

Performance Audit Report

Department of Health Health Professions Quality Assurance *Executive Summary*

Report No. 1000002



August 21, 2007



Washington State Auditor Brian Sonntag, CGFM

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A letter from State Auditor Brian Sonntag



**Brian Sonntag, CGFM
Washington State Auditor**

August 21, 2007

Citizens of Washington:

In May of 2006, Governor Christine Gregoire requested the State Auditor to conduct a performance audit of the state's Health Professions' Quality Assurance, an office of the Department of Health.

She asked that the audit address how the state licenses, regulates and disciplines health care providers and look for ways to conduct national criminal background checks on applicants and licensees, both with an eye toward improving patient safety.

Using the authority granted to our Office under Initiative 900, the work performed by the contractor, Clifton Gunderson LLP, has resulted in a solid, understandable performance audit packed with recommendations ranging from standardizing licensing, background checks and disciplinary processes to improving public education on how to express concerns about providers. In the report, we also make nine specific recommendations to the Legislature.

We appreciate Clifton Gunderson's 45 years of experience and the specific expertise they brought in auditing licensing, monitoring and enforcement of professional standards for several state agencies in Texas.

We also appreciate the cooperation we received from the Department through all phases of the audit, and its constructive responses to the findings. We also recognize the Department was taking steps to correct many of the areas noted before the audit work began.

We look forward to working with the Department and with the Legislature to put in place the recommendations.

Sincerely,

Washington State Auditor

Our audit authority

The complete text of Initiative 900 is available at www.sao.wa.gov/PerformanceAudit/PDFDocuments/i900.pdf.

Notices of public hearings are posted on the report page at www.sao.wa.gov/PerformanceAudit/audit_reports.htm.

Washington voters approved Initiative 900 in November 2005, giving the State Auditor's Office the authority to conduct independent, comprehensive performance audits of state and local government entities on behalf of citizens. The purpose of conducting these performance audits is to promote accountability and cost-effective uses of public resources.

The audit was conducted in accordance with Generally Accepted Government Auditing Standards as issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence that provides a reasonable basis for the findings and conclusions based on our audit objectives. We believe that the evidence obtained in the audit provides a reasonable basis for our findings and conclusions based on our audit objectives.

This audit also included a review and tests of various information systems, designed to identify potential vulnerabilities in system controls.

What's next?

The release of this audit report triggers a series of actions by the Legislature. The appropriate committee or committees will take the following actions:

- Hold at least one public hearing within 30 days of this report's publication to receive public testimony.
- Consider the findings and recommendations contained in this report during the budgeting process.
- Issue an annual report by July 1 detailing the Legislature's progress in responding to the State Auditor's recommendations. The report must justify any recommendations the Legislature did not respond to and detail additional corrective measures taken.

Follow-up performance audits of any state or local government entity or program may be conducted when determined necessary by the State Auditor.

Washington Governor Christine Gregoire asked the State Auditor's Office in May 2006 to review the state's processes for regulating health professionals and to recommend ways to improve the licensing and discipline of health care providers to protect patients. The Governor also asked the Auditor to recommend ways to conduct national criminal background checks on health care license applicants and on existing practitioners. In the letter dated May 3, 2006, the Governor said, "We must, collectively, look for every way possible to protect patients and improve our system for licensing and disciplining health care providers." (A complete copy of the Governor's letter is in Appendix A of this report.)

The day after her request to the Auditor's Office, the Governor directed the Department of Health to "promptly investigate, without exception, all allegations of sexual misconduct by all health care professionals within their respective governing authorities." She directed the Department to draft consistent definitions of sexual misconduct, establish clear and consistent protocols for such investigations and to report their progress in achieving those goals directly to her. That request is contained in Executive Order 06-03, located in Appendix G of this report.

The Governor is following up on the Department's progress in all of these areas partially through her Government Management Accountability and Performance initiative, in which agencies whose directors report to the Governor track and report on their performance and progress at semiannual forums.

In 2005 and 2006, Seattle media published articles describing the results of investigations of disciplinary actions taken against health care professionals. An investigative series published in the Seattle Times concluded that the Department of Health had failed to adequately investigate and discipline certain health care professionals who had sexually abused patients across the state between 1995 and 2005. The series of articles concluded that the failure to protect the public was due to a deficient system that fostered abuse through its weak regulation.

The Auditor's Office issued a request for proposals for the performance audit contract in July 2006. The Office awarded the contract to Clifton Gunderson LLP. Clifton Gunderson started the audit in November 2006.

How was the audit information collected?

Between November 2006 and July 2007, Clifton Gunderson reviewed documentation, including written policies and procedures, data, reports, and other information maintained by HPQA. They performed tests using random samples of data; interviewed and directly observed operational and administrative personnel; analyzed data obtained from various sources regarding aspects of performance, processes, and practices; and compared processes and practices to applicable laws and regulations.

Clifton Gunderson also researched Web sites and interviewed employees of licensing and regulatory agencies in Arizona, Colorado, Florida, New York, Texas, Utah, Virginia and Ontario, Canada, and the Urban Institute, the Health Policy Center, the National Council of State Boards of Nursing, and the Federation of State Medical Boards.

Executive Order 06-03

Washington State's health profession disciplining authorities and the secretary of Health shall:

- 1. Establish a comprehensive definition of sexual misconduct*
 - 2. Establish comprehensive protocols for investigating allegations of sexual misconduct*
 - 3. Provide an annual report to the Governor*
-

Objectives and Scope

Objectives

In May 2006, Governor Christine Gregoire asked the State Auditor to review Washington's health care licensing and disciplinary system. She requested that the audit:

1. Evaluate the professional licensing, oversight and disciplinary system starting with the receipt of licensing applications through the final resolution of complaints and monitoring of compliance with disciplinary actions.
2. Develop a description of the stages of the disciplinary process, identifying variations among disciplining authorities.
3. Identify activities that help move cases efficiently through the stages of the disciplinary process, including an evaluation of summary actions that are taken to quickly remove a provider from practice if the public is at risk of being harmed, and to determine if such activities are being uniformly and consistently applied.
4. Assess resources required to support the professional licensing, oversight and disciplinary system, including staffing levels, workload and timeliness of process compared to other states' benchmarks or best practices.
5. Compare Washington's licensing, oversight and disciplinary system to other states' systems.
6. Evaluate the case law and statutory and regulatory requirements to assess the effect of each on the disciplining authorities' ability to discipline credential holders and its ability to do so in a timely manner.
7. Suggest statutory, regulatory, and/or internal policy changes that would support more effective disciplinary practices that are consistent across professions.
8. Recommend methods of improving efforts to educate members of the public about their right to file complaints about health care providers with the Department of Health.
9. Recommend the best ways to access national criminal background checks for current credential holders and applicants.

Objectives and Scope

Additionally, Initiative 900 directs the State Auditor's Office performance audits to address the following elements:

1. Identification of cost savings.
2. Identification of services that can be reduced or eliminated.
3. Identification of programs or services that can be transferred to the private sector.
4. Analysis of gaps or overlaps in programs or services and recommendations to correct them.
5. Feasibility of pooling the entity's information technology systems.
6. Analysis of the roles and functions of the entity and recommendations to change or eliminate roles or functions.
7. Recommendations for statutory or regulatory changes that may be necessary for the entity to properly carry out its functions.
8. Analysis of the entity's performance data, performance measures and self-assessment systems.
9. Identification of best practices.

Scope

The audit was conducted from November 2006 through July 2007. The auditors analyzed data from July 1, 2005 through June 30, 2007, and, when appropriate, analyzed data from previous two-year budget cycles. The auditors surveyed HPQA staff, members of boards and commissions as well as the general public.

To obtain data and best practices information, the auditors contacted other states' licensing and regulatory authorities, reviewed information from their Web sites, and reviewed publications of national research institutes the Pew Health Professions Commission and the Urban Institute that describe practices in areas relevant to this audit that appear to be efficient and effective. Because there are few national standards for regulation of health care providers, there were few proven "best practices" identified. However, where appropriate, the auditors identified practices in other jurisdictions for the Department and the Legislature to consider.

See page xiii for tables that reference each of the Governor's requested items and each of the I-900 elements to the findings contained in this report.

About the Department of Health and HPQA

HPQA goals

HPQA goals are established to carry out the department mission and reflect the core business of the office. They are:

1. Ensure only qualified people provide services.
2. Ensure credentialed practitioners provide services according to standards.
3. Enhance the ability of the public to make informed decisions.
4. Improve the quality of its business.

The Office of Health Professions Quality Assurance, a division within the Washington Department of Health, regulates more than 300,000 health care professionals in 57 professions. HPQA, in partnership with 12 boards and four commissions, provides credentialing, complaint intake and assessment, investigation, discipline and oversees compliance with sanctions. HPQA's activities cost about \$27 million annually.

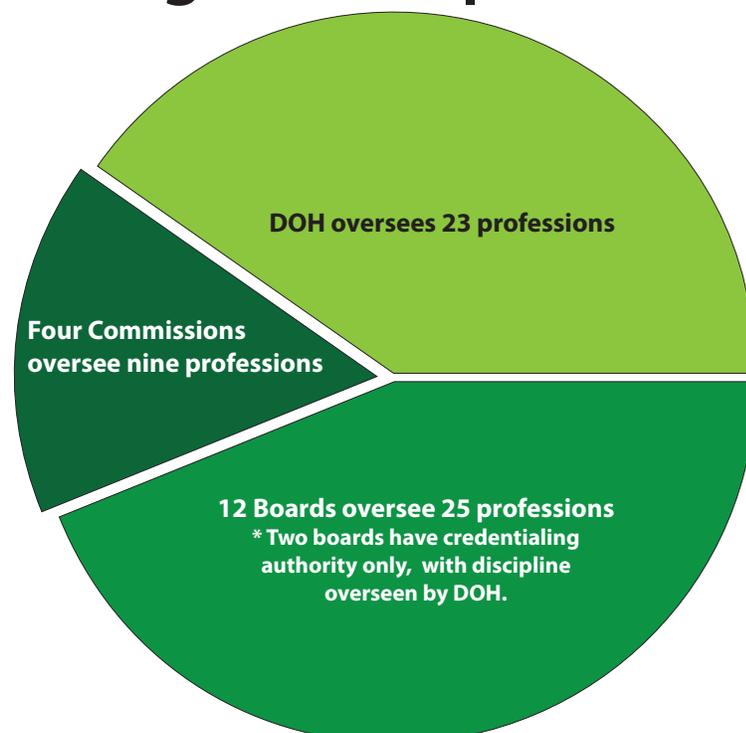
Each two-year budget cycle HPQA:

- Issues more than 70,000 new credentials and renews more than 400,000 credentials. This number increased in 2007, when new laws took effect that added five professions, comprising some 11,000 people, to the list of those who must be licensed.
- Processes more than 14,000 new complaints.
- Issues about 1,800 disciplinary orders to ensure providers practice safely or don't practice at all.
- Responds to more than 12,000 requests for public records.

HPQA structure

HPQA, on behalf of the Secretary of Health, directly oversees 23 professions and provides administrative support for all functions to 16 boards and commissions. Those 16 boards and commissions oversee the remaining 34 of the 57 professions.

Oversight of 57 professions



About the Department of Health and HPQA

- Ten boards – Board of Hearing and Speech, Board of Nursing Home Administrators, Board of Occupational Therapy Practice, Optometry Board, Board of Osteopathic Medicine and Surgery, Board of Pharmacy, Board of Physical Therapy, Podiatric Medical Board, Examining Board of Psychology, and Veterinary Board of Governors – oversee credentialing and discipline of 23 professions.
- Two boards – the Massage Board and the Denturist Board – do not have disciplinary authority. They only have credentialing authority. The Health Secretary oversees the discipline for those two professions.
- Four commissions – Chiropractic Quality Assurance Commission, Dental Quality Assurance Commission, Medical Quality Assurance Commission, and Nursing Care Quality Assurance Commission – oversee credentialing and discipline of nine professions.
- The Secretary of the Department of Health oversees the remaining 23 professions.

Each board and commission is authorized by law to adopt its own rules and standards. Having multiple disciplinary bodies and sets of standards can result in divergent outcomes when a practitioner holds multiple licenses. It can also result in inconsistencies in disciplinary actions between professions.

The Governor appoints the members of 15 of the boards and commissions; the Health Secretary appoints the members of the remaining board. In addition to the 16 boards and commissions, eight advisory committees help set licensing standards and discipline practitioners.

Balancing public expectations and due process

The Washington State Department of Health oversees many aspects of health care and public health. The job is broad and complex. The public expects good, safe health care 24 hours a day, seven days a week, 52 weeks a year.

HPQA issues licenses to people in many health-related jobs who practice in the state. Depending upon the profession, the required credential is a registration, a certification or a license. Licensing generally is the most stringent in terms of education and experience. Certifications require fewer qualifications. Registration is the least stringent.

The Department is guided by many laws and rules, court decisions, changing standards and the details of thousands of interactions between practitioners and patients. The Department's role in regulating health professions centers on patient safety.

When people file a complaint, they expect it to be acted on quickly. When a practitioner is found to be at fault, the public wants immediate, appropriate sanctions. At the same time, state law requires a fair process for both the public and the practitioner. Courts have said many times that the state must prove allegations of misconduct are true before disciplining a health professional.

A recent state Supreme Court ruling upheld that a license is considered property and consequently “clear, cogent, and convincing evidence” must be found in order

Each year, fewer than 5 percent of credentialed health professionals face disciplinary action. However, some 85 percent of HPQA's budget – \$23 million – is spent on discipline-related actions.

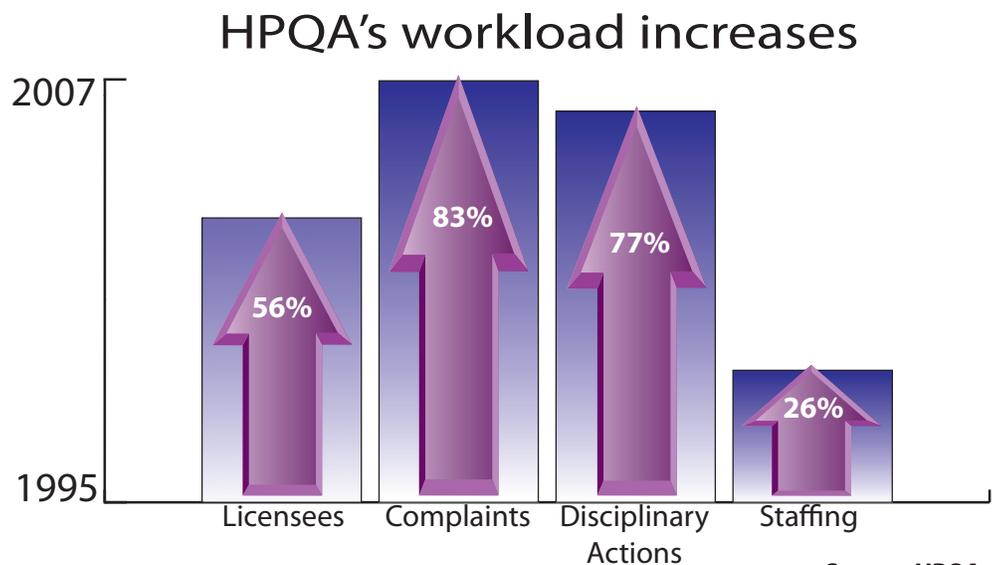
About the Department of Health and HPQA

to revoke the license. This is a higher standard than the previous standard requiring a “preponderance of evidence.” As a result, HPQA investigators will have greater difficulty finding sufficient evidence to sustain disciplinary action, particularly in cases that involve individuals who are unable to speak for themselves, such as minors or those who are incapacitated. Because the right to property is a constitutional provision, the Legislature cannot pass a law to modify that standard. Further complicating the ability of the Department to conduct timely investigation is that cases can involve complex issues of medical standards and quality of care.

HPQA responds to challenges

The workload for HPQA staff has increased significantly since 1995, as shown in the chart below.

- The number of licensees increased by 56 percent.
- Complaints increased by 83 percent.
- Disciplinary actions increased by 77 percent.
- The number of regulated professions increased by 36 percent from 42 to 57. That figure does not include the five professions added by the 2007 Legislature.
- Staffing for credentialing and discipline increased by 26 percent.



The rapid increase in workload and public expectations have highlighted some significant weaknesses, which the Department has taken steps to address. The Department recognizes it has many outdated systems and processes and is restructuring the division that houses HPQA for improved consistency and oversight. During the audit, we observed that HPQA has regularly taken steps during the past few years to improve its processes while facing new challenges in protecting patient safety.

About the Department of Health and HPQA

Since 2005, HPQA has taken the steps to address the following major program challenges:

- Public demand for more timely case resolution.
- Consistency of disciplinary actions.
- Public demand for more severe sanctions against practitioners.
- Limited capability of computer systems.
- Increased demand for public information about credential holders and disciplinary actions.

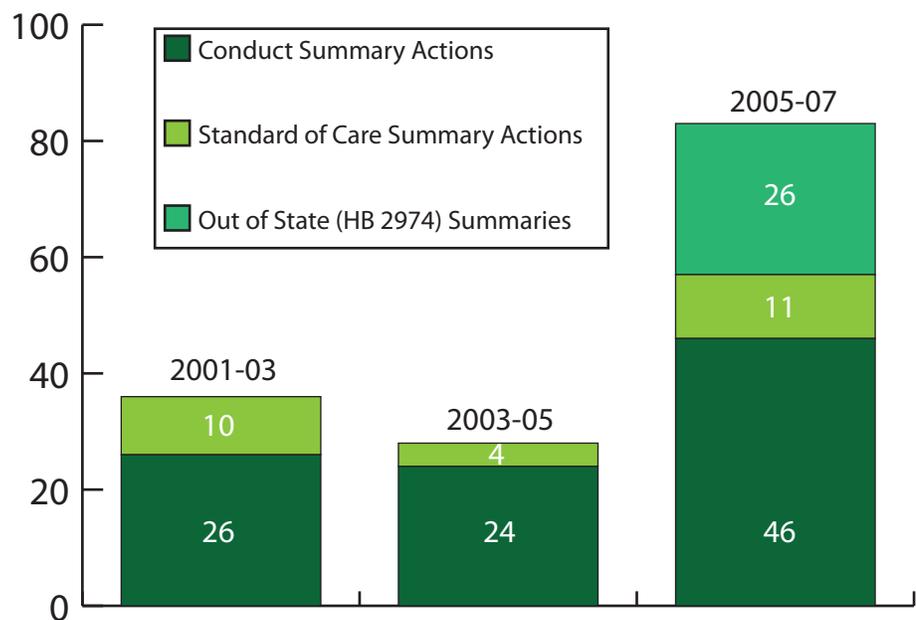
Auditors observed in the course of conducting the fieldwork that HPQA has taken steps during the past few years to improve its processes while facing new challenges in protecting patient safety. The following activities demonstrate HPQA's commitment to addressing these challenges:

- HPQA had already put into practice several best practices that auditors identified during their research, such as triaging complaints to ensure that the most serious complaints are promptly investigated and disciplinary action is taken.
- In late 2004, HPQA piloted the use of Expedited Case Management Teams to ensure that cases identified as a risk of causing imminent harm are treated with the utmost urgency. The teams were expanded to all professions in April 2006. Expedited Case Management Teams have more efficient investigation coordination and respond more quickly by immediately bringing together appropriate staff who decide if a complaint demonstrates sexual misconduct or imminent danger and should be forwarded to investigations as a case with the highest priority.
- In September 2006, HPQA issued a report that recommended legislative changes regarding registered counselors. Registered counselors have a high rate of sanctions and very minimal qualifications. It has been one of the most problematic professions that HPQA oversees.
- Increasing the use of background checks in the credentialing process. HPQA now uses background checks in the initial credentialing process using Washington State Patrol data regarding convictions and national databanks specializing in health care professionals.
- In May 2006, the Secretary of Health adopted Uniform Sanctioning Guidelines to apply to the professions that the Department regulates. These guidelines serve as a tool to consistently impose sanctions for similar violations. Currently, 10 of the boards and commissions have adopted the guidelines. Although she cannot require it under state law, the Secretary has stated she expects all of the boards and commissions to adopt the guidelines. HPQA is working with the boards and commissions to adopt the sanctioning guidelines.
- Increasing the use of summary actions against some health providers to protect patients. In fiscal year 2007 the use of summary actions has more than doubled over the previous year.

A glossary explaining the terms contained in this report is available in Appendix B.

About the Department of Health and HPQA

Summary Actions



Source: HPQA

- HPQA established a process in March 2007 to monitor all sanctions to ensure that they follow disciplinary guidelines. If a sanction does not appear appropriate, an inquiry is made to the disciplining authority to determine the basis for the decision.
- HPQA has increased the number of cases that have resulted in summary suspensions. In addition, all but one of the summary suspensions issued have been upheld in court. The chart above illustrates this.
- In 2004, legislation established the Joint Task Force on Criminal Background Check Processes to review and make recommendations to improve the state's criminal background check processes. In November 2006, the Department of Health released its study concerning the feasibility of conducting national criminal background checks on all current credential holders and new applicants.
- HPQA is moving toward pooling information technology systems that support the licensing, disciplinary, and adjudicative processes with a new technology system called Integrated Licensing and Regulatory System. As a result, staff have been cleaning up data from the old system and preparing it for conversion to the new system; testing the new system for quality assurance; documenting their requirements and desired modifications.

Findings and Recommendations

Our audit identified the following significant findings that HPQA must address in order to protect the public.

1. The state's governance structure involving HPQA and the Boards and Commissions responsible for regulating health care professions does not promote effective performance management.
2. Credentialing process inconsistencies and control weaknesses leave the potential for unqualified individuals to practice in Washington and leave citizens at risk.
3. Weaknesses in internal controls over the background check process and lack of national criminal background checks can expose the public to serious risk.
4. Changes in the complaint management process are needed to more accurately assess complaints and to improve responses to complainants.
5. HPQA's efforts to improve public education regarding citizens' rights to file complaints about credential holders with HPQA are insufficient.
6. Investigations of complaints are delayed by process issues and compromised by staffing concerns and internal control deficiencies.
7. Deficiencies in the disciplinary (legal) process have led to inconsistent and delayed discipline of practitioners who engage in unprofessional conduct or provide below standard of care.
8. The compliance process does not ensure that practitioners who have been disciplined comply with the terms of their sanctions.
9. DOH and HPQA oversight needs improvement to ensure that the credentialing and the regulatory processes are performing as intended.
10. The DOH internal audit function is understaffed and does not perform evaluations of HPQA to identify and report deficiencies that could impede HPQA's ability to achieve its goals.
11. Legacy information systems do not enable HPQA to effectively and efficiently license health practitioners, manage consumer complaints and monitor compliance with disciplinary action.
12. HPQA's disaster recovery and business continuity plans are not fully developed.
13. Hard copy files related to licensing and investigations are not physically secure.

We found two procedural issues relating to documentation in personnel files and replacement Social Security numbers that were not significant and are reported to management in a separate letter.

Recommendations to the Legislature

Each finding is accompanied by extensive recommendations, the effect of the recommendations and best practices in place at other organizations. Several recommendations require action from the Legislature. They are:

Overall conclusion

The audit results substantiated many previously identified issues. We have identified other issues and have helped determine many of the root causes of those problems. HPQA initiated many corrective actions after problems were identified both prior to and during our audit. Although much has been done to address the issues, some areas still need improvement to ensure public safety is protected.

Legislative Recommendations

A full list of recommendations is in Appendix C.

Finding 1

1. Amend the Written Operating Agreement statute (RCW 43.70.240) between HPQA and the boards and commissions to require the agreements to include negotiated performance-based provisions. The amendment should include:
 - A requirement that the written agreements are reviewed annually and revised as needed to continually drive performance to protect the public's interests.
 - Set an effective date as a deadline for these agreements to be revised and to become operational.
 - Require the results of the key performance measures (as appropriate to protect confidentiality) be posted on the Web sites of HPQA and each board and commission.

Finding 2

1. Eliminate the registered counselor credential as it currently exists.
2. For all registered professions, review and modify as needed existing laws that allow individuals to be credentialed with no educational or experience requirements.
 - Establish requirements that include at a minimum education, examinations, supervised training, and experience and offer credential types that reflect the requirements.
 - Offer a temporary credential for individuals who are completing educational requirements for supervised experience.

Finding 3

1. Give the Department the statutory authority to access Washington State Patrol criminal background information, particularly non-conviction data.
2. Give the Department the statutory authority to access the FBI database for national background checks and require HPQA to conduct national background checks on all credential holders.

Finding 6

1. Provide additional tools for obtaining records, documents and other evidence. These tools could include authorization to issue citations and fines for failure to provide documents in a timely manner.

Finding 7

We recommend that the Legislature adopt a law:

1. Requiring a deadline by which the sanction guidelines must be adopted.
2. Authorizing the Secretary to discipline all professions for misconduct, while the boards and commissions continue to discipline standard-of-care violations.
3. Indicate that any board or commission not adopting sanction guidelines by the deadline could be subject to losing its disciplinary authority and becoming an advisory committee.

Cross references to objectives and findings

| Initiative 900 Elements | Audit reference |
|---|--|
| Identification of cost savings | The purpose of this performance audit is public safety. Cost savings were not identified. |
| Identification of services that can be reduced or eliminated. | HPQA is installing a new computer system that will create efficiencies, change processes, and change the duties of staff. It is not appropriate to assess resources until the new system is operational. |
| Identification of programs or services that can be transferred to the private sector. | 2,3,6,7,8,9 |
| Analysis of gaps or overlaps in programs or services and recommendations to correct gaps or overlaps. | 4,6,7,8 |
| Feasibility of pooling information technology systems | 11, 12, 13 |
| Analysis of the roles and functions of the Office of Health Professions Quality Assurance and recommendations to change or eliminate Departmental roles or functions. | 2,4,5,6,7,8,9,10 |
| Recommendations for statutory or regulatory changes that may be necessary for the Office of Health Professions Quality Assurance to properly carry out its functions. | 4,6,7 |
| Analysis of Office of Health Professions Quality Assurance performance data, performance measures and self-assessment systems. | 9 |
| Identification of best practices | 2,3,4,6,7,8,10 |

| Governor's Letter & Audit Objectives | Finding Reference |
|---|--|
| Evaluate the professional licensing, oversight and disciplinary system and procedures starting with the receipt of licensing applications through final resolution of complaints and compliance monitoring. | 2,3,4,6,7,8,9,10,11,12,13 |
| Develop a description of the stages of the disciplinary process, identifying variations among disciplining authorities. | 4,6,7,8 |
| Identify activities that help move cases efficiently through the stages of the disciplinary process, including an evaluation of summary actions to quickly remove a provider from practice if the public is at risk of being harmed. Determine if such activities are being uniformly and consistently applied. | 4,6,7,8 |
| Assess resources required to support the professional licensing, oversight and disciplinary system, including staffing levels, workload and timeliness of process compared to other states' benchmarks or best practices. | Auditors interviewed regulatory staff and researched Web sites for 11 professions in six states to obtain resource data. The variety of governing structures, the lack of standard definitions and lack of data made it impossible to do a valid comparison. |
| Compare Washington's licensing, oversight and disciplinary system to other states' systems. | Practices in Other Jurisdictions - Findings 2,3,4,6,7,8,9 |
| Evaluate the case law and statutory and regulatory requirements to assess the effect of each on the disciplining authorities' ability to discipline credential holders and its ability to do so in a timely manner. | Findings 4,6,7 |
| Suggest statutory, regulatory and/or internal policy changes that would support more effective disciplinary practices that are consistent across professions. | Findings 4,6,7 |
| Recommend methods of improving public education about their rights to file complaints about licensees to be heard by the Department. | Finding 5 |
| Recommend the best ways to access national criminal background checks for current credential holders and applicants. | Finding 3 |

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Mission Statement

The State Auditor's Office independently serves the citizens of Washington by promoting accountability, fiscal integrity and openness in state and local government. Working with these governments and with citizens, we strive to ensure the efficient and effective use of public resources.

Americans with Disabilities

In accordance with the Americans with Disabilities Act, this document will be made available in alternate formats. Please call (360) 902-0370 for more information.



August 21, 2007

The Honorable Brian Sonntag
State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Subject: Performance Audit of the Department of Health, Office of Health Professions Quality Assurance

Dear Auditor Sonntag:

We are pleased to report the completion of our performance audit of the Department of Health, Office of Health Professions Quality Assurance for state fiscal years 2005 through 2007.

We appreciate the assistance Linda Long and the rest of your staff provided us during this engagement. We also would like to acknowledge the cooperation of Secretary Mary Selecky and her management staff at the Department of Health, Office of Health Professions Quality Assurance. Please feel free to contact me at (512) 342-0800 if you have any questions or need additional information regarding our report.

Sincerely,
Clifton Gunderson LLP

A handwritten signature in black ink, appearing to read "Frank N. Vito", is written over a large, light-colored circular scribble.

Frank N. Vito, CPA
Partner

Enclosures

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Finding 1: The state's governance structure involving HPQA and the Boards and Commissions responsible for regulating health care professions does not promote effective performance management.

Background

The citizens of Washington expect that cases of misconduct and substandard care be resolved in a timely manner and that disciplinary actions for violators are aligned with the severity of the violations and imposed consistently.

The authority to regulate the health care providers in 57 professions is divided between HPQA and 16 boards and commissions. The boards and commissions oversee 34 of the 57 professions. The Secretary of Health oversees the remaining 23 professions. State laws give the 16 boards and commissions the authority to set requirements and determine if an individual should be issued a credential, and 14 boards and commissions the authority to discipline professionals:

- Ten boards -- Board of Hearing and Speech, Board of Nursing Home Administrators, Board of Occupational Therapy Practice, Optometry Board, Board of Osteopathic Medicine and Surgery, Board of Pharmacy, Board of Physical Therapy, Podiatric Medical Board, Examining Board of Psychology, and Veterinary Board of Governors -- regulate 23 professions.
- Two boards -- the Massage Board and the Denturist Board -- do not have disciplinary authority.
- Four commissions -- Chiropractic Quality Assurance Commission, Dental Quality Assurance Commission, Medical Quality Assurance Commission, and Nursing Care Quality Assurance Commission -- regulate nine professions.

Responding to demands that government demonstrate successful performance in clear measurable terms, the Governor issued Executive Order 05-02 in February 2005. The order, Government Management, Accountability and Performance (GMAP) directs agencies to:

1. Develop clear, relevant and easy-to-understand measures that show whether or not programs are successful.
2. Demonstrate how programs contribute to the priorities that are important to citizens.
3. Gather, monitor, and analyze program data.
4. Evaluate the effectiveness of programs.
5. Hold regular problem-solving sessions within the agency to improve performance.
6. Allocate resources based on strategies that work.
7. Regularly report their results to the Governor at public forums.

HPQA provides performance information in aggregate at GMAP forums; it does not differentiate performance for individual boards or commissions.

State law (RCW 43.70.240) governing Written Operating Agreements directs the Secretary of Health and the boards and commissions to seek information from the regulated professions and the public and then to enter into agreements on administrative procedures. Fourteen of the boards and commissions have done so. The agreements between HPQA and the 14 boards and commissions blueprint HPQA's responsibilities to provide support services. The law does not set a deadline for

entering into an agreement nor does it provide a consequence for failing to enter an agreement.

Condition

State laws divide the authority to regulate health care professions between HPQA and 16 boards and commissions. This divided governance structure does not provide for clear lines of performance management and accountability with regard to the operations of the boards and commissions. Without these clear lines, it is difficult to create an effective performance management process to resolve the issues that have been identified with timeliness of case resolution and consistency of disciplinary actions.

State law does not require that HPQA, the boards and commissions negotiate and enter into agreements that include provisions to establish performance-based operating strategies and measures to ensure that they collectively fulfill their obligation to regulate the competency and quality of health care professionals. The absence of performance expectations in the operating agreements contributes to many of the conditions described throughout this report and results in inconsistent and, in certain instances, untimely credentialing, disciplining, and sanctioning.

Although HPQA is responsible for overseeing credentialing and discipline of health care professionals, it does not have responsibility or authority to direct the boards and commissions in matters relating to case resolution and disciplinary actions. This leaves HPQA in strictly an administrative role involving the collection and consolidation of data. However, because HPQA consolidates its and the boards' and commissions' data, a complete picture of the timeliness and the consistency of credentialing and disciplinary actions is not reported. Without a complete performance picture at the profession level, the boards and commissions are without key performance information restricting their ability to assess performance levels and make key management decisions to address situations where performance is not hitting desirable target levels. For example, problems that may be unique to a specific regulator are not identified and decisions to correct those problems are not made.

Likewise, the public, the Legislature and the Governor do not have a clear view of how effectively HPQA and each board and commission is meeting its commitment to protect the public because performance information specific to each regulatory body is not reported. The lack of detailed performance data and formal agreed-upon performance strategies and measures for each board and commission precludes holding the boards and commissions accountable for their performance to protect the public.

While HPQA is collecting data on some aspects of its performance, we found its performance management system needs improvements, which is discussed in Finding 9. HPQA does not collect data by board/commission or profession. Nor have HPQA, the boards or commissions established specific performance measures or performance targets in the areas of timeliness of case resolution and consistency of disciplinary actions.

Cause

The state law that established the requirement for operating agreements between HPQA and the boards and commissions, which was enacted in 1989 and amended in 1998, does not require these operating agreements to include performance expectations for the regulation of health care professionals. The law currently requires only that the operating agreements contain administrative procedures.

Recommendation

We recommend that the Legislature:

1. Amend the Written Operating Agreement statute (RCW 43.70.240) between HPQA and the boards and commissions to require the agreements to include negotiated performance-based provisions. The amendment should include:
 - A requirement that the written agreements are reviewed annually and revised as needed to continually drive performance to protect the public's interests.
 - Set an effective date as a deadline for these agreements to be revised and to become operational.
 - Require the results of the key performance measures (as appropriate to protect confidentiality) be posted on the Web sites of HPQA and each board and commission.

The operating agreements are a vital tool for ensuring consistency and timeliness of the regulation of health care professions. Amending RCW 43.70.240 will establish performance measurements for all entities involved in the credentialing and discipline of health care professionals. Publishing performance results will give citizens, the Governor, policymakers and others information they need to judge the effectiveness of government regulation of health care professionals.

Response

DOH RESPONSE: We agree there is a need for consistent performance expectations of boards and commissions. We believe the expectations should include measures of performance including timelines established in law, compliance with sanction guidelines, and other directives from the Governor.

OFM RESPONSE: We agree that continued improvement in performance monitoring across all disciplinary authorities, both in overall and by individual boards and commissions, could promote better oversight and regulation of the health professions. One way this could be accomplished is if the operating agreements between HPQA and the boards and commissions identified responsibilities for each entity, including specific performance measures. Government Management Accountability and Performance (GMAP) staff members are working with the Department of Health to examine ways to enhance performance expectations for health professions.

Criteria

See Appendix L.

Finding 2: Credentialing process inconsistencies and control weaknesses leave the potential for unqualified individuals to practice in Washington and leave citizens at risk.

Background

HPQA issues three types of credentials: registrations, certifications and licenses.

Registration

Registration is a process by which the state maintains an official roster of names and addresses of the practitioners in a given profession and, if required, the location, nature and operation of the health activity practiced. As of April 2007, HPQA credentialed 15 registered professions.

Certification

Certification is a voluntary process by which the state grants recognition to an individual who has met certain qualifications. The regulatory authority, either a board, commission, or the Secretary, determines the qualifications. Some non-certified personnel may perform the same tasks, but may not use “certified” in the title. As of April 2007, HPQA credentialed seven certified professions.

Licensure

A licensed profession requires an individual to meet pre-determined qualifications to engage in a health profession. The qualifications are set in law. Without a license, the practice of the specific health profession is unlawful. Licensure protects the scope of practice and the health care professional’s title. As of April 2007, HPQA credentialed 35 licensed professions.

The credentialing process for all professions is divided among five sections within HPQA. Each section is responsible for reviewing applicants’ qualifications and backgrounds to ensure the applicant meets the minimum requirements for the credential for which he/she is applying. The credentialing staff also processes renewals and monitors completion of continuing education requirements. In addition the sections include staff who perform initial complaint review (intake/assessment) case management, and compliance monitoring. A separate section, the Customer Service Center, processes renewals that cannot be automated, and monitors completion of continuing education requirements.

We researched and compared Washington to nine states for 12 professions. The states we selected were Arizona, California, Colorado, Florida, Illinois, New York, Texas, Utah and Virginia. Utah has an “umbrella” structure similar to Washington. Other states had both independent agencies regulating professions and one agency that regulated multiple professions. We also selected the states based on state size, and potentially similar credentialing numbers, and we included states that have been recognized for effective health regulation and licensing activities, such as California and New York. We compared Washington to these states for 12 professions for:

- Amount of application fee
- Type of credential issued
- Credential renewal period
- Education requirements
- Examination requirements

- Continuing education requirements
- Whether experience is required.

Appendix H contains a table showing the detail of how Washington’s credentialing structure compares to these states.

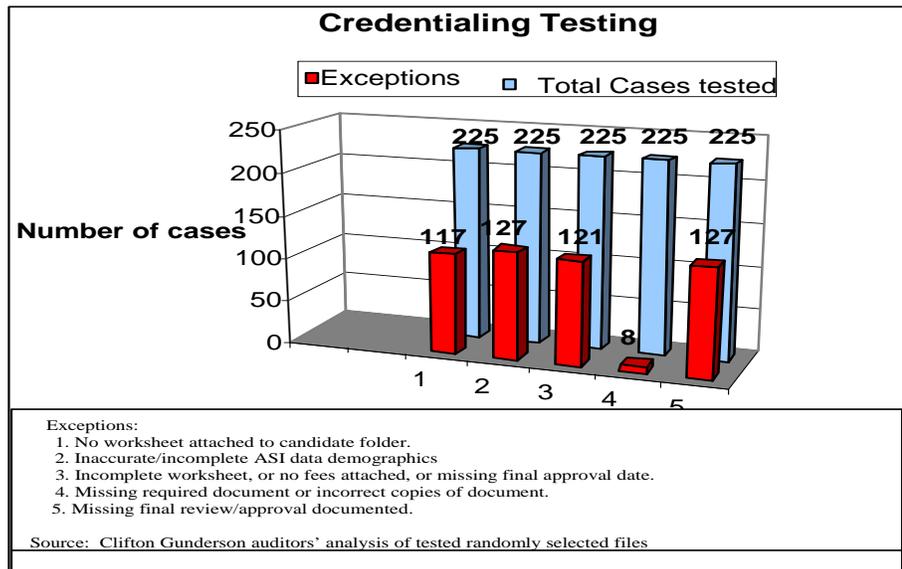
Condition

HPQA has not established sufficient procedures and adequate internal controls to ensure credentials are issued only to qualified individuals. Inconsistent processes and a lack of internal controls mean that HPQA cannot be certain that applicants seeking a credential meet all qualifications and background criteria before receiving a credential. In addition, HPQA does not have procedures to ensure that practitioners seeking renewal of credentials remain qualified to hold the credential.

We found exceptions in the following areas:

- Some staff did not consistently follow policies and procedures.
- Ineffective use of exams used to assess an applicant’s knowledge of health- and profession-related laws (jurisprudence exams). A lack of minimum age requirements for credentials.

Procedures. Credentialing is divided across five sections, each responsible for a group of professions. Methods of examining the information submitted for a new credential by applicants and verifying that all documentation is complete and accurate vary among the five sections. Each section has its own method to verify that applications are complete. In addition, applicants do not always provide all of the required information when they submit the application. HPQA retains those incomplete application packages for an indefinite length of time, even when there is no effort by the applicant to complete the credentialing process.



During our testing of applicant files, we found insufficient or missing evidence to determine that credentialing staff had adequately examined the applicants’ information and that required supporting documentation was submitted. For example, we found a lack of evidence that:

- The application data was complete and required documents were included.
- Application fees were paid.
- A supervisory review and approval of the submitted documents was complete.

Supervisory reviews are an important internal control to ensure only qualified individuals are given credentials. Supervisory reviews should ensure that procedures are followed and serve to identify errors that might otherwise go unnoticed. We found insufficient evidence that supervisory reviews regularly occurred.

We also found that the agency cannot verify the accuracy and completeness of credentialing data due to problems with their outdated computer system. For example, we found:

- 519 records where the Washington State zip code did not match U.S. Postal Service zip codes assigned to the state.
- Invalid dates, such as:
 - 182 cases in which the license expired prior to the licensee's birth date.
 - 12 records with expiration dates prior to 1950.
 - 182 records in which the birth date was in the future.

We discuss the problems with the data system in greater detail later in this report.

Jurisprudence Exams. Several professions require that applicants take and pass an exam to ensure the applicant has knowledge of Washington State laws that apply to the profession. However, not all professions that require the applicant to take the jurisprudence exam are held to the same standard. The Occupational Therapy jurisprudence exam includes answers for all of the exam questions and is posted on the DOH Web site with the application form. Applicants for Physical Therapist and Massage Therapist licenses are required to take and submit jurisprudence exams, but the exams are not graded and therefore have no effect on a candidate receiving a license.

Minimum Age. Few professions have a minimum age requirement to qualify for a credential. Registered professions have the least restrictive requirements and could result in a minor with no education or special training being eligible for a credential in a registered profession. The lack of a minimum age is less of a concern for certified and licensed professions because they require a specific level of education and/or specialized training.

There is statutory precedent for setting minimum age requirements. State law requires midwives to be at least 21 years of age; dispensing opticians must be at least 18.

Registered Professions. Because registered professions have the least stringent requirements for credentials, HPQA must issue credentials to individuals with only minimal information to determine if the candidate is qualified to be a health care practitioner. It is reasonable for the public to assume that an individual with a state-issued credential has met certain educational and experience standards that qualify the practitioner. In reality, an applicant for a registered credential is required to provide only personal contact information, pass a criminal background check, pay a fee, and take an HIV/AIDS safety class. No educational or specialized training, examination or supervised experience is required for these health care professionals.

The risk to the public is particularly notable for registered counselors. According to a September 2006 report prepared by the Department's Registered Counselors Task Force, while the number of registered counselors has increased by 5.2 percent between 1999 and 2005, the increase in formal disciplinary actions increased by 143 percent. The Seattle Times asserted in its "License to Harm" investigative series that registered counselors represented the largest number of offenders with reported sexual misconduct. In 2006, HPQA credentialed more than 17,000 registered counselors. The Registered Counselors Task Force recommended modifying existing laws regulating registered counselors. A bill supported by the Department was introduced during the

2007 legislative session that would have changed the requirements to receive a counselor credential. The bill did not pass.

Cause

- According to HPQA staff, on-the-job training has been the best way for employees to learn the credentialing process. Desk manuals are provided to new employees, but no process is in place to ensure the manuals are routinely revised. This has led to procedure manuals being outdated or containing incomplete information. Keeping such manuals up-to-date enables employees to consistently follow the proper procedures.
- HPQA's credentialing sections do not have consistent methods for capturing the information submitted by applicants and verifying that applicants' documentation is complete and accurate. Furthermore, we found insufficient evidence that a supervisory review is completed to ensure that only qualified individuals are given credentials.
- HPQA does not have a policy governing the use of jurisprudence examinations. It also lacks internal controls to ensure that staff grade exams when completing the exam is required for the credential.
- No state laws or rules require applicants to be a minimum age in order to receive a credential, with the exception of dispensing optician, midwife, or nurse assistant; thus, minors are not prohibited from being credentialed.
- By law, the only requirements to be credentialed as a registered counselor are four hours of HIV/AIDS safety training.

Recommendations

We recommend that HPQA:

1. Document policies and detailed procedures online and create a process to review and update the procedures periodically. Until procedures are available online, designate department section leaders to monitor and ensure that desk manuals contain up-to-date information.
2. Develop and follow internal controls to ensure that all applications contain required information and documents prior to issuing a credential. These standardized business practices should be established throughout the five credentialing sections. Examples include providing application requirement checklists, documenting supervisor approvals for each file credentialed, and conducting random audits within the section.
3. Ensure that the test process for professions requiring Jurisprudence Exams is consistent.
4. Determine if setting a minimum age requirement is appropriate for individual professions. If setting a minimum age requirement requires legislative action, the legislature should do so. It seems prudent to have a minimum age requirement for those professions that have no educational and/or examination requirement.

We recommend that the Legislature:

1. Eliminate the registered counselor credential as it currently exists.
2. For all registered professions, review and modify as needed existing laws that allow individuals to be credentialed with no educational or experience requirements.
 - Establish requirements that include at a minimum education, examinations, supervised training, and experience and offer credential types that reflect the requirements.
 - Offer a temporary credential for individuals who are completing educational requirements for supervised experience.

Strengthening controls governing the credentialing process related to reviewing and updating policies and procedures, implementing supervisory reviews, improving staff training, ensuring documentation is consistent, and implementing renewal application and periodic background checks will provide greater assurance that only qualified applicants are issued credentials. This will improve public safety.

Practices in Other Jurisdictions

As a result of our research and interviews with other regulatory agencies and boards, we identified the following as practices that HPQA might consider.

- Establish time limits to complete the steps in the application process for both applicants and agency staff (Arizona Board of Nursing). The Texas Board of Dental Examiners immediately returns application packages that have deficiencies to the applicant.
- Ensure that practitioners have the correct legal immigration status before issuing licenses; issue time-limited licenses that correspond to that status; monitor changes in legal status that allow licensees to work and remain in United States. (College of Nurse Ontario, Colorado – Division of Regulatory Agencies (DORA) and Arizona Board of Medicine)
- Ensure that information identifying individuals who are practicing without an appropriate credential are posted on-line. The Web sites include pictures, names, and aliases, of known, unlicensed imposters that can be checked by employers and consumers. (Texas Board of Nurse Examiners, Arizona Board of Medicine, Arizona Board of Nursing, and College of Nursing of Ontario)
- Participate in National, Centralized Physician Credential Verification (applies to medical physicians, osteopathic physicians and physician's assistants) to lighten the workload of state credentialing staff and reduce duplication of effort by gathering, verifying and permanently storing both osteopathic and medical physicians' and/or physician assistants' credentials in a central repository. Three states do not participate in the program; 13 states require credential applicants to use the program, and all the remaining states (including Washington) accept credential portfolios from the program.
- The Colorado Board of Medical Examiners is participating in the development and implementation of a federal, multi-state license portability demonstration project authorized under the Health Care Safety Net Amendments of 2002 and coordinated through the U.S. Office for the Advancement of Telehealth. North Dakota, Kansas, Colorado, Minnesota, Iowa, Idaho and Oregon in the western United States have joined to seek to eliminate redundancies in their physician application processes. The group calls for a central database that contains

printable digital image files, such as licensing applications, medical education and training credentials and examination transcripts, scanned by participating boards and accessible to all of the participating medical boards.

- Join the Interstate Nurse Licensure Compact which allows a nurse to have one license (in his or her state of residency) and to practice in other states (both physical and electronic), subject to each state's practice law and regulation. Under mutual recognition, a nurse may practice across state lines unless otherwise restricted. Once the compact is enacted, each compact state designates a Nurse Licensure Compact Administrator to facilitate the exchange of information between the states relating to compact nurse licensure and regulation. The National Council of State Boards of Nursing (www.ncsbn.org) researched, proposed, developed models, and help state Legislatures to implement the Interstate Nurse Licensure Compact. Twenty-two states have passed legislation and are, or soon will be, compact members.
- The Virginia Board of Dentistry requires that all credentialing documents be maintained on file for one year, and then be purged and kept on microfilm. Renewal credentials are required to attest to completing continuing education requirements and a random audit is conducted as a method of continuing education verification. The Virginia Board of Counseling also conducts a random audit as a method of continuing education verification. The Virginia Board of Nursing maintains documents on microfilm as well.
- The Utah Physician Assistant Licensing Board and the Utah Board of Osteopathic Medicine offer credential renewal services online using a credit or debit card. The system allows the renewing licensee to immediately print-out a confirmation of renewal that is as valid as a license certificate and can be used until a renewal certificate arrives by mail within two weeks.
- Arizona law (A.R.S. 32-2522 (G)) sets a time limit of one year after a statement of application deficiencies is sent to an applicant to remedy the deficiencies or the application is withdrawn.
- Florida Statutes have mandated that license applications and renewals be filed online since 2001.

Response

DOH RESPONSE: The audit report did not identify any individuals who were credentialed without meeting qualification standards.

To strengthen our credentialing process, we piloted a quality review process that will guide future practices. We are combining all credentialing staff into a single work unit to ensure consistency. We're also installing a new computer system — the Integrated Licensing Regulatory System —which has improved checks against errors. We are replacing desk manuals with online tools to speed updates, assure access, and improve consistency. All procedures are available on the HPQA intranet site.

These are important steps to achieve uniformity. In addition, we must strengthen our training program. We have used on-the-job training due to resource limitations. We agree a formal training program would increase effectiveness. That will require additional resources.

Three subject areas of this finding would require legislative action:

- Minimum age. The Legislature could establish a minimum age for health care professions, yet we have no current evidence that the lack of a minimum age has endangered any patients. It is unclear if a minimum age requirement would improve patient safety. It is common in some professions, such as health care assistants and nursing assistants, for workers to be under age 18.
- Registered counselors. In 2006, the Governor asked us to study the registered counselor profession. We requested legislation to change the profession's standards. The 2007 Legislature directed us to complete a second study, which will be available in November 2007.
- Registered professions. We encourage a legislative review of all registered professions that have no educational or experience requirements. The review may identify factors that would better protect patient safety.

Action Steps and Timeframe:

- We are conducting a second study of the registered counselors' profession as directed by the Legislature. November 2007.
- The new computer system will have improved checks against errors. June 2008.
- We are replacing desk manuals with online procedures. June 2008.
- We will identify necessary resources for a formal training program. October 2007.
- We will centralize our credentialing work units to promote standard business practices. June 2008.
- We will include audit suggestions and quality assurance pilot project results in revised procedures. June 2008.
- We will work with the boards to change the administration of the exams for the three professions mentioned in the report. December 2007.
- We will review the administration of jurisprudence exams with other boards and commissions in the context of their rules and policies. March 2008.

OFM RESPONSE: We agree that internal controls, appropriate documentation, and consistent procedures within HPQA are good ways to improve public safety. To this end, OFM has supported – and continues to support – HPQA's now nearly-completed installation of the Integrated Licensing Regulatory System, an automated system to improve the agency's credentialing and monitoring process.

Governor Gregoire directed the Department of Health (DOH) to recommend improved standards for registered counselors with the help of a task force. The work of the department to convene a second task force to develop credentialing guidelines for all registered counselors by January 1, 2008, led to agency request legislation in January 2007. The Legislature did not adopt this legislation in 2007, but did direct DOH to convene another task force that would recommend specific guidelines for registered counselors. The Governor and OFM will evaluate the recommendations of this study when received.

Criteria

See Appendix L.

Finding 3: Weaknesses in internal controls over the background check process and lack of national criminal background checks can expose the public to serious risk.

Background

The Joint Task Force on Criminal Background Checks was created during the 2004 legislative session. The legislation required the Task Force to review the state's criminal background check processes and make recommendations to improve it. The final report of the Joint Task Force on Criminal Background Checks was presented to the Legislature in January 2005. The report contained an analysis and description of state and federal legal requirements regarding criminal background checks, issues regarding privacy concerns, timeliness of responses to requests for background checks, employer concerns on requesting background checks, funding and increased technology issues. The Task Force urged further analysis and discussion on "Whether Washington should ratify, through state legislative action, either of two federal statutes focusing on background check programs, namely the National Crime Prevention and Privacy Compact Act (the Compact) and the Volunteers for Children Act (VCA)."

In 2006, the Department completed a comprehensive review of the feasibility of conducting national criminal background checks on all current credential holders and new applicants. The Department analyzed five basic options for conducting criminal background checks, including the available databases, the associated costs, effect on HPQA staff workload and the administrative impact on Washington State Patrol. The report concluded that while the "Department supports criminal history background checks because it recognizes their importance in protecting the public from criminal healthcare practitioners," it would continue its current process for conducting background checks. That process is described in the next two paragraphs.

In April 2001, after a six-month pilot on selected professions, HPQA began conducting criminal background checks on all applicants seeking an initial credential. Credentialing staff forward initial applications to HPQA investigative administrative staff who access the State Patrol database through the Washington Access To Criminal History (WATCH CJ) Database. Since June 2006, all new applicants are also checked through two national reporting federal databanks -- the Healthcare Integrity and Protection Data Bank (HIPDB) and National Practitioner Data Bank (NPDB).

- HIPDB maintains information for all professions except dentists, chiropractors and physicians.
- NPDB maintains background check information on dentists, chiropractors and physicians.
- Both databases contain only information for U.S. and Canadian practitioners.

The databanks are maintained by the federal government and include information related to the status of the practitioner, for example, medical malpractice payment, Medicare/Medicaid exclusions, civil or criminal conviction, and adverse license actions. HIPDB and NPDB regularly send reports to HPQA for review; however, these databanks do not provide absolute assurance that all criminal convictions are contained.

HPQA aims to complete background checks on candidates within 24 hours of receiving the application from the credentialing section. If the check identifies a match (hit)

between the applicant and a criminal record, HPQA conducts an investigation to determine whether to issue a credential.

On June 5, 2007, HPQA received notice from WSP that its status as a criminal justice agency had been reviewed as part of an internal WSP audit and that access to criminal background checks by DOH would be eliminated. Seven other agencies received similar notices. The WSP has restored access to HPQA on a temporary basis. Additionally, HPQA is not allowed access to the FBI criminal database without a state law specifically granting that authority. Therefore, the Department is legally restricted from conducting in-state background checks or accessing the FBI's criminal information.

Condition

HPQA's process for performing background checks needs improvement to ensure that applicants are qualified to receive credentials and credential holders remain qualified to practice in Washington. The process to document the completion of a background check and the results of the check is a manual process that is subject to human error. There is a real potential for a person with a criminal background to receive a credential to practice in Washington. Likewise, the lack of national criminal background checks affords an individual with criminal convictions in other states to obtain a credential in Washington.

According to the staff responsible for performing the criminal background checks, the WSP database does not include information on out-of-state criminal activities. In addition, staff stated that background checks are not performed when a credential is renewed or at any other time beyond the initial application. Any criminal activity that occurs after the individual is initially credentialed is not likely to be identified unless the professional self-reports the violation or is one of the convictions that WSP reports to DOH on a quarterly basis, as described below.

What is a hit?

A hit is a match between the applicant's name and date of birth and the WSP database.

A hit may be a conviction that causes HPQA to deny the credential to protect the public. A hit may also be a conviction that is, for example, more than 10 years old or expunged from the record, and this is not cause for the credential to be denied.

In 2006, HPQA started receiving a compact disc from WSP every quarter reporting violations of assault, homicide, sex offenses and kidnapping. If there is a match to a credential holder, the investigations unit conducts a check using the WATCH CJ database (reflecting conviction information) along with District court, Washington Criminal Information Center (WACIC) and Washington Central Computerized Enforcement Service System (ACCESS) databases (reflecting non-conviction information) to verify the hit.

To document that both types of background checks (WSP and HIPDB/NPDB) have been completed, the investigative staff stamps each application, indicating that a background check was conducted. Printouts of the results are generated only when there is a "hit," i.e., the databases contain negative information about the applicant. If no printout is included in the applicant's file, the stamp is the only verification that a background check was performed. The databases create a digital log each time a check is conducted on an individual. However, the digital log is purged from WSP after 60 days and from HIPDB and NPDB after 45 days.

HPQA assessed the feasibility of national criminal background checks and reported the results to the Governor in November 2006. That report described concerns about the accuracy of the national criminal database and effect of national checks on both the Department and WSP resources. The federal database has acknowledged limitations, detailed in a U.S. Department of Justice report published in June 2006.

Cause

- The State Patrol database provides information of criminal activity that occurs only in Washington state. HPQA does not obtain criminal information for credential holders who hold a credential in another state from that state. HPQA has not entered into a contract with an entity to conduct national criminal background checks.
- Neither Department policy nor state law requires background checks after the initial credential has been issued. HPQA does not require practitioners who are renewing a credential to complete a form to update information or to disclose criminal charges or disciplinary actions for all credentials in all states.
- Stamping applications after background checks are performed is a manual process. Assuming the investigators conduct an equal number of checks each day, each investigator handles 80 to 130 applications per day. This creates opportunities for errors, such as failing to stamp applications when background checks are completed or mistakenly stamping applications that did not have background checks. Internal controls are not in place to ensure this does not happen. Although results of searches can be printed, management has decided to limit printing to searches that return negative information for inclusion in the applicant's file. However, the Department has no review process to ensure the accuracy of background checks.

Recommendations

We recommend HPQA:

1. Consider periodic background checks (in-state criminal and national provider databases) after initial credentialing. For example, perform background checks at fixed time intervals, such as every five or seven years or when practitioners renew their credentials. Two alternatives are:
 - HPQA use a risk-based approach for determining the timing of these reviews based on the number of complaints and the level of sanctions issued for each profession.
 - The Legislature expand the list of convictions provided to the Department by the Washington State Patrol (WSP).
2. Consider requiring practitioners who apply for credential renewals to provide and attest to the validity of their information regarding any felony convictions in any other state or country, and to provide and attest to the validity of their information regarding disciplinary actions for credentials held in any state. Furthermore, if any Washington credential holder is disciplined for any infraction in another state or country, a timeline should be set for the credential holder to report that information to HPQA.
3. Institute a supervisory review process to be performed on a regular basis. Consider maintaining printouts of all completed background checks in the applicants' files.
4. Use the state law (RCW 43.70.250) requiring credential holders and applicants to bear the cost of background checks.
5. Outsource the checks to private companies if the Department determines that it does not have the resources to conduct its own national criminal background

checks. Appendix I contains a table showing companies that provide the service for other states.

We recommend the Legislature:

1. Give the Department the statutory authority to access WSP criminal background information, particularly non-conviction data (WACIC and ACCESS).
2. Give the Department the statutory authority and associated resources to access the FBI database for national background checks and require HPQA to conduct national background checks on all credential holders.

All of the national background check providers we researched have limitations on the completeness, accuracy, and timeliness of their data. In spite of the limitations, several other states have engaged these services.

Practices in Other Jurisdictions

As a result of our research and interviews with other regulatory agencies and boards, we identified the following as promising practices for HPQA to consider.

- Enter a Memorandum of Understanding that allows the Department to access the state's criminal database directly (Texas Board of Dental Examiners)
- Enter into a contract with a private company to take digital fingerprints. (Texas Board of Dental Examiners)
- Contract with a company to perform national background checks. (Texas Board of Dental Examiners)
- Require applicants to pay the fees for criminal background checks. (Utah Board of Nursing, Arizona Board of Nursing)
- Check several criminal and national disciplinary databases and audit self-reporting systems. (Colorado-DORA)
- Arizona law (A.R.S. 32-3280; Section made by exempt rulemaking, effective June 27, 2005: (A)) requires an applicant for licensure under this article other than for a temporary license, must submit a full set of fingerprints to the board, at the applicant's own expense, for the purpose of obtaining a state and federal criminal history records check.
- The Texas Board of Chiropractor Examiners cooperates with Texas Department of Public Safety (DPS) in sharing practitioners' information through program called Rapback. The practitioner's fingerprints are sent to DPS during the initial credentialing process and are entered into DPS record. Whenever DPS arrests a person whose fingerprints match the health care practitioners' fingerprints, DPS will send a "rap sheet" (criminal identification records or criminal history, which contains conviction and arrest information) to the board.
- Based on research, the costs and response times to obtain criminal data from private entities are varied. In some databases, the information can be obtained instantly, while other databases take hours or days. These databases retrieve information from government agencies including criminal justice agencies, local county information, state Department of Corrections, sex offender registries and court records. The information in these databases might not be as up-to-date as the information in federal government database. There is no guarantee that the search will result in finding records. There is disclaimer that sometimes records are not found

because the service may not retrieve information if the arrest was recent. The service retrieves most felony and misdemeanor convictions. Most of the databases provide instant results and the cost ranges from \$12.95 to \$149 per search.

- We identified 14 private companies that provide national criminal background searches. The cost per search ranged from \$13 to \$50. Some offered packages or discounts for large numbers of searches. The response time to the request for a background check ranged from instantly to 24 hours. In Appendix I we list the 14 companies, the coverage/type of information provided, the sources of data, the length of time to obtain the information and the cost/fee for the service.
- Identix is a company that provides digital fingerprinting and background checks in several states including Texas, California, Illinois, Florida, Michigan, Missouri, and Oklahoma. In Tennessee, electronic fingerprinting is provided by Cogent System. Texas charges the applicant \$40 and Tennessee costs the applicant \$56.

Response

DOH RESPONSE: We already conduct Washington State Patrol (WSP) criminal background checks on all new applicants — more than 53,000 a year. We receive background information from the non-criminal national provider data bases (NPD) on all applicants. We also check the WSP and NPD sources on incoming complaints. Based on 2006 legislation, we are able to compare criminal conviction data from the WSP with our credential records as it is available (quarterly). The Legislature authorized us to check for four types of convictions: assault, kidnapping, homicide, and sex offenses.

A legislative expansion of the convictions list to include all felonies would help identify offenders. For example, convictions for illegal drug use, felony driving while under the influence (DUIs), or fraud by a health professional may present a risk to patient safety. In the meantime, we are testing the use of a national Web-search service for public criminal conviction information.

This finding would require legislative action:

- The Legislature would have to take action to give the department access to the full range of convictions, federal criminal data and in-state non-conviction information including police reports. Legislative action supporting cooperation between law enforcement agencies and the department would promote patient safety.
- Staff and funding will be required for more background checks whether done by the department or contracted firms.

Action Steps and Timeframe:

- We are developing mandatory reporting rules with a timeline for reporting unprofessional conduct. May 2008.
- We will develop a quality assurance sampling process to audit completed background checks. September 2007.
- We are testing a national search service for public criminal conviction records. If it is useful, we will assess the cost of expanding it to all applicants. July 2008.

OFM RESPONSE: HPQA must implement background checks within the authority granted them in the law. While we agree with the recommendation to expand the list of crime types included in background checks for professional licensing, DOH will need to work with the Washington State Patrol, the Office of the Attorney General, and the Legislature to develop options that would provide access to additional background information for the department.

Criteria

See Appendix L.

Finding 4: Changes in the complaint management process are needed to more accurately assess complaints and to improve responses to complainants.

Background

HPQA's disciplinary system is driven through investigating complaints. It processes more than 7,000 complaints a year concerning health care providers. Complaints may come from a variety of sources, including patients, other health care professionals, insurance companies, health care provider facilities, and national associations. In addition, HPQA considers as complaints data bank reports that contain information about potential risks to the public and "hits" on criminal background checks.

HPQA uses a triage process to prioritize complaints in terms of patient safety. It reviews all complaints upon receipt for allegations of sexual misconduct or "imminent danger to the public," defined as a situation in which there is a serious risk of immediate adverse impact to public health, safety, or welfare. These cases are handled in an expedited manner.

Our research identified the triage process at Washington's Department of Health as a best practice because it ensures that the most serious complaints are promptly addressed.

HPQA has established procedures requiring that all complaints alleging sexual misconduct or imminent danger are the highest priority (priority one) and are immediately investigated. Expedited Case Management Teams (ECMT) review these complaints, often within 24 hours of receipt, to decide if the case should be forwarded to the investigations unit. Our research found that creating and using a team approach is another best practice in place at HPQA. The team process does not result in an immediate suspension of a credential since an investigation is still required, but it does ensure that those cases receive that highest priority and are promptly forwarded to investigators.

To further protect patient safety, the Governor issued an Executive Order in May 2006 requiring HPQA to develop a comprehensive definition of sexual misconduct that applies to all of the health profession disciplining authorities. The rules took effect September 1, 2006.

Complaints that do not involve sexual misconduct or imminent danger to the public are checked against HPQA's main database to determine if prior complaints have been made against the health professional. Staff also determine:

1. Whether HPQA has legal authority to take action.
2. If the circumstances being reported suggest violations of rule or law.

If either of these two conditions are not met, the complaint is closed.

If both of these two conditions are met, and the profession is regulated by the Health Secretary, a case management team immediately forwards complaints to investigators.

In the case of professions regulated by boards and commissions, complaints are referred to a panel of board or commission members to determine whether the case will be investigated. This practice came about because of a state Court of Appeals ruling in 2005 that requires boards and commissions to review all complaints to decide whether

they should be investigated. Before the ruling, boards and commissions could delegate this decision to HPQA staff, thereby speeding up the process. Boards and commissions may still delegate this decision to HPQA staff but must do so through rule-making.

HPQA has established timeframes for assessing complaints and guidelines to determine what action should be taken when a complaint is received. In the case of a complaint of sexual misconduct or in cases of imminent danger, the employee who identifies this type of complaint is required to immediately arrange an ECMT meeting. For professions that are regulated by the Health Secretary, the team reviews the complaint and decides if the case is a priority-one case. For professions regulated by a board or commission, the team, in conjunction with a three-member panel of the board or commission, decides if the case should be classified as a priority-one case and an investigation started. Agency rules require staff to review all complaints to determine if they involve imminent danger. HPQA procedure requires staff to convene ECMTs within two days of identifying the risk of imminent danger; agency rules require all cases to be assessed in 21 days from receipt of the complaint.

Condition

The disciplinary process at HPQA is almost exclusively complaint-driven. Changes have already been made to improve the way the Department responds to sexual misconduct and cases of imminent danger. However, despite the Department's creation and use of at least two best practices in this area, additional changes in the Department's complaint management process are needed to improve the accuracy of assessment and timeliness of responses.

Accuracy of assessment. Although HPQA has some written guidelines regarding classification of complaints, our tests revealed:

- Sections' intake and assessment staff do not consistently use and apply written assessment guidelines.
- Case management teams do not always use guidelines.
- Four out of five sections within HPQA did not modify the guidelines to include their unique needs.
- The staff is required to determine if other complaints have been filed, but the database does not include specific information about complaints so staff can meet this requirement.
- Minor complaints are closed with no action. Staff is unable to identify potential patterns of behavior that might escalate to unprofessional conduct or that consistently fall below a standard of care.

In addition, HPQA does not examine the number of complaints received within a specific time period to determine whether a health care professional's practice should be reviewed. For example, a practitioner who accumulates three below-threshold complaints within two years may be at risk for committing a future violation that may warrant disciplinary action.

Timeliness and complaint backlogs. Some sections consistently have backlogs of un-assessed complaints. Delays in assessing complaints increase the risk to the public of having health care professionals in practice that HPQA

should potentially investigate and discipline. According to the Washington Administrative Code 246-14-040, the basic initial assessment period is 21 days from receipt of the complaint. The code requires that all reports be reviewed within two working days to determine if they involve imminent danger and, if so, be immediately forwarded for processing and investigation.

We reviewed a report generated by the HPQA Timelines Tracking System that identified professions from 2005 to 2007 with a high percentage of cases with closed steps that exceeded the 21-day assessment.

- Podiatric complaints: 76 percent (29 of 38 steps closed after 21 days)
- Osteopathic complaints: 51 percent (71 of 140 steps closed after 21 days)
- Occupational Therapy complaints: 50 percent (9 of 18 steps closed after 21 days)
- Nursing home administrator complaints: 32 percent (18 of 57 steps closed after 21 days)
- Medical complaints: 38 percent (709 of 1853 steps closed after 21 days)

Proper Documentation. Documentation is a record of what decisions were made, why they were made and which rules, laws, and procedures were followed. Proper documentation of the complaint-handling process helps ensure that correct decisions are made and provides a record should further disciplinary actions be necessary. Lacking certain documents can potentially have a negative impact on HPQA's ability to successfully discipline health professionals. We tested 75 randomly selected complaint files from all sections and found significant inconsistencies in documentation. The table below illustrates the results of those tests.

| Document | # Applicable Files | # with Missing Document | Percent |
|--|--------------------|-------------------------|---------|
| Acknowledgement Letter ¹ | 73 | 61 | 83.6% |
| Closure Letter ² | 51 | 9 | 17.6% |
| Whistleblower Statement ⁴ | 74 | 5 | 6.8% |
| Case Assessment Worksheet | 75 | 48 | 64.0% |
| Case Management Team (CMT) Log | 75 | 10 | 13.3% |
| Computer Screen Prints | | | |
| ASI (Automated Systems Incorporated) | 75 | 11 | 14.7% |
| HTTS (HPQA Timelines Tracking System) | 75 | 25 | 33.3% |
| Garfield (internal system to check for multiple credentials) | 75 | 13 | 17.3% |
| American Medical Association ³ | 10 | 1 | 10.0% |

¹ Complaints were submitted anonymously in two cases and no acknowledgment letter

was necessary

² 24 complaints were still open

³ 65 complaints were not medical and did not require an AMA print-out

⁴ 1 complaint was against a veterinarian; Whistleblower statements are not required.

Source: Clifton Gunderson auditor analysis of randomly selected files.

All 75 files we reviewed contained the complaint form. However, 91 percent (68) of the files were missing one or more documents. In addition, we did not find evidence of supervisory reviews of complaint files that would identify missing documents or other errors.

The failure to provide written notification of a complaint to the credential holder is a violation of state law (RCW 18.130.095), which requires the credential holder be notified upon receipt of a complaint. No law requires that acknowledgement letters be sent to complainants. However, failing to send acknowledgement letters to complainants or advising respondents of complaints may lead the public to think that HPQA does not take complaints seriously.

Cause

- HPQA lacks an appropriate level of communication with intake and assessment staff and appropriate supervisory review of procedures. Many employees we interviewed stated that the Department not not supply them with procedures. In addition, a formal training process is not available for new employees, so they are not informed of the correct procedures for inputting complaint and investigation data into the systems. During our audit, a procedure was adopted on February 9, 2007, to provide detailed instructions for entering dates into the legacy system and timelines tracking databases throughout the disciplinary process. It is now available on the HPQA Intranet site.
- HPQA does not have a procedure that specifies the required documents to be included within each file.
- The office does not have a procedure that mandates the use of case assessment worksheets to document information related to prior complaints.
- Forty-three codes are used to classify complaints. Many complaints appear to fit a number of codes. The descriptions for identifying complaint types are quite broad, making it difficult for employees to distinguish between the categories. In addition, there are more than 30 closure codes. Although these are not as broad, the definitions are limited, making it difficult to determine which is appropriate.
- The process of handling complaints varies between the Health Secretary and boards and commissions, leading to some complaints exceeding the 21-day timeline.
- Boards/commissions that do not receive a large number of complaints on average do not conduct weekly reviewing panels. Reviewing panels are called only when necessary, which causes deadlines to be missed.
- The Secretary has urged the boards and commissions to formally adopt the Case Disposition Guidelines. However, they are not required to follow directions from the Secretary and may choose whether or not to adopt the guidelines. The guidelines provide a basis for decisions whether to close or investigate complaints.

- There is a lack of consistency in closing complaints and in authorizing investigations because there are no standardized guidelines used by all boards and commissions for determining if a complaint does not meet the requirements for initiating an investigation (HPQA refers to this as falling below threshold). This, in turn, causes inconsistencies regarding whether a complaint should be investigated. Thus, complaints that should result in sanctions are sometimes closed with no disciplinary action taken against the practitioner, potentially placing the public at risk.
- HPQA has not written a procedure based on RCW 18.130.095 that requires written notification to the respondent upon receipt of a complaint so respondents are not always notified as required by law. (The law has an exception to the notice requirement where the notification would impede an effective investigation.) No procedure or rule is in place that requires the use of written acknowledgment letters to complainants or when complainants should be notified. As a result, the complainant does not receive prompt acknowledgement of the complaint and is unaware that the complaint is being reviewed by HPQA.
- The procedure that defines imminent danger as a serious risk of immediate adverse impact to the public health, safety or welfare does not outline specific criteria to use when determining imminent danger.

Recommendations

We recommend that HPQA:

1. Work with the boards/commissions to adopt a set of standardized guidelines to determine if a complaint falls below threshold. This is in keeping with the intent of the Uniform Disciplinary Act to consolidate disciplinary procedures and has the additional benefit of promoting consistency. We recommend that boards and commissions use a threshold guideline checklist (like the Nursing Commission's) to determine if cases should be investigated. This checklist provides written, agreed-upon standards and is an effective practice for consistent decision-making. It could be shared with the boards/commissions to use during their decision-making process.
2. Expand the procedure that defines imminent danger (Procedure 212) to include criteria or examples of imminent harm complaints. Those examples should then be used during the intake/assessment process to ensure that complaints posing a serious threat to the public are handled in a timely manner.
3. Consider establishing the maximum number of complaints that a credential holder can receive within a defined period and develop procedures to initiate a practice review of the credential holder. We recommend the boards and commissions adopt a similar procedure.
4. Consider developing procedures to address complaints that are related to behaviors or shortcomings in care that might escalate to more serious violations. This might require statute or rule changes and coordination with boards and commissions.
5. Provide training on Procedure 209, which describes how HPQA databases are updated, who is responsible for updating them, and when data should be entered. HPQA should provide the training to all staff responsible for intake/assessment of complaints. Use of this procedure should be mandatory to maintain consistency across sections. This procedure also should be used when training new personnel. Supervisory reviews should be performed to ensure the procedure is followed.

6. Institute a procedure that reduces the amount of time that intake and assessment personnel have to copy and forward complaints to board/commission panels to one week from the initial receipt of the complaint. This would provide the boards and commissions two weeks to review the complaints, decide on a course of action and sign and return the authorization. HPQA should consider obtaining electronic imaging software to allow electronic, instant file transfers to the boards and commissions.
7. Develop and enforce a procedure that identifies the necessary documentation to be included within case files. This will ensure consistency among the sections and facilitate use of the files by the various users and protect HPQA's position in legal proceedings.
8. Implement a procedure that requires the use of case assessment sheets that include the details of prior complaints, even those closed below threshold. Such information is useful at Case Management Team meetings when deciding if an investigation is necessary because it allows the team to assess pattern-forming behavior.
9. Develop a list of specific definitions for complaint types and closure codes that facilitates the classification of complaints. Definitions should include examples of complaints that would fit into each category.
10. Adopt and enforce procedures that
 - Comply with state law regarding the use and timeliness of written notification to credential holders.
 - Require a written acknowledgement be sent to a complainant upon receipt and assessment of a complaint.
 - Require a quarterly written notification of the status of a complaint/case be sent to both the complainant and credential holder.

Implementing these recommendations should improve HPQA's complaint management processes and enable HPQA and the boards and commissions to assess the level of harm to the public consistently, to identify and monitor credential holders who may be unqualified, to inform complainants and respondents that complaints are being addressed, and to maintain a documented record of complaints and actions.

Practices in Other Jurisdictions

As a result of our research and interviews with other regulatory agencies and boards, we identified the following as promising practices that HPQA might consider.

- The Texas Department of State Health Services and the health profession boards send letters to complainants quarterly advising them of the status of the complaint/case.
- Engage volunteer dentists to provide expertise for review of standard-of-care complaints. Develop a training manual for volunteers to ensure consistency (Texas Board of dental Examiners).
- The Arizona Board of Nursing may choose to issue a "Letter of Concern." This is a letter from the Board expressing concern that a licensee, certificate holder or applicant may have engaged in questionable conduct, although the conduct does not necessarily violate the Nurse Practice Act. This is not classified as disciplinary action, but could offer opportunities to respond to complaints that are below threshold.
- The Utah Division of Occupational and Profession Licensing analyzes complaints for long-term patterns of behavior.

- If a complaint is outside the jurisdiction of the California Medical Board, staff will provide a referral to the appropriate state agency. According to the Licensed Chemical Dependency Handbook, if the Chemical Dependency Board in Texas receives a complaint outside of its jurisdiction, the Board will forward the complaint on to the appropriate agency as well.
- Illinois and Utah provide the public the opportunity to submit complaint forms electronically on their Web sites.

Response

DOH RESPONSE: We are pleased that the audit highlighted some of our practices – such as the team approach to high-priority cases – as a model. We are consolidating all intake staff into a single unit. This will ensure consistency and strengthen the complaint management process. We are installing a new computer system, Integrated Licensing and Regulatory System, with improved checks against errors. These changes will enable us to more quickly acknowledge complaints and keep complainants and credential-holders informed.

In 2006, we began reviewing the decisions to close cases without investigation (when the evidence available is “below threshold”). We will provide the threshold list used for Secretary-regulated professions to all boards and commissions for their adoption and use. We are expanding quality assurance processes to other activities.

Certain recurring complaints may escalate into more serious violations. Based on the audit suggestions, we will review other jurisdictions’ experience using the number and type of complaints to identify incompetent practitioners.

Action Steps and Timeframe:

- We will provide the threshold list used for Secretary-regulated professions to all boards and commissions for their adoption and use. March 2008.
- We will develop specific criteria for imminent danger. February 2008.
- We will evaluate the success of other states’ use of multiple complaints to identify incompetent practitioners. We will adopt practice review procedures if there is evidence they are effective. May 2008.
- We will evaluate the success of other jurisdictions’ experience with long-term behavioral indicators. If they are shown to be effective, we will adopt new procedures. May 2008.
- We will update training related to disciplinary case tracking after the first internal quality review. November 2007.
- We will seek funds to study the feasibility of electronic document management. It will include imaging of complaint files. October 2007.
- We will re-evaluate what should be included in case records and revise our procedures on how to organize and manage records. September 2008.
- We will develop a common case assessment worksheet for use in all Secretary-regulated professions and recommend its use in board/commission-regulated professions. November 2007.
- The database complaint types and closure codes are defined in manuals for the obsolete computer system, ASI. We have reduced the number of complaint types and closure codes for the new system. We have clear definitions for each. The new Integrated Licensing Regulatory System will be fully implemented by June 2008. June 2008.

- We will continue to send notification letters when we assess the complaint. We will look into the cost of additional notifications. June 2008.

OFM RESPONSE: It is notable that HPQA's triage process for prioritizing complaints was identified in the audit as a best practice. In addition, per the Governor's May 2006 Executive Order, sexual misconduct rules have been adopted by the Secretary and all boards and commissions.

Criteria

See Appendix L.

Finding 5: HPQA’s efforts to improve public education regarding citizens’ rights to file complaints about credential holders with HPQA are insufficient.

Background

As previously discussed, HPQA’s ability to identify and discipline practitioners who provide substandard care and who engage in unprofessional conduct largely depends upon the public reporting violations. As a result, the Governor requested that this audit incorporate suggestions for improving public education regarding their right to file complaints about credential holders.

Condition

HPQA does not have a budget for public education on its role in patient safety. Because of this, HPQA depends on three methods to inform and educate the public about the complaint process and HPQA’s role as the place to file complaints regarding unprofessional conduct and substandard care by health professionals.

- HPQA’s Web site explains the process of filing a complaint with HPQA.
- In 2006, Health Systems Quality Assurance – the division that houses HPQA -- hired a communications manager. One of the responsibilities of the position is increasing public awareness of what HPQA does. The Department does not have a budget for the public education effort. During the past year, HPQA has focused on earned media and responding to news articles about health professionals committing serious violations.

Earned media, such as a news story or opinion piece, is free media coverage. It is generally considered an efficient and cost-effective way to reach a large audience. The agency regularly provides news releases to Washington media outlets for their consideration about disciplinary actions taken against practitioners.

- Interviews with the media. The Assistant Secretary of Health responds to questions regarding health care professionals. During the interviews, the Assistant Secretary offers information about HPQA’s responsibility to receive complaints about health care professionals and to act upon the complaints.

Citizen Survey Questions

1. Have you or anyone in your immediate family, ever experienced what you would consider unprofessional conduct on the part of a health care professional who was treating you?
2. If you wanted to file a complaint about unprofessional conduct on the part of a health care provider, do you know where you would report it?
3. Where would you go for information about how to file a complaint?
4. The following are some ways that people could find out where to get information about the rights of health care patients. As I read each one, tell me how likely you personally would be to find that source useful. Very likely to use the source, Somewhat Likely, Not Very Likely, or Not AT All Likely to use that source. The first one is...
 1. the state Department of Health
 2. Public service announcements on television
 3. Posters in hospital and doctors’ waiting rooms
 4. Notices or advertisements in the newspaper
 5. Public service announcements on radio

As part of this audit we worked with a research firm to determine the effectiveness of HPQA’s public education efforts. A telephone survey of Washington citizens was conducted in February 2007 by Stuart Elway & Associates and FLT Consulting. The results of the survey indicate that HPQA needs to do more to educate the public regarding filing complaints to HPQA

The survey was a statistically valid telephone survey of 400 registered voters. The purpose of the survey was to determine whether Washington citizens would know where to file a complaint about unprofessional conduct on the part of a health care

provider, and if the Department or HPQA would be identified as a place to report the complaint. A secondary purpose was to identify where people would go for information about how to file a complaint. None of the respondents identified the Department or HPQA as the place they would report unprofessional conduct by a health professional, although 16 percent did state that they would contact the “State Health Board.” The most frequently identified sources to obtain information about how to file a complaint were the Internet (24 percent), followed by hospital administration (10 percent) and State Health Board (9 percent).

Cause

Until 2006, DOH and HPQA did not budget for a position or hire an employee to identify steps to improve public education. No budget request was made to fund public education in 2007.

Recommendations

Given that the complaint process is HPQA’s primary mechanism for identifying unprofessional conduct and substandard healthcare services, in order to more fully protect the public’s interests in these areas, we recommend that HPQA:

1. Develop and institute a public education strategy.
2. Determine the cost for a public education strategy and request funding for it from the Legislature.
3. Improve its Web site:
 - Create a prominently displayed link on the DOH home page to the HPQA complaints page.
 - Create a link on Access Washington to the HPQA Web site complaints page.
 - Work with other health agencies (such as the Health Care Authority or the Department of Social and Health Services) to create a link on their Web sites to the HPQA Web site complaints page.
 - Consolidate the complaints pages with the most important information on a single screen and link them to additional screens for more information. Currently a user must go through seven screens to get to the complaints form.
 - Consider providing complaint information in languages other than English.
 - Create an application to allow complaints to be submitted online.
 - Consider obtaining the services of a professional web developer.
 - Enhance the profiles and/or disciplinary action published on the Provider Credential Search Web site to assist the public in making informed decisions about selecting health care providers. Suggested examples:
 - Massachusetts – physician’s profiles are easy to find.
 - Arizona Medical Board – profile includes license history and status, medical education and training.
 - California – Web sites include phone number and online chat to obtain physician information.
4. Participate in other activities to promote public education. For example:
 - Participate in health fairs sponsored by other entities, such as state agencies, managed care organizations, and city and county organizations.
 - Make presentations at community organizations such as senior citizen centers and health support groups.

- Create brochures with information about HPQA, how to file a complaint, what types of complaints are handled by HPQA, what to expect after a complaint is filed, and how to use HPQA's Provider Search Web site.
- Include an informational brochure when sending an acknowledgement letter that the complaint was received.
- Create a large-print version of the brochures.
- Consider printing brochures in a language other than English.
- Create audio CDs and tapes with information for the visually impaired.
- Consider adding a toll-free number for complaints information that is easily remembered.
- Purchase inexpensive promotional items, such as pens or magnets, with HPQA's Web site and contact telephone number for complaint information and distribute.
- Contact other state(s) agencies that have paid for media campaigns to obtain ideas regarding ways to publicize submission of complaints about health care providers.
- Create and print posters containing information about how to file a complaint with HPQA.

Implementing the recommendations will provide the public with information about its right to complain about practitioners and how to file complaints about practitioners who engage in professional misconduct or provide substandard care. Ultimately, the public will be better protected if HPQA is informed of unqualified health care professionals and can take the necessary steps to sanction those professionals.

Response

DOH RESPONSE: A public information strategy would help people understand the complaint process. We expect increased public awareness to generate more complaints. We will have to be prepared to handle them. It is possible that any major public education campaign will require significant resource investment. It is imperative that as we increase public awareness of the complaint process that the infrastructure needed to respond to these complaints is sufficient.

Action Steps and Timeframe:

- We are developing a public awareness strategy and will identify its costs for the Legislature. June 2008.
- We will calculate the cost to redevelop our Web site to focus on customer needs. October 2007.
- We are testing outreach to vulnerable populations, particularly the elderly, based on the results of the February 2007 survey. December 2007.

OFM RESPONSE: We agree that public awareness of the complaint process for credential holders should be improved. We encourage HPQA to explore creative solutions and strategies to work with community partners and other sources to increase the reach and frequency of their public outreach efforts.

Criteria

See Appendix L.

Finding 6: Investigations of complaints are delayed by process issues and compromised by staffing shortages and internal control deficiencies.

Background

HPQA's investigations unit conducts investigations for the professions regulated by the Health Secretary and for those regulated by boards and commissions. The investigations unit prioritizes cases upon receipt. Complaints are triaged and assigned a priority:

- Priority one – sexual misconduct or imminent danger to the public
- Priority two – remaining high priority or serious cases where there is no imminent danger
- Priority three – all other cases

Investigators gather evidence by conducting interviews and obtaining and reviewing pertinent records. Then investigators draft a report, which is reviewed by the board/commission or HPQA case management team to decide if legal action should be considered.

The investigations unit has reorganized in order to streamline the way it functions and produces results. Prior to August 2004, the investigation function was separated into four sections. The methodology used by each section and their reports were inconsistent. In December 2004, HPQA consolidated its investigative units into one centralized unit, with the exception of pharmacy investigators and inspectors, to respond to a need for improved timeliness, accountability, and consistent sanctions. After the reorganization, the investigator qualifications were rewritten to make it easier for individuals with medical or clinical experience to qualify. The reorganization also remedied resource limitations by eliminating an inability to shift work from one unit to another because of the profession-specific knowledge and expertise. Investigators and staff attorneys now have primary assignments and secondary assignments. For example, an investigator who is also a licensed physician assistant would primarily investigate medical cases and could be assigned to investigate mental health cases as a secondary assignment.

Condition

We found that the investigation unit has a backlog of cases and the investigators must manage numerous cases simultaneously. HPQA policy requires that Priority One cases are immediately investigated. As a result, investigations of Priority Two and Three cases are delayed, creating backlogs of cases that exceed statutory timelines. Lower priority cases make up the backlogs. Potentially serious complaints may not be investigated promptly because the case was originally assessed as lower priority.

Case Management Teams

The CMT process ensures group assessment and decision-making in all matters that may lead to adjudicative action.

CMT Participants:

Program Manager(s)
Staff Attorney(s)
Chief Investigator or designee
Executive Director or designee

Washington Administrative Code 246-14-040, *Initial Assessment of Reports*, states that a decision must be made to investigate or close complaints prior to investigation within 21 days from initial receipt of the complaint. The Case Management Teams for Secretary-regulated professions meets regularly – at a minimum weekly – to decide if cases should be forwarded to the investigations unit. An investigator is assigned and the investigation is initiated. If the complaint pertains to a profession that is disciplined by a board/commission, the complaint must be presented to the board/commission in

order to obtain authorization to investigate. Some boards/commissions have standing meetings to consider authorizations. A 2005 Washington Court of Appeals ruling requires boards or commissions to authorize investigations. As a result, intake/assessment personnel must copy the complaint, redact identifying information, send the documents to the panel for review, and then wait for the panel to send back the signed authorization before the case can be investigated.

The 2004 reorganization was intended to increase the availability of investigators through cross-training. Previously, many of the investigators who were assigned medical or nursing cases had a medical or nursing background, in addition to law enforcement experience. Cases alleging improper standard of care usually require expert knowledge. A review of case assignments revealed that cases requiring medical or nursing background continue to be assigned to investigators with that expertise at the same levels prior to the 2004 reorganization. Some boards/commissions rely on contracted experts to develop and help assess their cases at the investigative stage of the process. Obtaining an opinion from an outside party can add significantly to the time required to investigate cases.

A Statement of Allegations is issued when the risk to the patient is minimal or there is no pattern of conduct.

A Statement of Charges is issued when the risk to patients is moderate to substantial, a failure to comply with prior orders, or a person cannot practice with reasonable skill or safety.

Process Delay Issues. The amount of time it takes to open an investigation can vary, depending on whether HPQA can initiate the investigation or whether approval to investigate must come from a board or commission. If HPQA can initiate the investigation, its procedures determine and control its ability to meet the timelines related to assessment of complaints. If a board or commission must authorize the investigation, additional time is required to copy the complaint, redact identifying information, and send the documents to the panel for review. Additionally the panel's review of the complaint and authorization of an investigation is time-consuming. Some boards and commissions review complaints during regularly scheduled meetings. Others, have reviewing panels that meet frequently to decide disciplinary issues. For example, for example the Nursing Care Quality Assurance Commission panel meets weekly.

Investigator Staffing Concerns: Each investigator carries an average caseload of 35 to 40 cases. While conducting multiple investigations at one time is unavoidable, the volume of cases carried by most investigators may be impairing the investigation process, as well as creating a backlog of cases that are considered lower priority. As a result, investigations may not be as thorough as warranted. Given the consistent annual increases in the number of complaints over the past decade, the problem is likely to worsen. Because of the consolidation of investigators into a single unit for 54 of 57 professions, we were unable to determine how the caseload compares to other states. In other states, professions were regulated by independent agencies with their own staff of investigators or in states that had umbrella agencies, the number and type of regulated professions and/or the organizational structure were significantly different.

HPQA is not consistently completing investigations in a timely manner. WAC 246-14-050 sets the time period for investigations at 170 days. HPQA has set internal timeline goals for completion of investigations: priority one cases should be completed within 30 days, priority two cases within 60 days and priority three cases within 170 days. Backlogs of cases that are not investigated or require an extended amount of time to complete are often an indication of an insufficient number of investigators.

HPQA does not provide formal internal training to new investigators. It has opted to use the Department of Personnel investigator training program developed under Executive Order 98-02 (see below). Several investigators noted during interviews that the training program is insufficient. One investigator noted that the process of becoming a new investigator is “sink or swim.” Another noted that the lack of a formal training program at HPQA made it more difficult to adjust to the new position.

Through the State Auditor’s Office, we engaged Elway Research, Inc. and FLT Consulting to conduct a survey of HPQA staff in February 2007 as part of the fieldwork. The online survey was sent to every HPQA employee. It focused on identifying “best practices” and “needed improvements” in HPQA work units. This survey was designed as an “indicator” or “pointer” to identify issues and areas that may benefit from a performance audit. According to the survey, 70 percent of the respondents from the investigations unit cited practices needing “significant improvement.” Fifteen percent of respondents rated training as “needs improvement;” 4 percent to 9 percent of respondents in all other units rated their training as needing “significant improvement.”

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| <p style="text-align: center;">Performance Audits HPQA Survey, Elway Research, Inc.</p> <p>Respondents were asked seven questions. They were asked to rate their work unit in terms of:</p> <ol style="list-style-type: none">1. Effectiveness - Getting the right things done;2. Economy - Cost of inputs (labor, materials, energy, etc.);3. Efficiency - Getting things done in reasonable time for reasonable cost; and4. Accountability - Answerable for performance. <p>They were then asked three open-ended (unaided) questions. They were asked to list:</p> <ol style="list-style-type: none">5. Best Practices, “any practices in your organization that you think are particularly outstanding, that lead to positive results.”6. Needed Improvements, “any practices in your division/region that you think need significant improvement, that may be hindering your/the agencies results.”7. Finally, since the previous questions were directed specifically at their own work unit, respondents were given a chance to comment on any other aspect of HPQA. |
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Executive Order 98-02 issued in 1998 by then-Governor Gary Locke and maintained by Governor Gregoire requires:

- All investigators to receive formal training.
- Agencies to ensure that employees receive training appropriate for their level of responsibilities.
- Agencies to develop written policies and procedures for state employees who conduct investigations, and
- Agencies to submit their investigation policies and procedures to the Department of Personnel for review and comment.

All new investigators must attend training developed by the Department of Personnel. Investigators who have previously completed equivalent training must petition to receive certification from that Department within 18 months of being hired. HPQA has elected to require all new investigators to attend the Department of Personnel-sponsored training. This ensures that all investigators are introduced to the administrative law arena, rather than relying on other investigative experience.

The Department of Personnel instituted a State Investigator Resource Committee (SIRC) to implement the Executive Order’s direction regarding approval of agency investigation policies and procedures. The SIRC is comprised of chief investigators from various state agencies, including DOH. All investigative bodies within state

agencies must have SIRC's approval of training topics, policies and procedures. The Health Department's guidelines were reviewed and approved by SIRC in 2000.

Internal Controls Deficiencies. We also found that HPQA's internal controls need strengthening to ensure that cases are fully investigated, timeframes are met, and that decisions to close or refer for legal action are made correctly. HPQA's controls do not sufficiently ensure that investigations are complete and properly documented. Supervisory reviews are an important control and should be conducted to ensure the sufficiency and completeness of each investigation. Inadequate or improperly executed investigations could lead to cases being erroneously closed. Although HPQA's investigative report form includes the supervisor's initials, the office does not have a formal policy requiring a supervisory review.

In the majority of the investigation files that we tested, there was evidence that a supervisory review was performed. However, 25 percent of the tested files -- 19 of 76 -- did not have sufficient evidence to establish that a supervisor had reviewed the case and approved the investigator's disposition of the case. For example, investigative reports are not prepared for a variety of reasons, including lack of jurisdiction, closure without investigation, incorrect respondent identified, incorrect routing to investigation unit, and non-cooperation of complainant.

We tested 76 randomly selected investigation files to determine whether timelines were met, based on priority level. Exceptions to the timeline goals included investigations that exceeded 170 days (unless an extension was granted) as well as priority one and two cases that exceeded the internal goals. Specifically:

- 10 percent (6 of 60) of files tested did not meet the investigation timelines.
- 21 percent (16 of 76) of the files tested did not have documentation to determine if the investigation timelines were met.

Cause

- In order to comply with state laws that require the boards and commissions to authorize investigations, the time from the receipt of a complaint to conducting an investigation necessarily increases.
- HPQA has guidelines, but not developed and documented policies and procedures, for conducting investigations.
- HPQA lacks policies and procedures that provide guidance to investigators regarding what documentation should be maintained in the case files. HPQA does not have procedures requiring a supervisory review and written approval (sign-off) of every case closed by investigations prior to the case being returned to the section in HPQA responsible for specific professions. A supervisory review may be completed; however it is not documented in the file.
- HPQA lacks a policy or procedure that mandates the use of case-tracking logs by investigators. Such logs would enable supervisors and staff to properly gauge workload levels and help to ensure that tasks are completed in a timely manner. Reports from the automated systems identify only case assignments and due/overdue dates.
- Investigators' caseloads are 35 to 40 cases. According to backlog data collected since July 1, 2005, 24 percent of all cases in investigations have exceeded the timeline. As a result, investigators must spend a significant amount of time

shifting priorities to clearing what have become overdue cases, which causes newer cases to be delayed and be at risk of exceeding timelines.

- A recent change in investigator qualifications has expanded the pool of candidates to make it easier for health care professionals to become investigators, even without law enforcement experience. Lack of specialized knowledge can cause delays if the disciplining authority wishes to hire a contractor with that knowledge to review investigations and presentation of the results.
- Investigative timelines are also affected by delays in procuring documents from employers and practitioners. There are limited mechanisms now available to investigators to timely obtain documents, records, and other evidence.

Recommendations

We recommend that HPQA:

1. With the boards and commissions work to improve processes to make them effective, efficient and reduce delays caused by shared responsibilities.
2. Establish written policies and procedures for conducting investigations. These policies and procedures may include a checklist to ensure that important steps of the investigation are not overlooked.
3. Investigation Service Unit should focus its efforts on decreasing the backlog of overdue investigative cases so resources can be expended on investigating complaints in a timely manner. This may require the addition of more investigators, possibly on a temporary basis, to decrease the backlogs. Once the backlog is reduced, management can more accurately assess the need for increased resources in this unit caused by the increased number of complaints.
4. Consider contracting with community physicians to consult on routine standard-of-care cases for a flat fee.
5. Evaluate whether it is most effective to hire investigators with specialized knowledge or whether it is more timely and cost effective manner to fill that need with consultants.
6. Comply with Executive Order 98-02 to ensure that all investigators receive appropriate training.
7. Consider coordinating its training with other governmental agencies and jurisdictions with similar responsibilities to fully utilize existing training sources as suggested in Executive Order 98-02 (2)(c).
8. Require supervisors to officially sign off on all investigations.
9. Develop a policy and procedure that requires the use of a standardized caseload tracking log by investigators that identifies the status of each case. An electronic application would provide a standard format for the data and could be made accessible to the staff and management as determined by HPQA.
10. Establish and follow a procedure that details the necessary documents to be included within each investigation file.

We recommend that the Legislature:

1. Provide additional tools for obtaining records, documents and other evidence. These tools could include authorization to issue citations and fines for failure to provide documents in a timely manner.

Putting the recommendations into practice would make the process to initiate investigations between HPQA and the boards and commissions more efficient. When HPQA reduces the backlogs, the public is more promptly and efficiently served. Improvements in the consistency and quality of the documentation of investigations will increase the likelihood that practitioners who should be disciplined will be appropriately disciplined.

Practices in Other Jurisdictions

As a result of our research and interviews with other regulatory agencies and boards, we identified the following as promising practices for HPQA to consider.

- To reduce investigation case backlogs and more efficiently use staff resources. Massachusetts began outsourcing the screening of most quality cases to cope with an emergency backlog of cases in 2000. Through a competitive process managers selected the Center for Health Dispute Resolution (CHDR) to review cases alleging substandard care. CHDR is paid per case for expert peer reviews and liaises with the senior board nurse. CHDR supplies only the expertise needed when it is needed, without the possible downtime of in-house staff.
- Administrators In Medicine (AIM), in partnership with the Federation of State Medical Boards (FSMB), has designed a national state medical board investigator certification program that will provide comprehensive, subject specific education and training for state medical board investigators. The goal of the program is to provide a resource to boards that would give specialized training to individuals who are in the position of investigating complaints received by medical boards. The program is specifically intended for investigators who have basic investigative skills, but are new investigating physicians. The program intends to provide continuing education and certification for individuals with more advanced skills. Washington HPQA sent the Assistant Chief Investigator and a few other investigators to attend the program this year in order to evaluate the usefulness of this program.
- The Virginia Department of Health professions laid out, in an organized fashion, timeframes based on case type/complexity for the timely investigation and adjudication of cases in an internal policy. Although these timeframes are not set in statute, they are “standards which the organization relies on when assessing individual, unit, and organizational performance.”
- The Arizona Medical Board pays community physicians a flat fee of \$150 per case to provide medical consultation to investigators on routine standard-of-care complaints and investigations. The protocol in those cases for the Board’s medical consultant to contact a community physician with appropriate medical expertise and independence to ask for their assistance in the case. Many of the community physicians choose to perform the work pro bono rather than accept the standard fee.
- To facilitate the investigations process, the California Medical Board initiated an Expert Review Program in 1994. Professionals who partake in this program assist the board by providing expert reviews and opinions on cases, conducting professional competency exams, physical exams, and psychiatric exams. Participants are paid \$100 an hour for conducting case reviews and oral competency exams and \$200 an hour for providing expert testimony. Requirements for participating in the program include the following:

- a. Possess a current California medical license in good standing; no prior discipline; no accusation pending; no complaint history within the last three years;
- b. Board certification in one of the 24 American Board of Specialties (the American Board of Facial Plastic & Reconstructive Surgery, the American Board of Pain Medicine, the American Board of Sleep Medicine and the American Board of Spine Surgery are also recognized) with a minimum of three years of practice in the specialty area after obtaining Board certification;
- c. Have an active practice (defined as at least 80 hours a month in direct patient care, clinical activity, or teaching, at least 40 hours of which is in direct patient care) or have been non-active or retired from practice no more than two years.

Potential barriers to adoption of these practices might include:

- Having adequate financial resources to hire additional investigators.
- Having adequate financial resources to contract with a third party to reduce the backlog of lower priority cases, but ensuring that the cases are adequately investigated before closure.
- Having access to medical expertise due to financial constraints and availability of experts.
- Consideration of additional time to initiate an investigation is needed due to the split of disciplinary authority between boards/commissions and HPQA.
- Having difficulty in obtaining medical records.
- Recent Washington Supreme Court ruling requiring a higher standard of proof.

Response

DOH RESPONSE: Patient safety is our first concern. Cases that endanger patients are the highest priority. Our next focus is to reduce the backlogs. Permanently eliminating backlogs will require more staff and resources. A successful public information campaign will increase complaint volume (see our response to Finding 5).

Processes for boards and commissions to authorize an investigation could be improved. For example, only two of 14 boards and commissions have adopted rules delegating the decision to HPQA staff. These rules should speed up the process. We are encouraging other boards and commissions to follow suit.

We have longstanding investigative guidelines approved by the state's oversight group, the State Investigator Resource Committee (SIRC). Guidelines, rather than rigid policies, are used to address the unique needs of each profession and type of unprofessional conduct.

We have used expert witnesses in investigations for standard of care cases. We will expand the use of experts. We have had supervisory review as part of the investigative report since 1989. We will be able to improve caseload tracking with the new computer system, which will support the use of a single tracking report for each investigator. We will examine the other suggestions in the audit report to improve the investigation process and adopt them as appropriate.

Legislative action could provide new tools for obtaining records, documents, and other evidence. In 2007, we proposed legislation to allow use of citations and fines for failure to provide documents in a timely manner.

Action Steps and Timeframe:

- We will propose improvements to the process to authorize an investigation. June 2008.
- We will identify resources needed for a formal training program. October 2007.
- A workload standards study is now underway to identify appropriate staffing levels. We will provide the report to the Legislature when it is completed. December 2007.
- We will complete the contract process for expert review of standard of care cases. December 2007.
- We will have a single caseload report for each investigator in the new licensing computer system. June 2008.
- We will re-evaluate what should be included in case records and revise our procedures on how to organize and manage records. September 2008.

OFM RESPONSE: We strongly support HPQA's on-going process improvement efforts and will consider requests for additional resources as part of the budget development process in the future.

Criteria

See Appendix L.

Finding 7: Deficiencies in the disciplinary (legal) process have led to inconsistent and delayed discipline of practitioners who engage in unprofessional conduct or provide below standard of care.

Background

The legal unit provides legal review of a complaint after an investigation is complete, prepares legal documents, and assists in managing a case once the health care professional is notified of allegations or charges. Prior to August 2004, the legal function was separated into four sections. The methodology and reports used by the sections were inconsistent. When the investigators were reorganized in August 2004, HPQA's legal units were consolidated into one centralized unit to respond to the need for improved timeliness, accountability and consistent sanctions. The reorganization also remedied an inability to shift work from one unit to another because of the profession-specific knowledge and expertise.

Once an investigation is complete, the board/commission panel or case management team decides if further action is necessary. If so, the case moves into the legal process. If legal action is necessary, a Statement of Allegations or Statement of Charges is issued.

If a Statement of Allegations is issued, the disciplinary case is resolved through a Stipulation to Informal Disposition (STID). A stipulation resolves a case without the health professional admitting to unprofessional conduct, but agreeing to corrective action. A stipulation is reported to national databanks that collect such information.

A Statement of Charges is issued when information and evidence obtained from an investigation substantiates the allegations and formal disciplinary activities are deemed necessary. A settlement conference is available, but not required, to all health professionals who have formally received a Statement of Charges. The desired outcome of the settlement conference is a mutually agreed-upon order that is presented to the disciplining authority for approval.

A health professional who is served with a Statement of Charges must answer within 20 days requesting a hearing, waiving the right to a hearing, or requesting a settlement. A hearing will result in the issuance of a Final Order, which dictates the disciplinary authority's final decision. All Statement of Charges and Final Orders are publicly disclosed, reported to national databanks and distributed to the media. The Final Order details the terms of the sanction.

If a health professional fails to answer a Statement of Charges or fails to participate in the adjudicative process, a Default Order is issued. A Default Order is a legal document authorizing the disciplinary authority to issue a Final Order without further participation by the health care professional.

In May 2006, the Health Secretary adopted Uniform Sanction Guidelines for the professions that she regulates. These guidelines serve as a tool to impose sanctions for assuring consistency for similar violations. As of July 2007, 10 of the 14 boards and commissions with disciplinary authority have voluntarily adopted the guidelines; however, state law says they are not required to do so. Two boards are piloting the guidelines. Two others, the Medical Quality Assurance Commission and Veterinary Board of Governors, will decide whether or not to adopt the revised guidelines during

summer 2007. The Secretary recognizes that it is the best interest of the public to ensure that sanctions are consistent and is strongly encouraging all of the boards and commissions to adopt the guidelines.

Actions taken against a health professional may include, but are not limited to: fines, counseling, re-training, practice limitation, suspension from practice, or credential revocation.

A summary suspension is a sanction that the disciplinary authority can impose when an investigation that indicates an immediate danger to the public if the health professional continues to practice. If this occurs, the health care professional cannot legally practice until a hearing is held.

Condition

While HPQA has made changes in its disciplinary process that have resulted in improvements in sanctioning violators and the time required to discipline violators, HPQA and the boards and commissions needs to further improve the consistency of sanctions imposed on health care professional for conduct or care violations, and to improve the timeliness of the resolution of disciplinary cases by taking all legal steps without delay.

Mandatory Suspensions. Mandatory suspensions are a second significant action that have affected the timeliness of disciplinary actions and improved public safety. Mandatory suspensions were enacted in 2006 by SHB 2974, Chapter 99, Laws of 2006 (see sidebar). Prior to this, disciplinary actions in Washington were not consistently imposed on health care professionals. Sanctions varied by profession and dissimilar sanctions were imposed for similar violations. The bill's intent was to resolve some of problems with the disciplinary system and promote patient safety.

SHB 2974, Chapter 99, Laws of 2006

Consistent with section 3 of this act, a disciplining authority shall issue a summary suspension of the license or temporary practice permit of a license holder prohibited from practicing a health care profession in another state, federal, or foreign jurisdiction because of an act of unprofessional conduct that is substantially equivalent to an act of unprofessional conduct prohibited by this chapter or any of the chapters specified in RCW 18.130.040. The summary suspension remains in effect until proceedings by the Washington disciplining authority have been completed;

Before the law was enacted, if HPQA found that a practitioner had been prohibited from practicing in another state, HPQA had to complete a full investigation into the underlying conduct before a sanction could be imposed. Investigations, as discussed in the previous section, are often slow and lengthy. The law empowers HPQA to deny a credential to or to suspend the credential of any practitioner whose credential is suspended or revoked in another state for an activity that would be a violation in Washington. In addition, the law permits the investigation to occur without obtaining prior authorization from the board/commission.

Once an investigation is complete, HPQA can move to the disciplinary process immediately for the professions under the authority of the Secretary. For all other professions, in cases other than mandatory suspensions, HPQA must present the findings of the investigation to the appropriate board or commission and the board or commission decides whether disciplinary action will be taken. Once the investigative report is received by the board/commission, a panel meets to determine whether further action is warranted. HPQA attorneys can suggest a possible sanction but the

board/commission can agree, choose another penalty, or choose to forego disciplinary action.

Summary Suspensions. HPQA has increased the number of summary suspensions for priority one cases that demonstrate imminent harm or sexual misconduct. We discussed in Finding 4 the formation of Expedited Case Management Teams that are designed to react quickly to this type of case. Although investigations are given the highest priority for these cases, the investigations must be complete to ensure that a practitioner engaging in such behavior is appropriately disciplined. As a result, improving the timeliness of disciplinary actions in summary suspension cases is due to the fast response identifying and classifying a complaint as a priority one case and beginning the investigation.

Sanctioning Guidelines. As previously stated, the Health Secretary adopted Uniform Sanctioning Guidelines in May 2006. The guidelines are a tool for HPQA to consistently impose sanctions for similar violations. In the past, significant variations have occurred in the severity or leniency of sanctions imposed for violations. However, the guidelines apply only to the professions that the Secretary has the authority to discipline. The Secretary does not have the authority to require that the boards and commissions adopt the guidelines. HPQA made presentations to the 14 boards and commissions with disciplinary authority explaining the guidelines and encouraging their adoption. The guidelines were revised in February 2007 and presentations made to the boards and commissions again. The chart below shows the boards and commissions that have adopted the guidelines.

| Board/Commission | Action |
|---|--|
| Dental Quality Assurance Commission | Adopted revised guidelines 6/7/07 |
| Board of Hearing and Speech | Adopted revised guidelines 4/27/07 |
| Nursing Care Quality Assurance Commission | Adopted revised guidelines 7/13/07 |
| Board of Nursing Home Administrators | Adopted revised guidelines 5/11/07 |
| Board of Occupational Therapy Practice | Adopted revised guidelines 6/19/07 |
| Board of Osteopathic Medicine and Surgery | Adopted original guidelines 11/06; adopted revisions 3/23/07 |
| Board of Pharmacy | Adopted revised guidelines 4/12/07 |
| Board of Physical Therapy | Adopted revised guidelines 5/14/07 |
| Examining Board of Psychology | Adopted revised guidelines 5/18/07 |
| Chiropractic Quality Assurance Commission | Adopted revised guidelines 7/19/07 |

Boards and commissions that have not adopted the guidelines are:

- Medical Quality Assurance Commission
- Optometry Board – pilot project
- Podiatric Medical Board – pilot project

- Veterinary Board of Governors

We tested 76 randomly selected disciplinary case files to determine whether the penalties/sanctions imposed for violations complied with the guidelines. A total of 45 cases were closed and resulted in sanctions. Three of the 45 cases (7 percent) had sanctions imposed that did not follow the sanction guidelines; all three were regulated by the Medical Quality Assurance Commission. The Medical Quality Assurance Commission had not adopted the sanction guidelines at the time of the testing. (See Appendix J for details of the violations and sanctions imposed.)

We also tested the files to determine compliance with the Department's timeframes. Of the 76 files tested, 28 files were, or will be, closed informally with a Stipulation to Informal Disposition and 48 files were, or will be, closed formally with an agreed order, final order, or final-default order.

We tested 28 cases that were closed informally and found:

- Seven of the 28 cases (25 percent) closed informally did not contain an updated HTTS printout in the Adjudicative Services Unit (ASU) file.
- 8 (29 percent) contained HTTS printouts that did not correctly reflect the dates on the documentation in the ASU files.
- 8 of 28 responses from respondents (29 percent), were not received within 14 days.
- All of the stipulations were signed by the Health Law Judge or Panel chair within 60 days and the stipulations were served to the respondents within 14 days.

We tested 48 cases that were closed formally and found:

- In eight of the 48 cases closed formally (17 percent), the HTTS printout did not correctly reflect the dates per the documentation in the ASU file.
- In 13 of 48 files (27 percent), an updated HTTS printout was not included in the ASU file.
- In 20 of the 48 files (42 percent), responses were not received from the respondent within 20 days and of those 20 late responses,
- Eight of the 20 did not result in default orders as directed by Department policy.

The adjudicative process was completed within 180 days in all of the 29 completed cases.

Procedural Delays. HPQA also deviates from its disciplinary procedures and Washington Administrative Code (WAC), causing delays in the disciplinary process. Default orders with mandatory sanctions should be imposed when a respondent fails to answer the Statement of Charges within 20 days or the extended time period allowed by law; however, HPQA is not complying with the timelines established in the WAC, allowing respondents who answer after this deadline to continue through the normal disciplinary process. As a result, disciplinary timelines are being extended. The disciplinary process is generally a time-intensive process. Every failure to adhere to timeframes lengthens the process for imposing sanctions, allowing a potentially unqualified professional to continue to practice.

Web Site Accuracy. Errors we identified on its Provider Credential Search Web site seriously undermine HPQA's efforts to inform the public regarding disciplinary actions

against practitioners. We found some errors in how HPQA describes the disciplinary action taken against health care providers published on its Web site, which is intended for the public to obtain important information about credentialed health providers. Once a case is closed through an adjudication, HPQA assigns and posts the order on the Web site and includes the reason code, referred to as Basis for Action codes, for the disciplinary action. Orders for cases before 1998 are not posted on the Web site. The Basis for Action codes are derived from the national data bank adverse action descriptions.

Three of the 20 (15 percent) Basis for Action codes associated with cases we tested did not appear to appropriately describe the health professional's conduct. One respondent was assigned a Basis of Action code of practicing beyond scope of practice instead of, in our opinion, unprofessional conduct. Of the two practitioners whose violations were based on sexual misconduct, the Basis for Action codes were patient abuse and negligence (activities described in the order) instead of sexual misconduct. Accuracy is very important because the disciplinary action information is intended to assist the public in making informed decisions about selecting health care providers.

Change to Priority One status. We reviewed 20 cases in which the priority level escalated from Priority Two or Three to a Priority One. We calculated the length of time before the status of the case was changed and we reviewed the investigation notes in the case files to determine the reason for the status change.

Twelve of the 20 cases we sampled were related to the legislation enacted in 2006 that required mandatory suspension of credentials. These 12 cases were under investigation when the law became effective. HPQA moved the cases to the legal unit as priority one cases and suspended the credentials. We found six cases in which unwarranted delays occurred in the disciplinary process. Examples of these delays were:

- The reviewing commission member was not present at case disposition presentations for five months.
- An investigation was not initiated for one year after the investigator was assigned.
- An investigation was under way for 191 days before it was determined that the status should be upgraded to a priority one case.

Cause

- HPQA's policies and procedures do not specify the information and documents that should be included in a disciplinary file.
- Timelines are not always enforced. HPQA staff stated that if they receive a late response to the Statement of Charges, they will often allow the respondent to continue through the normal disciplinary process with a hearing or settlement. However, issuing a default order immediately moves the case to the disciplinary authority (the administrative judge for Health Secretary-regulated professions and to panels for board and commission regulated professions) for a decision. The practitioner has lost the right to enter into a settlement or provide evidence at a hearing. Not issuing the default order allows the practitioner to continue to practice without penalty and prolongs the legal disciplinary process.
- The Sanctioning Guidelines that are designed to ensure appropriate and consistent sanctions have not been adopted by four of 14 boards and

commissions. The Health Secretary does not have the authority to require the boards and commissions to adopt the guidelines.

- There is no supervisory review of Basis-for-Action codes to detect human error prior to posting the information on the Web site.
- Some boards and commissions do not reassign cases when reviewing members are unavailable on a recurring basis.

Recommendations

We recommend that HPQA:

1. And the Department work with the Governor to determine if the Governor has the authority to require by Executive Order that all boards and commissions adopt the Sanctioning Guidelines by an agreed-upon date.
2. Ensure that staff prepare default orders for all cases where the respondent fails to respond to the Statement of Charges within 20 days.
3. Amend its current policies and procedures to specify what information and documents should be included in disciplinary files.
4. Ensure the accuracy of posted Basis of Action codes. Implementing a supervisory review of all Basis for Action codes before they are placed on the Department's Provider Credential Search Web site would be an effective control.

We recommend that the Legislature adopt a law:

1. Requiring a deadline by which the sanction guidelines must be adopted.
2. Authorizing the Secretary to discipline all professions for misconduct, while the boards and commissions continue to discipline standard-of-care violations.
3. Indicate that any board or commission not adopting sanction guidelines by the deadline could be subject to losing its disciplinary authority and becoming an advisory committee.

Implementing the recommendations would ensure that the Health Secretary and the boards and commission will use the same sanctioning guidelines to provide consistency of imposing similar sanctions for similar violations and that the sanctions are appropriate for the violation. The recommendations assure the public that the information regarding disciplinary actions on the Provider Credential Search Web site is accurate.

Practices in Other Jurisdictions

As a result of our research and interviews with other state regulatory agencies and board, we identified the following promising practices for HPQA's consideration. We also identified potential barriers or constraints that might impair HPQA's adoption of these practices.

- Arizona Medical Board implemented a four-stage disciplinary process that is efficient and eliminates backlogs. The four stages are:
 - Phase 1 (Finding)
 - Phase 2 (Recommendation) – The panel (three members of the staff investigation review committee) develops recommendation for discipline or non-discipline, and then the Executive Director reviews the panel's file and recommendation.
 - Phase 3 (Processing) – Executive Director makes the final decision on how to proceed with adjudication. If the Executive Director disagrees with the panel recommendation, the final decision is referred to the Board. Executive Director may also forward cases

that are too complex to be handled by the Board to Office of Administrative Hearing (OAH).

- Phase 4 (Adjudication) – Executive Director may refer all other cases to the Board for final disposition.

Cases move quickly through the process to the end of phase 2 because:

- Cases are opened quickly.
 - Dismissals are processed more quickly.
 - Complex and difficult cases are handled by experienced investigators with the responsibility and resources available to keep cases moving.
 - Administrative law judges hear the complex cases and make independent recommendations to the Medical Board for final actions.
 - Autonomy allows independent decision making on a specific element, but does not allow any one person to have overall decision-making, including the executive director.
 - Board members' time is reduced because they are not involved in hearing complex cases, participating in investigations, providing investigators with medical consultation, etc.
-
- New York State has a total separation of the credentialing and disciplinary functions and the authority over medical physicians. This practice has potential because preliminary results indicate that cases with little potential for successful prosecution are identified more quickly; investigators' caseloads have been reduced; and investigative resources are deployed more efficiently.
 - Various professions under the Virginia Department of Health, including medicine, veterinary medicine, and dentistry, have developed a sanctioning reference points manual that facilitates the consistent application of sanctions within each profession. Each independent Board uses the same concept, which entails a point system that helps determine what sanctions should be imposed. The manual is designed to fit the disciplinary needs of the regulated profession. Therefore, each sanctioning worksheet utilizes the same underlying principles; however, the worksheets were slightly modified to accommodate for the uniqueness of the various professions. This particular method for issuing sanctions allows for consistency while maintaining the uniqueness of each profession.
 - The Virginia Department of Health Professions has the entire adjudication process from initial receipt of the complaint through enforcement of orders available on the website. This manual provides detailed information pertaining to each step in the adjudicative process. Definitions are provided for key terms. This manual would be useful for public members interested in the processes as well as members who perform the processes.
 - The National Council of State Boards of Nursing Web site notes that upon completion of the discipline process, board staff members must notify both the

subject of the complaint and the person who made the complaint of the resolution. Stakeholders are provided a clear rationale for the board action.

We identified the following potential barriers:

- Financial and personnel constraints.
- Washington Supreme Court ruling requiring a higher standard of proof.
- HPQA does not have statutory authority to require all boards and commissions to adopt the Sanctioning Guidelines.

Response

DOH RESPONSE: Sanction guidelines promote consistent and uniform disciplinary outcomes. That is why the Secretary adopted guidelines in May 2006 for the 23 professions she regulates. Ten of 14 boards and commissions have adopted the Secretary's guidelines. We encourage the remaining boards and commissions to do so.

We issue a statement of charges when an investigation has been completed and there is evidence of unprofessional conduct on the part of a credential-holder. The respondent has 20 days to answer that statement of charges unless the health law judge allows more time. If the respondent does not answer by the end of 20 days, a default order may be entered. We draft the default order only after it is clear the respondent has missed the deadline.

The audit recommends we enter default orders on the 21st day. That means we would have to have the order ready in advance. This would cost additional resources without any gain in patient safety. In addition, the courts typically allow a practitioner to have a hearing when a late answer is filed. The State Supreme Court has noted, "...[d]efault judgments are precarious and not favored because, 'It is the policy of the law that controversies be determined on the merits rather than by default.'" *Lenzi v. Redland Ins. Co.* 140Wn.2d 267, 278 fn. 8 (2000) (Citation omitted).

Accuracy is important on our Provider Credential Search Web site when describing why discipline occurred. We follow the reporting standards of the national practitioner data banks. This requires use of a best-fit approach to match our statutory violations to the national data banks' descriptions. As the audit data showed, the best-fit approach does not always provide the entire picture of a case.

Action Steps and Timeframe:

- We will work with OFM to see whether further action is appropriate to require all boards and commissions to adopt the sanctioning guidelines. December 2007.
- We will continue to enter default orders according to the law. Ongoing.
- We will re-evaluate what should be included in case records and revise our procedures on how to organize and manage records. September 2008.
- We will review our options to assure accuracy in reporting disciplinary actions. June 2008.

OFM RESPONSE: Consistent sanction guidelines among all 57 health professions would increase clarity and add to both the public's and credential holder's understanding of the sanction process. OFM is pleased that DOH adopted Uniform Sanction Guidelines for professions regulated by the Secretary, and that several boards

and commissions followed suit. However, OFM will continue to work with DOH to assure that all boards and commissions adopt these guidelines.

Criteria

See Appendix L.

Finding 8: The compliance process does not ensure that practitioners who have been disciplined comply with the terms of their sanctions.

Background

The final step in the disciplinary process is ensuring that sanctioned practitioners comply with the imposed penalties. The Secretary of the DOH stated in a October 2005 memorandum, “When a provider has been placed on probation or stayed suspension, compliance with the conditions of probation or stayed suspension is essential. Particularly in cases involving serious physical injury to or death of a patient, and sexual contact with or abuse of a patient, a provider who is found to have violated the conditions of an order should be removed from practice for some period of time, at least until compliance is re-established. Violation of an order must not be rewarded by the mere entry of a new set of conditions that allow the violator to continue in practice.”

| |
|---|
| <p><u>Probation/Stayed Suspension</u> A period of time during which a health care professional must meet certain conditions set by the disciplinary authority in order to continue to practice.</p> |
|---|

HPQA staff monitors health professionals’ compliance with the conditions ordered in the health professional’s stipulation or Agreed/Final Order. Conditions may include practice reviews; urinalysis reports; patient notification; progress reports; and/or continuing education. Program compliance staff is required to monitor adherence with these conditions and send reminder letters to the health professional if he/she fails to meet the terms and due dates in the STID or Final/Agreed Order. When conditions of compliance are met, the health professional can request the reinstatement of his/her credential.

In cases of non-compliance, compliance officers may see a fast track hearing on a motion to suspend a credential or to modify the order. The fast track process is used to address noncompliance when:

- Public protection would not require that the violation be construed as a finding of unprofessional conduct
- Public protection warrants an indefinite suspension, or
- Non-compliance of the order could have resulted in minimal or moderate patient harm or actual patient harm resulting was minimal

Condition

We found significant deficiencies in the way HPQA documents its files and in the way it monitors health care professionals to ensure they comply with the terms of their sanctions.

Without adequately monitoring the compliance and completion of sanction requirements, HPQA cannot adequately protect the public and thus the public remains at risk.

We tested a total of 45 compliance files. The first 15 compliance files tested were associated with the 76 disciplinary files previously selected for the disciplinary testing which were tested for 48 requirements. (Each file can have multiple requirements that the practitioner must meet). We expanded our testing to include an additional 30

randomly selected files; these files included 108 compliance requirements. All files were tested to determine whether the practitioners were appropriately monitored and whether the files contained the required documentation.

Five of the 48 compliance requirements tested (10 percent) did not include documented evidence that the practitioner had successfully completed the requirements set in the order/STID within the agreed timeframe. At the time of the audit, one respondent had failed to comply with the terms and conditions of his order and still held an active credential. According to his order, the Board may hold a hearing to require the respondent to show cause why the credential should not be suspended. There was no evidence in the file to suggest that the board was aware of this noncompliance. Another respondent failed to comply on time with the terms and conditions of his order and his credential remained active. Per his agreed order, the suspension of his credential would be stayed if the conditions were met. However, he violated his order which should have resulted in immediate suspension of his credential.

Reminder letters were sent to eight respondents who had not submitted evidence of completion by the required date. Of these eight reminder letters, five (63 percent) were not sent to respondents within the required 30-day timeframe. Of these five late reminder letters:

- Two reminder letters were sent between 31 and 60 days after the due date.
- One reminder letter was sent between 61 and 100 days after the requirement due date.
- Two reminder letters were sent more than 100 days after the requirement due date.

One reminder letter was never sent to notify the professional that he/she had missed the compliance requirement due date. Although the file showed that a letter should have been sent, we found that the respondent had complied with the directions of the STID. Instead of a case of poor documentation, if there had been non-compliance the failure to follow-up potentially increases the delay of the professional's compliance with completion of the terms of the sanction.

Two of the 15 compliance files (13 percent) tested did not include the minimum requirements specified in the compliance monitoring procedure. In both instances, the compliance files did not include the credential demographic screen printout. The credential demographic screen printout includes respondent information such as his/her credential number and address.

We tested an additional 30 randomly selected compliance files to determine if the compliance files contained required documentation and were appropriately monitored. Of the 30 files tested, 108 requirements had to be met. Three (3 percent) of the 108 compliance requirements tested did not include evidence of successful completion. One health care professional who is currently being monitored failed to complete one of his requirements. There was no indication in the file that the compliance section has noted this noncompliance. One other health care professional failed to complete all of the required continuing education and was approved by the Medical Quality Assurance Commission for release from compliance monitoring without the successful completion.

Of the 30 compliance files tested, we found 11 exceptions.

- In seven cases, no reminder was sent
- In three cases the reminder letters were sent more than 100 days after the due date.
- In one case, the reminder letter was sent 52 days after the due date.

For six of the 30 files (6 percent), the compliance requirement summary worksheet entries did not match the requirements set forth in the Order or the Stipulation to Informal Disposition. Of those six files:

- Three compliance summary worksheet entries did not accurately reflect the requirement due date
- Two compliance summary worksheet entries could not be verified because the STID was not included in the file
- One requirement per the STID was not included on the compliance summary worksheet.

Seven of the 30 compliance files (23 percent) tested did not include the minimum documents as required by HPQA procedure. Of those seven files:

- Three did not include the Statement of Allegations.
- Two did not include the credential demographic screen.
- One did not include the STID, Statement of Allegations, or credential demographic screen.
- One did not include the Statement of Charges.

The five compliance units within HPQA do not have a standardized method for monitoring the completion of compliance requirements. Staff in three sections enter appointments on Outlook calendars as an alert to the compliance officer when a practitioner should have completed a requirement. This method appears to be effective for tracking compliance requirements; however, one section noted that the high volume of open compliance files and the shortage of staff has resulted in a backlog of compliance files.

Another division uses an Excel spreadsheet in conjunction with an Outlook calendar to monitor compliance requirement completion. The spreadsheet can be sorted by the due date column to identify which open compliance cases need attention on any given day.

One section uses a paper binder containing compliance requirement summaries to determine if a respondent is in compliance. The section will go through this binder manually about once a month. This process is tedious and the limited number of staff makes the task difficult to perform. Because the compliance officer must manually go through the large binder of compliance requirement summaries with multiple due dates noted on each one, there is a potential for due dates to be overlooked because of human error.

Cause

Ineffective monitoring and incomplete documentation appear to be caused by several factors:

- Lack of an effective, standard method to notify compliance officers that compliance requirements are due.

- Lack of an effective, standard method to notify compliance officers that reminder letters should be sent.
- Lack of written, detailed procedures for monitoring compliance status.
- Lack of supervisory reviews to ensure that staff are taking appropriate actions to monitor sanctioned practitioners and take necessary steps when practitioners fail to complete requirements of the sanctions.
- The current number of staff may be insufficient to order prevent backlogs and provide an effective level of monitoring.
- HPQA does not have a formal training program for new compliance officers, nor does it cross-train staff to ensure that in the absence of compliance staff, timely monitoring of sanctioned practitioners continues.
- HPQA does not have standardized reminder letters that all sections must send to respondents when entering the compliance program and when a compliance requirement is missed and a closure or reinstatement letter for a respondent once compliance monitoring has been concluded. Lack of standardization contributes to inconsistencies among sections. The compliance procedures do not limit the number of reminder letters that a practitioner can be sent before HPQA takes further action.

Recommendations

We recommend that HPQA:

1. Establish a standardized process of monitoring the due dates and terms and conditions of imposed sanctions. This process should provide automated notification to compliance officers when documentation of completed compliance requirements has not been received within the required timeframe. This process should be clearly documented in its current compliance monitoring procedure.
2. Modify its procedure to limit the number of reminder letters that a practitioner can be sent before taking other legal action.
3. Determine an optimum caseload for its compliance officers and consider increasing the staff responsible for ensuring that health care professionals comply timely and with the terms of imposed sanctions. HPQA should also consider outsourcing its compliance monitoring activity.
4. Develop a formal training process for new employees. A formal training program will ensure that each division is performing similar tasks in a consistent manner. Consistency will create efficiencies and will enable staff to become cross-trained to perform varying functions. Cross-trained staff will allow for flexibility if one division becomes bogged down with work due to staff shortages or increased workload. HPQA should also institute a process to ensure that desk manuals are consistently updated as new information is provided. Desk manuals will serve as an additional resource to staff members if they are unsure how to perform a particular task. Creating standardized training processes will address inconsistencies across the divisions and create a more efficient workplace.
5. Create compliance letter templates that can be used by the various sections to provide consistent information to respondents and ensure consistent decision-making. These templates should be documented in the current compliance monitoring procedure. HPQA may also want to place the templates on the intranet shared drive for ease of accessibility.

Instituting the recommendations will ensure that health care professionals comply with the terms of their sanctions or are referred for legal action. It is critical to public safety

that practitioners who are sanctioned for professional misconduct and substandard care are monitored and the terms of the sanctions are enforced. Practitioners who do not comply with the terms of their sanctions must be referred promptly for other actions allowed by statute and rule, such as summary suspension.

Practices in Other Jurisdictions

As a result of our research and interviews with other regulatory agencies and boards, we identified the following as practices for HPQA to consider.

- The Texas Board of Chiropractic Examiners contracts with an independent third party to monitor compliance in certain circumstances. The contracted compliance officer reports the practitioner's progress to the Board. This process saves the Board time and diminishes travel by Board members/employees that might be required to ensure that the respondent is compliant.
- The Texas Board of Medical Examiners employs compliance officers who meet on a regular basis with professionals whose sanctions include probation. The probationer is required to meet periodically with the Board to ensure that the practitioner is complying with the terms of the sanction. When used appropriately, this practice could potentially encourage a reluctant professional to comply with the terms of the sanction, thus avoiding further legal action.

Response

DOH RESPONSE: We are consolidating all compliance staff into a single work unit to ensure consistency in processes. We are also installing a new computer system, Integrated Licensing and Regulatory System, with automated deadline notices. Having a central compliance unit with a single management structure will ease training and workload assignment issues.

We are replacing desk manuals with online tools to speed updates, assure access, and improve consistency. All procedures are available on the HPQA intranet site. Training for new staff is now conducted on the job. We agree our training program should be strengthened. A formal training program would be more effective, and it would require additional resources.

We adopted a procedure in 2006 that requires a single reminder letter to practitioners who have not met a due date. We will continue to send follow-up requests for additional information where needed. The ILRS computer system will include standardized letters and compliance worksheets. The study on workload standards will help us set caseload expectations for compliance staff.

Action Steps and Timeframe:

- The new computer system will include automated notices and reminders. June 2008.
- We will complete a workload standards study now underway to identify appropriate staffing levels. We will provide the report to the Legislature when it is completed. December 2007.
- A central compliance unit will support consistency in the compliance process. June 2008.
- We will identify necessary training resources for a formal program. October 2007.

OFM RESPONSE: We are pleased that HPQA has already taken steps to reorganize their compliance work unit under a single management structure. Doing this is expected to provide better outcomes. We also look forward to working with HPQA and the Legislature to develop criteria for evaluating workload standards for HPQA's compliance activities.

Criteria

See Appendix L.

Finding 9: DOH and HPQA oversight needs improvement to ensure that the credentialing and the regulatory processes are performing as intended.

Background

Management's oversight of HPQA's performance and operation is crucial to ensuring that it achieves its goals and is accountable to the public. Management must systematically and objectively determine the relevance, efficiency, effectiveness and impact of the organization's activities in relation to its goals.

Management must assess the risk of an event occurring that could have an impact on the achievement of objectives. In other words, management must determine what activities will prevent or delay meeting its objectives. Once risk is identified, management must establish cost-effective controls. Controls are any actions taken by management, the oversight board, and other parties to mitigate risk and increase the likelihood that established objectives and goals will be achieved. Management plans, organizes, and directs the performance of sufficient actions to provide reasonable assurance that objectives and goals will be met.

We considered three types of oversight:

1. Management and supervisory reviews.
2. Performance management based on performance measures.
3. Evaluations by internal audit.

We considered whether HPQA has in place activities that should mitigate the risks that could prevent HPQA from achieving its goals. We found deficiencies in each type of oversight. In this section, we will address the oversight activities related to performance management through performance measures and the internal audit function. The lack of supervisory reviews was addressed in Finding 2 and evaluations by internal audit are addressed in Finding 10.

Performance Management and Performance Measures

HPQA's performance measurement system does not provide sufficient and accurate information to make it meaningful and useful to management and other decision-makers. The process of collecting, analyzing, and reporting performance information lacks the characteristics of a good performance measurement system. We measured HPQA's performance management system against the following criteria:

- Is it results-oriented? Does it focus primarily on outcomes and outputs?
- Is it selective? Does it concentrate on the most important indicators of performance?
- Is it useful? Does it provide information of value to the agency and decision-makers?
- Is it accessible? Does it provide periodic information about results?
- Is it reliable? Does it provide accurate, consistent information over time?

The Legislature and Governor directed HPQA to provide performance information about a variety of activities. However, HPQA's performance measure definitions are not well established and data elements that could be crucial to determining progress toward improving performance are not being captured. In addition, the measures reported are primarily based on manual counts, or data that may have been changed in their

information systems. For example, HPQA management uses spreadsheets to record performance measure data to be used by the Department in reporting to the Governor's Office at the Government Management Accountability and Performance forums. As a result, measures cannot be replicated to verify the accuracy of reported information. Furthermore, while HPQA does perform supervisory reviews of collected data, there is no policy regarding review or approval procedures for submitting and reporting performance measure data.

Program areas maintain separate tracking spreadsheets and databases to calculate their measures. They do not rely on ASI data in collecting performance measure data. Program areas generally do not reconcile the data they have collected against ASI data. According to HPQA, management is aware that the data in ASI lacks integrity, and their efforts to reconcile the ASI data and the spreadsheets have not been successful.

Cause

HPQA has not developed a performance management system that includes the critical elements of good performance measures, such as defined targets, documented definitions, and methodology for data collection and calculation. HPQA also does not have internal controls over the collection and reporting of the data used in the measures to ensure that the data is accurate. Inaccurate performance data can lead to misrepresentation of performance results, which in turn can lead to errors in management decisions and jeopardize the integrity of the entire management system. In addition, there are no established policies, procedures, or training for staff regarding the collection, calculation, and reporting of performance measures.

The information system, ASI, is a legacy system that lacks functionality to ensure data integrity -- that is, the data is correct, complete, sound, and has not been accidentally or maliciously modified, altered or destroyed. In addition, because its systems are unable to capture and reliably report much data, HPQA staff has developed other Excel and Access databases. When data is not in any system and is needed for the measures HPQA tracks, staff must conduct manual counts to collect required data.

Recommendations

We recommend that HPQA:

1. Develop and follow a performance management system that includes effective performance measures that:
 - Are derived from HPQA's mission and goals.
 - Contain appropriate types of measures, such as outcome, output, efficiency, input.
 - Include the characteristics of good performance measures:
 - Purpose/Definition/Importance - Explains what the measure is intended to show and why it is important.
 - Source/Collection of Data – Describes where the information comes from and how it is collected.
 - Method of Calculation - Clearly and specifically describes how the measure is calculated.
 - Data Limitations - Identifies any limitations about the measurement data, including factors that may be beyond the agency's control.
 - Calculation Type - Identifies whether the data is cumulative or non-cumulative.

- New Measure – Identifies whether the measure is new, has significantly changed, or continues without change from the previous biennium.
 - Target Attainment – Identifies whether actual performance that is higher or lower than targeted performance is desirable.
 - Explanation of Variance – If the actual performance varies for the target by an established amount, provides a reason for the difference.
2. Develop and follow an internal control structure that will ensure the reliability of the performance data that is collected and reported.
 3. Once performance measures are developed and implemented, select measures that are of importance to the public, including performance measures specific to boards and commissions, and post the results on the HPQA web site to inform the public.

Implementing a performance management system provides a framework for achieving results that is based on established targets. A good performance management system that includes relevant, well-defined performance measures can provide reasonable assurance that the information is properly collected, calculated, and accurately reported. It also provides performance information that will accurately and reliably report the progress in meeting standards and targets. HPQA management and other decision-makers would be able to rely on the information when making changes and improvements in policies, programs, and operations.

Practices in Other Jurisdictions

- Texas State Government started using performance measures in 1974 as a budgeting tool. In 1991, a new budgeting system for funding agencies was mandated. The system increased the emphasis on performance measures, basing funding on the results of agencies' measured and monitored accomplishments (performance) and efforts (outputs). The Governor and the Legislature expect agencies to focus on performance. Agencies are held accountable for performance variances. In the past, individual agencies have been identified with specific examples of targeted performance not realized, and corresponding budget reductions were assessed. Funding decisions are clearly influenced by agencies' previous projected and actual performance

Performance measures are integrated into the State's external accountability and fiscal decision-making systems. Successful agencies use performance information to:

- Effectively and efficiently manage their operations.
- Be an integral part of their strategic and operational management.
- Provide an opportunity to forecast outcome performance for the next five years.
- Be a basis for planning future agency actions.
- Help establish cause-and-effect relationships between performance, agency actions, and funding.

Successful performance management practices in Texas and around the nation show how performance measures can be used to improve agency operations, budgeting, and assessing progress.

- A report published by the U.S. Department of Health and Human Services “State Discipline of Physicians: Assessing State Medical Boards through Case Studies” included a question of all case study sites regarding the measuring of disciplinary performance. The report enumerates activities to be considered in well-designed and well-defined performance measures that will provide information to both the public and the regulatory board.

Response

DOH RESPONSE: We agree on the importance of performance management and improving our current system. We have enhanced our performance management system to meet the criteria suggested in the audit. The 2007-2009 Health System Quality Assurance division-wide strategic plan has specific performance measures for HPQA.

Action Steps and Timeframe:

- We will post measures of importance to the public on the agency Web site. June 2008.

OFM RESPONSE: The Governor is committed to accountability within state government and established the Government Management Accountability and Performance program (GMAP) to encourage performance improvement. As is being done in other key areas of government, GMAP will work with HPQA to improve performance of the state’s disciplinary process.

Criteria

See Appendix L.

Finding 10: The DOH internal audit function is understaffed and does not perform evaluations of HPQA to identify and report deficiencies that could impede HPQA's ability to achieve its goals.

Background

According to Government Auditing Standards and *International Standards for the Professional Practice of Internal Auditing*, the internal auditor is accountable to the head or deputy head of the government entity or to those charged with governance. Organizationally, the internal auditor should be located outside the staff or line-management function of the unit under audit. The Department's internal auditor reports to the Deputy Secretary. However, the internal auditor is not a member of and does not regularly attend senior management meetings. .

Internal audits identify and report operational and financial deficiencies that could impede HPQA's ability to achieve its goals. Internal audits that evaluate the activities and controls that management has implemented provide timely, objective information that aids decision-making and improves the organization's overall function.

Control processes are the policies and procedures, and activities that are part of a control framework, designed to ensure that risks are contained within the risk tolerances established by the risk management process. Controls may be preventive (to deter undesirable events from occurring), detective (to detect and correct undesirable events that have occurred), or directive (to cause or encourage a desirable event to occur). The concept of a system of control is the integrated collection of control components and activities that are used by an organization to achieve its objectives and goals.

Condition

HPQA does not have the benefit of routine, comprehensive evaluations performed by an internal auditor. The Department of Health is a complex organization with a very high degree of responsibility – the protection of the health of the citizens of Washington. The Department has only one internal auditor to test the adequacy of procedures and controls for the entire agency. Because of other duties, the internal auditor is able to spend only about half of his time each year -- approximately 800 hours -- performing audits. In the past two years, internal audit has performed seven HPQA financial controls audits: five of contracted impaired professionals programs managed by the department, an accounting information systems audit, and a financial audit of an internal fund. No program, operational, performance or internal control audits have been conducted.

We also found that the agency does not conduct a control self-assessment (CSA). An assessment is a tool for managers to assess the quality and effectiveness of the agency's internal controls, its exposure to risk and its compliance with established policies and procedures. Internal controls are designed to guide the agency in achieving its goals, in particular those related to effectiveness and efficiency of operations, reliability of financial and operating reporting, compliance with applicable legal requirements and public expectations, stewardship of public resources, and minimizing exposure to risk events.

Upon completion of the CSA, the internal auditor should review the responses and, if necessary, contact management for further discussion. A CSA can be cost-effective and save time and resources and should be used as a basis for the Annual Internal

Audit Plan. This plan, in turn should be used to help manage the entire financial and management risk of the agency.

Cause

Historically, only one internal auditor has provided oversight to the entire Department, which includes HPQA. Other priorities set by senior management have limited the time available to the internal auditor to plan and manage an internal audit program that is needed to address all of the significant risks to the agency's strategic and operational objectives.

Recommendations

We recommend that the Department:

1. Seek funding from the Legislature to add additional internal auditors to reduce risk by enabling the internal audit department to conduct more audits of areas and activities that are identified in the risk assessment.
2. Work with the internal auditor to implement a comprehensive and scheduled control self-assessment.
3. Consider outsourcing or co-sourcing with an external organization to provide additional capacity for the internal audit functions.

Independent and objective internal audits and implementation of control self-assessments would identify control and procedural deficiencies that could cause HPQA to not achieve its mission, and result in harm to the public. Management would then be able to take steps to address the deficiencies that potentially could allow credentials to be issued to unqualified individuals, and to correct weaknesses that fail to prevent the timely discipline professionals who have engaged in unprofessional conduct.

Practices in Other Jurisdictions

- The United States Government Accountability Office (GAO) asserts that the public, legislators, and government officials want to know whether government services and programs are being provided effectively, efficiently, in compliance with laws and regulations, whether programs are achieving their objectives, and the cost of doing so. GAO states that auditing gives the stakeholders the confidence that the information on the results of programs or operations, and the related internal control systems are reported accurately and completely. Government auditing by is a key and critical element to provide information that can lead to improved management, decision-making, oversight and accountability.
- Texas Internal Audit requirements require the appointment of an internal auditor .The internal auditor shall (1) report directly to the state agency's governing board or the administrator of the state agency if the state agency does not have a governing board;
(2) develop an annual audit plan; and (3) conduct audits as specified in the audit plan and document deviations; (4) prepare audit reports; (5) conduct quality assurance reviews in accordance with professional standards; (6) conduct economy and efficiency audits and program results audits.

Response

DOH RESPONSE: We will consider options to add capacity. This may include more internal audit staff and quality assurance. We will consider other options for audits that require specialized skills, such as technology systems. This will require additional resources.

Action Steps and Timeframe

- We will identify the costs of adding staff to the department's internal audit function. October 2007.
- We will update job descriptions to incorporate quality assurance as we consolidate functions. March 2008.
- We have begun a pilot of a Control Self Assessment in HPQA. September 2008.

OFM RESPONSE: Enhanced internal audit capacity can help improve processes and program implementation at HPQA. We look forward to working with HPQA in the normal budget process to identify a cost-effective approach to improve internal auditing capacity.

Criteria

See Appendix L.

Finding 11: Legacy information systems do not enable HPQA to effectively and efficiently license health practitioners, manage consumer complaints and monitor compliance with disciplinary action.

Background:

HPQA is charged with managing professional licensing programs to promote access to high quality, cost-effective health services.

Until 1988, the Department of Licensing regulated health care professions. Licensing tracked licensees with an antiquated Unisys computer system. Although HPQA is transitioning to a new system, it currently uses a system that is no longer supported by the vendor, Automated Systems, Inc (ASI). This system was acquired in the early 1990s. The database was modified from a real estate licensing program. It lacks the functionality and flexibility to allow HPQA to achieve its goals and to meet state legislative requirements to track disciplinary timelines and federal requirements to report all disciplinary actions taken against health care providers.

In 1997, the Legislature adopted a law requiring HPQA to regulate timelines related to disciplinary actions. In 1998, a federal mandate required all adverse actions taken against health care practitioners be reported to the Healthcare Integrity Protection Data Bank. HPQA developed “side-systems” to meet the legislative requirement and the federal mandate. Most of these side-systems are used for tracking and reporting purposes and were developed using various commercial, off-the-shelf software programs. These side-systems lack controls such as logging and password security and none integrate with the ASI, or legacy, system.

In 1997, the Department received state approval to seek replacement of the legacy system. After a few years of unsuccessful attempts to find a vendor for a new system, HPQA continued to operate the legacy system despite the fact the vendor no longer was in business and system limitations prevented compliance with new legislative requirements. In 2000, HSQA – the parent division of HPQA – was unable to come to terms with a selected vendor and canceled the project to replace the system. To meet the new requirements, the Department developed a separate disciplinary tracking system.

In 2002, the Department released a preliminary request for quotes and qualifications to determine the capability of commercial products to replace the legacy system. The conclusion was that commercial off-the-shelf systems had become more robust and more advanced than they were in the past; could meet 85 percent or more of the requirements; and could provide an enterprise, division-wide licensing and disciplinary system.

These results led the Department’s executive management to consolidate the HPQA licensing system replacement project into one division-wide solution in 2003. In 2004, the division initiated a business analysis and feasibility study; ultimately, HPQA contracted with a vendor who has provided government licensing systems for more than 17 years. That vendor produces a commercial application that can address many of the licensing needs of HPQA as well as other division programs. This project is referred to as the Integrated Licensing and Regulatory System (ILRS).

Work began on ILRS in March 2006. HPQA is working with a vendor to clean up the legacy data; to install the application in a quality assurance and test environment; to document requirements and desired modifications; to develop workflows; and to convert legacy data for use in ILRS.

The project appears to have an appropriate level of participation from management and monitoring from a third-party project-quality assurance reviewer. The quality assurance reviewer's reports have shown the project is progressing well. Our assessment of the ILRS project agrees with the quality assurance reports as of March 2007. The first phase of the ILRS project is scheduled for deployment in late 2007 with completion anticipated in Spring 2008.

We examined the information system controls and resources used by HPQA to support the licensing, disciplinary, and adjudicative processes to assess system security/internal control weaknesses; to determine the feasibility of pooling information technology systems; and to analyze HPQA performance data, performance measures and self-assessment systems. We identified and evaluated information systems used for each profession and the progress of ILRS.

We found improvements are needed in the HPQA legacy licensing information system and side-systems controls in terms of security settings, documentation, physical security of sensitive hardcopy files, and system and user administrative procedures if they are to be relied on when ILRS is fully implemented. Should HPQA not make the improvements that we identified in our audit, it can be anticipated that there will significant issues and concerns when converting the data from the legacy system to ILRS. The ILRS project was not implemented at the time of our audit and therefore we examined and assessed the implementation process rather than the application in production; however, the implementation process appears to be progressing well.

Condition 1

HPQA legacy information system and side-systems are not supported by vendors or Department staff. The legacy system and other application software used for licensing, complaint tracking, and the disciplinary process are not supported by the vendors. Department staff does not have the knowledge or skills to adequately support the legacy information systems and software. HPQA staff also does not have the skills or knowledge needed to administer HPQA servers and operating systems of these legacy and side-systems applications and databases.

Cause

The legacy system licensing software originally was a real estate licensing application that was modified in an attempt to meet the needs of HPQA. It could not be adjusted to react to changing regulatory reporting requirements and complaint tracking needs.

The vendor that provided the legacy system is no longer in business and the Department does not have the expertise to modify the system as needed. Also, side-systems developed by HPQA to meet new state and federal requirements do not interface with the legacy system and are not adequately maintained. These systems are scheduled for retirement when ILRS is moved into production.

Recommendations

We recommend that:

1. The Department establish and follow a process to ensure software is supported and maintained when ILRS is implemented; and that sufficient expertise not available in HPQA is retained to provide system and application support.
2. HPQA continue to follow their documented process and timeline for the implementation of ILRS.

HPQA servers and applications will maintain the latest security capabilities to reduce the risk of unauthorized access to sensitive data; reduce the likelihood of system failure; increase the stability of the processing environment; and support moving it from an insecure environment and solve HPQA's inability to rely on or effectively use its data. The new system also will allow HPQA the flexibility to keep up with changing requirements regarding reporting, and to fulfill its mission.

Condition 2

The HPQA legacy information system has security vulnerabilities.

During our audit, we noted:

- Multiple issues with passwords, such as passwords that do not expire, passwords that do not meet state standards for length and type of character, a lack of password lockout, and password event logging is not enabled.
- Weak encryption.
- Software is running that allows remote access to the legacy system.
- Logs (where available) are not regularly reviewed for the operating system used for the legacy database to ensure unauthorized access has not occurred.
- User accounts are not deleted from the system in a timely manner when employees leave the agency or no longer need the account.
- Anti-virus, patches, and other software updates are not routinely installed.
- The legacy system and user administration procedures need improvement. Currently, they could create security risks such as users retaining too much access to a system that could potentially allow them to perform unauthorized transactions that go without detection.

Cause

The HPQA servers are not part of the Department's information technology division's responsibility, so they are not part of the regular updating process. HPQA has the responsibility to maintain the servers. The Information Services Board and the Department have established technical standards for information processing and security, but these standards were not used in all instances when configuring these outdated HPQA systems. Given the age of the ASI system, the vulnerabilities also appear to be the result of lack of knowledge to make changes to that system, which could adversely affect processing or data. Access rights are not being kept up-to-date due to an inadequate process and communication among program managers, the human resources division and the information technology division when employment status changes.

Recommendations

We recommend that:

1. HSQA leverage Department resources or contract for enhanced security settings on HSQA legacy and related side-systems and servers until ILRS or another licensing application is operational. The effect of changes to these settings should be investigated before making changes to the system parameters. Changes may include but are not limited to:

- Installing patches and updates.
- Enabling logging, where prudent and possible, and monitoring the logs.
- Enabling or strengthening password settings where possible.
- Configuring HSQA servers to allow them to be controlled by the Department's primary network servers.
- Disabling unused services.

2. In compliance with Department policy, HSQA should periodically review and remove user IDs that are not being used. HSQA also should work with human resources and section managers to establish a method to notify the Office of Information Resource Management and HSQA IT Section of changes needed to user access. Enhancement of this process should include the following:

- Filing user access requests in alphabetical order by last name.
- Keeping a record of who has been authorized to have access, who has been granted access, and which resources they may access.
- Establishing procedures to ensure program managers are aware of their responsibility to maintain security through authorizing the commissioning and decommissioning of user accounts respective to their operations areas.
- Ensuring that user access to the system is maintained according to management authorization and duties are properly segregated.

Strengthening security settings and establishing a consistent process for granting and revoking user access to HSQA systems and applications reduces the risk that unauthorized persons could inappropriately access systems and data.

Condition 3

HPQA's controls over data integrity are inadequate.

We determined the legacy system has no controls over fees and payments recorded in that system. We found the amount of fees charged and the payments received could be modified by system users, along with the invoice and receipt numbers, and the names on the billings and the payments.

We also noted several other data integrity issues, including invalid zip codes; invalid license expiration dates such as dates that expired prior to birth dates and licenses where the birth date of the licensee was in the future. We found 34,543 records with blank date values. We also found three instances in which the reason for a disciplinary action was inconsistently documented between a side-system spreadsheet and the complaints tracking database, which resulted in the data being inappropriately displayed on the publicly available Provider Credential Lookup on the Department of Health Web site.

These exceptions are relatively small in number when compared with the entire population of records in the legacy applications and side-systems databases; however, they demonstrate data integrity issues. The time-consuming, manual reconciliation

process among systems is rarely performed; meaning discrepancies are not investigated and resolved in a timely manner, if at all.

Cause

Lack of data integrity controls are the result of several causes. Because the application is no longer supported by the vendor, HPQA is not able to modify the application when changes in functionality are needed. Data must be manually entered into the side-systems, which creates an increased risk for data entry errors and inconsistencies. Data reconciliation is cumbersome and time consuming, and often does not occur at all, further increasing the risk that data is not accurate and complete.

Recommendations

We recommend that HPQA establish and follow a process to review and correct data contained in the legacy and side-systems before the conversion to ILRS. This may include the need to periodically reconcile data across systems or run automated matching among databases to reduce errors. We also recommend HPQA refrain from developing new side systems.

Developing and using a process to review and correct data decreases the risk of invalid data being entered, stored, and used. This, in turn, reduces the time to correct data errors and inconsistencies and results in more accurate reporting of information regarding performance statistics and may lead to process improvement. It also lends itself to the entering correct data into ILRS.

Condition 4

HPQA legacy systems and side-systems do not log changes and other activity.

We looked at logging capabilities to see if changes to data within the legacy system and side-systems applications could be tracked. We found that changes in the legacy system to the fee amount, the transaction number, and data such as a provider's full name can occur without explicit logging of the change. The legacy system also does not maintain the historical data from which the data was changed. Many of the side-system databases used to log complaints and disciplinary processes do not track user actions and/or when changes were made. Only a few of the side-system databases have an audit trail capability.

Cause

The side-system spreadsheets and databases being used do not have the capability of logging changes unless specifically programmed to do so. The legacy system and side-system databases used for tracking and reporting purposes in HSQA do not maintain a history of changes and the dates of changes to data.

Recommendation

We recommend that HPQA establish and follow procedures to ensure changes to data are logged and historical data is kept. We also recommend this capability is included in ILRS and that no additional side systems that lack this capability be developed.

Creating and maintaining logs of changes to data allows easier and quicker correction of errors and accountability in case unauthorized changes to data are made.

Response

DOH RESPONSE: We identified and began to address the issues with our legacy information systems several years ago. We have acquired and are now installing a new computer system, Integrated Licensing and Regulatory System (ILRS). This system will resolve the issues identified by the audit. We are on track to implement ILRS in spring 2008. It is a modern system that meets agency and state standards.

It is high risk and not cost effective to modify the old, undocumented legacy computer system that will be decommissioned within a year. We will continue to follow the agency standard and regularly install security patches for all Microsoft equipment.

Action Steps and Timeframe:

- We are implementing the new ILRS computer system that meets agency standards. June 2008.
- We will develop a notification system between HSQA managers and the technology staff to maintain current system access for all users and IT development / maintenance staff. November 2007.
- We will update the user access records and restructure the way they are maintained. November 2007.
- HPQA is in the midst of analyzing and correcting data in the legacy systems in preparation for conversion to ILRS. This will continue until the new system is implemented. June 2008.

OFM RESPONSE: Following up on several years of work and investments in prior budgets, funds were included in the 2007-09 biennial budget to complete the replacement of HPQA's legacy information system. DOH is successfully moving forward with implementation of this project. DOH also has independent quality assurance (QA) in place to evaluate progress and regularly report findings and recommendations to senior agency leadership and the Department of Information Systems. OFM and DIS monitor the progress of the implementation of ILRS and are pleased that the new system is on track. Any action that would delay the timely implementation of this project would be ill-advised.

Criteria:

See Appendix L.

Finding 12: HPQA's disaster recovery plans and business continuity plans are not fully developed.

Condition

The HPQA's disaster recovery and business continuity plans are missing key elements, including detailed steps for relocating and recovering operations. For example:

- The agency-operated method for contacting key employees relies on communication such as a phones or computers that could be rendered unusable by a disaster.
- Plans do not specify that recovery sites be set up, or how to go about doing so.

Cause

Management has just begun to develop disaster recovery and business continuity plans for section-level operations and to establish recovery sites.

Recommendations

We recommend that HPQA:

1. Complete the disaster recovery and business continuity plans as quickly as possible.
2. Ensure at least one means of contact for key personnel is available that does not depend on an agency-operated communications network.
3. Ensure disaster recovery plans provide sufficient detail that an individual unfamiliar with them could follow the plan and bring about successful recovery.

We recommend that the Department complete development of an IT-recovery "hot site". Management stated that a site in Western Washington is being completed, and contract negotiations for support services are in progress for a site in Eastern Washington.

Disaster recovery and business continuity plans that include detailed steps for relocating and recovering operations would help HPQA ensure it is able to recover operations after a disaster within its recovery time objectives of 24 to 72 hours.

Response

DOH RESPONSE: We have completed business continuity plans for the most crucial HPQA work. This includes licensing and public access through the customer service center. We have developed disaster recovery plans for HPQA's most vital technology systems. We will focus next on investigative and disciplinary activities. The department will keep working with the Department of Information Services on a primary disaster recovery hot site.

Action Steps and Timeframe:

- We will complete a business continuity plan to sustain critical investigation and disciplinary activities. December 2007.
- We will develop an alternative means of contact for key personnel. December 2007.
- We will review disaster recovery plans to make sure there is sufficient information for staff to follow them. December 2007.
- We will have an interim disaster recovery site in operation. December 2007.
- We are working with the Department of Information Services for a primary hot site. April 2008.

OFM RESPONSE: We concur with HPQA's strategy to complete its disaster recovery and business continuity plan. Ensuring that critical state services are maintained in the event of a disaster is of statewide significance. To date, the state's planning emphasis has been placed on disaster recovery and providing redundant mainframe computing to enhance the state's ability to access and maintain information. Our next challenge in planning is to attend to the recovery of business functions and resources, such as alternate work space, mail delivery, and essential records.

We have determined that having an enterprise approach to business continuity is the most effective way to ensure that vital public services are maintained in the event of a disaster. It is not enough to be confident that an agency and their employees can communicate within the agency; it is crucial that inter-agency lines of communication can also be preserved.

Criteria

See Appendix L.

Finding 13: Hard copy files related to licensing and investigations are not physically secure.

Condition

Case files and provider files contain confidential and/or restricted data such as Social Security numbers. These files are not adequately secured. The building in which they are stored has exterior electronic surveillance cameras and exterior doors that can be opened with card keys. Inside the building, however, most files are not stored in locked rooms and no electronic surveillance is done; adjudication records and evidence are maintained in secure locations.

Cause

Secure areas such as lockable file storage rooms are not available in the building because high density shelving units are used instead which are not secured against unauthorized access. Also, the Department has neither established nor do employees adhere to a clean workspace policy.

Recommendation

We recommend that HPQA

- Employees ensure hardcopy documents that may expose sensitive information or data to unauthorized individuals are secure.
- Develop policies and procedures to address the physical protection of sensitive data and information contained in hardcopy documents. This can be done by establishing and adhering to the clean desk policy as well as training personnel on their responsibilities pertaining to it.

We recommend that HPQA

- Consider an alternative solution that is both more secure and offers other benefits and obtain a document imaging system that would make the information available only to employees who need it. Also, this would mitigate issues related to disaster recovery because images can be backed up off-site and restored. Documents should be properly imaged to ensure readability, easy retrieval and the ability to interface with the ILRS records. Additional funding would be necessary for HPQA to develop and implement an imaging system.

Physically securing sensitive information related to personal identity or investigations contained in hardcopy documents and files and maintaining a clean desk environment may reduce the likelihood that sensitive documentation could be lost or stolen and used inappropriately and/or in a way that could adversely affect HPQA and the public.

Response

DOH RESPONSE: We take file security seriously. We have enhanced physical security in our buildings. We use electronic identification for access, have security guards onsite in Tumwater, and keep adjudication records and evidence in secure locations. In addition, employees must sign confidentiality forms each year.

We have upgraded our policies on destruction of confidential records. These records must be deposited in locked containers and shredded. Electronic document management would provide the highest level of security, and that would require funding.

Action Steps and Timeframe:

- We will seek funding to study the feasibility of a division-wide electronic document management system. October 2007.

OFM RESPONSE: OFM will consider recommendations to improve file security within DOH as part of the normal budget process.

Criteria:

See Appendix L.

Appendix A

Letter from Governor Gregoire

CHRISTINE O. GREGOIRE
Governor



STATE OF WASHINGTON
OFFICE OF THE GOVERNOR

P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 753-6780 • www.governor.wa.gov

May 3, 2006

The Honorable Brian Sonntag
State Auditor
PO Box 40021
Olympia, WA 98504-0021

Dear Auditor Sonntag:

My resolve to keep patients safe in our state is stronger than ever. We must, collectively, look for every way possible to protect patients and improve our system for licensing and disciplining health care providers.

As you know, health professions discipline is a large, complex, and expensive system that, by statute, is divided between the Department of Health – responsible for administrative services for all professions – and different disciplining authorities, including the Department and 16 independent boards and commissions. The Department of Health's Office of Health Professions Quality Assurance (HPQA) credentials nearly 300,000 health care professionals in 57 professions. While all 57 regulated health professions are subject to the Uniform Disciplinary Act (UDA), there is significant variation in practice among the health professions by their respective disciplinary authorities.

The Department of Health has made strides to improve our regulatory system with respect to health professions discipline, but there is much more work to do. I have asked that Secretary Selecky take several actions in the short- and long-term to bring greater management and accountability to health professions discipline; however, I believe that your office is well situated to shed greater light on the discipline system and bring to bear innovative ideas for ensuring the safety of patients in Washington State.

Given the expertise of your team, I ask that you consider conducting a performance audit of our current health profession discipline process and identify opportunities for improvement. As we discussed, this could be done in collaboration with a national organization which has expertise on the subject with health profession regulation. Specifically, I believe that an external review should, among other things:

- Evaluate the professional licensing, oversight, and disciplinary system and procedures along the continuum from receipt of complaint to final resolution and compliance monitoring.
- Develop a description of the stages of the disciplinary process, identifying variations among disciplining authorities.



The Honorable Brian Sonntag
May 3, 2006
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- Identify activities that help move cases efficiently through the stages of the disciplinary process, including an evaluation of summary actions to quickly remove a provider from practice if there is a danger of public harm.
- Assess resources required to support disciplinary activities, including staffing levels, workload, and timeliness of process compared to other state benchmarks or best practices.
- Evaluate the case law, and statutory and regulatory environments, to assess the impact of each on disciplining authorities' ability to discipline credential holders.
- Suggest internal changes that would support more effective disciplinary practices that are consistent across professions.
- Consider methods of improving public knowledge about their rights to bring complaints forward to be heard.
- Compare Washington's licensing, oversight, and disciplinary system to other states' systems.
- Recommend ways to best access national criminal background checks for current credential holders and new applicants.

Due to the gravity of the situation before us and the complexity of health professions discipline, I do think that you are uniquely positioned to look – from the outside in – and provide insights and pathways for improvement. I look forward to hearing from you and I appreciate your consideration of this request to help ensure the safety of every patient in Washington.

Sincerely,



Christine O. Gregoire
Governor

cc: Mary Selecky, Secretary, Department of Health
Tom Fitzsimmons, Chief of Staff, Office of the Governor
Fred Olson, Deputy Chief of Staff, Office of the Governor
Marty Brown, Legislative Director, Office of the Governor
Laurie Dolan, Policy Director, Office of the Governor
Christina Hulet, Executive Policy Advisor

Appendix B

Glossary

- **Adjudicative Proceeding or Process:** The legal process used to resolve disciplinary matters. It begins with a statement of allegations of charges and includes efforts to settle a case rather than hold a formal hearing. If the case is not settled, it includes preparing for and conducting a formal hearing. Formal hearings are similar to trials in a court of law.
- **Agreed Order:** A document issued by the disciplinary authority that is negotiated by the health care professional and their attorney, if represented, with representatives from the Department of Health. The conditions regarding practice are agreed upon. The order is presented to the disciplinary authority and if approved, becomes final. The document is usually called a “Stipulated Finding of Facts, Conclusion of Law and Agreed Order.”
- **Appeal Process:** A health care professional has the right to appeal a final decision of a disciplinary authority to a court of appeals. The process involves filing a petition with a county superior court. Depending on the outcome, the health care professional can appeal to an appellate court. An appellate court’s decision sets precedence for future decisions of the same nature. The Washington State Supreme Court has also been petitioned by health care professions to hear their case, if they found the appellate court’s decision unsatisfactory.
- **Below Threshold:** Thresholds established by each disciplinary authority that are used as a basis in a case concerning a health care professional without an investigation or disciplinary action. Below threshold complaints are ones that suggest little or no risk of harm to the public.
- **Best Practice:** a practice which is most appropriate under the circumstances, especially as considered acceptable or regulated in business; a technique or methodology that, through experience and research, has reliably led to a desired or optimum result.
- **Board/Commission:** Members of a health care profession and public members appointed by the Governor to determine the competency and quality of health care professionals in a particular profession. The board’s authority is outlined in the law relating to the profession.
- **Case Disposition:** The process of evaluating evidence from an investigation and making a decision to take action or to close the complaint.
- **Certification:** A voluntary process by which the state grants recognition to an individual who has met certain qualifications. The regulatory authority, either a board, commission, or the Health Secretary, determines the qualifications. Some non-certified personnel may perform the same tasks, but may not use “certified” in the title. Some facilities and health care professions require certification. (RCW 18.120.020 Definitions)

- **Compliance and Monitoring:** The process used to monitor a health care professional who has been disciplined and must comply with specific conditions in order to practice. Conditions may include payment of fines, psychological evaluation and treatment, retraining, supervision, etc.
- **Continuing Education:** Education that is in addition to the educational requirements for entry into a profession. Continuing education helps health care professionals become aware of new developments in their field.
- **Corrective Action/Disciplinary Action:** Formal or informal actions a disciplinary authority can take to limit or restrict a health care professionals in practice or to impose conditions for practice. The health care professional may also be prevented from practicing as a result of the action.
- **Default Order:** A final order issued by the disciplinary authority when the licensee was notified and failed to answer or participate in the adjudicative process. A Default Order authorizes the disciplinary authority to issue a final order without further participation by the health care professional.
- **Disciplinary Guidelines:** Standards adopted by the Department of Health and all health care profession boards and commissions that provide a consistent approach for taking action against health care professionals.
- **Docket Number:** A tracking number assigned to cases by the Adjudicative Clerk Office. One docket number may be assigned to a number of cases that are resolved at the same time regarding a single health care professional.
- **Final Order:** A document issued by the disciplinary authority that is issued as a result of a formal hearing and is usually called “Findings of Fact, Conclusion of Law, and Final Order.”
- **Formal Hearing:** A proceeding in which evidence is heard by the disciplinary authority, in order to make a decision regarding the facts of the case. Both the health care professional and the representative for the Department of Health present their arguments. It is a formal proceeding similar to a trial that results in action for or against the health care professional.
- **Health Law Judge:** An attorney employed by the Department of Health to conduct adjudicative proceedings. For professions regulated by the Health Secretary, the Health Law Judge conducts the proceedings and makes the final decision. For boards and commissions, the Health Law Judge presides, but members of the board or commission make the final decision.
- **Health Systems Quality Assurance (HSQA):** A division within the Department of Health. The division is comprised of four major areas: Facilities and Services Licensing; Health Professions Quality Assurance (HPQA); Office of Community and Rural Health; and Office of Emergency Medical and Trauma System.

- **Jurisdiction:** A legal term that refers to the subject matter a disciplinary authority is allowed by law to address. If the disciplinary authority does not have jurisdiction, no action can be taken.
- **License:** A method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in a health profession. Without a license, the practice of the specific health profession would be unlawful. Licensure protects the scope of practice and the health care provider's title. (RCW 18.120.020 Definitions)
- **No Cause for Action:** A complaint that is closed because no violation of the law has been proven.
- **Panel:** Three or more members of a board or commission who have been designated to make disciplinary decisions on behalf of the board or commission. The law permits the use of panels.
- **Priority:** Priority one cases are those high priority cases where there is a risk of imminent harm (summary action is likely) or there is a countervailing interest. Priority two cases are all the remaining high priority cases. Priority three cases are all other complaints received which HPQA has jurisdiction.
- **Probation/Stayed Suspension:** A period of time during which a health care professional must meet certain conditions set by the disciplinary authority in order to continue to practice.
- **Program:** Department of Health staff that work to support the licensing, rulemaking and disciplinary processes for a regulated profession.
- **Public Member:** An individual serving on a board or commission who is not a member of the profession.
- **Registration:** A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. If required, a description of the service, location, nature, and operation of the health activity practice must also be provided. (RCW 18.120.020 Definitions)
- **Respondent:** A health care professional who has received notice of allegations against him/her.
- **Reviewing Member:** Usually a member of a board or commission assigned to review the evidence in a particular complaint against a health care professional. The member works with an investigator, a staff attorney, and/or an assistant attorney general to present a recommendation to the disciplinary authority about how the case should be resolved. The member brings their professional expertise to the process.
- **Revised Code of Washington (RCW):** Laws (also known as statutes) that are written by the Legislature and signed into law by the Governor. RCWs are filed by chapter with the Code Reviser. Title 18, Business and Professions, is the

chapter that refers to the regulation of health professions Revised Code of Washington (RCW).

- **Revocation:** A sanction that the disciplinary authority can impose as the result of a hearing in which the health care professional was found to have committed unprofessional conduct. A revocation ends the health care professional's right to practice their profession.
- **Sanctions:** Conditions that the disciplinary authority can impose as the result of a hearing in which the health care professional was found to have committed unprofessional conduct. Sanctions that can be imposed are defined in the Uniform Disciplinary Act and range from reprimand to revocation.
- **Service:** Service of a legal document means "posting in the United States mail, properly addressed, postage prepaid, or personal service. Service by mail is complete upon deposits in the United States mail."
- **Settlement Conference:** A settlement conference is a meeting made available to health care professionals once they have been notified of the allegations or charges against them. The health care professional and attorney, if represented, attend. They meet with representatives of the Department of Health including a staff attorney or an assistant attorney general. It is an opportunity to mutually agree upon conditions for continued practice, if the health care professional can practice safely. The Agreed Order must then be presented and approved by the disciplinary authority.
- **Statement of Charges:** A document issued that presents allegations of violations of the law, the Uniform Disciplinary Act, or other laws that pertain to health care professionals.
- **Stipulation to Informal Disposition (STID):** An informal method for the disciplinary authority to resolve a complaint against a health care professional. The document when issued is accompanied by another document called a "Statement of Allegations". If the health care professional agrees to sign the STID, he/she does not admit to unprofessional conduct, but does agree to corrective action. Additional training is an example of corrective action. STIDs are reportable to national data banks, but they are not open to public disclosure unless someone requests the information in the name of the specific health care professionals.
- **Summary Suspension (also referred to as summary action):**
 - A standard of conduct or standard of practice summary suspension is a sanction that the disciplinary authority can impose as the result of an investigation that indicates there is immediate danger to the public, if the health care professional continues to practice. The health care professional cannot legally practice until a hearing is held.
 - A mandatory summary suspension is a sanction that the disciplinary authority can impose as the result of an out-of-state action. This may include professionals prohibited from practicing in another state. If a

credential holder or applicant is prohibited from practicing in a health care profession in another state, because of an act of unprofessional conduct that is substantially equivalent to an act of unprofessional conduct prohibited in Washington, the credential holder or applicant is also prohibited from practicing a profession in Washington until the credential is restored.

- **Suspension:** A sanction that the disciplinary authority can impose as the result of a hearing in which the health care professional was found to have committed unprofessional conduct. A suspension ends the health care professional's right to practice their profession for a specific period of time and/or until certain conditions are met.
- **Uniform Disciplinary Act (UDA):** This is a chapter in Washington State law that provides standardized procedures for approving applicants for credentials and for disciplining health care professionals. The purpose is to assure the public of the professional competency and quality of health care professionals. Chapter 18.130 RCW Regulation of Health Professions – Uniform Disciplinary Act.
- **Unprofessional Conduct:** The Uniform Disciplinary Act identifies 25 violations of the law for which a health care professional can be charged with unprofessional conduct.
- **Washington Administrative Code (WAC):** An interpretation of statutes written by a government agency or board. WACs help clarify the terms that are found in related statutes (RCWs). WACs are legally binding and are filed by the chapter that refers to the regulation of health professions. Revised Code of Washington (RCW).
- **Whistleblower Protection:** Statutes that protect the identity of a person who files a complaint with the Department of Health. A person who files a complaint in good faith is immune from being sued in a civil action related to the filing of the complaint.

Appendix C

Findings and Associated Recommendations

| Finding | Recommendation |
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| <p>Finding 1: The state's governance structure involving HPQA and the Boards and Commissions, responsible for regulating health care professions, does not promote effective performance management.</p> | <p>We recommend that the Legislature:</p> <ol style="list-style-type: none"> 2. Amend the Written Operating Agreement statute (RCW 43.70.240) between HPQA and the boards and commissions to require the agreements to include negotiated performance-based provisions. The amendment should include: <ul style="list-style-type: none"> • A requirement that the written agreements are reviewed annually and revised as needed to continually drive performance to protect the public's interests. • Set an effective date as a deadline for these agreements to be revised and to become operational. • Require the results of the key performance measures (as appropriate to protect confidentiality) be posted on the Web sites of HPQA and each board and commission. <p>The operating agreements are a vital tool for ensuring consistency and timeliness of the regulation of health care professions. Amending RCW 43.70.240 will establish performance measurements for all entities involved in the credentialing and discipline of health care professionals. Publishing performance results will give citizens, the Governor, policymakers and others information they need to judge the effectiveness of government regulation of health care professionals.</p> |
| <p>Finding 2: Credentialing process inconsistencies and control weaknesses leave the potential for unqualified individuals to practice in Washington and leave citizens at risk.</p> | <p>We recommend that HPQA:</p> <ol style="list-style-type: none"> 5. Document policies and detailed procedures online and create a process to review and update the procedures periodically. Until procedures are available online, designate department section leaders to monitor and ensure that desk manuals contain up-to-date information. 6. Develop and follow internal controls to ensure that all applications contain required information and documents prior to issuing a credential. These standardized business practices should be established throughout the five credentialing sections. Examples include providing application requirement checklists, documenting supervisor approvals for each file credentialed, and conducting random audits within the section. 7. Ensure that the test process for professions requiring Jurisprudence Exams is consistent. 8. Determine if setting a minimum age requirement is appropriate for individual professions. If setting a minimum age requirement requires legislative action, the legislature should do so. It seems prudent to have a minimum age requirement for those professions that have no educational and/or examination requirement. <p>We recommend that the Legislature:</p> <ol style="list-style-type: none"> 3. Eliminate the registered counselor credential as it currently exists. 4. For all registered professions, review and modify as needed existing laws that allow individuals to be credentialed with no educational or experience requirements. <ul style="list-style-type: none"> • Establish requirements that include at a minimum education, examinations, supervised training, and experience and offer credential types that reflect the requirements. • Offer a temporary credential for individuals who are completing educational requirements for supervised experience. <p>Strengthening controls governing the credentialing process related to reviewing and updating policies and procedures, implementing supervisory reviews, improving staff training, ensuring documentation is consistent, and implementing renewal application and periodic background checks will provide greater assurance that only qualified applicants are issued credentials. This will improve public safety.</p> |
| <p>Finding 3: Weaknesses in internal controls over the background check process and lack</p> | <p>We recommend HPQA:</p> <ol style="list-style-type: none"> 6. Consider periodic background checks (in-state criminal and national provider databases) after initial credentialing. For example, perform background checks at fixed time intervals, such as every five or seven years or when practitioners renew their credentials. Two alternatives are: <ul style="list-style-type: none"> • HPQA use a risk-based approach for determining the timing of these |

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| <p>of national criminal background checks can expose the public to serious risk.</p> | <p>reviews based on the number of complaints and the level of sanctions issued for each profession.</p> <ul style="list-style-type: none"> • The Legislature expand the list of convictions provided to the Department by the Washington State Patrol (WSP). <ol style="list-style-type: none"> 7. Consider requiring practitioners who apply for credential renewals to provide and attest to the validity of their information regarding any felony convictions in any other state or country, and to provide and attest to the validity of their information regarding disciplinary actions for credentials held in any state. Furthermore, if any Washington credential holder is disciplined for any infraction in another state or country, a timeline should be set for the credential holder to report that information to HPQA. 8. Institute a supervisory review process to be performed on a regular basis. Consider maintaining printouts of all completed background checks in the applicants' files. 9. Use the state law (RCW 43.70.250) requiring credential holders and applicants to bear the cost of background checks. 10. Outsource the checks to private companies if the Department determines that it does not have the resources to conduct its own national criminal background checks. Appendix I contains a table showing companies that provide the service for other states. <p>We recommend the Legislature:</p> <ol style="list-style-type: none"> 3. Give the Department the statutory authority to access WSP criminal background information, particularly non-conviction data (WACIC and ACCESS). 4. Give the Department the statutory authority and associated resources to access the FBI database for national background checks and require HPQA to conduct national background checks on all credential holders. <p>All of the national background check providers we researched have limitations on the completeness, accuracy, and timeliness of their data. In spite of the limitations, several other states have engaged these services.</p> |
| <p>Finding 4: Changes in the complaint management process are needed to more accurately assess complaints and to improve responses to complainants.</p> | <p>We recommend that HPQA:</p> <ol style="list-style-type: none"> 11. Work with the boards/commissions to adopt a set of standardized guidelines to determine if a complaint falls below threshold. This is in keeping with the intent of the Uniform Disciplinary Act to consolidate disciplinary procedures and has the additional benefit of promoting consistency. We recommend that boards and commissions use a threshold guideline checklist (like the Nursing Commission's) to determine if cases should be investigated. This checklist provides written, agreed-upon standards and is an effective practice for consistent decision-making. It could be shared with the boards/commissions to use during their decision-making process. 12. Expand the procedure that defines imminent danger (Procedure 212) to include criteria or examples of imminent harm complaints. Those examples should then be used during the intake/assessment process to ensure that complaints posing a serious threat to the public are handled in a timely manner. 13. Consider establishing the maximum number of complaints that a credential holder can receive within a defined period and develop procedures to initiate a practice review of the credential holder. We recommend the boards and commissions adopt a similar procedure. 14. Consider developing procedures to address complaints that are related to behaviors or shortcomings in care that might escalate to more serious violations. This might require statute or rule changes and coordination with boards and commissions. 15. Provide training on Procedure 209, which describes how HPQA databases are updated, who is responsible for updating them, and when data should be entered. HPQA should provide the training to all staff responsible for intake/assessment of complaints. Use of this procedure should be mandatory to maintain consistency across sections. This procedure also should be used when training new personnel. Supervisory reviews should be performed to ensure the procedure is followed. 16. Institute a procedure that reduces the amount of time that intake and assessment personnel have to copy and forward complaints to board/commission panels to one week from the initial receipt of the |

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| | <p>complaint. This would provide the boards and commissions two weeks to review the complaints, decide on a course of action and sign and return the authorization. HPQA should consider obtaining electronic imaging software to allow electronic, instant file transfers to the boards and commissions.</p> <ol style="list-style-type: none"> 17. Develop and enforce a procedure that identifies the necessary documentation to be included within case files. This will ensure consistency among the sections and facilitate use of the files by the various users and protect HPQA's position in legal proceedings. 18. Implement a procedure that requires the use of case assessment sheets that include the details of prior complaints, even those closed below threshold. Such information is useful at Case Management Team meetings when deciding if an investigation is necessary because it allows the team to assess pattern-forming behavior. 19. Develop a list of specific definitions for complaint types and closure codes that facilitates the classification of complaints. Definitions should include examples of complaints that would fit into each category. 20. Adopt and enforce procedures that <ul style="list-style-type: none"> • Comply with state law regarding the use and timeliness of written notification to credential holders. • Require a written acknowledgement be sent to a complainant upon receipt and assessment of a complaint. • Require a quarterly written notification of the status of a complaint/case be sent to both the complainant and credential holder. <p>Implementing these recommendations should improve HPQA's complaint management processes and enable HPQA and the boards and commissions to assess the level of harm to the public consistently, to identify and monitor credential holders who may be unqualified, to inform complainants and respondents that complaints are being addressed, and to maintain a documented record of complaints and actions.</p> |
| <p>Finding 5: HPQA's efforts to improve public education regarding citizens' rights to file complaints about credential holders with HPQA are insufficient.</p> | <p>Given that the complaint process is HPQA's primary mechanism for identifying unprofessional conduct and substandard healthcare services, in order to more fully protect the public's interests in these areas, we recommend that HPQA:</p> <ol style="list-style-type: none"> 4. Develop and institute a public education strategy. 5. Determine the cost for a public education strategy and request funding for it from the Legislature. 6. Improve its Web site: <ul style="list-style-type: none"> • Create a prominently displayed link on the DOH home page to the HPQA complaints page. • Create a link on Access Washington to the HPQA Web site complaints page. • Work with other health agencies (such as the Health Care Authority or the Department of Social and Health Services) to create a link on their Web sites to the HPQA Web site complaints page. • Consolidate the complaints pages with the most important information on a single screen and link them to additional screens for more information. Currently a user must go through seven screens to get to the complaints form. • Consider providing complaint information in languages other than English. • Create an application to allow complaints to be submitted online. • Consider obtaining the services of a professional web developer. • Enhance the profiles and/or disciplinary action published on the Provider Credential Search Web site to assist the public in making informed decisions about selecting health care providers. Suggested examples: <ul style="list-style-type: none"> • Massachusetts – physician's profiles are easy to find. • Arizona Medical Board – profile includes license history and status, medical education and training. • California – Web sites include phone number and online chat to obtain physician information. 5. Participate in other activities to promote public education. For example: <ul style="list-style-type: none"> • Participate in health fairs sponsored by other entities, such as state |

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| | <p>agencies, managed care organizations, and city and county organizations.</p> <ul style="list-style-type: none"> ● Make presentations at community organizations such as senior citizen centers and health support groups. ● Create brochures with information about HPQA, how to file a complaint, what types of complaints are handled by HPQA, what to expect after a complaint is filed, and how to use HPQA's Provider Search Web site. ● Include an informational brochure when sending an acknowledgement letter that the complaint was received. ● Create a large-print version of the brochures. ● Consider printing brochures in a language other than English. ● Create audio CDs and tapes with information for the visually impaired. ● Consider adding a toll-free number for complaints information that is easily remembered. ● Purchase inexpensive promotional items, such as pens or magnets, with HPQA's Web site and contact telephone number for complaint information and distribute. ● Contact other state(s) agencies that have paid for media campaigns to obtain ideas regarding ways to publicize submission of complaints about health care providers. ● Create and print posters containing information about how to file a complaint with HPQA. <p>Implementing the recommendations will provide the public with information about its right to complain about practitioners and how to file complaints about practitioners who engage in professional misconduct or provide substandard care. Ultimately, the public will be better protected if HPQA is informed of unqualified health care professionals and can take the necessary steps to sanction those professionals.</p> |
| <p>Finding 6: Investigations of complaints are delayed by process issues and compromised by staffing shortages and internal control deficiencies.</p> | <p>We recommend that HPQA:</p> <ol style="list-style-type: none"> 11. With the boards and commissions work to improve processes to make them effective, efficient and reduce delays caused by shared responsibilities. 12. Establish written policies and procedures for conducting investigations. These policies and procedures may include a checklist to ensure that important steps of the investigation are not overlooked. 13. Investigation Service Unit should focus its efforts on decreasing the backlog of overdue investigative cases so resources can be expended on investigating complaints in a timely manner. This may require the addition of more investigators, possibly on a temporary basis, to decrease the backlogs. Once the backlog is reduced, management can more accurately assess the need for increased resources in this unit caused by the increased number of complaints. 14. Consider contracting with community physicians to consult on routine standard-of-care cases for a flat fee. 15. Evaluate whether it is most effective to hire investigators with specialized knowledge or whether it is more timely and cost effective manner to fill that need with consultants. 16. Comply with Executive Order 98-02 to ensure that all investigators receive appropriate training. 17. Consider coordinating its training with other governmental agencies and jurisdictions with similar responsibilities to fully utilize existing training sources as suggested in Executive Order 98-02 (2)(c). 18. Require supervisors to officially sign off on all investigations. 19. Develop a policy and procedure that requires the use of a standardized caseload tracking log by investigators that identifies the status of each case. An electronic application would provide a standard format for the data and could be made accessible to the staff and management as determined by HPQA. 20. Establish and follow a procedure that details the necessary documents to be included within each investigation file. |

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| | <p>We recommend that the Legislature:</p> <ol style="list-style-type: none"> 2. Provide additional tools for obtaining records, documents and other evidence. These tools could include authorization to issue citations and fines for failure to provide documents in a timely manner. <p>Putting the recommendations into practice would make the process to initiate investigations between HPQA and the boards and commissions more efficient. When HPQA reduces the backlogs, the public is more promptly and efficiently served. Improvements in the consistency and quality of the documentation of investigations will increase the likelihood that practitioners who should be disciplined will be appropriately disciplined.</p> |
| <p>Finding 7: Deficiencies in the disciplinary (legal) process have led to inconsistent and delayed discipline of practitioners who engage in unprofessional conduct or provide below standard of care.</p> | <p>We recommend that HPQA:</p> <ol style="list-style-type: none"> 2. And the Department work with the Governor to determine if the Governor has the authority to require by Executive Order that all boards and commissions adopt the Sanctioning Guidelines by an agreed-upon date. 2. Ensure that staff prepare default orders for all cases where the respondent fails to respond to the Statement of Charges within 20 days. 3. Amend its current policies and procedures to specify what information and documents should be included in disciplinary files. 4. Ensure the accuracy of posted Basis of Action codes. Implementing a supervisory review of all Basis for Action codes before they are placed on the Department's Provider Credential Search Web site would be an effective control. <p>We recommend that the Legislature adopt a law:</p> <ol style="list-style-type: none"> 4. Requiring a deadline by which the sanction guidelines must be adopted. 5. Authorizing the Secretary to discipline all professions for misconduct, while the boards and commissions continue to discipline standard-of-care violations. 6. Indicate that any board or commission not adopting sanction guidelines by the deadline could be subject to losing its disciplinary authority and becoming an advisory committee. <p>Implementing the recommendations would ensure that the Health Secretary and the boards and commission will use the same sanctioning guidelines to provide consistency of imposing similar sanctions for similar violations and that the sanctions are appropriate for the violation. The recommendations assure the public that the information regarding disciplinary actions on the Provider Credential Search Web site is accurate.</p> |
| <p>Finding 8: The compliance process does not ensure that practitioners who have been disciplined comply with the terms of their sanctions.</p> | <p>We recommend that HPQA:</p> <ol style="list-style-type: none"> 6. Establish a standardized process of monitoring the due dates and terms and conditions of imposed sanctions. This process should provide automated notification to compliance officers when documentation of completed compliance requirements has not been received within the required timeframe. This process should be clearly documented in its current compliance monitoring procedure. 7. Modify its procedure to limit the number of reminder letters that a practitioner can be sent before taking other legal action. 8. Determine an optimum caseload for its compliance officers and consider increasing the staff responsible for ensuring that health care professionals comply timely and with the terms of imposed sanctions. HPQA should also consider outsourcing its compliance monitoring activity. 9. Develop a formal training process for new employees. A formal training program will ensure that each division is performing similar tasks in a consistent manner. Consistency will create efficiencies and will enable staff to become cross-trained to perform varying functions. Cross-trained staff will allow for flexibility if one division becomes bogged down with work due to staff shortages or increased workload. HPQA should also institute a process to ensure that desk manuals are consistently updated as new information is provided. Desk manuals will serve as an additional resource to staff members if they are unsure how to perform a particular task. Creating standardized training processes will address inconsistencies across the divisions and create a more efficient workplace. 10. Create compliance letter templates that can be used by the various sections |

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| | <p>to provide consistent information to respondents and ensure consistent decision-making. These templates should be documented in the current compliance monitoring procedure. HPQA may also want to place the templates on the intranet shared drive for ease of accessibility.</p> <p>Instituting the recommendations will ensure that health care professionals comply with the terms of their sanctions or are referred for legal action. It is critical to public safety that practitioners who are sanctioned for professional misconduct and substandard care are monitored and the terms of the sanctions are enforced. Practitioners who do not comply with the terms of their sanctions must be referred promptly for other actions allowed by statute and rule, such as summary suspension.</p> |
| <p>Finding 9: DOH and HPQA oversight needs improvement to ensure that the credentialing and the regulatory processes are performing as intended.</p> | <p>We recommend that HPQA:</p> <ol style="list-style-type: none"> 1. Develop and follow a performance management system that includes effective performance measures that: <ul style="list-style-type: none"> • Are derived from HPQA's mission and goals. • Contain appropriate types of measures, such as outcome, output, efficiency, input. • Include the characteristics of good performance measures: <ul style="list-style-type: none"> ○ Purpose/Definition/Importance - Explains what the measure is intended to show and why it is important. ○ Source/Collection of Data – Describes where the information comes from and how it is collected. ○ Method of Calculation - Clearly and specifically describes how the measure is calculated. ○ Data Limitations - Identifies any limitations about the measurement data, including factors that may be beyond the agency's control. ○ Calculation Type - Identifies whether the data is cumulative or non-cumulative. ○ New Measure – Identifies whether the measure is new, has significantly changed, or continues without change from the previous biennium. ○ Target Attainment – Identifies whether actual performance that is higher or lower than targeted performance is desirable. ○ Explanation of Variance – If the actual performance varies for the target by an established amount, provides a reason for the difference. 2. Develop and follow an internal control structure that will ensure the reliability of the performance data that is collected and reported. 3. Once performance measures are developed and implemented, select measures that are of importance to the public, including performance measures specific to boards and commissions, and post the results on the HPQA web site to inform the public. <p>Implementing a performance management system provides a framework for achieving results that is based on established targets. A good performance management system that includes relevant, well-defined performance measures can provide reasonable assurance that the information is properly collected, calculated, and accurately reported. It also provides performance information that will accurately and reliably report the progress in meeting standards and targets. HPQA management and other decision-makers would be able to rely on the information when making changes and improvements in policies, programs, and operations.</p> |
| <p>Finding 10: The DOH internal audit function is understaffed and does not perform evaluations of HPQA to identify and report deficiencies that could impede HPQA's ability to</p> | <p>We recommend that the Department:</p> <ol style="list-style-type: none"> 4. Seek funding from the Legislature to add additional internal auditors to reduce risk by enabling the internal audit department to conduct more audits of areas and activities that are identified in the risk assessment. 5. Work with the internal auditor to implement a comprehensive and scheduled control self-assessment. 6. Consider outsourcing or co-sourcing with an external organization to provide additional capacity for the internal audit functions. <p>Independent and objective internal audits and implementation of control self-</p> |

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| achieve its goals. | assessments would identify control and procedural deficiencies that could cause HPQA to not achieve its mission, and result in harm to the public. Management would then be able to take steps to address the deficiencies that potentially could allow credentials to be issued to unqualified individuals, and to correct weaknesses that fail to prevent the timely discipline professionals who have engaged in unprofessional conduct. |
| <p>Finding 11: Legacy information systems do not enable HPQA to effectively and efficiently license health practitioners, manage consumer complaints and monitor compliance with disciplinary action.</p> | <p>We recommend that:</p> <ol style="list-style-type: none"> 3. The Department establish and follow a process to ensure software is supported and maintained when ILRS is implemented; and that sufficient expertise not available in HPQA is retained to provide system and application support. 4. HPQA continue to follow their documented process and timeline for the implementation of ILRS. <p>HPQA servers and applications will maintain the latest security capabilities to reduce the risk of unauthorized access to sensitive data; reduce the likelihood of system failure; increase the stability of the processing environment; and support moving it from an insecure environment and solve HPQA's inability to rely on or effectively use its data. The new system also will allow HPQA the flexibility to keep up with changing requirements regarding reporting, and to fulfill its mission.</p> <p>We recommend that:</p> <ol style="list-style-type: none"> 1. HSQA leverage Department resources or contract for enhanced security settings on HSQA legacy and related side-systems and servers until ILRS or another licensing application is operational. The effect of changes to these settings should be investigated before making changes to the system parameters. Changes may include but are not limited to: <ul style="list-style-type: none"> • Installing patches and updates. • Enabling logging, where prudent and possible, and monitoring the logs. • Enabling or strengthening password settings where possible. • Configuring HSQA servers to allow them to be controlled by the Department's primary network servers. • Disabling unused services. 2. In compliance with Department policy, HSQA should periodically review and remove user IDs that are not being used. HSQA also should work with human resources and section managers to establish a method to notify the Office of Information Resource Management and HSQA IT Section of changes needed to user access. Enhancement of this process should include the following: <ul style="list-style-type: none"> • Filing user access requests in alphabetical order by last name. • Keeping a record of who has been authorized to have access, who has been granted access, and which resources they may access. • Establishing procedures to ensure program managers are aware of their responsibility to maintain security through authorizing the commissioning and decommissioning of user accounts respective to their operations areas. • Ensuring that user access to the system is maintained according to management authorization and duties are properly segregated. <p>Strengthening security settings and establishing a consistent process for granting and revoking user access to HSQA systems and applications reduces the risk that unauthorized persons could inappropriately access systems and data.</p> <p>We recommend that HPQA establish and follow a process to review and correct data contained in the legacy and side-systems before the conversion to ILRS. This may include the need to periodically reconcile data across systems or run automated matching among databases to reduce errors. We also recommend HPQA refrain from developing new side systems.</p> <p>Developing and using a process to review and correct data decreases the risk of invalid data being entered, stored, and used. This, in turn, reduces the time to correct data errors and inconsistencies and results in more accurate reporting of information regarding performance statistics and may lead to process improvement. It also lends itself to the entering correct data into ILRS.</p> |

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| | <p>We recommend that HPQA establish and follow procedures to ensure changes to data are logged and historical data is kept. We also recommend this capability is included in ILRS and that no additional side systems that lack this capability be developed.</p> <p>Creating and maintaining logs of changes to data allows easier and quicker correction of errors and accountability in case unauthorized changes to data are made.</p> |
| <p>Finding 12: HPQA's disaster recovery plans and business continuity plans are not fully developed.</p> | <p>We recommend that HPQA:</p> <ol style="list-style-type: none"> 4. Complete the disaster recovery and business continuity plans as quickly as possible. 5. Ensure at least one means of contact for key personnel is available that does not depend on an agency-operated communications network. 6. Ensure disaster recovery plans provide sufficient detail that an individual unfamiliar with them could follow the plan and bring about successful recovery. <p>We recommend that the Department complete development of an IT-recovery "hot site". Management stated that a site in Western Washington is being completed, and contract negotiations for support services are in progress for a site in Eastern Washington.</p> <p>Disaster recovery and business continuity plans that include detailed steps for relocating and recovering operations would help HPQA ensure it is able to recover operations after a disaster within its recovery time objectives of 24 to 72 hours.</p> |
| <p>Finding 13: Hard copy files related to licensing and investigations are not physically secure.</p> | <p>We recommend that HPQA</p> <ul style="list-style-type: none"> • Employees ensure hardcopy documents that may expose sensitive information or data to unauthorized individuals are secure. • Develop policies and procedures to address the physical protection of sensitive data and information contained in hardcopy documents. This can be done by establishing and adhering to the clean desk policy as well as training personnel on their responsibilities pertaining to it. <p>We recommend that HPQA</p> <ul style="list-style-type: none"> • Consider an alternative solution that is both more secure and offers other benefits and obtain a document imaging system that would make the information available only to employees who need it. Also, this would mitigate issues related to disaster recovery because images can be backed up off-site and restored. Documents should be properly imaged to ensure readability, easy retrieval and the ability to interface with the ILRS records. Additional funding would be necessary for HPQA to develop and implement an imaging system. <p>Physically securing sensitive information related to personal identity or investigations contained in hardcopy documents and files and maintaining a clean desk environment may reduce the likelihood that sensitive documentation could be lost or stolen and used inappropriately and/or in a way that could adversely affect HPQA and the public.</p> |

Appendix D

Legislative recommendations

Finding 1: Performance-Based Operating Agreements

1. Amend and enhance the Written Operating Agreement statute RCW 43.70.240 to require performance-based agreements between the Secretary and the boards and commissions.
2. Include in the amendment a requirement that the written agreements are reviewed annually and that performance changes be incorporated.
3. Set a deadline for agreements to be signed and effective.
4. Require the results of the key performance measures be posted on the Web sites of HPQA and each board and commission.

Finding 2: Credentialing:

1. For all registered professions, review and modify as needed, existing laws that allow individuals to be credentialed with no educational or experience requirements.
 - a. Establish requirements that include at a minimum education, examinations, supervised training, and experience and offer credential types that reflect the requirements.
 - b. Offering a temporary credential for individuals who are completing educational requirements for supervised experience.
2. Eliminate the registered counselor credential as it currently exists.

Finding 3: Criminal Background Checks:

1. The state Legislature needs to give the Department the statutory authority to access Washington State Patrol (WSP) criminal background information, particularly non-conviction data (WACIC).
2. The Washington Legislature should give the Department the statutory authority to access the FBI database for national background checks and require HPQA to conduct national background checks on all credential holders.

Finding 6: Investigations

1. Provide additional tools for obtaining records, documents and other evidence. These tools could include authorization to issue citations and fines for failure to provide documents in a timely manner.

Finding 7: Disciplinary (Legal):

1. Requiring a deadline by which the guidelines must be adopted.
2. Authorizing the Secretary to discipline all professions for misconduct, while the boards and commissions continue to discipline standard of care violations.
3. Indicate that any board or commission not adopting sanction guidelines by the deadline could be subject to losing its disciplinary authority and becoming an advisory committee.

Appendix E – Governor’s and Audit Objectives

| May 3, 2006 Governor’s Letter & Audit Objectives | Audit Reference |
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| 1. Evaluate the professional licensing, oversight and disciplinary system and procedures starting with the receipt of licensing applications through final resolution of complaints and compliance monitoring. | Findings 1,2,3,5,6,7,8,9,10,11 |
| 2. Develop a description of the stages of the disciplinary process, identifying variations among disciplining authorities. | Findings 3,5,6, |
| 3. Identify activities that help move cases efficiently through the stages of the disciplinary process, including an evaluation of summary actions to quickly remove a provider from practice if the public is at risk of being harmed. Determine if such activities are being uniformly and consistently applied. | Findings 3,5,6 |
| 4. Assess resources required to support the professional licensing, oversight and disciplinary system, including staffing levels, workload and timeliness of process compared to other states’ benchmarks or best practices. | <p>1. HPQA is installing a new computer system, ILRS, which will create efficiencies, change processes, and change the duties of staff. Assessing resources at this time will not be useful when ILRS is live. It would be appropriate to assess the resources and the changes HPQA makes to respond to the new environment after ILRS is operation.</p> <p>2. We interviewed regulatory staff and researched web sites for eleven professions in six states to obtain resource data. Because of the variety of governing structures (umbrella agencies for all/some of the professions , independent boards for specific professions),the lack of standardized definitions, data not identified by profession data not collected for each of the categories, we were unable to do a valid and useful comparison.</p> |
| 5. Compare Washington’s licensing, oversight and disciplinary system to other states’ systems. | Best Practices for Findings 1,2,3,5,6,7,8. |

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| 6. Evaluate the case law and statutory and regulatory requirements to assess the effect of each on the disciplining authorities' ability to discipline credential holders and its ability to do so in a timely manner. | Findings 3,5,6 |
| 7. Suggest statutory, regulatory and/or internal policy changes that would support more effective disciplinary practices that are consistent across professions. | Findings 3,5,6 |
| 8. Recommend methods of improving public education about their rights to file complaints about licensees to be heard by the Department. | Finding 8 |
| 9. Recommend the best ways to access national criminal background checks for current credential holders and applicants. | Finding 2 |

Appendix F I-900 elements

| Initiative 900 Elements | Audit Reference |
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| 1. Identification of services that can be reduced or eliminated. | HPQA is installing a new computer system, ILRS, which will create efficiencies, change processes, and change the duties of staff. Assessing resources at this time will not be useful when ILRS is live. It would be appropriate to assess the resources and the changes HPQA makes to respond to the new environment after ILRS is operation. |
| 2. Identification of programs or services that can be transferred to the private sector. | Findings 1,2, 5,6,7,8, |
| 3. Analysis of gaps or overlaps in programs or services and recommendations to correct gaps or overlaps. | Findings 4,5,7,8 |
| 4. Feasibility of pooling information technology systems. | Findings 9-11 |
| 5. Analysis of the roles and functions of the Office of Health Professions Quality Assurance and recommendations to change or eliminate Departmental roles or functions. | Findings 1,3,4,5,6,7,8,9,10,11 |
| 6. Recommendations for statutory or regulatory changes that may be necessary for the Office of Health Professions Quality Assurance to properly carry out its functions. | Findings 3,5,6 |
| 7. Analysis of Office of Health Professions Quality Assurance performance data, performance measures and self-assessment systems. | Finding 8 |
| 8. Identification of best practices | Best Practices cited in Findings 1,2,3,5,6,7,8, |
| 9. Identification of cost savings | The purpose of this audit is public safety and, as such, only limited information was identified, but not quantified, for cost savings. |

Appendix G

Executive Order 06-03, Investigation of Health Professional Sexual Misconduct, May 4, 2006

EXECUTIVE ORDER 06-03 INVESTIGATION OF HEALTH PROFESSIONAL SEXUAL MISCONDUCT

WHEREAS, it is Washington State's paramount duty to protect the public and ensure safe, quality health care; and

Washington residents deserve a system that makes patient safety the top priority and instills confidence in the professionalism and training of their health care providers; and The state's disciplining authorities, including the Department of Health and state boards and commissions, are responsible for ensuring patient safety by regulating health care professions and sanctioning those providers who exhibit unprofessional conduct; and Sexual misconduct by health professionals in Washington is unacceptable and demands

strong regulatory action by the state's disciplining authorities to better protect the public.

NOW, THEREFORE, I, Christine O. Gregoire, Governor of the State of Washington, direct all health profession disciplining authorities, including those reporting to the Secretary of Health and independent boards and commissions, to promptly investigate, without exception, all allegations of sexual misconduct by health care professionals within their respective governing authorities.

It is not the policy of Washington State to tolerate sexual misconduct, particularly by health care providers who act in service to the public. Rather, it is the policy of Washington State to thoroughly investigate all allegations of such conduct.

Washington State's health profession disciplining authorities shall work collaboratively with the Secretary of Health to:

- 1) Establish a comprehensive definition of sexual misconduct, no later than September 1, 2006, that will be used in investigations of such conduct across all State health care professions; and
- 2) Establish comprehensive protocols for investigating allegations of sexual misconduct, no later than July 1, 2006, to ensure that any State action in this regard is uniform across all State health professions; and
- 3) Provide an annual report to the Governor on the application of these tasks.

This Executive Order shall take effect immediately.

Signed and sealed with the official seal of the State of Washington, on this 4th day of May

2006, at Olympia, Washington.

By:

Christine O. Gregoire
Governor

BY THE GOVERNOR:
Secretary of State

Appendix H– How Washington compares to other states

This table compares Washington credentialing requirements for 12 professions to those professions regulated in 9 other states. Ranking orders are explained in a legend at the end of the table.

| Professions | States | Application Fee** | Type of Credential | Renewal Period | Education Req. (degree) | Exam Required | CPE Req. (per year) | Experience Req. | Min. age required |
|--|------------------------|-------------------|----------------------|----------------|--------------------------------|---------------------------------------|---------------------|-----------------|----------------------------|
| Advanced Registered Nurse Practitioner ^{a)} | Washington | \$65 | Licensed | 2 | Master | National Exam | 15 | No | not required |
| | Other States* | \$75-\$287 | Certified - Licensed | 2-4 | Bachelor - Special Training | National Exam, English Prof. Test | 0-25 | No-Yes | 18 years old (NY) |
| | Washington Rank | 1 | | 1 | 3 | | 2 | | |
| Chemical Dependency Professional | Washington | \$100 | Certified | 1 | Associate | National Exam | 40 | Yes | not required |
| | Other States* | \$25-\$250 | Certified - Licensed | 1-2 | High School - Bachelor | State Exam, National Exam | 0-40 | Yes | 18 years old (NY) |
| | Washington Rank | 5 | | 1 | 5 | | 1 | | |
| Chiropractor | Washington | \$300 | Licensed | 1 | Bachelor | National Exam | 25 | Yes | not required |
| | Other States* | \$100-\$385 | Licensed | 1-3 | Associate - Master | National Exam | 12-50 | No-Yes | 21 years old (CO, NY) |
| | Washington Rank | 8 | | 1 | 4 | | 3 | | |
| Dentist | Washington | \$325 | Licensed | 1 | Special Training | National Exam | 21 | Yes | not required |
| | Other States* | \$100-405 | Licensed | 1-3 | Special Training | State Exam, National Exam | 0-25 | No-Yes | 18 (CA, FL), 21(NY, TX) |
| | Washington Rank | 6 | | 1 | 1 | | 3 | | |
| Licensed Practical Nurse | Washington | \$70 | Licensed | 1 | Bachelor | National Exam | 0 | Yes | not required |
| | Other States* | \$50-\$220 | Licensed | 2-4 | Associate - Master | National Exam, English Prof. Test | 0-15 | No-Yes | 17 years old (CA, NY) |
| | Washington Rank | 3 | | 1 | 2 | | 7 | | |
| Midwife | Washington | \$450 | Licensed | 1 | High School+ Special Training | National & State Exam | 0 | Yes | not required |
| | Other States* | \$25-\$500 | Certified - Licensed | 1-3 | High School - Special Training | National, State, & English prof. Test | 0-30 | No-Yes | 18(AZ), 19(CO), 21(FL, NY) |
| | Washington Rank | 9 | | 1 | 5 | | 7 | | |
| Certified Nurse Assistant | Washington | \$15 | Certified | 1 | Special Training | Omnibus (Federal Required Exam) | 0 | No | not required |
| | Other States* | \$0-\$115 | Certified | 2 | High School - Special Training | State, National Exam | 0-24 | No-Yes | 16(IL,CA), 18(FL) |
| | Washington Rank | 4 | | 1 | 1 | | 3 | | |

| Professions | States | Application Fee** | Type of Credential | Renewal Period | Education Req. (degree) | Exam Required | CPE Req. (per year) | Experience Req. | Min. age required |
|---|------------------------|-------------------|--------------------|----------------|--|--|---------------------|-----------------|-----------------------|
| Registered Nurse Assistant ^{b)} | Washington | \$15 | Registered | 1 | No education required | Complete state training program and exam | 0 | No | not required |
| | Other States* | NA | NA | NA | This profession is not regulated in the other 9 states, therefore cannot be ranked | | | | |
| | Washington Rank | | | | | | | | |
| Osteopathic Physician & Surgeon | Washington | \$650 | Licensed | 1 | Special Training | National Exam | 50 | Yes | not required |
| | Other States* | \$200-\$805 | Licensed | 1-3 | Special Training | State, National Exam | 0-50 | Yes | not required |
| | Washington Rank | 8 | | 1 | 1 | | 1 | | |
| Physician | Washington | \$335 | Licensed | 2 | Special Training | National Exam | 50 | Yes | not required |
| | Other States* | \$200-\$805 | Licensed | 1-3 | Special Training | National, State, & English Prof. Test | 0-50 | No-Yes | 21 years old (CO, NY) |
| | Washington Rank | 4 | | 2 | 1 | | 1 | | |
| Registered Nurse | Washington | \$70 | Licensed | 1 | Special Training | National Exam | 0 | Yes | not required |
| | Other States* | \$30-\$150 | Licensed | 2-4 | Associate - Special Training | National, English Prof. Test. | 0-15 | No-Yes | 18 years old (NY) |
| | Washington Rank | 4 | | 1 | 1 | | 7 | | |
| Sex Offender Treatment Provider ^{c)} | Washington | \$500 | Certified | 1 | Master | State Exam | 20 | Yes | not required |
| | Other States* | \$0-\$308 | Reg - Cert - Lic. | 1-3 | Bachelor - Master | State Exam, National Exam | 0-13 | Yes | not required |
| | Washington Rank | 5 | | 1 | 1 | | 1 | | |

* Other states include: Arizona, California, Colorado, Florida, Illinois, New York, Texas, Utah, and Virginia. The number provided is the range applied to these states.

** Application fee only covers initial application (does not include exam fees).

a) Profession is not regulated in 1 state: Virginia

b) Profession is not regulated in the other 9 states :AZ, CA, CO, FL, IL, NY, TX, UT, VA

c) Profession is not regulated in 5 states: AZ, CA, FL, IL, NY

Ranking order: Application fee - lowest to highest fee

Renewal Period - shortest to the longest period

Education Requirement - highest to the lowest level of education (Special Training = highest level; no education = lowest).

Special training includes advanced or specialized training program, e.g. medical school, dental school, or state approved training

CPE Requirement – Most to the least number of CPE hours required.

Appendix I - Comparison list of private companies offering national criminal background check services

| Entity Name | Coverage (Type of Information) | Source of Information | Response Time | Cost/Fee per Search |
|---|---|---|---|--|
| Criminal Record Search (Employment Screening Resources) http://www.esrcheck.com/services/services_detail.php | National Criminal Record (Felony and misdemeanor convictions and pending cases, usually including date and nature of offense sentencing date, disposition and current status) at least seven years back. | Federal court record and central courthouse. | Instant | Full services packages are priced at \$99.00 to \$149.00 |
| Nationwide Criminal Records search (Info Cubic LLC) http://www.criminal-records-search.com/nationwidecriminalrecords.htm | Nation-wide | Criminal Database search can come from statewide repositories, local county information, Corrections Departments, sex offender registries and Administration of Courts records | Results will be sent by e-mail in a matter of hours | \$39.95 |
| The Criminal Record Database (Pacific Information Resources, Inc) http://premium.searchsystems.net/index.php | Each database contains felony convictions; some also contain misdemeanors and/or traffic violations. | Databases are acquired from government agencies and are updated on a regular basis. Washington Courts and Corrections Court records of felony and misdemeanor dispositions from all county superior courts since 1997, updated quarterly. Corrections records of statewide felony and gross misdemeanor criminal convictions and guilty pleas since 1988, updated monthly | Immediate results | \$29 |
| CriminalWatchDog.com http://www.criminalwatchdog.com/# | Includes: All available statewide criminal and sex offender databases. At no additional cost this search includes: Sexual predator data from 50 states, FBI Most Wanted, US Marshals, DEA, ATF, Customs, US Secret Services and America's Most Wanted. Offender Photos now available with many records decisions. | <ul style="list-style-type: none"> • court systems • Corrections Departments • law enforcement • sex offender registries • other related state, county and municipal agencies | Instant | \$18.95 |

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|--|---|--|--|---|
| <p>ChoicePoint National Criminal File http://www.screenow-cc.com/</p> | <p>Nationwide: convictions for murder, kidnapping, rape, arson and drug trafficking. Records data file updated every 30, 60, 90, 180 days based on record repository schedules. New CP proprietary records added daily – an average of 22,000 criminal record searches are conducted daily by CP and all identified criminal records are added to the National Criminal data file.</p> | <ul style="list-style-type: none"> • Federal Fugitive files • Department of Corrections prison, parole and release files • Administrative Office of Courts records • State criminal record repositories • ChoicePoint proprietary information • Prison parole and release files • Records from other state agencies <p>Sex Offender Registries - 34 states and the District of Columbia (AL, AK, AR, CA, CO, CT, DC, DE, FL, ID, IL, IA, KS, KY, LA, ME, MD, MI, MN, NE, NH, NJ, NM, NY, NC, ND, OH, RI, SC, TN, TX, UT, VT, WV, and WY).</p> | <p>On-site, same-day research capabilities at almost every court, legislature and agency in the country.</p> | <p>\$25.00/search (but can bargain for volume sales.)</p> |
| <p>Instant Criminal Checks http://www.intelius.com/search-name.php?searchform=criminal1 https://www.intelius.com/search-faq.php#27</p> | <p>Nationwide: felony, misdemeanor, federal, & county offenses.</p> | <p>Variety of different public records sources from data partners. However, some of the sources are courthouses, county and other government offices. These offices can be slow to update public information.</p> | <p>Instant</p> | <p>\$49.95</p> |
| <p>Nationwide Criminal Records and Sex Offenders Database (Background Check Systems, Inc) http://www.background-checks-systems.com/nationwide_criminal_database_searches.htm</p> | <p>Nation-wide.</p> | <p>Department of Correction, Courts, Administrative Office of the Courts, sex and violent offender lists.</p> | <p>Instant</p> | <p>\$49.95</p> |

| | | | | |
|--|--|--|--|--|
| <p>PC Instant People Check http://www.instantpeoplecheck.com/</p> | <p>Search national and local criminal records directly from most statewide records.</p> | <p>Databases are maintained and updated regularly from information submitted by the courts and other criminal justice agencies.</p> | <p>Instant</p> | <p>\$29.95/search (regular price) \$4.00/search (for more than 300 searches). \$0.95/search for 20,000-30,000 \$0.25/search for 300,000</p> |
| <p>Sentry Link http://www.sentrylink.com/web/loadCriminalReport.do</p> | <p>A comprehensive criminal check showing felonies, misdemeanors, sex offenses and more at the state and county levels.</p> | <p>Information contained in and re-sold by SentryLink LLC is compiled from public records obtained from state and local government offices and may not be 100% complete or accurate.</p> | <p>Instant (in 60 seconds)</p> | <p>\$19.95</p> |
| <p>Live National Criminal Records (may contains all type of disposition). http://www.querydata.com/about.htm</p> | <p>Court Records, Sex Offender lists, and Department of Correction record from 47 states.</p> | <p>The information is hand searches. Query Data has "Bonded" record retrievers in all counties in every state in the country for access to Criminal and Civil records.</p> | <p>Query Data is available with an average turnaround of 24 hrs.</p> | <p>\$12.95</p> |
| <p>Check Criminal database www.checkcriminal.com</p> | <p>Information including: Felonies, Misdemeanors, Sexual Offenses, Court Info, Case Number, Offense, Offense Date, Offense Code, Disposition Date, Name, Date of Birth and Gender.</p> | <p>Search accesses an industry leading 345 local agencies (police Departments, Department of corrections and various courts) throughout the U.S. The criminal data is updated either daily, monthly or quarterly depending on the state.</p> | <p>Instant</p> | <p>\$16</p> |

| | | | | |
|--|---|---|---|--|
| <p>Certified Background Services, Inc. https://www.criminalcbs.com/</p> | <p>50 states nationwide criminal and sex offender.</p> | <p>Database covers all 50 states for Felony, Misdemeanor, Sexual Offender and Predator. Using City, State and Federal databases.</p> | <p>Instant – results are archived for 5 days.</p> | <p>\$13 Discount rates (all searches must be conducted at the same time):</p> <ul style="list-style-type: none"> • 25-99 searches - \$12/search • 100-499 searches - \$11/search • 500+ searches - \$10/search |
| <p>National Criminal Record Public Registry (NCRPR) https://www.ncrpr.org/</p> | <p>Searches check for Felony, Misdemeanor, Sex Offender and other criminal offense records.</p> | <p>Search from an industry leading 345 criminal database sources throughout the U.S.</p> | <p>Instant</p> | <p>\$34.95/search \$5.95/search for 20,000-40,000 (1,666 - 3,333/mo) \$3.85/search for 300,000 in single batch</p> |
| <p>National Criminal Background Check http://www.backgroundferret.com/</p> | <p>National: County Court, Correction records, and sex offender records.</p> | <p>Includes a search of more than 175 criminal public record and proprietary databases containing a combined total of more than 200 million criminal records.</p> | <p>Results returned by email within 4 hours if ordered between 9am - 4pm Eastern Time, excluding holidays</p> | <p>\$34.95</p> |
| <p>Intelius http://www.intelius.com/</p> | <p>State-wide and nation-wide criminal checks from public records. Criminal checks include felony, misdemeanor, federal, & county offenses.</p> | <p>Public records.</p> | <p>Instant</p> | <p>\$19.95/ state-wide search \$49.95/ nation-wide search \$6.50/search for 20,000-30,000</p> |

Appendix J

Sanctions Imposed That Were Not Consistent with Guidelines

| Violation/Conduct | Sanction Imposed | Comments |
|--|--|---|
| <p>Respondent issued multiple narcotic pain medication prescriptions for Patient A. During this time, Patient A, a physician who had previously been Respondent's physician sponsor, also issued narcotic pain medication prescriptions for Respondent. Respondent did not sufficiently document his encounters with Patient A in the patient chart</p> | <ul style="list-style-type: none">• Respondent shall successfully complete the online self study course entitled "Practice Protection: The Principles of Risk Management"• Provide copies of chart notes pertaining to any patient encounters with Patient A occurring within 1 year of the effective date of STID• Within 90 days submit paper with no less than 1000 words, with references, regarding the ethical issues raised by dual relationships in the medical setting; pay \$1000 for administrative costs incurred in this case within 90 days. | <p>Substance abuse matrix, tier 2 is misuse of drugs or alcohol with a risk of patient harm. The minimum sanction is probation or suspension for 2 years. There were also several aggravating circumstances to this case: number of events and inappropriate use of prescription drug.</p> <p>Stipulation to Informal Disposition signed by panel chair on October 11, 2006</p> |

Respondent performed a laparoscopic oophorectomy on Patient A. Respondent's laparoscopic procedure resulted in perforation of the small bowel. This is a rare but recognized complication of this procedure. Respondent was not aware of the complication at the time of discharge. Respondent's system of follow-up contact with the patient during the first post operative hours was insufficient to learn of the patient's signs of distress in time to effect life saving repair surgery.

Respondent failed to appropriately treat a sickle cell crisis in Patient A. Patient A suffered significant, permanent neurologic injury.

- Respondent shall submit a paper of no less than 1000 words within 90 days on trochar injuries related to endoscopic procedures and response systems for bowel, ureteral, or bladder injury.
- Within 90 days, submit a policy regarding post-operative follow-up on outpatient surgery patients, and a plan for, or description of, the implementation of this policy.
- Pay \$1000 for the administrative costs incurred in this case.
- Submit paper of no less than 1,000 words, with references, regarding current recommendations for prevention and treatment of stroke in pediatric sickle cell patients.
- Reimburse costs to the Commission in the amount of \$1000 within 90 days.

Sanction does not appear to be appropriate because per sanction guidelines, the sanction range for practice below standard with patient harm is probation or suspension for 2 years to suspension for 7 years to revocation.

Stipulation to Informal Disposition signed by panel chair on November 22, 2006

Per the sanction guidelines for practice below the standard with significant patient injury, the range is suspension for 5 years to indefinite suspension or permanent revocation.

Stipulation to Informal Disposition signed by panel chair on August 24, 2006

Appendix K

Bibliography - Practices in Other Jurisdictions

Finding 2: Credentialing:

Practice 1:

- http://www.azbn.gov/documents/applications/RN_LPN%20Exam%20Packet.pdf
- Interview with Executive Director of Texas Board of Dental Examiners on March 20, 2007

Practice 2:

- <http://www.cno.org/reg/nonmemb/applying.html>
- <http://www.dora.state.co.us/registrations/Affidavit-Eligibility.pdf>
- http://www.bomex.org/license/Application_MD_license.pdf

Practice 3:

- http://www.azbn.gov/documents/applications/RN_LPN%20Exam%20Packet.pdf
- www.cgfns.org
- <http://www.op.nysed.gov/nursing.htm>

Practice 4:

- <https://www.bne.state.tx.us/disciplinaryaction/imposteralert.html>
- <http://www.azmd.gov/>
- <http://www.azbn.gov/Disciplinelmposters.asp>
- Interview with Manager of College Nurses of Ontario (CNO) on April 3, 2007

Practice 5:

- www.fsmb.org

Practice 6:

- www.ncsbn.org

Practice 7:

- Interview with Licensing Administrative Assistant of Virginia Board of Dentistry on March 26, 2007
- Interview with Administrative Assistant of Virginia Board of Counseling on March 26, 2007
- Interview with Office Manager of Virginia Board of Nursing on April 2, 2007

Practice 8:

- www.dopl.utah.gov

Practice 9:

- <http://www.azpaboard.org/Regulatory/PAStatutes/>

Practice 10:

- http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=Ch0456/ch0456.htm

Finding 3: Criminal Background Checks

Practice 1:

- Interview with Executive Director of Texas Board of Dental Examiners on March 20, 2007

Practice 2:

- Interview with Executive Director of Texas Board of Dental Examiners on March 20, 2007

Practice 3:

- Interview with Executive Director of Texas Board of Dental Examiners on March 20, 2007

Practice 4:

- http://www.dopl.utah.gov/licensing/licensing_fees.html
- <http://www.azbn.gov/AgencyFees.aspx>

Practice 5:

- <http://www.dora.state.co.us/electrical/forms/ELECreapplication.pdf>

Practice 6:

- <http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/32/03280.htm&Title=32&DocType=ARS>

Practice 7:

- <http://www.tbce.state.tx.us/>

Practice 8:

- See Appendix I

Practice 9:

- See Appendix I

Practice 10:

- See Appendix I

Finding 4: Complaint Management:**Practice 1:**

- Interview with Midwifery Program Director of Professional Licensing Certification Unit Department of State Health Services on April 13, 2007

Practice 2:

- Interview with Executive Director of Texas Board of Dental Examiners on March 20, 2007

Practice 3:

- Interview with Executive Director of Arizona Board of Medicine on April 6, 2007

Practice 4:

- http://www.dopl.utah.gov/investigations/complaint_process.html

Practice 5:

- http://www.mbc.ca.gov/Complaint_Info.htm

Practice 6:

- <https://www.idfpr.com/dpr/FILING/Complaint.asp>
- <http://www.dopl.utah.gov/investigations/complaint.html>

Finding 6: Investigations

Practice 1:

- <http://aspe.hhs.gov/daltcp/reports/2006/stdiscp.htm>

Practice 2:

- <http://www.aimmembers.org/aimmembers/>

Practice 3:

- http://www.dhp.state.va.us/dhp_guidelines/Guid Doc 76-13.1.doc

Practice 4:

- Interview with Executive Director of Arizona Board of Medicine on April 6, 2007

Practice 5:

- http://www.mbc.ca.gov/Expert_Reviewer.htm

Finding 7: Disciplinary (Legal)

Practice 1:

- www.azmd.gov

Practice 2:

- http://www.health.state.ny.us/nysdoh/opmc/annual/anrpt2002_2004.htm

Practice 3:

- <http://www.dhp.state.va.us/dentistry/guidelines/60-2%20Sanction%20reference%20pts.pdf>

Practice 4:

- http://www.dhp.state.va.us/Enforcement/enf_guidelines.htm

Practice 5:

- https://www.ncsbn.org/Vol8_CORE_revised.pdf

Finding 8: Compliance

Practice 1:

- Interview with the Director of Enforcement of the Texas Board of Chiropractor Examiners on April 11, 2007.

Practice 2:

- <http://www.tmb.state.tx.us/>

Finding 9: Management Oversight

Practice 1:

- <http://www.sao.state.tx.us/Resources/Manuals/prfmguide/guide2006.pdf>

Practice 2:

- <http://aspe.hhs.gov/daltcp/reports/2006/stdiscp.htm>

Finding 10: Internal Audit

Practice 1:

- <http://gao.gov/govaud/ybk01.htm>

Practice 2:

- <http://www.legis.state.tx.us/tlodocs/77R/billtext/html/HB00609F.htm>

Appendix L Criteria

Finding 1: Performance-Based Operating Agreements

Revised Code of Washington 43.70.240, *Written Operating Agreements*, states, “The secretary and each of the professional licensing and disciplinary boards under the administration of the department shall enter into written operating agreements on administrative procedures with input from the regulated profession and the public. The intent of these agreements is to provide a process for the department to consult each board on administrative matters and to ensure that the administration and staff functions effectively enable each board to fulfill its statutory responsibilities. The agreements shall include, but not be limited to, the following provisions:

- (1) Administrative activities supporting the board's policies, goals, and objectives;
- (2) Development and review of the agency budget as it relates to the board; and
- (3) Board related personnel issues.

The agreements shall be reviewed and revised in like manner if appropriate at the beginning of each fiscal year, and at other times upon written request by the secretary or the board.”

Executive Order 05-02 Government Management, Accountability and Performance (GMAP) directs agencies to develop a performance management system that includes clear, relevant performance measures that show whether or not programs are successful.

Finding 2: Credentialing:

Statutes and rules do not consistently require that a credentialed health care professional be at least 18 years of age to issue a credential except for two professions: midwifery (Title 18.50 RCW (age 21)), and dispensing opticians (Title 18.34 RCW). The intent of requiring a credential health care professional to have achieved legal age of majority is intended to better protect the public.

Finding 3: Criminal Background Checks

RCW 43.43.825 (1)(2), When the state patrol receives information that a person has pled guilty to or been convicted of one of the felony crimes involving homicide, assault, kidnapping, or sex offenses, the state patrol shall transmit that information to the Department of Health.

- (1) Upon a guilty plea or conviction of a person for any felony crime involving homicide under chapter [9A.32](#) RCW, assault under chapter [9A.36](#) RCW, kidnapping under chapter [9A.40](#) RCW, or sex offenses under chapter [9A.44](#) RCW, the prosecuting attorney shall notify the state patrol of such guilty pleas or convictions.
- (2) When the state patrol receives information that a person has pled guilty to or been convicted of one of the felony crimes under subsection (1) of this section, the state patrol shall transmit that information to the Department of health. It is

the duty of the Department of health to identify whether the person holds a credential issued by a disciplining authority listed under RCW [18.130.040](#), and provide this information to the disciplining authority that issued the credential to the person who pled guilty or was convicted of a crime listed in subsection (1) of this section.

[2006 c 99 § 8.]

It is the duty of the Department of Health to identify whether the person holds a credential issued by a disciplining authority, and provide this information to the disciplining authority that issued the credential to the person who pled guilty or was convicted of a crime.

1. Use the federal government database for national background checks through National Crime Prevention and Privacy Compact (Compact).

The Department of Justice's Federal Bureau of Investigation (FBI) maintains the National Crime Information Center (NCIC). Information in the NCIC is obtained from local, state, federal and international criminal justice agencies. The Compact provides an electronic information sharing system among the federal government and the states to exchange criminal history records for purposes authorized by Federal or State law, such a background checks for governmental licensing and employment (Title 42, Chapter 140, Subchapter II, §14616). Under this Compact, FBI and the state agree to maintain detailed databases of their respective criminal history records, and to make them available to the federal government and state for authorized purposes. The rationale is that health care professionals are inherently mobile populations that have access to vulnerable populations. With recent shortages and active recruitment for health care professionals, there is evidence that some people entering the health care occupations have criminal histories and some of these crimes (especially theft) have high recidivism rates.

The state's Joint Task Force on Criminal Background Check recommended ratifying the Compact. As of May 8, 2006, 27 states have joined the Compact and 10 more states have memorandums of understanding to implement the process. Having access to information from multiple states could prevent people with criminal backgrounds outside Washington from getting licensed. The Washington State Patrol would serve as the state Compact officer once the Compact is adopted.

In order to implement this recommendation, the Department must to have statutory authority to access federal records. The Department of Justice has developed criteria based on Public Law 92-544 for approving state statutes:

- The statute must exist as a result of a legislative enactment.
- It must require that applicants be fingerprinted.
- It must, expressly or by implication, authorize the use of FBI records for screening applicants.
- It must identify the specific category(ies) of licensees/employees falling within its purview, thereby avoiding overbreadth.
- It must not be against public policy.
- It must not identify a private entity as the recipient of the results of the record check.

The U.S. Department of Justice requires fingerprints in order to use the FBI database. The Department of Health has researched the cost of purchasing a live-scan fingerprinting machine, but found the cost prohibitive. We recommend it further research the possibility of sharing the cost with other health agencies. HPQA should also consider working with the legislature to be appropriated the needed funds as a capital expense. HPQA should also consider obtaining authority to assess a fee to each credential holder to cover the cost of the background check.

Finding 4: Complaint Management:

HPQA Procedure 209 entitled *HPQA Disciplinary Database Entries* details instructions for inputting dates into ASI and HTTS throughout the disciplinary process.

209.3A-209.3D details complaint receipt procedures and

209.4A-209.4D details investigation procedures.

209.3A, states "...new complaint data must be entered within 5 working days of receipt of the complaint".

209.3B states, "the date stamp appearing on the complaint is the "start" date, and appears as the complaint date in the data systems" when entering new complaint data,

209.3C states, "the date of the closure decision (CMT meeting date of Board/Commission decision date) not the date of the closure letter, is the end date for the intake step. The closure letter must occur within 5 working days of the decision".

209.3D states, "The date the investigation unit received the request is the start date. The investigator assignment must occur within three working days of receipt of the case."

209.4 is followed when the investigation is complete.

209.4A describes the case disposition start date in HTTS as the date the program received the investigation report.

209.4B states, "The date of the decision (CMT meeting date of Board/Commission decision date) is the end date for the case disposition step." The procedure step goes on to state closure letters must occur within five working days of the decision.

According to the HTTS user manual, when users are logged into HTTS, a drop down box exists where the complaint type/code is to be entered. This drop down box provides all the available code numbers along with a brief two to five word description of each code. Users choose the code that best fits the complaint based on the description provided in that box. The same is true for closure codes. A brief description of each code is provided. This code is determined at the case management team meetings, as a group.

246-14-040 WAC, *Initial Assessment of Reports*, states that a decision must be made to investigate complaints or close prior to investigation within 21 days from initial receipt of the complaint. If the complaint pertains to a Board/Commission profession, a recent court ruling from the Court of Appeals, A& B v. Yoshinaka , requires board/commission panels to review incoming complaints to determine whether to authorize investigation. The prior practice was for HPQA staff to review and authorize investigation based on guidelines provided by the board/commission. The case resulted in HPQA adopting a new procedure that mandated an authorization sticker to be signed by a member of the Board/Commission authorizing panel. An acceptable alternative is an email or fax from a member of the authorizing panel. As a result, intake/assessment personnel must copy the complaint, send this to the panel for review, and then wait for the panel to send back the signed authorization before the case can be transferred to investigations.

HPQA Procedure 205, *Case Disposition Decisions*, outlines guidelines for determining if a case is within the jurisdiction of the Department of Health. The guidelines also help to determine if a violation has been determined per the complaint, or if the complaints is below threshold criteria. Secretary professions are required to follow this procedure; the procedure is recommended for Board/Commission use. The case disposition guidelines provide “ a criteria and framework for the consistent identification of complaints that fall below the threshold level established by the statutory mandated disciplining authorities” (Pages 4-7 in particular relate to complaint assessment). These guidelines are mandatory for Secretary Professions and certain Boards/Commissions. Furthermore, HPQA Procedure 212, *Imminent Danger Cases*, provides steps to take to determine if a complaint is to be classified as imminent danger.

HPQA Procedure 212.1B defines imminent danger as “...when there is a serious risk of imminent adverse impact to the public health, safety, or welfare. Imminent danger reports require immediate action and may lead to summary action such as suspension, limitation, or restrictions of a practitioner’s credential.”.

HPQA Procedure 205, *Case Disposition Decisions*, case disposition guidelines state that “single or non-pattern complaints with little or no patient harm” can be closed below threshold. The only way to determine if a provider has repeated complaints is to research prior complaints to determine if a pattern is occurring.

Organizations should have formal, standardized training for employees. Employees should have access to policies and procedures to provide accurate information to perform their jobs. If desk manuals are used for this purpose, the manuals should be readily available to provide detailed procedures for completing common tasks.

Employees should also be cross-trained so that when employees are sick or on vacation, the work is not left undone until the employee returns.

Finding 5: Public Education

Pew Health Professions Commission “Reforming Health Care Workforce Regulation *Policy Considerations for the 21st Century*. Report on the Taskforce Health Care Workforce Regulation” , December 1995. p. 30, discusses the problem that consumers often do not know where to turn when they have problems with a licensed health professional. The report recommends that states should “Make public access to the complaints and discipline process simple and clear, Information about filing a complaint, the standards by which a complaint is judged, investigation procedures, discipline, and appeals should be explained in a manner that is simple and clear.” Also (p.. 20) the report identifies public information outreach efforts by the Medicare Peer Review Organizations’ outreach programs, including: printed brochures, targeted presentations, citizen advisory groups, public service announcements, and toll-free numbers.

“What Makes a Good Web Site – IPN Survey: Web Site Design Criteria”
[hppt://www.tbchad.com/ipngweb.html](http://www.tbchad.com/ipngweb.html)

Finding 6: Investigations

According to the HPQA webpage, the mission statement of the Health Professions Quality Assurance division of the Department of Health is to “Protect and enhance the health of the people of Washington State by assuring access to safe, competent health care providers.” One of the ways this is accomplished is by “Ensuring only qualified

people provide services” to the public. If a health care provider is jeopardizing his or her ability to protect the public, HPQA initiates an investigation against that particular individual. It is therefore the responsibility of HPQA to provide thorough, complete investigations from which to draw conclusions regarding the practitioner in question

246-14-050 WAC states that the basic time period for investigation

(1) Investigation is the process of gathering information which examines the complaint and the situation surrounding the complaint.

(2) The basic time period for investigation is one hundred seventy days.

[Statutory Authority: RCW [18.130.095](#)(1). 00-10-114, § 246-14-050, filed 5/3/00, effective 7/2/00.]

HPQA has several internal goals in relation to investigation timelines: completing priority one cases within 30 days, priority two cases within 60 days and priority three cases within 170 days.

RCW 18.130.095, Uniform Procedural Rules states, “A licensee must be notified upon receipt of a complaint, except when the notification would impede an effective investigation.” The investigator shall inform such persons in writing of, “The nature of the complaint; that the person may consult with legal counsel at his or her expense prior to making a statement; and that any statement that the person makes may be used in an adjudicative proceeding conducted under this chapter”.

Organizations should have formal, standardized training for employees. Desk Manuals should be present to provide detailed procedures for completing common tasks.

Finding 7: Disciplinary (Legal)

Organizations should have formal, standardized training for employees. Desk manuals should be present to provide detailed procedures for completing common tasks. Employees should also be cross-trained so that when employees are sick or on vacation, the work is not left undone until the employee returns.

Basis for Action Codes are the data reporting description from the Healthcare Integrity and Protection Data Bank (HIPDB). The RCW 18.130.180 violations found under the Conclusions of Law on the order or stipulation to informal disposition (STID) determine which Basis for Action Code should be reported on Washington Department of Health’s Provider Credential Search webpage. If there is more than one violation listed under the Conclusions of Law, the most egregious violation is chosen for the Basis for Action.

246-10-204(1) WAC states “...if a party fails to respond to initiating documents according to WAC 246-10-203, that party will be deemed to have waived the right to a hearing, and the secretary shall enter a final order without further contact with that party.”

RCW 34.05.440(1): “Failure of a party to file an application for an adjudicative proceeding within the time limit or limits established by statute or agency rule constitutes a default and results in the loss of that party's right to an adjudicative proceeding, and the agency may proceed to resolve the case without further notice to, or hearing for the benefit of, that party, except that any default or other dispositive order affecting that party shall be served upon him or her or upon his or her attorney, if any.”

246-14-090 (1) WAC, "Procedures for adjudication of statement of charges are contained in chapters 246-10 and 246-11 WAC. Those rules provide for twenty days to file an answer, with a sixty-day extension for good cause..."

DOH HPQA *Sanction Guidelines* developed by the Secretary of Health to determine the appropriate sanction relative to the conduct of the respondent.

To date, the *Sanction Guidelines* have been adopted by the Secretary for all the professions she regulates and by nine boards and commissions: Dental Quality Assurance Commission, Board of Hearing and Speech, Nursing Care Quality Assurance Commission, Board of Nursing Home Administrators, Board of Occupational Therapy Practice, Board of Osteopathic Medicine and Surgery, Board of Pharmacy, Board of Physical Therapy, and Examining Board of Psychology. The Optometry and Podiatric boards are testing the use of the revised guidelines. The Medical Quality Assurance Commission and the Veterinary Board of Governors will decide whether or not to adopt the guidelines Summer 2007. The Chiropractic Quality Assurance Commission has opted to continue using guidelines adopted prior to the Secretary's guidelines availability.

RCW 18.130.040 authorizes certain boards and commissions disciplinary authority and RCW 18.130.050 provides authority for the Secretary, boards and commissions. The Secretary does not have the authority to require the boards and commissions to adopt the guidelines.

Finding 8: Compliance

HPQA Procedure 262 states that compliance officers should:

- Determine the type of reports due and who must submit them
- List the type of reports due and the due dates on the compliance worksheet
- Record received reports on the compliance worksheet, and
- Place all reports received in the compliance file.

HPQA Procedure 262.1 requires:

"Program staff should establish a compliance file for each practitioner subject to conditions or terms of a final order or stipulation to informal disposition (STID)."

"The file, at a minimum includes:

- Copy of the initiating document (Statement of Allegations or Statement of Charges)
- Copy of the original signed order or STID
- Compliance requirement summary worksheet that contains key elements and
- Credential demographic screen."

HPQA Procedure 262.3 states "that legal proceedings, rather than a compliance appearance, should be initiated if there is any reason to believe that a respondent is not in compliance with the order or STID.

HPQA Procedure 262.3A indicates: If the disciplinary authority finds the respondent is not in compliance with the order or STID, the case should follow established legal procedures to:

- Initiate a hearing on motion for failure to comply
- Refer to collection
- Issue a Statement of Charges.

HPQA Procedure 262.4A-C states that if a respondent fails to meet the terms of an order or STID by the due dates set forth in the order, staff send a reminder letter to the respondent. The reminder letter is sent no later than 30 days after the due date. This letter identifies:

- The missing items
- The respondent's failure to perform required tasks
- A deadline for submitting the required information

Finding 9: Management Oversight

The Revised Code of Washington (RCW) 43.17.385 includes the provisions that agencies shall ensure their performance system includes 1) "clear, relevant, and easy-to-understand measures for each activity"; 2) "gathers, monitors, and analyzes activity data"; and 3) "uses the data to evaluate the effectiveness of programs to manage process performance, improve efficiency, and reduce costs". The performance system is defined in RCW 43.17.380 as an "integrated, interdisciplinary system of measures, tools, and reports used to improve the performance of a work unit or organization".

Executive Order 05-02, Government Management, Accountability And Performance (GMAP) includes requirements of each agency to 1) develop clear, relevant and easy-to-understand measures that show whether or not programs are successful, to 2) gather, monitor, and analyze program data, and 3) base decisions on accurate, up-to-date information.

- The Performance Management Collaborative consists of a seven state core including Illinois (lead state), Missouri, West Virginia, New Hampshire, New York, Alaska, and Montana. Five additional partners include the Association of State and Territorial Health Officers, the National Association of County and City Health Officials, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Association of State and Territorial Local Health Liaison Officials. The Performance Management Collaborative defines performance management as the: "...practice of actively using performance data to improve the public's health. This practice involves strategic use of performance measures and standards to establish performance targets and goals, to prioritize and allocate resources, to inform managers about needed adjustments or changes in policy or program directions to meet goals, to frame reports on the success in meeting performance goals, and to improve the quality of public health practice."

Texas State Auditor's Office, Guide To Performance Measure Management, 2006 Edition. Definitions of measures:

- Outcome Measure - A quantifiable indicator of the public and customer benefits from an agency's actions
- Output Measure - A quantifiable indicator of the number of goods or services an agency produces
- Efficiency Measure - A quantifiable indicator of productivity expressed in unit costs, units of time, or other ratio-based units
- Explanatory/Input Measure - An indicator of factors, agency resources, or requests received that affect a state entity's performance.

Finding 10: Internal Audit Function

Institute of Internal auditors, “internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.”

The International Standards for the Professional Practice of Internal Auditing (Standards) provide guidance for the conduct of internal auditing. Standard 2030, Resource Management, states that the “chief audit executive should ensure that internal audit resources are appropriate, sufficient, and effectively deployed to achieve the approved plan.”

Practice Advisory 2030-1: Resource Management provides an interpretation of Standard 2030 from the Internal Standards for the Professional Practice of Internal Auditing. It states, “internal auditors should consider the following suggestion when evaluating internal audit resources. This guidance is not intended to represent all the consideration that may be necessary during such an evaluation, but simply a recommended set of items that should be address...Staffing plans and financial budgets, including the number of auditors and the knowledge, skills, and other competencies required to perform their work, should be determined from engagement work schedules, administrative activities, education and training requirements, and audit research and development effort.”

Standard 2230, Engagement Resource Allocation, states “internal auditors should determine appropriate resources to achieve engagement objectives. Staffing should be based on an evaluation of the nature and complexity of each engagement, time constraints, and available resources.” Financial budgets, including the number of auditors and the knowledge, skills, and other competencies required to perform their work, should be determined from engagement work schedules, administrative activities, education and training requirements, and audit research and development effort.”

Standard 2230, Engagement Resource Allocation, states “internal auditors should determine appropriate resources to achieve engagement objectives. Staffing should be based on an evaluation of the nature and complexity of each engagement, time constraints, and available resources.”

SAAM 20.20. Internal Control Policies describes the requirements, responsibilities, and activities of internal control function for Washington state government agencies .

Finding 11: IT Legacy Systems

The Network and Web Server Security Policy, Washington Department of Health, Section C, “Hardening Servers” requires that:

- I. “System software shall be removed or upgraded prior to a vendor dropping support.
 1. The Technology Resource Manager and each division/program senior IT Manager shall ensure a migration plan for removing or upgrading OS systems and Web Software is established and documented in the agency change management system.”

The Access Control Security Standards, Washington Department of Health, requires that:

A. "General Access

- I. DIRM and agency divisions/programs shall implement appropriate access security measures to safeguard DOH IT resources against unauthorized access.
 1. Access security shall be set at an appropriate level to minimize security risks, meet data classification requirements and to ensure the availability of data, as defined by agency business requirements. All access security methods must meet agency technology standards.
 2. The IT Security Officer (ITSO) shall perform ongoing assessments of DOH access control methods and procedures to ensure compliance with these standards.
- II. Access to DOH networks shall be administered by DIRM
 1. DIRM and each division/program shall assign one or more qualified IT Service Administrators (ITSA). The ITSA shall be responsible to oversee the day-to-day running and security of the division/program network systems and for ensuring that all assigned network servers are secured against unauthorized access attempts.
 - a) This responsibility shall be given only to reliable, trusted employees who have demonstrated responsible ownership and who fully understand the operation of the network.
 - b) Service administrators shall be completely familiar with agency policies regarding security and operations, and shall have demonstrated a willingness to enforce those policies
 2. The DIRM ITSA shall have administrative authority over all network systems and shall be responsible for the security configuration management of organizational units, users and computers.
 3. In the event of a malfunction, network access security systems shall default to a denial of access privileges. The systems or services they support must remain unavailable until such time as the problem has been rectified.
 4. Access to the state mainframe is administered by DIS and shall be coordinated through the IT Security Office.
- III. Access to IT resources shall be restricted unless authorized.
 1. Network user-IDs shall be requested in writing and approved by the user's immediate supervisor. Requests shall be submitted to the DIRM Technical Services using the [IT Security Request form](#).
 - a) Each user-ID shall be uniquely associated with a user. Permitted exceptions are user-IDs used for training purposes and program batch runs. The ITSO may approve exceptions when shared user-IDs are the only practical solution to a documented business need.

2. Network access shall be limited to the IT resources needed to permit users to accomplish assigned job duties.
3. Access to non public data shall be limited to users with a need-to-know and shall be authorized in writing by data owners. See the [Data Security Standards](#) for additional requirements.
4. Access can be authorized in two ways:
 - a) Explicitly (data owner (or the designated Data Steward) approval is required and must be documented)
 - b) Implicitly (The agency, division or program designates the data can be viewed by specific groups or roles.)
5. Types of users that may access DOH networks are as follows:
 - Administrators - Internal users responsible for network resources.
 - Privileged - Internal users with a need for greater access rights or permissions.
 - Users - Internal users with general access.
 - Others - External users with a need to access some resources
6. Access permissions, or user rights, may be granted on an individual or group/role basis. However, the maintenance of group/roles is more efficient and therefore, the assignment of individual permissions should be the exception.
 - a) Group/role permissions should be based upon organizational units and job functions. Specific access rights (or privileges) for each group or user must be included in the access control rules. Such records shall be considered confidential and shall be protected accordingly.

See the [Microsoft recommended Best Practices for Permissions and User Rights](#) for more information.

IV. Administrator accounts shall be strictly limited.

1. Administrator accounts shall be assigned to Information Technology staff whose job duties require administrative rights and shall only be used for the purpose of performing administrative functions.
2. Administrative accounts shall be configured so that the scope of authority is limited to the specific areas needed to perform assigned job duties.

See the Microsoft recommended [Best Practices for Delegating Active Directory Administration](#) for configuration guidance.

3. Two types of administrative responsibility shall be assigned: service management and data management.
 - a) Service administrators are responsible for maintaining and delivering the directory service. This includes managing the domain controllers and configuring the directory service.
 - i) Data administrators are responsible for maintaining the data that is stored in the directory service and on domain member servers.
4. Use of service administrator accounts shall be limited to changing the Active Directory service configuration and reconfiguring domain controllers.

5. Day-to-day administrative tasks, such as account and member server management, shall be delegated to data administrators.
Data administrators shall not be given the authority to modify service administrator accounts
 6. For each user who is assigned administrator functions, two accounts shall be created:
 - a) One regular user account to be used for normal tasks (such as email and browsing the internet); and
 - b) One administrator account to be used only for performing administrative tasks. This account shall not be email enabled or used for running applications that are used every day, such as Microsoft Office, or for browsing the Internet.
 7. Default Windows Administrator accounts shall not be used. Following are minimum steps that shall be followed to protect these accounts from compromise.
 - a) Rename the account
 - b) Change the description
 - c) Create a decoy account
 - d) Configure a complex pass phrase for the accountSee the Microsoft document [Securing Active Directory Administrative Groups and Accounts](#) for configuration guidance.
 8. The locations where administrative accounts can log on shall be restricted to specific administrator workstations.
See the Microsoft document [Strengthening Security on Service Administration Accounts and Groups](#) for configuration guidance.
- v. DIRM and/or each division/program shall ensure access privileges associated with user-IDs shall be suspended as follows:
1. Immediately for employees being terminated with cause.
 2. Within 3 working days for employees who voluntary terminate or transfer to another division or program
 3. Within 30 days for employees who remain within the program, but whose duties change
 - a) Those privileges that are no longer needed shall be identified and suspended or revoked.
 4. Accounts that have been inactive for 60 days or longer.

- vi. DIRM and/or each division/program shall ensure privileges and/or access to services and data that are no longer required are identified and disabled.

This includes, but is not limited to:

1. Database and application accounts, Blackberry and cell phone services, list serves and Fortress/Transact accounts; and
 2. The disposition of files stored on the network including home drive files and email accounts.
- VII. User-IDs shall be deleted after 180 days of inactivity.
1. At a minimum, the ITSA shall perform semi-annual review cycles and delete any user-ID that meets or exceeds the 180 days of inactivity.
- VIII. Adequate methods of authentication must control access to DOH IT resources.
1. Windows authentication is the minimum standard for general network access.
 2. Application authentication methods may include user-ID and password (such as Windows or SQL Authentication), digital certificates, smart cards and/or tokens (such as Secure ID).
 3. The level of authentication assurance required shall be based upon the confidential or classification level of the resource/information being accessed. See the [Data Security Standards](#) for specific requirements.

B. Password Standards

- I. Passwords must be hardened in accordance with ISB IT Security Standards.
 1. Passwords shall be a minimum of eight characters long and contain at least one special character and two of the following three character classes: upper case letters, lower case letters, and numerals.
 - a) Application and database owners shall provide guidance on creating hardened passwords for systems that limit the use of special characters.
 2. Passwords shall not contain the user's name or any part of their full name.
 3. Passwords shall be changed a minimum of every 120 days.
 4. Passwords shall be changed as soon as they expire with the limit of one grace logon.
 - a) User-IDs associated with batch runs are an exception to the above change requirement as these passwords never expire. Minimum lengths and composition are the same as above. (A batch user-ID has no services authorized.)
 5. After a maximum of five incorrect login attempts, accounts shall be locked for a minimum of 20 minutes or until administrator reset.
 - a) Network logon accounts or application accounts that access confidential or restricted information shall always require administrator reset.
 6. Password administration rules shall be systematically enforced.
 7. Passwords shall not be stored or transmitted in clear text.
 8. Exceptions must be documented, reported to the ITSO and approved by the CIO.
- II. Employees are accountable for any access to data and/or computer systems gained through the use of their user-ID and password combination.
 1. User-IDs and/or passwords shall not be shared. A user-ID shall not be used by anyone except the individual to whom it was issued.

2. The IT Security Officer (or designee) may perform password cracking or guessing on a periodic or random basis. If a password is guessed or cracked during one of these scans, the user will be required to change it.

E. Audit Trail

Audit trails collect records of network events by recording system or application processes and user activity. In conjunction with appropriate tools and procedures, audit trails provide a means to help accomplish several security-related objectives, including individual accountability, reconstruction of events, intrusion detection, and problem identification.

- III. To ensure adequate records are collected, reviewed and maintained, DIRM and each division/program shall establish and document procedures for authorizing, recording and monitoring of system access.

At a minimum the procedures shall establish processes that address:

1. Authorization

- a) The collection, maintenance and archival of records documenting who authorized the access, when and why.
- b) Review and adjustment, as necessary, of access control records to ensure each user/group/role has authorized access to the resources necessary to meet job requirements.

2. Recording and Monitoring

- a) The collection, review, maintenance, and archival of event logs; to include the user-ID, date, time, action and results.
- b) The extent of the details to be collected and the
- c) of review shall be based on the criticality of operation, risk factors and/or the classification or confidentiality of the information.
 - At a minimum, electronic audit trail records must record the user, date, time, action and results (i.e. successful or unsuccessful).
- d) Basic events to be collected and reviewed shall include:
 - Logon and Logoff
 - Successful and unsuccessful access attempts.
 - Additions, deletions, and changes to service administrator accounts, workstations, and policies
 - Use of administrative privileges
 - Account management
 - Event log management
 - Policy change.
- e) The review of event logs and activity shall include the reporting of access violations to the ITSO for further action, which may include one-on-one training with authority.”

Department of Health Naming Standards define the following conventions as acceptable naming conventions:

| Domain |
|-----------------|
| DOH (Internal) |
| DOHZ (DMZ) |
| DOHX (External) |
| DOHD (Dev Lab) |

| Application |
|--------------------|
| PRD (PHRED) |
| SHR (Shared) |
| PLN (Plone) |
| BB (Blackberry) |
| ACR (Acorde) |
| TTP (TestTrackPro) |
| CTX (Citrix) |
| |

| Function ID |
|---------------------|
| DB (Database) |
| AP (App) |
| WB (Web) |
| UT (Utility) |
| FL (File) |
| GC (Global Catalog) |
| MX (Exchange) |
| PR (Print) |
| UT (Utility) |
| X (Secure) |

| Location ID |
|-------------|
| TUM |
| SPO |
| KNT |
| PHL |

| Number ID |
|-----------|
| 01 |
| 02 |
| Etc |

| Environment |
|----------------|
| P (Production) |
| Q (QA) |
| D (DEV) |

The Network Security, Workstation Security Policy, Washington Department of Health , Section B, "Workstation Configuration" states that.

B. Workstation Configuration

- I. Workstation software and operating systems shall be configured and managed securely.
 1. [Agency standard](#) software and operating systems that incorporate the most current security patch updates must be installed before the workstation is deployed into the production environment.
 2. All systems shall have the [agency standard](#) anti-virus software installed and configured for effective operation prior to connecting to the network.

Finding 12: IT Disaster Recovery

Information Services Board Policy, IT Disaster Recovery and Business Resumption Planning Standards, Revised as of April 2002 requires all state agencies to have disaster recovery plans and to update them annually. The policy states:

“Each agency is responsible and accountable for its own disaster recovery/business resumption program. Agencies using external services shall coordinate their disaster recovery/business resumption plans with service providers.

The disaster recovery/business resumption plan is primarily for agency use. Agencies may adapt this standard to meet individual needs, but all applicable elements of the standard must be included in their plan. A disaster recovery/business resumption plan must contain enough information to enable agency management to assure the agency's ability to resume mission-critical

computing and telecommunications services and operations. A disaster recovery/business resumption plan may contain references to another organization's disaster recovery/business resumption plan, or to an agency's internal policy, standards, or procedures manual. The State Auditor may audit agency disaster recovery/business resumption plans and test results for compliance with policy and standards.

Agencies shall review, update, and test their disaster recovery/business resumption plans annually, or more frequently if appropriate. Agencies must update their plans whenever agency computing or telecommunications environments undergo significant changes. Such changes may include: physical facility, computer hardware/software, telecommunications hardware/software, telecommunications networks, application systems, organization, or budget.”

Finding 13: Physical Security

The Physical Security Standard, Washington Department of Health, Section A *“Data Centers, Computer Rooms and Telecommunication Facilities”* makes requirements for physical access to data centers and other facilities containing security sensitive information. Sensitive hard copy documentation should be subject to similar controls.

II. Facility access control

Physical access controls must be in place to restrict the entry and exit of personnel from any areas where computer and/or network equipment is located. This includes, but is not limited to, areas containing system hardware, wiring used to connect elements of the system, supporting services (electric power), backup media, and any other elements required for the system's operation.

1. Entrance to facilities housing equipment that provides critical services or stores confidential/restricted data shall be controlled via electronic access control with the capability of providing an audit trail.
 - a) An intrusion detection system shall be installed on the facility entrance.
 - b) CCTV surveillance cameras with time-lapse video recording will be provided whenever possible
 - c) Facility access control and intrusion detection systems will have Uninterrupted Power Supply (UPS) backup.

Appendix M

Department of Health and Office of Financial Management Response



STATE OF WASHINGTON

August 16, 2007

The Honorable Brian Sonntag
State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor Sonntag:

Thank you for this opportunity to formally respond to the performance audit of the regulation of health professions. Like Governor Gregoire, we strongly support the use of performance audits as an important tool to improve state government, which is why we worked closely with the Auditor's staff on this audit. We appreciate the level of commitment and professionalism of both your staff and the audit contractor, Clifton Gunderson, LLC.

Patient safety is the Department of Health's (DOH) first priority in credentialing and disciplining health practitioners. We agree with many suggestions in the audit report and have started implementing them. We appreciate the Auditor's acknowledgment that DOH had begun addressing major challenges before the audit was undertaken. Specifically, the audit recognized DOH has already been working on:

- Speeding action on disciplinary cases;
- Bringing more consistency to disciplinary sanctions;
- Adopting consistent sexual misconduct rules for all professions;
- Using national databanks and State Patrol conviction records to more thoroughly check the background of health care providers;
- Increasing punishments for serious infractions;
- Expanding public access to information on sanctions against their health providers; and
- Improving the department's information systems.

We have enclosed a joint response and action plan and will report our progress on completing these action items at the Governor's upcoming Government Management Accountability and Performance forums.

The report also makes several recommendations to the Legislature to strengthen the oversight of health care professionals. We look forward to working with the Legislature as it evaluates the audit and to receive the maximum possible benefit from the work of the Auditor's staff.

Sincerely,

Handwritten signature of Mary C. Selecky in black ink.

Mary C. Selecky, Secretary
Department of Health

Handwritten signature of Victor A. Moore in black ink.

Victor A. Moore, Director
Office of Financial Management

Enclosure

cc: Tom Fitzsimmons, Chief of Staff, Governor's Office
Joyce Turner, Deputy Chief of Staff, Governor's Office
Larisa Benson, Director, Government Management Accountability and Performance

**Official Response to the Performance Audit of Licensing of Health Care Practitioners
From Department of Health and Office of Financial Management
August 16, 2007**

This document was prepared in response to the final audit report delivered to the Health Professions Quality Assurance office (HPQA) at the Department of Health (DOH). We have provided a coordinated response for each finding from both the Department of Health and the Office of Financial Management (OFM). Our intent is that this organization will make it easier to copy and paste our response after the appropriate finding section in the report.

Finding 1: The state’s governance structure involving HPQA and the Boards and Commissions, responsible for regulating health care professions, does not promote effective performance management.

DOH RESPONSE: We agree there is a need for consistent performance expectations of boards and commissions. We believe the expectations should include measures of performance including timelines established in law, compliance with sanction guidelines, and other directives from the Governor.

OFM RESPONSE: We agree that continued improvement in performance monitoring across all disciplinary authorities, both in overall and by individual boards and commissions, could promote better oversight and regulation of the health professions. One way this could be accomplished is if the operating agreements between HPQA and the boards and commissions identified responsibilities for each entity, including specific performance measures. Government Management Accountability and Performance (GMAP) staff members are working with the Department of Health to examine ways to enhance performance expectations for health professions.

Finding 2: Credentialing process inconsistencies and control weaknesses leave the potential for unqualified individuals to practice in Washington and leaves citizens at risk.

DOH RESPONSE: The audit report did not identify any individuals who were credentialed without meeting qualification standards.

To strengthen our credentialing process, we piloted a quality review process that will guide future practices. We are combining all credentialing staff into a single work unit to ensure consistency. We’re also installing a new computer system — the Integrated Licensing Regulatory System — which has improved checks against errors. We are replacing desk manuals with online tools to speed updates, assure access, and improve consistency. All procedures are available on the HPQA intranet site.

These are important steps to achieve uniformity. In addition, we must strengthen our training program. We have used on-the-job training due to resource limitations. We agree a formal training program would increase effectiveness. That will require additional resources.

Three subject areas of this finding would require legislative action:

- **Minimum age.** The Legislature could establish a minimum age for health care professions, yet we have no current evidence that the lack of a minimum age has endangered any patients. It is unclear if a minimum age requirement would improve patient safety. It is common in some professions, such as health care assistants and nursing assistants, for workers to be under age 18.

- **Registered counselors.** In 2006, the Governor asked us to study the registered counselor profession. We requested legislation to change the profession's standards. The 2007 Legislature directed us to complete a second study, which will be available in November 2007.
- **Registered professions.** We encourage a legislative review of all registered professions that have no educational or experience requirements. The review may identify factors that would better protect patient safety.

Action Steps and Timeframe:

- We are conducting a second study of the registered counselors' profession as directed by the Legislature. November 2007.
- The new computer system will have improved checks against errors. June 2008.
- We are replacing desk manuals with online procedures. June 2008.
- We will identify necessary resources for a formal training program. October 2007.
- We will centralize our credentialing work units to promote standard business practices. June 2008.
- We will include audit suggestions and quality assurance pilot project results in revised procedures. June 2008.
- We will work with the boards to change the administration of the exams for the three professions mentioned in the report. December 2007.
- We will review the administration of jurisprudence exams with other boards and commissions in the context of their rules and policies. March 2008.

OFM RESPONSE: We agree that internal controls, appropriate documentation, and consistent procedures within HPQA are good ways to improve public safety. To this end, OFM has supported – and continues to support – HPQA's now nearly-completed installation of the Integrated Licensing Regulatory System, an automated system to improve the agency's credentialing and monitoring process.

Governor Gregoire directed the Department of Health (DOH) to recommend improved standards for registered counselors with the help of a task force. The work of the department to convene a second task force to develop credentialing guidelines for all registered counselors by January 1, 2008, led to agency request legislation in January 2007. The Legislature did not adopt this legislation in 2007, but did direct DOH to convene another task force that would recommend specific guidelines for registered counselors. The Governor and OFM will evaluate the recommendations of this study when received.

Finding 3: Weaknesses in internal controls over the background check process and lack of national criminal background checks can expose the public to serious risk.

DOH RESPONSE: We already conduct Washington State Patrol (WSP) criminal background checks on all new applicants — more than 53,000 a year. We receive background information from the non-criminal national provider data bases (NPD) on all applicants. We also check the WSP and NPD sources on incoming complaints. Based on 2006 legislation, we are able to compare criminal conviction data from the WSP with our credential records as it is available (quarterly). The Legislature authorized us to check for four types of convictions: assault, kidnapping, homicide, and sex offenses.

A legislative expansion of the convictions list to include all felonies would help identify offenders. For example, convictions for illegal drug use, felony driving while under the

influence (DUIs), or fraud by a health professional may present a risk to patient safety. In the meantime, we are testing the use of a national Web-search service for public criminal conviction information.

This finding would require legislative action:

- The Legislature would have to take action to give the department access to the full range of convictions, federal criminal data and in-state non-conviction information including police reports. Legislative action supporting cooperation between law enforcement agencies and the department would promote patient safety.
- Staff and funding will be required for more background checks whether done by the department or contracted firms.

Action Steps and Timeframe:

- We are developing mandatory reporting rules with a timeline for reporting unprofessional conduct. May 2008.
- We will develop a quality assurance sampling process to audit completed background checks. September 2007.
- We are testing a national search service for public criminal conviction records. If it is useful, we will assess the cost of expanding it to all applicants. July 2008.

OFM RESPONSE: HPQA must implement background checks within the authority granted them in the law. While we agree with the recommendation to expand the list of crime types included in background checks for professional licensing, DOH will need to work with the Washington State Patrol, the Office of the Attorney General, and the Legislature to develop options that would provide access to additional background information for the department.

Finding 4: Changes in the complaint management process are needed to more accurately assess complaints and to improve responses to complainants.

DOH RESPONSE: We are pleased that the audit highlighted some of our practices – such as the team approach to high-priority cases – as a model. We are consolidating all intake staff into a single unit. This will ensure consistency and strengthen the complaint management process. We are installing a new computer system, Integrated Licensing and Regulatory System, with improved checks against errors. These changes will enable us to more quickly acknowledge complaints and keep complainants and credential-holders informed.

In 2006, we began reviewing the decisions to close cases without investigation (when the evidence available is “below threshold”). We will provide the threshold list used for Secretary-regulated professions to all boards and commissions for their adoption and use. We are expanding quality assurance processes to other activities.

Certain recurring complaints may escalate into more serious violations. Based on the audit suggestions, we will review other jurisdictions’ experience using the number and type of complaints to identify incompetent practitioners.

Action Steps and Timeframe:

- We will provide the threshold list used for Secretary-regulated professions to all boards and commissions for their adoption and use. March 2008.
- We will develop specific criteria for imminent danger. February 2008.

- We will evaluate the success of other states' use of multiple complaints to identify incompetent practitioners. We will adopt practice review procedures if there is evidence they are effective. May 2008.
- We will evaluate the success of other jurisdictions' experience with long-term behavioral indicators. If they are shown to be effective, we will adopt new procedures. May 2008.
- We will update training related to disciplinary case tracking after the first internal quality review. November 2007.
- We will seek funds to study the feasibility of electronic document management. It will include imaging of complaint files. October 2007.
- We will re-evaluate what should be included in case records and revise our procedures on how to organize and manage records. September 2008.
- We will develop a common case assessment worksheet for use in all Secretary-regulated professions and recommend its use in board/commission-regulated professions. November 2007.
- The database complaint types and closure codes are defined in manuals for the obsolete computer system, ASI. We have reduced the number of complaint types and closure codes for the new system. We have clear definitions for each. The new Integrated Licensing Regulatory System will be fully implemented by June 2008. June 2008.
- We will continue to send notification letters when we assess the complaint. We will look into the cost of additional notifications. June 2008.

OFM RESPONSE: It is notable that HPQA's triage process for prioritizing complaints was identified in the audit as a best practice. In addition, per the Governor's May 2006 Executive Order, sexual misconduct rules have been adopted by the Secretary and all boards and commissions.

Finding 5: Improve public education regarding citizens' rights to file complaints about credential holders with HPQA

DOH RESPONSE: A public information strategy would help people understand the complaint process. We expect increased public awareness to generate more complaints. We will have to be prepared to handle them. It is possible that any major public education campaign will require significant resource investment. It is imperative that as we increase public awareness of the complaint process that the infrastructure needed to respond to these complaints is sufficient.

Action Steps and Timeframe:

- We are developing a public awareness strategy and will identify its costs for the Legislature. June 2008.
- We will calculate the cost to redevelop our Web site to focus on customer needs. October 2007.
- We are testing outreach to vulnerable populations, particularly the elderly, based on the results of the February 2007 survey. December 2007.

OFM RESPONSE: We agree that public awareness of the complaint process for credential holders should be improved. We encourage HPQA to explore creative solutions and strategies to work with community partners and other sources to increase the reach and frequency of their public outreach efforts.

Finding 6: Investigations of complaints are delayed by process issues and compromised by staffing shortages and internal control deficiencies.

DOH RESPONSE: Patient safety is our first concern. Cases that endanger patients are the highest priority. Our next focus is to reduce the backlogs. Permanently eliminating backlogs will require more staff and resources. A successful public information campaign will increase complaint volume (see our response to Finding 5).

Processes for boards and commissions to authorize an investigation could be improved. For example, only two of 14 boards and commissions have adopted rules delegating the decision to HPQA staff. These rules should speed up the process. We are encouraging other boards and commissions to follow suit.

We have longstanding investigative guidelines approved by the state's oversight group, the State Investigator Resource Committee (SIRC). Guidelines, rather than rigid policies, are used to address the unique needs of each profession and type of unprofessional conduct.

We have used expert witnesses in investigations for standard of care cases. We will expand the use of experts. We have had supervisory review as part of the investigative report since 1989. We will be able to improve caseload tracking with the new computer system, which will support the use of a single tracking report for each investigator. We will examine the other suggestions in the audit report to improve the investigation process and adopt them as appropriate.

Legislative action could provide new tools for obtaining records, documents, and other evidence. In 2007, we proposed legislation to allow use of citations and fines for failure to provide documents in a timely manner.

Action Steps and Timeframe:

- We will propose improvements to the process to authorize an investigation. June 2008.
- We will identify resources needed for a formal training program. October 2007.
- A workload standards study is now underway to identify appropriate staffing levels. We will provide the report to the Legislature when it is completed. December 2007.
- We will complete the contract process for expert review of standard of care cases. December 2007.
- We will have a single caseload report for each investigator in the new licensing computer system. June 2008.
- We will re-evaluate what should be included in case records and revise our procedures on how to organize and manage records. September 2008.

OFM RESPONSE: We strongly support HPQA's on-going process improvement efforts and will consider requests for additional resources as part of the budget development process in the future.

Finding 7: Deficiencies in the disciplinary (legal) process have led to inconsistent and delayed discipline of practitioners who engage in unprofessional conduct or provide below standard of care.

DOH RESPONSE: Sanction guidelines promote consistent and uniform disciplinary outcomes. That is why the Secretary adopted guidelines in May 2006 for the 23 professions she regulates.

Ten of 14 boards and commissions have adopted the Secretary's guidelines. We encourage the remaining boards and commissions to do so.

We issue a statement of charges when an investigation has been completed and there is evidence of unprofessional conduct on the part of a credential-holder. The respondent has 20 days to answer that statement of charges unless the health law judge allows more time. If the respondent does not answer by the end of 20 days, a default order may be entered. We draft the default order only after it is clear the respondent has missed the deadline.

The audit recommends we enter default orders on the 21st day. That means we would have to have the order ready in advance. This would cost additional resources without any gain in patient safety. In addition, the courts typically allow a practitioner to have a hearing when a late answer is filed. The State Supreme Court has noted, "...[d]efault judgments are precarious and not favored because, 'It is the policy of the law that controversies be determined on the merits rather than by default.'" *Lenzi v. Redland Ins. Co.* 140Wn.2d 267, 278 fn. 8 (2000) (Citation omitted).

Accuracy is important on our Provider Credential Search Web site when describing why discipline occurred. We follow the reporting standards of the national practitioner data banks. This requires use of a best-fit approach to match our statutory violations to the national data banks' descriptions. As the audit data showed, the best-fit approach does not always provide the entire picture of a case.

Action Steps and Timeframe:

- We will work with OFM to see whether further action is appropriate to require all boards and commissions to adopt the sanctioning guidelines. December 2007.
- We will continue to enter default orders according to the law. Ongoing.
- We will re-evaluate what should be included in case records and revise our procedures on how to organize and manage records. September 2008.
- We will review our options to assure accuracy in reporting disciplinary actions. June 2008.

OFM RESPONSE: Consistent sanction guidelines among all 57 health professions would increase clarity and add to both the public's and credential holder's understanding of the sanction process. OFM is pleased that DOH adopted Uniform Sanction Guidelines for professions regulated by the Secretary, and that several boards and commissions followed suit. However, OFM will continue to work with DOH to assure that all boards and commissions adopt these guidelines.

Finding 8: The compliance process does not ensure that practitioners who have been disciplined comply with the terms of their sanctions.

DOH RESPONSE: We are consolidating all compliance staff into a single work unit to ensure consistency in processes. We are also installing a new computer system, Integrated Licensing and Regulatory System, with automated deadline notices. Having a central compliance unit with a single management structure will ease training and workload assignment issues.

We are replacing desk manuals with online tools to speed updates, assure access, and improve consistency. All procedures are available on the HPQA intranet site. Training for new staff is now conducted on the job. We agree our training program should be strengthened. A formal training program would be more effective, and it would require additional resources.

We adopted a procedure in 2006 that requires a single reminder letter to practitioners who have not met a due date. We will continue to send follow-up requests for additional information where needed. The ILRS computer system will include standardized letters and compliance worksheets. The study on workload standards will help us set caseload expectations for compliance staff.

Action Steps and Timeframe:

- The new computer system will include automated notices and reminders. June 2008.
- We will complete a workload standards study now underway to identify appropriate staffing levels. We will provide the report to the Legislature when it is completed. December 2007.
- A central compliance unit will support consistency in the compliance process. June 2008.
- We will identify necessary training resources for a formal program. October 2007.

OFM RESPONSE: We are pleased that HPQA has already taken steps to reorganize their compliance work unit under a single management structure. Doing this is expected to provide better outcomes. We also look forward to working with HPQA and the Legislature to develop criteria for evaluating workload standards for HPQA's compliance activities.

Finding 9: DOH and HPQA oversight needs improvements to ensure that its credentialing and its regulatory processes are performing as intended.

DOH RESPONSE: We agree on the importance of performance management and improving our current system. We have enhanced our performance management system to meet the criteria suggested in the audit. The 2007-2009 Health System Quality Assurance division-wide strategic plan has specific performance measures for HPQA.

Action Steps and Timeframe:

- We will post measures of importance to the public on the agency Web site. June 2008.

OFM RESPONSE: The Governor is committed to accountability within state government and established the Government Management Accountability and Performance program (GMAP) to encourage performance improvement. As is being done in other key areas of government, GMAP will work with HPQA to improve performance of the state's disciplinary process.

Finding 10: The DOH internal audit function is understaffed and does not perform evaluations of HPQA to identify and report deficiencies that could impede HPQA's ability to achieve its goals.

DOH RESPONSE: We will consider options to add capacity. This may include more internal audit staff and quality assurance. We will consider other options for audits that require specialized skills, such as technology systems. This will require additional resources.

Action Steps and Timeframe

- We will identify the costs of adding staff to the department's internal audit function. October 2007.
- We will update job descriptions to incorporate quality assurance as we consolidate functions. March 2008.
- We have begun a pilot of a Control Self Assessment in HPQA. September 2008.

OFM RESPONSE: Enhanced internal audit capacity can help improve processes and program implementation at HPQA. We look forward to working with HPQA in the normal budget process to identify a cost-effective approach to improve internal auditing capacity.

Finding 11: Legacy information systems does not enable HPQA to effectively and efficiently license health practitioners, manage consumer complaints and monitor compliance with disciplinary action.

DOH RESPONSE: We identified and began to address the issues with our legacy information systems several years ago. We have acquired and are now installing a new computer system, Integrated Licensing and Regulatory System (ILRS). This system will resolve the issues identified by the audit. We are on track to implement ILRS in spring 2008. It is a modern system that meets agency and state standards.

It is high risk and not cost effective to modify the old, undocumented legacy computer system that will be decommissioned within a year. We will continue to follow the agency standard and regularly install security patches for all Microsoft equipment.

Action Steps and Timeframe:

- We are implementing the new ILRS computer system that meets agency standards. June 2008.
- We will develop a notification system between HSQA managers and the technology staff to maintain current system access for all users and IT development / maintenance staff. November 2007.
- We will update the user access records and restructure the way they are maintained. November 2007.
- HPQA is in the midst of analyzing and correcting data in the legacy systems in preparation for conversion to ILRS. This will continue until the new system is implemented. June 2008.

OFM RESPONSE: Following up on several years of work and investments in prior budgets, funds were included in the 2007-09 biennial budget to complete the replacement of HPQA's legacy information system. DOH is successfully moving forward with implementation of this project. DOH also has independent quality assurance (QA) in place to evaluate progress and regularly report findings and recommendations to senior agency leadership and the Department of Information Systems. OFM and DIS monitor the progress of the implementation of ILRS and are pleased that the new system is on track. Any action that would delay the timely implementation of this project would be ill-advised.

Finding 12: HPQA's disaster recovery plans and business continuity plans are not fully developed.

DOH RESPONSE: We have completed business continuity plans for the most crucial HPQA work. This includes licensing and public access through the customer service center. We have developed disaster recovery plans for HPQA's most vital technology systems. We will focus next on investigative and disciplinary activities. The department will keep working with the Department of Information Services on a primary disaster recovery hot site.

Action Steps and Timeframe:

- We will complete a business continuity plan to sustain critical investigation and disciplinary activities. December 2007.
- We will develop an alternative means of contact for key personnel. December 2007.
- We will review disaster recovery plans to make sure there is sufficient information for staff to follow them. December 2007.
- We will have an interim disaster recovery site in operation. December 2007.
- We are working with the Department of Information Services for a primary hot site. April 2008.

OFM RESPONSE: We concur with HPQA's strategy to complete its disaster recovery and business continuity plan. Ensuring that critical state services are maintained in the event of a disaster is of statewide significance. To date, the state's planning emphasis has been placed on disaster recovery and providing redundant mainframe computing to enhance the state's ability to access and maintain information. Our next challenge in planning is to attend to the recovery of business functions and resources, such as alternate work space, mail delivery, and essential records.

We have determined that having an enterprise approach to business continuity is the most effective way to ensure that vital public services are maintained in the event of a disaster. It is not enough to be confident that an agency and their employees can communicate within the agency; it is crucial that inter-agency lines of communication can also be preserved.

Finding 13: Hard copy files related to licensing and investigations are not physically secure.

DOH RESPONSE: We take file security seriously. We have enhanced physical security in our buildings. We use electronic identification for access, have security guards onsite in Tumwater, and keep adjudication records and evidence in secure locations. In addition, employees must sign confidentiality forms each year.

We have upgraded our policies on destruction of confidential records. These records must be deposited in locked containers and shredded. Electronic document management would provide the highest level of security, and that would require funding.

Action Steps and Timeframe:

- We will seek funding to study the feasibility of a division-wide electronic document management system. October 2007.

OFM RESPONSE: OFM will consider recommendations to improve file security within DOH as part of the normal budget process.

**Regulation of Health Professions Performance Audit - 2007
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| Finding | DOH Action Step | Due Date | Lead |
|----------------|--|-----------------|-------------|
| F1 | We will follow any legislative direction regarding changes to operating agreements between HPQA and the boards and commissions. | TBD | Legislature |
| F2 | The new computer system will have checks against errors. | Jun-08 | DOH |
| F2 | We are replacing desk manuals with online procedures. | Jun-08 | DOH |
| F2, F6, F8 | We will identify necessary resources for a formal training program. | Oct-07 | DOH |
| F2 | We will centralize our credentialing work units to promote standard business practices. | Jun-08 | DOH |
| F2 | We will include audit suggestions and quality assurance pilot project results in revised procedures. | Jun-08 | DOH |
| F2 | We will work with the boards to change the administration of the exams for the three professions mentioned in the report. | Dec-07 | DOH |
| F2 | We will review the administration of jurisprudence exams with other boards and commissions in the context of their rules and policies. | Mar-08 | DOH |
| F2 | We will follow any legislative direction regarding establishing a minimum age for health care professions. | TBD | Legislature |
| F2 | We are conducting a second study of the registered counselors' profession. | Nov-07 | DOH |
| F2 | We will follow any legislative direction regarding registered professions. | TBD | Legislature |
| F3 | We will follow any legislative direction regarding additional authority to conduct background checks. | TBD | Legislature |
| F3 | We are developing mandatory reporting rules with a timeline for reporting unprofessional conduct. | May-08 | DOH |
| F3 | We will develop a quality assurance sampling process to audit completed background checks. | Sep-07 | DOH |

**Regulation of Health Professions Performance Audit - 2007
DOH Action Plan**

| Finding | DOH Action Step | Due Date | Lead |
|----------------|--|-----------------|-------------|
| F3 | We are testing a national search service for public criminal conviction records. If it is useful, we will assess the cost of expanding it to all applicants. | Jul-08 | DOH |
| F4 | We will provide the threshold list used for Secretary-regulated professions to all boards and commissions for their adoption and use. | Mar-08 | DOH |
| F4 | We will develop specific criteria for imminent danger. | Feb-08 | DOH |
| F4 | We will evaluate the success of other states' use of multiple complaints to identify incompetent practitioners. We will adopt practice review procedures if there is evidence that they are effective. | May-08 | DOH |
| F4 | We will evaluate the success of other jurisdictions' experience with long-term behavioral indicators. If they are shown effective, we will adopt new procedures. | May-08 | DOH |
| F4 | We will update training related to disciplinary case tracking after the first internal quality review. | Nov-07 | DOH |
| F4, F13 | We will seek funds to study the feasibility of electronic document management. It will include imaging of complaint files. | Oct-07 | DOH |
| F4, F6, F7 | We will re-evaluate what should be included in case records and revise our procedures on how to organize and manage records. | Sep-08 | DOH |
| F4 | We will develop a common case assessment worksheet for use in all Secretary-regulated professions and recommend its use in board/commission-regulated professions. | Nov-07 | DOH |
| F4 | The database complaint types and closure codes are defined in manuals for the obsolete computer system, ASI. We have reduced the number of complaint types and closure codes for the new system. We have clear definitions for each. The ILRS system will be fully implemented by June 2008. | Jun-08 | DOH |

**Regulation of Health Professions Performance Audit - 2007
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| Finding | DOH Action Step | Due Date | Lead |
|----------------|---|-----------------|-------------|
| F4 | We will continue to send notification letters when we assess the complaint. We will look into the cost of additional notifications. | Jun-08 | DOH |
| F5 | We are developing a public awareness strategy and will identify its costs for the Legislature. | Jun-08 | DOH |
| F5 | We will calculate the cost to redevelop our Web site to focus on customer needs. | Oct-07 | DOH |
| F5 | We are testing outreach to vulnerable populations, particularly the elderly, based on the results of the February 2007 survey. | Dec-07 | DOH |
| F6 | We will propose improvements to the process to authorize an investigation. | Jun-08 | DOH |
| F6 | We have state-approved investigation guidelines in place. | Done | |
| F6, F8 | A workload standards study is now underway to identify appropriate staffing levels. We will provide the report to the Legislature when it is completed. | Dec-07 | DOH |
| F6 | We will complete the contract process for expert review of standard of care cases. | Dec-07 | DOH |
| F6 | We already have these practices in place to ensure all investigators receive appropriate training. | Done | DOH |
| F6 | We already have these practices in place requiring supervisors to officially sign off on all investigations. | Done | DOH |
| F6 | We will have a single caseload report available for each investigator in the new licensing computer system. | Jun-08 | DOH |
| F6 | We will follow legislative direction regarding additional investigative tools. | TBD | Legislature |
| F7 | We will work with OFM to see whether further action is appropriate to require all boards and commissions to adopt the sanctioning guidelines. | Dec-07 | DOH |
| F7 | We will continue to enter default orders according to the law. | Ongoing | |

**Regulation of Health Professions Performance Audit - 2007
DOH Action Plan**

| Finding | DOH Action Step | Due Date | Lead |
|----------------|---|-----------------|-------------|
| F7 | We will review our options to assure accuracy in reporting disciplinary actions (basis of action). | Jun-08 | DOH |
| F7 | We will follow any legislative direction regarding sanction guidelines. | TBD | Legislature |
| F7 | We will follow any legislative direction regarding discipline for misconduct. | TBD | Legislature |
| F7 | We will follow any legislative direction regarding consequences of not adopting sanction guidelines. | TBD | Legislature |
| F8 | The new computer system will include automated notices and reminders. | Jun-08 | DOH |
| F8 | We adopted a procedure in 2006 that requires a single reminder letter to practitioners who have not met a due date. We will continue to send follow-up or requests for additional information where needed. | Ongoing | DOH |
| F8 | A central compliance unit will support consistency in the compliance process. | Jun-08 | DOH |
| F8 | The compliance procedure, which includes the letter templates, is available on the HPQA Intranet site. We are replacing desk manuals with online procedures. | Done | DOH |
| F9 | We have enhanced our performance management system to meet the criteria suggested in the audit. | Done | DOH |
| F9 | We will post measures of importance to the public on the agency Web site. | Jun-08 | DOH |
| F10 | We will identify the costs of adding staff to the Department's internal audit function. | Oct-07 | DOH |
| F10 | We will update job descriptions to incorporate quality assurance as we consolidate functions. | Mar-08 | DOH |
| F10 | We have begun a pilot of a Control Self Assessment in HPQA. | Sep-08 | DOH |
| F10 | We will contract out specialized internal audits as needed. | As needed | DOH |

**Regulation of Health Professions Performance Audit - 2007
DOH Action Plan**

| Finding | DOH Action Step | Due Date | Lead |
|----------------|---|-----------------|-------------|
| F11 | We are implementing the new ILRS computer system that meets agency standards. | Jun-08 | DOH |
| F11 | We will continue to regularly install security patches, as they are available. | Ongoing | DOH |
| F11 | We will develop a notification system between HSQA managers and the technology staff to maintain current system access for all users and IT development / maintenance staff. | Nov-07 | DOH |
| F11 | We will update the user access records and restructure the way they are maintained. | Nov-07 | DOH |
| F11 | HPQA is in the midst of analyzing and correcting data in the legacy systems in preparation of the conversion to ILRS. This will continue until the new system is implemented. | Jun-08 | DOH |
| F11 | We will avoid the use of computer "side systems." | In progress | DOH |
| F12 | We will complete a business continuity plan to sustain critical investigation and disciplinary activities. | Dec-07 | DOH |
| F12 | We will develop an alternative means of contact for key personnel. | Dec-07 | DOH |
| F12 | We will review disaster recovery plans to make sure there is sufficient information for staff to follow them. | Dec-07 | DOH |
| F12 | We will have an interim disaster recovery site in operation. | Dec-07 | DOH |
| F12 | We are working with the Department of Information Services for a primary "hot" site for disaster recovery. | Apr-08 | DOH |
| F13 | We have upgraded our policies on destruction of confidential records to require that they be deposited in locked containers and shredded. | Done | DOH |
| F13 | We have policies in place regarding confidential materials. | Done | DOH |

Appendix N: Management Letter to Department of Health



Performance Audit Department of Health, Health Professions Quality Assurance For State Fiscal Years 2005 through 2007 Management Letter

August 21, 2007

Mary C. Selecky, Secretary
Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504-7890

Dear Ms. Selecky:

We have completed our performance audit of the Office of the Health Professions Quality Assurance (HPQA). Our performance audit covered the State of Washington (State) fiscal years 2005 through 2007 (July 1, 2004 through June 30, 2007), as well as previous biennia when necessary. The audit was conducted pursuant to contract 0706-C-HCVC-01 between the Washington State Auditor's Office and Clifton Gunderson LLP.

OBJECTIVES, SCOPE AND METHODOLOGY

The objectives of the performance audit of HPQA for fiscal years 2005 through 2007 (July 1, 2004 through June 30, 2007), as well as previous biennia when necessary were to:

1. Evaluate the professional licensing, oversight, and disciplinary system starting with the receipt of licensing applications through the final resolution of complaints and monitoring of compliance with disciplinary actions.
2. Develop a description of the stages of the disciplinary process, identifying variations among disciplining authorities.
3. Identify activities that help move cases efficiently through the stages of the disciplinary process, including an evaluation of summary actions that are taken to quickly remove a provider from practice if the public is at risk of being harmed, and to determine if such activities are being uniformly and consistently applied.
4. Assess resources required to support the professional licensing, oversight and disciplinary system, including staffing levels, workload and timeliness of process compared to other states' benchmarks or best practices.
5. Compare Washington's licensing, oversight, and disciplinary system to other states' systems.

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6. Evaluate the case law and statutory and regulatory requirements to assess the effect of each on the disciplining authorities' ability to discipline credential holders and its ability to do so in a timely manner.
7. Suggest statutory, regulatory, and/or internal policy changes that would support more effective disciplinary practices that are consistent across professions.
8. Recommend methods of improving efforts to educate members of the public about their right to file complaints about health care providers with the Department of Health (DOH).
9. Recommend the best ways to access national criminal background checks for current credential holders and applicants.

We also addressed the nine elements of the Citizen's Initiative 900 while conducting our audit. The elements are:

1. Identification of cost savings.
2. Identification of services that can be reduced or eliminated.
3. Identification of programs or services that can be transferred to the private sector.
4. Analysis of gaps or overlaps in programs or services and recommendations to correct them.
5. Feasibility of pooling the entity's information technology systems.
6. Analysis of the roles and functions of the entity and recommendations to change or eliminate roles or functions.
7. Recommendations for statutory or regulatory changes that may be necessary for the entity to properly carry out its functions.
8. Analysis of the entity's performance data, performance measures, and self-assessment systems.
9. Identification of best practices.

We conducted this performance audit from November 2006 through July 2007. As part of our audit, we interviewed HPQA staff and reviewed HPQA documents. We analyzed data for the 2005-2007 biennium and, when appropriate, analyzed data from previous biennia. Surveys were conducted of HPQA staff, boards and commissions as well as the general public. To obtain data and information about practices in other jurisdictions, we contacted other states' licensing and regulatory authorities, reviewed information from their web sites, and reviewed publications of national research institutes.

In our audit report dated August 21, 2007, we identified several findings and made recommendations for consideration by HPQA management and the Legislature. In addition to those findings and recommendations, we also identified the following matters, that were not significant to the objectives of the audit, for management's consideration.

Personnel Files

Prior to July 1, 2006, the Washington State Department of Personnel (DOP) conducted recruitment for HPQA and maintained the personnel files. This consisted of collecting applications and screening candidates for minimum qualifications. When the DOH assumed its agency's human resources responsibility, DOP did not provide copies of the applications to the new DOH Human Resource Department to maintain in their personnel files. As a result, the files of some employees do not contain certain documents which provide verification of education and experience. Having documentation of qualifications of DOH employees maintained by the Human Resource Department of DOH ensures that there is a record that its employees are qualified for their positions and will avoid even the appearance that an employee has not met the minimum requirements. We also found that DOH's Human Resources Department does not have documented policies and procedures identifying the documentation that should be maintained in the personnel files. We recommend that written policies and procedures are developed which identify the documents that should be maintained and that procedures are implemented to verify that the policy is followed.

Social Security Numbers

HPQA is required by law to ask all license applicants to furnish Social Security Numbers (SSNs). SSNs are then entered into the credentialing database and used as one identifier for background checks. Although HPQA credentialing application forms state that a SSN is required, HPQA procedures direct staff to issue credentials to individuals who cannot provide a SSN but who are otherwise qualified. If an applicant does not have a SSN, staff provide the applicant a form requesting the reason why the applicant is ineligible to have a SSN. Should the applicant have a federal taxpayer identification number, it is accepted in lieu of a SSN. Upon receiving the form stating that the applicant is ineligible to be assigned one, HPQA Customer Service assigns a number to use as a replacement for the SSN, which then enables the applicant to be credentialed. The list of numbers used as replacements for missing SSNs starts with 111-11-1111 and continues sequentially.

HPQA does not have a process in-place to monitor individuals who were assigned a replacement SSN and were awarded credentials to ensure that they should continue to be credentialed. HPQA's automated system lacks the ability to flag credential holders who have replacement numbers. Having the ability to generate an automated indicator would trigger a review of the health care professional to determine if the individual should be required to provide documentation that the individual continues to be ineligible for assignment of a SSN and should continue to be credentialed.

The replacement numbers that HPQA uses is the same series of numbers that the federal Social Security Administration has assigned to New York State. If HPQA continues to assign this series of numbers, it could assign a number that the Social Security Administration has already assigned to a New York State resident.

Mary C. Selecky, Secretary
Washington State Department of Health
August 21, 2007
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We recommend that HPQA review and make any needed changes to its policy and procedures regarding assignment of replacement numbers for SSNs to individuals ineligible to receive one from the federal Social Security Administration and to ensure its internal policies and procedures are consistent and comply with applicable laws. We also recommend that HPQA use a set of numbers that the Social Security Administration has not assigned to any other state. Numbers above 800-xx-xxxx are available at this time. HPQA should reassign numbers that it has previously assigned to credential holders to prevent duplication of numbers that are or will be assigned to residents in the state of New York.

We appreciate the opportunity to present these matters and are available to provide assistance in implementing any of the recommendations.

This letter is intended solely for the information and use of the management of HPQA, and is not intended to be, and should not be, used by anyone other than these specified parties.

Clifton Henderson LLP

Austin, Texas

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