BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
BRETT TYLER QUAVE, MD	)	STIPULATED ORDER
LICENSE NO. MD157375	)	
	)	

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. Brett Tyler Quave, MD (Licensee) is a licensed physician in the State of Oregon.

2.

On February 24, 2022, the Board issued a Complaint and Notice of Proposed Disciplinary Action (Notice) in which the Board proposed to take disciplinary action for violations of the Medical Practice Act, specifically: ORS 677.190(1)(a) unprofessional conduct, as defined in ORS 677.188(4)(a) (*any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public*); ORS 677.190(1)(a) unprofessional conduct, as defined in ORS 677.188(4)(a) (*any conduct or practice contrary to recognized standards of ethics of the medical profession*); and ORS 677.190(17) willful violation of a Board law or rule, specifically, ORS 677.510(7) (*A physician assistant's supervising physician shall ensure that the physician assistant is competent to perform all duties delegated to the physician assistant. The supervising physician or supervising physician organization and the physician assistant are responsible for ensuring the competent practice of the physician assistant.*) and OAR 847-050-0037(2) (*supervising physicians are personally responsible for the direction, supervision and regular review of the medical services provided by the physician assistant, in keeping with the practice agreement or Board-approved practice description*).

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Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee admits that physician assistants under his former supervision were in one instance disciplined pursuant to a Stipulated Order and in another instance retired while under investigation pursuant to a Stipulated Order. Licensee neither admits nor denies, but the Board finds that Licensee's conduct as described in paragraphs 4.2.3, 4.4.6 and 4.4.8 of the February 24, 2022, Complaint and Notice of Proposed Disciplinary Action violated ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); and ORS 677.190(17), specifically, ORS 677.510(7) and OAR 847-050-0037(2). Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Practitioner Data Bank and the Federation of State Medical Boards. Licensee understands the terms of this Order and signs freely, without fraud or duress.

4.

Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following terms and conditions:

4.1 Licensee's practice setting must be pre-approved by the Board's Medical Director, and Licensee must adhere to the practice's well-established procedures for the evaluation and treatment of complex pain patients to include the following:

4.1.1 Licensee will prescribe Narcan for all patients with an MED >/= 50, as recommended by the 2022 CDC Guidelines.

4.1.2 Licensee will maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition of the patient and only consider initiating or maintaining opioid therapy if benefits are anticipated to outweigh risks to the patient.

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4.1.3 Licensee will work with patients to establish treatment goals for pain and improvement in function and consider how opioid therapy will be discontinued if benefits do not outweigh risks.

4.1.4 When initiating opioid therapy for acute, subacute, or chronic pain, Licensee will generally prescribe immediate release opioids instead of extended-release and long-acting opioids.

4.1.5 When opioid pain medication is deemed to be appropriate and necessary for a patient to preserve functionality and quality of life, Licensee will attempt to do so at the lowest effective dosage. This practice will be conducted following the principles of compassionate, individualized, flexible, and person-centered care. In general, this can usually be accomplished at doses </= 50 MED, although sometimes higher doses are required. Doses > 90 MED should be avoided if possible or carefully justified with regular reassessment of risks and benefits.

4.1.6 Licensee will offer or arrange for treatment with evidence-based medications to treat chronic pain patients with opioid use disorder.

4.2 Licensee must review and assess patients on potentially dangerous regimens. For the purpose of this Order, potentially dangerous regimens include:

4.2.1 Opioid medication(s) (other than agonist/antagonists such as buprenorphine) in excess of 30 days in any 120-day period and concomitantly in excess of 90 morphine equivalent dose (MED) as calculated by the CDC calculator.

4.2.2 Opioid medication(s) (other than agonist/antagonists) in excess of 30 days in a 120-day period that are prescribed in combination with any chronic benzodiazepine or carisoprodol (Soma) or both.

4.2.3 Buprenorphine prescribed in combination with pure opioid agonists.

4.2.4 Opioid medication(s) in excess of 30 days in a 120-day period that are prescribed in combination with any chronic benzodiazepine (defined as in excess of 30 days in a 120-day period) or carisoprodol or any of the hypnotics zolpidem, zaleplon, eszopiclone, doxylamine, or ramelteon.

1 4.2.5 Patients on chronic opioids with a concomitant substance use disorder
2 (SUD) involving a second, non-opioid substance (e.g., alcohol use disorder;
3 methamphetamine use disorder; etc.).
4 4.3 When conducting evaluations and follow-up visits with patients on potentially
5 dangerous regimens as defined in term 4.2, Licensee must document in the patient chart:
6 4.3.1 All current diagnoses;
7 4.3.2 Assessment of patient's functional status and the benefit of the drug
8 regimen;
9 4.3.3 Date and findings related to monitoring, to include urinary drug screens
10 (UDS) and checks of the Oregon Prescription Drug Monitoring Program (PDMP) and
11 any actions taken regarding any aberrancies discovered (e.g., multiple prescribers
12 according to the PDMP; more than one early refill; or contraband substances or absence
13 of prescribed medicines or metabolites in the UDS, etc.). In the event that a PDMP check
14 has not been conducted within the prior six-month period, a PDMP check must be
15 conducted and placed in the patient medical record;
16 4.3.4 In the event that a UDS has not been conducted during the prior 6-month,
17 period one must be conducted and documented in the patient medical record; aberrancies
18 must be documented and the plan for appropriate remediation documented;
19 4.3.5 In the event that a Material Risk Notice (MRN) and a pain contract have
20 not been completed in the prior 12-month period, they must be completed and placed in
21 the patient medical record; and
22 4.3.6 In the event that a patient taking chronic methadone has not had an EKG
23 performed in the prior 12-month period, one must be performed and recorded in the
24 patient chart and any abnormal findings must be followed up appropriately;
25 4.4 When conducting evaluations and follow-up visits with patients identified in term
26 4.2 who are prescribed chronic opioids without benzodiazepines or carisoprodol, Licensee must
27 attempt tapering as described below:
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4.4.1 For patients with an oral or parenteral opioid dose in excess of 300 MED as calculated by the CDC calculator, at the time of the visit described in term 4.3 (the index dose), tapering should occur at 10% of the then current dose per month until the MED is 300 or less. Patients on intrathecal opioid medications above the recommended national consensus guidelines should be tapered at 5-10% of the current intrathecal dose per month until current accepted guidelines are reached.

4.4.2 For any patients whose index MED is 300 or less, or any patient successfully tapered down to MED 300 as outlined above, the taper must follow CDC Tapering Guideline for Prescribing Opioids for Chronic Pain with a goal of 5-10% of the then current dose per month until the MED by the CDC calculator is 90 or less.

4.4.3 The patient must be monitored for symptoms of opioid withdrawal and, should any occur, these must be clearly documented in the patient chart and treated appropriately, possibly including a temporary pause of the taper, but not any reversal of the taper, and tapering must resume when withdrawal symptoms have resolved.

4.4.4 When such withdrawal symptoms occur, consideration must be given to transitioning to buprenorphine and the decision-making discussed and documented in the patient chart.

4.4.5 If buprenorphine is not tolerated, a return to a pure agonist is acceptable, but tapering must resume when symptoms resolve.

4.5 When conducting evaluations and follow-up visits with patients identified in term 4.2 who are prescribed opioids in combination with benzodiazepines or carisoprodol or the two together, Licensee must attempt tapering as described below:

4.5.1 Licensee must stop carisoprodol and hypnotics immediately.

4.5.2 Tapering opioids must begin as prescribed in term 4.4 above.

4.5.3 When the MED is 90 or less, Licensee must taper chronic benzodiazepines at a rate of at least 20% of the then current dose per month until benzodiazepines are stopped.

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4.5.4 Licensee must monitor the patient for symptoms of benzodiazepine withdrawal and, should any occur, this must be clearly documented in the patient chart and treated appropriately, possibly including a temporary partial reversal of the taper, but tapering must resume when withdrawal symptoms resolve.

4.5.5 If the patient is being prescribed carisoprodol, hypnotics, or benzodiazepines by a provider outside of Licensee's office (as is most commonly the case), Licensee will alert the provider prescribing the carisoprodol, hypnotic, or benzodiazepine of the dangerous medication combination and collaborate to make a plan to wean and discontinue the carisoprodol, hypnotic, or benzodiazepine. If the carisoprodol, hypnotic, or benzodiazepine is considered essential for the safety and well-being of the patient by the outside prescribing provider, the opioid will either be weaned in the fashion noted in term 4.4 and ultimately discontinued or consideration can be given to converting the direct opioid agonist to buprenorphine. Licensee will review the PDMP to ensure the patient has picked up a prescription of Narcan and provide instructions on its use.

4.6 In the event that a patient identified in term 4.2 cannot or will not taper or transfer to another provider, Licensee will discuss the case with a fellow physician colleague in his pain management practice and co-manage the patient with that physician. If necessary or if directed to do so, Licensee will refer the patient to an appropriate specialist outside of the pain practice such as an addiction specialist or psychiatrist. For the purposes of this Order, co-management must consist of a referral for a formal consultation with a specialist, chart review by the specialist, and a conversation between Licensee and the specialist. The patient must be managed in accordance with the recommendations of the specialist. Video conferencing is acceptable for the consultations with the specialist. All reports from and consultations with the specialist regarding the patient must be retained in a patient's medical record maintained by Licensee. Licensee must bear the cost of any remuneration due the specialist not covered by a third-party payor.

4.7 The above terms do not apply to Licensee's care of patients who are being managed for cancer-related pain, palliative care, hospice, or end-of-life care.

4.8 At the discretion of the Board or its designees, random, no notice chart audits and office visits may be conducted by Board designees.

4.9 Licensee must inform the Compliance Section of the Board of any and all practice sites, as well as any changes in practice address(es), employment, or practice status within 10 business days. Additionally, Licensee must notify the Compliance Section of any changes in contact information within 10 business days.

4.10 Licensee must obey all federal and Oregon state laws and regulations pertaining to the practice of medicine.

4.11 Licensee stipulates and agrees that any violation of the terms of this Order shall be grounds for further disciplinary action under ORS 677.190(17).

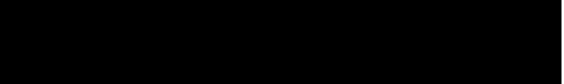
4.12 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

IT IS SO STIPULATED THIS 8th day of June, 2023.

BRETT TYLER QUAVE, MD

IT IS SO ORDERED THIS 6th day of July, 2023.

OREGON MEDICAL BOARD
State of Oregon



ERIN L. CRAMER, PA-C
BOARD CHAIR