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2016 NCSBN Discipline Case Management Conference - Virginia's Sanction Reference Point System: An Empirically Based Approach to Ensure Fairness

Event
2016 NCSBN Discipline Case Management Conference

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Presenter
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- [Dr. Carter] Well thank you all for inviting me. This is an exciting opportunity to share a little bit of what we've done. I will tell you upfront, I am a data wonk and this is what drove a lot of what we've done. My background:- I'm an experimental psychologist. So, we're those folks that do the time and motion studies and all those kinds of things so, the numbers really help me to frame the world. And I'd like to just share what we've done really over 15, almost 16, year period in Virginia. Just give you a quick background on the program. I'll get a little bit into the methodology. We can't begin to get into the particulars the way we have done in the past because as we have evolved our methodology over time, I guess that it's been about 15 years, when we first started trying to figure out an empirical basis for rendering sanctioning decisions in Virginia, we were doing search because the research just was not there. It's a little bit better now, but I just wanted to explain that upfront. Since we instituted our program, we actually have an evaluation of this program, ongoing, and I'll have a Q&A session. All right. Just let me give you a little bit of background about the Department of Health Professions, like some of the other organizations earlier today, the Department of Health Professions is an umbrella agency. We house 13 licensing boards, the Board of Health Professions, and several programs also. Under that, of course umbrella, is the Board of Health Professions and I'll speak to that just a little bit later. They have representatives from each of the licensing boards so, you have a nursing member, from medicine, dentistry, so forth, five citizen members. And we could not have begun to do this project without the help of a dear colleague is with Visual Research Incorporated that is a contractor and his name is Neil Carter. In your packages you will an article that he and I worked on for you and it was published in J&R in April. I can sit into the details a little bit more. I like to give just a quick overview because most of you do know your Administrative Process Acts and they're very similar, but I just want to give you that overview for Virginia and you go, "Why are you doing sanction reference points, " and the answer is you need, as a governmental entity, I'm sorry, we need to be transparent, we've got to be neutral, we need to be consistent, and the sanction that you impose should be proportional. How many folks here know whether or not you are any of those things, right? In terms of your boards, it's very hard to demonstrate that without the data and we do have that data through our program.

So, we're considering this a track record of success beginning in 2004 and that's when our first program was first instituted. We started, and I'll tell you a little bit more about that later, with the Board of Medicine in 2001. They were our guinea pigs. Nursing followed in 2004 and so forth, but we've had a track record of success since that time. That's our structure and you can look at that in your packages. Each of the boards is at the bottom there. Board of Health Professions to the side. There's an office of director above it. Just to give you a sense of how we're organized. And there's my little Board of Health Professions. That's not our table. We have a big table. Every single member of the Board of Health Professions has an equal vote in anything that we do and our job is, we have lots of little powers and duties, relate to different things, but our job is to conduct independent research on policy issues. We make recommendations to the governor or Secretary of Health and Human Resources or Director of General Assembly on all kinds of matters that pertain to the regulation of Health Professions. The prescriptive authority for nurses in Virginia came through the Board of Health Professions, a study way back in the '90s, so, kind of proud of that. We also look at agency performance, and here's a kicker, I bet you most states don't have in your statute, my board is supposed to periodically review the investigatory, disciplinary, and enforcement processes of the department and the individual boards... Anyway, well, who are you? To ensure the public protection and on top of that the fair and equitable treatment of health practitioners or professionals. So, that's in statute. I assume the role of the executive director for the Board of Health Professions, even though I've been with the department since the 1990s, in 2001. And you kind of look at all your different powers and things you're responsible for and I really took it to heart. I said, "I'm supposed to ensure the fair and equitable treatment of Health Professions. How do we do that?" There are over 5,000 cases that come into our department every year across our 13 licensing boards. You can't begin to have anybody from Board of Health Professions looking over the shoulder of everybody that deals with discipline, but I said, "There's got to be a way." Well, first of all, I'm going to give you a little overview of the process too. If you go to the link on there, we do have a brochure that explains our disciplinary process. As with every state, we have an Administrative Process Act. Every case is a case-by-case decision. That's still the case. No pun intended. It is complaint driven, largely. Our investigators conduct our investigations from our enforcement division. Probable cause determination is handled by the respective boards and how the cases are disposed are handled by their respective licensing boards. We do have additional legal support from a unit called the Administrative Proceedings Division. Those are largely legal assistants and from the office of the attorney general. Okay, so, what are sanction reference points? Okay. The media, I don't care which board you are, but it's really particularly on medicine, the boards being too lenient or it's too harsh. Well, who's going to say it's too lenient? The complainant, right? Who's going to say it's too harsh? respondent, all right. Worse yet, it's inconsistent. Why does his case come out... Why did he get this sanction, but this person over here got another one? Did we have any way at all to defend ourselves from any of those kinds of questions? No. Does anybody else have a way to defend yourself from those kinds of questions? It's really tough, but if we go back to the original reason, we have to ensure fairness. Well, how do we determine this? The agency since its inception, really back in the 1970s, had been collecting statistical data to basically describe how many cases have you had? How were they resolved? What kinds or categories of cases are they? Are they fraud cases? Are they standard of care? Those kinds of things. So, we had the numbers basically, in terms of global insight into the types of cases that we have and how they're resolved, but you never knew why one sanction

was handed versus another. It's just no way to do that. And you go, "Why aren't y'all on the ball better? Why didn't you know this better?" All right. I'm sure most of the boards here are in the same boat. Your board members are involved with a lot of your case decisions. They are practitioners of the profession. They may be citizen members. How many have actual judges? Legal judges on your board? Anybody? See, all right. A lot of them don't even have attorneys that are actually board members, but you serve in a quasi-judicial role. You have to determine whether or not a violation has occurred. You also have to determine what do we do with it. And I was with the Board of Veterinary Medicine and Optometry as their executive director for 17 years and when we'd go into sessions after our case was heard... As you heard this morning, you had the presentations made, you go into closed session. And they said, "Okay, we agree that this is a violation. We agree this is the section of code it applies to. All right. Now, what have we done in the past, " because they have to figure out what do you do? And this is a case-by-case thing, okay? All right. So, they ask staff this because, "Hey, you've been around a long time Liz. Can you help us understand what have we done in the past?" And my answer would be no because if you go by my memory, or staff's memory, you remember the most egregious things, you remember the simplest things. You don't think about what a normal, typical case's resolution is and there's multiple factors in all kinds of cases. By us having that question asked repeatedly, it is inherently biasing. Where are our attorneys if they're here? It is inherently biasing because it's subjective memory, okay? It's also occurring in closed session when you go. For most cases, when you go into closed session, you're there, your board members are there, the ones involved in the case decision, the administrative proceedings division staff is there to help support us. Who's not there? When that door closes the respondent is not there. The respondent's attorney is not there and so, argument was coming forth saying, "Well, what's going on in those closed sessions when you determine your sanctioning?" They call it ex parte communication and they were starting to rattle some sabers at us and we said, "Okay, we got to find a way to help give these boards a tool that will help us figure out the severity of the misconduct to tie it to some factor that we could explain the why in a far better way than we'd done before. Okay, so I'm going to go a little bit into our purpose and our guiding principle and the methodology that we use. We stole heavily, joke intended, from the criminal justice system's approach to sentencing guidelines. And I'll also speak about how ours were developed using that model and a little bit more on the development and how we continue to monitor it. Okay, back in 2001, my board said, "Okay, you're going to provide a empirical systematic analysis of board sanctions for offenses and arrive some kind of reference points, whatever that's going to be, for board members and an educational tool for respondents and the public so, they have some idea what to hang their hats on. Which factors are the most important when you're rendering a sanctioning decision. And we're like, "Oh, just thank you for that, how we're going to handle this." We were very fortunate because we are an umbrella organization and we do play nicely. Don't we ladies from Virginia? We play very nicely with one another. We help each other. We had internal staff sit down with us to give us some recommendations for what you think we should be doing and they said, "Well, right of the bat, for a sanction reference system to be successful, it's got to be developed with complete board oversight, " and that means their licensing board. You can't just have Board of Health Professions just telling them what to do. You need to sit down and talk with the boards. It's got to be value neutral and it's got to be grounded in sound data analysis and it has to be voluntary. We can't force any of the boards to use sanction reference or refer to it exactly. We ask that you fill out some sheets, we'll talk about that in a little bit, but it's not compelled. It just

is a tool. Okay? All right. With criminal justice, we hear cases all the time about why was a sentencing so light or so harsh? We just had something this very week about that in the media. And back in the 1970s and '80s, our department of criminal justice services in Virginia was charged with developing something to help the justices, and this is work that goes across a lot of the states, to determine the relative influence of offender and offense factors to what are the things that should be influencing the sanction or the sentencing that comes out of that. And so, they use a multivariate model. They look for things that are statistically significant in predicting what the outcome is and they came up, they're the geniuses here, they came up with a model that allows you to extract those factors that the judges themselves deemed to be unwarranted or they call them extra legal, we would call them biasing factors, like gender, race, ethnicity, time of day, a thousand different things. But you could pull it out of the model so, what you're left with are those factors that should come into play. And so, you put your scored points based on the relative weight in the statistical model. It's pretty calculated if you want to put it that way. Your points are totaled and they're compared against thresholds of standardized tables that tell you that the different levels of sentencing severity, which ones would apply. And the system is continually monitored. There's a whole division within the Virginia supreme court offices that now monitor, on an ongoing basis, all the sentences that are handed down in our state from the criminal justice system and they do the analyses over and over again. They feed it back to the justices and you adjust those tables as you need to. So, we said, "Okay, that sounds like a really good deal. We'll try that in Virginia." So, first thing we had to do, what is the board done in the past? And then of course the big question is why? So, we did what is called our descriptive analysis first. We have individual orders that are on our website. We have case categories within a computerized system. There's all kinds of information that you can pull, but we needed to find out what is important to the boards. What do you think is an important thing that we should be looking to as we go back and look through cases? We'll look through case files. We'll look through notices, minutes, those kinds of things to find the information that we need. And we did determine it's got to be board specific because the board of nursing's cases are different, they really are, than the board of dentistry. The board of dentistry, for example, they care about the number of teeth involved in a case, okay, not that you don't. Not that you don't care about teeth, but it really is a significant thing for them and it is not so much so for some of the other boards. Well, over 100 factors came out from interviews that was staffed with board members, with the attorney general's office, and others to help us go look for these things. Let's see if we can find, empirically, what made the influence from the offense side and from the respondent's side in the case file, and so forth. So, we pulled a sample and I believe it was six years for the board of nursing the first go round. This was back in 2004. We went back six years because you have to have a large enough n size or large enough sample size to do the multivariate statistics that are required for this kind of analysis. Then, we started with medicine, then nursing, and you see the 2001, 2004. 2004 was when we instituted the board of medicine's SRPs. Nursing was 2006. And then once we got those larger boards, all the way down to the size of... It was dentistry, farming, veterinary medicine, some of the smaller boards like audiology and speech language pathology with less than about 5,000 licensees, we couldn't use the multivariate statistics, but we learned from these other boards and we worked with the individual boards to say, "Are you okay with these thresholds and these kinds of cases? Would this apply to you?" So, we worked through them and we completed all of our boards analyses and launched their SRPs by 2010. Okay, so, as we met with each board, what we did is we showed them the results of their statistical analyses of those factors and

again, based on the significance and the weighting, the removal of the extra legal factors, we left to them. They had to tell us what they believed should not play a role in the future. Nursing was wonderful. You didn't have many adjustments that you really needed to make. I think one of the things that was removed was whether or not the respondent showed up for the hearing. We took that out so, that's off. For medicine, again they were our guinea pig if you want to call it that, they had believed in their hearts of hearts if it were unfair at all, they said, "We may have been unfair to our international medical graduates. We just feel like we might have been a little harsher with them. What do the facts show?" No, it didn't. They were harsher with women, they were harsher if you were an older practitioner, and they were harsher if you did not have an attorney present, okay? Holding all factors constant, all those hundred other factors constant, those three factors would pop up and you would lose your license in those instances with greater severity or frequency than you did with anything else. So, of course they said, "Oh my gosh. We didn't know that." So, we take that out. So, those factors are pulled out of the algorithm that results in the scoring for medicine so, okay, again, that's something that's done in open board sessions so, the public can see what you're doing. Okay. They understand were important in the past for the types of cases that existed in the past and removing those extra legal factors for the future. Our modeling, we try to model the middle 70 to 75% of cases. You don't want to have everything model then there's no point in doing it. But we also ask, and I'll show you in just a second... There are worksheets that we use that are scored. The board has to approve those sheets and the cut scores for the points and so forth. And the how. We explain and it's a 35 paged document that I'm not going to belabor you with right now. It is available. At the bottom of the page you see the Board of Nursing's Manual. We have an SRP manual that really explains the background in quite a bit of detail. It gives you instructions for which sheets to use under which circumstances. Not every case applies to SRPs. If these are repeat offenses, we did our original analyses, it was for the first time around, okay? Certain things that relate to CE, we don't deal with. A lot of different things like that and for some of the other boards that have facilities, we don't include that information and licensure eligibility doesn't include any SRPs, but pretty much everything else is. So, as with the criminal justice system, the points are totaled, the offense scales, and the respondent, and then you have a recommended range of sanctions that you'll see on a grid. Now, these are wide. Things like treatment monitoring as opposed to go ahead and take their license. Send it over to a formal hearing so that their license can go or no sanction at all. There had been allegations, not against board of nursing, it's because somebody knew somebody or because they looked nice that day, all these things that shouldn't affect it, this eliminates that. So, we ask, and I'll tell you about this in just a second too, we ask when the boards do depart from the range of sanctions that we said should apply to the case, that you explain why so we can monitor it and make sure that our modeling will keep pace because your sanctioning culture will change over time. It just does. The kind of cases that you see, "We're going to have a whole bunch of opioid cases popping in here aren't we? Oh yeah, that's going to be a lot of fun." We also provide training to the board members, to staff, attorney, and the general public. We've offered it twice for the bar association and first go round they got CE for it, but we try to make everything we can as public as possible. The manuals that's referenced here is on the website for the Board of Nursing. It's also on the Board of Health Profession's website. The manual is provided, correct me if I'm right, when the respondent is sending the case you're coming in for an informal, they're referred to the manual so, they know. Okay. All right. That's hard to see that, I know. I apologize for that if you have it in the booklet. Our basic sanctioning outcomes fall into

about four different categories. You can either recommend for a formal suspension or revocation and that's something at an informal level you don't do, but you can recommend that it go there. And you'll see there's a bunch of little smaller types within that: state suspension, suspend or revoke the right to renew, suspension or revocation, recommend the formal. And then treatment monitoring is a whole range of topic areas. You're placed under terms. What does it mean to be placed under terms? Well, going through all those case files and looking at the orders and so forth, we figured these are the kinds of terms, so it would be: restrictions on drug administration, you have to inform the board of beginning or changing employment, those kinds of things. That falls under treatment monitoring. And then we collapsed for reprimand. It's going to be a monetary penalty, reprimand or CE, or sometimes no sanction is appropriate. For the Board of Nursing, it varies by board, there are three worksheets. We collapsed a lot of the cases into three types: the inability to safely practice worksheet, the standard of care, and unlicensed activity or fraudulent activity. You'll see a worksheet here, it's hard to see it here, but this is actually the scoring sheets that we use and you'll see an example of the dimensions on the bottom. You have at your table's a better explanation. You hopefully you see this. Actually it looks like this. It actually goes into explaining what those points mean or what each of those offenses, what it actually means. So, it's in words, not just in numbers. And as I mentioned before, we have a cover sheet. When you have reasons for departure for every case that the SRPs are used for, we want to know how the case is resolved, we want to know if you departed, and your reasons for departure, but you'll see that also in the SRP manual. And we collect those documents from each of the boards every month and we keep an ongoing monitoring of compliance or at least agreement with the SRP rates and what are aggregating and mitigating departure reasons are. And as you can see on the Board of Nursing is 79%, this was as of December, and some of the boards it's more or less, but this is how we keep track of... Now, if something falls too far below that 70, we start to look at the points. We talk with the board and we say, "Let's look at your cases again and see if we need to make adjustments. So, this is an ongoing iterative adjustment that's done. Okay. So, at the end of 2010, all the boards had their SRPs in place and so, my Board of Health Professions said, "Okay, now it's time to do evaluation, " and so, we said, "Okay, how do you want us to evaluate it?" And so they said, "We need to look again to see fi we achieved the aims that we were aiming for here: neutrality, proportionality, consistency. One of the things that comes up, was the SRP training adequate or do we need to do a better job of that? We, again, looked at the feedback for departures, reexamined the worksheets, and we had to modify some of the thresholds for some of the boards over time. Again, this is a 15 year period. We also wanted to look...if there was any kind of unintended consequences. One of the not horribly unintended, but we do add a little bit of extra work for the staff for the boards because they have to fill out these sheets and maintain those, but it's not bad is it guys? Look at that. Yeah, thank you. Yes, we like to hear that. Okay. That was a pun intended. And then over time, not only you're sanctioning culture, the kinds of cases that you have, the ways that you can resolve cases also change over time. And for example, when we started this back in 2004 for you guys, we didn't have what are called confidential consent agreements. I'm sure some of the boards have those. We didn't have advisory letters. So, none of that stuff. So, a lot of the cases that were marginally, there may be a little bit of a violation, maybe not, maybe we can just advise you in a letter to do a better job of record keeping or those kinds of things. Those kinds of cases tended to go more towards that. Not for everybody, but for some of the boards they tended to use that so, some of the cases that would've fallen into SRPs, had been resolved otherwise.

All right. Let's give you the results of the evaluation because I'm getting close on time. Okay. One thing we were just overjoyed is that overall it's pretty much stayed about an 80% agreement rate, which is more than what we'd hoped for. There's some individual boards, as you can see in the monitoring page, you'll get 60% every once in awhile or you'll get 80%, but it hovers in that upper 70s and 80s. We did find we needed, after asking everybody, can we have more training and we try to do that every time that the board needs to update their SRP, we will conduct training with the board members. And every once in awhile if it's a big change like nursing back in 2011, we did have the bar association and made a public training session available for them. We also train our investigators using this. This helps them to understand the factors that the boards want to know about as far as what they think are important things that relate to case decisions so, we do provide that for that group and our administrative proceedings division as well. One of the things that had not occurred or consistently... I think you all were always right, you always did what you're supposed to do. We had to make sure that the completed worksheet, not just the manual, the completed worksheet was actually shared with the respondent and his or her attorney if indeed an attorney was present for them. And that had been a bit inconsistent. Some of the boards were like, "Oh, I forgot we were supposed to do that." Well, yeah, you are. If they ever ask you, you have to give it to them. You have a right to appeal. SRPs are not used at formal hearings and for Virginia that's the last thing that the board can do before it goes to the court system. The AG's office just said leave that alone. Just do it for your informals and also nursing, I know you use it for prehearing consent orders as well so, we also have that mechanism so, prior to going to a formal hearing, you can use an SRP so, I just want to make sure that you're aware of that. And let's see, and I'd already mentioned about the CCAs and advisory letters. The original, and I mean way back in 2001, when this was search and not research, the AGs were very nervous about us using this. It's not in code other than me having to ensure fairness and they said, "Well, as soon as you get an appeal, if it goes to formal we got to watch this." Well, since 2004, how many appeals do you think we've had? It's right there of course. You can read it. We've had none. And we had 1,000 of cases over time so, we're very proud of that. And one other benefit that we hadn't anticipated is that we also heard from attorneys who are respondents who have often said well, we know generally what the board will do because I know the same factors that my client has offended on some particular thing or this is their first time on this kind of case. They know how to use the SRP so they can know upfront, pretty much, with some degree of certainty, the kinds of disciple that will be imposed. And so they said, "Look, can we just negotiate this before it goes to a hearing? Can we just do that?" And so it has really... Not to take business away from you at all, but it actually, when 2013, we did this particular evaluation, we found that for the Board of Nursing, the attorney involvement dropped in half. We did not have attorneys come to proceedings as much, I'm sorry. I'm sorry. I did that to you. I didn't mean to. DIdn't know. We also found... Now, I know board of nursing uses what are called agency subordinates a lot, and again, you heard earlier some folks have panels because it's just so hard to get...there's so much work to do that they have legislation that allows for designated agency subordinates to hear cases. And I think it's ultimately...it still has to be approved by the full board, but the agency subordinates can take on a lot of that work so, we train our agency subordinates with our SRPs. It gives them clear insight. You know exactly what the factors are that make the most significance and so that has helped them. We found that proportionality held much better than it was before so, the severity of what happened to the client or the circumstances relating to the offender, you tended to get the harsher

sentences, and the ones where it was lighter, you tend to be lighter. So, that held for every board and neutrality, believe it or not, when I talked about the departures either mitigating or aggregating, the mitigating ones tended to favor males for nursing and I know we had just done a review of trying to figure out are we being unfair to males on a national council state's board, nursing was looking into that, and at least for Virginia, based on the data that we have and for evaluation review, we went back and also, we got a new sample of cases, we did find that. So, that was a little surprising, but that's our evaluation to date. All right, I'm available for any questions you might have. Yes? - [Woman] When you talked about 80% agreement rate, I'm assuming that means that the model that you created, the recommended outcome was what the board members agreed was the right outcome. So, were they seeing the result of that model prior to... When they decided to depart, was it based upon knowledge of what that model was dictating? - Right because the sheet itself will tell you what the model dictates. - Right. Or were they deliberating first and then seeing what the model said after they made a decision. - I'll turn it over to the people who actually deal with the board and doing the discipline thing. That is Jody. - [Jody] Hi, I'm Jody Power. I'm one of the deputy executive directors for the Virginia board. It depends. I would think that there might be a little bit influenced if they had seen ahead of time. - It depends on the committee. When we're doing informal conferences, which is when we utilize the SRPs as Dr. Carter said, we can do that conducted by a committee of two members of the board or an agency subordinate. Depending on that decision makers confidence level, sometimes two members of the board, they're right in sync, they know what they want to do as soon as you go into closed session. When they're not confident or they disagree or "I'm not sure, " sometimes they'll work out the SRPs first and see, okay, where does it say we should be thinking versus I know what we want to do. This is what we want to do. Now, let's add up the points and see if it comports. So, it really does depend, but one supports the other either way. And I just do want to say, there's nothing that requires the board to follow this so, that case-by-case determination is still a case-by-case determination. And we just document the reason for departure and that could be a lot of things. It could be a lot of things. - It's a tool. - As you know you can get into a hearing and something just goes, the more they talk, the worse it gets so, you can get some additional findings of fact that really scare you about an individual's practice and may make the board lean harsher. You just document that. If you see a pattern then, Dr. Carter comes bak to us periodically, we have an evaluation, and see about that, but, so, it depends. How's that? - But again, the most important thing, it is your tool. If we need to make changes, we do do that and everything is during a public meeting so that's pretty significant. Any other questions? All right. If you do, please follow my e-mail. I'm very happy to talk about this if anybody...call me. I have examples of the actual manual here. I've told you to go to the website, but we do have it if you care to look at that. That's over at the table. We really are excited about this. This gives you, the board members when their coming in, particularly the new board members, you're pretty much on even footing with the other board members in terms of what decisions you make in terms of sanction because you have systematized law in a way that judges always have. They've had notated case decision that have been in the past and the weightings and so forth, but you're pretty much on an even footing as is the public, as is the respondent, and anyone else that's involved in the case because we now have this documented. And like I say, we're very proud of it and we hope you enjoyed hearing about it and thank you very much.