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OFFICE OF THE STATE COMPTROLLER

July 2, 2009

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 2008-F-29

Dear Dr. Daines:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution; and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health (Department) Office of Professional Medical Conduct to implement the recommendations contained in our audit report, *Office of Professional Medical Conduct Complaints and Investigations Process* (2005-S-21).

Background, Scope and Objectives

The Office of Professional Medical Conduct's (OPMC's) mission is to protect the public through the investigation of professional misconduct issues involving physicians, physician assistants and specialists' assistants (collectively called licensees). Where appropriate, OPMC is responsible for taking disciplinary action in cases involving professional misconduct. Section 6530 of the State Education Law defines the 47 acts that constitute professional misconduct. Examples of misconduct include obtaining a medical license fraudulently or practicing the profession while impaired by alcohol, drugs, physical disability or mental disability. Any licensee found guilty of such misconduct is subject to penalty, which may include censure and reprimand, fines and/or revocation of his or her medical license.

Section 230 of the Public Health Law makes OPMC responsible for investigating all complaints that it receives, and it gives OPMC the authority to investigate any suspected misconduct. A judgment or settlement in a medical malpractice case does not constitute misconduct in and of itself. In such a case, OPMC would have to determine whether the facts of the case constitute an act of misconduct, as defined by the State Education Law. OPMC's policy is to investigate a licensee in situations involving potential malpractice based on certain criteria. OPMC typically begins an investigation based on a complaint received from the public, other medical professionals, or governmental agencies. These entities provide OPMC with the majority of the

cases it investigates. However, OPMC will independently open an investigation if it determines one is needed.

Our initial audit report, which was issued on August 9, 2007, determined whether the Department's OPMC had effective controls in place to identify, track and investigate complaints of alleged physician medical misconduct. We also reviewed the extent to which OPMC obtained and used malpractice information as a source for investigations of potential misconduct. We found that OPMC was thorough in its investigation of cases of potential misconduct, and generally tracked complaints effectively. However, OPMC officials made limited efforts to proactively identify cases of potential misconduct or ensure that they received all complaints from the various external and internal sources that exist. In addition, OPMC needed to improve the timeliness of some of its investigations. The objective of our follow-up was to assess the extent of implementation, as of June 4, 2009, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made significant efforts to address the recommendations from the initial report. We determined that the Department implemented each of the report's five recommendations.

Follow-up Observations

Recommendation 1

Take steps to ensure that all complaints are received from the various reporting entities. To accomplish this OPMC needs to establish a method of informing and reminding reporting entities of the importance of properly referring all cases of potential misconduct to OPMC.

Status - Implemented

Agency Action - OPMC officials advised that they now frequently contact the Office of the Medicaid Inspector General to get potential misconduct case information for Medicaid related cases. OPMC personnel also scan data from the Bureau of Hospital Services and send requests to that Bureau for recommendations on potential hospital-related cases to open. In addition, OPMC officials have been working with the Office of the Attorney General to finalize and implement a case referral procedure from that office.

Recommendation 2

Make better use of malpractice information as part of the investigation of potential cases of misconduct by:

- *opening investigations into all cases which meet OPMC's existing malpractice criteria, including the 177 instances we identified during the audit,*
- *modifying the existing malpractice investigation criteria to include a frequency standard for the number of malpractice cases or payments a licensee may have,*

- *obtaining and using the OCA malpractice information as a source of malpractice information, and*

- *ensuring the use of comprehensive information when investigating cases involving malpractice*.

Status - Implemented

Agency Action - OPMC officials advised that they have reviewed the 177 instances identified in our audit report. These cases included 192 physicians, and OPMC opened investigations for 124 of them. OPMC officials also advised us that investigations were not opened for the remaining 68 instances for several reasons. For example, in 35 instances, the age of the available data exceeded the six-year record retention requirement. Also, in 15 other instances, the courts had dismissed the complaints. In other instances, medical problems were not attributable to physician error. Further, in several cases, the providers were not physicians, and therefore these cases were not under the jurisdiction of OPMC.

OPMC officials advised that, in 2008, they adopted a payment frequency standard for the number of malpractice cases or payments a licensee may have. The standard developed is six medical malpractice payouts in five years on behalf of the same licensee. Officials stated that they conducted a retrospective review when the standard was adopted, and identified about 25 licensees who met this standard. Upon further review, OPMC found that 10 of the licensees had, through previous OPMC disciplinary actions, already lost their medical license, and misconduct investigations were opened on the remaining 15 licensees.

OPMC officials told us that the OCA malpractice information does not have sufficient detail to be useful in OPMC's investigations. For example, the OCA data does not include clinical, event, severity and payment information needed for an investigation. In addition, OCA data is incomplete because settled cases are deleted and are not recoverable. However, OPMC officials advised that the State's Medical Malpractice Data Collection System (MedMal) is an effective source of information that OPMC can use for investigations. The MedMal database contains information provided by insurance companies about medical malpractice cases, and the information is retained on MedMal after the cases are settled. Insurance companies and self-insured businesses are required by law to update the MedMal database, as appropriate.

In the fall 2008, OPMC officials distributed a new section of their Manual of Investigative Operations. The Manual indicated that, in addition to investigating complaints, the OPMC will commence investigations based on information gathered from other sources of information about physicians' medical malpractice incidents. Specifically, the Manual cited Section 315 of the State Insurance law that mandates reporting of medical malpractice claims, settlements, verdicts and/or judgments to the State MedMal system or to the National Practitioner Data Bank.

Recommendation 3

Establish procedures through which OPMC could proactively identify potential cases of misconduct for investigation.

Status - Implemented

Agency Action - In 2008, the OPMC staff began daily reviews of compilations of news articles, searching for stories involving licensees under OPMC jurisdiction. If a review identifies a potential occurrence of misconduct, an investigation is opened. OPMC has also implemented a monthly review of the state medical malpractice database, as required by patient safety legislation signed into law in August, 2008. OPMC officials also indicated that they investigated the National Practitioner Data Bank and the Health Integrity and Protection Data Bank as potential sources for misconduct cases. However, officials found these sources did little to help identify new cases because they require the name of a specific physician in order to begin a query, thereby limiting broad-based searches for potential new issues.

Recommendation 4

Take steps to help ensure cases of potential misconduct are investigated in a timely manner. At a minimum, management should:

- *develop a formalized time standard for investigations, and*
- *include as part of the new tracking system, adequate features to allow management to measure and compare field offices' caseload, staffing and production.*

Status - Implemented

Agency Action - OPMC's Manual on Investigation Operations now includes case completion time standards. The standard for high priority cases is within 150 days of receipt. For lower priority cases, the standard is calculated on an annual basis, based on the number of cases in the previous year and the number of staff hours available to work on them. OPMC officials stated that the standard for lower priority cases was 250 days in 2006, 236 days in 2007 and 234 days in 2008. Also, OPMC has established a goal to have less than 5 percent of its cases take more than two years to complete.

In spring 2008, OPMC implemented a new case management tracking system (TRAKKER) which generates reports about individual investigators, including current workloads by categories of priority. TRAKKER also produces monthly reports that are used by management to monitor field office and total program performance. Twice a year, OPMC officials visit field offices to conduct on-site reviews of investigative operations. During these reviews, officials use TRAKKER information to assess overall field office caseloads, the number and status of cases assigned to individual investigators, and case ages. Using this information, management evaluates progress and status of investigations and identifies next steps for each investigator. TRAKKER data is also used to make case assignments by field office and investigator. In addition, OPMC managers have used TRAKKER data to analyze

and redistribute workloads among the field offices, based on their respective availabilities of staff.

Recommendation 5

Perform a cost benefit study to determine the resources needed, as well as any other changes, to meet the standards developed for timely completion of investigations. The study should produce an action plan to address all identified needs.

Status - Implemented

Agency Action - OPMC officials performed two analyses of staffing and other resources needed for timely completion of investigations. The first analysis pertained to the revisions to the State's Patient Safety Law (enacted in November 2008), which added new mandates for OPMC. The new mandates included the continuous review of medical malpractice information to identify instances of potential misconduct and the initiation of investigations where warranted. In light of these mandates, OPMC officials analyzed both central and regional office projected caseloads and backlogs. Based on their analysis, officials projected that 21 additional people (investigators, physician reviewers, and attorneys) were needed to handle the anticipated workload increase. Officials also informed us that they were able to fill six of these positions.

For the budget for the 2009-10 fiscal year, OPMC officials again analyzed staffing needs and concluded that 39 more people (investigators, clinicians, attorneys, and support staff) were needed to complete investigations adequately and timely. Because the OPMC is funded by physicians' biennial registration fees, officials requested an increase in the biennial fees to pay for additional staff. However, the legislature did not include this request in the appropriations for the 2009-10 year.

Major contributors to this report were Karen Bogucki, Don Collins and David Pleeter.

We want to thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Brian E. Mason
Audit Manager

cc: Mr. Stephen Abbott, DoH
Mr. Thomas Lukacs, DoB