

The Special Committee on Evaluation of Quality of Care and Maintenance of Competence

Approved by the House of Delegates of the Federation of State Medical Boards of the United States, Inc.,
as policy May 1998

Revised Policy adopted by House of Delegates April 1999

Preamble

The Federation of State Medical Boards recognizes, as protectors of the public health and safety, state medical boards are accountable for the quality of health care provided by physicians within their jurisdictions as well as for assuring physician licensees are competent to practice medicine. To assist state medical boards in assuring standards of quality and competence within their jurisdictions, in April 1996, Federation President James E. West, MD, established the Special Committee on the Evaluation of Quality of Care and Maintenance of Competence.

The role of the state medical board in assuring quality of care and physician competence has increasingly become a major consumer issue, and therefore has gained the interest of the federal government. In February 1993, the U.S. Department of Health and Human Services, Office of the Inspector General, issued a report on state medical boards and their approaches to quality of care cases, wherein a variety of innovative approaches were identified. The report concluded that two factors are necessary in order for states to successfully handle quality of care cases: (1) adequate funding and (2) a serious and ongoing commitment to protect the public interest by actively addressing quality of care cases.¹ As evidenced by the rising number of medical malpractice claims, negative media reports, legislative initiatives and criticisms of the overall health regulatory system, there appears to be a public perception that state medical boards could do a better job in handling quality of care cases and assuring ongoing medical competence.

The Special Committee on Evaluation of Quality of Care and Maintenance of Competence was charged with

- evaluating and analyzing current procedures utilized by state medical boards in identifying and investigating complaints involving the quality of care rendered by a physician;
- assessing the effectiveness of different approaches currently utilized by state medical boards to identify and investigate such complaints;
- identifying sources of information/data which may be useful to medical boards in the evaluation of quality of care and maintenance of competence;
- recommending to state medical boards methods to liaison with peer review groups, third party payors, PROs, etc., to enhance the boards' ability to evaluate complaints regarding quality of care as well as determining ongoing competence of physicians;
- recommending enhanced methods of obtaining information and utilizing personnel in the evaluation of complaints regarding quality of care;
- recommending the most effective/appropriate methods of investigating complaints regarding quality of care; and
- recommending the most appropriate methods of assessing the continued competency of licensees.

In furtherance of its charge, the committee received presentations on innovative approaches for handling quality of care cases from several member medical boards and for physician assessment and evaluation. The committee also reviewed results of a survey of member medical boards regarding their processes for handling quality of care cases as well as pertinent reference materials.

The committee agreed prevention is integral to state medical boards' effectiveness in improving the quality of care provided to the public. State medical boards can improve the overall quality of care by reducing problems in their physician population through preventive measures such as education, communication, and collaboration with other interested agencies and organizations.

Evaluation of Quality of Care and Maintenance of Competence

The Special Committee on Evaluation of Quality of Care
and Maintenance of Competence

Section I. Definitions

For the purposes of its report, the committee has defined the following terms:

Assessment. A formal system to evaluate physician competence necessary to perform safely and effectively within the physician's scope of practice.

Competence. Possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of professional physician practice while adhering to professional ethical standards.

Dyscompetence. Failing to maintain acceptable standards in one or more areas of professional physician practice.

Incompetence. Lacking the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of professional physician practice.

Quality Care. The provision of health care services for individuals and populations that increase the likelihood of desired patient outcome(s) and are consistent with current professional knowledge and practice.

Remediation. The process whereby deficiencies in physician performance identified through an assessment system are corrected, resulting in an improved state of physician competence.

Section II. Identification

Recommendation One:

State medical boards should develop and implement methods to identify physicians who fail to provide quality care and therefore warrant further evaluation by the state medical board.

State medical boards are accountable to the public to assure physicians within their jurisdiction maintain a level of competence likely to ensure the delivery of health care consistent with current professional knowledge and practice. In order to achieve this public accountability, additional sources of information and data should be utilized in identifying physicians whose practice may warrant further evaluation. Specifically, the committee recommends state medical boards

- establish, expand and enforce statutory reporting requirements as specified in Section XII, Compulsory Reporting and Investigation, A Guide to the Essentials of a Modern Medical Practice Act,² and, if applicable, seek legislative authority to impose penalties for failure to report. Such

- requirements apply to physician licensees, other health care professionals, hospitals, medical societies, professional liability carriers, and third-party payors;
- expand and/or clarify reporting requirements so information regarding physician quality of care issues, physician impairment, physician deselection from managed care participation, Medicare/Medicaid exclusions/restrictions, and loss/restriction of hospital privileges and/or medical staff memberships are reported to the state medical board together with the reasons therefor;
 - establish a liaison with state and local medical societies to educate and increase awareness among physicians of their professional obligation to report colleagues who fail to meet professional standards;
 - adopt a process for licensing or registering physicians enrolled in postgraduate training programs, based on the policy of the Federation of State Medical Boards³;
 - expand self-reporting by utilizing the reregistration process to gather information regarding changes in health status, continuing medical education, malpractice claims, judgments and/or settlements, specialty board certification status, changes in practice location, medical staff memberships and hospital privileges, and participation in health plans⁴; and
 - establish liaison committees with Peer Review Organizations (PRO) in order to utilize PRO performance and outcome data, and enhance the boards' ability to identify dyscompetent physicians, including the exchange of information related to any disciplinary actions taken against a licensee.

Recommendation Two:

States should enact mandatory reporting requirements and state medical boards should be provided the authority to impose penalties upon those individuals and institutions failing to comply with reporting requirements.

The disciplinary function of all state medical boards is primarily complaint driven. Therefore, a board's effectiveness in handling quality of care cases is enhanced by its ability to receive valid information from reliable sources.

The vast majority of complaints received by state medical boards are from the public. However, these complaints are less likely to result in formal board action or prosecution, especially as related to quality of care issues, than reports from physicians, other health care professionals, hospitals, professional societies, managed care organizations and insurers.

According to the FSMB 1995-1996 *Exchange, Section 3*, a comprehensive presentation of information regarding medical boards' structure and disciplinary functions, 46 boards have mandatory reporting requirements for all licensees, with only 23 boards having civil penalties for failing to report. Other health care professionals are only required to report in 12 jurisdictions. Hospitals, other health care provider entities (HMOs, IPPs, clinics), professional liability insurance carriers and medical professional societies are required to report possible medical practice act violations in many jurisdictions.⁴ In order to gain necessary and reliable information, states should enact mandatory reporting requirements and state medical boards should be provided the authority to impose penalties upon those individuals and institutions failing to comply with reporting requirements.

Recommendation Three:

State medical boards should develop and implement proactive methods of identifying the individual dyscompetent physician, as well as opportunities for improving physician practice in problematic areas.

Historically, the disciplinary function of state medical boards may be characterized as reactive. The committee suggests that measures to prevent breaches of professional conduct and improve physician

practice will greatly enhance public protection. In order to proactively identify physicians who may be dyscompetent as well as to identify opportunities to improve physician practice, the committee suggests state medical boards

- conduct random audits of pharmacy records to identify prescribing trends which indicate less than effective or obsolete therapies;
- implement systems to effectively monitor prescribing of controlled substances to prevent inappropriate prescribing and/or drug diversion activities;
- emphasize the importance of maintenance of clear and concise patient records through the issuance of guidelines, educational efforts and communications with licensees;
- gather and utilize physician performance and outcome data received from sources such as PROs and managed care organizations, including entering into formal agreements to facilitate reporting of disciplinary actions involving a quality of care issue taken by a managed care organization against a licensed physician;⁵
- develop a system of markers to identify licensees warranting evaluation, such markers to include, but not be limited to
 - health status/age;
 - number of complaints;
 - number of malpractice claims/settlements/judgments;
 - multiple and/or frequent changes in practice location;
 - changes in area of practice without formal retraining;
 - adverse actions by PROs, third-party payors;
 - failure of specialty board recertification examination(s); and
 - physician's whose practice is not subject to peer review by other entities, i.e., the physician with no affiliations to hospitals, clinics or managed care panels.

Section III: Evaluation and Investigation

Recommendation Four:

State medical boards should implement and utilize processes to enhance evaluation and investigation of cases wherein the quality of care rendered is in question.

The committee reviewed and evaluated the processes whereby state medical boards address complaints involving quality of care and identified elements the committee believed essential to the enhanced evaluation and investigation of quality of care cases. These elements included the employment of a physician acting as the board's medical director and employment of other health care professionals, inclusion of medical board members in the investigation process, and utilization of peer review panels.

To enhance the process whereby state medical boards evaluate and investigate cases involving quality of care issues, the committee suggests state medical boards

- utilize the services of a staff or consultant medical director (MD/DO), preferably with medical board experience;
- utilize individuals with health care experience and background as a part of the investigative team (e.g., nurses, physician assistants, advanced nurse practitioners);
- utilize medical expertise in the evaluation and investigative process; and
- utilize established practice guidelines.

Recommendation Five:

State medical boards should utilize a list of qualified physicians from which to select peer review panels in the evaluation and investigation of quality of care cases.

Peer review is essential to effective evaluation of quality of care cases, and state medical boards should encourage the voluntary participation of licensees as reviewers. The committee suggests state medical boards foster cooperative relationships with state and local medical societies and/or state PROs to secure available physician reviewers.

Recommendation Six:

State medical boards should develop and implement systems to efficiently process quality of care complaints.

In order to best protect the public, complaints and reports involving quality of care issues must be processed in a timely and efficient manner. The committee suggests state medical boards develop a system to screen quality of care complaints and reports that incorporate complaint screening, determination of jurisdiction, categorization, and prioritization. Investigation of complaints should be conducted in the order of priority. All complaints recommended for closure after investigation should be reviewed by both public and professional members of the medical board.

The committee recommends, if appropriate, state medical boards conduct an informal conference with the physician to include selected members of the medical board, board attorney(s), investigators, and board support staff. The informal conference would provide a forum for the physician to be personally interviewed and provide additional information as to the circumstances, systems and practices which form the basis of the complaint(s).

Recommendation Seven:

State medical boards should broaden the scope of investigation beyond the incident report or complaint. The committee suggests, if deemed appropriate following screening, the investigation of quality of care cases not be limited to the incident (the subject of the complaint/report) and the investigation include, but not be limited to

- a large sampling of patient records to identify a pattern of care;
- office practices, systems and procedures;
- performance/discharge data of hospitals, PROs and managed care organizations; and
- interviews with colleagues, peers and patients.

Recommendation Eight:

State medical boards should review their Medical Practice Act and pursue legislative support for statutory language to validate the board's subpoena authority and provide the board access to external peer review records.

To adequately protect patients, state medical boards should have subpoena authority to conduct comprehensive reviews of patient and physician office records. Additionally, it is critical state medical boards have administrative authority to access otherwise protected peer review records to determine if the physician whose performance is in question is likely to cause patient harm without board intervention.

Section IV: Disposition

Recommendation Nine:

Based upon investigative findings, state medical boards should utilize distinct disciplinary tracks in the disposition of quality of care cases.

The committee identified three tracks for disposition of cases involving quality of care issues.

- Track One. Cases in which no violation of the medical practice act was found, severity was determined to be low-level, and thereby the quality issue may be resolved either by closure, educational letter, conference or other means.

- Track Two. Cases where quality issues are present and indicate a likelihood of formal board action. Boards may utilize the full range of disciplinary action, including license revocation, restriction, probation and reprimand. Boards also may consider corrective action agreements, quality intervention plans, or other agreements requiring licensees to fulfill board mandated requirements for assessment and retraining.
- Track Three. Cases in which patient harm is imminent and emergency action by the medical board is warranted, including summary suspension, injunction and/or order for mental/physical examination/evaluation.

Section V: Assessment and Remediation

Recommendation Ten:

State medical boards should identify and utilize available means of physician assessment and remediation. Physician assessment and remediation are critical elements in assuring physician competence; state medical boards should utilize available programs offering assessment services and require dyscompetent physicians to participate in focused remediation programs. The committee encourages state medical boards to utilize the Federation's Special Purpose Examination (SPEX), or other examination as may become available and approved by the medical board. The SPEX may be a valuable assessment tool in that the examination is easily accessible to licensees and is offered via computer in approximately 220 testing sites throughout the United States and its territories.

On behalf of state medical boards, the Federation of State Medical Boards and the National Board of Medical Examiners have initiated a comprehensive national center for physician assessment of both cognitive skills and mental/physical impairments. This assessment will engage a series of evaluation tools including the SPEX or other similar computerized examination, computer-based case simulations and judgment analysis, and standardized patients. Following the assessment, the center will provide a report to the referring medical board with recommendations for remediation of the identified deficiencies.

Recommendation Eleven:

The Federation of State Medical Boards, on behalf of its member boards, should collaborate with other organizations to develop standards for programs offering remedial medical education.

In order to assure the quality and integrity of remedial medical education programs, standards must be developed to the satisfaction of state medical boards. Programs incorporating and complying with such standards could then be approved for referral of licensees. Additionally, the committee encourages state medical boards to initiate collaborative efforts with state medical societies, institutions offering medical education and training, and/or other medical professional organizations in supporting programs offering remedial medical education programs.

Section VI: Strategies to Enhance Quality of Care and Assure Maintenance of Physician Competence

Recommendation Twelve:

State medical boards should develop programs to enhance overall physician practice.

As a means of ensuring continued physician competence, programs should be implemented to enhance overall physician practice in addition to disciplining individual physicians. The committee suggests the following preventive measures to enhance physician practice:

- sponsor educational programs
- share information regarding best practice and established practice guidelines

- communicate to licensees in the form of newsletters or other means regarding recommendations for “best practice” in problematic areas, i.e., pain management, record keeping and boundary issues
- collaborate with medical schools to educate students as to compliance with state laws governing the practice of medicine as well as professional ethical and boundary issues
- establish a state-wide consortium consisting of the state medical board, medical professional societies, medical education programs, hospitals and health care organizations, and professional liability carriers, to sponsor medical educational opportunities to licensed physicians (continuing, focused and/or remedial)

Conclusion

State medical boards are ultimately accountable for the quality of care rendered within their jurisdictions and for the competence of those providing such care. Quality of care cases pose a particular challenge to state medical boards in that they are often difficult to define, require additional and often costly board resources, and, more than other breaches of professional conduct, require special medical and legal expertise in order to successfully prosecute. The effectiveness of state medical boards in these areas is dependent upon improving methods of processing quality of care cases, implementing measures to improve overall physician practice, and enhancing the competence of practicing physicians. To achieve this goal, it requires the continued commitment of medical board members and staff to improving the quality of health care amid changing health care settings.

References

1. DHHS, Office of Inspector General. State medical boards and quality-of-care cases: promising approaches. February 1993.
 2. FSMB. A Guide to the Essentials of a Modern Medical Practice Act. April 1997.
 3. FSMB. Licensure of Physicians Enrolled in Postgraduate Training Programs. April 1996.
 4. FSMB. 1995-1996 Exchange. pp 38-39.
 5. FSMB. Special Committee on Managed Care (preliminary Recommendations).
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