PRESCRIPTION FOR CHANGE:
NEW JERSEY HEALTH CARE CONSUMER INFORMATION ACT

EXECUTIVE SUMMARY

On June 23, 2003, the New Jersey Health Care Consumer Information Act ("Profile Law") was enacted, requiring the Division of Consumer Affairs ("Division") to implement a means to provide the public with information in the form of individual profiles, to enable them to make informed choices about their physicians and podiatrists. More specifically, the Division was given the responsibility to:

- collect and maintain specific information concerning all physicians and podiatrists ("practitioners") licensed in the State;
- make the information available to the public through electronic and other appropriate means, at no charge;
- establish a toll-free telephone number for members of the public to contact the Division to obtain a paper copy of a profile and to make other inquiries about the profiles;
- contract with a public or private entity for the purpose of developing, administering and maintaining the practitioner profiles; and
- monitor the work of the entity to ensure that the profiles are properly developed and maintained.

As required by the statute, the profile system went into operation on June 23, 2004, offering the public more information than has ever before been publicly available. Since that date, the profile web site – at www.njdoctorlist.com – has been accessible to the public twenty-four hours a day, seven days a week; the telephone help line is staffed eight hours a day, five days a week. Between June 23, 2004 and October 1, 2005, there were nearly two hundred sixty thousand visits to the New Jersey Health Care Profile web site, with well over four million pages of the site accessed. Use of the web site by both the public and the licensees has been constant, at a reasonably active level since the original peak period. Both the public and licensees have shown a preference for online access.

Section 5 of the Profile Law also requires the Director of the Division ("Director") to make recommendations on whether the profile should be expanded to include other health care professionals. At this time the Division supports the inclusion of dentists and chiropractors in a larger profile system. In establishing the time frames for the implementation of the recommended expansion, effort should be made to dovetail the timing with two schedules -- in the first instance, the schedule for registration renewal in each field and in the second, the schedule for the criminal history background checks (mandated by the Health Care Professional Responsibility and Reporting Enhancement Act, P.L. 2005, c. 96, which went into effect on October 31, 2005.) The scheduling of additional professions should follow only after dentists and chiropractors have been integrated.

The Division's experience with the profile over the period of its operation, and its contributors and users, has enabled it to identify a number of areas in which the profile could be improved. In this report the Division recommends five specific actions that could be undertaken, some with legislative support, that would enable the profile to better serve consumer needs:

Malpractice Reporting

In compliance with the statutory directive, the profile on each practitioner includes information on malpractice actions to which that practitioner has been a party within the preceding five years. Specifically the profile contains the date, the dollar amount and the type (judgment, settlement, arbitration) of payment. The Profile Act explicitly requires that the malpractice payment data be provided in "context", so that the number of malpractice actions is to be characterized as "below average", "average" or "above average" as compared to practitioners in the same specialty field. In making these distinctions, there must first be a determination of the average number of actions in each specialty. The average number is derived by dividing the number of malpractice payments in a specialty by the number of doctors in that specialty. In application, that number is nearly always equal to a number less than one. Thus, the comparison of the specific physician's malpractice experience to such an average is of little value in assisting consumers in making informed choices and the mandate, although well-intentioned, has resulted in the inclusion of a characterization which is virtually meaningless and confusing. The information that may best serve the public, with numbers this small, are the number of malpractice matters by specialty, the number of licensees in the specialty and the number of matters involving the individual licensee -- all information currently available on the profile. Deletion of the contextual comparison would actually reduce the confusion.

Technical Limitations

The "fields" in the profile have been populated from information derived from a number of sources – the files of the Medical Board, a database purchased from the American Medical Association and from practitioners themselves. Data is exported from these multiple sources, "uploaded" and managed by an outside vendor. Some portions of the resulting database are available to the public through the profile; other information is considered confidential and is available to practitioners only through a secure site. The complex interactions occurring during the data import and export processes have resulted in occasional glitches. Technological enhancements should be implemented to enable full integration of all of the data into a profile, without the need to import data, in an effort to minimize these problems. These enhancements should certainly be addressed should the profile be expanded to include other health care providers, as is recommended here. Any legislative enactment expanding the profile should allow sufficient time to make the needed technological adjustments.

Practitioner Participation

Although during the start-up phase, every practitioner was supplied with a notice of the content of his or her profile, asked to correct any mistakes and add pertinent information, as many as 19,705 licensees have not provided the additional information sought. This low level of participation leaves many gaps in optional categories (like office hours and insurance accepted), as well as in some of the mandated categories (like post graduate education). Increased involvement and cooperation of practitioners would certainly benefit the consumers. The Division will be exploring ways by which licensees can be encouraged, or even compelled, to add content to the profile. Rule making may be undertaken to establish sanctions for the provision of misinformation or for the failure to correct information known to be in error. Legislative consideration might also be given to shifting some of the optional content into the mandatory category.

Criminal and Out-of-State Disciplinary Data

Information about criminal convictions and out-of-state disciplinary matters comes to the Board of Medical Examiners from a variety of sources - the courts, the Federation of State Boards of Medical Examiners, licensees themselves and the media. While the Board's first responsibility must be to evaluate the information to determine if an action against the New Jersey license is warranted, better efforts need to be undertaken to integrate the data coming from these diverse outside sources into the profile. To date, these "fields" have been populated primarily through self-reports. No systematic approach now exists to electronically post updates in these fields. Operational enhancements should be pursued to facilitate the inclusion of this vital information. With criminal history background checks ultimately to be required of all licensees, attention can be focused on devising a process for channeling reports of convictions more directly into the profile system. Electronic linkage to sources of information from out-of-state source should also be explored, and stepped up enforcement of reporting requirements should be undertaken.

Data Sources

As noted above, information in the profile is derived from many sources. In its effort to meet the statutory deadline, the Division entered into an agreement with the American Medical Association (AMA), by which it was able to quickly obtain an electronic file that included medical school information, specialty certification and sub-specialty certification, as well as the physician's self described field of medicine. By this agreement, the Division also obtains monthly data updates from the AMA -- and has an ongoing financial commitment to pay for those updates. In the upcoming months the Division will undertake a review of the sources upon which it presently relies to determine whether other options may be available to integrate new information, at less cost. In addition, it will examine how it can better elicit cooperation from licensees, by integrating an update responsibility into the renewal process

Welcome to the New Jersey Health Care Profile

New Jersey Health Care Consumer Information Act
Prescription For Change

On June 23, 2003, Governor McGreevey signed the New Jersey Health Care Consumer Information Act ("Profile Law"), mandating the creation of a web-based profile system to provide consumers with an array of information about individual physicians and podiatrists ("practitioners").[1] The system developed includes information with respect to more than 33,500 practitioners authorized to practice; as well as 670 whose licenses have been suspended, revoked, and voluntarily surrendered.[2] On June 23, 2004, the New Jersey web site providing practitioner profiles went "live" on the Internet at www.njdoctorlist.com.[3] The web site is accessible twenty-four hours a day, seven days a week. Consumers can also seek information by mail or by using a toll-free telephone, staffed by English and Spanish speaking customer service representatives, eight hours a day, five days a week. Within a few days following implementation, the briefly overwhelming numbers of "hits" on the web site and telephone calls from practitioners and the public stabilized. Between June 23, 2004 and October 1, 2005, there have been nearly two hundred sixty thousand visits to the New Jersey Health Care Profile web site, with well over four million pages of the site accessed.

In compliance with section 5 of P.L. 2003, c. 96, the Division welcomes the opportunity to report to the Legislature that it has met challenges that were entrusted to it. The Division has assembled accurate data from its own internal files and outside sources, devised a procedure to provide profiled licensees with an opportunity to verify the data collected and the option to contribute additional information about their practices and achievements, and designed and launched a means to make this information available to the public in a free, user friendly format. By this report, the Division will provide a brief summary of how it has been able to meet these goals, the lessons learned and recommendations for enhancements and expansions. Through the issuance of this report, the Division hopes it will assist the Legislature as it considers future legislative direction concerning the profile.

Historical Context

Up until the late 90's, most of the information that the licensing boards maintained on health care professionals was on paper. The first technological improvements allowed for the automation of the licensing function, and thus data collection of the content of applications began. Over the last fifteen years legislative enactments have required the collection of more and more information on licensees -- particularly as to practitioners.

- Beginning in 1983, legislation was enacted which required health care facilities to notify the Medical Board of certain disciplinary proceedings or actions

[1] The bill had been passed by the Senate on May 29, 2003 and by the Assembly on June 12, 2003. Governor McGreevey signed the P.L. 2003, c.96 on June 23, 2003, thus requiring implementation by June 23, 2004. The statute is codified at N.J.S.A. 45:9-22.21 et. seq.

[2] The statute requires a system that includes, at a minimum, the profiles of all physicians and podiatrists "licensed" in the State; however it does not explicitly exclude individuals who are no longer licensed, either as a matter of law or by their own choice.

[3] The profiles are also accessible at www.njconsumeraffairs.com/njphys.htm,

resulting in the suspension of privileges or removal or suspension from the medical staff. (P.L. 1983, c. 247, N.J.S.A. 26:2H-12.2).

- That law was dramatically expanded with the passage of the Professional Medical Conduct Reform Act of 1989 ("Panel Act") (P.L. 1989, c.300). Provisions of this statute, specifically sections codified at N.J.S.A. 26:2H-12.2, set forth in greater detail the types of events health care facilities that would trigger the obligation to report.
- In addition, this Act changed the physician oversight structure by creating a new layer of review – a body authorized to recommend action to the Board - named the Medical Practitioner Review Panel ("Panel"). N.J.S.A. 45:9-19.8. The Panel was given the responsibility to review the notices of the reportable events occurring at health care facilities, as well as actions taken by HMOs, notices of medical malpractice settlements, arbitration awards and judgments or termination or denial or surcharge on medical malpractice liability insurance coverage. N.J.S.A. 45:9-19.9. The collection of this data laid the foundation for the profile system.

Public interest in gaining access to information about individual practitioners began to escalate to a demand in the late 1990s. New Jersey's first legislative effort designed to create a "profile" on each New Jersey licensed practitioner was S.766, introduced on February 26, 1998 by Senators Codey and Sinagra.[4] The New Jersey Senate Health Committee favorably reported a substitute for the bill on October 18, 1999, with the key elements intact, and with the stated intention to "enable health care consumers to make informed choices about their physicians and podiatrists in a way that is not prejudicial or unfair to physicians or podiatrists." Thus, even in its first incarnation, there was a balance struck between the consumer's desire for access to information and the practitioner's interest in assuring that the information was accurate and fairly explained -- particularly as to malpractice reports. Building the support needed to pass this initiative would not happen overnight. Senators Codey and Sinagra introduced similar legislation in the next two sessions. In 2000, S.575, and in 2002, S.571 were each introduced with the same provisions[5].

Over the years that followed the consumer interest grew even stronger. With expanded reliance upon managed care for health insurance and health providers, consumers were frequently faced with the need to leave the care of practitioners with whom they had long standing relationships and choose others about whom they knew very little. Meanwhile other states were ahead of New Jersey in addressing this recognized need. Two years before the first bill was introduced in the New Jersey, Massachusetts enacted the first statutorily-mandated physician profile system in the country. Other states followed suit. In 1999, the Federation of State Medical Boards[6] charged a Special Committee on Physician Profiling with the task of assessing the kinds of information that were available to the public and the sources of this information. In the period between 1997 and 1999, twelve additional states passed profile laws.

[4] The bill was co-sponsored by Senators Vitale and Bryant.
[5] The Assembly bills were also introduced in these sessions with A.2439 introduced by Assemblyman LeRoy Jones in May 2000 and A. 915 introduced by Assemblymembers Edwards and Weinberg in January 2002.
[6] The Federation of State Medical Boards (FSMB) is a national organization of the seventy medical boards of the United States, the District of Columbia, Puerto Rico, Guam, Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands.

The Division was keenly aware of the legislative interest in New Jersey, as well as the developments in other states. Even before the Profile Law was enacted, it had started an evaluation of the information it had available through its own files. As it embarked on the installation of an automated licensing system in 2001, the Division recognized that the system would need to serve as an important platform for the introduction of a profile system in the future. Although implementation of the new automated licensing technology was fraught with its own obstacles and conversion of data from the myriad formats in which it had been stored proved to be a difficult and time consuming task, the technological improvement initiated in 2000 were essential to the Division's long term ability to take on the task then still subject to legislative debate.

The combination of these events seems to have provided the necessary impetus for eventual enactment of the legislation. When the Senate Health, Human Services and Senior Citizens Committee reported a substitute for Senate bill S.571 on May 30, 2002, its purpose was clear. The Profile Law (in its third debut) was intended "to enable health care consumers to make informed choices about their physicians and podiatrists in a way that is not prejudicial or unfair to physicians or podiatrists." (Statement to Senate Committee on Health, Human Services and Senior Citizens Substitute for S. 571.) This newest version did contain one additional important legislative recognition. Both the 1983 effort to encourage voluntary reporting and the 1989 Panel Act had maintained strong provisions for protecting physician information from the public.[7] S. 571 made clear that the consumer need for certain information would outweigh the prior concern for confidentiality -- paving the way for the disclosure of data relating to hospital privilege actions, malpractice resolutions, criminal convictions and out of state disciplinary actions not yet the subject of in-state discipline.

By December 12, 2002, both bodies of the Legislature had passed the Profile Law. Governor McGreevey conditionally vetoed the bill on January 27, 2003 and recommended consideration of a number of amendments, extending the time for implementation and recognizing that some caveats regarding comprehensiveness of the information in certain fields would be in order. On May 19, 2003 the Senate unanimously concurred with the Governor with regard to the recommendations and on June 12, 2003 the Assembly unanimously concurred as well. On June 23,

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[7] N.J.S.A. 45:9-19.3, prior to the passage of the Profile Law, had kept all information provided to the Medical Board confidential until final disposition of an investigation.

> Any information concerning the conduct of a physician or surgeon provided to the State Board of Medical Examiners pursuant to section 1 of P.L.1983, c.248, C.45: 9-19.1), section 5 of P.L.1978, c.73 (C.45:1-18) or any other provision of law, is confidential pending final disposition of the inquiry or investigation by the board . If the result of the inquiry or investigation is a finding of no basis for disciplinary action by the board, the information shall remain confidential.

The Profile Law made clear:

> The provisions of this section shall not apply to information that the Division of Consumer Affairs in the Department of Law and Public Safety, or its designated agent, is required to include in a physician's profile pursuant to P.L.2003, c.96 (C.45:9-22.21 et al.)

The recently enacted S.1804, Health Care Professional Responsibility and Reporting Enhancement Act, (P.L. 2005, c.96), repealed this section, repeating and expanding the provision in a new section, N.J. S.A. 45:1-36. It also preserves access to information necessary for the profile. In addition, the Profile Law amended the Panel Act, again, to resolve the conflict in favor of consumer access through the profile, by lifting the confidentiality protections that had applied to records obtained by the Panel if the information in those records was to be included in the profile.

2003, Profile Law was signed, establishing that profiles should become operational within 365 days, by June 23, 2004.

The Start-Up

1. Finding a Data Management Vendor to Build the Platform

Pursuant to N.J.S.A. 45:9-22.24, the Division, was given the authority to enter into a contract with a "public or private entity for the purpose of developing, administering and maintaining" the profile. In the exercise of this authority, and in accordance with all contracting requirements established by the Division of Purchase and Property, the Division entered into a contract with Maximus, the contract vendor that developed the profile system in New York. Although there are marked differences in the mandated procedures and content of the New York profile, the familiarity that Maximus had already developed proved invaluable as the Division moved forward with its own planning. Not only was there a need to focus on the integration of information from an array of potentially incompatible sources, but the planners needed to be mindful that the process protections afforded to practitioners upon the integration of new information in the future. Any system developed to implement the Profile Law would need to have a variety of automatic features built in to permit smooth operation over the long term. In general, the product that was developed has allowed the Division to meet its goals. Moreover, the vendor has been responsive when programming changes have been needed to address unanticipated data glitches or unforeseen technical problems that have arisen as new categories of information are melded into the system. The Division has been satisfied that the initial "build " of the profile system was adequate to the needs at the outset, within the allowable time. Nonetheless it has recognized that improvement in functioning could and should be achieved prior to any legislated expansion.

2. Accumulating the Profile Content, in the Most Efficient Manner

The Profile Law identified two types of information that were to be included in the profiles -- that which was mandated and that which the practitioner might elect to provide. Specifically, the profiles were to include:

Required Information

- Medical school(s) attended and the year medical degree received;
- Graduate medical education, including all internships, residencies, and fellowships;
- Year first licensed;
- Year first licensed in New Jersey;
- Location of office practice site(s);
- Medical Malpractice payments made in the last five years, including date, dollar amount and type (judgment, settlement, arbitration)[8];

[8] The Division had originally requested additional information from individual insurers and insurance associations authorized to issue medical malpractice liability insurance in the State, as the statute had contemplated might be useful. N.J.S.A.45:9-22.23 (10)c. Some additional cooperation was gained from individual entities; however

- New Jersey disciplinary actions taken against the licensee within the last ten years and, where a disciplinary action has resulted in continuing limitation or restriction, such limitations or restrictions that are currently applicable to the license;
- Other state or licensing entity disciplinary actions within the last ten years;
- Description of health care facility actions, for reasons related to practitioner's competence, misconduct or impairment, involving privilege revocations or involuntary restrictions, resignations or non-renewal of hospital or health care facility privileges, or restriction of privileges at a health care facility taken in lieu of or in settlement of a pending disciplinary case within the last ten years; and
- Convictions of crimes of the first through fourth degree within the last ten years.

Optional Information:

- Board certifications;
- Board sub-certifications;
- Office hours;
- Languages other than English spoken by the physician or podiatrist;
- Languages other than English for which translation services are provided;
- Accessibility of office(s) to persons with disabilities;
- Whether Medicare assignment is accepted;
- Participation in the Medicaid program;
- Health insurance plans accepted;
- Medical school appointments or teaching responsibilities within the last ten years; and
- Hospitals at which privileges are held.
- Right from the start there was a recognition that before the profile system could "power up," the potential sources of accurate, reliable information that were electronically available to the Board to populate even the "required" fields needed to be identified and evaluated to assure that the delivery format would be compatible and that the content was reliable. Much of the required information was known to the Board, but maintained in scattered places and in many formats -- hand written cards and files, archived application files, first generation electronic files, home-grown databases and through the newly introduced automated licensing system, known as Licensure 2000 or L2K. For

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indications that reporting was incomplete persisted. In cooperation with the Department of Banking and Insurance, the Division will continue efforts to enhance insurer compliance with reporting obligations. In addition, the Division requested assistance in connection with its audit of the information reported to the Board, initiated pursuant to the Health Care Quality Improvement Act of 1986 (HCQIA) and, in particular, Section 424(c)(1) of HCQIA, which requires insurers to report malpractice payments to the Medical Board. (This federal law, as amended, authorized the National Practitioner Data Bank.)

example, the Board had gathered information about every practitioner's educational background at the time of licensure. But retrieval of that data would have entailed a manual review of the individual archived files. Data regarding specialty fields of practice had been requested on biennial renewal forms for a number of years, but it was not then available in L2K and would have to have been culled for unfiled batches of renewal forms. Thus, it was recognized that reliance on the Board's own records would be extraordinarily labor intensive and time consuming.

Use of external sources of this information was next considered. Fortunately, the Division was able to negotiate a financial arrangement whereby the American Medical Association (AMA) would provide an electronic file containing medical school information, specialty certification and sub-certification, as well as the physician's field of medicine[9] - as to each New Jersey licensed physician. This agreement with the AMA however did involve a substantial financial commitment at the outset, as well as an ongoing expenditure for monthly data updates. Information about podiatrists also was made available to the Board in a unified electronic form

The information on file, as supplemented by the databases of professional associations, was still not sufficient to populate all of the "fields." Nor could any of the information be posted without first affording licensees the opportunity to dispute the content, consistent with the statutory mandate. Thus, it was clear that there would need to be outreach to licensee that would need to serve the dual purpose of 1) providing a mechanism to assure that errors could be corrected and 2) filling in gaps, particularly as to the optional data. On a going forward basis, because changes in the information are inevitable, the mechanism to be utilized needed to have the capacity to be updated online or in hard copy.

The first step in obtaining practitioner input involved a regular first class mailing to all current licensees introducing the profile and explaining the available features. E-mails were also sent to various professional associations urging participation. Although practitioners were encouraged to use the online process (complete with a PIN number) to access and review their own profiles, they were told they could request a paper copy. Unquestionably, though, there was a design bias toward online participation as it is less costly to operate and more efficient for all concerned. A practitioner electing to participate online could sign on to the system, complete the survey, provide missing data, enter corrections, review the new information and approve the profile all at one sitting or, at their election, in phases. Completion of paper survey by necessity required more time, and thus provided shorter time frames within which to lodge a dispute.

In reviewing the profile content, practitioners were asked to verify its accuracy, supply the required information if it was missing and optional information, such as Board certifications held or insurance plans accepted, as desired. The survey, whether completed online or on paper, addressed the full range of information - including discipline, criminal convictions, out-of-state actions, hospital /facility adverse actions and malpractice. Once the licensee responded to the survey and the information was entered into the profile, the licensees were given either electronic access to or hard copy of the survey to review. There was a forty-five day period provided, during which changes or corrections were to have been requested/made before the profile is available to

[9] The initial data collection by the AMA includes a "field of medicine" that is self-selected by each physician. The various "field of medicine" have been categorized in specialties recognized by the American Board of Medical Specialties.

the public-- which period satisfied the thirty days required by statute and an additional fifteen day across-the-board extension.[10] Notwithstanding the efforts to make the process as efficient and user-friendly as possible, many practitioners, to this day, have still not reviewed their profiles either through the secure online site or by requesting a hard copy. In accordance with the statutory scheme, if no dispute as to the content of the profile is raised before the expiration of the review period, the profile was to be posted, as is. Regrettably, the low level of participation has left many profiles devoid of much of the optional information that consumers might find valuable.

3. Organizing and Displaying the Profile Content

With respect to the design format, the profile was divided into four separate parts, which in the online version are accessible through individual tabs on a bar -- Education, Practice Information, Legal Actions and Professional Activities. Disclaimers reflect that information may not be comprehensive and that voluntarily provided information is not verified and is updated only when the practitioner chooses to do so.

- Education - - This section includes an identification of the practitioner's medical school and graduate medical education (residency training), as well as additional training obtained. Board certifications and sub-certifications as appear in this section, as were reflected in association databases. Practitioners responding to the survey, or updating their profiles can provide supplementary data regarding medical school(s) attended, the year the medical degree received, as well as all internships and residencies.[11]
- Practice Information -- The profile should include the location of the licensee's practice, the year in which the practitioner was first licensed in any state and the year in which a New Jersey license was first issued. This section of the profile also is intended to capture information about the practice that could have a bearing on choices a prospective patient might make such as, the other languages spoken at the practice or the health plans accepted. Too often this section is populated with "None Reported."
- Professional Activities -- The profile may also report the practitioner's participation in the academic community, by reflecting appointments of to medical school faculties within the most recent 10 years;
- Legal Actions -- This subsection of the profile captures an array of information which may be vital to consumers -- malpractice actions, New Jersey discipline (including license practice restrictions), discipline in other states, actions taken by health care entities with respect to privileges and criminal convictions. Significantly, the Profile Law provides that these matters will be dropped from the profile with the passage of time. Malpractice is included if the payment was made within the past five years. New Jersey discipline is included if the order was entered (or there is license practice restriction) within the past ten years. Health care facility actions are included if the action occurred within the past

[10] If requested corrections are not supported by the facts available, the change is not made.

[11] During the initial phase of the profile data collection, the instructions in combination with provision of "pull-down" information could be read to exclude fellowship information -an unintentional oversight, later corrected.

ten years. Criminal convictions that occurred within the past ten years are included.

4. Designing a Process for Resolution of Disputed Information

The system had to be built to accommodate the "changes in profile" information in the future and to permit the necessary opportunity to dispute any information that the that statute requires. The process contemplates the following steps:

- The Division first notifies the licensee that there has been a change in profile information;
- The licensee is given thirty days to go to his or her profile online or request a hard copy and review and approve or dispute the information.
- To dispute the information online, the licensee enters a check mark in the box which signifies disagreement.
- If the licensee does not want to use the online reporting system, he or she contacts the profile center to dispute the information.
- If a dispute has been identified, an investigation is undertaken to verify the accuracy of the data.
- If the Board office is satisfied that the information is accurate, it will be posted to the site.
- If the licensee is not satisfied, he or she is advised to contact the reporting entity to challenge the reported information and, if and when, the board receives a revised report, the new information will be posted, and a copy is sent to the licensee.
- If the licensee offers no response to the new information or agrees that the information is accurate, the change also becomes part of the public profile.

When an adverse action is taken by a health care entity (as with self-reports of malpractice payments), the information receives a "disputed status" for internal purposes until the status is "resolved" through a check against other immediately accessible reporting sources. Again, this information is available to the public because it was self-reported information. When new information concerning adverse actions becomes available from outside the profile process, through reports from health care facilities, these reports trigger the "change in profile" process cited above. The board office regularly receives notice of the disputes from the profile vendor, Maximus.

Caveats on Content

1. Self-reporting of Criminal Convictions and Out-of-State Actions

Because the real time pressures faced in implementing the protocol, several approaches were adopted which, while expedient and necessary at the time, have rendered the content of some parts of the profile less reliable than they might be had time permitted a more intensive and expansive search. Information that pertains to disciplinary actions in other states and criminal convictions has been derived primarily from practitioner self reports. This approach was taken for two reasons: 1) no current electronic assimilation of that information could be imported into the profile because no separate electronic file existed and 2) data concerning these legal actions when derived from the a self- report would not need to await practitioner review. Certainly self-reports are not the optimal source for obtaining content for this section of the profiles. But it bears noting that when those actions precipitate a regulatory response in New Jersey – when the conviction or out of state suspension is used as a predicate for New Jersey discipline – the in-state action is automatically merged into the profile through L2K. And, actually a number of licensees, as part of the profile start-up, did self-report malpractice actions, out-of-state discipline, and criminal convictions. Within the first six weeks of the profile implementation, twenty licensees had reported criminal convictions through the web site. On a going forward basis, convictions and out of state matters that come to the Board's attention are now loaded in the profile as "active" matters, triggering the issuance of the letter notifying the practitioner of an impending change in the profile and providing the 30 days to access the site and dispute the accuracy of the entry before a public posting.

2. Medical Malpractice - Contextual Comparisons

In the medical malpractice section of the profile, consumers can learn of malpractice payments made by or on behalf of individual practitioners – whether made as a result of a judgment or arbitration awards or as a result of a settlement agreement -- during the preceding five years. The specific data provided includes the date and type of the payment and the dollar amount. In addition, the Profile Act explicitly requires a disclaimer which cautions consumers about the import of the data, by advising that "settlement of a claim and, in particular, the dollar amount of the settlement, may occur for a variety of reasons. . ." which do not necessarily reflect negatively on the professional competence or conduct of the practitioner.[12]

The Profile Act also requires that the malpractice payment data be provided in "context." The statute sets forth the means to develop this "context." The method requires the determination of the average number of payments made by all practitioners in a particular specialty. The number of malpractice payments made on behalf of the individual is then compared to the average number for all in the specialty. That number is to be displayed on the profile within the context of average, above average (where the number of malpractice payments is in excess of the average) and below average (where the number of payments made is fewer than the average). The statistical mean number of malpractice payments per doctor is calculated by dividing the total number of payments by the number of doctors in the specialty. Because the calculated "mean" number is less than one, the percentage requires use of a statistical determination. This determination is necessary for

[12] Indeed, it was because of the inclusion of this language in the disclaimer that the Division concluded that the Legislature must have intended that the actual dollar amount be posted.

purposes of making the statutory categorization into one of three categories -- below average, average and above average. Statistically, the practitioners who have made no payments are categorized as having made a "below average" number of payments. Those who have made one malpractice payment are categorized as having made an "average" number of payments, and those who have made two or more malpractice payments are categorized as having made an "above average" number of payments.[13] Given the very small numbers of malpractice actions involved, these characterization may actually be more misleading than helpful. The posting of the number of doctors in that specialty who made malpractice payments within the last five years probably gives the consumer a more useful guide than the characterization itself.

3. Disputed Updates for Medical Malpractice and Health Care Entity Reporting

The Profile Law, in its attempt to balance the interests of the public and practitioners, expressly required the development of a process for disputing both as to the initial profile content and updates. Once a month, the Board office receives a report from Maximus which contains reports of malpractice payments or health care facility actions which licensees have disputed, as well as those that have been self-reported. Initially all such reports are held – and internally classified as "disputed" while attempts are made to verify the facts. As to the self-reports, no notice is sent alerting the practitioner to an impending post, unless the confirmation process has revealed information at odds with the report. With respect to information derived from other sources, an opportunity for practitioner review before posting would be provided. Resolution of the dispute process is a labor intensive process, which can take weeks to track down and verify whether the dispute is valid. Developing relationships with health care entities and insurers has assisted in foreshortening the delays inherent in the process.

4. New Jersey Disciplinary Actions

This section of the profile is perhaps the most important to consumers seeking information about prospective health care providers. It is electronically populated on a bi-weekly basis directly from the Division's automated licensing system, L2K . But it is important however to bear in mind what is not included. When an order is entered against a practitioner it is summarized and entered into L2K. Formal disciplinary action may be predicated on a consumer complaint, a report of a sister state, a Panel recommendation after review of malpractice reports or hospital privilege actions or reports received from other government entities. Consistent with the Profile Law, information concerning such actions is not added to the profile until due process has been provided to the practitioner, a formal order has been prepared and filed and the "change of profile" process has been followed . Thus formal complaints containing allegations of wrongdoing are not found in the profile. Nor does the profile contain action that occurred more than ten years unless the order includes an ongoing limitation on practice. Nor is the actual Board order directly linked to the profile site. The Consumer Advisory however does alert consumers that a more recent order can be obtained through the Board's website, www.njmedicalboard.gov.

[13] For example, a specialty has 9589 doctors and the number of malpractice awards in the specialty in the last five years is 281. The average number of malpractice awards in the specialty is equal to .029.

Lessons Learned

1. Expansion of the Class Included

Because it had primarily viewed the profile as a tool for consumers in search of a practitioner, initially the Division elected to include in the profile only those who were authorized to actively practice. Retired licensees, including those licensees who are over 65 years of age who had chosen the reduced licensure fee retirement status as permitted under N.J.S.A. 45:9-19.15, were not included. Nor were those who had allowed their license to lapse – even if the lapse was very recent. And, those practitioners who were precluded from practicing by virtue of a disciplinary order of revocation or active suspension were also omitted. Some of all three categories have now been now added to the site because of a perceived consumer interest. Indeed, those over 65 in the reduced fee category, are authorized to engage in practice and their inclusion would have been appropriate from the start. Recently lapsed practitioners may, upon the fulfillment of certain administrative steps, be reinstated and thus their inclusion might be helpful to consumers. Accordingly, at present, practitioners whose registrations expired in 2005 are subject to a limited listing -- the license number, the year of first licensure and New Jersey licensure.[14] Practitioners whose licenses lapsed prior to the most recent renewal period will not be included. Finally, while the statute focuses on licensees, it does not preclude the inclusion of those who are not currently authorized to practice and a determination was made to add those who have surrendered in lieu of discipline and those barred from practice via an order of suspension or revocation.

2. The Inclusion of Fellowships

In its first incarnation the system was set up to display only the educational data pertaining to graduate programs (internships and residencies) approved by Accreditation Council for Graduate Medical Education (ACGME). The Division subsequently recognized that the original data source did not include fellowships, which although approved and included in the hospital teaching curriculum, would not "meet" the ACGME requirement. When other site content was changed, the language limiting post graduate education to "ACGME approved" programs was removed.

3. Malpractice

When the profile went "live" in June 2004, the malpractice information within the immediate past 5 years was posted by showing payment made or by showing "IN DISPUTE". The designation "IN DISPUTE" meant that a licensee had received notice of a reported malpractice and had not yet responded or had responded, challenging the accuracy of the report. As a consequence of the system design, when the "IN DISPUTE" response was activated, its entry shielded all the other malpractice payment report information for that licensee. Thus, by way of example, if a practitioner had three actions -- with only one in dispute -- the two undisputed ones would not be displayed. A change in programming was effectuated to enable the profile to show

[14] With the introduction of the optometrists to the system early this year, profiles for recently lapsed licensees will reflect the status "Expired."

the number of undisputed malpractice payments, even while the disputed payment was being evaluated.[15] The programming necessary to allow the section to show both in dispute and other reported incidents of malpractice is being developed and will be added to the system with the addition of the optometrist section of the profile.

4. Hospital and health care facility privilege revocations or restrictions

In its early stages, there was no means for a practitioner to contest the description of adverse actions occurring at hospitals and other health care facilities -- there was no "check-off" box. That feature has now been integrated into the process on a secure page.

15 The programming correction initially caused an inadvertent glitch, in which a large number of malpractice records were blocked for a for a short period of time.

Enhancements in the Works

1. Out of state disciplinary actions

As noted above, reports of out-of-state discipline are discovered in several ways – through self-reports, via confirmation from other sources, or in the Federation of State Medical Boards' monthly report. Efforts are underway to ensure that data coming from all of these sources are efficiently made part of individual profiles. Self-reports, because they need not be subjected to practitioner review, can be swiftly posted – once it is confirmed that the report accurately reflects the action in the other jurisdiction. Of course, if confirmation process reveals information at odds with the self report, the practitioner will be given an opportunity for review and dispute before posting the data.[16] There have been 64 out-of-state actions self-reported and 89 discovered in confirming the self-reported information. Automated transfer of this data directly to the profile is not yet possible, though it remains a long term goal.[17] The most comprehensive source of information about sister-state actions is the regular monthly report from the Federation of State Medical Boards. While the preliminary focus of attention upon receipt of these reports has been and will continue to be enforcement, exploration of a mechanism to systematically integrate the data into the profile system, either manually or electronically, is underway.

2. Criminal Convictions

In an effort to supplement the self reporting of criminal convictions, a pronged approach is contemplated. Although licensees have a statutory and regulatory responsibility to report criminal convictions to the Board, such reporting is infrequent. Discipline for the failure to report should be pursued, to heighten the awareness of the responsibility. In addition, although current New Jersey law[18] requires courts to report criminal conviction reports to the Board, compliance with this directive is not uniform among the counties. More efficient and consistent ways of obtaining this information, preferably through electronic options are being explored.

3. Reporting of Actions Taken by Health Care Entities

Under state and federal law, the Board and the Panel receive reports of hospital and health care facility Adverse Actions. There were 132 self-reported adverse actions. The state law requires

[16] When an action is "discovered" in this way, the information is not now entered into the profile track and is not immediately available to the public. This is a consequence of some barriers that were initially present in the two track data management system requiring additional programming steps both at the vendor, Maximus, and the Division. Based on various factors, including number of profiles affected, the Division is evaluating either manual or automated management of the Out-of-State Discipline category to provide the information to the profile system. An automated system requires a new file transfer export/import mechanism both at the Division and the vendor to integrate with the vendor system. The adjustment is expected to be made following completion of this evaluation.

[17] The Search Tips section of the profile will be revised to urge consumer to check the New Jersey Disciplinary Action segment because an out-of-state action could be reflected in appear as the basis for New Jersey discipline.

[18] The clerk of every court wherein any person licensed to practice medicine and surgery in this state is convicted of a crime shall make a report thereof in writing to the board upon blanks provided by the board. The report shall state the name and address of the person so convicted, the date thereof, the nature of the crime of which he was convicted and the sentence imposed by the court. N.J.S.A. 45:9-19.

a broader range of reporting than does the federal law.[19] These reported matters are contained in a table in the Panel database maintained in the Medical Board office. The information is posted on the Profile in the Hospital and Healthcare Facility Privilege Restrictions category. Self-reports of adverse actions by licensees are also posted here. The Adverse Actions information from the database maintained at the Medical Board is sent to be incorporated into the Profile system weekly.

4. Regulations

Although the Profile Law gave the Director the authority to promulgate regulations within 180 days of its effective date, because the statute itself provided sufficient guidance, regulations were not deemed essential during the start-up phase. Initial energies were focused on implementation and, in fact, the practical experience gained over the last eighteen months has helped to better identify regulatory needs. A regulation is now in development -- and its design will be sufficiently flexible to integrate future expansions of the profile to include optometrists (already added to the mix under P.L. 2004, c. 96,) as well as any other health care professionals that may be added later. While the regulation will provide a general backdrop, it will also:

- identify the universe of licensees who will be included -- those who are active, inactive, suspended or revoked, retired (no longer paying registration fees), or newly lapsed.
- establish that the cost of creating and maintaining the profile system will be shared by the boards whose licensees are included, through an apportioned assessment.
- make clear the process for review of proposed changes and identify the circumstances when the notice is not required, as with self reports, deletions because of the passage of time or contextual comparisons that may change as a result of a system re-calibration (as distinguished from an individual claims experience.)
- provide authority for sanctions to a licensee for failure to correct erroneous data or provide required information.
- implement measures to ensure greater licensee participation, as changes occur and as part of the biennial renewal process, with enforcement options identified.

[19] Hospital privileges actions that are to be reported to the Board in accordance with federal reporting requirements and those to be posted pursuant to N.J.S.A. 45:9-22.23 are not identical. N.J.S.A. 26:2H-12.2b, most recently amended by P.L. 2005, c.96, requires the reporting of considerably more that the federal law creating the National Practitioner Data Bank.

Recommended Expansion and Future Needs

1. Expansion To Other Licensees

By section 5 of the Profile Law, the Legislature has asked the Director to address the issue of expanding the profile to include other health care professionals - specifically, although not exclusively, dentists, advanced practice nurses, physician assistants, physical therapists and chiropractors.[20] Based on degree of practice independence and the likelihood that consumers would be making their own selection of provider, the Division recommends that dental and chiropractic licensees be added over the next three years. Although there will be challenges inherent in such an expansion, those groups have been selected because:

- The numbers of licensees involved are relatively small. There are 8,201 dentists with active licenses; and 63 dentists with either suspended, revoked or surrendered licenses. There are 3161 chiropractors with active licenses; 696 chiropractors with either suspended, revoked or surrendered licenses; and there are 414 chiropractors with expired licenses.
- Efficiencies can be achieved in data collection because of scheduling of biennial registration renewal and the newly imposed criminal history background checks (to be completed within the next four years). Dentists' biennial registration renewal will occur between August and November 2007 with their criminal history background checks targeted for the month of August 2008. Chiropractors' biennial registration renewal will occur between June and September 2007, with their criminal history background checks targeted for the month of December 2008.
- Dentists are already subject to the data collection system utilized in the system maintaining the National Practitioner Bank. Dentist and chiropractor licensee groups are subject to the HIP Database federal flagging system. As a consequence, they are subject to a data collection requirement that provides the Division with the ability to confirm self-reports.
- Although, preliminary outreach has not identified a source of available information (akin to the AMA database) from which education data could be extracted, the reduced number may better facilitate the manual retrieval of information.

Even so, some adaption to the profile requirement would likely be necessary to reflect the unique attributes of both professions, particularly as to education requirements and specialty classifications. In any event, sufficient advance planning and time to coordinate with the professional societies and licensees will be are critical.

[20] Optometrists, originally to be evaluated for addition to the profile process, became subject to the profile through legislation broadening their scope of practice very soon after the practitioner profiles went "live".

2. Specific Recommendations for Legislative Amendments

The Division welcomes the opportunity to share the benefit of its experience with the Legislature, and to make several concrete and specific recommendations to enhance the content of the profile in the future.

- Delete the requirement in the law to provide average experience and to categorize individuals as above, at or below that average. The number of malpractice matters by specialty, the number of licensees in the specialty and the number of matters involving the individual licensee provide sufficient information.
- Authorize the use of the biennial renewal form to provide updates to the profile content on a regular basis.
- Mandate the submission of some of the information which is now optional.
- Establish a compatible operational linkage between the courts and the Division to permit up-to-date inclusion of medical malpractice data and criminal convictions.
- Assure that expansions that may be forthcoming allow for sufficient time to obtain the data and optimize a smooth technical transition.

Conclusion

Since the system became available to the public in June 2004, close to five million pages of the public site have been visited, with an average of sixteen pages accessed per visit. There have been between 16,000 and over 18,000 visits to the public site every month since March of 2005.[21] Unquestionably there is a solid base of users. The recommendations contained in this report are intended to expand upon the information the public needs and to facilitate continued fine-tuning.

[21] The Website usage report is attached as an appendix to this report.

New Jersey Health Care Profile Website Usage
Accumulative 2004 - 2005

	Public Site			Doctor Site		
	VISITS	PAGES	AVERAGE	VISITS	PAGES	AVERAGE
Jun-04	21,067	631,740	29.99			
Jul-04	33,352	662,496	19.86	320	9,399	29.37
Aug-04	18,101	258,376	14.27	1682	51,734	30.76
Sep-04	14,381	182,832	12.71	1057	34,702	32.83
Oct-04	13,988	166,822	11.93	657	24,305	36.99
Nov-04	12,813	155,089	12.10	967	35,539	36.75
Dec-04	1,230	155,381	126.33	775	32,871	42.41
2004 Total	**114,932**	**2,212,736**	**19.25**	**5,458**	**188,550**	**34.55**
Jan-05	13,410	179,531	13.39	666	26,174	39.30
Feb-05	8,073	109,824	13.60	522	22,052	42.25
Mar-05	18,379	242,296	13.18	3,224	73,274	22.73
Apr-05	17,798	234,312	13.17	1,342	37,179	27.70
May-05	18,039	239,321	13.27	1,090	32,297	29.63
Jun-05	17,157	207,054	12.07	620	22,781	36.74
Jul-05	16,291	206,763	12.69	526	22,926	43.59
Aug-05	18,417	247,704	13.45	821	32,396	39.46
Sep-05	17,424	227,659	13.07	811	31,843	39.26
Oct-05	17,534	406,463	23.18	622	25,693	41.31
Nov-05	16,921	439,587	25.98	584	26,336	45.10
Dec-05	15,342	168,803	11.00	779	30,877	39.65
2005 Total	**194,785**	**2,909,317**	**14.94**	**11,607**	**383,838**	**33.07**
TOTAL	**309,717**	**5,122,053**	**16.54**	**17,065**	**572,388**	**33.54**