IN THE MATTER OF	*	**BEFORE THE**
STEPHANIE HILL, PA-C	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: C06152	*	**Case Number: 2219-0109A**

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CONSENT ORDER

On September 30, 2020, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged Stephanie Hill, PA-C (the "Respondent"), License Number C06152, under the Maryland Physician Assistants Act (the "Act"), Md. Code Ann., Health Occ. §§ 15-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.) The relevant provisions of the Act under Health Occ. § 15-314 provide the following:

Health Occ § 15-314:

(a) Subject to the hearing provisions of § 15-315 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum, may reprimand any physician assistant, place any physician assistant on probation, or suspend or revoke a license if the physician assistant:

...

(22) Fails to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [and]

...

(40) Fails to keep adequate medical records[.]

On December 2, 2020, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of

this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

Panel A finds the following:

1. At all times relevant, the Respondent was licensed to practice as a physician assistant in the State of Maryland. The Respondent was originally licensed in Maryland on June 21, 2016. Her license expired on June 30, 2019 and is non-renewed.

2. The Respondent worked as a physician assistant at a primary care medical practice in Montgomery County, Maryland from March 1, 2018 to June 29, 2018 ("Employer 1") and at a different medical office from August 3, 2018 to October 23, 2018 ("Employer 2"). [1]

The Complaint

3. On or about October 24, 2018, the Board received a Termination of Employment (Delegation Agreement) Report ("Termination Report") notifying the Board that the Respondent was terminated from Employer 1 effective June 29, 2018. The Termination Report stated that the Respondent was terminated for "quality of care issue."

Board Investigation

4. On receipt of the Termination Report, the Board initiated an investigation which included requesting a written response from the Respondent, interviewing the Respondent, subpoenaing employment records from Employers 1 and 2, interviewing

[1] To maintain confidentiality, the name of the hospital or patients will not be identified in this Consent Order.

employees of Employers 1 and 2, subpoenaing seven patient records and transmitting the records to a reviewing organization to conduct an expert review.

5. The Board interviewed two physicians and an office manager of Employer 1 who confirmed that the Respondent was placed on a performance improvement plan because of concerns with her ability to capture the patients' complaints, her timeliness in completing medical notes, her timeliness in responding to messages, her failure to be accessible and her failure to properly document patient records. Because the Respondent did not sufficiently improve her performance, her performance improvement plan was extended for another thirty days. Employer 1 terminated the Respondent on June 29, 2018 after she failed to sufficiently improve her performance.

6. The owner of Employer 2 confirmed that the Respondent was hired on August 3, 2018, and was terminated on October 23, 2018, due to patient care issues, the Respondent's failure to timely complete charts, the Respondent's failure to timely review patient labs and her failure to follow up with patient calls.

Expert Review

7. In furtherance of its investigation, the Board subpoenaed the medical records of seven patients to whom the Respondent provided medical care and submitted those records and related materials for a practice review to a physician assistant delegated to work in internal medicine.

8. The reviewer concluded that the Respondent failed to meet the standard of quality care in four of seven patient records (Patients 1, 2, 3, and 6) and that the

Respondent failed to maintain adequate medical records in five of seven cases (Patients 1, 2, 3, 5, and 6).

9. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to keep adequate medical records when performing evaluations and treatment of patients when she failed to: obtain records from prior providers; take complete health histories; conduct complete evaluations; order applicable tests; and follow up with the patients. The Respondent also failed to document the diagnosis, symptoms, patient surgical history, family history, social history or allergies for many patients. The Respondent further: failed to document the completion of lab tests; failed to counsel patients on substance abuse; failed to coordinate care with other providers; failed to address patients' medical complaints; and reached an incorrect diagnosis.

10. Examples of Respondent's deficiencies are set forth in the following patient summaries:

Patient 1

11. Patient 1, a female in her teens, presented as a new patient with diagnoses of anemia, monopolar depression and nut allergy. The Respondent: failed to obtain records from her prior provider; failed to obtain labs; and failed to note her health history, including menstruation history, surgical history, family history, social history, depression screen and overall maintenance/screening interview to include: physical activity, smoking history alcohol/substance abuse, safety/home environment, sensory screening/eye exam and sexual history. The Respondent's notes failed to include Patient 1's surgical, family,

or social history and did not list depression as an active problem, even though Patient 1 was taking medication for depression.

Patient 2

12. Patient 2, a male in his mid-twenties, presented with complaints of tremors that caused paranesthesia and numbness throughout his body. Patient 2 screened positive for severe depression despite being on medications. The Respondent did not adequately address Patient 2's psychiatric issues and failed to contact Patient 2's providers to address his critical values.

13. The Respondent's treatment records were inadequate and failed to contain sufficient details regarding Patient 2's depression score and how it would be addressed. The Respondent also failed to review Patient 2's surgical, family, or social history. The Respondent failed to provide Patient 2 with any counseling regarding substance abuse. The Respondent should have coordinated care for Patient 2's neurological condition with Patient 2's other care providers. The Respondent's progress notes for Patient 2's present illness were vague and did not include the quantity of his tremors. The Respondent's progress notes contained no surgical history, medical history, social history or allergies and the vaccine history was unclear. The diagnosis was inconsistent with the findings.

Patient 3

14. Patient 3, a female in her mid-sixties, presented with severe abdominal and low back pain. She returned for treatment five days later with continued lower abdominal and left sided back pain. During the initial visit, the Respondent failed to order a urinalysis culture for a suspected urinary tract infection and a basic metabolic panel for a

further evaluation of kidney function. The Respondent should have evaluated Patient 3 with a renal ultrasound or CT scan. The Respondent failed to address Patient 3's pain, although Patient 3 reported a pain score of 9/10. The Respondent's progress notes for Patient 3 were vague and failed to document the updated labs performed during the second visit.

Patient 5

15. Patient 5, a female in her mid-forties, was seen by the Respondent for bruising of her right upper leg. Patient 5's medical record contained information written on a handwritten note that was not in Patient 5's clinical note, and it was not clear if the information was included in Patient 5's chart and available for other providers to see. The printed care plan that was provided to the patient was not included in Patient 5's note. There was no documentation of Patient 5's current medications.

Patient 6

16. Patient 6, a female in her mid-fifties, had a history of hypertension, hypothyroid and migraines and was seen by the Respondent for her routine annual health exam, migraine and hypertension. The Respondent met appropriate standards for the delivery of quality of care for a routine physical examination, but Respondent's diagnosis for the encounter was incorrect. The Respondent's diagnosis of Patient 6 was listed as "Z00.00, Encntr for general adult medical exam w/o abnormal findings." However, Patient 6 had an abnormal finding of hypertension.

17. The Respondent acknowledged hypertension in the assessment with a recommendation for Patient 6 to take blood pressure at home to determine if the reading

was elevated due to white coat syndrome. The Respondent recommended a follow up in six months, but if it were not white coat syndrome, Patient 6 should have had repeat readings in the clinic and readings of both arms with medications to be addressed.

18. The Respondent did not address Patient 6's elevated cholesterol or her migraines. The Respondent's progress notes were incomplete, because she did not document the results of the labs and only stated that labs were reviewed. The Respondent also failed to document and include in the assessment/plan that Patient 6's thyroid panel lab work was within the normal range.

CONCLUSION OF LAW

Based on the Findings of Fact, Disciplinary Panel A of the Board concludes as a matter of law that the Respondent failed to meet the standard of care for the delivery of quality medical care, in violation of Health Occ. § 15-314(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 15-314(a)(40).

ORDER

It is thus by an affirmative vote of a majority of a quorum of Disciplinary Panel A of the Board, hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent is placed on **PROBATION**[2], for a minimum period of **TWO (2) YEARS**. During the probationary period the Respondent shall comply with the following probationary terms and conditions:

[2] The time period of the probation and the conditions for probation are tolled until Respondent applies for reinstatement and is administratively reinstated by the Board. Upon her reinstatement

(1) Within **SIX MONTHS**, the Respondent is required to take and successfully complete a course in the recordkeeping. The following terms apply:

(a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;
(b) the disciplinary panel will accept a course taken in person or, during the state of emergency, a course over the internet;
(c) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the course;
(d) the course may not be used to fulfill the continuing medical education credits required for license renewal;
(e) the Respondent is responsible for the cost of the course

(2) The Respondent shall provide her supervisor with a copy of this Consent Order and any other documents the disciplinary panel deems relevant and she shall ensure that her supervising physician:

(1) reviews the records of 10 patients each month, such patient records to be chosen by the supervisor and not the Respondent;
(2) meets in-person with the Respondent at least once each month and discuss in-person with the Respondent the care the Respondent has provided for these specific patients;
(3) be available to the Respondent for consultations on any patient;
(4) maintains the confidentiality of all medical records and patient information;
(5) provides the Board with quarterly reports which detail the quality of the Respondent's practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve patient care; and
(6) immediately reports to the Board any indication that the Respondent may pose a substantial risk to patients;

(3) if the disciplinary panel, upon consideration of the supervisory reports and the Respondent's response, if any, has a reasonable basis to believe that the Respondent is not meeting the standard of quality care or failing to keep adequate medical records in his or her practice, the disciplinary panel may find a violation of probation after a hearing; it is further

ORDERED that after the minimum period of probation imposed by the Consent Order has passed and the Respondent has fully and satisfactorily complied with all terms and conditions for the probation, the Respondent may submit a written petition to the disciplinary panel for termination of the probation. The Respondent may be required to appear before the disciplinary panel to discuss his or her petition for termination. If the

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the probation and conditions will go into effect.

disciplinary panel determines that it is safe for the Respondent to return to the practice of medicine without the enhanced supervisory requirements, the probation shall be terminated through an order of the disciplinary panel. If the disciplinary panel determines that it is not safe for the Respondent to terminate these conditions, the probationary terms shall be continued through an order of the disciplinary panel for a length of time determined by the disciplinary panel, and the disciplinary panel may impose any additional terms and conditions it deems appropriate;

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board. The Executive Director signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if the disciplinary panel determines there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

ORDERED that this Consent Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

02/17/2021
Date

Signature on File

Christine A. Farrelly, Executive Director

CONSENT

I, Stephanie Hill, PA-C, assert that I am aware of my right to consult with and be represented by counsel in considering this Consent Order and in any proceedings that would otherwise result from the charges currently pending. I have chosen to proceed without counsel and I acknowledge that the decision to proceed without counsel is freely and voluntarily made.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 15-315 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

Signature on File

12/31/2020
Date

Stephanie Hill, PA-C

NOTARY

STATE OF Florida

CITY/COUNTY OF Miami Dade

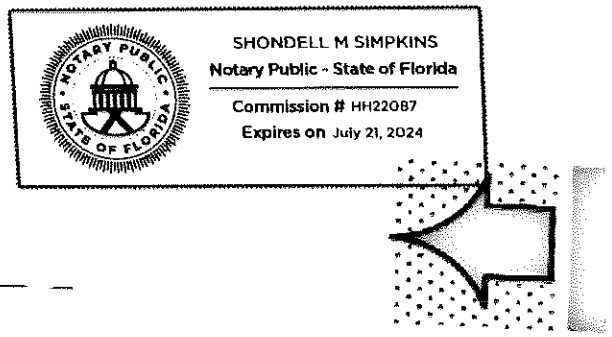
I HEREBY CERTIFY that on this 31st day of December 2020, before me, a Notary Public of the foregoing State and City/County, personally appeared Stephanie Hill, PA-C, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Type of Identification Produced State of Maryland Driver License.

Shondell M Simpkins HH22087

Notary Public



My Commission expires: 07/21/2024

Notarized online using audio-video communication