STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: William F. Long, MD	)	Docket No. MPC 160-1019

AMENDED STIPULATION AND CONSENT ORDER

NOW COME William F. Long, MD, and the State of Vermont, by and through Vermont Attorney General Thomas J. Donovan, Jr. and the undersigned Assistant Attorney General Megan Campbell, and agree and stipulate as follows:

1. William F. Long, MD, ("Respondent") of St. Johnsbury, Vermont holds Vermont medical license number 042.0009733 first issued by the Vermont Board of Medical Practice on August 10, 1998. Respondent is a physician who describes his current medical practice as devoted to providing therapeutic mental health services to patients.

2. Jurisdiction in this matter vests with the Vermont Board of Medical Practice ("the Board") pursuant to 26 V.S.A. §§ 1353-1354, 1370-76 and 3 V.S.A. §§ 809-814, and other authority.

FINDINGS OF FACT

3. Respondent is a solo practitioner in St. Johnsbury, Vermont providing mental health services. He was originally trained as a physician specializing in obstetrics and gynecology, although he no longer practices or retains board certification in that field.

4. The Board opened the above-captioned matter in October of 2019, upon information that Respondent was prescribing stimulant medication to a patient with an active substance use disorder. The matter was assigned to the Central Investigative Committee of the Board ("the Committee").

5. The Committee conducted an extensive investigation of Respondent's prescription practice for patients receiving controlled substances. This investigation included, but was not limited to, the review of medical records and prescribing histories for ten of Respondent's patients.

6. The Committee's investigation identified practice deficiencies related to Respondent's prescribing of controlled substances. The Committee found concerning prescribing practices in the charts of seven of the ten patients whose records were reviewed, hereinafter referred to as Patients 1-7.

7. Respondent continued to prescribe controlled substances to Patients 1-7 all of whom actively struggled with substance use disorders. For several patients, Respondent continued to prescribe addictive medication during periods when he knew his patients were relapsing. Examples of Respondent's concerning prescribing practices include:

a. Respondent was seeing Patient 1 for psychotherapy. Patient 1 had an active substance use disorder involving opioids and alcohol, as well as chronic health issues which included attention deficit hyperactivity disorder ("ADHD"), post-traumatic stress disorder ("PTSD"), depression, and lower back pain. Patient 1 was in a Medication-Assisted Treatment ("MAT") program with another provider.

b. Respondent was Patient 1's mental health provider, yet he prescribed her short-acting opioids to treat acute pain for conditions such as dental pain in May 2017 and hip/buttock pain from June 2017 to April 2018. Respondent did not institute safety measures to monitor for the potential diversion of this medication. Respondent also failed to follow requirements of the Vermont Department of Health's Rule Governing the Prescribing of Opioids for Pain effective July 1, 2017 including obtaining a signed Informed Consent from the patient, using a Controlled Substance Treatment Agreement, and performing a risk assessment.

c. Respondent prescribed Patient 1 immediate release methylphenidate, a stimulant sold under the brand name Ritalin. He made no documentation in Patient 1's records of consideration of safer prescribing choices with a lower misuse potential given her substance use disorder, such as a long-acting stimulant.

d. Patient 1 frequently requested replacement prescriptions for Ritalin from Respondent from 2016 onward when her medication was reportedly lost, stolen, or dropped in the toilet. He provided these replacement prescriptions without any documentation that he checked the Vermont Prescription Monitoring System ("VPMS") to verify what other medications she was prescribed at the time. Respondent was required to check the VPMS system before writing a replacement prescription under the Vermont Department of Health's VPMS Rule.[1]

e. Respondent issued replacement prescriptions for Ritalin to Patient 1 on September 21, 2016 and April 3, 2017 after he discovered that she had not been truthful with him about

[1] Section 6.2.3 of the VPMS Rule mandates that controlled substance prescribers or their delegates query the VPMS system "prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance." Ritalin is a Schedule II controlled substance. This requirement was also in the prior VPMS Rule effective on August 1, 2015.

her medical care on at least two occasions, and received a phone call from a pharmacist expressing concerns about the patient's Ritalin prescription. The patient falsely reported that she had undergone a hip Xray for a fall. She also misrepresented her dosage of suboxone. When the patient was confronted with the discrepancy in her suboxone dosage, she told the Respondent that she had returned the higher dose of suboxone to her MAT program, a claim he never verified with that provider.

f. On April 30, 2018 Patient 1 relapsed on Ritalin by taking her prescribed medication in quantities greater than prescribed. She was also arrested for domestic assault on that date after an attempt to take her husband's Ritalin. [2] Despite Respondent's knowledge of this relapse, on June 27, 2018 he restarted Patient 1's prescription for immediate release Ritalin.

g. Respondent maintained Patient 1 on a long-term prescription of alprazolam, a short-acting benzodiazepine. This prescription was not indicated for this patient given her other prescribed medications and her substance use disorder, as the medication has a high addictive potential and presents a risk of respiratory depression which can be fatal when combined with opioids. Respondent prescribed this medication to Patient 1 at a relatively high dosage (2 mg three times a day) without documenting any communication of the risks of this medication with the patient.

h. Respondent was also the mental health provider for Patient 2, a patient with a substance use disorder relative to opioids, as well as ADHD, PTSD, and depression. During

[2] Respondent also was the mental health provider for Patient 1's husband and prescribed his Ritalin. Respondent had been notified in 2016 that Patient 1's husband was also receiving Ritalin from a second prescriber.

Respondent's treatment of Patient 2, this patient was also seeing a MAT provider for treatment.

i. Respondent prescribed Patient 2 opioids for dental pain without notifying or coordinating with the patient's other providers.

j. Respondent prescribed Patient 2 the benzodiazepine clonazepam at the dosage of 2 mg twice a day from April 2016 to January 2017. Respondent knew that Patient 2 was injecting heroin during the time he was prescribed this benzodiazepine.

k. Respondent's benzodiazepine prescription put Patient 2 in violation of his treatment contract with his MAT provider who was prescribing methadone to Patient 2. Respondent knew the benzodiazepine violated the treatment contract and sanctioned Patient 2's use of the medication in violation of the contract. Respondent did not include documentation in the patient's medical record that he recognized the polypharmacy risks presented by the patient's combined use of heroin, methadone, and the benzodiazepine or that he discussed these risks with Patient 2.

l. In November 2019, Respondent prescribed short-acting Adderall, a stimulant with a high addictive potential, to Patient 2 with knowledge that Patient 2 had recently relapsed on cocaine and heroin. Patient 2's records do not document Respondent's reasoning for prescribing short-acting Adderall rather than safer long-acting medication alternatives which are less susceptible to misuse and diversion.

m. Respondent was the mental health provider for Patient 3, who struggled with substance use disorder related to both opioids and alcohol. Patient 3's other medical conditions included depression, PTSD and chronic pain.

n. In February of 2017, Respondent treated Patient 3's insomnia with the benzodiazepine clonazepam at a dosage of 2 mg at bedtime. Respondent did not discontinue or taper this prescription despite learning that Patient 3 relapsed on opioids two months later. He also did not document communication with Patient 3 about the risks of this polypharmacy.

o. Respondent never queried the Vermont Prescription Monitoring System to determine what if any other prescriptions were being prescribed to Patient 3.[3]

p. Respondent was the mental health provider for Patient 4. Patient 4 had a diagnosis of ADHD as well as a complex substance use disorder pertaining to opioids, cocaine, marijuana, and alcohol. Patient 4 was enrolled in a MAT program with another provider at the time he received treatment from Respondent.

q. Respondent prescribed Patient 4 short-acting stimulants to treat his ADHD. These prescriptions have a high drug misuse potential and hence a high street value compared to long-acting stimulants. He continued these prescriptions for Patient 4 with knowledge that Patient 4 had misused stimulants during prior substance use disorder relapses. Respondent also knew that Patient 4 at times sold these short-acting stimulant prescriptions to buy narcotics.

r. Respondent failed to alter his practice of prescribing short-acting stimulants for Patient 4 in response to Patient 4's heroin overdose in August 2018 or the patient's fentanyl misuse in February 2019.

s. Respondent never queried the Vermont Prescription Monitoring System to determine what if any other prescriptions were being prescribed to Patient 4.

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[3] According to section 6.2.4 of the Vermont Department of Health's VPMS Rule effective on July 1, 2017 a prescriber or their delegate must query the VPMS system "at least annually for patients who are receiving ongoing treatment (treatment without meaningful interruption) with an opioid Schedule II, III, or IV controlled substance." Clonazepam is a Schedule IV controlled substance.

t. Respondent also was the mental health provider for Patient 5, who had a substance use disorder related to alcohol as well as chronic conditions which included ADHD, PTSD, and depression.

u. Respondent prescribed Patient 5 a short-acting stimulant with a high misuse potential. He did not adequately document a rationale for this prescription choice rather than a safer long-acting stimulant given the patient's substance use disorder.

v. Respondent also prescribed benzodiazepines to Patients 5, 6, and 7, who were all patients with substance use disorders, on a long-term basis. He did not document consideration or discussion with the patients of the risks of this prescribing choice.

w. Respondent prescribed Patient 5 and Patient 6 opioids for dental pain without notifying or coordinating with their other providers.

8. On April 7, 2021, Respondent entered into a Voluntary Limitation of Practice Agreement with the Board regarding opioid prescribing.

CONCLUSIONS OF LAW

9. The Board may find "that failure to practice competently by reason of any cause on a single occasion or on multiple occasions constitutes unprofessional conduct." 26 V.S.A. § 1354(b). "Failure to practice competently includes, as determined by the board... (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice." 26 V.S.A. § 1354(b)(1) and (2).

10. Respondent failed to conform to the essential standards of acceptable and prevailing practice in his care of Patients 1-7 As their treating mental health provider, he failed

to make safe prescribing decisions for these patients given their documented substance use disorders, and in the cases of Patients 1- 4, evidence of current relapse.

11. The Board may further find unprofessional conduct when there is a "gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions, that degree of care, skill, and proficiency that is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred." 26 V.S.A. § 1354(a)(22).

12. Respondent grossly failed to meet this standard in his medical treatment for Patient 1, Patient 2, Patient 3, and Patient 4. His actions prescribing short-acting stimulants to Patients 1, 2, and 4 despite his knowledge of the patients' relapses, and in the case of Patient 4, that the patient was actively diverting the medication he was prescribing, constitute gross failures to meet the standard. His prescribing of short-acting benzodiazepines to Patients 2 and 3 at high dosages despite their relapses on opioids constituted gross failures to meet the standard. The described failures to meet the standard constitute gross failures because of the dangerous additive sedative effects of this polypharmacy and because these prescriptions were neither safe nor indicated for these patients. In all instances above the failure to adequately consider safer options and document the reasons for treating these patients using drugs with a high potential for misuse and harm contribute to the conclusion that these were gross failures to meet the standard.

13. Respondent regularly prescribed opioids to Patient 1 over a ten-month period to treat chronic pain from a variety of medical conditions. The Vermont Department of Health's Rule Governing the Prescribing of Opioids for Pain ("the Rule") establishes minimum standards for prescribers to follow when prescribing opioids, to which Respondent failed to adhere during the course of this patient's treatment. It is unprofessional conduct to fail to comply with

"provisions of federal or State statutes or rules governing the practice of medicine" pursuant to 26 V.S.A. § 1354(a)(27). Respondent committed unprofessional conduct when he failed to comply with the following requirements of the Rule:

a. A prescriber prescribing an opioid for the first time during the course of treatment for a patient shall receive a signed informed consent from the patient which includes information about the drug's potential for misuse and addiction as well as the risk of overdose when the medication is combined with alcohol or other medications. Rule § 4.3.3;

b. Section 6.1.3 of the Rule requires a prescriber prescribing opioids for pain lasting longer than 90 days to document the benefits and relative risks of the opioid in a risk assessment; and

c. Section 6.2.1.5 of the Rule mandates that a prescriber prescribing opioids for pain lasting longer than 90 days include a signed Controlled Substance Treatment Agreement in the patient's medical record including the functional goals of treatment, dispensing pharmacy choice, safe storage and disposal of the medication, and requirements to reasonably and timely inform the prescriber if the patient is misusing the prescribed medication.

14. Respondent failed to comply with the Vermont Prescription Monitoring Rule when he did not query VPMS prior to writing replacement prescriptions for Patient 1's Ritalin as required by section 6.2.3 of the VPMS Rule. He also never queried VPMS during the course of his treatment of Patient 3 or 4 despite prescribing both patients controlled substances. He was required to query VPMS at least annually under section 6.2.4 of the VPMS Rule. Respondent committed unprofessional conduct by failing to comply with these State rules governing the practice of medicine pursuant to 26 V.S.A. § 1354(a)(27).

15. Consistent with Respondent's cooperation with the Board, he agrees that if the State were to file charges against him it could satisfy its burden at a hearing and a finding adverse to him could be entered by the Board, pursuant to 26 V.S.A. §§ 1354(a)(22), (a)(27) and § 1354(b)(1) and (2).

16. Respondent agrees that the Board will adopt and incorporate as its facts and conclusions in this matter Paragraphs 1 through 14 above, and further agrees that this is an adequate basis for the Board actions set forth herein. Any representation by Respondent herein is made solely for the purposes set forth in this agreement.

17. Therefore, in the interest of Respondent's desire to fully and finally resolve the matter presently before the Board, he has determined that he shall enter into this instant agreement with the Board. Respondent enters no further admission here, but to resolve this matter without further time, expense and uncertainty; he has concluded that this agreement is acceptable and in the best interest of the parties.

18. Respondent agrees and understands that by executing this document he is waiving any right to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with a specification of charges and evidence, to cross-examine witnesses, and to offer evidence of his own to contest any allegations by the State.

19. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matter shall be resolved by the Board. Thereafter, the Board will take no further action as to this matter absent non-compliance with the terms and conditions of this document by Respondent.

20. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this document, the entire agreement shall be considered void. Respondent agrees that if the Board does not accept this agreement in its current form, he shall not assert in any subsequent proceeding any claim of prejudice from any such prior consideration. If the Board rejects any part of this agreement, none of its terms shall bind Respondent or constitute an admission of any of the facts of the alleged misconduct, it shall not be used against Respondent in any way, it shall be kept in strict confidence. And it shall be without prejudice to any future disciplinary proceeding and the Board's final determination of any charge against Respondent.

21. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in his permanent Board file, shall constitute an enforceable legal agreement, and may and shall be reported to other licensing authorities, including but not limited to: the Federation of State Medical Boards Board Action Databank and the National Practitioner Data Bank. In exchange for the actions by the Board, as set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order.

22. The parties therefore jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Board, it may enter an order implementing the terms and conditions herein.

ORDER

WHEREFORE, based on the foregoing and the consent of Respondent, it is hereby ORDERED that:

1. Respondent shall be REPRIMANDED for the conduct set forth above.
2. Upon Board approval of this Stipulation, Respondent is hereby relieved from the Voluntary Limitation of Practice Agreement that went into effect on April 7, 2021, but his license will thereupon be conditioned according to the terms below.
3. Respondent's medical license shall be CONDITIONED as follows:
    a. Respondent shall not prescribe opioids. This condition will be permanent. He shall contact the U.S. Drug Enforcement Agency ("DEA") to inform the DEA that his license is conditioned in this manner.
    b. The sole exception to the opioid-prescribing prohibition is that Respondent may prescribe opioids for a single patient, (hereinafter "Patient 1"), until July 1, 2021.[4] Respondent shall cease prescribing all opioids to Patient 1 after July 1, 2021 and he shall not write any opioid prescriptions for Patient 1 that can be filled after July 1, 2021. Respondent is not to increase the prescribed morphine milligram equivalent ("MME") dosage for Patient 1 between the date that this Agreement is signed and July 1, 2021. This exception is created to allow continuity of care for Patient 1 as Respondent is anticipated to have greater barriers to identifying another prescriber and transferring this patient's medical care.

[4] Patient 1's identity is set forth in a confidential sealed filing appended to this Agreement as Appendix A.

c. Respondent shall identify a professional mentor who is available to consult with him for the duration of his medical practice. This mentor will be a psychiatrist or a physician specializing in mental health treatment. His mentor and his practice monitor, as required below in subsection e, should be different people - unless the Committee grants written approval for one provider to fulfill both of these roles. In the event that the Committee approves one provider to be both Respondent's professional mentor and his practice monitor, the Committee may modify the timing and format of the mentor and practice monitoring reports to facilitate the effective transmission of information. Furthermore, the Committee may reconsider its decision that one provider can fulfill both of these roles, and again require separate providers, if it finds at any time that there are issues with the sufficiency of the mentorship/practice monitoring documentation or that additional supervision would benefit Respondent.

Respondent shall obtain approval from the Committee for his choice of mentor. Respondent shall submit in writing to the Committee the mentor's name, contact information, and curriculum vitae. The Committee retains discretion to approve or disapprove the choice of mentor for any reason. The Committee shall communicate in writing its decision to Respondent. If the proposed mentor is not approved, Respondent remains responsible for using the procedure outlined here to select and submit his choice of another proposed mentor for Committee consideration.

The purpose of the mentorship is to provide Respondent with supervision, thus, Respondent and his mentor should communicate at least monthly. Respondent

should submit letters authored by the mentor to the Committee summarizing these communications and including the dates they conferred. These letters should be submitted on the following schedule:

1. Letters should be submitted every three months for the first year.
2. After the first year, Respondent can apply to the Committee to reduce the frequency of the letters to once every six months for the second and third year of the mentorship.
3. At the end of three years Respondent can apply to the Committee to end the mentoring requirement. The decision to end the mentoring requirement at that time will be in the sole discretion of the Committee. Respondent will continue to submit letters to the Committee on an annual basis after the third year of mentoring, until such time as the Committee releases him from the mentoring condition.
4. The Committee will communicate any decision regarding the frequency of mentorship letters or ending the mentorship requirement to Respondent in writing.

If at any time his mentor can no longer participate in the mentorship or is deemed unsuitable by the Committee, Respondent will identify a new mentor who will also be subject to preapproval by the Committee as outlined above. Respondent shall notify the Committee within ten days of learning his mentor is unable to serve, and submit the name, address, and curriculum vitae of a new proposed

mentor within thirty days from that notification unless that time is extended by the Committee for good cause shown.

d. Respondent shall successfully complete two AMA PRA Category 1 continuing medical education ("CME") courses on the following topics: (1) professional boundaries and enabling; and (2) responsible prescribing to include preventing diversion or misuse of controlled substances. Each CME course must be completed no later than one (1) year after this Stipulation is approved by the Board. Respondent shall seek prior approval, in writing, from the Committee for each CME course. These courses must be live in-person or live interactive courses offered remotely. Upon successful completion of each CME course, he shall provide the Committee with proof of attendance. Respondent shall also provide the Committee with a brief written narrative of each CME course which will document what he learned from each course, and how he will apply that knowledge to his practice. Respondent shall provide proof of attendance and the written narrative to the Committee. Respondent shall be solely responsible for all costs associated with meeting these CME requirements.

e. Respondent shall have a "practice monitor" who is a practicing psychiatrist or a physician specializing in mental health treatment for five (5) years subject to the terms and conditions set forth in the attached Practice Monitoring Agreement ("Agreement"), which is incorporated by reference and attached hereto as Exhibit A. The Agreement establishes the procedures for Committee preapproval of the practice monitor and replacement if necessary. The practice monitoring requirement will not begin until the official "start date" as defined in the attached

Agreement. Respondent shall comply with the terms and obligations of the Agreement. Respondent shall provide a copy of this Stipulation and Consent Order to the practice monitor. Respondent shall be responsible for ensuring that the practice monitor complies with the terms and obligations of the Agreement. If after three years Respondent has received consistently positive reports from his practice monitor, he can submit a written request to the Committee to end the monitoring requirement. Such a request will not be considered by the Committee until Respondent has provided three (3) years of favorable and timely monitoring reports. The decision whether to grant or deny the requested relief shall be solely within the discretion of the Committee. The practice monitoring requirement will not cease until the Committee has approved, in writing, Respondent's request to end the monitoring.

f. Respondent shall pay a $5,000 administrative penalty consistent with 26 V.S.A. § 1374(b)(2)(A)(iii). Payment shall be made to the "State of Vermont Board of Medical Practice," and shall be sent to the Vermont Board of Medical Practice office, at the following address: David Herlihy, Executive Director, Vermont Board of Medical Practice, P.O. Box 70, Burlington VT 05402-0070. Payment shall be due no later than two (2) months after this Stipulation and Consent Order is approved by the Board.

SIGNATURES

Dated at Chelsea, Vermont, this ____ day of July, 2021.

STATE OF VERMONT
THOMAS J. DONOVAN, JR.
ATTORNEY GENERAL

by: E-SIGNED by Megan Campbell on 2021-07-22 11:09:05 EDT

Megan Campbell, Esquire
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, VT 05609-1001

Dated at _____, Vermont, this ____ day of _____, 2021.

E-SIGNED by William Long MD on 2021-07-22 12:15:53 EDT

William F. Long, MD
Respondent

AS TO WILLIAM F. LONG, MD
APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

Signed on Behalf of the Vermont Board of Medical Practice

By: _____
Richard Bernstein, MD
Chair
Vermont Board of Medical Practice

Vote documented in the Vermont Board of Medical Practice meeting minutes, dated **August 4**, 2021.

Dated: **August 4, 2021**

PRACTICE MONITORING AGREEMENT

Vermont Board of Medical Practice

William F. Long, MD

Docket No. MPC 160-1019

1. Pursuant to a Stipulation and Consent Order entered into by William F. Long, MD ("Dr. Long") and the Vermont Board of Medical Practice ("the Board") in docket no. MPC 160-1019, Dr. Long has agreed to retain a practice monitor to monitor his medical practice. The purpose of this Practice Monitoring Agreement ("Agreement") is to set forth the terms of the practice monitoring component of Dr. Long's Stipulation and Consent Order (attached and incorporated by reference). This Agreement will be signed by Dr. Long and the practice monitor approved by the Central Investigative Committee ("the Committee").
2. Dr. Long is responsible for selecting a practice monitor.
3. The practice monitor chosen by Dr. Long shall be a Vermont licensed physician with an unconditioned license who has experience in the areas of psychiatry or mental health treatment and stimulant medication prescribing.
4. Dr. Long shall obtain approval from the Committee for his choice of practice monitor. Dr. Long shall submit in writing to the Committee the practice monitor's name, contact information, and curriculum vitae. The Committee retains discretion to approve or disapprove the choice of practice monitor for any reason. The Committee shall communicate in writing its decision to Dr. Long. If the proposed practice monitor is not approved, Dr. Long remains responsible for using the procedure

outlined in paragraphs 2 through 4 of this agreement to select and submit his choice of another proposed practice monitor for Committee consideration.

5. The Board shall not bear any of the costs associated with the practice monitor.
6. Dr. Long shall provide the practice monitor with a copy of the fully executed Stipulation and Consent Order.
7. The practice monitoring shall start within sixty (60) days of the date that the Board approves the Stipulation and Consent Order (hereinafter referred to as the "start date").
8. The practice monitor will follow all state and federal health privacy regulations and statutes, including, but not limited to, HIPAA, and will review and sign any necessary HIPAA authorizations, business associate agreements, or any other required documents to enable access to, and review of, patient protected health information.
9. The practice monitor shall perform a record review every ninety (90) days of Dr. Long's patients with a focus upon those prescribed stimulant medication and/or benzodiazepines. The practice monitor shall select ten (10) of Dr. Long's patients who receive stimulant and/or benzodiazepine medications and review their records, unless there are fewer than ten, in which case it shall be a total of ten including other patients prescribed other controlled substances.
10. The practice monitor shall review any other documents, records, files, logs, etc. that will provide the requisite information needed to prepare written monitoring reports.
11. In the event that Dr. Long joins a group practice, the practice monitor shall speak with Dr. Long's co-workers to obtain the requisite information needed to prepare the written monitoring reports.

12. The practice monitor shall prepare a detailed, written practice monitoring report for each ninety (90) day review. The practice monitor shall meet with Dr. Long every ninety (90) days to discuss the findings of his/her record review. Dr. Long is responsible for ensuring that there is appropriate documentation of each ninety (90) day record review and discussion. Such documentation shall include the date of each record review, and the date and length of time of each discussion between the practice monitor and Dr. Long regarding the findings of each chart review. This documentation shall be submitted with each ninety (90) day practice monitoring report.
13. The practice monitor shall submit each written practice monitoring report to the Committee for five (5) full years. Dr. Long may request relief from this condition after three (3) full years of favorable reports. It will be up to the Committee's sole discretion whether to grant this modification to the length of practice monitoring.
14. The first report shall be submitted no later than sixty (60) days after the practice monitoring agreement is signed.
15. Dr. Long shall be responsible for ensuring that the following is reviewed by the practice monitor and discussed and documented in the practice monitoring reports:
    a. Documentation of each chart review performed by the practice monitor during that review period including the findings of the chart review;
    b. Whether Dr. Long's psychiatric care practice meets the applicable standard of care;
    c. Whether Dr. Long's prescribing practices, including the prescribing of stimulants and/or benzodiazepine medications, meets the standard of care;

d. Whether Dr. Long's clinical monitoring of patients to whom he is prescribing stimulants and/or benzodiazepine medication meets the standard of care;

e. Whether Dr. Long's medical recordkeeping is in accordance with the standard of care;

f. Whether Dr. Long's general medical treatment meets the applicable standard of care; and

g. Recommended improvements to Dr. Long's practice. Although the practice monitor will need to review patient charts to become familiar with patient medical history, the focus of the practice monitoring will be improving Dr. Long's practice prospectively.

16. Dr. Long shall be responsible for ensuring that the practice monitor's reports are timely submitted to the Committee.

17. At the end of the monitoring period, Dr. Long shall submit a written request to the Committee to end the requirement for monitoring. Such a request shall not be considered by the Committee until Dr. Long has provided favorable and timely monitoring reports for five complete years, or three complete years if the Committee approves Dr. Long's request for early relief from the monitoring requirement. The practice monitoring requirement shall not cease until the Committee has approved, in writing, Dr. Long's request to end the monitoring.

18. In the event that the practice monitor can no longer monitor Dr. Long's practice, Dr. Long shall notify the Committee in writing within five (5) business days. Within thirty (30) days of providing notice to the Committee, Dr. Long shall submit the name

of a proposed replacement practice monitor which will be subject to the approval process outlined in paragraphs two through four.

19. Upon notice to the Committee that the practice monitor can no longer serve, Dr. Long has sixty (60) days to obtain Committee approval for a new practice monitor. If a new practice monitor is not approved in that time, Dr. Long shall cease prescribing any stimulants and/or benzodiazepines. Dr. Long shall not resume prescribing stimulants or benzodiazepines until a new practice monitor is approved by the Committee and can begin monitoring his practice. The Committee will endeavor to communicate their decision regarding the approval of a new proposed practice monitor to Dr. Long within thirty (30) days of when he submits the proposed monitor's name, contact information, and curriculum vitae to the Committee. In the event that the Committee's response is delayed beyond thirty (30) days, that additional response time will not count toward the 60-day limit that Dr. Long has to find a new practice monitor or cease prescribing stimulants and benzodiazepines.
20. The Committee retains the unfettered discretion to disapprove Dr. Long's practice monitor at any time. If the Committee disapproves Dr. Long's practice monitor, it will provide Dr. Long with written notice of the disapproval and a brief explanation of the reasons for its decision. Upon receiving this notice Dr. Long shall immediately notify his practice monitor that he/she is no longer authorized to monitor his practice under this Agreement. Consistent with paragraph eighteen above, Dr. Long will seek Committee approval for a new practice monitor. He will cease prescribing stimulants and benzodiazepines if a new monitor is not approved by the Committee within sixty (60) days until such time as the Committee approves a new monitor.

21. Dr. Long and the practice monitor agree that they have both read this Agreement in its entirety and agree to all of the terms and obligations set forth herein.

22. Dr. Long and the practice monitor agree that the terms of this Agreement cannot be amended or modified in any way without written approval of the Committee.

Signatures

DATED at St. Johnsbury, Vermont, this _____ day of July, 2021.

E-SIGNED by William Long MD
on 2021-07-22 12:16:22 EDT

_____
William F. Long, MD

DATED at Montpelier, Vermont, this _____ day of July, 2021.

_____
Practice Monitor