MINUTES

North Carolina Medical Board

May 14-16, 2014

1203 Front Street
Raleigh, North Carolina

General Session Minutes of the North Carolina Medical Board Meeting held May 14 -16, 2014.

The May 14 - 16, 2014 meeting of the North Carolina Medical Board was held at the Board's Office, 1203 Front Street, Raleigh, NC 27609. Cheryl L. Walker-McGill, MD, President-Elect, called the meeting to order. Board members in attendance were: Paul S. Camnitz, MD, President; Ms. Thelma Lennon; Eleanor E. Greene, MD; Subhash C. Gumber, MD; Mr. Michael Arnold; Ms. H. Diane Meelheim, FNP; Debra A. Bolick, MD; Timothy E. Lietz, MD; Barbara E. Walker, DO and Mr. A. Wayne Holloman. Absent was Pascal O. Udekwu, MD, Secretary/Treasurer.

Presidential Remarks

Dr. Cheryl L. Walker-McGill, President-Elect, commenced the meeting by reminding the Board members of their duty to avoid conflicts of interest with respect to any matters coming before the board as required by the State Government Ethics Act. No conflicts were reported.

Minute Approval

Motion: A motion passed to approve the March 20, 2014 Board Minutes, the March 31, 2014 Special Board Meeting Minutes and the April 11, 2014 Hearing Minutes.

Presentations

1. David Henderson, Executive Director, debriefed the Federation of State Medical Boards 2014 Annual meeting with the Board.
2. Charlene Morris, PA-C, President, NC Academy of Physician Assistants and Marc Katz, PA-C, President-Elect, NCAPA, gave a presentation to the Board.
3. Dr. Michael Bryant, Secretary, Cumberland County Medical Society, gave a presentation on Maintenance of Licensure to the Board.
4. Dr. Warren Pendergast, Medical Director, NC Physician's Health Program, gave the Board the PHP Compliance report.

Proposed Settlement

Rogers, Rayna Larain, DO – Fayetteville, NC
The Board was represented by Mr. Todd Brosius. Dr. Rogers was present and was represented by Mr. Jim Wilson.

The Board voted to accept the proposed Consent Order.

EXECUTIVE COMMITTEE REPORT

The Executive Committee of the North Carolina Medical Board was called to order at 4:00 p.m. on Wednesday May 14, 2014, at the offices of the Board. Members present were: Paul S. Camnitz, MD, Chairperson; Cheryl L. Walker-McGill, MD; Eleanor E. Greene, MD; and Mr. Michael J. Arnold. Members absent were: Pascal O. Udekwu, MD. Also present were R. David Henderson (Executive Director), Hari Gupta (Director of Operations) and April F. Pearce, CPA (Comptroller).

Open Session

1) Financial Statements

   a) Monthly Accounting

      The Committee reviewed the compiled financial statements for February 2014 and March 2014. March is the fifth month of fiscal year 2014.

      Committee Recommendation: Accept the financial statements as reported.

      Board Action: The Board accepted the Committee's recommendation.

   b) Investment Account Statements

      The Committee reviewed the investment statements for March and April 2014.

      Committee Recommendation: Accept the investment statements as reported.

      Board Action: The Board accepted the Committee's recommendation.

2) Old Business

   a) Task Tracker

      The Committee reviewed outstanding items on the Task Tracker report.

      Committee Recommendation: Regarding the Key Performance Indicators project: (1) look for activities to measure even if we are currently doing well in those areas, (2) collect timeline data from other state medical boards to reference in setting goals, and (3) identify ways to measure the quality of our work such as survey responses and random quality assurance checks. Otherwise, accept the Task Tracker report as reported.

      Board Action: The Board accepted the Committee's recommendation.

   b) CCMS Concerns

      Members of the Cumberland County Medical Society (CCMS) have raised concerns regarding various Board processes and procedures. Most of those concerns have been resolved by the Board addressing basic misunderstandings or incorporating CCMS'

recommendations into Board policies and procedures. However, two issues remain: (1) what information, if any, is required to be disclosed to a complainant when the Board sends a private letter of concern (PLOC) to a licensee, and (2) whether the Board can consider all initial reviews of complaints or other information regarding possible violations of the Medical Practice Act as "inquiries" and only consider a matter an "investigation" if/when the Board takes action (public or private). Cases where no public or private action was taken are referred to as "Accept as Information" (AAI).

Committee Recommendations:

- Decline the request for further modification of the language in closure letters to complainants in cases where a licensee has received a PLOC. In an attempt to address these concerns, the Board previously modified the closure letter to omit the fact that the licensee received a PLOC. The Committee believes the current language to the complainant (". . . the Board had concerns, which it shared with [the licensee]") is necessary to meet the requirements of N.C. Gen. Stat. Section 90-16(e1).

- Regarding the request to consider all initial reviews of complaints or other information regarding possible violations of the Medical Practice Act as "inquiries" and only consider a matter an "investigation" if/when the Board takes action (public or private):
    - For the approximately 25% of complaints closed (AAI) without obtaining a response from the licensee, treat those as <u>not</u> having been an investigation.
    - Decline the request to consider matters that are eventually closed as AAI after obtaining a response from the licensee as an "inquiry" and not as an "investigation." After consulting with Board Counsel, the Committee believes that various provisions in the Medical Practice Act prevent the Board from taking this action. However, the Committee recommends that staff meet with a broader group of stakeholders to gather information regarding collateral consequences from Board investigations resulting in AAI and report the results to the Board prior to the 2015 session of the North Carolina General Assembly. Stakeholders should include the North Carolina Medical Society, CCMS, North Carolina Hospital Association, health insurance carriers, medical malpractice insurance carriers, medical staff services organizations and other organizations that employ a credentialing process for North Carolina licensees. Those discussions should, among other things, examine whether it is possible to amend the Medical Practice Act in a way that does not undermine the Board's ability to protect the public but would result in a more fair process for handling matters resolved with AAI.

Board Action: The Board accepted the Committee's recommendations.

c) OSA Report

On April 8, 2014, the Office of the State Auditor (OSA) released a report entitled: "Performance Audit, North Carolina Physicians Health Program." The audit included several recommendations for the Physicians Health Program, the NC Medical Board,

and the NC Medical Society. Staff submitted a proposed action plan and timeline in response to the OSA recommendations.

Committee Recommendation: Accept the action plan with proposed changes.

Board Action: The Board accepted the Committee's recommendation.

3) New Business

a) Strategic Planning Discussions

Last year, the Administrators in Medicine Assessment Program (AIMAP) report recommended that the Board undergo formal strategic planning (AIMAP Rec. #8). The Board decided to postpone this until 2014 so that the new members could get some experience on the Board.

Committee Recommendation: Plan a formal strategic planning session for the Friday of the September 2014 Board meeting and bring in an outside expert to facilitate this session.

Board Action: The Board accepted the Committee's recommendation.

b) Proposed Changes to Renewal Questions

The Committee discussed proposed changes to the annual renewal questions as recommended by the Senior Staff Review Committee (SSRC). The renewal questions have not been updated to reflect changes to the license application in 2012. Also, the current renewal questions are not capturing important out-of-state disciplinary information.

Committee Recommendation: Accept the proposed changes to the annual renewal questions.

Board Action: The Board accepted the Committee's recommendation.

The Committee adjourned at 6:00 p.m.

POLICY COMMITTEE REPORT

Committee Members: Dr. Walker-McGill, Acting Chairperson; Dr. Bolick and Ms. Lennon.
Absent from the meeting were Dr. Udekwu, Chairperson; Mr. Arnold.
Staff: Todd Brosius and Wanda Long

1. Old Business
    a. Position Statement Review
        i. Departures from or Closings of Medical Practices (APPENDIX A)

05/2014 Committee Discussion: Mr. Brosius reported that no conflicts were identified with the current Position Statement and the recently published brochure.

05/2014 Committee Recommendation: No changes to the current Positions Statement are necessary.

05/2014 Board Action: Approve the Committee Recommendation.

1. Old Business
    a. Position Statement Review
        ii. Telemedicine (APPENDIX B)

05/2014 Committee Discussion: Ms. Apperson reported on the Telemedicine guidelines that were recently adopted by the FSMB.

05/2014 Committee Recommendation: Dr. Udekwu, Mr. Arnold and Ms. Apperson to begin reviewing the Board's current Telemedicine Position Statement and provide the Policy Committee their recommendations at the July Committee meeting.

05/2014 Board Action: Approve the Committee Recommendation.

1. Old Business
    a. Position Statement Review
        iii. Policy for the Use of Controlled Substances for the Treatment of Pain (APPENDIX C)

05/2014 Committee Discussion: Dr. Sheppa reviewed his proposed Position Statement and the comments received by interested parties. Dr. Walker-McGill felt that the title may suggest that the statement is for chronic pain and not for acute pain as well. The proposed statement is currently on the Board's website soliciting comments thru May 23rd.

05/2014 Committee Recommendation: Table until the July 2014 meeting. Continue to review and receive comments.

05/2014 Board Action: Continue to review and receive comments thru May 23rd. After May 23rd the most up-to-date draft will be sent to the Board members for final review. Unless there are further concerns, the guidelines will be approved and published.

1. Old Business
    b. Integrative Medical Society request for reconsideration of the Treatment of Obesity position statement with reference to use of HCG

05/2014 Committee Discussion: The Committee discussed the action taken by the Executive Committee at the March 2014 Board meeting.

05/2014 Committee Recommendation: No action is necessary.

05/2014 Board Action: Approve the Committee Recommendation.

2. New Business:

a. Position Statement Review

1/2010 Committee Recommendation: (Loomis/Camnitz) Adopt a 4 year review schedule as presented. All reviews will be offered to the full Board for input. Additionally, all reviews will be documented and reported to the full Board, even if no changes are made.

1/2010 Board Action: Adopt the recommendation of the Policy Committee.

2. New Business:
a. Access to Physician Records

05/2014 Committee Discussion: The Committee reviewed the current Position Statement and determined that no changes were necessary.

05/2014 Committee Recommendation: Allow 2 weeks for the absent Committee members to review the current Position Statement. If they do not concur that no changes are necessary, then table until the July meeting.

05/2014 Board Action: Approve the Committee Recommendation.

2. New Business:
b. Prevent Child Abuse North Carolina (APPENDIX E)
Issue: Request that the NC Medical Board consider issuing a position statement encouraging physicians to access training in recognizing and responding to child maltreatment.

05/2014 Committee Discussion: Elaine Cabinum-Foeller, MD, Associate Professor of Pediatrics, Brody School of Medicine and Medical Director of TEDI Bear Children's Advocacy Center addressed the Committee requesting that the Board issue a Position Statement regarding encouraging physicians to access training in recognizing and responding to child maltreatment. Although the Board has published an article in the past regarding this issue that is available on its website, they believe that a Position Statement would carry more weight.

05/2014 Committee Recommendation: Table until July to allow adequate time to obtain feedback from key stake holders.

05/2014 Board Action: Approve the Committee Recommendation.

LICENSE COMMITTEE REPORT

The License Committee of the North Carolina Medical Board was called to order at 2:30 p.m., May 14, 2014, at the office of the Medical Board. Members present were: Subhash Gumber, MD, Acting Chairperson, Diane Meelheim, FNP-BC, Timothy Lietz, MD, and Mr. A. Wayne Holloman. Also present: Paul Camnitz, MD, Scott Kirby, MD, Patrick Balestrieri, Carren Mackiewicz, Joy Cooke, Michelle Allen, and Mary Rogers. Absent: Mr. Michael Arnold

Open Session

Old Business

None

New Business

1. ACGME International Accreditation

Issue: ACGME is now accrediting training programs outside the US. It is the opinion of the legal and licensing departments that the 1 and 3 year ACGME approved postgraduate training requirements can consist of training outside the US, if ACGME approved. See bookmark for statute and rule related to this item.

Committee Recommendation: Staff is requested to gather information on the accreditation process for Accreditation Council on Graduate Medical Education-International (ACGME-I) for the Board's review.

Board Action: Staff is requested to gather information on the accreditation process for ACGME-I for the Board's review.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

> Nine licensure cases were discussed. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

LICENSE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

> Eleven licensure interviews were conducted. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

ALLIED HEALTH COMMITTEE REPORT

The Allied Health Committee of the North Carolina Medical Board was called to order at 1:00 p.m., Wednesday, May 14, 2014 at 1203 Front St., Raleigh, NC. Committee Members present were: H. Diane Meelheim, FNP-BC, Chairperson; Subhash C. Gumber, MD and Barbara E. Walker, DO. Also present were Marcus Jimison, Lori King, CPCS, Quanta Williams, Jane Paige, Katharine Kovacs, Thom Mansfield, Don Metzger, Cathie Field, Jerry Allen, Tanya Darrow, and Varsha Gadani.

OPEN SESSION

PHYSICIAN ASSISTANTS

Proposed Changes to Physician Assistant Rules - Marcus Jimison, the Committee and guests discussed.

Issue: Proposed changes to physician assistant rules to clarify that Board rules are not intended to be used as a basis for vicarious liability in medical malpractice actions.

Committee Recommendation: Table discussion, solicit feedback and hold telephone conference the week before the July, 2014 Board Meeting.

Board Action: Table discussion, solicit feedback and hold telephone conference the week before the July, 2014 Board Meeting.

NC EMERGENCY MEDICAL SERVICES

1. No items for discussion.

ANESTHESIOLOGIST ASSISTANTS

1. No items for discussion

NURSE PRACTITIONERS

1. No items for discussion

CLINICAL PHARMACIST PRACTITIONERS

1. No items for discussion

PERFUSIONISTS

1. Open session portion of the March Perfusionist Advisory Committee (PAC) minutes

Issue: The open session minutes of the March PAC meeting have been sent to the Committee members for review.

Board Action: Accept the report of the open session minutes as information.

POLYSOMNOGRAPHIC TECHNOLOGISTS

1. No items for discussion

NURSE PRACTITIONER JOINT SUBCOMMITTEE

The Nurse Practitioner Joint Subcommittee (NPJS) was called to order at 6:10 pm May 13, 2014 at the office of the NC Board of Nursing (NCBON). Members present were: Bobby Lowery, NP, Chairperson (NCBON); Barbara E. Walker, DO (NCMB); Cheryl Duke, RN (NCBON); Diane Meelheim, NP (NCMB); and Peggy Walters, RN (NCBON). Subhash C. Gumber, MD (NCMB) was absent. Also present was: Chandra Graves (NCBON); Donna Mooney (NCBON); Eileen Kugler (NCBON); Jack Nichols (NCBON); Marcus Jimison (NCMB); David Kalbacker (NCBON); Julie George (NCMB); David Henderson (NCMB); Amy Fitzhugh (NCBON); Angela Ellis (NCBON) and Quanta Williams (NCMB).

1. Approval of minutes of September 17, 2013
    a. Motion: To approve the open and closed session minutes of the September meeting. Passed.

2. Old Business
    a. Pilot Project
    Ms. George reported that 17 cases had been handled so far by the Nurse Practitioner Joint Sub Panel. There have been no extractions and the panel appears to be working well. The Nurse Practitioner Joint Subcommittee (NPJS) is pleased with the format of the information. In November, the NPJS will make a final decision on the pilot project.

3. New Business
    a. Compliance Review Summary 2013
    Total compliance is up from 73% in 2012 to 80% in 2013. Please see the attached table for more information.

    b. Ratification of Actions
    The NPJS voted unanimously to ratify the actions of the Joint Sub Panel.

4. Other Business
    a. Report of disciplinary actions taken since the last meeting

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not

considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Two approval applications were reviewed. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session

DISCIPLINARY (COMPLAINTS) COMMITTEE REPORT

The Disciplinary Committee (Complaints/Malpractice) of the North Carolina Medical Board was called to order at 8:00 a.m. on May 14, 2014 at the office of the Medical Board. Board Members present were: Cheryl Walker-McGill, MD (chairperson), Mr. A. Wayne Holloman, Timothy Lietz, MD, H. Diane Meelheim, FNP, and Barbara Walker, DO. Absent: Pascal Udekwu, MD, Staff present: Judie Clark, Scott Kirby, MD, Michael Sheppa, MD, Katharine Kovacs, PA, Carol Puryear, Lisa Hackney, Thom Mansfield, Todd Brosius, Brian Blankenship, Patrick Balestrieri and Marcus Jimison.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Complaints) Committee reported on twenty-eight complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

DISCIPLINARY (MALPRACTICE) COMMITTEE REPORT

The Disciplinary Committee (Complaints/Malpractice/ME) of the North Carolina Medical Board was called to order at 8:00 a.m. on May 14, 2014 at the office of the Medical Board. Board Members present were: Cheryl Walker-McGill, MD (chairperson), Mr. A. Wayne Holloman, Timothy Lietz, MD, H. Diane Meelheim, FNP, and Barbara Walker, DO. Absent: Pascal Udekwu, MD. Staff present: Judie Clark, Scott Kirby, MD, Michael Sheppa, MD, Katharine Kovacs, PA, Carol Puryear, Lisa Hackney, Thom Mansfield, Todd Brosius, Brian Blankenship, Patrick Balestrieri and Marcus Jimison.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not

considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Malpractice) Committee reported on forty-four cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

INVESTIGATIVE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Fifteen informal interviews were conducted. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (INVESTIGATIVE) COMMITTEE REPORT

Committee Members Present: Cheryl Walker-McGill, MD (chairperson), A. Wayne Holloman, H. Diane Meelheim, FNP, Timothy Lietz, MD, Barbara Walker, DO. Absent: Pascal Udekwu, MD. Staff Present: Jerry Weaver, Jenny Olmstead, David Allen, Lee Allen, Bob Ayala, Therese Babcock, James Bowman, Loy Ingold, David Hedgecock, Bruce Jarvis, Don Pittman, Rick Sims, Karen Nenstiel, Thom Mansfield, Brian Blankenship, Todd Brosius, Patrick Balestrieri, Marcus Jimison

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Investigative) Committee reported on forty-three investigative cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

ADJOURNMENT
This meeting was adjourned at 10:45 a.m., May 16, 2014.

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Pascal O. Udekwu, MD
Secretary/Treasurer

CURRENT POSITION STATEMENT:

Departures from or closings of medical practices

Departures from or closings of medical practices are trying times. If mishandled, they can significantly disrupt continuity of care and endanger patients.

Provide Continuity of Care
Practitioners continue to have obligations toward their patients during and after the departure from or closing of a medical practice. Practitioners may not abandon a patient or abruptly withdraw from the care of a patient. Patients should therefore be given reasonable advance notice (at least 30 days) to allow other medical care to be secured. Good continuity of care includes preserving and providing appropriate access to medical records.* Also, good continuity of care may often include making appropriate referrals. The practitioner(s) and other parties that may be involved should ensure that the requirements for continuity of care are effectively addressed.

It is the position of the North Carolina Medical Board that during such times practitioners and other parties that may be involved in such processes must consider how their actions affect patients. In particular, practitioners and other parties that may be involved have the following obligations.

Permit Patient Choice
It is the patient's decision from whom to receive care. Therefore, it is the responsibility of all practitioners and other parties that may be involved to ensure that:

- Patients are notified in a timely fashion of changes in the practice and given the opportunity to seek other medical care, sufficiently far in advance (at least 30 days) to allow other medical care to be secured, which is often done by newspaper advertisement and by letters to patients currently under care;
- Patients clearly understand that they have a choice of health care providers;
- Patients are told how to reach any practitioner(s) remaining in practice, and when specifically requested, are told how to contact departing practitioners; and
- Patients are told how to obtain copies of or transfer their medical records.

No practitioner, group of practitioners, or other parties involved should interfere with the fulfillment of these obligations, nor should practitioners put themselves in a position where they cannot be assured these obligations can be met.

Written Policies
The Board recommends that practitioners and practices prepare written policies regarding the secure storage, transfer and retrieval of patient medical records. Practitioners and practices should notify patients of these policies. At a minimum, the Board recommends that such written policies specify:

- A procedure and timeline that describes how the practitioner or practice will notify each patient when appropriate about (1) a pending practice closure or practitioner departure,

(2) how medical records are to be accessed, and (3) how future notices of the location of the practice's medical records will be provided;

- How long medical records will be retained;
- The procedure by which the practitioner or practice will dispose of unclaimed medical records after a specified period of time;
- How the practitioner or practice shall timely respond to requests from patients for copies of their medical records or to access to their medical records; In the event of the practitioner's death or incapacity, how the deceased practitioner's executor, administrator, personal representative or survivor will notify patients of the location of their medical records and how patients can access those records; and
- The procedure by which the deceased or incapacitated practitioner's executor, administrator, personal representative or survivor will dispose of unclaimed medical records after a specified period of time.

The Board further expects that its licensees comply with any applicable state and/or federal law or regulation pertaining to a patient's protected healthcare information.

*NOTE: The Board's Position Statement on the Retention of Medical Records applies, even when practices close permanently due to the retirement or death of the practitioner.

(Adopted January 2000) (Amended August 2003, July 2009)

CURRENT POSITION STATEMENT

Telemedicine

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care.

The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff -- Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Examinations -- Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate examination prior to diagnosing and/or treating the patient. However, this examination need not be in-person if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.

Other examinations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate examination may be a violation of law and/or subject the licensee to discipline by the Board.[1]

Licensee-Patient Relationship – The licensee using telemedicine should have some means of verifying that the person seeking treatment is in fact who he or she claims to be. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, physical examination and appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Medical Records -- The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate evaluation of the patient's presenting symptoms, and

relevant components of the electronic professional interaction must be documented as with any other encounter.

The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record.

Licensure -- The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina.[2] Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license.

North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards Web site: http://www.fsmb.org/directory_smb.html.

(Adopted July 2010)

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[1] See also the Board's Position Statement entitled "Contact with Patients before Prescribing."

[2] N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)f

MEMO
From: Dr. Sheppa
To: Policy Committee
Re: Stakeholder comments on Draft Pain Policy Document
May 2014 Board Book

What follows below are comments and suggestions from stakeholders who responded to our request to review the March 2014 board approved draft policy on the use of opiates for the treatment of pain. Suggestions that have been incorporated into the draft policy document are highlighted in this memo in red, below, with corresponding page and line reference; comments of potential significance/interest from stakeholders are ***underlined and italicized*** in black in this memo. Comment and suggestions in this memo are listed by stakeholder with relevant identifying information.

The draft policy document, as originally approved by the policy committee and Board in March 2014, is attached to this memo. Changes incorporating stakeholders' suggestions and staff edits are highlighted in the attached document in red and correspond to the red highlighted changes in this memo.

Dr. James Finch (family medicine/pain management/addiction):

General comments:
I had some concern with the Tips on Diversion section: I thought most of the behaviors listed related to misuse or abuse broadly, rather than specifically to diversion, so I revised the introductory sentence (P 15 L12,13) just before the lists to say this. Also, the "What you should do when confronted by a suspected drug abuser", I changed to the broader (P15 L 30,31) "What to do when the clinician suspects misuse, abuse or addiction" and made it more clinically focused rather than policing the patient's identity.

Finally, I was a bit confused by the Primary Care section because it focused mostly on acute pain and the FSMB policy statement was for using opioids for chronic pain. I then looked back at the draft you sent for comment and realized it was titled "…for the treatment of pain." ***Is this document meant to be for both acute and chronic pain? If so, a great deal more attention needs to be given to this section and the entire document would need to be reviewed and revised in that regard.***

I thought the ED section was broadly applicable to chronic pain, although the first 3 bullets seem overly directive for a guideline document and I wasn't sure where the 30 pill max came from, since it is much higher than the standard many EDs are moving toward (e.g.: 2-3 day supply).

Line by line changes:

P7 L8 change *and* to *as well as*
P7 L23 change *can* to *may*
P8 L2 after "addiction" change to: including the role of medication assisted treatment, such as substitution therapies with methadone or buprenorphine in appropriately licensed practices or facilities.

P8 L12 add *when available* after providers
P8 L 24 add In addition, Obtaining a toxicology screen, such as a urine drug screen, is a useful tool in the setting of risk assessment prior to prescribing opioids. It may reveal the use of controlled medications such as opioids or benzodiazepines other than those prescribed or may reveal the use of other illicit drugs.

P9 L3 add after follows, or other routine physical activities
P9 L12 add after use, of non-opioid analgesics [including]

P9 L19-21 change goals to, goals for pain relief and functional improvement...[change functional improvement to improved physical, functional and psychosocial activity]
P 10 L20-25 comment: I would think these last 2 bullets more appropriate for the treatment agreement section.
P11 L10-11change "with over the counter medications, non-steroidal antiinflammatory drugs and acetaminophen" to non-opioid medications
P 11 L 17 change "…activities. Attention will be focused on…" to "as well as"
P11 L27 add after affect "while monitoring for adverse effects"
P12 L4 add after contacts, "including the medications effects on function as well as signs of adverse effects such as sedation or other impairment."

P 12 L18-19 add after helpful, "and more time efficient in general medical settings."
P12 L33,34 and P 13 L1 add after treatments, "Clinicians should avoid over-reliance on opioids as the primary or only treatment modality, including using opioid dose escalation as the only response to a complaint of inadequate pain relief."

P13 L 14 change be not to need to be observed
P13 L 15 delete "drug panels"
P 13 L 16 after laboratory based add …"tests. These tests do not typically identify a particular specific drug within a class. However, the tests are available as panels and immunoassays for specific drugs can be included. It is important that the clinician to formulate these panels to include the particular medications being prescribed and preferably the drugs commonly abused in the local community."
P13 L 23 chang e including to "such as"
P14 L 6-8 delete: " A recent study on LC-MS/MS results following immunoassay POC testing in addiction treatment settings found very high rates of false negatives and positives (128, 129)
P14 L10 change opioids to " illicit or prescribed medication misuse…"
P 14 L34 delete, such as unsanctioned dose escalations
P 15 L 15 change "light of" to "situations suggestive of apparent misuse or abuse of a drug, such as a failed drug screen...
P 15 L16-18 delete (not attending physician therapy, failure to obtain prescribed imaging, failure to attend appropriate interventional procedures etc
P15 L25 change call them to,"he or she should be notified"
P15 L26 change it to, "This is one reason that it
P 15 L28-30 delete " and "Random pill counts should not be part of Informed consent and Treatment Agreements but" and insert "and that it should be reviewed" after "Agreement"
P15L37 delete "it is highly likely that" and change"is" to "may be"
P 16 L 4 delete diverting and /or
P16 L5-9 [paraphrased by Sheppa] after order insert "If you have strong evidence that the patient is diverting his or her opioid medication, that is generally an indication that the medication needs to be discontinued and alternative treatments initiated. If the clinician believes the diversion represents a significant public health risk, he or she should give consideration to

reporting the individual to law enforcement. An alternative to this is forwarding the information to the NC CSRS and asking them to look into a broader pattern of diversion."

P16 L12-13 delete "diverting medications", insert "seeking opioid medications for reasons other than legitimate pain relief, such as abuse, addiction or diversion, includes:

P16 L29 after Norco insert "without a clear clinical history justifying this preference).
P16 L38 delete Unimpressive Imaging
P17L1 delete "needle tracks", "insert injecting behavior (old or recent "track marks" or multiple healed or current abscesses) or marked nasal erythema from insufflation ("snorting")."
P17L4 delete "smoke" insert (if you're familiar with that smell).
P17L14-15 delete early refills, insert, recurrent early refills for lost or stolen prescriptions or following increased use without consultation with prescriber.
P17 L16-17 delete
P17 L19-28, delete
P 17 L30-31, delete confronted by a suspected drug abuser, insert, medication misuse, abuse or addiction is supected:
P17 L38-40, delete, insert, Investigate suspicions further by presenting and discussing specific concerns with the patient, re-checking NCCSRS information, increasing the use of drug screens, talking with family members.
P17 L 36-37, delete.

P 17 L41-43 insert, "until concerns are resolved and if it is safe to do so and increase frequency of visits and drug screens." after quantities.

P18 L18 beginning with "when" delete through the work "OR"

P18 L24-25 delete "the patient who has become physically dependent", insert "in the setting of appropriate use but inadequate response and the patient has become physically dependent, they..."
P18 L26-27, before "Withdrawal" insert "In the setting of abuse or addiction and when it is necessary to discontinue quickly because of safety, withdrawal...

Dr Janice Huff (former board member)

Again I think this is a huge improvement - and will be a good thing!!
My thoughts: (I don't know how to do those track change things)

Page 14 - Line 6 - What does LC-MS/MS [Sheppa: presumably Liquid Chromatography-Mass Spectrometry] stand for? I didn't see it before and didn't see it defined anywhere -

Page 15 - Lines 28-30 - confusing and seem contradictory to me -

Page 16 - Line 29 - I think the drug is Norco - instead of Narco

Page 22-23- Emergency Department section - Why not just keep using "licensees" or "physicians" instead of words like "providers" and "practitioners". Also - EDs do not prescribe drugs - people do. So I didn't really like all the references to "EDs" as if they were people [Sheppa: all terms changed to reflect ED nomenclature comments]
P22L36 - not sure how pragmatic this is going to be for the "big cities" with multiple hospitals. May be OK in smaller towns with one hospital. Certainly there are programs where the entities

like a big hospital and CCNC are looking at high ED utilizers and coming up with collaborative plans for some of these patients, many of whom are drug abusers, but this is a pretty select group of people with a pretty big team working together to make sure the EDs have plans on these people. But it is intensive and not being done for a huge group of patients yet I don't think. Now if we could make all the big hospital systems in the state sign up for the HIE this could be done - and would be a huge benefit in many ways - including putting a plan like this on these charts so everyone across the state knew the plan!

Page 23 – Line 6-10 - should you say something like "access the NCCSRS and if not problematic, OK to prescribe a limited number of pills.....
Line 10 - isn't this already the law in NC?

P23L26 - "complies" doesn't seem right - should it be "in compliance"?

P24L1- should it be multiple instead of multi?

Page 24L24 - space between has and been - (sorry - couldn't resist this one- my OCD)

Page 28 - Line 38 - should hydrocodone be in this list? Doesn't the US consume 95% of the world's hydrocodone or something?

Drs. Kenneth Michau, Brian Weiss, Stephen Johnson (emergency medicine)

Document looks good as is

Drs. William Walker and Ralph Loomis (former Board members)

Document looks good as is

Dr. Thomas Hill (former board member)

Many pain patients w/o financial resources, seen “on the side” by docs who want to help and care for the patients other problems primarily, drawn into pain management unwittingly

Precedex for opiate withdrawal

P3 l 16 lack of objective evidence of pain generator in face of chronic opiate use = addiction need to go to addict ion specialist

P 5 L31 add language to incorporate EXISTING patients as well as New patients

P6 L 36 pt doesn’t follow advice, either terminate or refer to addictionologist
Regardless of pt willingness they need to get consultation referral etc or suffer consequences

P10 L16-17 risk of obese, sleep apnea patients and other problems that increase opiate risk, extra caution w these patients.

Dr. Udekwu

(Several helpful format edits included in document)

Managing Post-Operative Pain

Have an office or practice policy on narcotics refills and provide this to patients at the time surgery is scheduled. This should include policies regarding lost or stolen prescriptions as well as early refills. A uniform office or practice policy covering usual variations in behavioral responses to pain may assist in defining the quantity of medications and the frequency of refills. Patients with a history of narcotic dependency should be considered for a preoperative pain agreement where the limits of type, quantity and duration of post-operative pain management is defined. Preoperative consultation with chronic pain management specialists should be considered. In most cases postoperative prescriptions should not include long acting narcotic preparations or exceed 60 pills per prescription, patients with more severe pain would be expected to be seen and assessed more frequently to evaluate the success of their pain management. Non narcotic options for post-operative pain relief should be sought where appropriate. In general the management of acute post-operative pain should not need to exceed six weeks.

Sheppa grammatical changes :

p 10 line 4 should read: "When treating chronic pain, use of a written informed consent, and a treatment agreement is recommended (80,81,82,83,84). They may be combined into one document for convenience."

P6 line 13 should be: functional, and psychosocial activities, and mitigating risk of misuse, abuse, diversion

Reviewer from State Advisory Council (SAC) comments:
Scott K. Proescholdbell, MPH
N.C. Department of Health and Human Services
Head, Injury Epidemiology and Surveillance Unit

It seems to me that there should be some explicit recognition of the role of physicians in prescribing naloxone. While the draft Statement refers readers (p. 11, lines 21-24) to the Position Statement on drug overdose prevention, that position statement is regarding physician cooperation with separate overdose prevention programs. In my opinion the opioid prescribing statement should encourage, or at least mention, the co-prescription of naloxone to at least some opioid patients.

Chris Ringwalt, DrPH
Senior Research Scientist for Evaluation
Injury Prevention Research Center
Editor: Journal of Primary Prevention
Campus Box 7505
University of North Carolina at Chapel Hill

It seems to me that I may have received this document from one of you, with an invitation to review and comment. I think it is very thorough, and that the Medical Board has every reason to be pleased with it. However, I wonder if the Board might consider beefing up the section on consulting the state's CSRS. Right now, the pertinent paragraph on page 8 (lines 16-22) seems a bit thin. Perhaps the Board would consider strongly suggesting the use of CSRS for *every* patient, *every* time the physician is considering prescribing the patient a controlled substance. Note that I am not advocating mandatory consultation, which I think is a non-starter.

In addition, the policy might be more specific as to the risk (or warning) signs that physicians should look for. Right now, those specified on page 16 (lines 17-19) seem a bit vague and open ended. As a starting point, consider some of the metrics that we have already shared with you, in addition to "multiple providers, multiple pharmacies, prescriptions for multiple types and medications, out of area doctors, etc.":

- patients who travel long distances to reach multiple physicians
- patients who travel long distances to fill prescriptions at non-mail order pharmacies
- multiple prescriptions for opioids and benzodiazepines
- temporally redundant prescriptions (e.g., a new prescription filled more than a week before another is due to terminate)

I like the statement on page 6 (lines 16-18) that the "Board will consider the unsafe or otherwise inappropriate treatment of pain to be a departure from best clinical practice, taking into account whether the treatment is appropriate to the diagnosis *and the patient's level of risk."* In conjunction with the sentence in the previous paragraph, in which the Board will "judge the validity of the physician's treatment of a patient on the basis of available documentation," would it be helpful to mention that one source of documentation is a record in the patient's file of the patient's history of filled prescriptions for controlled substances as obtained from the CSRS?

I think that's it. If I can be of any further use to you in this regard, please let me know.

Please find below some feedback I have received from Robert Rich MD, Advocacy Chair (North Carolina Academy of Family Phyisicans?), who is also involved with Project Lazarus and was lead author on our national (AAFP) policy on opioid use

1) In general the policy is well written and follows the suggestions as formulated in the FSMB model policy well. I did find some conflicting verbiage on page 15 and would ask that lines 28-32 on that page be clarified.
2) The policy outlines use of the best treatment practices that we are already advocating for as part of Project Lazarus.
3) The policy uses wording such as “recommends”, “should use” but does not mandate required training, use of certain procedures, required documentation, etc. It does call for the posting and availability of a practice’s opioid prescribing policy but I have been advocating that practices do that anyway.
4) In general, I am comfortable with the policy as it is written and will refer to it for educating practices about Project Lazurus when it is formally approved and released to the public. I would suggest that NCMB or representative be willing to do a CME session at the Winter Meeting to educate providers about best management practices and I would be willing to assist in anyway if desired.

Hendree Jones, PhD, member of the NC Pregnancy and Opioids Exposure Stakeholder workgroup

Page 4, after reference 10- the CDC report on women and overdoses with opioid pain medications should be noted with something along the lines of their main results

"Deaths from opioid pain relievers (OPRs) increased fivefold between 1999 and 2010 for women; OPR deaths among men increased 3.6 times. In 2010, there were 943,365 ED visits by women for drug misuse or abuse. The highest ED visit rates were for cocaine or heroin (147.2 per 100,000 population), benzodiazepines (134.6), and OPR (129.6). ED visits related to misuse or abuse of OPR among women more than doubled between 2004 and 2010."
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6226a3.htm

Page 5, line 27: They need to specify what safeguards they are talking about—give some examples

Page 7, there is a nice section about assessment of social and vocational issues on page 8 it only mentions referral for addiction evaluation and treatment—there needs to be an explicit statement about evaluation and assistance with for each area of need like social, vocational etc.

Page 8, line 14: the issue about CFR 42 pt 2 needs to be noted as well as getting proper releases of information before requesting records

Page 9, lines 34 and P 10 L1-2: they also need to talk about the safe use of medication—take only as prescribed, do not give others your medication etc. makes sure REMS citations are given

Page 11 line 30: the Good Samaritan law should be noted here

Page 18: Please, please and please add a section on the fact that it is unethical to abruptly discontinue a woman's medication when she becomes pregnant—this is an issue we see all the time from providers who are treating pain. They drop women from their practice and then the women have no place to go for their care –some end up buying medications off the street. This is a dangerous practice that needs to be addressed.

POLICY FOR THE USE OF OPIATES FOR THE TREATMENT OF PAIN (as approved by policy comm. and board, March 2014, with current changes in red)

Introduction

Since the 2004 publication of the North Carolina Medical Board's Policy for the Use of Controlled Substances for the Treatment of Pain, a considerable body of research and experience has made it evident that the Board's 2004 Policy required revision. The updated policy presented here takes into consideration recent evidence that risk associated with opiates has surged, while evidence for benefits has remained controversial and insufficient. Over the last decade opioid sales have increased in parallel with an increase in the morbidity and mortality associated with these drugs. At the same time approximately one in four patients seen in primary care settings suffers from pain that interferes with the activities of daily living (1).

The challenges faced by North Carolina Medical Board licensees who care for patients taking opiates for pain are significant. The North Carolina Medical Board is committed to helping its licensees meet those challenges successfully. By doing so the Board and its licensees will help promote public health and the individual well-being of the citizens of our state. For the sake of simplicity, in the document that follows the word "physician" is used to represent all North Carolina Medical Board Licensees who use opiates for the treatment of pain.

The majority of this updated policy applies to the treatment of chronic pain and the use of opioid analgesics. Guidance for assessing and managing acute pain in primary care is also provided. The Board recognizes that the use of opiates in end of life and palliative care may present unique benefits and risks. Concepts and guidelines presented in this policy will be useful and generally apply to the use of opiates for end of life and palliative care. However, the Board's Position Statements on end of life and palliative care take precedence over information presented here.

The updated policy contains three sections. Section 1 begins with a preamble of information and a statement of the Board's goals. The preamble is followed by conceptual overviews discussing responsibility for appropriate pain management and opiate prescribing, and prevention of opiate diversion and abuse. Section 2 provides guidelines to physicians that are linked to concepts presented in Section 1. The guidelines provide information that physicians can use to help them evaluate and manage pain appropriately and prescribe opiates responsibly. The guidelines provide the Board a framework to assess physicians' treatment of pain, and a means to determine whether opiate medications are used in a manner that is medically appropriate and in compliance with North Carolina State and federal laws and regulations. Section 3 contains a glossary of terms.

In developing this updated policy the Board has relied heavily on the Federation of State Medical Board's 2013 Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain. The Board also acknowledges the work of, and extends its thanks to the Indiana Medical Licensing Board, and the efforts of the State of Indiana's Attorney General, the Indiana State Department of Health's Chief Medical Officer, and the Indiana Prescription Drug Abuse Task Force. As the North Carolina Medical Board has developed this updated policy, it has borrowed freely and taken material verbatim, with permission, from *"First Do No Harm, The Indiana Healthcare Providers Guide to the Safe, Effective Management of Chronic Non-Terminal Pain*.

The Board encourages all physicians to review the Federation of State Medical Board's 2013 Model Policy at http://www.fsmb.org/pdf/pain_policy_july2013.pdf, and the State of Indiana's "*First Do No Harm"* document at http://www.in.gov/bitterpill/docs/First_Do_No_Harm_V_1_0.pdf for additional helpful information.

SECTION I - ***Preamble***

The North Carolina Medical Board is obligated under the laws of the State of North Carolina to protect public health and safety. This obligation is reflected in the Board's mission statement to "...regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina." The Board believes that a fundamental component of good medical practice includes the appropriate evaluation and management of pain. Responsibly prescribed opiate medications may help North Carolina physicians treat their patients' pain safely and effectively, and improve their quality of life. The Board is aware that the undertreatment of pain is recognized as a serious public health problem that compromises patients' function and quality of life (2, 3).

However, it must be understood that chronic pain is often intractable, and that in most cases the current state of medical knowledge and medical therapies, including the use of opioid analgesics, does not provide for the complete elimination of chronic pain (4, 5, 6). Furthermore, chronic pain and its attendant opioid use have become an enormous burden to patients, medical institutions and our society. There are over 50 million estimated chronic pain patients in the United States. Medical expense data places the cost of chronic pain, including direct and indirect costs, at well over $100 billion per year. As many as 15-20% of primary care visits result in a prescription being given for opioids. However, despite the increased use of pain interventions, including opioids, many patients are dissatisfied and report inadequate pain control. The aggressive use of pain intervention resources has not been associated with commensurate clinical benefit. Robust increases in pain expenditures from 1997 to 2005 did not translate into improvements in self-assessed health status and pain (7).

Persistent pain, like all chronic illnesses, is managed optimally with a bio-psychosocial model and not with the opio-centric practices of the past. Data from a large population-based study suggests that those on chronic high-dose opioids may fare worse over time than those on lower doses or none at all. Quality of life measures for patients in the study using high-dose opioids were lower than those on a low dose regimen, and patients were four times less likely to "recover" significantly during the five years of the study (8).

Between 1997 and 2010, opioid use increased dramatically. However, increased use of opioids has not been accompanied by adequate evidence to support the effectiveness and safety of long-term opioid therapy, and has been complicated by opioid-related overdoses, substance abuse, and prescription costs to society that have escalated to unacceptable levels. Leonard J. Paulozzi, a medical epidemiologist at the Center for Disease Control and Prevention (CDC), during congressional testimony reported that "the number of deaths in the narcotics category that involved prescription opioid analgesics increased from 2,900 in 1999 to at least 7,500 in 2004,

an increase of 160% in just five years." Accidental drug overdose is currently the leading cause of injury-related death in the United States for people between the ages of 35-54 (9). In addition to nearly 16,000 prescription opioid-related deaths in 2010, the rise in opioid use has fueled a substantial increase in substance use disorders. Approximately nine people are admitted for prescription opioid abuse treatment for every one opioid prescription-related death (10).

An analysis on 2006 data related to the cost of nonmedical use of prescription opioids placed the total at $53.4 billion (11). The CDC's estimate on those same costs in 2009 was over $70 billion. Lost productivity was the largest single contributing factor, contributing to 79% of this cost. Clearly, suboptimal risk stratification and monitoring of patients prior to opioid therapy, combined with current practices of prescription writing, are creating enormous emotional and financial burdens on a national level.

In North Carolina, six-hundred and seventy three North Carolinians were reported to have died in 2012 from unintentional poisoning by opioids other than opium and heroin (12). Extrapolating data from the 2011 and 2012 National Survey on Drug Use and Health suggests that as many as 70% of these opiate related deaths are associated with a prescription medication shared by or stolen from the individual for whom the drug was prescribed.

In presenting this Policy for the Use of Opiates for the Treatment of Pain, it is the North Carolina Medical Board's goal to provide guidelines that may help to improve the quality of life for those North Carolinians who suffer from pain, and reduce the morbidity and mortality associated with the inappropriate use of opiates and other controlled substances prescribed to treat pain.

Responsibility for Appropriate Pain Management and Opiate Prescribing:

The evaluation and management of pain is integral to the practice of medicine. All physicians should be knowledgeable about the process of evaluating their patients' pain and function, and be familiar with methods of managing pain safely and effectively. The process of evaluation and management of a patient's pain should be based on an established physician-patient relationship. Patients with chronic pain should be assessed for the potential for substance abuse and coexistent mental health conditions. Objective and verifiable goals that incorporate physical, functional and social domains should be prominent components of a patient's treatment plan. Non- pharmacologic treatment interventions and use of non-opiate pain medications should be explored before beginning opioid medications. When controlled substances are to be used to treat chronic pain, their use should be accompanied by informed consent and treatment agreements. If opiate medications are part of a treatment plan, they should be prescribed or administered in response to an identified medical condition that qualifies for treatment with a controlled substance. Physicians should be aware that there is very little data to support the use of long term opioid therapy for common causes of chronic pain such as fibromyalgia, low back pain, pelvic pain, functional bowel disorders and chronic headache. Physicians prescribing controlled substances should understand and comply with applicable federal and North Carolina State requirements. Follow up monitoring of a patient's response to treatment should include the patient's progress in achieving objective and verifiable goals, and should insure that the patient is using prescribed medications safely. Treatment plans and prescribed medications should be adjusted as needed, and referral to consultants made when necessary. Opioids should be tapered or discontinued when a patient's pain is poorly controlled on appropriate doses of medication or if there is no physical, functional, and

psychosocial improvement with opioid treatment. The medical record should provide documentation of all relevant aspects of the physician's evaluation and management, including diagnoses and treatment plans, periodic assessment of the patient's progress toward identified goals, medications prescribed and results of medication monitoring, evidence of compliance with treatment agreements, and pertinent results of laboratory, radiographic and ancillary services, including consultations and referrals.

Preventing Opioid Diversion and Abuse:
The Board recognizes that patients and other individuals who inappropriately use opiates place their own health in jeopardy and create a public health problem (13). Physicians who fail to prescribe opiates responsibly may contribute to patients' and other individuals' drug misuse and diversion (14, 15, 16). The Board expects physicians to incorporate safeguards into their practices to minimize the risk of misuse and diversion of opiates as well as other controlled substances (17, 18, 19, 20, 21, 22, 23, 24).

The appropriate evaluation and management of a patient's pain, including the prescribing of opiate medications is the treating physician's responsibility. Physicians who prescribe, order, dispense, or administer controlled substances using evidence based or current best clinical practices should not fear disciplinary action from the Board. Conversely, the Board will consider the failure to prescribe controlled substances responsibly to be a departure from the standards of practice and will investigate such allegations, utilizing current clinical practice guidelines and expert review in determining whether or not standards of care have been met.

Allegations of inappropriate pain management, including the failure to prescribe controlled substances responsibly, will be evaluated on an individual basis. The Board may use a variety of sources to determine the appropriateness of treatment including prescribing information obtained from the North Carolina Controlled Substance Reporting System (NCCSRS). The Board will not take disciplinary action against a physician for deviating from this Policy when the physician can establish a reasonable cause for the deviation.

The Board will judge the validity of the physician's treatment of a patient on the basis of available documentation. Goals of treatment are the effective control of the patient's pain using appropriate doses of medication, achieving improved physical, functional, and psychosocial ~~function~~activities, and mitigating risk of misuse, abuse, diversion, and overdose (25, 26, 27).

The Board will consider the unsafe or otherwise inappropriate treatment of pain to be a departure from best clinical practice, taking into account whether the treatment is appropriate to the diagnosis and the patient's level of risk.

SECTION II – *Guideline*[28]

Overview:
The guidelines in the North Carolina Medical Board's Policy on the Use of Opiates for the Treatment of Pain are meant to help physicians evaluate and manage pain appropriately, prescribe opiates responsibly, and prevent opioid diversion and abuse. Incorporating the guidelines into best practices behavior will help physicians mitigate some of the burdens that pain and its attendant opiate use place on patients, physicians, medical institutions, and society.

The Board recommends the following as best practices behavior when using opiates to treat pain.

Patient Evaluation and Risk Stratification

The physician should personally participate in the process of every patient's evaluation. The nature and extent of the evaluation depends on the type of pain and the context in which it occurs. For example, meaningful assessment of chronic pain demands a more detailed evaluation than an assessment of acute pain. Assessment of a patient's pain should include the nature and intensity of the pain, past and current treatments for the pain, any underlying or co-occurring disorders and conditions, and the effect of the pain on the patient's physical, functional and psychosocial activities (29).

For every patient with pain, the initial work-up should include a systems review and relevant physical examination, and laboratory investigations as indicated (30, 31, 32, 33). Such investigations help the physician address the nature and intensity of the pain, and its impact on the patient's physical, functional and psychosocial activities, and alcohol and drug use.

Social and vocational assessment is useful in identifying supports and obstacles to treatment and rehabilitation. For example, does the patient have good social supports, housing, and meaningful work? Is the home environment stressful or nurturing (34)? When applicable, the patient's evaluation should include information from family members and/or significant others (35, 36, 37, 38).

Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse should be part of the initial evaluation (39, 40, 41, 42, 43, 44). These assessments, should ideally be completed prior to a decision to prescribe opioid analgesics, and should inquire into any history of physical, emotional or sexual abuse, which are risk factors for substance misuse (45, 46, 47, 48). Use of a validated screening tool, such as the Screener and Opioid Assessment for Patients with Pain (SOAPP-R; 49) or the Opioid Risk Tool (ORT; 50) can save time in collecting and evaluating information and determining the patient's level of risk.

Patients who have a history of substance use disorder (including alcohol) are at elevated risk for failure of opioid analgesic therapy and are at high risk for experiencing harm from this therapy, since exposure to addictive substances often is a powerful trigger of relapse (51, 52, 53). Whenever possible treatment of a patient who has a history of substance use disorder should involve consultation with an addiction specialist before opioid therapy is initiated and include follow-up as needed. Patients who have an active substance use disorder should not receive opioid therapy until they are established in a treatment/recovery program (54), or alternatives such as co-management with an addiction professional are established. Physicians who treat patients with chronic pain are strongly encouraged to be knowledgeable about addiction, including recognizing behaviors that indicate addiction, and how and when to refer patients for addiction evaluation and treatment.

All patients should be screened for depression and other mental health disorders as part of risk evaluation. There is a clear association between mental illness and opioid related morbidity and mortality. Patients with untreated depression and other mental health problems are at increased risk for misuse or abuse of controlled medications, addiction, and overdose (55).

Information provided by the patient is a necessary but insufficient part of the evaluation process. Reports of previous evaluations and treatments should be confirmed by obtaining records from other providers. Patients occasionally provide fraudulent records. If there is reason to question the truthfulness of a patient's report, records should be requested directly from the patients other providers (56, 57).

Information from the North Carolina Controlled Substance Reporting System (NCCSRS) should be part of every patient's initial evaluation and subsequent monitoring program. Physicians should register with the NCCSRS and become familiar with analyzing and using NCCSRS data. Information from the NCCSRS should be used to help confirm each patient's compliance with treatment plans and opiate medication agreements. Relevant information from the NCCSRS should become part of the patient's medical record.

Obtaining a toxicology screen, such as a urine drug screen, is a useful tool in the setting of risk assessment prior to prescribing opioids. It may reveal the use of controlled medications such as opioids or benzodiazepines other than those prescribed or may reveal the use of other illicit drugs.

In dealing with a patient who is taking opioids prescribed by another physician—particularly a patient on high doses - evaluation and risk stratification assume even greater importance (58, 59, 60). As with all patients the physician's decision to prescribe opioid analgesics should reflect the totality of the information collected, the physician's own knowledge and comfort level in prescribing and the resources for patient support that are available in the community (61, 62, 63).

Development of a Treatment Plan and Goals:

In chronic pain the goals of treatment include reasonably attainable improvement in pain and activity; improvement in pain-associated problems such as sleep disturbance, depression, and anxiety; and avoidance of unnecessary or excessive use of medications (64, 65). According to the International Association of the Study of Pain, activity goals should be set in three separate domains. The physical domain is the exercise program the patient follows,. The functional domain involves tasks of everyday living. The social domain relates to pleasurable social activities (66). Effective means of achieving treatment goals vary widely, depending on the type and causes of the patient's pain, other concurrent issues, and the preferences of the physician and the patient.

Early treatment with non-pharmacologic interventions including physical therapy, exercise, and cognitive behavioral techniques, should be employed whenever possible. First line pharmaco-therapy should be the appropriate use of non-opioid analgesics including over the counter medications, non-steroidal anti-inflammatory drugs, and acetaminophen. Other treatment modalities including minor interventions such as anesthetic and steroid joint injections, cutaneous stimulators, topical anesthetics, and local therapies employing heat, massage, and manipulations should be considered before using opiates.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly. Clear-cut, individualized goals for pain relief and improved physical, functional and psychosocial activity should be set to help guide the choice and response to treatment (67). The treatment plan should contain information supporting the selection of pharmacologic and nonpharmacologic therapies. The plan should specify the objectives that will be used to evaluate the control of pain and achievement of specific physical, functional and psychosocial activity goals (68, 69, 70, 71). The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered (72, 73, 74, 75).

Informed Consent and Treatment Agreement:

The decision to initiate opioid therapy should be a shared decision between the physician and the patient. The physician should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics) with the patient, with persons designated by the patient, or with the patient's surrogate or guardian if the patient is without medical decision-making capacity (76, 77). If opioids are prescribed, the patient (and possibly family members) should be counseled on safe ways to store and dispose of medications (78, 79).

~~When treating chronic pain, use of a written informed~~ consent, and a treatment agreement are recommended (80,81,82,83,84). They may be combined into one document for convenience."~~Use of a written informed consent, and a treatment agreement is recommended (80, 81, 82, 83, 84). They may be combined into one document for convenience.~~

Informed consent documents typically address:

- The potential risks and anticipated benefits of chronic opioid therapy.
- Potential side effects (both short- and long-term) of the medication, such as constipation and cognitive impairment.
- The likelihood that tolerance to and physical dependence on the medication will develop.
- The risk of drug interactions and over-sedation, including the increased risk of using opiates in diseases and conditions such as obesity and sleep apnea~~.~~
- The risk of impaired motor skills (affecting driving and other tasks).
- The risk of opioid misuse, dependence, addiction, and overdose.
- The limited evidence as to the benefit of long-term opioid therapy.
- The physician's prescribing policies and expectations, including the number and frequency of prescription refills, as well as the physician's policy on early refills and replacement of lost or stolen medications.
- Specific reasons for which drug therapy may be changed or discontinued (including violation of the policies and agreements spelled out in the treatment agreement).

Treatment agreements outline the joint responsibilities of physician and patient in the management of chronic pain (85, 86, 87) and may be applicable in some cases of acute pain. Treatment agreements are indicated when opioid or other abusable medications are prescribed. Agreements typically discuss:

- The goals of treatment, in terms of pain management, restoration of activities, and safety.

- The patient's responsibility for using medication safely (e.g., not using more medication than prescribed, not using an opioid in combination with alcohol or other potentially dangerous substances; storing medications in a secure location; and safely disposing of unused medication).
- The patient's responsibility to obtain prescribed opioids from only one physician or practice.
- The patient's agreement to periodic drug testing of blood, urine, hair, saliva, or other body material.
- The physician's responsibility to be available or to have a covering physician be available to care for unforeseen problems and to prescribe scheduled refills.

Initiating an Opioid Trial:

Generally, safer alternative treatments including non-pharmacologic and minor interventions and first line pharmaco-therapy with over the counter medications, non-steroidal anti-inflammatory drugs, and acetaminophen should be considered before initiating opioid therapy. When the decision to use an opiate has been made, it should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 90 days) and with specified evaluation points. The physician should explain that progress will be carefully monitored for benefit and harm in terms of the effects of opioids on the patient's level of pain, and on the patient's physical, functional and psychosocial activities. Attention will be focused on adverse events and risks to safety (88). Patients at risk of an opiate overdose should be identified. The Board ~~endorses efforts to reduce the number of drug overdoses by making opioid antagonists such as naloxone available to patients at risk of an opiate overdose~~ expects . ~~—~~physicians who prescribe opiates to help insure that naloxone is readily available to patients who are identified as being at risk of an opiate overdose. Readers are referred to the Board's Position Statement, "Drug overdose prevention."

When initiating opioid therapy, the lowest dose possible should be given to an opioid naïve patient and titrated to affect while monitoring for complications. Opioid therapy should begin with a short acting drug and rotate to a long acting/extended release if indicated. A decision to continue opioid therapy beyond the trial period should reflect a careful evaluation of benefits, adverse events, and potential risks (89).

Ongoing Monitoring and Adapting the Treatment Plan:

The physician should regularly review the patient's progress, including any new information about the etiology of the pain or the patient's overall health and level of activities (90, 91, 92). When possible, collateral information about the patient's response to opioid therapy including the medications' effects on physical, functional, and psychosocial activities, as well as signs of adverse effects such as sedation or other impairment.should be obtained from family members or other close contacts. The physician should regularly review North Carolina Controlled Substance Reporting System data. The patient should be seen more frequently while the treatment plan is being initiated and when the opioid dose is being adjusted (93 - 100). As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled less frequently.

At each visit, the results of chronic opioid therapy should be monitored by assessing what have been called the "5As" of chronic pain management. These include a determination of whether the patient has had a reduction in pain (Analgesia), improved physical, functional and psychosocial Activity, the presence of Adverse effects, evidence of Aberrant substance-related behaviors, and a change in Affect (101, 102). Validated brief assessment tools that measure pain and physical, functional and psychosocial activities, such as the three- question "Pain, Enjoyment and General Activity" (PEG) scale (103) may be helpful and more time efficient in general medical settings.

Continuation, modification or termination of opioid therapy for pain should be contingent on the physician's evaluation of the patient's progress toward treatment goals and assessment of substantial risks or adverse events (104, 105, 106, 107). A satisfactory response to treatment would be indicated by a reduced level of pain, and improved physical, functional and psychosocial activities (108, 109). Information from family members or other caregivers should be considered in evaluating the patient's response to treatment (110, 111, 112). Use of measurement tools to assess the patient's level of pain, activity, and quality of life (such as a visual analog or numerical scale) can be helpful in documenting therapeutic outcomes (113, 114).

Risks associated with opioids increase with escalating doses. The physician should avoid opiate dose escalation without adequate attention to risks or alternative treatments. Clinicians should avoid over-reliance on opioids as the primary or only treatment modality, including using opioid dose escalation as the only response to a complaint of inadequate pain relief. The physician should be continuously attentive to the use of opiates with other respiratory depressants such as benzodiazepines or alcohol, and using opiates in the setting of other comorbidities such as mental illness, respiratory disorders and sleep apnea, and a pre-existing substance use disorder.

Periodic Drug Testing:

Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs (115, 116). Drug testing is an important monitoring tool because self-reports of medication use and behavioral observations are not always reliable (117, 118, 119, 120, 121). Urine may be the preferred biologic specimen for testing because of its ease of collection and storage and the cost-effectiveness of such testing (122). When testing is conducted as part of pain treatment, forensic standards are generally not employed. Sample collection may not need to be ~~not~~ observed, and chain-of-custody protocols are not customarily followed. Initial testing may be done using class-specific immunoassay ~~drug panels (~~point-of-care or laboratory-based tests. These tests do not typically identify a particular specific drug within a class. However, the tests are available as panels and immunoassays for specific drugs can be included. It is important that the clinician formulate these panels to include the particular medications being prescribed and preferably the drugs commonly abused in the local community.~~)~~, which typically do not identify particular drugs within a class unless the immunoassay is specific for that drug. If necessary, initial testing can be followed with more specific techniques, including gas chromatography/mass spectrometry (GC/MS) or other chromatographic tests (123). In drug testing in a pain practice, it is important to identify the specific drug not just the class of the drug.

Physicians should be knowledgeable about the specific drug tests they order. They should be aware of the limitations, sensitivity and specificity of the tests they order, and take care to order tests appropriately (124). When a drug test is ordered, it is important to specify that it include the opioid being prescribed (125). Because of the complexities involved in interpreting drug test results appropriately, it is advisable to confirm significant or unexpected results with the testing laboratory's toxicologist or a clinical pathologist (126, 127).

While immunoassay, point of care (POC) testing has utility in the making of temporary and "on the spot" changes in clinical management, its limitations with regard to accuracy have recently been the subject of study. The use of point of care testing for making long term and permanent changes in patient management may not be justified until the results of confirmatory testing with more accurate methods such as LC-MS/MS are obtained. A recent study on LC-MS/MS results following immunoassay POC testing in addiction treatment settings found very high rates of "false negatives and positives" (128, 129).

Test results that suggest ~~opioid~~ illicit or prescribed medication misuse should be discussed with the patient. The discussion should occur in a positive, supportive fashion, to strengthen the physician-patient relationship, encourage healthy behaviors, and produce behavioral change when needed. Results of drug testing and subsequent discussion with the patient should be documented in the medical record (130). Periodic pill counting is a useful strategy to confirm medication adherence and minimize diversion. Data from the North Carolina Controlled Substance Reporting System (NCCSRS) should be reviewed before beginning opiates and as a routine part of monitoring and adapting a patient's treatment plan. (131, 132, 133, 134, 135). If the patient's progress is unsatisfactory, the physician must decide whether to revise or augment the treatment plan, whether other treatment modalities should be added to or substituted for the opioid therapy, or whether a different approach—possibly involving referral to a pain specialist or other health professional—should be employed (136, 137, 138, 139, 140).

Evidence of misuse of prescribed opioids demands prompt intervention by the physician (141, 142, 143, 144, 145, 146). Patient behaviors that require such intervention typically involve recurrent early requests for refills, multiple reports of lost or stolen prescriptions, obtaining controlled medications from multiple sources without the physician's knowledge, intoxication or impairment (either observed or reported), and pressuring or threatening behaviors (147). The presence of illicit or unprescribed drugs, (drugs not prescribed by a physician) in drug tests requires action on the part of the prescriber. Some aberrant behaviors are more closely associated with medication misuse than others (148, 149). Most worrisome are patterns of behavior that suggests recurring misuse, such as unsanctioned dose escalations, deteriorating physical, functional or psychosocial activities, and failure to comply with a treatment plan (150).

Documented drug diversion or prescription forgery, obvious impairment, and abusive or assaultive behaviors require a firm, immediate response (151, 152, 153, 154). Failure to respond can place the patient and others at significant risk of adverse consequences, including accidental overdose, suicide attempt, arrest and incarceration, or death (155, 156, 157, 158). For this reason, physicians

who prescribe chronic opioid therapy should be knowledgeable about substance use disorders and be able to distinguish substance use disorders from physical dependence on opiates.

Tips on Diversion:[159]

One of the most difficult duties that a physician has as it relates to the prescribing of opioids to patients with chronic pain is the issue of opioid diversion. Even in light of a failed urine drug screen (UDS) with confirmation, an inconsistent NCCSRS report, and or noncompliance (not attending physical therapy, failure to obtain prescribed imaging, failure to attend appropriate interventional procedures, etc.) it is difficult to know when a patient is diverting prescription opioids. However, the prescriber may feel the patient is diverting after ascertaining a history, or the medical office receives a phone call from an anonymous source that the patient is selling his/her opioid medication. Perhaps the most effective way to appropriately decide if the patient is diverting is the combination of a random pill count and a concomitant UDS with a confirmation.

If you believe a patient may be diverting a medication, ~~call them~~he or she should be notified to come in to the office between scheduled appointments. ~~It~~ This is one reason that it is of vital importance that a random pill count be part of the Physician-Patient Informed Consent and Treatment Agreement and ~~. Random pill counts should not be part of Informed Consent and Treatment Agreements but should~~ be reviewed with the patient at the time the agreement is signed. If a random pill count reveals medication quantities that fall short of amounts expected from prescribing instructions, it is vital to perform at that exact point in time a urine drug screen with confirmation. If the patient's UDS confirmation is negative for the prescribed opioid, it is very strong evidence that the patient is diverting, and it is safe to stop prescribing. If the UDS conformation comes back with the appropriate medication in the patient's urine, but the random pill count is short, it is highly likely that the patient is either taking more medication than prescribed, or the patient is taking some of the medication but is diverting a portion of the prescription. At this point, a conversation with the patient should occur. If the patient is over-taking the medication, it may be a good idea to seek a pain management consultation to get a reassessment of the true pain generator(s). If you believe the patient is diverting ~~and/or~~or abusing medication, a referral to an addiction specialist is in order. If you have strong evidence that the patient is diverting opioid medication, the medication should be discontinued and alternative treatments initiated. If the physician believes the diversion represents a significant risk to public health, consideration should be given to reporting the individual to law enforcement or asking the NCCSRS for assistance.

A list of items that should raise the physician's awareness about the possibility that a patient is ~~diverting~~ seeking opioid medications for reasons other than legitimate pain relief ~~medications~~ includes:

Suspicious history:

- Patient referred is already taking controlled substances; especially combinations of narcotics, muscle relaxants, use of sedative/hypnotics
- Soft diagnosis − perhaps based solely on chief complaint
- Multiple doctors and pain physicians in the past
- Patient travelled out of the way to come to your clinic
- Solicitous behavior frequently heard: "You're the best. I always wanted to come to you."
- No past medical records; unable to obtain records from "referring doctor"

- Patient brings records that look old, tattered or suspicious in some other way
- Patient asks for a specific controlled substance (example: prefers Lortab® over Noarco)

Suspicious physical exam:

- No abnormal findings
- Abnormal findings in exam room inconsistent with witnessed behavior (patient has normal gait from car to office door, but limps once inside door)
- Exaggerative behaviors, pain is always a 10 on a scale of 1 to 10.
- Unimpressive imaging
- Presence of injecting behavior (old or recent "track marks" or multiple healed or current abscesses) or marked nasal erythema from insufflation ("snorting")needle "tracks"
- Patient smells like marijuana smoke

Equivocal compliance:

- NCCSRS shows multiple providers, multiple pharmacies, prescriptions for multiple types and of medications, out of the area doctors, etc.
- UDS is refused or abnormal; patient offers multiple excuses; presence of any illegal substances (marijuana)
- Inconsistent test results over time
- Patient seeks earlyrecurrent early refills for lost or stolen prescriptions or for increased opioid use without consultation with prescriber refills
- Patient has excuses for lost pills (lost my prescription, my dog ate my pills, etc.)

No or Eequivocal clinical improvement:

- Subjective improvement alone does not count
- Lackof evidence of oObjective improvement in physical, functional and psychosocial activities,may include the following: is the patient going back to work, attending appointments with a spouse (who can confirm improvement), showing a need for less
- Lack of evidence of decreasing use of opioid medications, visiting emergency rooms visits less, etc.

What you should do when the clinician suspects misuse, abuse or addiction confronted by a suspected drug abuser:

- Request picture I.D. or other I.D. and a Social Security number. Photocopy these documents and include in the patient's record.
- Call a previous practitioner, pharmacist or hospital to confirm the patient's story.
- Confirm a telephone number, if provided by the patient.
- Confirm the current address at each visit.
- Investigate suspicions further by presenting and discussing specific concerns with the patient, re-checking NCCSRS information, increase the use of drug screens, talk with family members
- Write prescriptions for limited quantities until concerns are resolved and it is safe to do so, and increase frequency of visits and drug screens .

Consultation and Referral:

The treating physician should seek a consultation with, or refer the patient to, a pain, psychiatry, addiction, or mental health specialist as needed (160, 161). For example, a patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment (162, 163).

Physicians who prescribe chronic opioid therapy should be familiar with treatment options for opioid addiction (including those available in licensed opioid treatment programs [OTPs]) and those offered by an appropriately credentialed and experienced physician through office-based opioid treatment [OBOT]), so as to make appropriate referrals when needed (164, 165, 166, 167).

Discontinuing Opioid Therapy:

Throughout the course of opioid therapy, the physician and patient should regularly weigh the potential benefits and risks of continued treatment and determine whether such treatment remains appropriate (168). Opioids should be tapered or discontinued when a patient's pain is poorly controlled on appropriate doses of medication OR if there is no improvement in physical, functional or psychosocial activity with opioid treatment. Reasons for discontinuing opioid therapy include resolution of the underlying painful condition, emergence of intolerable side effects, inadequate analgesic effect, deteriorating physical, functional or psychosocial activities, or significant aberrant medication use (169, 170).

If opioid therapy is discontinued, in the setting of appropriate use but inadequate response and the patient has become physically dependent, they ~~the patient who has become physically dependent~~ should be provided with a safely structured tapering regimen. In the setting of abuse or addiction, when it is necessary to discontinue opioids quickly because of safety, withdrawal ~~Withdrawal~~ can be managed either by the prescribing physician or by referring the patient to an addiction specialist (171). The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate (172, 173, 174).

Medical Records:

Every physician who treats patients for chronic pain must maintain accurate and complete medical records. The medical record should include the following (175, 176, 177, 178):

- Copies of the signed informed consent and treatment agreement.
- The patient's medical history.
- Results of the physical examination and all laboratory tests.
- Results of the risk assessment, including results of any screening instruments used.
- A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity).
- Instructions to the patient, including discussions of risks and benefits with the patient and any significant others.

- Results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and physician, functional and psychosocial improvement.
- Notes on evaluations by and consultations with specialists.
- Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors (179, 180, 181, 182, 183, 184, 185). These may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers.
- Authorization for release of information to other treatment providers.
- The medical record must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record (186). The name, telephone number, and address of the patient's pharmacy also should be recorded to facilitate contact as needed (187). Records should be up-to-date and maintained in an accessible manner so as to be readily available for review (188).

- Good records demonstrate that a service was provided to the patient and establish that the service provided was medically necessary. Even if the outcome is less than optimal, thorough records protect the physician as well as the patient (189, 190, 191, 192).

Assessing and Managing Pain in Primary Care [193]

Acute pain was once defined simply in terms of duration. It is now viewed as a complex, unpleasant experience with emotional and cognitive, as well as sensory features that occur in response to tissue trauma. In contrast to chronic pain, relatively high levels of pathology usually accompany acute pain. The pain resolves with healing of the underlying injury. Acute pain is usually nociceptive, but may be neuropathic. Common sources of acute pain include trauma, surgery, labor, medical and dental procedure and acute disease states.

Acute pain serves an important biological function, as it warns of the potential for, or extent of, injury. A host of protective reflexes (e.g., withdrawal of a damaged limb, muscle spasm, autonomic responses) often accompany it. Acute pain might be mild and last just a moment, or it might be severe and more prolonged. Acute pain, by definition, does not last longer than six months and it resolves when the underlying cause of pain has been treated or has healed. An accurate assessment of acute pain should be performed when a patient presents with pain to the healthcare setting. A solid understanding of the person and the etiology of the pain are essential for the development of an effective and appropriate short-term pain management plan.

Recommendations For Primary Care

- Develop an office policy for opioid prescribing and have this clearly posted and available for patients.

- Perform a thorough history and physical at the onset.

- Acute pain patients should be frequently evaluated for physical, functional and psychosocial improvement, with adjustments to treatment as needed. It is almost always contraindicated to include refills on opioid prescriptions for acute pain.
- Educate your patients about pain and analgesia. Explain the underlying diagnosis causing the pain, the natural history of the condition, and how your patient can help the healing process.
- If medically possible, exhaust non-opioid medications and collaborate with other professionals, including physical therapists and pain specialists. Consider nontraditional therapies such as acupuncture and massage therapy.
- Opioids are often not required for acute pain. If you feel a brief course of opioids are indicated and appropriate, be thoughtful and thorough in your discussions and practice.
- Always prescribe a complete pain management program when an opioid is used to treat acute pain:
    - utilize NSAIDS
    - develop and recommend specific exercises
    - utilize other modalities (e.g. heat, ice, massage, topical medications)

- Prescribe opioids intentionally. With the first opioid prescription, set patient responsibilities and the expectation that opioids will be discontinued when the pain problem has resolved or is not responding to what you are doing.
- Write the taper on the prescription (e.g. 1 po every 6 hours for 3 days, 1 po every 8-12 hr for 3 days, 1 po every 24 hr for 3 days, stop).
- Do not prescribe long-acting or controlled-release opioids (e.g., long-acting oxycodone and oxymorphone, fentanyl patches, long-acting hydromorphone and morphine or methadone) for acute pain.

- Consider performing risk stratification, urine drug monitoring and have a low threshold for accessing and monitoring the NCCSRS at the onset of pain care.

- Give clear instructions to take opiates only as prescribed, not more frequently or in greater quantities. Educate your patients about the risks of taking opioid analgesics, including, but not limited to: overdose that can slow or stop their breathing and even lead to death; fractures from falls, especially in patients aged 60 years and older; drowsiness leading to injury, especially when driving or operating heavy or dangerous equipment; and tolerance and addiction. Educate your patients about acute pain – tell them it is likely that their acute pain will diminish and resolve, and tell them that prolonged (several weeks of) scheduled opioids may actually impair their ability to fully recover.

- Patients should be advised to avoid medications that are not part of their treatment plan because they may worsen the side effects and increase the risk of overdose from opiates.

- Prepare patients that it may be difficult to taper off opioids, particularly from higher dose regimens, even when they are eager to do so.

- Consider referrals and consultations with a pain specialist if the patient is not responding to your treatment plan. You may want to do this early in the course of treatment if the patient does not respond to standard first line medications and before you prescribe narcotics. Pain specialists may offer procedures or other interventions that will help your patient improve and avoid unnecessary opiate use.

- It is critical to assure that patients are provided with easy to follow and graduated activity instructions that help them quickly improve their quality of life in physical, functional and social domains.

Recommendations for Emergency Departments

- Emergency medical ~~practitioners~~ physicians should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.

- Emergency medical ~~providers~~ physicians should not provide replacement doses of methadone for patients in a methadone treatment program.

- Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches and methadone) should not be prescribed ~~from the ED~~by emergency department physicains .

- Emergency department physicains~~EDs~~ are encouraged to use information from the NCCSRS before prescribing opioids.

- Physicians who manage patients with chronic pain should be encouraged to send patient pain agreements to local ~~EDs~~ emergency departments for reference, and work to develop appropriate plans for the evaluation and management of their patients in the emergency departments ~~ED~~ in conjunction with emergency department ~~p~~physicians ~~ractitioners~~.

- Whenever possible when evaluating a patient with an exacerbation of chronic pain, the emergency medicine physician should contact the patient's primary opioid prescriber and access the NCCSRS. If analgesics are to be prescribed, only enough pills to last until the office of the primary opioid prescriber's opens should be provided.

- Prescriptions for controlled substances from ~~the~~ emergency department physicains~~ED~~ should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription.

- Prescriptions for opioid pain medication from emergency department physicains ~~the ED~~ for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.

- When appropriate, ~~ED~~ emergency department patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.

Compliance with Controlled Substance Laws and Regulations:

To prescribe, dispense or administer con- trolled substances, the physician must be registered with the DEA, licensed by the state in which he or she practices, and ~~complies~~ in compliance with applicable federal and state regulations (194).

Physicians are referred to the *Physicians' Manual of the U.S. Drug Enforcement Administration* for specific rules and regulations governing the use of controlled substances. Additional resources are available on the DEA's website at www.deadiversion.usdoj.gov,

SECTION III: *Definitions* [195]

For the purposes of these guidelines, the following terms are defined as follows:

Aberrant drug-related behaviors: Actions that indicate addiction, including the following: rapidly escalating drug dosage, running out of prescriptions early, acquiring prescription drugs from outside sources, inconsistent UDS, ~~multi-~~multiple providers from NCCSRS data, stolen medications chewing/snorting/injecting medications, and altering/stealing/selling prescriptions.

Abuse: A term with a wide array of definitions, depending on context. The American Psychiatric Association defines drug abuse as "a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by one or more behaviors." DSM-V replaces the term "abuse" with "misuse" (196) In addition; **Substance abuse (SA)** can mean the use of any substance(s) for non-therapeutic purposes, or use of medication for purposes other than those for which it is prescribed. The medical diagnosis of SA is defined by any one of the following four criteria during a 12-month period: (1) failure to fulfill major obligations at work, school, or home; (2) recurrent use in situations in which it is physically hazardous; (3) recurrent substance-related legal problems; (4) continued use despite persistent social or interpersonal problems (197). Substance abuse can lead to substance dependence.

Acupuncture: An ancient oriental medical technique where needles are placed at anatomic points along the 12 meridians of the body. Oriental medical theory, passed down for thousands of years, states that vital energy (chi) flows through the body along these 12 meridians. Although current medicine does not fully understand how acupuncture works, we do know from functional MRI studies that acupuncture activates/deactivates particular areas of the brain during needling. In addition, it is known that endorphin (endogenous opioid) levels rise during needling. Clinically, acupuncture has been successfully employed to treat a variety of disorders including opioid addiction (198).

Acute pain: The normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. Acute pain is generally time-limited. Duration of acute pain generally coincides with the time frame of normal healing, and serves to protect an injured body segment.

Addiction: A primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Addiction is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction (199).

Adverse childhood events (ACE): This refers to childhood abuse (physical, emotional, or sexual), neglect, domestic violence, and household dysfunction. ACE is a significant risk factor for alcohol and drug abuse. There is a linear relationship between amount of ACEs and negative health outcomes (200).

B**iofeedback**: This behavioral therapy method can teach a person to gain awareness and control over physiologic processes like blood pressure, skin temperature, heart rate, and etc. via real-time feedback of said parameters to the person. Biofeedback has been used to treat a wide variety of diseases, including psychiatric disorders such as anxiety, attention-deficit hyperactivity disorder (ADHD), and substance use disorders (SUD) (201).

Change: To make or become different. Major life changes, such as overcoming an addiction, often occur in five stages, as follow: (1) pre-contemplation stage is when a person has not yet considered making a change; (2) contemplation stage is when a person thinks of making a change, but doesn't know how, or even if the change is worth making; (3) preparation stage is when a person becomes ready to change and makes change plans; (4) action stage occurs when people carry out their change plans; (5) and finally, the maintenance stage occurs when a person tries to make the change stick over time. Relapses sometimes occur, and can be a normal part of change. A person may relapse several times before permanent change takes hold. Research shows that skipping any one of the change stages often results in failure of change to take hold (202).

Childhood sexual abuse (CSA): This is a strong predictor of psychopathologies in adulthood, including a three-fold elevated risk for alcohol and drug dependence (203).
Chronic pain: The state in which pain persists beyond the usual course of an acute disease or healing of an injury or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Comorbidity: The presence and effect of two illnesses occurring in the same person simultaneously or sequentially. For example, there is significant psychiatric comorbidity in persons with substance dependence. That is, many individuals who abuse and depend on drugs or alcohol may have an underlying psychiatric condition such as depression, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety disorder, obsessive-compulsive disorder (OCD), etc. Other non-psychiatric comorbidities such as respiratory, cardiac, renal, or hepatic disease, sleep apnea, or seizures are also important in the consideration of chronic opiate therapy (204).

Conversion: A person is helped to see their addiction as a disorder which needs treatment. Unfortunately, so many people lose nearly everything in their lives and hit rock bottom before conversion is achieved (205).

Counter-motivation: Is resistance against change. The term includes the complex biological, psychological, and social factors involved with resisting a change. When asked about a making a change, a person may display counter-motivation by interrupting, ignoring, arguing, denying, daydreaming, reminiscing, etc. (206).

Dependence or **Physical dependence:** A state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction. The medical diagnosis of **Substance dependence (SD)** is defined by any three of the following seven criteria during a 12-month period: (1) tolerance; (2) withdrawal; (3) substance often taken in larger amounts or over longer period than intended; (4) persistent desire or unsuccessful efforts to cut down or control use; (5) great deal of time spent in activities necessary to obtain, use, or recover from the substance; (6) important social, occupational, or recreational activities given up or reduced; (7) continued use despite knowledge of having persistent or recurrent physical or psychological problem likely to have been caused or exacerbated by the substance (207).

Detoxification (Detox) or **medically supervised withdrawal**: Gradual reduction, or tapering, of a medication dose over time, under the supervision of a physician, to achieve elimination of tolerance and physical dependence [109]. Detoxification may be aided by medical intervention, or occur naturally via the body's detoxification pathways. Detoxification is one of the first steps in the treatment of addiction (208).

Discrepancy: This can refer to the difference between current situation and future goals. A counselor may help a client develop this in order to incite a desire to change (209). For example, a person is currently unemployed, living on the streets, and using heroin which has caused poor health. This person has wanted children and their own home since childhood, but now sees the discrepancy between current situation and future dreams. Perhaps this person will gain new motivation to change.

Diversion: The use of prescription drugs for recreational consumption, i.e. diverting them from their original medical purpose (210). The Federal Controlled Substances Act (CSA) establishes a closed system of distribution for drugs classified as controlled substances. Records must be kept from the time a drug is manufactured to the time it is dispensed. Any pharmaceutical which escapes the closed system is said to have been "diverted" and is illegal. Those people who "diverted" the drug are in violation of the law (211). Conversely, drug diversion may also refer to legal programs which educate, rehabilitate, and "divert" first-time drug offenders from jail and their original destructive life course (212).

Guided Imagery: This technique uses the imaginative capacity of one's own mind to create a relaxed state or, alternatively, to overcome some troubling aspect of life. This method of therapy has been used with success as one treatment for chronic pain (213).

High: Abused drugs (e.g. alcohol, nicotine, some prescription medications, and opioids) raise dopamine levels in the limbic system faster, higher, and longer than any natural reward (e.g. food and sex), causing a euphoric sensation (214).

Hypnosis: A procedure which alters one's state of consciousness to a mode that is more accepting of suggestion. This procedure is believed to create a way around the typical

evaluative, critical, conscious mind and communicate directly with one's subconscious. Hypnosis has been used for smoking cessation, but with conflicting results (215).

Lapse: A brief episode of drug use after a period of abstinence which is usually unexpected, of short duration, has relatively minor consequences, and is marked by a patient's desire to return to abstinence. A lapse can progress into a full-blown relapse with sustained loss of control (216).

Maintenance treatment: Dispensing or administering an opioid medication (e.g. methadone or buprenorphine) at a stable dose over 21 days or more for the treatment of opioid addiction (217).

Medication-assisted treatment (MAT): Any treatment of opioid addiction that includes a medication (i.e. methadone, buprenorphine, or naltrexone) and is approved by the FDA for opioid detoxification or maintenance treatment (218)).

Meditation: The self-regulation of attention. During mindfulness meditation one must focus their full attention on a designated object of meditation, like one's breath. This exercise trains the mind and provides a person with relaxation, metacognition, and the revelation of previously subconscious ideas. By focusing the mind, one can work to reduce pain and change the negative mental/emotional states involved with addiction (219).

Misuse or **non-medical use**: Incorporates all uses of a prescription medication other than those that are directed by a physician and used by a patient within the law and requirements of good medical practice (220).

Motivation: Complex mixture of biological, psychological, and social factors that together drive a person (221).

Motivational interviewing: A directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence (222). Ambivalence is the conflict of opposing ideas and attitudes which the client must articulate and resolve on his/her own, only guided by the counselor. For example, a client must first ask, "Am I ready to quit?" honestly and then decide within themselves which path to trod. It is the counselor's duty to lead them to this question, guide the process, and instill within them the confidence to pursue a change.

Neuroplasticity: The ability of the nervous system to adjust or compensate to an injury or disease (223). Often neuroplasticity is a good thing, but with persistent pain or chronic drug/alcohol use, these changes can make matters worse, or cause new problems altogether (e.g. psychiatric disorders or opioid induced hyperalgesia).

Opioid abuse/dependence: Repeated use of a drug while producing problems in three or more areas over a 12-month period. Areas include tolerance, withdrawal, overdose, and use despite impending adverse consequences. The most commonly abused opioid is oxycodone from diverted prescriptions. Others include hydrocodone~~, followed by~~ morphine, meperidine, fentanyl, methadone, buprenorphine, butorphanol, tramadol and pentazocine (224).

Opioid Treatment Program (OTP), Methadone Clinic, or Narcotic Treatment Program: Any federally certified treatment program which provides supervised assessment and medication-assisted treatment of patients who are addicted to opioids (225).

Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is a complex experience embracing physical, mental, social, and behavioral processes, compromising the life of many individuals (226).

Pseudoaddiction: The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors of pseudoaddiction resolve upon institution of effective analgesic therapy. Addiction and pseudoaddiction can both occur in the same person (227).

Reciprocal risk factors: One primary condition puts you at risk for a second condition, but the second condition also can exacerbate symptoms of the first. For example, bipolar disorder puts a person at risk for developing substance abuse or addiction via cyclical mood changes. In return, substance abuse
exacerbates a person's bipolar disorder – creating a destructive cycle (228).

Recovery: A process of change through which individuals improve health and wellness, live a self- directed life, and strive to reach full potential. Recovery must arise from hope and is person-driven. Recovery occurs via many pathways; is holistic; and must be supported by peers, allies, relationships, and social networks. Recovery is culturally-based and influenced; is supported by addressing trauma; involves individual, family, and community strengths and responsibility. Finally, recovery must be based on respect (229).

Rehabilitation (Rehab): Rebuilding a person's life as a whole after addiction or some other traumatic event. This process is complex and may involve a combination of changes in the biological, psychological, and social aspects of a person's life. This is often the most time intensive element of recovery and may take months to years (230).

Relapse: A breakdown or setback in a person's attempt to change or modify any target behavior. Relapse may also be defined as an unfolding process in which resumption of substance misuse is the last event in a long series of maladaptive responses to internal or external stressors or stimuli. Relapse may be influenced by many aspects of life including physiologic and environmental factors (231).

Self-efficacy: A person's belief that change is possible and that they can accomplish it (232). In general, a person must first believe that they are fully capable before they undertake a change. For example, one must have confidence and know they are strong enough to leave drugs/alcohol. During this process it is important for both counselors and clients to remember that everyone has unused potential and that everyone is capable of change.

Self-medication: The use of un-prescribed drugs to treat a medical problem. Self-medication is sometimes used by individuals with mental disorders to ameliorate the discomfort of their disease. However, these patients often become addicted to their medications and thus comorbidity develops (233).

Tolerance: A physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect. Or, a reduced effect is observed with a constant dose over time. Tolerance may, or may not, be evident during opioid treatment and does not

equate with addiction. Tolerance can occur to an opioid's analgesic effects and to its unwanted side effects, i.e. sedation, and nausea (234). Physiologically, when using a drug like alcohol, nicotine, some prescription medications, or opioids, changes take place in the brain. Over time, these changes down-regulate natural dopamine production and reduce the brain's ability to respond to dopamine. An addict will perceive this relative lack of dopamine in the brain as increased tolerance, and he/she will often counter it with increased drug use (235).

Trial period: The period of time when medication or other treatment efficacy is tested to determine whether treatment goals can be met. If goals cannot be met, the trial is discontinued and an alternate treatment may be considered (236).

Waiver: Documented authorization from Secretary of Health and Human Services that exempts a qualified physician from rules applied to Opioid Treatment Programs (OTPs) and allows him/her to use buprenorphine for treating addiction in an office-based practice (237).

Withdrawal: If drug use is stopped abruptly, a withdrawal syndrome can occur where adaptive body responses, originally present to counter and detoxify the drug, become unopposed and often produce a painful experience for the drug user. Withdrawal is the cardinal sign of physical dependence on a drug (238).

POSITION STATEMENT	ADOPTED	SCHEDULED FOR REVIEW	LAST REVISED/ REVIEWED/ ADOPTED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED
Departures from or Closings of Medical	Jan-00	Jul-13	Jul-09	Aug-03			
Telemedicine	May-10	Nov-13	May-10				
Access to Physician Records	Nov-93	Mar-14	Sep-10	Aug-03	Mar-02	Sep-97	May-96
Policy for the Use of Controlled Substances for the Treatment of Pain	Sep-96	Mar-14	Jan-13	Sep-08	Jul-05		
Medical Supervisor-Trainee Relationship	Apr-04		Nov-10	Apr-04			
Advertising and Publicity	Nov-99		Nov-10	Sep-05	Mar-01		
Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care	Oct-99		Jan-11	Oct-99			
HIV/HBV Infected Health Care Workers	Nov-92		Jan-11	Jan-05	May-96		
Writing of Prescriptions	May-91		Mar-11	Mar-05	Jul-02	Mar-02	May-96
Laser Surgery	Jul-99		Mar-11	Jul-05	Aug-02	Mar-02	Jan-00
Office-Based Procedures	Sep-00		May-11	Jan-03			
Sale of Goods From Physician Offices	Mar-01		May-11	Mar-06			
Competence and Reentry to the Active Practice of Medicine	Jul-06		Jul-11	Jul-06			
Prescribing Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties	May-98		Sept-11	Nov-05	Jan-01	Jul-98	
Referral Fees and Fee Splitting	Nov-93		Jan-12	Jul-06	May-96		
Self- Treatment and Treatment of Family Members and Others With Whom Significant Emotional Relationships Exist	May-91		Mar-12	Sep-05	Mar-02	May-00	May 96
Availability of Physicians to Their Patients	Jul-93		May-12	Nov-11	Jul-06	Oct-03	Jan-01
Sexual Exploitation of Patients	May-91		May-12	Sep-06	Jan-01	Apr-96	
Care of the Patient Undergoing Surgery or Other Invasive Procedure	Sep-91		Jul-12	Sep-06	Mar-01		
The Physician-Patient Relationship	Jul-95		Jul-12	Sep-06	Aug-03	Mar-02	Jan-00
The Retired Physician	Jan-97		Jul-12	Sep-06			
Physician Supervision of Other Licensed Health Care Practitioners	Jul-07		Sep-12	Jul-07			
Medical Testimony	Mar-08		Sep-12	Mar-08			
Advance Directives and Patient Autonomy	Jul-93		Nov-12	Mar-08	May-96		
End-of-Life Responsibilities and Palliative Care	Oct-99		Jan-13	Mar-08	May-07		

Drug Overdose Prevention	Sep-08		Mar-13	Sep-08			
Professional Use of Social Media	Mar-13		Mar-13				
The Treatment of Obesity	Oct-87		May-13	Nov-10	Jan-05	Mar-96	
Contact With Patients Before Prescribing	Nov-99		May-13	Jul-10	Feb-01		
Medical Record Documentation	May-94		May-13	May-09	May-96		
Retention of Medical Records	May-98		Jul-13	May-09			
Capital Punishment	Jan-07		Jul-13	Jul-09			
Professional Obligations pertaining to incompetence, impairment, and unethical conduct of healthcare providers	Nov-98		Sept-13	Mar-10	Nov-98		
Unethical Agreements in Complaint Settlements	Nov-93		Sept-13	Mar-10	May-96		
Guidelines for Avoiding Misunderstandings During Physical Examinations	May-91		Jan-14	Jul-10	Oct-02	Feb-01	Jan-01

CURRENT POSITION STATEMENT:

Access to medical records

A licensee's policies and practices relating to medical records under his or her control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. Such policies and practices should conform to applicable federal and state laws governing health information.

It is the position of the North Carolina Medical Board that notes made by a licensee in the course of diagnosing and treating patients are primarily for the licensee's use and to promote continuity of care. Patients, however, have a substantial right of access to their medical records and a qualified right to amend their records pursuant to the HIPAA privacy regulations.

Medical records are confidential documents and should only be released when permitted by law or with proper written authorization of the patient. Licensees are responsible for safeguarding and protecting the medical record and for providing adequate security measures.

Each licensee has a duty on the request of a patient or the patient's representative to release a copy of the record in a timely manner to the patient or the patient's representative, unless the licensee believes that such release would endanger the patient's life or cause harm to another person. This includes medical records received from other licensee offices or health care facilities. A summary may be provided in lieu of providing access to or copies of medical records only if the patient agrees in advance to such a summary and to any fees imposed for its production.

Licensees may charge a reasonable fee for the preparation and/or the photocopying of medical and other records. To assist in avoiding misunderstandings, and for a reasonable fee, the licensee should be willing to review the medical records with the patient at the patient's request. Medical records should not be withheld because an account is overdue or a bill is owed (including charges for copies or summaries of medical records).

Should it be the licensee's policy to complete insurance or other forms for established patients, it is the position of the Board that the licensee should complete those forms in a timely manner. If a form is simple, the licensee should perform this task for no fee. If a form is complex, the licensee may charge a reasonable fee.

To prevent misunderstandings, the licensee's policies about providing copies or summaries of medical records and about completing forms should be made available in writing to patients when the licensee-patient relationship begins.

Licensees should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those records.*

When responding to subpoenas for medical records, unless there is a court or administrative order, licensees should follow the applicable federal regulations.

[*] See also Position Statement on Departures from or Closings of Medical Practices.

(Adopted November 1993) (Amended May 1996, September 1997, March 2002, August 2003, September 2010)

PHYSICIANS PRESENTED AT THE
MAY 2014 BOARD MEETING

Abdu, William Alan	MD
Abdulmajeed, Firas Nabeel	MD
Abedi, Scott Sina	MD
Adam, Lindsay Elise	MD
Agboola, Olabunmi	MD
Aguilar, John	MD
Akinyemi, Foluke Adeola	MD
Alavian, Shereen Azam	MD
Ali, Sadiq	MD
Aljishi, Wael Zaki	MD
Allen, Mathias Wallace	MD
Andrews, Charles William	MD
Ansley, Katherine Cox	MD
Arhebamen, Ebinehita	MD
Arrieta, Julio Miguel	MD
Asandra, Christopher Formmit	MD
Awan, Amjad Naeem	MD
Azarcon, Fernando Cunanan	MD
Bader, Matthew Thomas	MD
Baker, Delores Faye	MD
Balachandran, Sivanthan	MD
Bandi, Sindura	DO
Bates, James Myrick	MD
Bayles, Bruce Callahan	MD
Bazylewicz, Daniel Bynum	MD
Bedoya, Armando Diego	MD
Behalal-Bock, Christele	MD
Bell, Woodrow Anthony	MD
Berkowitz, Joshua Norstrom	MD
Betito, Shara Ann David	MD
Blagrave, Troy Alexander	MD
Blake, Hugo Guillermo	MD
Boin, Markus Alexander	MD
Borstad, Gregory Clark	MD
Bradley, Anika Goodwin	MD

Broga, Mary Dawson	MD
Brooks, Millard Colin	MD
Brown, Patrick Allen	MD
Bryant, Ashley Lovegrove	MD
Bullock, William Michael	MD
Burbank, Allison Jane	MD
Burgardt, Sara Tavernier	MD
Burkhart, Brian Wesley	MD
Burton, Elan Chanel	MD
Busch, Michael Ryan	DO
Cadet, Magdalena	MD
Campbell, Dennis Michael	MD
Cannon, Eliot Howard	MD
Cardella, Stephanie Davis	MD
Carter, Lucretia Ann	MD
Caruso, Louis	MD
Cash, Cassandra Lane	MD
Castillo, Marcela Carolina	MD
Cayelli, Maria Aurora Obleada	MD
Chadha, Shannon Nicole	MD
Chakrabarti, Anjan K	MD
Chamberlain, Rachel Elaine	MD
Chang, Min Ho	MD
Charo, Satish	MD
Chaves, Ian Joseph	MD
Chester, Earl Michael	MD
Cho, William	MD
Chung, Bruce	MD
Clarke, Raymond Elroy	MD
Cobb, Lauren Patterson	MD
Cohen, David Joshua	MD
Collins, Jeannie	MD
Connelly, Mark Stephen	MD
Cooley, Adam Daniel	DO
Copponex, Keri	MD
Corley, Bonnie Sierra	MD
Cox, Eric Russell	MD
Cox, James Gregory	MD
Cox, Thomas Philip	MD
Cox, Tiffany Candace	MD
Crane, Scott Anthony	MD
Cruz Colon, Merari	MD
Cunningham, Samantha Lynne	DO
D'Alessio, David Andrew	MD
Dandy, Zorana Margareta	MD

Daniel, Alyssa Searles	MD
Darsie, Marin Elyse	MD
Davis, Thomas Preston	MD
Day, Wendy Krout	MD
De Ment, Samuel Houston	MD
Deines, Jake James	MD
Desai, Sheetal	MD
Determann, Jason Robert	MD
Dharod, Ajay	MD
Dizon, Arthur Michael	MD
Doak, Hoyt Buchannan	MD
Dodgen, Amber Cathleen	MD
Dolezal, Rudolph Frank	MD
Dolgner, Anna Elise Teeter	MD
Donohoe, Andrew Joseph	MD
Dorsch, James Alexander	MD
Dorsey, Ann Le	MD
Dorton, Leighanne Hoskins	MD
Douglas, Laurie Lea	MD
Dowling, Michael Scott	MD
Drimer-Kagan, Taly	MD
Drosieko, Amanda Guyton	MD
Duke, Meredith Colleen	MD
Echague Colman, Ramon Antonio	MD
Edwards, Johnathan James	MD
Eichenberger, Joshua Lee	MD
Eichhorn, Ryan Edward	DO
Eitel, Douglas Ray	MD
Elaprolu, Kishore	MD
Elliott, Amanda Leigh	MD
Ellis, Clayton Tyler	MD
Eluri, Swathi	MD
Erickson, David Andrew	MD
Evans, Julia Sudjai	MD
Everett, Vanessa Lynn	MD
Evers, Michael Francis	DO
Fagan, Royce Milton	MD
Falcone-Gritter, Lori	DO
Farela, Hector Marcelo	MD
Feldman, Amy Sarah	MD
Feldmann, Edward	MD
Ferkel, Eric Ian	MD
Fetter, Maya Dagher	MD
Fleishman, Kenneth Edwin	MD
Fletchall Belle, Catherine Marie	DO

Frey, Ala Stanford	MD
Frye, NailaRashida Larena	MD
Funches, Josalyn Camille	MD
Gaeta, Stephen Andrew	MD
Gallagher, Joel Louis	MD
Gathers, Sekuleo	MD
Ghadimi, Kamrouz	MD
Ghiaseddin, Ashley Parham	MD
Giovacchini, Coral Xantia	MD
Glicksman, Zachary Samuel	MD
Goldman, Matthew Patrick	MD
Goodson-Gerami, Leah Rebecca	DO
Graves, Donna Chandler	MD
Gray, Ernest Robin	MD
Gregory, Michael Walter	MD
Griggs, Christopher Allen	MD
Grimm, John Piper	MD
Gross, Andrew Francis Leigh	MD
Gupta, Sonia	MD
Hairford, Amber Moser	MD
Haney, John Carroll	MD
Hanmer, Janel Zelsnack	MD
Harbin, James Douglas	MD
Harper, Willie Earl	MD
Harrell, Misha Oswald	DO
Hart, Darlington Ibifubara	MD
Hauck, Margaret Gipson	MD
Hawk, Angela Fisher	MD
Hearn, Bevin Elizabeth	MD
Heling, Andrew Zachary	MD
Henderson, Kamal Hanee	MD
Hendry, Robert Malcolm	MD
Heninger, Wendelin Marie	MD
Herndon, Alison Claire	MD
Hicks, John Reddick	MD
Hildebrand, Jason Paul	MD
Hill, Charles Arthur	MD
Hines, Andrew Uriah	MD
Hoff, Heather Sue	MD
Hoffman, James	DO
Holdgate, Nicholas	MD
Hollowell, Lauren Alexandra	MD
Houghton, Damon Eugene	MD
Houseknecht, Kristin Walsh	MD
Hsu, Andrew Ray	MD

Hudson, Janice Marie	MD
Hughes, Jennifer Rebecca	MD
Hughes, Julia Terese	MD
Hunt, Christiane Kelly	DO
Hunt, Patricia Catherine	DO
Hurd, Marie Anne	DO
Hurst, Rebecca Lynn	MD
Husain, Zehra	MD
Iroku, Ugonna Chidebe	MD
Jaffe, Adam Robert	DO
Jain, Vikalp	MD
Javadi, Sanaz	MD
Jegede, Olugbemiga Ebenezer	MD
Jennings, Stuart Clark	MD
Jessie, Timothy Antonio	MD
Johnson, David Bryan	MD
Joshi, Hiren Jagdish	MD
Joyner, Patrick Wakefield	MD
Justice, Phillip Eugene	DO
Kampe, Doris	MD
Kaplan, Shelby Ann	MD
Karikari, Isaac Obiri	MD
Kasten, Kevin Richard	MD
Kaufman, William Sargent	MD
Keller, Frank Goulding	MD
Kerg, Melissa Fenner	MD
Khaira, Divis Kaur	MD
Khalid, Omer	MD
Khan, Farah	MD
Khan, Muhammad Arsalan	MD
Kiely, Amanda Elizabeth	MD
Kilpatrick, Lauren Ann	MD
Kim, Myung Hyo	MD
King, Jennifer Carroll	MD
King-Tucker, Rebecca Suzanna	MD
Knapik, Thersia Jeane	MD
Knettel, Christine Thomas	MD
Knight, Ryan Melink	MD
Koberlein, George Christopher	MD
Kodali, Sashikanth	MD
Kommel, Daniel Brent	DO
Kopke, Sonali Soral	DO
Koser, Andras	MD
Kovell, Robert Caleb	MD
Krashin, Jamie Sarah Weiss	MD

Kreiner, Melanie Marie	MD
Kroll, Peter Brian	MD
Kuremsky, Jeffrey Griffin	MD
Kwon, Andrew	MD
Lareau, Craig Richard	MD
Lash, Tyler Donald	MD
Laughlin, Frank	MD
Lawsin, Loredo Manuel	MD
Lerche, Eric Benjamin	DO
Lipton, Matthew David	MD
Litchfield, Norman Paul	MD
Liu, Pai	MD
Lockett, Lawrence Mark	MD
Long, Andrea Michelle	MD
Long, James Alan	MD
Lopez-Morell, Lorraine	MD
Lucin, Tricia	MD
Magill, Ashleigh Marie	MD
Magill, Mark Erich	MD
Mago-Shah, Deesha Dhaval	MD
Mahoney-Tesoriero, Katherine	MD
Maisonave, Yasmin	MD
Maki, Ahmed	DO
Mammarappallil, Joseph George	MD
Mann, Laura Beth	MD
Manzari, Nicholas J	MD
Marchant, Bryan Edward	MD
Mathew, Soni	MD
Matthews, Cody Elias	DO
Matthews, Kirk Joseph	MD
Mazhar, Kashif	MD
McBeth, Ryan Kent	MD
McCahill, Peter Woods	MD
McEntee, Jennifer Jo	MD
McGinn, Margaret Kathryn	MD
McGrath, Michael Steven	MD
McGrath, Todd Michael	MD
McLaurin, Mary Ann	MD
Menard, Mary Kathryn	MD
Miller, Deana Helen	MD
Miller, Diane Lee	MD
Mitchell, Aaron Philip	MD
Mitchell, Thomas Creighton	MD
Mock, Clare Kelleher	MD
Mogal, Harveshp Darabshah	MD

Mogannam, Paul Nabeel	MD
Moore, Catherine Elizabeth	MD
Morejon, Alberto	DO
Mountjoy, Ryan James	MD
Mrelashvili, Davit	MD
Mudrick, Colin Alexander	MD
Mullins-Frashier, Erin Marie	DO
Murphy, Geoffrey Scott	MD
Muslimani, Alaa	MD
Muzaffar, Bilal	MD
Myrick, William Michael	MD
Nagaraja, Harsha Ghatge	MD
Nelson, Lawrence Grant	MD
Nicholson, Elizabeth Smith	MD
Noel, Richard Joseph	MD
Norris, Jeanette Elizabeth	MD
Nussbaum, Nathan Coleman	MD
Ochoa Nunez, Luis Alberto	MD
Okpalike, Martin	MD
Oliverson, Bryant G	MD
Olney, Stacey Cassandra	MD
Oloruntoba, Omobonike Oyindasola	MD
Ordaz Vernet, Enrique Jose	MD
Owens, Yvette Nicole	MD
Pace, Jesse William	DO
Padilla, Leybelis	MD
Page, Laura Caitlin	MD
Palmer, Jacquelyn Anne Virgi	MD
Pancholi, Suchita Shirish	MD
Parasca, Adrian	MD
Parikh, Mona	MD
Patel, Purvi Rajanikant	DO
Patel, Yuval Adrash Dinesh	MD
Patterson, Jonathan Ryan	MD
Patterson, Morgan Uriah Amanda	MD
Pennington, Emily Joy	MD
Pennock, Gregory Keith	MD
Peters, Luke Allen	MD
Petersen, Anne Katherine	MD
Phillips, Brett Thomas	MD
Pierce, Julian Thomas	MD
Polin, Carrie Monica	MD
Poole, Shannon Rise	MD
Proctor, Matthew Scott	MD

Pugh, Terrence MacArthur	MD
Quevedo, Reinaldo James	MD
Raimer, David William	MD
Rathbun, Kimberly Michelle	MD
Renner, Richard John	MD
Rhoads, Charles Francis	MD
Rice, David Jamaar	MD
Richardson, Anne Shelton	MD
Rietz, Ashley Marie	MD
Ritter, Samuel Isaac	MD
Rivera, Lisa Katherine	DO
Roberts, John Victor	MD
Robertson, Tia Laurice	MD
Robinson, Shaun Bradley	MD
Robinson, Todd Wayne	MD
Ronald, Leah Scanlin	MD
Rose, Amanda Marie	MD
Rountree, Michael Brian	MD
Rubelowsky, Joseph John	MD
Ryan, Adam Thomas	MD
Ryder, Sara Elizabeth	MD
Sadun, Rebecca Eli	MD
Saldana, Sandra	MD
Samuels, Victoria Rene	MD
Sandbulte, Jennifer Thomas	MD
Sanderlin, James Barry	MD
Sanders, Terry Gene	MD
Saraceno, Elli Bonnett	MD
Saunders, Jeffrey Austin	MD
Savaliya, Vipul Arvindhai	MD
Sawhney, Victor	MD
Schaefer, Laura Elizabeth	MD
Schiff, Lauren Dalya	MD
Schooler, Gary Robert	MD
Scialla, Julia Jarrard	MD
Scialla, Timothy Jude	MD
Scott, Christopher Dean	MD
Scott, Jennifer King	MD
Scott, Robert Eugene	MD
Selak, Monica Ann	MD
Shah, Rahul	MD
Sharp, Allison	DO
Shrode, Charles Willard	MD
Sieber, Martha Ann	DO
Silverman, Rod Spencer	MD

Silverstein, Evan	MD
Simpkin, Rebecca Kay	MD
Sinno, Mona Anwar	MD
Smith, Theodore Ravenel	MD
Smith, Thomas Warren	MD
Smith, Vernon Curtiss	MD
Soles, Meredith Key	MD
Sombutmai, Chut	DO
Sprouse, Gretchen Dawn Egbert	MD
Stanton, Monica Williams	MD
Steljes, Alan David	MD
Stephens, Sarah Ellen Elza	MD
Stevens, Mark Thomas	MD
Stup, Bryan Dwayne	MD
Suarez, Arturo	MD
Sung, Julia Anne Marsh	MD
Supaswud-Franks, Tingnong	MD
Sutton, Charles Kenneth	MD
Swiger, Kristopher Joel	MD
Tan, Antoinette Roslyn	MD
Tanner, Allen Hershel	MD
Tarokh, Saeed	MD
Tarugu, Shilpa	MD
Teel, Nickole Rucker	MD
Tegen, Lance Patrick	MD
Thimmappa, Brinda	MD
Thompson, Eric Michael	MD
Thompson, James Austin	MD
Thomsen, William Christopher	MD
Thorp, Brian David	MD
Thottathikunnath George, Wales	MD
Tichindelean, Carmen	MD
Ting, Juk Ling	MD
Treese, Theodore R	MD
Trimble, Aaron Thomas	MD
Trott, Joscelyn Anthony	MD
Tucker, Elizabeth Anne Foard	MD
Tulbert, Brittain Hammill	MD
Tunke, Laura	MD
Turner, Kevin Orlando	DO
Tutera, Dominic Fredrick	MD
Van Horn, William Archie	MD
Vander Schaaf, Emily Beth	MD
VanSweden, Paul	MD
Virkler, Joel Andrew	DO

Voris, Andrew Charles	MD
Wagner, William Frederick	MD
Wasserman, Sara Dana	MD
Weisberg, Lynne Beth Willing	MD
White, Gina McClure	MD
Willen, Shaina Marissa	MD
Williams, Adam Richard	MD
Williams, Felicia Nicole	MD
Williams, John Howard	MD
Willis, Heather Lynn	MD
Wysham, Nicholas Graham	MD
Yadav, Sunny	MD
Yang, Jing-Jing	MD
Yarbrough, Craig Michael	MD
Yee, Edward S.	MD
Yokubaitis, Kendall Walters	MD
Yu, Michael Kuo-Pin	MD
Zelig, Craig Michael	MD
Ziomek, Paul Henry	MD

APPENDIX G

Nurse Practitioner & Clinical Pharmacist Practitioner Approvals
Issued As of May 2014

Nurse Practitioners

NAME	PRIMARY SUPERVISOR	PRACTICE CITY
Susan Blair Hill	Edgar Lee McPherson	Winston-Salem
Lindsey Wright Naumuk	David Patrick Boyte	Durham
Wendy Smith Fields	Frederick Ernest Moore	Yanceyville
Kristina Brown Deloache	Wayne Alfred Price	Chapel Hill
Emina Riebock	Matthew Charles Wakefield	Greensboro
Michael S Jutte	Terence William Kolb	Sylva
Andrea Doreen Jutte	Terence William Kolb	Sylva
Rhonda Wells Lucas	Ignacio Cabezudo	Yanceyville
Kathryn Humphrey Dries	Robert William Patterson	Sanford
Lucretia Paul Newkirk	Sanjay Batish	Leland
Leanna Jo Worsham	Jonathan Mark Collins	Charlotte
Marlynna Christian Haas	Boris Michael Krivitsky	Charlotte
Karen Alice Schneider	Michael James	Raleigh
Kawanna Torrie Skinner	Andrew Eluonye Ighade	Charlotte
Lindsey Nichole Ricci	Billy Lee Price	Hickory
Susan Miskovich Mehta	Michael John Lalor	Winston-Salem
Myron Javon Falkner	Rajeshree Tulloo Dimkpa	Salisbury
Janice Sellers Macopson	Fernando Alberto De La Serna	Morganton
Jennifer Renee Mako Turner	Beat Daniel Steiner	Raleigh
Theresa Robertson Mcdonald	James Lawrence Horwitz	Hendersonville
Diane Janine Duffy	James Lawrence Horwitz	Hendersonville

Rebecca Dawn Shatley	Kenneth Frank Curl	North Wilkesboro
Rebecca Dawn Shatley	Kenneth Frank Curl	North Wilkesboro
Rebecca Dawn Shatley	Kenneth Frank Curl	North Wilkesboro
Rebecca Dawn Shatley	Ademola Olubusola Aderoju	North Wilkesboro
Linda Simpson Grimes	Herbert William Harris	Chapel Hill
Joanna Campbell Hunter Egan	Jomari Sheila Torres	Salisbury
Lindsey Foster Strader	Gary Anthony Smith	Henderson
Teresa W Blanc	Courtney Dawn Mull	Marion
Jennifer Raynor Smith	Johnnie Lewis Moultrie	Hope Mills
Sandra Krol Baker	Gary Norman Greenberg	Raleigh
Nancy Elizabeth Frye	Suzanne Elizabeth Hilton	Winston-Salem
Ashley Smith Barnes	Shannon Ramsey Jimenez	Goldsboro
Lee-Marie Davis Hinson	Timothy Lee Dagenhart	Salisbury
Janice Tillery Myrick	Mario Grazia Fiorilli	Roanoke Rapids
Mika Lynn Johnson	Ronnie Lynn Jacobs	Asheville
Jamie Vano	Pierce Butler Irby	Charlotte
Susan Lill Craven	Randall Robert Joe	Asheville
Susan Lill Craven	Sampson Emanuel Harrell	Durham
Susan Lill Craven	Sampson Emanuel Harrell	Durham
Jeffrey John Maynard	Mario Augusto Rojas	Winston-Salem
Robert Christopher Pennebaker	James Shelton Wells	Hillsborough
Christopher Keith Parris	Jerry Thomas Ziglar	Yadkinville
Christy Williams Welborn	Denzil Dean Patton	Greenville
Danielle Elisabeth Hecht	Darlyne Menscer	Charlotte
Molly Jean Crossman	Gretchen Sauer Stuart	Chapel Hill
Wilmot Lambert	Jaspal Singh	Charlotte
Autumn Kirsten Peterson	George Ofori-Amanfo	Durham
Paige Koonts Tesh	Cherrie Dawn Welch	Winston-Salem
Erin Elise Huprich	Janet Kidd Dear	Burlington
Kristen Leigh Coletti-Giesler	Thomas James Doohan	Monroe
Sara Jean Deasley	Robert William Lenfestey	Durham
Jamie Vano	Gaurav Sachdev	Charlotte
Sherry Lisette Clark	Annmarie Mazzocchi	Winston Salem
Richard Patrick Worth	Jerry Thomas Ziglar	Yadkinville
Albert Petrus Wirawan	Ugwuala Nwauche	Charlotte
Kathy Koehn Mills	Thomas Emil Gross	Mooresville
Lada Flynn	Alexander Ong Sy	Raleigh
Sharon Golden-Myers	Hector Estepan	Patterson
Kelly Jean Pate	Singaravelu Jagadeesan	Cary
Lynn Nicholson Bryant	James Gary Guerrini	Clemmons
Erica Gustavson Howard	Janet Kidd Dear	Burlington
Ashley Harwell Lauer	Jerry Thomas Ziglar	Yadkinville
Lizette Dalmau Retis	Mark Warren McManus	Morganton
Mary Perry	Gonzalo Cabral	Wilson
Julie Spradlin Small	Robert Harvey Weinstein	Wilmington

Christopher D. Breuer	Robert Michael Smith	Charlotte
Meghan Elizabeth Husmillo	Jon-David Hoppenfeld	Charlotte
Elaine Dorean Kauschinger	Adrienne Christine Tounsel	Raleigh
Angela Champion	Sanziana Alina Roman	Durham
Carole Jane Worthington	Michael Avandale Lawrence	Greenville
Lynn Elizabeth Lam	Vikram Reddy Penumalli	Greensboro
Valerie Lavoie	James Youngchull Kim	Greensboro
Ravi K Jasti	Kenneth Stuart Lee	Greenville
Lisa Bailey Wilbanks	Sachin Surendra Mody	Matthews
Megan Lisa Hribernik	Jonathan Michael Bishop	Winston Salem
Christel Daye Fehr	Chad Daniel Howard	Charlotte
Layne Cox Weaver	Philip Hanks McGowen	Oak Ridge
Robert Christopher Salter	Edward Parker Hays	Charlotte
Camille Marie Patti	Christopher Eugene Lord	Charlotte
Aubrey Anne Balmer	Victor Adan	Franklin
Darren Thomas Absher	Louie Keith Scott	Winston Salem
Denise Shivar Neal	Henry Alexander Easley	Wilmington
Anna Shaw Kirk	Daniel Jordan Forest	Winston-Salem
Tracy Vaughn	Jomari Sheila Torres	Salisbury
Heather Anderson Grant	Jerry Thomas Ziglar	Yadkinville
Sheri Jean Komdeur	Mihaela Alina Vatca	Elkin
Kelly Quinn	Patrick Jacques Laguerre	Mooresville
Ashley Jean Jones	Tracy Lee Phelps	Shelby
Emily Bissinger Rivenbark	Midesha Pillay	Wilmington
Stephanie Lomax Johnson	John Francis Kliesch	Charlotte
Vivian Jill Lowery	Mathukutty Joseph	Rutherfordton
Josephine Ochulo Onuoha	Archana Kumar	Greensboro
Lisa J. Ryan	Caroline McIntosh Guerry Lewis	Hendersonville
Pauline Deannia Faircloth	David Alan Schutzer	Fayetteville
Sondra Huffman Solomon	Herbert William Harris	Chapel Hill
Erin Nicole De Guzman	Herbert William Harris	Chapel Hill
Sara Lynne Kitts	Brian Mingtao Go	Raleigh
Ashley Harwell Lauer	James Stuart McGrath	Yadkinville
Sarah Elizabeth Mccloy	Chris Michael Teigland	Charlotte
Wendi Lynne Harper-Lonabaugh	Carole Sue Saltzman	Asheville
Katherine Joy Kelly	Laura Kristin Newby	Durham
Julie Ann Wallace	Jonathan Mark Collins	Charlotte
Lauren Nicole Browne	Christopher Snyder	Charlotte
Valarie Mae Goines	Sylvia Maria McQueen	Brentwood
Colleen Theresa Wojciechowski	Jeannette Fischer Stein	Durham
Jasmine Marie Richards	Mathukutty Joseph	Rutherfordton
Julie Elizabeth Alexander	Gary Norman Greenberg	Raleigh
Alison Jean Brancato	Joseph Michael Falsone	Raleigh
Amie Marie Gray	David Lee Simel	Durham
Donna Hooks Mclean	Gary Gene Leonhardt	Greenville

Maria Candela Gil	Scott Cody Elston	Morrisville
David Edward Guinn	Larry Shelton Kilby	North Wilkesboro
Jennifer Leslie Simpson	Robert Ataollah Nahouraii	Charlotte
Tabatha Lee Obeda	Godfrey Dele Onime	Lumberton
Sandra Anne Klug	Beth Gillen Hodges	Asheboro
Shakti Akshay Desai	John Joseph Hart	Knightdale
Jacqueline Annette Sroka	Ellen Shannon Story	Charlotte
Brenda Lewis Poole	Ram A. Sapasetty	Kinston
Brenda Lewis Poole	Ram A. Sapasetty	Kinston
Brenda Lewis Poole	Ram A. Sapasetty	Kinston
Eileen A. Slavin	James Alexis MacDonald	Winston-Salem
Lashonda Hogue Barnette	James Edward Needell	Gastonia
Jami Ann Bell	John Leighton Wilson	Asheville
Courtney Chostner Whitley	Andrew Robert Shulstad	Charlotte
Charlotte Lum Nche	Rebecca Blanchard Everly	High Point
Amy Bolynn Turlington	Robert James Updaw	Charlotte
Nicole Brooker	Myleme Ojinga Harrison	Raleigh
Elizabeth Ann Burkholder	Sachin Surendra Mody	Matthews
Megan Lynn Monroe	John Willard Cromer	Wilmington
Corey Allyson Guess	Theodore Alan Frank	Charlotte
Michelle Franklin Edwards	Michelle Allyson Matthews	Greensboro
Sonya Minter Montgomery	Joseph Charles Crozier	Durham
Nicholas Scott Bassett	Anne Elizabeth Stephenson	Butner
Karen Patterson Pulido	Robert William Monteiro	Chapel Hill
Robin Brown Cook	Roshni Parag Patel	Monroe
Ijeoma Chinego Anen	Alexander Ong Sy	Raleigh
Ashley Marie Bostian	Christopher John Magryta	Salisbury
Jamie Poling Dickerhoff	David Alan Schutzer	Fayetteville
Laurel Kay Socha	Dukjin Im	Fairfax
Lorraine Lea Waguespack	Tara Nichole Piech	Goldsboro
Tabitha Hunt Cousart	James Stuart McGrath	Yadkinville
Jessica Woodie Rutledge	Sherry J Saxonhouse	Charlotte
Joan Elizabeth Lange	Kenneth Robert Huber	Charlotte
Jens Kersten Palmer	Seung Won Kim	Raleigh
Andrea Doreen Jutte	Edward Parker Hays	Charlotte
Michael S Jutte	Edward Parker Hays	Charlotte
Megan Lynn Monroe	John Willard Cromer	Wilmington
Rebecca Dawn Gray	Richard Micheal Pavelock	Statesville
Sara Little Hubbell	Scott Cody Elston	Morrisville
Donna Botz Adams	Carlos Manuel De Castro	Durham
Theresa B. Keiser	James Almer Smith	Raleigh
Laureen Claire Koehler	Gregory Lee Jones	Belhaven
Keatah Bakari Brooks	Amy Catherine Denham	Chapel Hill
Karen Schramm Saylor	Jessica Stewart	Chapel Hill
Monica Robinson Durant	Sonya Wynee Buchanan	Cleveland

Lauren Hunter Langley	Robert McLain Adams	Wilmington
Kenneth Nathan Gregory	Lillian Patricia Burke	Greenville
Jena Lynn Welch Coltrane	Pamela D. Harris	Wilmington
Kandace Burnette Page	Timothy Lee Dagenhart	Salisbury
Danielle Maria Mazzocca	Thomas Edwin Meek	Rutherford College
Kim Renae English	David Anthony Henderson	Charlotte
Roland William Rogers, II	Jennifer Lynn Abbott	Asheville
Heather Michelle Boykin	Eric Warren Raasch	Raleigh
Pamela Lowry Burr	Rebecca Jean Love	Shelby
Lela Louise Badham Peele	Susan Downer Foreman	Greenville
Wendy Errett Leogrande	Larry Joe Russell	Hendersonville
Lindsay Alder Wojciechowski	Andrea Steele Lukes	Durham
Celia Forno	Jamila Randolph Battle	Raleigh
Darla Stilley Stevens	Scott Shannon Lindblom	Charlotte
Felicia Denise James	Todd Frederick Griffith	Charlotte
Elizabeth Ellis Kenemer	James Richard Sowell	Lenoir
Charlotte Watson Cassell	Darryl Rhyne	Elkin
Martha Jean Arietti	Daniel Jordan Forest	Winston-Salem
Katie Olive Gilbert	James Richard Sowell	Lenoir
Stephanie Ann Winfrey	Scott Farrell Gallagher	Winston-Salem
Jamie Ambler Banwell	Elizabeth Estill Campbell	Raleigh
Kathy Jo Asbury	James Richard Sowell	Lenoir
Darren Thomas Absher	James Gary Guerrini	Clemmons
Karen Cooke Lewis	Steven Lee Sanderson	Hickory
Carolyn Lyda Carter	Christopher John Patterson	Spartanburg
Burton Otis Shelton	Christopher James Phillips	Winston-Salem
Susan Nolette Benware	Rodger Alan Liddle	Durham
Melissa Hope Locklear	Seung Won Kim	Raleigh
Carla A Gibson-Detering	Elizabeth Ann Lacy	Shelby
Tracy Rubash Land	Mark Kevin Jacob	Greenville
Shelia Moorer Griffin	Melissa Jo-Ann Weatherspoon-Cupid	Charlotte
Crista Katherine Walters	Dwight Dudley Koeberl	Durham
Shelly Gupton Kutchma	David Timothy Tanaka	Durham
Leigh K. Mcgowan	Gregory Vincent Collins	Charlotte
Christine Hicks Thomas	Carol Minnette Gibbs	Durham
Amy Howell Hudson	Christopher David Seiders	Asheville
Tania Mattioli Carter	Karen Elina Bowen	Kernersville
Deneda Thomas Daye	Rajeshree Tulloo Dimkpa	Salisbury
Tammy Denise Garcia	Rajeshree Tulloo Dimkpa	Salisbury
Ertha Jeter	Joseph Robert Zanga	Durham
Perry Samuel Jenkins	Marie Ann Sprague	Camp Lejeune
Belinda Kyeiwah Kyere	Michelle Allyson Matthews	Greensboro
Mary Catherine Scott Lowe	Kaaren Sue Sailer	Charlotte
Kathryn Ann Stansbury-Rollack	Charles Edward Jahrsdorfer	Greenville

Lucretia Paul Newkirk	Michael George Rallis	Burgaw
Lucretia Paul Newkirk	Michael George Rallis	Burgaw
Sandra Jensen Rieske	Jose Enrique Gonzalez	Wilmington
Theresa A. Isaacs	Rebecca Jean Love	Shelby
Chizomam Ugoeze Ononiwu	Erika Beth Gromelski Myers	Charlotte
Stephanie Nichole Machalicky	Maria Carmela La Via	Chapel Hill
Brooke Howie Grooms	Staley Thomas Jackson	Lumberton
Mary Nneka Egbuniwe	Alehegn Asres	High Point
Sara Zelikoff Robertson	Shamsher Singh Ahluwalia	Burlington
Marie Huffmaster Thomas	Walter Azubuike Ezeigbo	Winston-Salem
Rebecca C. Owens	Eve Applebaum Knapp	Greensboro
Kandice Leigh Reining Jones	Darren Wohl	Mebane
Heather Davenport Small	Jerry Allen Simpson	Greenville
Jennifer Sprung Parsons	Richard Levi Boortz-Marx	Durham
Jennifer Linville Warren	Wynne Elizabeth Woodyear	High Point
Jennifer Linville Warren	Wynne Elizabeth Woodyear	High Point
Karin Denise Looper	Rebecca Concetta Tummons	Grover
Karin Denise Looper	Rebecca Concetta Tummons	Grover
Arnette Olivia Everett	Lacy Alston Colson	Raleigh
Jill Patton Fleming	Louie Keith Scott	Winston Salem
Andrew Emerson Craig	David Steven Lancaster	Charlotte
Kerri Jill Smith	Fernando Rodrigo Moya	Wilmington
Wanda Barley Watlington	Katherine Ann Farris	Winston-Salem
Kathy Sanders Settle	Jamie Alpern Lovdal	Fort Bragg
Regina Kirwan Wardwell	Laurel Evans Broadhurst	Black Mountain
Lois Kachner Smith	Boris Michael Krivitsky	Charlotte
Lois Kachner Smith	Rebecca Jean Love	Shelby
Margaret Mozingo Mullins	Danielle J. Darter	Jefferson
W. Gail Floyd Sherman	Robert Wilson Kieffer	Asheville
Kathy Garner Brown	Kristin Denise Hicks	High Point
Eva Karol Fields	Frederick David Weigel	Asheville
Amy Lohse Nix	Michael Joseph Hoilien	Fort Bragg
Victoria Runyon Snyder	Joseph Todd Perry	Winston-Salem
Mallory Williams Grose	Louie Keith Scott	Winston Salem
Felicia Patterson Washington	Lionel Fernando	Rose Hill
Jennifer Michele Marzolf	James Franklin Barwick	Washington
Traci R. Bramlett	Edgar Olin Horger	Wilmington
Alicia Ann Nossov	Marian Janet Lenhart Keyser	Raleigh
Latricia Dail Chastain	Philip Dean Veatch	Albemarle
Bryan Keith Monroe	James Earl West	Pembroke
Myron Javon Falkner	Logan Gabriel Graddy	Durham
Audra Cave Malone	Donna Brock McGee	Horse Shoe
Mctisa Michelle Lane	Kingsley Chuks Ugochukwu	Fuquay-Varina
Melanie Denny	Michael Dean Sheaffer	Franklin
Sharon Rising Wilkerson	Robert William Patterson	Sanford

Corazon Ignacio Halsey	Rosemary Jackson	Miami
Judith Cashwell Jackson Malina	Jason Bradley Kihneman	Hickory
Judith Cashwell Jackson Malina	Jason Bradley Kihneman	Hickory
Lora D Solomon	Jonathan Keith Stoudmire	Concord
Jo A Dowell	Adrienne Charles Classen	Elkin
Jennifer Domville Navra	John Joseph Hart	Knightdale
Jennifer Schwartz Dziwanowski	Kent Vincent Lucas	New Bern
Andrea Wilkes Mcchesney	Susan Merle Rakley	Durham
Sally Irene Cody	Mark Alan Gilbert	Murphy
Julie Diana Baker	Adrienne Christine Tounsel	Durham
Angela Jacquelyn Sharpe	Frank Salvatore Pancotto	Concord
Robin Rosenberg Viviano	Jamila Randolph Battle	Raleigh
Teresa Nell Duncan	Jeffrey Allen Walker	Asheville
Joanna Morris Kumar	Michelle Elaine Wilkinson	Gastonia
Kimberly Sharna Squires	Pamela Jean Wright-Etter	Charlotte
Julie Ann Wallace	John Steven Corder	Hickory
Kathleen Ann Rowe	Jeffrey Edward Abrams	Raleigh
Lisa Mcintosh Long	Mark Tillotson	Bolivia
Mary Zech Chapley	Carroll Bracey Robertson	Elizabeth City
Amanda Cole Valentine	Julie Marie Pinder	Winston-Salem
Sandra Schoenitz Terry	Herman Chavis	Red Springs
Anne Maria Green	Christine Ann Petzing	Nags Head
Jennifer Doby Davis	William Elbert Means	Winston-Salem
Kimberly Baker Gitter	Patrick Hank Pun	Durham
Elizabeth Leigh Bell	Tracy Lynn Setji	Durham

CLINICAL PHARMACIST PRACTITIONERS

Arey, Jane Jennelle
Clark, Kristie Dawn
Clements, Julia Freudenberg
Elden, Jennifer Ann
Herman, Erika Susanne
Maldonado, Angela Que
Morgan, Katherine Parise
Peak, Jared Daniel
Stehmer, Theresa Marie

APPENDIX H

Anesthesiologist Assistant, Perfusionist & Provisional Perfusionist Licenses
Issued As of May 2014

Perfusionists:

None

Anesthesiologist Assistants:

None

APPENDIX I

North Carolina Medical Board
PA Licenses Approved
May 2014

Initial PA Applicants Licensed 03/01/14 – 04/30/14

PA-Cs

Name	
Abe-Lathan, Moboluwade Duduyemi	03/06/2014
Albright, Elizabeth Rae Bakisae	03/18/2014
Awad, Ehab Anwar	04/15/2014
Bailey, Alexis	04/25/2014
Ballard, Brandon Wayne	04/16/2014
Becker, Natalia Kohl	03/07/2014
Belayneh, Zelalem Amare	03/21/2014
Bell, Robert Edward	03/12/2014
Bennett, Kristine Marie	03/21/2014
Bleau, Tracey Amanda	03/18/2014

Boles, Benjamin Keith	03/04/2014
Bolton, Joshua Kyle	03/05/2014
Boyd, Brandon Alexander	03/24/2014
Boyle, Rebecca	03/21/2014
Broyan, Channing Constance	03/19/2014
Buckingham, Brandie Rose	03/17/2014
Coleman, Joseph	03/21/2014
Comer, Megan Boyd	03/12/2014
Conner, Seth G	03/05/2014
Dager, Katie Lynn	04/30/2014
Dement, Jared K	03/25/2014
Diaz De Arce, Matthew Ryan	04/30/2014
Doviak, Lorna Frances-Jacqueline	4/30/2014
Dunford, Kathleen Jones	03/24/2014
Eller, Lauren	04/16/2014
Epstein, Melissa Anna	03/14/2014
Fiori, Michele Christine	03/05/2014
Gage, Colin H	04/09/2014
Gandarillas, Jesus Manuel	04/04/2014
Gilbert, Lynn Styers	04/30/2014
Godfrey, Alexandra Heloise	4/30/2014
Gray, Kelli Lauren	04/09/2014
Guilford, Jennifer Elaine	04/30/2014
Hackler, Timothy Marshall George	03/24/2014
Hardy, Abigail Joan	04/16/2014
Henderson, Joshua Mark	04/09/2014
Hoefer, Tiffani Ann	04/16/2014
Horton, Deyanira L	04/03/2014
Howell, Katy Lee	03/24/2014
Huyghue, Yolanda Marie	04/09/2014
Janocha, Jennifer Marie	03/19/2014
Leddy, Margaret Gorman	03/07/2014
Lee, Elizabeth	03/18/2014
Longoria, Nicole Marie	04/23/2014
McCarthy, Shawn	04/15/2014
Mckinney, Ashley	03/25/2014
McNamara, Megan	03/05/2014
Mencel, Johanna Elizabeth Hughes	04/16/2014
Miele, Erin Lee	04/15/2014
Moles, Kyndra Dawn	04/16/2014
Moore, Catrina Tia	03/21/2014
O'Donnell, Shannon Michelle	03/04/2014
Perez, Kristen Leigh	03/21/2014
Pozeg, Dena Marie	04/03/2014
Puryear, Joel Harry	03/05/2014

Reynolds, Ross Anthony	03/04/2014
Richardson, Jordan Elizabeth	04/08/2014
Rockwell, Alexis Ann	03/12/2014
Scherbart, Krista Kathleen	04/25/2014
Schulenborg, Laura	03/25/2014
Soma, Robert William	04/30/2014
Stavenger, Christopher Paul	04/09/2014
Stoia, Joel	04/30/2014
Thomas, Carissa Leigh	04/30/2014
Webb, Brittany Meadows	04/17/2014
Wuerthele, Megan	03/04/2014

PA-Cs Reactivations/Reinstatements/Re-Entries

Name

Benge, Timothy Fred	04/22/2014
Gambill, Cara Lee	03/17/2014
Jackson, Eugene Francis	03/25/2014
Lee, Lee-Thierry Tien	04/24/2014
Vail, Cynthia S.	04/10/2014

Additional Supervisor List 03/01/14 – 04/30/14

PA-Cs Name	Primary Supervisor	Practice City
Abe-Lathan, Moboluwade	Housman, Tamara	Raleigh
Adams, Tiffanie	Nguyen, Tuong	Charlotte
Adams, Tiffanie	Nguyen, Thao	Charlotte
Albright, Elizabeth	Fleishman, Samuel	Fayetteville
Al-Jarboua, LaTasha	Monds, Alvah	Gatesville
Anderson, Kenneth	Gardner, Todd	Statesville
Asher Prince, Heather	Gay, Cynthia	Chapel Hill
Ashton, Kristine	Smith, James	Raleigh
Barrow, Kenneth	Buzzanell, Charles	Asheville
Beam, Amanda	Ahmed, Maqsood	Knightdale
Bechtol, Brian	Geertz, Christopher	Hickory
Becker, Natalia	Maughan, Robert	Fayetteville
Belayneh, Zelalem	Gerardo, Charles	Durham
Bell, Caroline	Murphy, Sean	Winston Salem
Berg, Pilar	Gumber, Subhash	Raleigh
Biermann, Jennifer	Stuart, Gretchen	Chapel Hill
Black, Tracy	Collins, Jonathan	Charlotte
Blocher-Steiner, Sarah	Peace, Robin	Lumberton
Bodner, Gayle	Forest, Daniel	Winston Salem
Bolduc, Gary	Anderson, Kent	Goldsboro

Boles, Benjamin	Bissette, Stephen	Winston Salem
Boney, Mary	Prose, Neil	Durham
Bosley, Jeffrey	Klumpar, David	Pinehurst
Boyd, Brandon	Schranz, Craig	Elizabeth City
Boyle, Rebecca	Shah, Radhika	Durham
Bradey, George	Veser, Belynda	Columbus
Bradley, Robin	Patel, Ashesh	Concord
Branch, Sara	Wood, Christopher	Sanford
Brandt, Sarah	Glass, Gregory	Mount Holly
Brown, Sara	Voulgaropoulos, Menelaos	Huntersville
Brydge, Aleta	Oliver, David	New Bern
Buckingham, Brandie	Sachdev, Gaurav	Charlotte
Buckingham, Brandie	Sachdev, Gaurav	Charlotte
Buckingham, Brandie	Singh, Jaspal	Charlotte
Buckland, David	Bradley, Betty	Biscoe
Burke, Dalissia	Anderson, Robert	Charlotte
Burke, Dalissia	Ellington, John	Charlotte
Butler, Kimberlee	Strickland, James	Burlington
Caban, Ami	Fleishman, Henry	Charlotte
Caceres, Jorge	Roberts, Joseph	Tarheel
Caffey, Karen	Bowen, Samuel	Hickory
Callagy, Karen	Pridgen, James	Holly Ridge
Caputo, Shawne	Nixon, Deborah	Charlotte
Cargill, Laura	Kiger, Tara	New Bern
Carpenter, Iliana	Bayless, Teah	Durham
Caudell, Judd	Price, Cecil	Winston Salem
Chambers, Detra	Belk, Cathy	Dunn
Chambers, Gregory	Raad, George	Charlotte
Chavis, Anthony	Keating, Janet	Butner
Cheney, David	Tedesco, Mark	Charlotte
Childers, Zesta	Fowlkes, William	Wilson
Childers, Zesta	McCaleb, Jane	Roanoke Rapids
Churchill, Kimberly	Curtin, Brian	Charlotte
Clement, Ryan	Stanley, Samuel	Durham
Cohen, Bambi	Lachiewicz, Paul	Durham
Cohen, Keisha	Burson, Jana	Fayetteville
Coleman, Joseph	Vaden, Tracela	Charlotte
Colley, Harvey	Denning, Christopher	Gastonia
Comer, Megan	Shah, Binit	Huntersville
Conner, Seth	Lindblom, Scott	Charlotte
Cowell, Jacqueline	Abrons, Seymore	Wilmington
Crawford, Todd	Llewellyn, Samara	Winston Salem
Curtis, Tami	Koewler, Thomas	Charlotte
Cutler, Robert	Buchanan, Sonya	Charlotte
Cyril, Sabrina	Hager, Angela	Fayetteville

Czuchra, Dennis	Biggers, William	Kinston
Dasnoit, Robert	Weingold, Matthew	Greensboro
Dasnoit, Robert	Kuzma, Kevin	Greensboro
Davis, Ashley	Catz, Nitzan	Smithfield
DelBene, Laura	Skipper, Eric	Charlotte
Dell'Orso, Thaddeus	Alleman, Matthew	Raleigh
Despaigne, Policarpo	Lyons, Esther	Edenton
Diaz Perez, Juana	Sun, Yun	High Point
Diaz, Roger	Clark, William	Raleigh
Diaz, Roger	Samia, Mark	Raleigh
Dicker, Elizabeth	Stuart, Gretchen	Chapel Hill
Diehl, Jason	Perry, Glenn	Charlotte
Dorsey, Natalie	Coin, Wendy	Asheville
Doty, Elissa	Abrams, Jeffrey	Raleigh
Driver, Phyllis	Watson, Stanley	Clayton
Dropkin, Evan	Abbruzzese, James	Durham
Dropkin, Evan	Blobe, Gerard	Durham
DuCharme, Robert	Kiefer, Mark	Lincolnton
DuCharme, Robert	Mazzola, Joseph	Morganton
DuCharme, Robert	DePietro, Perry	Charlotte
DuCharme, Robert	Koch, Daniel	Lincolnton
DuCharme, Robert	MacGuire, Osborne	Morganton
Dyer, Eric	Beam, Robert	Kernersville
Earl, Tracy	Wolyniak, Joseph	Charlotte
Eddins, Marla	Singh, Jaspal	Charlotte
Elam, Mary Jo	Rowson, Jonathan	Laurinburg
Eller, Lauren	Ginn, Thomas	Salisbury
Embry, Brandy	Reyes, Rodolfo	Dunn
Ensign, Todd	Towarnicky, Michael	Pollocksville
Fields, Bobby	Piech, Tara	Goldsboro
Fiori, Michele	Kon, Neal	Winston Salem
Flores, Elizabeth	Ferrucci, William	Rutherford College
Flowers, Sunnie	Conforti, John	Winston Salem
Fulford, Samantha	Dalvi, Gauri	Hope Mills
Fulford, Samantha	Shuler, Jimmie	Spring Lake
Funk, Tracy	Wells, Matthew	Fayetteville
Fuqua, Jennifer	Forest, Daniel	Winston Salem
Gage, Colin	Laing, Valerie	Knightdale
Gaines, Catherine	Britt, Samuel	Lumberton
Galgano, Christopher	Daggubati, Ramesh	Greenville
Galgano, Christopher	Jacob, Mark	Greenville
Gallagher, Erin	Rizzieri, David	Durham
Galloway, Ayanna	Qureshi, Nosheen	Charlotte
Gambill, Cara	Ruch, David	Durham
Gandarillas, Jesus	Martinie, Daniel	Charlotte

Gandhi, Safal	Nunley, James	Durham
Gann, Tiffany	Moore, Donald	Madison
Garris, Erin	Chowdhury, Sharif	Raleigh
Gartman, Jennifer	Peace, Robin	Lumberton
Gartman, Truman	Shakir, Mohamad	Fayetteville
Gauthier, Cherie	Koewler, Thomas	Huntersville
Glasgow, Cheryl	Forest, Daniel	Winston Salem
Gonzales, Lazaro	Fukushima, Takanori	Raleigh
Graham, Barbara	Baptiste, Kimberly	Fayetteville
Graham, Jennifer	Simmons, Andrea	Lumberton
Grippon, Nathalie	Perry, Robert	Greenville
Groh, Christopher	Hurrelbrink, Lester	High Point
Gvalani, Bhavna	Harrelson, Anna	Clayton
Hall, Cheryl	Halberg, Andy	Hendersonville
Hallock, Jason	Kolb, Terence	Sylva
Hanopole, Jennifer	Walsh, Thomas	High Point
Hanopole, Jennifer	Bowen, Karen	Kernersville
Hardin, Lindsey	Halberg, Andy	Hendersonville
Harding, Jamie	Kathard, Haresh	Louisburg
Harding, Leeanna	Raad, George	Charlotte
Harp, Wayne	Bowen, Samuel	Hickory
Hartman, Nancy	Gouzenne, Stacey	Greensboro
Henderson, Alveta	Everly, Rebecca	High Point
Hesse, Candice	Lambeth, William	Cary
Hill, Crystal	Bryant, Michael	Fayetteville
Hill, Tina-Marie	Hays, Edward	Rutherfordton
Hinshaw, Jeffrey	Hunter, Kyle	Danbury
Hinson, Sherry	Martin, William	Elkin
Hlavacek, Sarah	Seaman, David	Louisburg
Ho, Thuy	Pierre, Shervon	Gastonia
Ho, Thuy	James-Nzambele, Shana	Gastonia
Hobbs, Joseph	Persaud, Kavita	Winnabow
Hogan, Justin	Halberg, Andy	Sylva
Hogan, Justin	Patel, Hiren	Asheville
Holland, Geoffrey	Rose, Junius	Wilmington
Holmes, Jessica	Patterson, Robert	Sanford
Hoover, Ryan	Fajgenbaum, Michael	Raleigh
Hope, Jessica	Sachar, Ravish	Raleigh
Hout, Brittany	Mitchell, Rajan	Randleman
Howard, Brittany	Tebbit, Christopher	Charlotte
Howell, Ashley	Gibbs, Michael	Charlotte
Hunt, Hal	Lowry, Tulula	Pembroke
Hunter, Sara	Selley, Victoria	Morehead City
Hurley, Patrick	Ziglar, Jerry	Yadkinville
Isaac, Irene	Joslyn, Emerson	High Point

Izquierdo, Joanna	Toledo, Teodoro	High Point
Jackson, Eugene	Mutch, Gary	Eden
Jackson, Eugene	Dallara, John	Eden
Jackson, Eugene	Mortenson, Ashley	Eden
Jackson, Eugene	Lekwuwa, Okafor	Eden
Janocha, Jennifer	Neuspiel, Daniel	Charlotte
Janocha, Jennifer	Baker, Marty	Charlotte
Jasienowski, Julie	Mitchell, Rajan	Asheboro
Jenkins, Ambria	Yenni, Lawrence	Raleigh
Jenkins, Ambria	Charron, George	Raleigh
Johnston, Rebecca	Lucas, Wayne	Pinehurst
Johnston, Rebecca	Swantkowski, Thomas	Pinehurst
Jones, Andrew	Llewellyn, Samara	Winston Salem
Jones, Kimberly	Morris, Kenneth	Durham
Jones, Lauren	Oberer, Daniel	Charlotte
Kalevas, Karen	Johnson, David	Raleigh
Keen, Robert	Martin, William	Elkin
Kelly, Andrea	Patel, Jitendra	Mooresville
Kelly, Andrea	Gray, Lee	Huntersville
Kelly, Andrea	Cowen, Jonathan	Mooresville
Kerwood, Bethany	Johnson, Michael	Charlotte
Kirby, Kaci	Lee, Melvin	Burlington
Kirk, John	Kader, Ronald	Southern Pines
Konopka, Suzanne	Halberg, Andy	Sylva
LaBonte, Edwina	Halberg, Andy	Brevard
Labs, John	Kim, Edward	Charlotte
Lachowicz, Michael	Smull, David	Winston Salem
Lackey, Jodi	Maughan, Robert	Fayetteville
Lancaster, Rebecca	Mayo, Philip	Goldsboro
Land, Phillip	Chodri, Tanvir	Randleman
Langworth, Rita	Shaw, Kathryn	Raleigh
Lawrence, Leo	Gardner, Todd	Statesville
Le, Bach Tuyet	Gray, Lee	Charlotte
Le, Bach Tuyet	Bray, Kirsten	Charlotte
Leedy, David	Powell, Bayard	Winston Salem
LeGrande, Catherine	Bonsall, Richard	Winston Salem
Lekity, Sarah	Guerrini, James	Clemmons
Levan Elbel, Stephanie	Taavoni, Shohreh	Durham
Lindsley, Alan	FitzHarris, Joseph	Fayetteville
Lisi, Bethany	Shearin, Mary	High Point
Lister, Steven	Roush, Timothy	Charlotte
Lockridge, Emily	Dasher, James	High Point
Lonneman, Kimberly	Weingarten, James	Southport
Lonneman, Kimberly	Bocook, Jessica	Southport
Lonneman, Kimberly	Heter, Michael	Wilmington

Lowery, Jan	Washington, Toni	Pinehurst
Lutz, Michael	Kihneman, Jason	Hickory
Maier, Andrew	Radiontchenko, Alexei	Kernersville
Majka, Peter	Gupta, Manoj	Smithfield
Malanka, Phyllis	Androssov, Andrei	Jacksonville
Maloy, Kelsey	Murphy, Charles	Durham
Mangin, Ross	Shields, Thomas	Winston Salem
Marsh, Mary	Gochnour, Julie	Raleigh
Mason, Ashley	Tuttle, Harrison	Raleigh
Mattera, Paul	Fowlkes, William	Wilson
Mayfield, Evan	Collins, Roger	Raleigh
McCain, Wilda	Patterson, Robert	Fayetteville
McCall, Tanya	Kader, Ronald	Southern Pines
McCann, Raquel	Wells, Roxie	Raeford
McHatton, Timothy	Perry, Robert	Greenville
McMasters, Joy	Vaden, Tracela	Charlotte
McNamara, Megan	Loesch, Heather	Wilmington
Medlin, Laura	Fike, Edgar	Rocky Mount
Medlin, Laura	Martin, Robert	Rocky Mount
Medlin, Laura	Miller, David	Rocky Mount
Melvin, Jacquetta	Stuart, Gretchen	Fayetteville
Michaels, Chase	Badger, Michael	Greensboro
Miele, Erin	Leitner, Joshua	Asheville
Miller, Bruce	Kiger, Tara	New Bern
Minor, David	Frank, Harrison	Charlotte
Mistrot, Sarah	Monahan, Michael	Raleigh
Mohr, Ashley	Jones, Robert	Charlotte
Moles, Kyndra	Tedesco, Mark	Gastonia
Moore, Catrina	Papadonikolakis, Anastasios	Lumberton
Moore, Erin	Quaranta, Brian	Asheville
Moretz, Katherine	Broadhurst, Laurel	Black Mountain
Morgan, Diana	Warshauer, Leo	Wilmington
Morimoto, Victoria	Pillinger, David	Charlotte
Mueller-Brady, Sandy	Pridgen, James	Surf City
Murdock, Monica	Miller, Michael	Charlotte
Na, Judy	Wood, Christopher	Sanford
Neal, Gabrielle	Gottschalk, Bernard	Wilmington
Nelson, Stacy	Kader, Ronald	Southern Pines
Nevels, Marcella	Zamor, Philippe	Charlotte
Norton, Elizabeth	Phillips, Danny	Youngsville
Novak, Lara	Sadler, Natalie	Carrboro
Nowicki, Donna	Stuart, Gretchen	Chapel Hill
Nutt, Linda	Schmeltzer, Paul	Charlotte
O'Buch, Greta	Campbell, Stephen	Asheboro
O'Connor, Brian	Kliesch, John	Charlotte

O'Connor, Brian	Gouzenne, Stacey	Charlotte
Oden, Kristin	Masere, Constant	Lillington
O'Grady, Holly	Lichtenberger, Frank	Charlotte
Ogunniyi, Sola	Frederick, Maximus	Raleigh
Oliveri, Tia	Smith, John	Winston Salem
O'Sullivan, Robert	Mann, Scott	Goldsboro
Overby, Jennifer	Fleming, Brian	Fayetteville
Overby, Jennifer	Mitchell, Sharon	Fayetteville
Page, Constance	Zia, Asif	Lillington
Palmer, Deborah	Williams, Derek	Winston Salem
Parrish, Danielle	Maybee, David	New Bern
Pate, Robert	Brown-Warburton, Heather	Fayetteville
Pavlovic, Megan	Patterson, Robert	Wilmington
Payne, Mark	Kilpatrick, Michaux	High Point
Pedacchio, Misty	Barnes, Daniel	pinehurst
Perkins, Shawnie	Aronoff, Gerald	Charlotte
Person, Jennifer	Biggers, William	Kinston
Pettit, Michelle	Anciano Granadillo, Carlos	Greenville
Phero, Brittany	O'Brien, Patrick	Raleigh
Phillips, Jason	Stopyra, Jason	Asheboro
Phillips, Katlin	Boodram, Natasha	Monroe
Pilkington, Cynthia	Wilkins, Ezra	Raleigh
Poovey, Leah	Pithwa, Sapna	Charlotte
Potts, Timothy	Collins, Steven	Winston Salem
Poulard, Robert	Muhammad, Warees	Fayetteville
Poulard, Robert	Olson, Elis	Fayetteville
Poulard, Robert	Crawford, Clifford	Fayetteville
Powers, Christopher	O'Neal, Scott	Charlotte
Powers, Laurie	Hessenthaler, Mark	Fayetteville
Pozeg, Dena	Goodman, David	Fayetville
Pretter, Leslie	Kerner, Paul	Durham
Prince, Colleen	Motyka, Thomas	Chapel Hill
Quiles, Carmen	Ferguson, Robert	Hope Mills
Quiles, Carmen	Zappa, Michael	Fayetteville
Rabon, Patricia	Falge, Robert	Zebulon
Rader, Nancy	Thompson, Donovan	Lincolnton
Ramirez, Claudia	Harrelson, Anna	Asheville
Reid, Kim	Dagenhart, Timothy	China Grove
Reimers, Charles	Reed, John	Lumberton
Reule, William	Singer, Ronald	Charlotte
Reynolds, Ross	Sharts, Michael	Greenville
Ricker, Melissa	Fernandez, Gonzalo	Garner
Ricker, Melissa	Roy, Brandon	Raleigh
Riffe, Leigh	Readling, Randy	Salisbury
Roach, Jennifer	Burgess, Earle	Charlotte

Robinson, Anthony	Mandhare, Vijaysinha	Raleigh
Rodgers, Carolyn	Pleasant, Henry	Raleigh
Rojas, Brian	Charles, Kirk	Raleigh
Saint, Faith	Fleishman, Henry	Charlotte
Saxena, Neetaben	Box, Emily	Charlotte
Scherer, Christine	Ray, Dipes	Elizabeth City
Schulenborg, Laura	Singh, Jaspal	Charlotte
Schulenborg, Laura	Sachdev, Gaurav	Charlotte
Schuman, Amanda	Bregier, Charles	Matthews
Scoggins, Vince	Sanchez, Ivan	Shelby
Scoggins, Vince	Rosenberg, Brian	Columbus
Scotece, Cecelia	Tan, Valiant	Elizabeth City
Setzler, Heather	Cox, Christopher	Durham
Sexton, Jeremy	Koch, Daniel	Lincolnton
Shaver, Robin	Tedesco, Mark	Charlotte
Shaw, Lindsey	Hall, Timothy	Charlotte
Shedarowich, Kenneth	Slaughter, Van	Pinehurst
Sheets, Victoria	Murphy, Sean	Winston Salem
Shelton, Donna	Dixon, Donovan	Rocky Mount
Shepherd, Angela	Christy, Ralph	Concord
Sierra-Donovan, Mariaeugenia	Wells, Roxie	Raeford
Skinner, Ann	Kolb, Terence	Sylva
Skweir, Suzanne	Stewart, Christopher	Lillington
Smith, Elaine	Thompson, Eric	Charlotte
Smith, Elaine	Patel, Jitendra	Mooresville
Smith, Frances	Gibbs, John	Greenville
Smith, Sean	Ziglar, Jerry	Yadkinville
Snyder, David	Simpson, Jerry	Greenville
Spinicchia, Matthew	Zappa, Michael	Raeford
Srikantha, Venayagaratnam	Mitchell, James	Goldsboro
St. Clair, Robin	Phillips, Christopher	Winston Salem
Stack, Ian	Kader, Ronald	Southern Pines
Stamey, Catherine	Ta, Nang	Charlotte
Stanislaus, Bryan	Lagadapati, Bhavani	Morrisville
Stouder, April	Sutton, Linda	Durham
Sullivan, Colleen	Colwell, Steven	Charlotte
Svedberg, Kelly	Stoudmire, Jonathan	Charlotte
Tahey, James	Best, Randall	Butner
Talbert, Karen	Fernando, Lionel	Wilmington
Talley, Courtney	McNamara, Michael	High Point
Tanner, Van	Miller, Carlton	Durham
Tannery, Krista	Winkley, James	Pinehurst
Taxman, Steven	Chiang, Ambrose	Durham
Tennant, Sara	Abraham, Victor	Wilmington
Tester, Hillary	Watkins, Robert	Cary

Tinsley, Audrey	Ordonez, Esperanza	Raleigh
Todd, Ivy	Young, Cynthia	Cary
Todd, Ivy	Saini, Hari	Fayetteville
Todd, Ivy	Manly, Julie	Raleigh
Todd, James	Seward, Daniel	Concord
Turk, Elona	Harrell, Russell	Aberdeen
Valente, Louis	Smith, William	Winston Salem
Velaz-Faircloth, Maria	Trujillo-Zapata, Jaime	Winston Salem
Wagner, Shawn	Worthen, Mark	Belhaven
Wallace, Connie	South, Bethany	Salisbury
Wallace, Todd	Sy, Alexander	Raleigh
Wangerin-Lile, David	Teater, Donald	Waynesville
Waronsky, Roy	Taylor, William	Salisbury
Weegar, James	Madduri, Murthy	Gastonia
Weiss, Carla	Seder, Jeffrey	Wilmington
Weiss, Daniel	Daggubati, Ramesh	Greenville
Weiss, Daniel	Jacob, Mark	Greenville
Wells, Sarah	Patel, Ashesh	Concord
West, Elizabeth	Hall, Russell	Durham
Westmoreland, Amanda	Williams, Jonathan	Morehead City
Wheeler, Emily	Schoenfeldt, Brent	Albemarle
Wheeler, Hugh	Italia, Hirenkumar	Monroe
White, Steven	DePietro, Perry	Charlotte
Whitney, Douglas	Garison, Gary	Fayetteville
Wiles, Marie	Bitner, Matthew	Henderson
Wilkerson, Sarah	Skalak, Anthony	Greenville
Williams, Mathew	Thomason, Jason	Winston Salem
Williamson, Al	Kader, Ronald	Pinehurst
Williamson-Leon, Tonya	Zimmerman, Clinton	Boone
Wilmoth, Jennifer	Meloy, Thomas	Winston Salem
Wilson, P.	Kenney, James	Henderson
Winn, Jennifer	Halberg, Andy	Asheville
Wolf, Teresa	Rosen, Robert	Winston Salem
Wolpert, Kenneth	Patel, Amit	Raleigh
Wright, Lauren	Patel, Jay	Raleigh
Wright, Lindsay	Luoma, David	Dallas
Wuerthele, Megan	Brown, Robert	Asheboro
Yang, Pangnhia	Purcell, Peter	Lenoir
Yang, Pangnhia	Bast, Randal	Lenoir
Young, Michelle	Kindl, James	Greensboro
Zayas, Teddi	McBride, Robert	Charlotte
Zimmerman, Donielle	Van Trigt, Peter	Greensboro