mg or greater without adequately

documenting the need for that treatment contrary to the provisions of 201 KAR 9:270, Section 4(c)(3). See e.g., Exhibit 1, marked page 1737; Exhibit 18, marked page 6553.

181. While Dr. Vincent did not disagree with the substantial majority of Dr. Jorrisch's factual findings related to the failure to follow the requirements of the regulation, he and his experts offered various rationales justifying his prescribing practices, including his own expertise in treating OUD patients, the evolving nature of the understanding of OUDs, and the potency of opiates such as fentanyl, and harm reduction. See Exhibit 1, marked pages 1715-1802; CH 5, 3:58-4:13 p.m.; CH 7, 10:38-10:42 a.m.

182. Dr. Vincent failed to incorporate abnormal drug screens into appropriate clinical reasoning to support the continuation or modification of treatment and failed to accurately document the same in the patient record, as required by 201 KAR 9:270, Section 2(4)(e)(5)(f)(ii). See for example, Exhibit 1, marked page 1752 and 1757; CH 4, 11:47 a.m and 1:34 p.m. and 2:59-3:00 p.m.

183. If a physician decides to veer from the standard of care, there needs to be clear documentation in the record to go in another direction. CH 3, 1:42 p.m.

184. In addition to finding that Dr Vincent's care and treatment related to a patient's opiate use disorder failed to meet the standard of care in violation of the Board's statutes and regulations, Dr. Jorrisch also found Dr. Vincent's care and treatment of patients with StUD, often as a result of their addiction to methamphetamine, violated the Board's statutes and regulations by his prescribing

stimulants and other medications to those patients under the guise of treating them for ADHD and ADD. Exhibit 1, marked page 1713.

185. Persons with StUD differ from those with an OUD because the former is chasing the high rather than attempting to prevent withdrawal. EV 1, 1:33-1:34 p.m.

186. Suboxone is not used to treat a meth addiction but is used in combination with other medications for patients diagnosed with both OUD and StUD. CH 1, 10:28-10:29 a.m.

187. StUD patients experience fatigue, lack of concentration, and difficulty completing tasks and will turn to illicit drugs to obtain symptom relief. EV 1, 1:38 p.m.

188. Dr. Vincent testified that nothing raises dopamine level like methamphetamine. EV 1, 1:37 p.m.

189. Therefore, controlled substances are not an effective tool for treating StUD, and instead, cognitive therapy and twelve-step type programs are used for treatment. EV 1, 1:35 p.m.

190. Dr. Jorrisch testified that the "great majority" of physicians acknowledge the standard of care for the treatment of StUD is not to prescribe stimulants for the condition. CH 3, 1:43 p.m.

191. Dr. Hardison admitted in his testimony that no drugs, including stimulants, are routinely recommended for treatment of StUD, and behavioral therapy and contingency management are the only treatments proven to work for those patients. CH 4, 10:06 a.m.; Exhibit 1, marked page 869.

192. Dr. Murphy acknowledged in his own testimony that he did not prescribe stimulants for his own patients suffering from StUD. CH 11, 10:12 a.m.

193. Persons with Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder, however, have symptoms similar to persons with StUD. EV 1, 1:39 p.m.

194. Therefore, there has been some discussion among addiction specialists and studies published concerning the treatment of StUD patients with stimulants such as Adderall, but that is irrelevant to the issue of whether Dr. Vincent has complied with the Board's statutes and regulations since they do not authorize the use of stimulant medications for the treatment of StUD. EV 1, 1:39-1:44 p.m.

195. Since Adderall and Ritalin are Schedule II amphetamine or amphetamine-like controlled substances, the prescribing of those medications are governed by the provisions of 201 KAR 9:016, Section 3(2)(a)-(f), which authorizes the use of stimulants for the treatment of certain specific medical conditions that include ADHD but not StUD.

196. Dr. Jorrisch testified that while it is completely appropriate to treat ADHD in children with Adderall, it is not within the standard of acceptable and prevailing medical practice in Kentucky to prescribe Adderall to an adult who has StUD unless that person had a documented diagnosis of ADHD. CH 3, 9:17 a.m.

197. Thus, Dr. Jorrisch's opinion is simply a recognition and application of the requirements of 201 KAR 9:016, Section 3(2)(a)-(f) that represent the standards of acceptable and prevailing medical practice in Kentucky.

198. Furthermore, even without the strict provisions of 201 KAR 9:016, Section 3(2)(a)-(f), Dr. Jorrisch noted that since there currently is not good support for the use of medications for the treatment of StUD, the danger of prescribing stimulants to the patient already suffering from StUD is always highlighted in the studies that advocate for the use of those medications. EH 3, 9:40 a.m.

199. Thus, even without the specific prohibition in the Board's regulation, Dr. Vincent would have been expected under the requirements of the Board's regulation to provide in his patient notes a clear and detailed explanation for the prescribing of stimulants to such patients, which he did not do.

200. Even if Dr. Vincent were qualified to diagnose a patient's ADHD, the Board asserts that Dr. Vincent improperly prescribed Ritalin and Adderall for the treatment of patients' StUD under the guise of a diagnosis of ADHD and ADD when there was not adequate support and justification in the patients' medical records for such diagnoses.

201. Dr. Vincent agreed with Dr. Hardison's approach of treating methamphetamine addiction with stimulants. CH 5, 3:58 p.m.

202. Dr. Vincent prescribed Ritalin to Patient 5, a personal friend, without proper justification based upon the assertion that Care Now had made the diagnosis of ADHD, but there's no support in his own patient chart for that diagnosis. CH 6, 2:40 and 2:51 p.m.

203. Dr. Vincent continued Dr. Hardison's prescriptions for Patient 6 for Adderall to address the patient's StUD. Exhibit 1, marked page 1740. CH 6, 3:59-4:02 p.m.

204. Dr. Vincent prescribed controlled substances that are often misused by patients with an OUD, such as promethazine, hydroxyzine, and gabapentin, but he "did not show clear rationale [for medications that] carried inherent dangers." Exhibit 1, marked page 1713.

205. Among persons with an OUD, Dr. Jorrisch stated that "in particular gabapentin, a controlled substance, is widely misused [and is] dangerous with its sedative properties," and therefore, "its prescription by Dr. Vincent in his patients necessitated clear rationale for an FDA approved purpose to be acceptable," which he failed to do in his patient notes. Exhibit 1, marked pages 1713; CH 3, 9:18-9:19 a.m.

206. Since it's "well known" that patients with an OUD misuse gabapentin, a physician should avoid prescribing that medication. CH 3, 9:18 a.m.

207. Although gabapentin is approved for specific uses, "it would not be acceptable to use under the guise of pain management" and is not approved for the treatment of pain, anxiety, or other mental health issues. Exhibit 1, marked page 1713 and 1747. EV 3, 3:19-3:21 p.m.

208. Dr. Vincent, however, prescribed gabapentin for unknown conditions or for the treatment of pain. See Dr. Jorrisch's review of Patients 1, 4, 6, 7, 9, 12, 13, 14, 16, 17, and 18. Exhibit 1, marked pages 1715-1802.

209. For example, the patient note for Patient 18 on August 3, 2021, states simply "Gabapentin increased." Exhibit 74, marked page 28080.

210. He continued Patient 1's prescription for fifteen months allegedly to treat her pain in anticipation of carpel surgery. CH 4, 10:52-10:56 a.m.

211. The hearing officer notes that Dr. Vincent asserted that because he was prescribing gabapentin "off label," which meant it was not prescribed for an FDA approved use, he was authorized to prescribe the medication for any reason, but at the same time, he asserted he was under no obligation to state specifically in the patient notes, in spite of the requirements of the applicable regulations to the contrary, the diagnosis and the justification for prescribing gabapentin to the patient, and more importantly for the patients at issue in this action, the justification for prescribing to a patient who is being treated for SUD. 201 KAR 9:260, Section 2.

212. In addition to misusing gabapentin, OUD patients are also "well known to misuse benzodiazepines" and therefore, benzodiazepines are generally to be avoided and are contraindicated for those patients. CH 3, 9:20 and 9:22 a.m.

213. Dr. Jorrisch noted a physician must be concerned that a patient who is being treated with buprenorphine is also using sedative-hypnotic medications, including include benzodiazepines generally, and Xanax specifically, particularly from the standpoint of sedation and possible respiratory suppression, overdose, and death. CH 3, 1:31 p.m.

214. The benefit to the patient in prescribing benzodiazepines must be greater than the risk, especially for a patient who may not only be misusing his prescribed medication but is also taking unprescribed benzodiazepines. CH 3, 1:31 p.m.

215. Taking unprescribed benzodiazepines presents a strong safety issue, and it's not within the standard of care to prescribe them in such a circumstance. CH 3, 1:32 p.m.

216. Benzodiazepines could be used, however, in an "urgent situation" to allow a patient to detox and avoid withdrawal as the patient enters treatment, but it would be "foolhardy" to prescribe them PRN ["as needed"] rather than in a "specific, guided course" since such patients cannot manage withdrawal on their own. CH 3, 9:21 a.m.

217. The gradual withdrawal from benzodiazepines represented the standard of care, and a safe withdrawal course of treatment may extend over a couple of weeks, but a month or more would be excessive. CH 1, 4:14 p.m.; CH 3, 9:21 a.m.

218. The fact that patients are rarely able to taper their benzodiazepine use is not a reason to continue prescribing the medication but is a reason to have them enter a higher level of care due to the danger of the continued use of benzodiazepines with an OUD. CH 3, 9:22-9:23 a.m.

219. In response to Dr. Jorrisch's criticism of his prescribing practice related to benzodiazepines, Dr. Vincent asserts that by continuing to prescribe benzodiazepines he's engaging in "harm reduction" by offering to prescribe Patient 6 klonopin if he would stop taking illicit benzodiazepines, a practice Dr. Jorrisch described as dangerous, counter-therapeutic, and contrary to the policy of ANS to wean the patients from benzodiazepines. CH 4, 11:47-11:48 a.m.

220. While harm reduction is a legitimate goal and necessary for some patients, the physicians' discretion in treating patients is not unlimited, especially when the patient continues to misuse controlled substances, and Dr. Vincent was required to follow the Board's statutes and regulations in exercising his discretion. CH 3, 2:22-2:23 p.m. and 2:27-2:28 p.m.

221. Dr. Vincent's patient note for Patient 18 dated July 20, 2021, does not provide an explanation for increasing the patient's Xanax but states simply "increased Xanax to 2 mg three times daily." Exhibit 24, marked page 28056.

222. The same note, however, does explain Dr. Vincent's reasoning for an increase in Patient 18's suboxone dose, to address his "cravings and [to] decrease relapse potential." Exhibit 24, marked page 28056.

223. Dr. Hardison asserted that many patients with an OUD also have anxiety issues and placing them on a long-acting, low dose benzodiazepine while being treated with buprenorphine for their OUD helps to keep them in the recovery program and helps to keep them from seeking benzodiazepines illicitly. CH 1, 4:27-4:30 p.m.

224. In addition, Dr. Hardison asserted that more patients die if you take them off benzodiazepine than if you keep them on the medication while treating their OUD with buprenorphine. CH 1, 4:22-4:24 p.m.

225. Whether the patient suffers from OUD or StUD, Dr. Hardison characterized his overall goal for patient treatment is to prevent relapse and keep them in recovery since patients may die if they relapse. CH 1, 10:29-1031 a.m.

226. The hearing officer will assume that Dr. Hardison's approach to the prescribing of benzodiazepines is also representative of ANS's and Dr. Vincent's approach.

227. If the physician believes the prescribing of benzodiazepines is necessary for a patient with an OUD, the reasons for its use must be well documented, and the

physician must have the experience and training in treating the panic, anxiety, or other associated conditions for which that medication has been prescribed. CH 3, 9:23 a.m.

228. Dr. Jorrisch noted that benzodiazepine prescriptions for patients with a diagnosis of StUD or of a sedative-hypnotic use disorder may be appropriate in some circumstances, but the physician's reasoning must be well documented, which the records indicate Dr. Vincent did not do. CH 3, 9:23 a.m.; CH 4, 11:48 a.m.

229. In addition, there are other medications and other methods, including behavioral techniques, to manage the patient's mental health problems, which should be the first course of treatment. CH 3, 9:23 a.m.

230. ANS did not have a taper protocol for benzodiazepines prior to January 2023, which suggests the facility did not prioritize the need to wean patients from the medication. CH 5, 4:10-4:12 p.m.

231. Even when prescribing to a patient addicted to benzodiazepines, the standard of care is to switch the patient from Xanax to longer acting Klonopin and to prescribe for a short course of treatment not extending beyond a couple of weeks since a longer period of time is excessive. CH 3, 9:21 a.m.; CH 7, 10:43-10:45 a.m.

232. Dr. Vincent did not taper Patient 7's benzodiazepine but kept him on a consistent dose of the medication in spite of the patient running out early and continued anxiety, and apparently, without the patient's referral to a higher level of care. CH 6, 4:29 p.m.; Exhibit 1, marked page 1747.

233. Patient 7's notes also indicated that he was taking two benzodiazepines at the same time but it was unclear whether that was an error in the notes because the

matter wasn't addressed. CH 4, 1:14-1:15 p.m.

234. Although patients with addiction issues frequently have mental health issues that also must be addressed, Dr. Vincent failed to consider whether the patients needed a higher level of care than could be provided through his own medical practice. CH 4, 2:21 p.m.; CH 6, 4:29 p.m.; Exhibit 1, marked page 1747. See also, CH 4, 11:09 a.m., for the failure to make a timely referral for Patient 4.

235. While Dr. Vincent had some experience and training to address mental health issues as an addiction specialist, he doesn't have the training and expertise for full treatment of mental health disorders, such as a three-year psychiatry residency, and some of his patients with mental health disorders associated with their addictions needed referral to a higher level of psychiatric care, which they did not receive.

236. In addition, there's no evidence in his patient records that Dr. Vincent was providing psychiatric care, much less a higher level of care that can be provided by a trained psychiatrist, for his patients' mental health disorders.

237. Patient 4 was referred to psychiatric care by Dr. Vincent but not until well after he began treating the patient, and Dr. Vincent continued to prescribe controlled substances even with the patient's continued mental health problems and his lack of response to the medications. CH 4, 11:09-11:11 a.m.

238. For this same patient Dr. Vincent recommended he take CBD oil, which is not within the standards of practice for a physician to recommend that for any kind of medical condition. CH 4, 11:18-11:20 a.m.

239. Dr. Jorrisch explained that patients need guidance on how to deal with issues, and for a physician to recommend or authorize a product such as CBD that has mood altering properties and is related to products that are misused by patients is "poor guidance." CH 4, 11:19 a.m.

240. There is not a strict contraindication for a patient with SUD to be prescribed benzodiazepines, but that has to be done under the right circumstances and in consultation with an expert, such as a psychiatrist. CH 3, 2:05 p.m.; Exhibit 1, marked page 1713.

241. Thus, the issue in this action is not whether Dr. Vincent is qualified to diagnose and treat a person with an addiction to benzodiazepines, but whether, as Dr. Jorrisch found, he placed too much reliance on continuing benzodiazepine prescriptions, had inadequate justification for the medication in the patient records, and should have referred the patient to a higher level of care when his treatment was not successful.

242. As Dr. Jorrisch summarized in his report, "there are alternative medications to BZD's [benzodiazepines] to help manage [anxiety.] Psychiatry expertise would be helpful. But definitely in patients with identified sedative hypnotic use disorder, in those known to be misusing sedative hypnotics (including alcohol), being treated with medications that cause sedation, the risks may be too high to consider the use of BZD's." Exhibit 1, marked page 1713.

243. For example Dr. Jorrisch noted for Patient 1 that a benzodiazepine "would be generally contraindicated in a patient with SUD," and Dr. Vincent offered to

prescribe klonopin to Patient 6 if he would stop taking illicit benzodiazepines, which practice Dr. Jorrisch described as "dangerous and counter-therapeutic" and doesn't suggest an effort to wean the patient off of benzodiazepines. Exhibit 1, marked page 1718; CH 4, 11:47-11:48, 11:51-11:52 a.m.

244. Thus, while prescribing benzodiazepines in some situations may be necessary, Dr. Vincent did not comply with the standards in 201 KAR 9:260, Section 2, by providing in his patient notes a clear diagnosis, starting with safer medications, documenting his reasoning for continuing the medications over a long course of treatment, and referring such patients to a psychiatrist with experience and credentials in treating anxiety, panic disorders, and other associated diagnoses.

245. There is no requirement that a physician continue stimulant or sedative-hypnotic medications if the patient had been prescribed them by an earlier provider, but instead, the new physician must contact the previous provider for the patient's medical records and must document the reasons for continuing those medications. Dr. Vincent did not follow those guidelines and standards of care. CH 3, 9:28 a.m.

246. The off-label use of gabapentin is not a better course of treatment for patients treated with benzodiazepines who suffer from anxiety, panic disorders or other associated mental health conditions and is not approved by the FDA for that purpose. CH 3, 9:24 a.m.

247. Dr. Jorrisch found that Dr. Vincent's "identification of alcohol use was deficient. Use was evident in several patients reviewed but was not addressed by Dr. Vincent." Exhibit 1, marked page 1711.

248. For example, Patient 6 reported drinking ten beers two days before his office visit with Dr. Vincent on March 22, 2022, but he did not record in his office notes having counseled the patient on his alcohol use. Exhibit 41, marked page 7951; CH 6, 3:28 p.m.

249. Dr. Jorrisch noted a similar failure by Dr. Vincent to address ongoing alcohol use by Patients 5, 7, and 18. Exhibit 1, marked pages 1737, 1747, and 1800 respectively.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over this action pursuant to KRS 311.591 and KRS 311.595.

2. The administrative hearing was conducted in accordance with the provisions of KRS Chapter 13B and KRS 311.591.

3. Under KRS 13B.090(7), the Board had the burden to prove by a preponderance of the evidence the allegations against Dr. Vincent.

4. The Board has met its burden to prove Dr. Vincent violated KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12).

5. The testimony and exhibits admitted into evidence at the administrative hearing support the conclusion that Dr. Hardison violated three of the Board's regulations governing the prescribing of controlled substances, and as a result his conduct violated KRS 311.595(9), as illustrated by KRS 311.597(4), by failing to conform to the standard of acceptable and prevailing medical practice in Kentucky, and he

violated KRS 311.595(12), by failing to comply with the standards set forth in the Board's regulations governing controlled substances.

6. Under 201 KAR 9:016, Section 6, a violation of the standards established in the regulation for the use of amphetamine and amphetamine-like anorectic controlled substances shall constitute a violation of KRS 311.595(9) and KRS 311.597.

7. Dr. Vincent violated 201 KAR 9:016, Section 3, by prescribing amphetamine and amphetamine-like controlled substances to treat medical conditions that are not included in Section 3(2)(a)-(f) of the regulation.

8. Under 201 KAR 9:260, Section 9, a violation of the standards established in the regulation for the prescribing of controlled substances shall constitute a violation of KRS 311.595(9) and (12).

9. Dr. Vincent violated 201 KAR 9:260, Section 2(1)(a)-(I), by failing to have adequate documentation to support the prescribing of controlled substances and violated Section 2(2) by failing to have adequate documentation to support and justify not complying with the professional standards for prescribing controlled substances, such as benzodiazepines and gabapentin.

10. Dr. Vincent violated 201 KAR 9:260, Section 2(2) by increasing doses of controlled substances without providing adequate justification for the increase.

11. Since the preponderance of the evidence supports the conclusion that Dr. Vincent failed to apply and follow all of the requirements of 201 KAR 9:016 and 201 KAR 9:260 for prescribing stimulants and other controlled substances, by his conduct he violated KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12).

12. The evidence showed that while Dr. Vincent complied with some of the guidelines and requirements in 201 KAR 9:270 for the prescribing of buprenorphine in the treatment of Opioid Use Disorder, the preponderance of the evidence shows he failed to apply and follow all of the requirements of Sections 2 and 4 of the regulation and failed to properly document in his medical records all of the relevant information related to his prescribing practices in sufficient detail to determine that he complied with the professional standards for administering the medication.

13. Dr. Vincent violated numerous provisions of 201 KAR 9:270, Sections 2 and 4, as set forth in the Findings of Fact above, including prescribing the mono product to patients who did not have a documented allergy to naloxone and continuing to prescribe the mono product to an individual even after their drug screen was positive for Suboxone without questioning the patient or documenting the need to continue prescribing the mono product.

14. Dr. Vincent failed to obtain a complete patient history and failed to obtain past treatment records, or failed to document efforts to obtain those records when treating a patient with buprenorphine as required by 201 KAR 9:270, Section 2(4)(a)(2)(b).

15. He failed to obtain COWS scores or to document the reason not to perform an in-office induction or document reasons why it wasn't performed as required by 201 KAR 9:270, Section 2(4)(c).

16. Dr. Vincent initiated induction at greater than 4 mg of buprenorphine and exceeded 16 mg on the first day of treatment in violation of 201 KAR 9:270, Section

2(4)(c)(3).

17. Dr. Vincent failed to initiate re-induction for patients who had a lapse in treatment in violation of 201 KAR 9:270, Section 2(4)(d).

18. Dr. Vincent violated 201 KAR 9:270, Section 2(4)(e)(5)(a), by failing to document abnormal KASPER findings and incorporating them into appropriate clinical reasoning to support continuation or modification of treatment.

19. Dr. Vincent violated 201 KAR 9:270, Section 2(4)(e)(5)(f)(ii), by failing to document abnormal drug tests and his clinical reasoning for continuing the treatment with controlled substances.

20. Dr. Vincent violated 201 KAR 9:270, Section 4(1) by failing to document in sufficient detail all relevant information to enable the Board to determine whether he has conformed to the professional standards for administering buprenorphine.

21. Dr. Vincent violated 201 KAR 9:270, Section 4(2), by failing to document his professional determination not to comply with the Board's standards in the regulation and failing to provide the facts in support of the deviation from the standard.

22. Under 201 KAR 9:270, Section 5, any violations of Sections 2, 3, ane 4 of the regulation "shall constitute" violations of KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12). Therefore, by his conduct, Dr. Vincent violated the 201 KAR 9:270, Sections 2 and 4, and violated KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12).

23. To the extent Dr. Vincent or his expert witnesses assert a violation of those regulations does not constitute a departure from or a failure to conform to the standards

of acceptable and prevailing medical practice in Kentucky in violation of KRS 311.595(9), as illustrated by KRS 311.597(4), such assertions carry no weight because they are contrary to the very language of the applicable regulations themselves.

24. In addition, the general credibility of the expert witnesses and the reliability of their opinions are greatly diminished and called into question when the expert offers opinions that are contrary to the provisions of the applicable regulations.

25. Dr. Vincent asserts that Dr. Jorrisch is not qualified to evaluate his medical practice because Dr. Jorrisch does not have the same psychiatric qualifications as Dr. Vincent as reflected by his certification in Addictionology through the American Board of Preventative Medicine.

26. The hearing officer finds Dr. Jorrisch was fully qualified to offer expert opinions on the care and treatment of patients with SUD, OUD, or StUD. In addition, Dr. Jorrisch is presumptively qualified under the provisions of 201 KAR 9:240, Section 5(5). The hearing officer finds that Dr. Jorrisch was fully qualified by background, training, and experience to conduct the review and to offer expert opinions on the issues in this action. His alleged lack of comparable expertise related mostly to Dr. Jorrisch's opinions on the necessity of Dr. Vincent referring patients to a higher level of psychiatric care when the patient was not compliant with the current treatment program. Dr. Jorrisch stated generally that such a referral was necessary because the care Dr. Vincent provided was not working, and Dr. Jorrisch has the training and expertise to know whether that was true and to offer his opinion on what needed to be done. In addition, there's been no evidence presented that Dr. Vincent was offering

psychiatric care to his patients that would constitute the necessary higher level of care. Irrespective of Dr. Vincent's qualifications and certifications, someone with a higher level of psychiatric expertise than his own was needed for a consultation regarding the patient's care, and Dr. Vincent's failure to refer those patients to a higher level of care was the basis for Dr. Jorrisch's opinion regarding a violation of the standard of care. Such an opinion was well within Dr. Jorrisch's expertise and appropriate for the hearing officer to consider in issuing this recommendation.

27. Dr. Vincent violated KRS 311.595(9), as illustrated by KRS 311.597(4), due to his failure to refer patients to a higher level of care and to a physician with more expertise when his treatment of patients for OUD and StUD who were having relapses and continuing to use illicit controlled substances and who had psychiatric conditions that required a higher level of expertise in light of the patients' lack of progress under Dr. Vincent's care for issues related to their addiction.

28. After the close of the proof at the administrative hearing Dr. Vincent filed in his case a motion to supplement the record and to dismiss the Board's *Complaint* action. *Motion to Supplement the Evidence and to Recommend Dismissal Based Upon Ongoing Developments in the Amendment of 201 KAR 9:270.* Initially, the hearing officer notes he has no authority to set aside a Board regulation, and the allegations in this action go beyond the violations of a single regulation. In addition, all of the violations found in this action relate to the statutes and regulations that were in effect at the time of the misconduct at issue in the case. Furthermore, to the extent Dr. Vincent asserts the standards for the care and treatment of patients addicted to controlled

substances are "evolving" and that the current regulations are "out of step with current acceptable standards of practice," the Board's regulations allow a physician a degree of latitude in his care and treatment of patients outside the specific provisions of the applicable regulations, but the physician is required to document the reasons for acting outside the requirements of the regulation, which Dr. Vincent did not do. 201 KAR 9:260, Section 2(2); 201 KAR 9:270, Section 4(2). Hence, the assertion that somehow the licensees rights to due process have been violated by his failure to comply with the provisions of the regulation is without merit. At most, Dr. Vincent's assertion as to the evolving treatment of SUD set forth in the motion relate to the appropriate disciplinary action that the Board may take against the licensee for his violation of the Board's regulation. The licensee may raise that argument directly with the Board in his exceptions to this recommendation. There can be no question, however, that the licensee was in violation of multiple provisions of the applicable regulations, in addition to the requirement that he explain his reasoning for any deviations from the standards set forth in the regulations.

29. In addition, the hearing officer notes that Dr. Vincent's own expert witness questioned the adequacy of Dr. Vincent's documentation for his prescribing of buprenorphine, which inadequacy is a violation of the applicable regulation and the basis for finding there is a preponderance of evidence in the record that his record keeping violated the standard of acceptable and prevailing medical practice in Kentucky. 201 KAR 9:270, Sections 4 and 5.

30. Based upon Dr. Vincent's prescribing practices for buprenorphine, stimulants, and benzodiazepines, the preponderance of the evidence supports the conclusion that and gabapentin violated KRS 311.595(9), as illustrated by KRS 311.597(4).

31. The preponderance of the evidence also support the conclusion that Dr. Vincent violated KRS 311.595(12) based upon his violation of more than one "valid regulation of the board," including 201 KAR 9:016, 201 KAR 9:260, and 201 KAR 9:270.

32. Dr. Vincent violated KRS 311.595(9), as illustrated by KRS 311.597(4), by recommending a patient take CBD oil. That product is not recommended for the treatment of any type of medical condition since it has mood altering properties and is related to products that are misused by patients.

RECOMMENDED ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, the hearing officer recommends the Board find Dr. William K. Vincent in violation of KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311. 595(12), and for those violations, the hearing officer recommends the Board take any appropriate action against Dr. Vincent's license to practice medicine in Kentucky.

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4) a party has the right to file exceptions to this recommended decision:

> A copy of the hearing officer's recommended order shall also be sent to each party in the hearing and each party shall have fifteen (15) days from the date the recommended order is mailed within which to file exceptions to the

recommendations with the agency head.

A party also has a right to appeal the Final Order of the agency pursuant to KRS 13B.140(1) which states:

> All final orders of an agency shall be subject to judicial review in accordance with the provisions of this chapter. A party shall institute an appeal by filing a petition in the Circuit Court of venue, as provided in the agency's enabling statutes, within thirty (30) days after the final order of the agency is mailed or delivered by personal service. If venue for appeal is not stated in the enabling statutes, a party may appeal to Franklin Circuit Court or the Circuit Court of the county in which the appealing party resides or operates a place of business. Copies of the petition shall be served by the petitioner upon the agency and all parties of record. The petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested. The petition shall be accompanied by a copy of the final order.

Pursuant to KRS 23A.010(4), "Such review [by the circuit court] shall not constitute an appeal but an original action." Some courts have interpreted this language to mean that summons must be served upon filing an appeal in circuit court.

SO RECOMMENDED this 15th day of October, 2024.

Thomas J. Hellmann

THOMAS J. HELLMAN
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CERTIFICATE OF SERVICE

I hereby certify that this Recommended Order was sent by email this 15th day of October, 2024, to:

JILL LUN
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK STE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

for filing; and a true copy was also sent by email on the same date to:

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