Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PERFORMANCE INDICATORS, ANNUAL REPORTS, AND STATE MEDICAL DISCIPLINE: A STATE-BY-STATE REVIEW

Richard P. Kusserow
INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

In this study, we seek to contribute to the development and use of performance indicators for State medical boards.

BACKGROUND

How many complaints has a State board received? How many investigations has it initiated? How long has it taken to complete an investigation? How many disciplinary actions per licensee has it taken? How many nondisciplinary educational actions has it taken? In this report, we pose these and 15 other basic questions about the performance of State medical boards, and then identify the extent to which they are answered in the annual reports of these boards. We focus on questions concerning medical discipline, the sphere in which most of our prior work has been conducted. Questions concerning medical licensure are also of importance and warrant similar attention.

FINDINGS

Thirty-three State medical boards issue an annual report; 3 others issue a biennial report.

Overall, the reports provide few answers to the 20 questions. Two answer none of the questions at all. The others rarely offer trend data and typically provide past-year data that respond to only a few of the questions.

The reports are most likely to answer questions concerning the number of complaints received and disciplinary actions taken. In regard to complaints, 29 reports provide summary data for the past year and 12 for prior years as well; for disciplinary actions, the corresponding numbers are 30 and 14.

The lack of information concerning the processing time for cases under review is particularly striking. For the three questions posed on this matter, only three reports provide any information at all.

CONCLUDING OBSERVATIONS

The major value of performance indicators is the opportunity they can provide to make comparative assessments and to raise questions on how performance can be improved.

We suggest that State legislatures mandate that the boards establish a series of performance indicators and provide data on them in annual reports. Toward this end, the National Conference of State Legislatures, the National Governors' Association, the Council of State Governments, the Federation of State Medical Boards, and the United States Public Health Service can play valuable supportive roles as agents for the exchange of ideas and information.

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INTRODUCTION

Performance indicators, expressed in terms of percentages and ratios, can be valuable mechanisms for assessing results and pinpointing accountability. In themselves they do not provide definitive answers about performance. But they can serve as useful guideposts that raise important questions about why things are the way they are and how they might be better. This is particularly so if the data are presented regularly and in a manner that allows for comparative assessment--both of an organization's performance over time and of its performance vis-a-vis that of other like organizations.

In the business world, managers, investors, and others have long relied on performance indicators in assessing a corporation's profitability. Indeed, the Securities and Exchange Commission (SEC) has identified a long list of such indicators and has mandated that any publicly traded corporation provide quarterly data on them. The data address sales per share, earnings per share, percent return on equity, debt-to-equity ratio, and many other performance-related measures.

In the public sector, where objectives tend to be more varied and less precisely defined, performance indicators have been much less commonly used. Yet, in recent years, in response to widespread concern about governmental performance, they have been gaining increased attention. This is apparent in the fields of education and health care, where major efforts are underway to improve the capacity to measure and track performance.[1] It is also apparent in the Chief Financial Officers Act of 1990, which among other things calls for Federal agencies to provide for "the systematic measurement of performance" as part of an integrated accounting and financial management system.[2]

Thus far, State medical boards, which are responsible for the licensure and discipline of physicians, have not made much use of performance indicators. Some movement in that direction, however, appears to be underway. In the fall of 1990, the Federation of State Medical Boards (FSMB), with support from the United States Public Health Service (PHS), initiated a project to develop a self-assessment instrument for the boards.[3] At about the same time, the Citizen Advocacy Center, which provides support to public members of professional licensing boards, issued a draft set of indicators that could be used for evaluating medical boards.[4] More recently, in a May 1991 legislative proposal addressing medical liability and malpractice problems, the White House called for State medical boards to collect and issue a range of performance-related data.[5]

These initiatives are in accord with a recommendation we made in an August 1990 report entitled "State Medical Boards and Medical Discipline,"

(OEI-01-89-00560).[6] In that report, we called upon both the FSMB and the PHS to support the development of quantitative indicators that could contribute to assessment of board performance. Both parties supported the recommendation.

PURPOSE

Through this report, we seek to contribute to the further development and use of performance indicators for State medical boards. In so doing, we address only those board responsibilities concerning medical discipline, the sphere in which most of our prior work has been concentrated. Similar attention, we believe, is warranted for those responsibilities concerning medical licensure.

METHODOLOGY

Instead of proposing specific ratios and percentages that might be used as indicators, we identify 20 basic questions that could provide the basis for such ratios and indicators (see appendix B). We take this approach because it focuses attention on the kind of information that could provide the foundation for developing quantitative indicators.

We pose questions that concern three different facets of the boards' disciplinary responsibilities: (1) the detection of alleged violations, (2) the review of alleged violations, and (3) the resolution of cases. The questions are straightforward ones that are likely to be of interest to those associated with boards and to relevant outsiders, such as governors, State legislatures, and the public. They emerge primarily from our prior work in the field and from our review of an insightful study conducted recently by the Virginia Department of Health Professions.[7]

For each of the 20 questions, we then determine the extent to which answers are available in annual reports on the State medical boards.[8] For the 36 boards that we found produce such reports,[9] we review the most recent reports and indicate whether or not the answers are available, both for the most recent year and for prior years.

We focus on annual reports because of their regular issuance and their public nature. Like the annual reports of corporations conforming to SEC requirements, they represent what can be a visible and important means of accountability to key constituencies.[10]

In the following pages, we start out with an overview of the States having annual reports and of the content of those reports. We then present the State-by-State data for each of the 20 questions, grouped in the 3 categories noted above. We close with a few concluding observations.

STATE MEDICAL BOARDS WITH ANNUAL REPORTS

In an important recent document, an expert panel convened by the Federation of State Medical Boards (FSMB) indicated what it regarded to be the vital elements of a modern State medical board.[11] Among these was the issuing of an annual report. Each year, the panel noted, a board should submit to the governor, the legislature, and the public "a formal report summarizing its licensing and disciplinary activity for that year."[12] It then specified 14 categories of data that at a minimum should be included in the report. Many of them correspond to questions we pose in the following pages.

Compared with the vision set forth by the FSMB panel, the current reality is quite different. Most striking is that the District of Columbia (hereafter referred to as a State) and 14 States still do not produce an annual report (table 1), and they include two of the most populous States in the country--New Jersey and Ohio. Both of these States regularly compile reports naming the physicians who have been disciplined and cite the disciplinary actions taken against them but do not issue yearly statistical summaries in the reports.

The 36 reports that are issued vary greatly. They range from a single-page listing of data on various actions taken by a board to a more than 300-page document including little summary data but detailed descriptions of the findings and conclusions on cases brought before the board. Some are written and organized to reach a general audience; others are presented as technical pieces intended for a limited audience.

Some of the reports offer background information on the board and explanations of some of the activities undertaken during the year. Few provide any analysis of the data's implications for the performance of a board.

Overall, the reports do not provide many answers to our 20 questions. Two of the 36 reports, in fact, answer none of the questions at all. The others seldom provide trend data and typically offer past-year data that are responsive to only a few of the questions.

Many and perhaps most of the State boards do have computerized data bases that could provide many more answers to the questions than those that are presented in the annual reports. Some even prepare summaries of these data bases, which they use for their own information and/or to respond to inquiries made of them.

Table 1

STATE MEDICAL BOARDS WITH ANNUAL REPORTS

State	
AL	X
AK	X
AZ	X
AR	
CA	X
CO	X
CT	X
DE	
DC	
FL	X
GA	
HI	
ID	X
IL	X
IN	X
IA	X
KS	
KY	X
LA	X
ME	X
MD	X
MA	X
MI	X
MN	X
MS	X
MO	
MT	X
NE	
NV	X
NH	
NJ	
NM	X
NY	X
NC	X
ND	
OH	
OK	
OR	X
PA	X
RI	
SC	X
SD	X
TN	
TX	X
UT	X
VT	X
VA	X
WA	X
WV	X
WI	X
WY	X
Total	36

Key: An "X" in the column indicates that an annual report providing information on the activities of the State medical board has been issued in 1989 or thereafter.

Source: State medical boards as reported to the Office of Inspector General.

DETECTION OF ALLEGED VIOLATIONS

In this first set of questions, we direct attention to the identification of physicians who may warrant disciplinary action. We focus on two key variables: complaints and cases.

Complaints, as we and the boards commonly use the term, are broadly defined as possible cases brought to the board's attention by outside sources. They involve claims of alleged wrongdoing submitted by consumers or others. They also involve referrals (sometimes mandated) made by hospitals, law enforcement agencies, professional associations, malpractice insurers, and others.[13] Thus, by the term "complaint," we refer to external sources, of all kinds, that bring possible cases to the attention of the boards.

Because all complaints do not and perhaps should not lead to formal investigations, we distinguish them from cases that boards have actually opened for investigation. This universe of cases is most likely, although not necessarily, smaller than that of complaints. It can be larger since cases can be opened through proactive internal efforts of the boards as well as through complaints from external parties.[14]

In this section we pose 8 questions and review the extent to which the 36 annual reports provide answers to them. The first two questions address the number of complaints received and the number of cases opened; the next two ask if information is provided that compares these totals to the number of licensed physicians in the State. Such information can be more useful than the absolute numbers in assessing changes occurring over time or differences among State boards.

The last four questions introduce two additional variables: complaint source and complaint type. The former we discussed above; the latter distinguishes among various kinds of allegations, such as inappropriate prescribing, criminal misconduct, or self-abuse of drugs. In reviewing data on the type of complaints, the reader should recognize that upon investigation the grounds for possible board action can differ from the nature of the complaint that initiated the process.

The following tables indicate that the reports are much more likely to present data on complaints than on cases opened for investigation. The most complete data concern the absolute number of complaints, with 29 of the 36 reports presenting such data for the past year and 12 for prior years as well. Data on complaints per licensed physician in the State, by complaint source, and by complaint type are almost completely lacking.

In regard to cases opened for investigation, only 16 of the reports offer such information for the past year and 6 for previous years. No reports provide the information on a per-licensed-physician basis, two do so on the basis of complaint source, and four do so on the basis of complaint type.

Question #1

HOW MANY COMPLAINTS HAS THE STATE MEDICAL BOARD RECEIVED?

State	Past Year Data Provided	Trend Data Provided
AL	X	
AK		
AZ	X	X
CA	X	X
CO	X	
CT	X	X
FL	X	X
ID	X	X
IL		
IN		
IA	X	
KY	X	
LA	X	
ME	X	
MD	X	
MA		
MI	X	
MN	X	X
MS	X	
MT	X	X
NV	X	
NM	X	
NY	X	
NC	X	
OR	X	X
PA		
SC	X	
SD	X	X
TX	X	
UT		
VT	X	X
VA	X	X
WA	X	X
WV	X	
WI		
WY	X	
Total	29	12

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s).

Source: State medical boards as reported to the Office of Inspector General.

Question #2

HOW MANY CASES HAS THE BOARD OPENED FOR INVESTIGATION?

State	Past Year Data Provided	Trend Data Provided
AL		
AK	X	
AZ		
CA	X	X
CO		
CT	X	
FL	X	X
ID		
IL		
IN		
IA	X	
KY	X	
LA	X	
ME		
MD	X	
MA		
MI	X	
MN		
MS	X	
MT		
NV		
NM		
NY		
NC		
OR	X	X
PA	X	
SC		
SD	X	X
TX	X	X
UT		
VT		
VA		
WA	X	X
WV		
WI		
WY	X	
Total	16	6

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s).

Source: State medical boards as reported to the Office of Inspector General.

Question #3

HOW MANY COMPLAINTS PER LICENSEE HAS THE BOARD RECEIVED?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT	X	
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total	1	

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s).

Source: State medical boards as reported to the Office of Inspector General.

Question #4

HOW MANY CASES PER LICENSEE HAS THE BOARD OPENED?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total		

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s).

Source: State medical boards as reported to the Office of Inspector General.

Question #5

HOW MANY COMPLAINTS FROM EACH COMPLAINT SOURCE HAS THE BOARD RECEIVED?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN	X	X
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX	X	
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total	2	1

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). Among the "complaint sources" that might be identified are consumers, other licensees, hospitals, medical societies, etc.

Source: State medical boards as reported to the Office of Inspector General.

Question #6

HOW MANY CASES FROM EACH COMPLAINT SOURCE HAS THE BOARD OPENED?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD	X	
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX	X	
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total	2	

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). Among the "complaint sources" that might be identified are consumers, other licensees, hospitals, medical societies, etc.

Source: State medical boards as reported to the Office of Inspector General.

Question #7

HOW MANY COMPLAINTS OF EACH TYPE HAS THE BOARD RECEIVED?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT	X	
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN	X	X
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX	X	
UT		
VT		
VA		
WA		
WV	X	
WI		
WY	X	
Total	5	1

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). Among the "types" of complaints that might be identified are gross negligence, incompetence, inappropriate prescribing/treatment, self abuse of drugs or alcohol, sexual misconduct, etc.

Source: State medical boards as reported to the Office of Inspector General.

Question #8

HOW MANY CASES OF EACH TYPE HAS THE BOARD OPENED?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT	X	
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD	X	
MA		
MI		
MN		
MS	X	
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX	X	
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total	4	

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). Among the "types" of cases that might be identified are gross negligence, incompetence, inappropriate prescribing/treatment, self abuse of drugs or alcohol, sexual misconduct, etc.

Source: State medical boards as reported to the Office of Inspector General.

REVIEW OF ALLEGED VIOLATIONS

We frame this second category of questions around the process of obtaining, assessing, and acting upon information concerning physicians who may have committed a violation. We focus on one vital and relatively easy to measure variable: time.

We ask how long the process takes, once a case is opened, to reach two critical points: the completion of an investigation and the resolution of the board's action involving a physician under investigation. That resolution may take the form of the closing of a case, a disciplinary action, or a nondisciplinary educational action.[15]

We recognize that the review process involves many other important considerations, but we regard time as a good initial performance indicator that can help identify and generate follow-up actions that can improve the process. If the amount of time it takes a board to conduct an investigation or resolve actions is increasing or is high relative to that of other boards, it is important to find out why this is so. The resultant inquiry and explanations might well identify weaknesses in how a board prioritizes cases, in the adequacy of its resources, in the training and/or capability of its investigative staff, and the like. It may also identify problems outside the board, such as delays in the office of the State attorney, that slow down the process and that State officials will have to address if a board is to expedite its review process.

It is also important to recognize that if a board's review time is decreasing and/or is less than that of other boards, there may be explanatory factors that still raise concerns about the effectiveness of the process. It may be, for instance, that a board is able to process cases relatively quickly because it avoids complex cases involving the adequacy of medical care rendered and concentrates on cases that involve less patient harm but are easier to process. Thus, we add two questions that address processing time in relation to the type of case involved.

Unfortunately, the reports are almost totally lacking in information that could lead to the kind of inquiry noted above. For the four questions posed, only three reports provide any information at all. Another report (California) notes in passing that the review process, from complaint to resolution, takes about 2 years but offers no further details on the point.

Question #9

HOW LONG, ON AVERAGE, HAS IT TAKEN FROM THE OPENING OF A CASE TO THE COMPLETION OF AN INVESTIGATION?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO	X	
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX	X	
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total	2	

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s).

Source: State medical boards as reported to the Office of Inspector General.

Question #10

HOW LONG, ON AVERAGE, HAS IT TAKEN FROM THE OPENING OF A CASE TO THE COMPLETION OF AN INVESTIGATION, FOR EACH TYPE OF CASE?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total		

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). Among the "types" of cases that might be identified are gross negligence, incompetence, inappropriate prescribing/treatment, self abuse of drugs or alcohol, sexual misconduct, etc.

Source: State medical boards as reported to the Office of Inspector General.

Question #11

HOW LONG, ON AVERAGE, HAS IT TAKEN FROM THE OPENING OF A CASE TO THE RESOLUTION OF ACTION?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO	X	
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total	1	

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). "Resolution of action" is the final board action on the case.

Source: State medical boards as reported to the Office of Inspector General.

Question #12

HOW LONG, ON AVERAGE, HAS IT TAKEN FROM THE OPENING OF A CASE TO THE RESOLUTION OF ACTION, FOR EACH TYPE OF CASE?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD	X	
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total	1	

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). "Resolution of action" is the final board action on the case. Among the "types" of cases that might be identified are gross negligence, incompetence, inappropriate prescribing/treatment, self abuse of drugs or alcohol, sexual misconduct, etc.

Source: State medical boards as reported to the Office of Inspector General.

RESOLUTION OF CASES

In this final category, we emphasize two additional variables: disciplinary actions and nondisciplinary educational actions. By disciplinary actions, we refer to those license revocations, suspensions, probations, reprimands, fines, or other such actions intended to penalize a physician for a given violation. By nondisciplinary educational actions, we refer to those actions that do not involve a disciplinary order but are intended to help a physician improve his or her practice of medicine. They might, for instance, involve a medical counseling session with board-associated physicians.

Disciplinary actions are the most widely used and controversial indicator of board performance. The American Association of Retired Persons, in a 1987 report, asserted that the simplest way to determine how well a board is performing is to identify how many disciplinary actions it is taking.[16] But others maintain that such an indicator is a poor one on the grounds that it can lead to distorted perceptions of board performance and can encourage a system of quotas.

We recognize that a singular and simplistic use of disciplinary actions in assessing board performance can be dysfunctional. It is for that reason that we complement them in this report with the other variables identified earlier and with the strictly educational interventions some boards direct to physicians. By regularly issuing data concerning these variables, boards can facilitate balanced and comprehensive assessments of their performance.

A final question we introduce has to do with how a board action is taken rather than with the action itself. It addresses the number of cases settled through consent agreements rather than through evidentiary hearings. Some feel that consent agreements are appropriate approaches that enable boards to carry out their responsibilities to the public more quickly. Others argue that they can lead to disciplinary actions that are too lenient and that can impede action against the same physician in another State in which he or she may be licensed. For both sides, and for those who have no preconceived view of the matter, the question, if answered, can help frame considerations in light of recent realities and lead to useful follow-up questions relating consent agreements to source of complaints and type of cases.

The reports provide more information on disciplinary actions than on any other variable identified. Thirty of them indicate the number of such actions taken in the past year and 27 distinguish those actions by type. For prior years, 14 indicate total disciplinary actions and 10 identify them by type.

Among the remaining questions, ten reports offer some information on consent agreements, four on disciplinary actions by type of case, and two on educational actions. For four questions, those concerning actions per licensee and actions by complaint source, none of the reports provides any answers at all.

Question #13

HOW MANY CASES OPENED FOR INVESTIGATION HAVE: (A) BEEN CLOSED WITHOUT ACTION, (B) RESULTED IN DISCIPLINARY ACTION, AND (C) RESULTED IN NONDISCIPLINARY EDUCATIONAL ACTION?

	A		B		C	
State	PY	TD	PY	TD	PY	TD
AL	X		X			
AK	X		X			
AZ	X	X	X	X		
CA	X	X	X	X	X	X
CO	X		X			
CT	X		X			
FL	X		X			
ID			X	X		
IL						
IN	X					
IA			X			
KY			X			
LA	X		X			
ME	X		X			
MD	X		X	X		
MA	X		X	X		
MI			X			
MN	X	X	X	X		
MS			X			
MT	X	X	X	X		
NV						
NM			X			
NY			X	X		
NC			X			
OR			X	X	X	X
PA						
SC	X		X			
SD	X	X	X	X		
TX	X	X	X	X		
UT						
VT			X	X		
VA	X		X	X		
WA	X	X	X	X		
WV						
WI	X		X			
WY	X		X			
Total	21	7	30	14	2	2

Key: An "X" in the past year (PY) column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the trend data (TD) column indicates information is provided for previous year(s). "Disciplinary actions" are official board actions intended to penalize a licensee. "Nondisciplinary educational actions" are official board actions not associated with any disciplinary action against a licensee and intended to educate a licensee on some matter involving the practice of medicine.

Source: State medical boards as reported to the Office of Inspector General.

Question #14

HOW MANY DISCIPLINARY ACTIONS PER LICENSEE HAVE BEEN TAKEN?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total		

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). "Disciplinary actions" are official board actions intended to penalize a licensee.

Source: State medical boards as reported to the Office of Inspector General.

Question #15

HOW MANY NONDISCIPLINARY EDUCATIONAL ACTIONS PER LICENSEE HAVE BEEN TAKEN?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total		

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). "Nondisciplinary educational actions" are official board actions not associated with any disciplinary action against a licensee and intended to educate a licensee on some matter involving the practice of medicine.

Source: State medical boards as reported to the Office of Inspector General.

Question #16

HOW MANY DISCIPLINARY ACTIONS FROM EACH COMPLAINT SOURCE HAVE BEEN TAKEN?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total		

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). "Disciplinary actions" are official board actions intended to penalize a licensee. Among the "complaint sources" that might be identified are consumers, other licensees, hospitals, medical societies, etc.

Source: State medical boards as reported to the Office of Inspector General.

Question #17

HOW MANY NONDISCIPLINARY EDUCATIONAL ACTIONS FROM EACH COMPLAINT SOURCE HAVE BEEN TAKEN?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA		
CO		
CT		
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME		
MD		
MA		
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA		
WV		
WI		
WY		
Total		

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). "Nondisciplinary educational actions" are official board actions not associated with any disciplinary action against a licensee and are intended to educate a licensee on some matter involving the practice of medicine. Among the "complaint sources" that might be identified are consumers, other licensees, hospitals, medical societies, etc.

Source: State medical boards as reported to the Office of Inspector General.

Question #18

HOW MANY DISCIPLINARY ACTIONS FOR EACH TYPE OF CASE HAVE BEEN TAKEN?

State	Past Year Data Provided	Trend Data Provided
AL		
AK		
AZ		
CA	X	X
CO		
CT		
FL		
ID		
IL		
IN	X	
IA		
KY		
LA		
ME		
MD		
MA	X	
MI		
MN		
MS		
MT		
NV		
NM		
NY		
NC		
OR		
PA		
SC		
SD		
TX		
UT		
VT		
VA		
WA	X	X
WV		
WI		
WY		
Total	4	2

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). "Disciplinary actions" are official board actions intended to penalize a licensee. Among the "types" of cases that might be identified are gross negligence, incompetence, inappropriate prescribing/treatment, self abuse of drugs or alcohol, sexual misconduct, etc.

Source: State medical boards as reported to the Office of Inspector General.

Question #19

HOW MANY DISCIPLINARY ACTIONS OF EACH TYPE HAVE BEEN TAKEN?

State	Past Year Data Provided	Trend Data Provided
AL	X	
AK	X	
AZ	X	X
CA	X	X
CO	X	
CT	X	
FL	X	
ID	X	X
IL		
IN	X	
IA	X	
KY	X	
LA		
ME	X	
MD	X	
MA	X	
MI	X	
MN	X	X
MS	X	
MT	X	X
NV		
NM		
NY	X	
NC	X	
OR	X	X
PA		
SC		
SD	X	X
TX	X	X
UT		
VT	X	X
VA		
WA	X	X
WV		
WI	X	
WY	X	
Total	27	10

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s). "Disciplinary Actions" are official board actions intended to penalize a licensee. Among the "types" of disciplinary actions taken against licensees are license revocations, license suspensions, license probations, reprimands, fines, etc.

Source: State medical boards as reported to the Office of Inspector General.

Question #20

HOW MANY CASES HAVE BEEN SETTLED THROUGH A CONSENT AGREEMENT AS OPPOSED TO AN EVIDENTIARY HEARING?

State	Past Year Data Provided	Trend Data Provided
AL		
AK	X	
AZ		
CA		
CO		
CT	X	
FL		
ID		
IL		
IN		
IA		
KY		
LA		
ME	X	
MD	X	
MA		
MI		
MN		
MS	X	
MT		
NV		
NM		
NY		
NC	X	
OR	X	X
PA		
SC		
SD		
TX	X	X
UT		
VT		
VA		
WA	X	X
WV		
WI		
WY	X	
Total	10	3

Key: An "X" in the first column indicates information is provided in the latest annual report issued in 1989 or thereafter. An "X" in the second column indicates information is provided for previous year(s).

Source: State medical boards as reported to the Office of Inspector General.

CONCLUDING OBSERVATIONS

The major value of performance indicators is the opportunity they can provide for comparative assessments. For instance, identifying the number of complaints a board has received from consumers in 1990 is likely to mean little in itself. But, if that number is compared with parallel numbers for prior years, then a reviewer can determine if there has been a change and, if so, ask why. Similarly, if a board's performance on some indicator is compared with like boards in other States, a reviewer can see if that board's performance differs from the others and, if so, seek to learn the reasons. The Virginia Department of Health Professions, in its recent report, addressed such interstate comparisons as follows:

> It is clearly in the interest of individual regulatory boards to compare their enforcement experience with the experience of boards governing like professions in other States. Once these comparisons are made--using a consistent nomenclature and standardized measures of enforcement activity--boards may wish to examine the regulatory environment (regulatory provisions, resources, and organizational structure) in which they operate for an explanation of significant differences in performance. If structural impediments to public protection and the fair and equitable treatment of licensees are identified, efforts should be made to remove those impediments.[17]

In the middle of the above quotation is a term that is of great consequence to any comparative effort: "a consistent nomenclature." Establishing such a nomenclature obviously would be far more difficult across States than within them, but in either case it is vital if comparative data are to be relied upon. When comparisons are made, whether they involve earnings per share of corporations or complaints to medical boards per licensed physician, definitions must be consistent if they are to be useful.

The specific questions that would carry the most comparative value is a matter that warrants further examination and experimentation. We view the ones we have posed as preliminary suggestions meant to stimulate inquiry and momentum toward the establishment and use of performance indicators. Yet, given the minimal performance-related data we found in the annual reports, it may be that little momentum is likely as long as the collection and issuance of such data are voluntary. For that reason, we suggest that State legislatures mandate that State medical boards establish a series of performance indicators and provide data on each of them in annual reports made available to governmental officials and the public. Toward this end, the National Conference of State Legislatures, the National Governors' Association, the Council of State Governments, the Federation of State Medical Boards and the United States Public Health Service can play valuable supportive roles as agents for the exchange of ideas and information.

APPENDIX A

ENDNOTES

1. In the educational field, the White House and the National Governors' Association have established a panel to gauge the nation's progress toward six mutually agreed upon education goals. Toward that end, one of the tasks of the panel is to select precise measures and to assess progress in reaching the goals.

   In the health care field, the movement to establish medical practice guidelines follows the same direction. Of particular note are the efforts of the Agency for Health Care Policy and Research in the United States Public Health Service to establish Medicare practice guidelines addressing such areas as cataracts, prostate disease, and pain management.

2. See H.R. 5687-6, Section 902, "Authority and Functions of Agency Chief Financial Officers."

3. The project involves identifying the most significant indicators of medical board performance. See Federation of State Medical Boards, <u>FSMB Newsletter</u>, no. 36 (September 1990).

4. See Health Advocacy Services, American Association of Retired Persons, <u>Citizen Advocacy News</u>, vol. 2, no. 3 (4th quarter, 1990).

5. The proposed legislation is entitled the "Health Care Liability Reform and Quality of Care Improvement Act of 1991." It provides financial incentives for the States to carry out tort and quality of care reforms.

6. In addition to the report already mentioned in the text, we have issued the following reports concerning State medical boards: "Medical Licensure and Discipline: An Overview, (P-01-86-0064), June 1986; "State Medical Boards and Medical Discipline: A State-by-State Review," (OEI-01-89-00562), August 1990; and "Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada" (OEI-01-89-00561), February 1991.

7. Virginia Department of Health Professions, the Board of Health Professions, <u>A Review of Enforcement and Discipline in the Department of Health Professions</u>, June 1990.

8. We wrote to each State medical board, requesting a copy of its most recent annual report. For those boards that did not respond, we followed up with a call to determine if, in fact, the board or some State

agency produced an annual report on the board's activities. We defined the reports as being documents produced annually that were made available to the State legislature, governor's office, and the public. We did not include internal data summaries or periodic summaries or studies. Also, we did not require that the data provided in the reports distinguish actions taken against physicians as opposed to other licensees under the board's jurisdiction. Such a distinction would obviously be helpful for intra-State assessments and essential for inter-state comparisons.

In computing and presenting the data, we stressed accuracy and precision. We conducted two checks of all the data, one by ourselves and one by the boards involved. Still, with the meaning of data categories in annual reports sometimes unclear, it is possible that there are some mistakes or omissions.

9. Three States, Minnesota, Virginia, and Wisconsin, produce a report every 2 years. We include them in our review.

10. As we note subsequently in the text, we recognize that many boards have access to much more information on their performance than is presented in an annual report. Our focus here is not on the information available or periodically presented, but on that regularly made available in annual reports directed to external audiences.

11. Elements of a Modern State Medical Board: A Proposal, August 1989.

12. Ibid., p. 15.

13. Different boards may define complaints and other variables addressed in this report in different ways. Over time, especially if boards were to engage in interstate comparisons, consistency in these definitions is important. Our intent in this report, however, is limited to determining whether or not an annual report includes data (in the form of yearly summaries) addressing the variables posed in the questions, even if the variables are defined somewhat differently in different States.

14. For example, many boards now seek to identify "markers" of possible violations by requiring that physicians, as part of their license renewal applications, submit information on various actions or conditions that would be of concern to the boards. Such information leads, in some cases, to the opening of an investigation.

15. It may also be desirable to include cases that did not involve a disciplinary action but did involve a referral to an impaired physicians program. We did not include such cases in our review because our

prior investigations indicated that such referrals are often not treated as an official, documented board action.

16. American Association of Retired Persons, Effective Physician Oversight: Prescription for Medical Licensing Board Reform, 1987.

17. A Review of Enforcement and Discipline in the Department of Health Professions, p. 6.

APPENDIX B

THE TWENTY QUESTIONS

1. How many complaints has the State medical board received?

2. How many cases has the board opened for investigation?

3. How many complaints per licensee has the board received?

4. How many cases per licensee has the board opened?

5. How many complaints from each complaint source has the board received?

6. How many cases from each complaint source has the board opened?

7. How many complaints of each type has the board received?

8. How many cases of each type has the board opened?

9. How long, on average, has it taken from the opening of a case to the completion of an investigation?

10. How long, on average, has it taken from the opening of a case to the completion of an investigation for each type of case?

11. How long, on average, has it taken from the opening of a case to the resolution of action?

12. How long, on average, has it taken from the opening of a case to the resolution of action for each type of case?

13. How many cases opened for investigation have been closed without action, resulted in disciplinary action, and resulted in nondisciplinary educational action?

14. How many disciplinary actions per licensee have been taken?

15. How many nondisciplinary educational actions per licensee have been taken?

16. How many disciplinary actions from each complaint source have been taken?

17. How many nondisciplinary educational actions from each complaint source have been taken?

18. How many disciplinary actions for each type of case have been taken?

19. How many disciplinary actions of each type have been taken?

20. How many cases have been settled through a consent agreement as opposed to an evidentiary hearing?