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Justification Review

January 2003 Report No. 03-06

While Medical Quality Assurance Improving, Licensure Needs Increased Accountability

at a glance

The consolidation of the Medical Quality Assurance Program into the Department of Health was achieved in an efficient and effective manner. The program has improved the timeliness of its complaint process and its response to serious complaints. While the program has not issued licenses by default, it lacks data on how long it takes to process license applications. The program has recently addressed the problem of delinquent licenses, but needs data to evaluate the success of its efforts. While the department is beginning an electronic continuing education tracking system, it may not be effective unless the Legislature amends the law to make provider registration mandatory.

We recommend that

- the program track the actual number of days that it takes to process license applications,
- the program assess the effectiveness of its new delinquent license policy, and
- the Legislature consider alternatives to the electronic continuing education tracking system.

Purpose

Section 11.513, *Florida Statutes,* directs the Office of Program Policy Analysis and Government Accountability to complete a program evaluation and justification review for each state agency that is operating under a performance-based program budget. Justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs.

This report is one of three that reviews the Health Care Practitioner and Access Program administered by the Department of Health. This report addresses the performance of Florida's Medical Quality Assurance Program. In two other reports we address the performance of the Brain and Spinal Cord Injury Program and the Bureau of Emergency Medical Services.

Background

The program's mission is to protect and promote the public health by regulating health care professions and establishments. The program regulates 37 health care professions and related establishments that provide these services. (See Exhibit 1.)

Exhibit 1
The Program Regulates 37 Health Care Professions

Regulated Health Care Professions	
▪ Acupuncture	▪ Midwifery
▪ Athletic Training	▪ Naturopathy
▪ Audiology	▪ Nursing
▪ Certified Master Social Worker	▪ Nursing Home Administration
▪ Certified Nursing Assistants	▪ Nutrition
▪ Chiropractic Medicine	▪ Occupational Therapy
▪ Clinical Laboratory Personnel	▪ Opticianry
▪ Clinical Social Work	▪ Optometry
▪ Dental Hygiene	▪ Orthotics
▪ Dentistry	▪ Osteopathic medicine
▪ Dietetics	▪ Pharmacy
▪ Electrolysis	▪ Physical Therapy
▪ Hearing Aid Specialists	▪ Physician Assistant
▪ Marriage and Family Therapy	▪ Podiatric Medicine
▪ Massage Therapy	▪ Prosthetics
▪ Medical Physicists	▪ Psychology
▪ Medicine	▪ Respiratory Care
▪ Mental Health Counseling	▪ School Psychology
	▪ Speech-Language Pathology

Source: Department of Health, Division of Medical Quality Assurance.

The program has three major functions—licensure, public information, and enforcement. Licensure requirements and the conditions for professional discipline are statutorily established separately for each profession. [1]

Licensure. The program administers professional testing and processes licensure applications. Licensure helps ensure that practitioners meet minimum standards in order to protect the public from unqualified practitioners. In Fiscal Year 2001-02, the Division of Medical Quality Assurance, which administers the program, processed 67,143 applications from new applicants seeking licensure and approved 60,372.

Program staff reviews these applications to determine whether applicants meet the minimum requirements for licensure and have submitted all of the required materials. The program must notify applicants within 30 days that their applications have been received and whether additional information is needed. Once an application is considered complete, state law requires the program to approve or deny applications within 90 days; if this deadline is not met, the program must issue a license by default, which could endanger consumers. [2] Program employees verify the applicant's transcripts, test scores, references, and other documents and compare this information to board licensure standards.

The program also processes licensure renewals for existing licensees. Licensees must renew their licenses biennially and must fulfill continuing education requirements. Many health care professions have the option of renewing their licenses through the program's website. When filing for renewal, the licensee attests that all continuing education credits are complete. Licenses that are not renewed biennially as required by law are designated as delinquent. [3] A license is delinquent by midnight of the renewal date and the licensee must pay an additional delinquency fee.

As of June 30, 2002, 757,670 health care professionals held active licenses to practice while 74,501 professionals held delinquent or inactive licenses. [4]

Public Information. The program's website makes information available to the public about health care providers through two systems. The Health Care License Lookup system provides current licensure information for all licensed health care providers. This data includes information about whether licensees have active, valid licenses and when their licenses expire. The Practitioner Profile system

[1] Chapters 457-468, *F.S.*

[2] Chapter 120, *F.S.*

[3] Under Florida law it is a misdemeanor to practice with a delinquent license for less than 12 months and a felony to practice with a delinquent license for more than 12 months.

[4] A license becomes delinquent at midnight the day the renewal is due. A license is inactive when a practitioner, (for example one who is retiring from practice), requests a change in the status of their license, rather than letting the license become delinquent.

allows consumers to access specific information about doctors and advanced registered nurse practitioners. The system provides profiles of each licensee, including educational and work experience, hospital privileges, and malpractice insurance. The practitioner profiles also list any criminal convictions as well as any disciplinary actions imposed by the state licensing board.

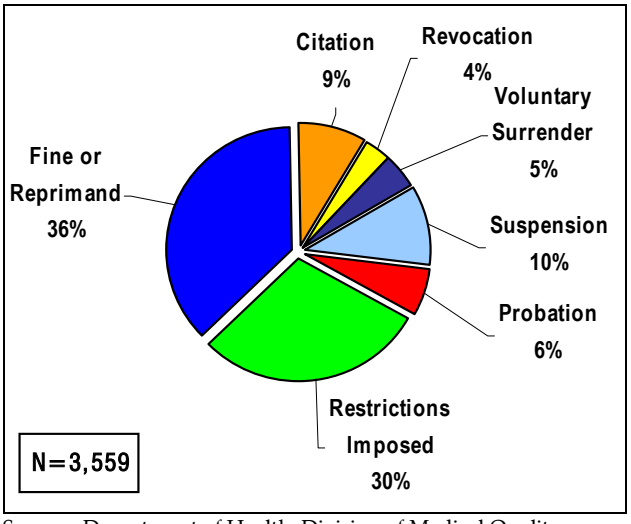
Enforcement. The program disciplines practitioners who have violated minimum standards of care or licensure requirements. The program processes and investigates complaints against practitioners who may be incompetent, impaired, or otherwise guilty of misconduct. In these investigations, personnel determine whether sufficient evidence exists to meet the statutory threshold of legal sufficiency.[5] In Fiscal Year 2001-02, the program received 10,543 complaints from the public, plus an additional 21,214 reports from other agencies that are required by law to report certain events. (See Appendix B.) For example, a hospital has to report certain patient deaths, which might in turn result in action against a doctor or nurse.

Once the investigation is complete, attorneys prepare a recommendation for the probable cause panel of the respective licensing board as to whether the complaint should go forward or be dismissed. In Fiscal Year 2001-02, 6,431 legally sufficient complaints were investigated and referred to the appropriate boards.

Probable cause panels for the health professions boards review these recommendations and determine whether a formal administrative complaint should be filed against the practitioner. If an administrative complaint is filed by the licensing board, the practitioner can agree to a settlement and admit wrongdoing. Or, as an alternative, the licensee can ask for an informal or formal hearing before the board or take the case to the Division of Administrative Hearings.

Discipline of health care practitioners takes many forms, from the relatively minor to the severe. In Fiscal Year 2001-02, 36% of the disciplined practitioners were given fines or reprimands, while 30% of cases resulted in some type of restriction of the provider's license. (See Exhibit 2.) Included under restrictions are penalties by which obligations are imposed on the practitioner, for example, a requirement to complete some type of continuing education course. A more serious licensure restriction might require a doctor to have a nurse present whenever certain examinations are conducted.

Exhibit 2
Fines and Reprimands Were the Most Common Form of Health Practitioner Discipline in Fiscal Year 2001-02



Source: Department of Health, Division of Medical Quality Assurance.

Other forms of discipline include citations that are similar to fines but are issued for less serious infractions such as advertising violations or failure to complete the necessary courses to renew a license. The most severe action the board can take is to revoke a license, which means the person can no longer legally practice the profession. Sometimes practitioners voluntarily surrender their licenses as part of

[5] Legal sufficiency is defined broadly in statute. According to s. 456.073, *F.S.,* a complaint is legally sufficient "if it contains ultimate facts that show a violation of this chapter, of any of the practice acts relating to the professions regulated by the department, or of any rule adopted by the department or a regulatory board in the department has occurred."

their discipline. The board also might temporarily suspend a practitioner's license to practice pending the outcome of a criminal complaint. Or, the board might require some type of probationary period, for example, following the completion of a drug treatment program.

Organization

The Department of Health assumed full responsibility for the Medical Quality Assurance Function as of July 1, 2002. Prior to that date (from 1997 until 2002), the program was divided between the Agency for Health Care Administration, which was responsible for complaint intake, investigations, and other related functions, and the Department of Health, which housed the regulatory boards. A 2001 OPPAGA report determined that this division of responsibility created several problems such as diffused responsibility for program administration. [6] Consistent with an OPPAGA recommendation, the 2002 Legislature consolidated the Medical Quality Assurance within the Department of Health.

Program activities are divided between the department and the 22 regulatory boards and 6 councils. The department has direct authority over five professions as well as broad responsibilities over licensure and enforcement. Department employees process license applications, investigate complaints filed against practitioners, and provide administrative support to the professional boards such as helping with travel for board meetings, public records requests, and centralized purchasing.

Members of the regulatory boards and councils are appointed by the Governor or department secretary. Board members share authority with the department for developing rules for licensure, establishing exams, setting fees, guidelines for discipline and unlicensed practice of the profession.

Resources. The Legislature appropriated $51,421,924 and 544 FTEs for the program for Fiscal Year 2002-03. [7] Almost all of these monies are appropriated from the Medical Quality Assurance Trust fund, which receives licensure and other fees paid by the various health professions. Program revenues as of June 30, 2002, totaled $65,827,986 and provided excess revenues, including interest, of $15,582,788 for Fiscal Year 2001-02.

Findings

Consolidation of the enforcement process was achieved in an efficient and effective manner

The 2002 Legislature mandated consolidation of the program in the Department of Health effective July 1, 2002. Prior to this change, the program was split between the Department of Health and the Agency for Health Care Administration. The Agency for Health Care Administration was responsible for complaint intake, investigations, and other functions under an interagency memorandum of understanding. In a prior report, we found that while consolidation of the program would streamline program administration and management within a single chain of command, it would not necessarily result in a cost savings or address issues regarding the enforcement process. [8]

We have concluded that the transition was completed in an orderly manner and presented no major problems. On July 1, 2002, the program's 253 FTE positions were transferred from the Agency for Health Care Administration to the Department of Health (DOH) to fulfill the 2002 Legislature's mandate to consolidate the program. The transition did

[6] *Program Review: Consolidation of Medical Quality Assurance Governance Structure Only a Partial Solution*, Report No. 01-50, October 2001.

[7] Legislative appropriations do no reflect program FTEs and resources expended within the department but outside the Division of Medical Quality Assurance such as indirect administrative costs and indirect salaries.

[8] *Program Review: Consolidation of Medical Quality Assurance Governance Structure Only a Partial Solution*, Report No. 01-50, October 2001.

not require a physical move of personnel or resources.

During consolidation, Department of Health officials took steps to improve the program. Program management established a task force to review the way that final discipline orders are processed and to test a new attorney-in-the-field model of service provision. The task force on final orders has proposed a number of recommendations to create a more uniform and consistent process for the boards. DOH is also locating two attorneys in South Florida field offices to work with investigators. Program officials will assess the effectiveness of the new model program at the end of Fiscal Year 2002-03.

The department is also addressing a potential conflict of interest resulting from consolidation. The conflict concerns the attorneys employed to prosecute some discipline cases. Because the attorneys who advise some of the health practitioner boards are housed at the Department of Health, program officials have decided to house attorneys who prosecute discipline cases for these boards in the Attorney General's office rather than at the Department of Health.[9] The program has developed an agreement with the Attorney General's office to house the attorneys that prosecute discipline cases. The department has developed a new agreement to cover this relationship with the Attorney General's office that runs through the end of Fiscal Year 2002-03.

The program has not issued licenses by default, but needs additional data to improve accountability

The program is required by law to notify applicants within 30 days that their applications have been received and whether additional information is needed. Once an application is considered complete, the program must approve or deny it within 90 days or the license must be issued by default, which could endanger the public.

The program has not issued licenses by default, but lacks data on how long it actually takes to process license applications. It has recently taken action to better address the problem of delinquent licenses. The program needs to maintain better accountability data on the licensing process.

The program has not issued licenses by default, but it lacks data to verify its performance. The Legislature has established a goal that the program process 100% of applications for licensure within 90 days. The program has reported that it met this goal each year from Fiscal Years 1999-00 through 2001-02. However, the department does not track the actual number of days that it takes to process license applications. It instead uses the fact that it has not had to issue any licenses by default as evidence of meeting the legislative standard. This proxy measure is inadequate as it does not provide the Legislature or department management needed information to determine how long the process takes, or whether the program's performance has improved or declined over time. Program personnel need to begin tracking the number of days that it takes to issue licenses.

The department has taken action to better address delinquent licenses, but needs data to evaluate the success of its efforts. In the past, the program did not have an effective method for enforcing laws and rules that prohibit practicing with a delinquent license. Prior to June 2002, the program notified licensees at the end of two years that failure to renew would make their licenses null and void.[10] As a result, some practitioners could have been out of compliance for up to two years.

[9] Prosecutors for 13 boards will be housed at the Attorney General's office, including Boards of Acupuncture, Athletic Training, Chiropractic, Clinical Laboratory Personnel, Hearing Aid specialists, Massage Therapy, Occupational Therapy, Opticianry, Orthotists and Prosthetists, Physical Therapy Practice, Respiratory Care, Speech-Language Pathology, and Audiology.

[10] If a delinquent licensee renews his/her license, the program assesses a fine equal to the amount of the renewal fee. In addition, if the program receives a specific complaint alleging that someone was practicing with a delinquent license, the enforcement section would conduct an investigation that could result in disciplinary action by the board.

Program officials have taken action to improve compliance with licensure laws and reduce the potential for licensees to practice with delinquent licenses. They began implementing a new policy in June 2002 that requires staff to send a notice to any licensee who fails to renew within 30 days. This notice informs the delinquent licensee about the penalties for practicing without a valid license.

The program plans to refer licensees who still fail to renew to its enforcement unit for investigation. This will include calling practitioners' offices and site visits to determine if the licensee is still in business. If the investigation determines that a licensee is practicing without a current license, the program can issue a cease and desist order as well as take disciplinary action.

Program management said they are using the results of these investigations to determine the scope of the problem concerning delinquent licenses. As of June 30, 2002, there were over 58,200 delinquent licensees, of which 23,700 were in-state licensees. Program management believes that most delinquent licensees are deceased, retired, or have moved out of state and, therefore, do not represent a threat to health care consumers. However, program management does not currently have the data they need to verify this assertion.

We believe the program should begin collecting information to assess the success of the new delinquent license policy. Program managers should collect information on the number of licenses that become delinquent, the number of licensees who are found to be practicing with a delinquent license, the amount of revenue collected from delinquent license fines, and the number of cease and desist orders issued.

The program's electronic continuing education tracking system will likely require mandatory registration to be effective

The 2001 Legislature mandated that the program implement an electronic continuing education system, effective July 1, 2001, as part of the program's electronic licensure renewal system. [11] The purpose of the new system is to improve compliance with continuing education (CE) requirements. Most of the regulated health professions require licensees to take regular CE training courses, and compliance with these requirements has been a long-standing problem. While the department is taking steps to establish the electronic system, it may not be effective unless the Legislature amends the law to make provider registration mandatory.

The program has historically used two methods to monitor compliance with CE requirements—post-renewal and pre-renewal audits. In post-renewal audits, board staff requires a sample of licensees who have just renewed to submit proof they attended the required CE courses. These audits have found noncompliance rates ranging from 4% to 33% (varying by profession). However, the audits are time-consuming for both licensees and staff because licensees must obtain and submit proof that they have taken the required courses. If the licensee has not maintained this documentation, they must contact their course providers to obtain the information. This results in many calls and numerous document submittals to the program.

Some boards conduct pre-renewal audits in which a sample of licensees is notified six months in advance that they will be required to submit proof of CE credits during their upcoming renewal. Pre-renewal audits are more practitioner friendly because licensees have six months to get CE hours completed prior to renewal and they only need to submit one set of documents to the program, and some boards have found that compliance is higher. For example, the Board for Clinical Social Work, Marriage and Family Therapy and Mental Health Counselors found only 1% non-compliance in a 2000 pre-renewal audit.

[11] Chapter 2001-277, *Laws of Florida*.

The new electronic system was intended to streamline continuing education tracking and improve compliance. The system is to maintain an electronic database that lists the courses that each licensee has completed. This information is to be submitted by the course providers. Ideally, this would eliminate the need for pre- and post-renewal audits because the program would have complete records of the CE courses taken by all licensees. Through a request for proposal, the program selected a vendor to implement an electronic system at no cost to the state. [12]

While the new system shows promise, it may not be effective unless provider registration becomes mandatory. As currently envisioned, the system will rely on voluntary reporting by course providers who will be required to pay $1.60 per licensee per course hour to have their attendance recorded. However, there is no requirement that CE providers participate in the system. While the vendor plans aggressive marketing, some course providers will likely refuse to participate or pay the course registration fee.

The vendor's marketing will be complicated by the large number of CE course providers and the fact that the department does not have a list of such providers. Although approximately 3,000 providers have registered with the program, some boards, such as the Board of Medicine, grant approval to hundreds of thousands of CE providers who operate throughout the U.S. as well as internationally. Some boards accept courses approved by national organizations rather than making these course providers register with the program. Program management believes that the new system will not include complete CE information for all licensees, and as a result, the program may need to continue to operate its existing manual system for licensees.

The Department of Business and Professional Regulation recently established a similar electronic system to track CE courses for the professions that it regulates. However, unlike the Medical Quality Assurance system, provider registration is mandatory. There is no fee for reporting, as the system was developed by the department.

The program needs to monitor course reporting under the new system. Should the system, as it develops, produce incomplete information because of non-reporting, the program would need to continue to conduct its pre- and post-renewal reviews. This is not a desirable option as these reviews are burdensome to both licensees and the department (which estimates that uses 8.75 full-time equivalent employees to conduct these audits).

As an alternative, the Legislature could amend the law and mandate that CE course providers register with the state. A second alternative would be to turn over responsibility for CE monitoring to the professional associations. One board is considering making a national association responsible for tracking continuing education. Many associations are continuing education providers and already track course attendance for the courses they provide.

The program has improved the timeliness of its complaint process

The Legislature requires the program to process complaints in a timely manner, and it has established a performance standard that 85% of complaints must be referred for probable cause within 180 days. Timely processing is important to both protect citizens who may be harmed by health care professionals who violate licensing standards as well as to practitioners who may be subject to unfounded complaints.

The program has met the timeliness standard for recommending cases for probable cause. As shown in Exhibit 4, in Fiscal Year 2001-02, the program referred more than 90% of cases to probable cause within 180 days, exceeding the 85% standard. The program improved its performance from 88.7% in Fiscal Year

[12] At the time of our review, a protest had been executed by a second vendor who submitted an RFP to the program.

1999-00. [13] The program attributes the improved performance to better monitoring and tracking of complaints. The program now requires that staff make a determination of legal sufficiency within 10 days and that complaints be investigated with 90 days, which provides the remaining 80 days for its attorneys to make a recommendation as to the existence of probable cause.

Program's response to serious complaints has improved

The Legislature also requires a swift response to serious situations that might endanger the public's health, safety, and well-being. The program can initiate emergency action in situations that represent an immediate threat to consumers, referred to as a Priority I complaint. The legislative standard is that 25% of Priority I complaints should result in emergency action. A second legislative standard is that the program should take emergency action in Priority 1 practitioner investigations within an average of 90 days. Rapid action in such cases is important to protect the public. For instance, unless the program takes emergency action to suspend their licenses, physicians charged with sexual assault could be released from jail and continue to practice.

As shown in Exhibit 4, the program met the legislative standard for the percentage of Priority I complaints that resulted in emergency action in both Fiscal Years 2000-01 and 2001-02. The program has also improved performance and met the timeliness standard for issuing emergency actions. In Fiscal Year 2001-02, the program took an average of 87 days to take an emergency action, 3 days better than the mandated 90 days and a significant improvement from 123 days the in prior year.

Program officials attribute the improved performance for serious complaints to a new team approach for Priority I complaints, better monitoring of complaints, and downgrading complaints if additional information reveals that the threat to consumers is not significant. The new team approach includes legal assistance from program attorneys from the moment a Priority I complaint is received. By working with attorneys, investigators can insure that they have the information necessary to obtain an emergency order. In addition, program managers have improved monitoring by tracking and reviewing on a daily and weekly basis where complaints are in the process and how long they are taking. [14]

[13] The 180-day measure includes only cases that were closed within a fiscal year, rather than all cases that were opened.

[14] In our prior report, we recommended that the program establish procedures to maintain the documentation needed to verify its performance information reported to the Legislature. During the current review, the enforcement program provided backup documentation for the program's performance for Fiscal Year 2001-02.

Exhibit 4
Program Response to Serious Complaints Has Improved, 1998-2002

Enforcement Measures	Fiscal Year 1997-98	1998-99	1999-00	2000-01	2001-02	Fiscal Year 2001-02 Legislative Performance Standard
Percent of Complaints Referred for Probable Cause within 180 days [1]	NA	NA	83.0%	88.7%	90.3%	85.0%
Percent of Priority I practitioner Investigations resulting in Emergency Action	4.0%	3.0%	13.0%	29.0%	29.4%	25.0%
Average length of time (in days) to take emergency action in Priority I practitioner investigations	98	76	124	123	87.1	90

[1] The Legislature established this measure for Fiscal Year 2000-01.
Source: Department of Health.

In our prior report, we recommended that program officials seek ways to improve cooperation with the states attorneys who may be initiating criminal charges against health care practitioners. In May 2001, program managers explained that their ability to take emergency action was sometimes limited by a lack of access to information contained in criminal complaints.[15] The program reports that they have not taken specific action to implement this recommendation. According to program officials, the states' attorneys continue to express concern about releasing information that might compromise their criminal cases. Program officials say they have taken steps to identify cases in which they can pursue emergency action without information on criminal complaints.

Conclusions and Recommendations

The program has not issued licenses by default, but lacks needed data on the licensing process. We recommend that the program start tracking the actual number of days that it takes to process license applications. We also recommend that the program assess the effectiveness of the new delinquent license policy by tracking the number of licensees who become delinquent, the number who are found to be practicing on a delinquent license, the amount of revenue collected from delinquent license fines, and the number of cease and desist orders issued.

The new electronic continuing education system will likely be flawed because of incomplete data. We recommend that the Legislature consider two alternatives to improve compliance with continuing education requirements. The first is to amend the law and require CE course providers to register with the state. Alternately, the state could turn over responsibility for CE monitoring to the professional associations.

Agency Response

In accordance with the provisions of s. 11.513, *Florida Statutes,* a draft of our report was submitted to the secretary of the Department of Health for his review and response. The Secretary's written response is reprinted herein (see Appendix C, pages 13-15).

[15] *Justification Review: Health Care Regulation Program Agency for Health Care Administration*, Report No. 01-24, May 2001.

Appendix A

Statutory Requirements for Program Evaluation and Justification Review

Section 11.513, *Florida Statutes,* provides that OPPAGA Program Evaluation and Justification Reviews shall address nine issue areas. Our conclusions on these issues as they relate to the Medical Quality Assurance Program are summarized in Table A-1.

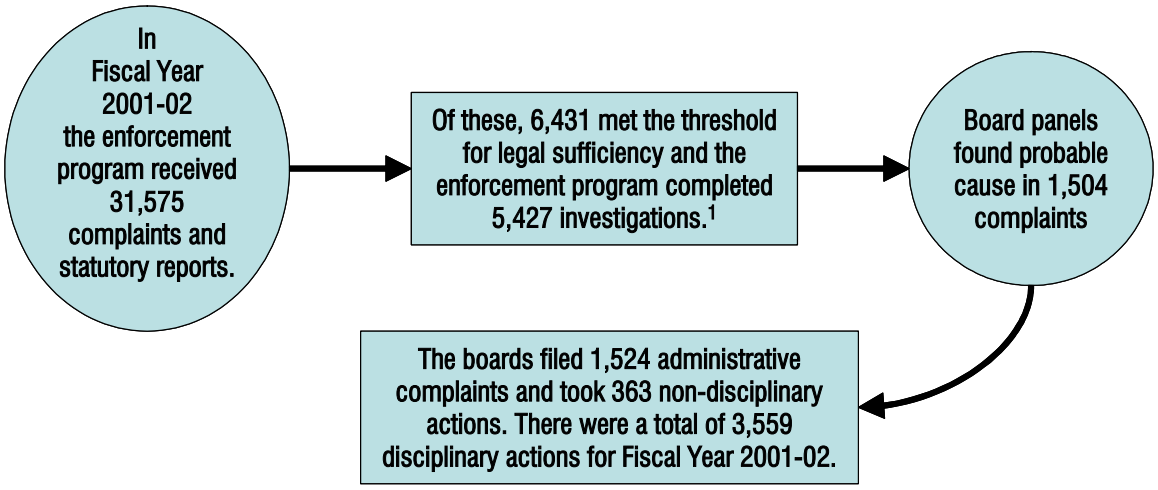
Table A-1
Summary of the Program Evaluation and Justification Review of the Health Care Practitioner and Access Program

Issue	OPPAGA Conclusion
The identifiable costs of the program	The Legislature appropriated $51,421,924 and 544 FTEs for the program for Fiscal Year 2002-03.
The specific purpose of program, as well as the specific public benefit derived therefrom	The program's mission is to protect and promote the public health by regulating health care professions and establishments.
Progress toward achieving the outputs and outcomes associated with the program	The Legislature has established a goal that the program process 100% of applications for licensure within 90 days. The program has reported that it met this goal each year from Fiscal Years 1999-00 through 2001-02. The program met the legislative standard for the percentage of Priority I complaints that resulted in emergency action in both Fiscal Years 2000-01 and 2001-02. The program has also improved performance and met the timeliness standard for issuing emergency actions. In Fiscal Year 2001-02, the program took an average of 87 days to take an emergency action, 3 days better than the mandated 90 days and a significant improvement from 123 days the in prior year.
An explanation of circumstances contributing to the department's ability to achieve, not achieve, or exceed its projected outputs and outcomes, as defined in s. 216.011, *F.S.*, associated with the program	Program officials attribute the improved performance for serious complaints to a new team approach for Priority I complaints, better monitoring of complaints, and downgrading complaints if additional information reveals that the threat to consumers is not significant. The new team approach includes legal assistance from program attorneys from the moment a Priority I complaint is received. By working with attorneys, investigators can insure that they have the information necessary to obtain an emergency order. In addition, program managers have improved monitoring by tracking and reviewing on a daily and weekly basis where complaints are in the process and how long they are taking.
Alternative courses of action that would result in administering the program more efficiently or effectively	We recommend that the program start tracking the actual number of days that it takes to process license applications. We also recommend that the program assess the effectiveness of the new delinquent license policy by tracking the number of licensees who are found to be practicing on a delinquent license, the amount of revenue collected from delinquent license fines, the number of cease and desist orders issued, and the number of licenses that turn null and void. We recommend that the Legislature consider two alternatives to improve compliance with continuing education requirements. The first alternative is to amend the law and mandate that CE course providers register with the program. Second, the state could turn over responsibility for CE monitoring to the professional associations.
The consequences of discontinuing the program	Regulation of health care professionals serves to protect the public's health, safety, and welfare by establishing minimum educational and examination requirements that provide reasonable assurance that persons licensed are qualified. If regulation were discontinued, the public would not be adequately protected against providers who do not meet minimum standards due to incompetence, negligence, or impairment.

Issue	OPPAGA Conclusion
Determination as to public policy, which may include recommendations as to whether it would be sound public policy to continue or discontinue funding the program, either in whole or in part	All 50 states establish licensure standards and enforce rules and laws pertaining to health care professions. While some experts question whether the regulation protects the public or benefits the economic interests of the profession by raising the price for services, no states have deregulated these important professions.
Whether the information reported pursuant to s. 216.031(5), *F.S.*, has relevance and utility for evaluation of the program	The department does not track the actual number of days that it takes to process license applications. The program instead uses the fact that it has not had to issue any licenses by default as evidence of meeting the legislative standard. This proxy measure is inadequate as it does not provide the Legislature or department management needed information to determine how long the process takes, or whether the program's performance has improved or declined over time. The program needs to begin tracking the number of days that it takes to issue licenses.
Whether state agency management has established control systems sufficient to ensure that performance data are maintained and supported by state agency records and accurately presented in state agency performance reports.	In our prior report, we recommended the program establish procedures to maintain the documentation needed to verify its performance information reported to the Legislature. During the current review the enforcement program provided backup documentation for the program's performance for Fiscal Year 2001-02.

Appendix B

Medical Quality Assurance Enforcement Program Flow Chart, Fiscal Year 2001-02



[1] Because practitioner discipline is an ongoing process, not all complaints received in a given year will result in completed investigations. In the same way, findings of probable cause and formal discipline may result from complaints filed in previous years.

Source: Department of Health.

Appendix C

Jeb Bush
Governor

John O. Agwunobi, M.D., M.B.A.
Secretary

January 14, 2003

John W. Turcotte, Director
Office of Program Policy Analysis
& Government Accountability
111 West Madison Street, Room 312
Tallahassee, FL 32399-1475

Dear Mr. Turcotte:

Thank you for the opportunity to respond to the Office of Program Policy Analysis and Government Accountability's [OPPAGA] justification review, *While Medical Quality Assurance Improving, Licensure Needs Increased Accountability.*

Please find enclosed our response to the report recommendations made to the Legislature.

We appreciate the opportunity to comment. If you have questions, please contact us.

Sincerely,

/s/
John O. Agwunobi, M.D., M.B.A.
Secretary, Department of Health

JOA/mhb
Enclosure

Preliminary and Tentative Findings Response

OPPAGA Justification While Medical Quality Assurance Improving, Licensure Needs Increased Accountability

Finding	*Recommendation*	*Management's Response*	*Corrective Action Plan*
The program has not issued licenses by default, but needs additional data to improve accountability.	We recommend that the program start tracking the actual number of days that it takes to process license applications.	We concur with the recommendation.	1. Piloting with Board of Nursing the collection of data on days required to issue deficiency letters to applicants and time period between issuance of letter and issuance of license. 2. Develop template for use by all professions for developing management reports that capture this data, identifying time lapse for each step in licensure process. Pilot in Board of Nursing. 3. Upgrade of PRAES (MQA database) will consider enhancements and result in changes in business practices that may enable data to be collected and analyzed electronically.

Finding	*Recommendation*	*Management's Response*	*Corrective Action Plan*
The program has not issued licenses by default, but needs additional data to improve accountability.	We recommend that the program assess the effectiveness of the new delinquent license policy by tracking the number of licensees who become delinquent, the number who are found to be practicing on a delinquent license, the amount of revenue collected from delinquent license fines, and the number of cease and desist orders issued.	We concur with the recommendation.	1. Notify delinquent licensees by letter and follow up with investigation those who do not respond. 2. Purge files of deceased practitioners by performing data match with Office of Vital Statistics. 3. Monitor amount/increases in delinquent fees. 4. Upgrade of PRAES (MOA database) will consider enhancements to report fine amounts electronically by disposition codes.
The new electronic continuing education system will likely be flawed because of incomplete data.	We recommend that the Legislature consider two alternatives to improve compliance with continuing education requirements. The first alternative is to amend the law and mandate that CE course providers register with the state. Alternately, the state could turn over responsibility for CE monitoring to the professional associations.	The department has recently awarded a bid to a vendor to develop and operate an electronic continuing education (CE) tracking system. However, the bid award is currently being contested by another vendor. As this process may result in an administrative hearing, the beginning date of development of the system is unknown. The criteria upon which the system is predicated assumes that the successful bidder will incentivize continuing education providers to the degree that they will not be competitive in the field without using the system, thus ensuring eventual full use of the system. Likewise, licensees will be incentivized to use providers that use the system. Although full use of the system may take some time to accomplish, the department would like to evaluate the degree of success of the vendor before considering alternatives. The vendor is not being paid with state funds and will be highly motivated to make the system workable and profitable. Not all professional associations are currently in a willing and able posture to assume the task of CE tracking for licensees. There is some activity in this direction on the national level with certain associations of state regulatory boards (e.g., chiropractors, optometrists), but the professions are in varying states of readiness on this issue.	

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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Project supervised by Nancy Dufoe, Chief Analyst (850/487-9242)

Project conducted by Mary Alice Nye (850/487-9243) and Rae Hendlin (410-4795)

Frank Alvarez, Staff Director

John W. Turcotte, OPPAGA Director