Performance Audit of the Nevada State Board of Medical Examiners

For the 8 Year Period
Beginning July 1, 2003 and Ending June 30, 2011

REPORT TO THE LEGISLATIVE COMMISSION

July 13, 2012

Submitted by:

The Federation of State Medical Boards of the United States, Inc.

Janelle A. Rhyne, MD
Kathleen Haley, JD
Randal E. Manning, MBA
Tammy L. H. McGee, MBA
Brian Blankenship, JD
Maegan Carr Martin, JD

Submitted to:

Director
Legislative Counsel Bureau
401 S. Carson Street
Carson City, Nevada 89701-4747

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OBJECTIVES

The Federation of State Medical Boards of the United States, Inc., (FSMB) conducted this audit of the Nevada State Board of Medical Examiners ("the Board") pursuant to the terms of Section 41 of Chapter 508, Statutes of Nevada 2003[1] and the Request for Proposal ("RFP") of the Legislative Commission, dated December 9, 2011[2]. The Legislative Commission directed that the performance audit include, without limitation, a comprehensive review and evaluation of:

a) The methodology and efficiency of the Board in responding to complaints filed by the public against a licensee.
b) The methodology and efficiency of the Board in responding to complaints filed by a licensee against another licensee.
c) The methodology and efficiency of the Board in conducting investigations of licensees who have had two or more malpractice claims filed against them within a period of twelve months.
d) The methodology and efficiency of the Board in conducting investigations of licensees who have been the subject of one or more peer review actions at a medical facility that resulted in the licensee losing his/her professional privileges at the medical facility for more than thirty (30) days within a period of twelve (12) months.
e) The methodology and efficiency of the Board in taking preventative steps or progressive actions to remedy or deter any unprofessional conduct by a licensee before such conduct results in a violation under NRS Chapter 630 that warrants disciplinary action.
f) The managerial and administrative efficiency of the board in using the fees that it collects pursuant to NRS Chapter 630.

This audit included an examination of the records described in the Response to the RFP; a site visit to the Board offices on May 8th and 9th, 2012, including interviews with three Board members, six staff members, and the Board's external financial auditor[3]; and a review of the materials listed in Attachment 1.

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[1] NRS 630.127
[2] See Attachment 2
[3] See Attachment 4

REPORT

Pursuant to NRS 630.003, the Nevada Board of Medical Examiners ("the Board") is charged to ensure that only competent persons practice medicine, perfusion and respiratory care in Nevada. The audit finds that the Nevada Board of Medical Examiners meets or exceeds all statutory obligations pursuant to NRS 630.003 and has employed proper methodologies and efficiencies with regard to the performance measures set forth at NRS 630.127. Although the Board is faithfully executing its obligations and performing quite efficiently, the individuals responsible for conducting this audit believe that there is always room for improvement, and this report contains recommendations accordingly. The report contains recommendations addressing the enumerated objectives of the Legislative Counsel Bureau's RFP as well as other recommendations presented in the spirit of the statutory stipulation directing that the review and evaluation be without limitation.[4]

The following is a summary of the Board's existing policies and procedures and the audit team's findings relating specifically to the performance measures (a) through (f) set forth at NRS 630.127. The audit team's recommendations are reiterated in the Executive Summary immediately subsequent to this report.

a) **The methodology and efficiency of the Board in responding to complaints filed by the public against a licensee.**
b) **The methodology and efficiency of the Board in responding to complaints filed by a licensee against another licensee.**

The Board does not process complaints based on the source of the complaint; rather, the Board investigates all allegations of violations within its jurisdiction and prioritizes each complaint on the basis of seriousness of violation and risk posed to the public. Upon receipt of a complaint, the Board determines whether the case should be designated low, medium or high priority. High priority cases are those cases that pose an emergency situation involving imminent risk to the public. The Board is empowered to respond to emergency situations with immediate action and in some cases, summary suspensions. High priority cases must be supervised by either the Chief or Deputy Chief of Investigations.

The last audit report produced and submitted in 2003, recommended that the Board implement a system through its database management software for assigning and tracking high, medium or low priority to investigative cases that suggest risk to the public. Board representatives report that although the Board has always had a system for prioritizing, or, "triaging," cases, following the 2003 audit report, the Board implemented an electronic system to allow it to prioritize cases in the Board's computer database.

Receipt of a complaint triggers an acknowledgement letter to the complainant from the Chief of Investigations advising the complainant that a case will be opened and assigned to an investigator.[5] Once an investigator is assigned to the case, he or she will contact the complainant again with his or her contact information.[6] At that time, the investigator may also seek additional evidence from the complainant and will provide a status update. Complainants and investigators alike are encouraged to

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[4] NRS 630.127(7)
[5] See Attachment 5
[6] See Attachment 6

communicate frequently, primarily by phone. Investigators are required to submit forty-five (45) day follow-up letters[7] to the complainant advising the complainant of the status of his or her case.[8]

The audit team believes that the Board's methodology in responding to complaints filed by the public and licensees is appropriate and efficient. The current system of prioritizing cases manually and electronically ensures that the Board responds quickly to cases warranting its immediate attention. Because the Board is authorized to respond to emergency situations with immediate action, and in some cases, summary suspensions, the audit team believes the Board enjoys the proper level of statutory discretion and authority.

The audit team also approves of the frequency with which the Board communicates with complainants, the availability of investigators and the quality of the communications exchanged. The Board's current system—sending an acknowledgement letter upon receipt of a complaint and status updates every forty-five (45) days—is comprehensive, yet efficient.

Although the 2003 audit report contained the recommendation that the Board send a letter to the complainant when the investigation is complete and the report has gone for review by the Medical Reviewer and an Investigative Committee, the Board chose not to implement this recommendation because the investigation is not complete when the report has been submitted for review by the Medical Reviewer and an Investigative Committee, but when the file has been reviewed by the assigned Investigative Committee. After the assigned Investigative Committee has reviewed the file and the investigation is complete, the case moves from the Investigative Division to the Legal Division and a status update letter to the complainant is generated. During the legal process, the complainant will receive quarterly updates from the Legal Division. Although the case's progress through the investigative process does not trigger correspondence, a complainant still receives status update letters every forty-five (45) days until the case reaches the Legal Division, at which time the complainant will begin receiving quarterly updates.

If formal charges are brought, complainants are advised that the proceeding is public and given instructions on how to access the documents available to them. Complainants are also advised of the hearing date, time and location. The Board notifies complainants of the results of the adjudication once a Board decision is rendered.

c) The methodology and efficiency of the Board in conducting investigations of licensees who have had two or more malpractice claims filed against them within a period of twelve (12) months.

The Board investigates medical malpractice claims uniformly, without regard to how many claims have been filed against a licensee in any twelve (12) month period. Information of multiple malpractice claims does inform the investigative process; however, the probative value of two or more malpractice claims in a twelve month period is limited to a determination by an Investigative Committee that the claims, taken together, illustrate a physician's regular failure to observe the appropriate standard of medical care.

The Board's current practice is to open an investigation upon learning of any medical malpractice case. Information of subsequent malpractice claims become part of any existing investigation file and is

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[7] See Attachment 7

[8] See Investigations Division Operations Manual, Section II, subparagraph (d), "Jurisdictional Review."

examined accordingly; however, subsequent claims are not given any special weight in remedial or disciplinary determinations.

The Board's treatment of medical malpractice cases is guided by existing Nevada legislation. NRS 630.3069, for instance, requires the Board to conduct an investigation after receiving certain information concerning resolution of a medical malpractice claim.[9] Further, the Nevada Revised Statutes includes several provisions requiring reporting from multiple sources, including insurance companies[10], the clerk of the court[11] and physicians[12]. NRS 629.051 requires health care providers to retain the health care records of his or her patients for five years after their receipt or production. These statutory provisions, taken together, have influenced the Board to observe the process described herein. It is thought, that by opening an investigative case on every malpractice case, the Board is best poised to properly record and triage cases, obtain records within the statutorily required records retention period, and when necessary, proceed to a full investigation.

The majority of state boards do not investigate every malpractice claim filed in the state. The Nevada Board investigates all medical malpractice claims based on their interpretation of applicable statutes. The audit team recommends that the Board engage in a comprehensive review of its existing statutes to determine which cases, and to what extent, those cases must be developed in order to meet the investigative requirements set out in statute. The team further recommends that the Board determine a threshold, or triggering event, that will initiate the Board's investigation of a medical malpractice claim as is the current practice of most state medical boards.[13] This approach allows for state boards to receive reports of medical malpractice and act when protection of the public so requires, but does not require any particular action or investigation of malpractice claims that may not contain meritorious allegations.

The Board routinely uses its medical reviewers to examine case files to determine whether a full investigation is required. In many instances, the medical reviewer will counsel against engaging in a full investigation, resulting in administrative closure of the case. A case that is administratively closed may be opened later if development of further facts so warrant. State medical boards commonly employ licensed physicians to serve as medical reviewers and/or medical directors, though there is no prescribed formula for their utilization.[14] The Board currently employs one-part time reviewer for approximately twenty (20) hours per week and two alternate reviewers that work on cases in which the on staff reviewer must be recused. While the current system of three part-time medical reviewers may diminish consistency in the evaluation of cases and related recommendations, the audit team recognizes that the geographic duality that exists in Nevada may require that the Board utilize the services of more

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[9] "If the Board receives a report pursuant to the provisions of NRS 630.3067, 630.3068, 690B.250 or 690B.260 indicating that a judgment has been rendered or an award has been made against a physician regarding an action or claim for malpractice or that such an action or claim against the physician has been resolved by settlement, the Board shall conduct an investigation to determine whether to impose disciplinary action against the physician regarding the action or claim, unless the Board has already commenced or completed such an investigation regarding the action or claim before it receives the report."

[10] NRS 630.3067

[11] NRS 630.307(6)

[12] NRS 630.307(2)

[13] In Maine, for instance, the medical board does not open an investigation until the third medical malpractice suit is filed within ten years.

[14] *Elements of a State Medical and Osteopathic Board*, Section I, subsection 2, "Staff Positions," http://www.fsmb.org/pdf/GRPOL_Elements_Modern_Medical_Board.pdf

than one medical reviewer. The Board reports that the staff reviewer lives and works in the 'North' and interacts with a high percentage of licensees, thus his recusal is frequently required. Though it may be necessary to have an alternate medical reviewer for these instances, the audit team recommends that the Board, over time, implement a medical reviewer arrangement that will result in greater consistency in the case review process. For example, the Board could employ one full-time or nearly full-time medical reviewer for the majority of cases and then utilize the services of one, rather than two, medical reviewer for those instances in which the staff reviewer has a conflict. The audit team strongly encourages the Board to involve physician members in the medical reviewer hiring process in all future instances, as they are uniquely qualified to evaluate candidates' aptitude.

d) The methodology and efficiency of the Board in conducting investigations of licensees who have been subject to one or more peer review actions at a medical facility for more than thirty (30) days within a period of twelve (12) months.

Subject to certain statutory limitations, all medical societies, hospitals, clinics and other medical facilities licensed in Nevada are required to report to the Board any change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care while the practitioner is under investigation, as well as the outcome of any disciplinary action taken by a facility or society.[15] This reporting requirement assures that the Board is aware of peer review actions taken against licensees and is able to engage in the proper investigative procedures. Like medical malpractice claims, the Board investigates instances of peer review actions uniformly, without regard to how many actions have been taken against a licensee in any twelve (12) month period.

The 2003 audit report contained the dual recommendations that the Board obtain current mailing addresses of all hospitals and other treatment facilities from the Bureau of Licensing, Nevada State Health Division, and periodically remind all hospital administrators, chiefs of medical staff and medical societies of their reporting requirements. The online publication of the addresses of all hospitals and other treatment facilities under the purview of the Nevada State Health Division rendered the first recommendation moot. However, with respect to the second recommendation, the Board reports that their efforts to remind applicable entities of their reporting requirements are ongoing. The Board's Hospital Liaison Program allows Board representatives to deliver these reminders in person as part of on-site visits. Additionally, reminders are published in quarterly newsletters and materials produced as part of the Board's outreach program.

State medical boards regularly cite difficulty obtaining information concerning actions taken by hospital and other medical facilities. Impressively, the Board reports that it has succeeded in obtaining 100% reporting from hospitals and medical facilities. The Board reports this feat after aggressively cross-checking the lists of actions generated by Nevada hospitals and other medical facilities with National Practitioner Databank information (NPDB).

To complement its optimal reporting achievement, in 2011 the Board developed a legislative initiative that was supported and ultimately introduced by a physician member of the Nevada State Legislature. The proposed legislation reduced the facility reporting period from thirty (30) to five (5) days for any privilege status change resulting when the medical, mental or psychological competence of a licensee is

[15] N.R.S. § 630.307(3)

at issue, or in cases where suspected or alleged substance abuse exist in any form.[16] The bill was ultimately passed and is codified at NRS 630.307.

e) The methodology and efficiency of the Board in taking preventative steps or progressive actions to remedy or deter any unprofessional conduct by a licensee before such conduct results in a violation under this chapter that warrants disciplinary action.

The most recent audit report generated in 2003 included the recommendation that the Board seek legislative revisions that would enable it to reach a broader range of undesirable behaviors. Specifically the report suggested that Nevada Revised Statutes § 630.301 be amended to include felony convictions and other offenses involving moral turpitude as a basis for discipline or denial of a license. Over the sequence of several legislative sessions, the recommended revisions were incorporated and the Nevada Revised Statutes now specify that felony convictions[17] and additional convictions, including those involving moral turpitude[18], may serve as the bases of discipline or denial of a license.

The 2003 audit report also called on the Board to seek to amend the Nevada Revised Statutes to include a definition of unprofessional conduct. During the 2009 Legislative Session, a definition of unprofessional conduct was codified. Unprofessional conduct now refers to "any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board."[19] As the Nevada Administrative Code then, as now, includes standard of practice regulations prohibiting specific acts, the Board has not engaged in rulemaking specific to the legislation.

By broadening the scope of the Board's disciplinary jurisdiction, these legislative developments empower the Board to remedy and deter behavior that relates more peripherally to the practice of medicine, but which bears quite heavily on a practitioner's ethics and professionalism, characteristics most members of the public still expect health care professionals to possess and which feature centrally in the practice of quality medicine. Additionally, most state medical boards have statutorily endorsed an "unprofessional conduct" provision in their Medical Practice Act; thus, this legislative development brought the Board into better alignment with its peers.

The Board seems to recognize the value the dissemination of licensure and disciplinary information and consumer awareness campaigns can have on remedying, preventing and deterring unprofessional conduct, as the Board has consistently published a newsletter of disciplinary actions to licensees and has recently engaged in a new compartmentalized outreach program to ensure consumers understand the role and importance of the Board. The newly launched consumer awareness campaign consists primarily of a consumer brochure and a series of presentations which the Board routinely customizes to fit the needs of the public audience. The consumer brochure is intentionally quite broad and includes information regarding the Board's mission, services, website, the Medical Practice Act, the adjudication process, conduct that may warrant discipline of a licensee, information on how to file a complaint and a listing of the state agencies responsible for the regulation of other health care professionals.[20]

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[16] 2011 SB 168
[17] N.R.S. 630.301(1)
[18] N.R.S. 630.301(11)(a-g)
[19] N.R.S. 630.306(16)
[20] See Attachment 8

Although the Board has, for some time, published brochures and other print educational materials for distribution, the Board only recently began printing its materials in Spanish. The Board initiated this practice to reach a more accurate representation of its demographic and to target the illegal practice of medicine so prevalent in the Hispanic community. To facilitate receipt of these Spanish language brochures, the Board emphasizes distribution of these materials in areas where the Hispanic community gathers.

Previous brochures were developed with the dual purposes of educating the public on the role and function of the Board as well as educating physicians on how they may more safely operate and practice medicine within the statutory confines of the Medical Practice Act. While the audit team acknowledges the importance of educating physicians on the expectations—statutory and otherwise—corresponding to medical licensure, the team favors a focus on providing quality medical care and patient safety and believes the latest reincarnation of the Board's consumer outreach program more satisfactorily achieves that end.

In interviews conducted during the on-site portion of the audit, Board members and staff regularly acknowledged that the Board's relationship with other agencies, organizations and the public has improved significantly since the 2003 audit. This improvement is the result of a carefully executed plan to create and maintain partnerships when practical, and otherwise, develop and sustain relationships, for the sake of efficiency and effectiveness. To illustrate improved relations, board staff offered anecdotal evidence. While in the recent past the media routinely printed stories critiquing the Board without ever engaging the Board in any type of fact-finding dialogue, many members of the media now contact the Board in advance to determine their accuracy. The media's impact on public perception cannot be overemphasized and media reports can be particularly misleading when a story contains bare facts or insufficient information. State medical boards around the country routinely deal with criticism from the media concerning their disciplinary processes as the media commonly lacks understanding or knowledge of the rules and laws that guide a board's disciplinary decisions. The Board's improved relationship with the Nevada media allows it to ensure that accurate information is being provided to the public, a particularly important development given the complaint-driven nature of state medical boards. The Board relies on complaints in carrying out its mandate to protect the public, thus it is imperative that the public not only understand the Board's role, but also trust the Board's commitment to quality medicine.

While the audit team applauds the Board's efforts and achievements with respect to its stakeholder and public outreach, the team recommends that the Board continue to evaluate and refine its existing public relations campaign. In interviews, Board members and staff acknowledged that the Board Executive Director generally acts as the face of the organization, interacting with members of the public when necessary. This is consistent with the Public Relations Policy set forth in the Policies and Procedures Manual which allows the President of the Board to delegate the role of board spokesman to the Executive Director.[21] It is the audit team's position that the Executive Director is uniquely poised to respond to inquiries from the media, the public and other organizations as he or she will normally have the most comprehensive knowledge of the Board's processes as well as more regular availability. Although the Executive Director should be free to delegate any or all of these responsibilities when practical or appropriate, it is crucial that the Board project a harmonized voice for the reasons mentioned in the preceding paragraphs.

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[21] See Attachment 9

By design, materials and other information developed as part of the consumer outreach program align seamlessly with the Board's additional education outreach activities. In 2011, the Board partnered with the University of Nevada Reno College of Medicine to develop Continuing Medical Education presentations on statutes, regulations and ethics.[22] The Board has also developed program materials to serve as a guide to governmental regulatory agencies and law enforcement partners of the Board seeking to better understand the Board's enforcement processes.

The aforementioned initiatives demonstrate the Board's commitment to preventing, remedying and deterring unprofessional conduct by licensees. Thus, the audit team is satisfied that the Board is acting with the statutorily prescribed methodology and efficiency.

f) The managerial and administrative efficiency of the Board in using the fees that it collects pursuant to this chapter.

The 2003 report included the recommendation that the Board create an audit committee to whom each audit would be presented in person by the authors of the report. Rather than create an Audit Committee, the Board chose to implement an evaluation system by which the audit report is examined by the Executive Director, Finance Manager, the full Board and the public. Currently, at the conclusion of each audit report, the auditors brief the Board Secretary/Treasurer, the Executive Director and the Finance Manager prior to the next regularly scheduled Board meeting. At the Board meeting, the Secretary/Treasurer presents the full audit report, audit findings and the management letter to the full Board. The authors of the audit report attend the Board meeting to answer questions and discuss all aspects of the audit with the Board, who then decide whether to approve the report. Public comment is accepted for audit-related agenda items.

The Board, like state medical boards across the country, is used to operating within a rigid budget; however, the current economy has presented a new set of complex challenges. To properly prioritize budget items, the Executive Director engages in frequent, informal conversations with the Division Chiefs. Though no formal system exists for prioritization of budget items, the Executive Director reports that conversations are frank and frequent.

The most recent financial audit report concluded in 2011 and did not include any findings. Audit findings reported in 2009 related mostly to segregation of duties. All 2009 findings were resolved by 2010. Conversations with the external auditor during the on-site portion of the audit revealed unequivocal approval of the Executive Director's oversight of Board financials as well as approval of the Board's "extraordinary transparency." The Board hired a full-time Finance Manager in 2009 who also received high praise from the external auditor.

The overwhelming majority of the Board's fees are collected online and deposited automatically into the Board's bank account. To the extent fees are received through the mail, they are entered into a log book. Copies of all deposits are presented to the Finance Manager for reconciliation while the Executive Director opens all bank statements and signs all checks. This accounting system is consistent with other state boards across the country as well as within the State of Nevada. Board staff seem to fully understand the interrelatedness of protecting against fraud and carrying out the Board's mandate to protect the public.

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[22] See Attachment 10

Interviews with staff members suggested that the Board's operations may benefit from system-wide IT upgrades. The Executive Director indicated that the Board is in the process of determining what IT upgrades or system is most accurate and efficient and thus necessary. As the need for an IT upgrade was almost uniformly cited in conversations with Board staff, the audit team recommends that the Board develop an implementation plan, including a budget, deliverables and a timeline, to enable it to move forward with obtaining a new IT system.

With respect to NRS 630.127(a)-(b), the audit team is satisfied that the Board acts with the statutorily required diligence and efficiency. The Board promptly acknowledges receipt of complaints and corresponds regularly with complainants. The audit team applauds the Board's implementation of an electronic complaint triaging system that allows it to prioritize and respond to complaints based on seriousness of the alleged violation and risk posed to the public.

While similarly satisfied with the Board's diligence in conducting investigations of licensees who have had two or more malpractice claims filed against them within a period of twelve (12) months, the audit team believes that the Board may be conducting more investigations than required by statute. The audit team recommends that the Board revisit all applicable statutes pertaining to allegations of medical malpractice to determine which cases, and to what extent those cases, must be investigated in order for the Board to meet its statutory obligations. The audit team recommends that the Board identify and implement a threshold, which if met, will trigger investigation of a medical malpractice claim. The audit team does not recommend adoption of any particular threshold, but strongly encourages the Board to engage in a self-assessment to determine in what ways it may improve the consistency of its medical malpractice investigations process.

The audit team further recommends that the Board consider ways in which it may improve the consistency of its medical review process, including the possibility of supplementing one nearly full-time, on staff medical reviewer with one alternate medical reviewer to be utilized only when the staff reviewer's recusal is necessary. The team believes that this change has the potential to result in cost savings to the Board and will result in greater consistency. The audit team strongly encourages the Board to involve physician members in the medical reviewer hiring process as physician members are well positioned to evaluate candidates.

The Nevada Board is commended for achieving 100% reporting from Nevada hospitals and medical facilities. The audit team applauds the Board for its role in enacting 2011 SB 168, which reduced the facility reporting period from thirty (30) to five (5) days for privilege status changes resulting when the medical, mental or psychological competence of a licensee is at issue, or in cases where suspected or alleged substance abuse exist. These developments illustrate the Board's continued commitment to refining existing policies and procedures to assure it is fully and efficiently meeting its statutory obligations.

A successful state medical board should have a robust outreach program to consumers and its licensees. The Board's current consumer outreach and continuing medical education programming, as well as amendments to the Nevada Revised Statutes, demonstrate the Board's continued and deliberate efforts to prevent, remedy and deter unprofessional conduct in the State of Nevada.

While acknowledging much progress has been made, the audit team strongly encourages the Board to continue to identify new and innovative ways to reach and educate the public and other stakeholders. The team further recommends that the Board either reemphasize or revise the Board's existing public relations policy. The Board's Policies and Procedures Manual contains the existing policy and provides that the official spokesperson for the Board is the Board President, who may delegate as a matter of policy, or on a case-by-case basis, the responsibility of spokesperson to the Executive Director.[23]

[23] See Attachment 9

However, interviews with Board members and staff indicated that the Executive Director acts as Board spokesperson, though it is unclear whether an official delegation by the Board President has been made. It is the position of the audit team that the Executive Director is best positioned to act as official Board spokesperson as he or she will normally have the most comprehensive knowledge of the Board's processes and procedures as well as more regular availability. While it appears that this is the current practice of the Board, the audit team recommends existing policy be reemphasized or revised to reflect current practice.

The audit team was pleased to find that the most recent financial audit report, conducted in 2011, did not include any audit findings. The last audit findings were reported in 2009 and were resolved by 2010. Impressively, particularly in this current economic environment, the Board has managed to find savings without diminishing board productivity while reportedly maintaining quite high employee morale. The audit team values the Board's commitment to operating within a lean budget; however, the team also recognizes that it is sometimes necessary to invest in infrastructure and other upgrades, often significantly, in order to maximize efficiency. In interviews with Board staff, a near universal request was made for system-wide IT upgrades or a new IT system altogether. Though the Executive Director indicated that the Board is exploring IT options, the audit team recommends that the Board develop a plan for a new IT system, including a budget and timeline for implementation, in the very near future. The team further recommends that the Board establish a more formal system for prioritization of budget items, as no system is currently in place.

COMPARATIVE DATA

The FSMB's *Summary of Board Actions* was first published to provide accountability for medical boards to the public and to educate the media and the public of the significant volume of work performed by medical regulatory boards. Since its inception in 1985, the *Summary of Board Actions* has allowed the FSMB to capture and produce data reported by state allopathic and osteopathic boards on a national scale. Board action data eventually led to the development of the FSMB's Composite Action Index (CAI), a weighted averaging of statistics that allows a board to compare its level of disciplinary activity to itself over time.

The CAI is the arithmetic mean of four ratios provided in the FSMB's *Summary of Board Actions*: Total Actions/Total Licensed Physicians, Total Actions/Practicing In-State Physicians, Total Prejudicial Actions/Total Licensed Physicians, and Total Prejudicial Actions/Practicing In-State Physicians. Each of the four ratios offers a useful and interesting measure of activity within a jurisdiction; however, to depend on any one as a definite measure would be to ignore significant variables represented in the others. Therefore, the FSMB has created the CAI to combine the four ratios into a single composite ratio for each board. This simple device, the CAI, permits relevant variables to contribute in a balanced way to a final figure that can be useful in measuring an individual board's disciplinary activity over time; however, it does not take into account variables such as:

- Cohort differences in licensee population, such as training, experience, rural/urban distribution, number of in-state medical schools and training opportunities, etc.
- Preventive measures, such as early intervention in treating impaired physicians, peer review, and use of early intervention assessment/remediation programs before complaints and malpractice suits arise.
- Limitations inherent in different statutory schemes that enable licensing boards to take disciplinary actions.
- Board resources, funding and staffing.
- Economies of scale, differences between large and small boards.

This index is one indicator of performance as qualified above. Although the CAI is a barometer that can signal significant changes in a medical board's disciplinary activity level, changes in a board's funding, staffing levels, changes in state law and many other factors can also impact the number of actions taken by a board.

In April 2012, the FSMB House of Delegates adopted the Report of the Workgroup to Examine Composite Action Index (CAI) and Board Metrics which determined that the following four state board processes collectively contribute to overall regulatory success: licensing, license renewal, continued competency and structure and discipline. The Report recommended that the FSMB create a set of metrics encompassing the entire spectrum of these processes rather than the admittedly one-dimensional CAI in an effort to more fully and accurately represent the important work of the state medical boards. Because the CAI data is available until 2013, and further, because the CAI data was included in the 2003 audit report, the most recent data is made available here. However, the audit team cautions the use of any single metric or measure as a standard for a state medical board's efficacy.

Nevada State Board of Medical Examiners CAI

2003-2011

2003	2004	2005	2006	2007	2008	2009	2010	2011
4.22	1.36	3.75	3.72	4.58	NR	6.09	7.07	9.55

Higher numbers correspond to an increased number of disciplinary actions; however, it is imperative to acknowledge that increases in disciplinary activity does not necessarily correlate to improved Board functions.