Washington State Auditor's Office

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Performance Audit

Medical Discipline in Washington

November 7, 2016

We found the state's medical practice regulations and the disciplinary processes of both the Medical Quality Assurance Board (MQAC) and the Board of Osteopathic Medicine and Surgery (BOMS) meet the legislative intent of supporting quality healthcare and public safety. The state's laws incorporate many of the regulatory best practices and guidelines suggested by experts in the field; both boards follow most of the best practices we identified, conducting investigations in response to complaints lodged by members of the public.

However, the existence of two boards conducting essentially identical work allows opportunities for inconsistent treatment of complaints and contributes to inefficiencies that could be avoided by merging the two organizations. Whether or not the state opts for merger, we identified issues in law that the Legislature might address to offer more disciplinary flexibility to the boards, as well as practical activities each board can undertake to improve data management and processes.

Report Number: 1017904

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Executive Summary

In Washington, medical doctors and physician assistants (PAs) are licensed and regulated by the Medical Quality Assurance Commission (MQAC), while osteopathic doctors and PAs are licensed and regulated by the Board of Osteopathic Medicine and Surgery (BOMS). These boards are also responsible for investigating complaints about physicians and PAs and imposing sanctions when appropriate. The sanctions range from remedial, such as writing a paper or giving a presentation, to license revocation. Other medical professionals are regulated either by similar boards or by the Department of Health (DOH).

Washington, like every other state, relies heavily on doctors to regulate other doctors. This has long been an area of concern, with both national and Washington-based groups critical of the approach. Members of the Washington Advocates for Patient Safety group contacted the State Auditor's Office with concerns that the system does not adequately protect the public.

This performance audit examined the process by which MQAC and BOMS assess and investigate complaints; how they communicate with the people who have filed complaints, those accused of misconduct, and the general public; and how they ensure sanctions are completed. Our audit did not review the correctness of the boards' decisions to investigate or the final disposition of complaints. Because the audit scope was related to the boards' disciplinary processes, we did not examine their licensing functions or educational requirements.

We reviewed 8,600 complaints made to MQAC and BOMS, covering almost six years, and we reviewed the complete case files of 330 complaints. We then compared what we found to a selection of best practices related to medical complaint processes in the following areas:

- The composition and role of a state medical board
- Adequacy of investigations
- Enforcement of sanctions
- Transparency of processes
- Public visibility of the boards
- Timeliness of processes
- Consistency of complaint assessment

In addition, we interviewed staff and management for both boards, and we attended the closed meetings where the boards consider the results of investigations and decide whether to issue sanctions.

Washington's laws lay groundwork for effective boards, but disparities between MQAC and BOMS raise concerns

Consistent application of the laws governing medical practice is a keystone of Washington's regulatory framework. The Uniform Disciplinary Act (UDA) applies a universal sanctioning schedule for health professions and requires that boards and commissions create procedures to ensure substantially consistent application of the UDA. While these efforts decrease the risk of inconsistency, they do not eliminate it. In a 2013 report to the Legislature, the Department of Health (DOH) noted that the "very similar professions of DOs [doctors of osteopathy] and MDs [medical doctors] had inconsistent standards, practices, and outcomes."

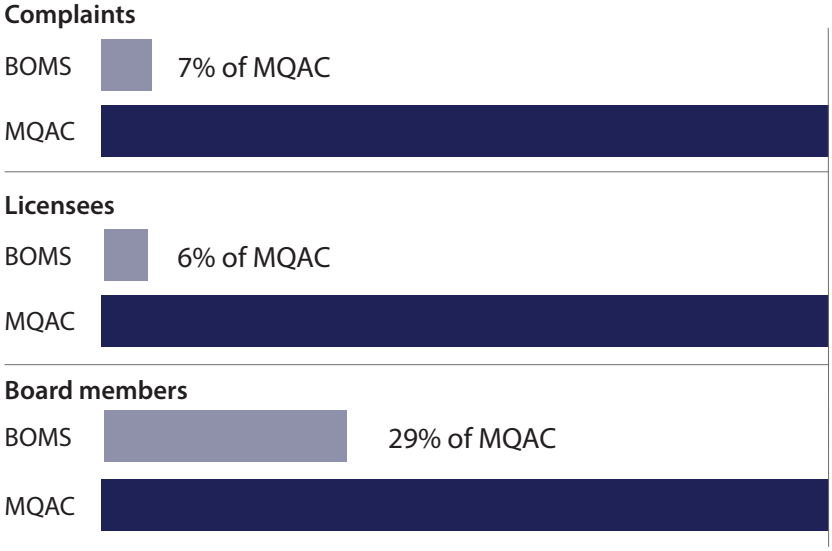
MQAC and BOMS serve very similar professions, review similar issues and operate in an identical regulatory environment. Nonetheless, they regulate very different numbers of providers, and their boards differ in size and composition. We found multiple differences in how MQAC and BOMS manage their affairs and regulate their providers:

- **Board size and composition:** Both MQAC and BOMS have public members, but only MQAC meets the best practice of having at least 25 percent public members
- **Timeliness of complaint assessment:** MQAC's larger board, meeting more frequently, is able to assess cases within mandated timeframes 95 percent of the time, while BOMS assessed cases within its deadlines 78 percent of the time in the 21 months ending September 2014
- **Rates of complaint investigation:** BOMS opens proportionally fewer investigations, including closing some cases when MQAC would open one
- **Control over budget and staffing:** MQAC controls its budget and staffing, including legal counsel and dedicated clinical investigators; BOMS does not and shares resources with more than 70 other professions
- **Representation of physician assistants:** MQAC includes them as board members, BOMS does not

The graphic below shows the differences in complaints, licensees and members of the two boards.

BOMS compared to MQAC

Fewer complaints, fewer licensees, fewer members



Source: Department of Health.

The state has, over the last decade, sought to reduce its number of boards and commissions; Governor Gregoire issued executive orders to that effect. The public also desires more streamlined services with clear identification of regulatory oversight. Initiative 900 directs the State Auditor's Office to identify duplicative services and make recommendations to eliminate them as part of the performance audit process.

The state could improve consistency and timeliness of complaint resolution for patients by merging BOMS with MQAC

A merger of the two boards would eliminate these inconsistencies completely, but agency management expressed concerns about possible negative consequences to the osteopathic profession if the boards were merged. We reviewed multiple sources, both national and for the 36 states that regulate medical and osteopathic doctors through one medical board, and found no advocacy for moving to separate regulation. We also found no correlation between composite or separate boards and the number of osteopathic doctors in a given state; the factor that most influences the numbers practicing in a state is the presence of an osteopathic medical school. Furthermore, a merged board would not preclude issuance of a separate DO credential: issuing multiple, differing credentials for MDs and PAs is already commonplace at MQAC.

Due to the much smaller size of BOMS in comparison to MQAC, an increase in workload for osteopathic members is inevitable if such a merger were to occur. However, we concluded the merger would not increase the workload of current MQAC members.

We believe the risk of inconsistent treatment of the public's complaints is greater than the benefit of a separate board for osteopathic providers. One consolidated board, with osteopathic representation, would deliver more consistent consideration of complaints and so better serve the public.

Per-member workload would decrease in a new merged board

Source: Department of Health.

The boards could benefit from law or rule changes

While medical boards in most states need only to establish that a "preponderance of evidence" shows that a provider committed a violation, Washington's Supreme Court requires that state regulatory bodies meet a higher standard of proof, "clear and convincing," which can make it more difficult for boards to take action against a provider. One possible solution recommended by the Federation of State Medical Boards (FSMB) is the establishment of a non-disciplinary Letter of Concern, but patient safety advocates have expressed multiple concerns, including that its use could result in less transparency in disciplinary actions.

We also noted that Washington's UDA lacks several violations recommended by FSMB, such as not protesting an inappropriate managed care denial; we recommend the boards, together with the Legislature, consider whether these additional violations should be established in law or administrative code.

We also found room for improvement in the ways both boards communicate with the public

During our comparison of best practices to the ways that both boards address visibility and transparency, we identified several areas for improvement on how boards:

- Communicate their presence and purpose to the public
- Use technology, such as a website, to facilitate communication
- Interact with people with limited proficiency in written English
- Interact with people who have filed complaints

It is important that boards clearly and effectively communicate with the public as well as their members. The public must know how to file a complaint – a process which should be as simple as possible – and be aware of disciplinary actions taken against medical professionals. If patients do not know who regulates the medical professional they wish to file a complaint about, they may send their complaints to the wrong organization and it may not be investigated.

Both boards have procedures in place to notify complainants and respondents (those against whom the complaint was made) that a complaint has been lodged and whether they have authorized an investigation. We found that in cases where a complaint resulted in discipline, neither board regularly notified the complainant, despite a statutory requirement to do so. We also found that both boards could do more to ensure that potential complainants know how to submit a complaint.

Both boards already made some improvements to their communications, but told us that making improvements to their website pages – including online forms and foreign-language translations – is not entirely in their control because DOH provides their internet support.

The boards generally assess their complaints promptly but there is room for improvement

Finally, we found that MQAC, which assesses complaints weekly, generally meets the mandated 21-day window, hitting its target 95 percent of the time. Because BOMS assesses complaints every other week, it meets its target less often, at 78 percent of the time (although it was much lower before 2012). Both boards generally meet their other timeliness targets to complete investigations within 170 days and to dispose of cases within 140 days, and when they do not, it is often because the case is unusually complex. However, we found issues with the data used to track timeliness, and both boards could benefit from additional quality assurance steps.

Recommendations

The Medical Quality Assurance Commission and the Board of Osteopathic Medicine and Surgery generally do a good job of meeting legislative intent to protect the public by using education and discipline to improve the practice of medicine in Washington. However, we identified areas of improvement for both boards, including recommendations for statutory changes to the Legislature:

We recommend the Legislature:

1. Merge BOMS and MQAC into one board by adding three osteopathic physicians to the commission.
2. Ensure a minimum of 25 percent public members on the state medical boards, whether this is two separate entities or one merged board.

3. Modify the Uniform Disciplinary Act so all healthcare professionals must post information in a prominent location about where to file complaints.

We recommend MQAC and BOMS (or the merged board recommended above) work with the Legislature to:

4. Determine whether the statutory definition of unprofessional conduct should better reflect the Federation of State Medical Boards guidelines. In doing so, consider the overall impact to healthcare-related professions if the UDA is changed.
5. Work with the Legislature to determine whether the UDA should allow the disciplinary authority to issue a Letter of Concern in situations where the boards cannot meet the standard of proof, but enough evidence exists to show informal reporting to the provider could improve public safety. In doing so, consider the overall impact to healthcare-related professions if the UDA is changed.

We recommend MQAC and BOMS (or the merged board recommended above) work with DOH to:

6. Improve the usability of their webpages, including addition of a translation tool to the website. In deciding what languages to translate to, consider Department of Justice guidelines for written translations.
7. Improve the Provider Credential Search, with consideration of legal restrictions, including the provider search function, to allow for broader provider searches. In doing so, ensure it includes information recommended by FSMB, such as location, specialty and board certification, summaries of violations and enforcement actions, as well as information that can be voluntarily added by providers such as insurance information and whether new patients are accepted.

We recommend MQAC and BOMS (or the merged board recommended above):

8. Continue to improve correspondence by incorporating Plain Talk principles into their communications with complainants and respondents.
9. If the Legislature does not modify the UDA, expand outreach to the public, specifically by using their rulemaking authority to require that all providers post information in a prominent location about where to file complaints.
10. Regularly evaluate whether staff are following policies and procedures, including whether they are accurately entering data into the Integrated Licensing and Regulatory System.
11. Modify current performance measurement activities to regularly evaluate the nature and volume of complaints, the adequacy and consistency of enforcement actions, as well as how well the boards are meeting their mission to protect the public.

We recommend MQAC:

12. Modify procedures to ensure complainants are sent letters at the end of all cases.

Introduction

In any profession, there is the possibility for error. In the practice of medicine, errors can have life-altering consequences. To ensure quality care, most of Washington's medical professionals are regulated by state-level boards or commissions in a host of specialties, from audiology to psychology. These boards establish, monitor and enforce qualifications for licensure, consistent standards of practice and continuing competency. One way medical boards ensure quality care is by receiving complaints about substandard care, imposing discipline with the aim of improving doctors' practice when remediation is possible or removing them from practice when it is not.

For the most part, boards are composed of professionals working in the field they regulate. In Washington, medical doctors and physician assistants (PAs) are licensed by the Medical Quality Assurance Commission (MQAC), and osteopathic doctors and PAs are licensed by the Board of Osteopathic Medicine and Surgery (BOMS). All follow the state's Uniform Disciplinary Act (UDA), a complex law with many provisions addressing misconduct, malpractice and disciplinary sanctions for providers who do not meet professional standards. MQAC and BOMS license about 31,000 and 1,800 providers respectively.

In the 1960s, nationwide concerns about public accountability and the ability of professionals to adequately police the actions of their colleagues led to changes in the role and structure of medical boards. One important change was the addition of people from outside the profession to the boards. In 1975, the Legislature added the first public member to what was then the Board of Medical Examiners.

The system nonetheless continues to have critics, both nationally and in Washington. One national advocacy group, Public Citizen, monitors the actions of medical boards, and for many years has ranked them based on the percentage of doctors disciplined each year. A key concern of this group is the high degree of variability between state boards and between different years with the same state board, which they take to mean that some states are not as strict in enforcing standards as others. For example, in the most recent (2012) report, Washington was noted for greatly increasing the rate of serious disciplinary actions over the last decade. From 2002 to 2004, MQAC took 221 "serious actions" per 100,000 providers, ranking in the lowest 10 states; from 2009 to 2011, it took 445 actions per 100,000 practitioners, high enough to put the state in Public Citizen's top ten. Despite their stated criticism of the ranking, the improvement was so significant that MQAC reported the number to the Legislature in 2013 to support its continued independence from the Department of Health (DOH) in regulating medical doctors.

In Washington, a group of individuals dissatisfied with the outcome of specific cases related to relatives' deaths have lobbied for improvements to medical oversight. In 2011, their efforts resulted in legislation requiring greater transparency in the disciplinary process for health professionals. They then organized into a formal group, Washington Advocates for Patient Safety. In 2014, as this audit was in progress, a member of this group was appointed to MQAC as a public member by Governor Inslee.

We designed this audit to answer the following question:

- Do the investigative and related processes of MQAC and BOMS support the legislative intent of the Uniform Disciplinary Act to ensure quality healthcare and protect the public through their disciplinary activities?

Background

The development of regulatory boards for medical and osteopathic practitioners

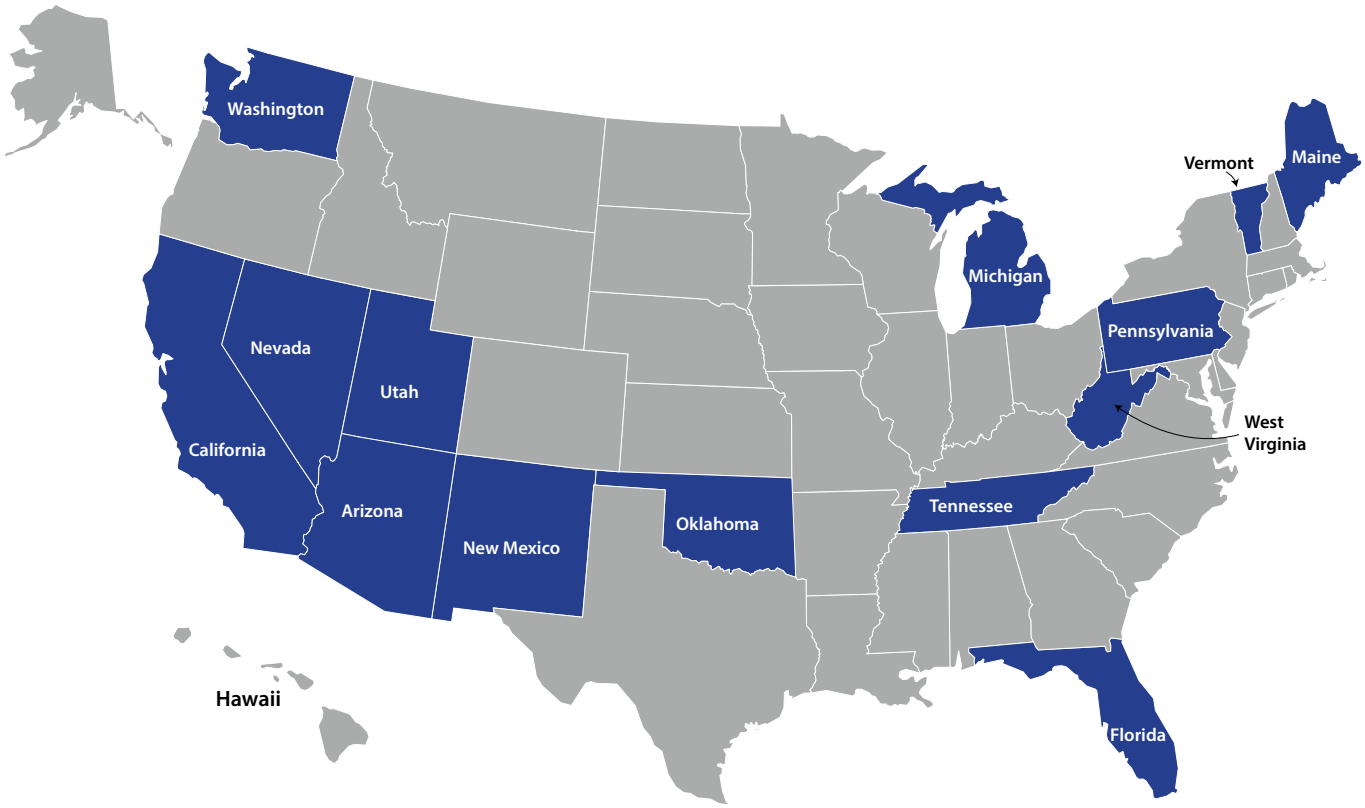
In 1889, the Supreme Court ruled that states could require doctors to be licensed, establishing the modern concept of medical licensing that is used in all 50 states today. Osteopathic medicine arose as an alternative to prevailing medical approaches of the late 19th century. Rather than treating symptoms, osteopathic medicine emphasized treatment of the body as a system and stressed the manipulation of joints and bones during diagnosis and treatment. Originally, osteopathic medicine excluded the use of drugs or cutting into the body.

Over time, the two practices of medicine have become increasingly similar in training and practice. A 2001 study by researchers at Michigan State University found that more than half the osteopathic doctors responding to a survey used osteopathic manipulative medicine – the primary practice unique to osteopaths – on fewer than 5 percent of their patients. Osteopathic medical training now includes all the fundamentals of medical doctor training and osteopathic doctors now regularly perform surgery and prescribe medicines.

In 2015, the two accrediting organizations for medical and osteopathic doctors merged into a single accreditation system that allows for the distinctiveness of osteopathic medicine.

Most states regulate these professions through one board, typically made up of both medical and osteopathic physicians. Washington is one of 14 states that regulate osteopathic and medical doctors separately, as shown in **Exhibit 1**.

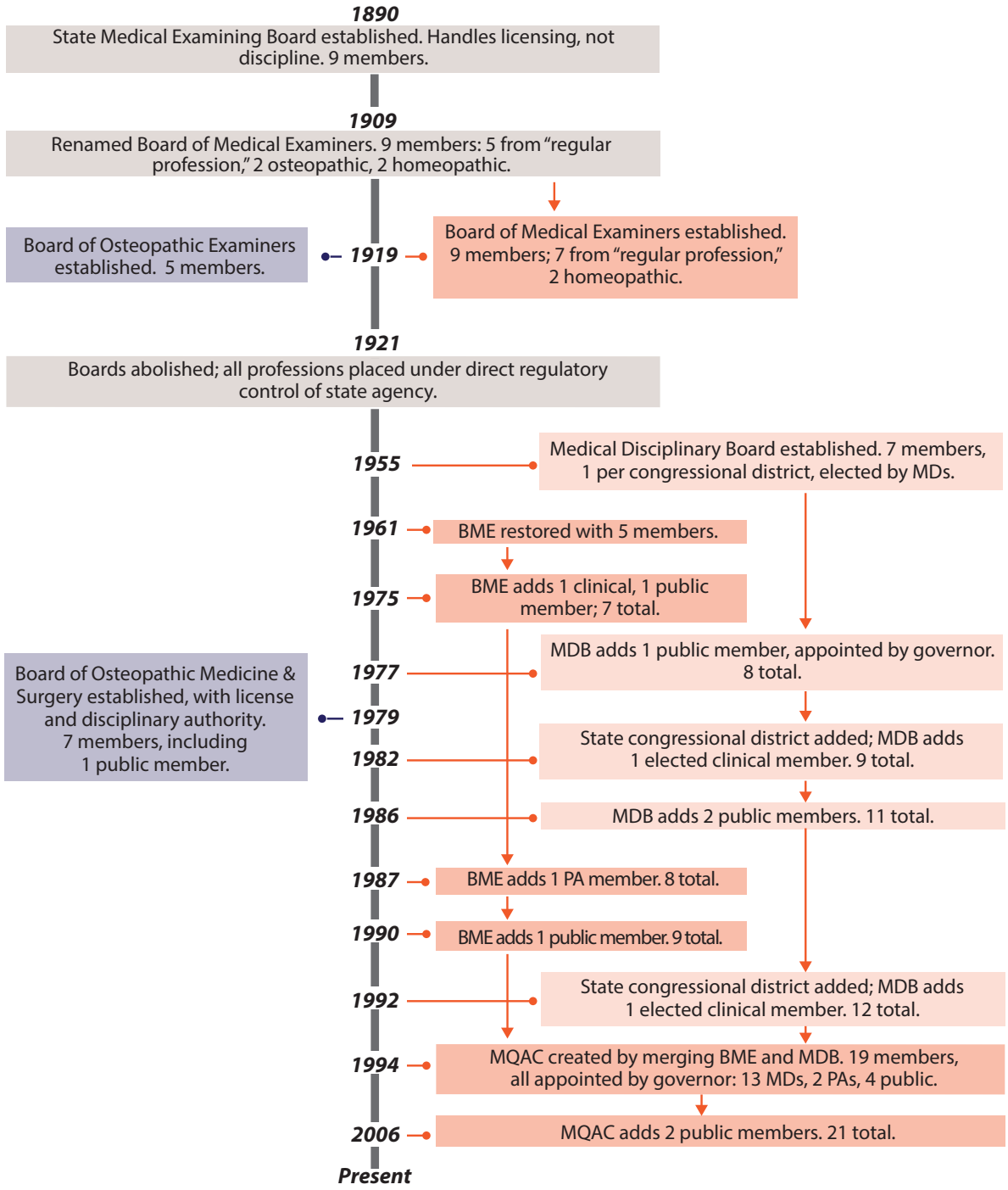
Exhibit 1 – Washington is one of 14 states that regulate osteopathic and medical physicians separately



Washington's medical board structure has evolved to suit changing times and conditions

Over the years, Washington has changed its views on the best way to regulate medical and osteopathic professionals. One board governed both professions from 1909 until 1919; two boards did so from 1919 to 1921. Then both boards were among dozens abolished as part of a statewide reform, and regulatory control of all doctors moved to various state agencies. Two boards covering medical doctors were re-formed in 1955 and 1961, and merged in 1994 into the Medical Quality Assurance Commission (MQAC). Osteopathic doctors remained under direct state agency regulation until the Board of Osteopathic Medicine and Surgery (BOMS) was restored in 1979. **Exhibit 2** illustrates this regulatory timeline and also notes changes in board composition.

Exhibit 2 – A timeline of medical regulatory bodies in Washington



BME: *Board of Medical Examiners*
BOMS: *Board of Osteopathic Medicine and Surgery*
MDB: *Medical Disciplinary Board*
MQAC: *Medical Quality Assurance Commission*

Boards exist to protect the public

The legislative purpose behind both boards is to "assure the public of the adequacy of professional competence and conduct in the healing arts." Both boards oversee licensing, including discipline for providers, and are empowered to set policies having to do with the practice of medicine. These policies often provide guidance to providers on important current issues. However, board members spend most of their time handling disciplinary matters: complaints, investigations and sanctions.

In addition to merging and separating the two boards, the Legislature has changed the composition of both boards repeatedly. In addition to describing the composition of each board, state law specifies the number of clinical and public members, how often the boards must meet, and what issues they must consider. Providers and nonprofessionals may apply to sit on either board through an online application on the Governor's Office's website and are appointed by the Governor as vacancies occur. The current composition of the boards is shown in **Exhibit 3**.

Exhibit 3 – Composition of MQAC and BOMS

Goals	MQAC	BOMS
Total number of members	21	7
Number of public members	6	1
Number of meetings of full board annually	8	6
Number of meetings to assess complaints annually	52	26
Average number of complaints received annually (over audit period, 2009-2014)	1,518	110
Total number of licensees (as of June 30, 2015)	30,710	1,828

Source: Department of Health.

Public and clinical membership on boards is important for accountability

One constant with medical regulatory boards is the requirement that the majority of the board be professionals in the regulated practice. As a practical matter, doctors are the only people with the expertise needed to adjudicate highly technical cases that hinge on the practice of medicine.

In the 1970s, the Legislature endorsed the importance of adding nonprofessionals to the boards, declaring "that the addition of public members on all health care commissions and boards can give both the state and the public, which it has a statutory responsibility to protect, assurances of accountability and confidence in the various practices of health care." Sociologist Ruth Horowitz, who has served on and studied state medical boards, made the case for public members in a book entitled *In the Public Interest: Medical Licensing and the Disciplinary Process* (Rutgers University Press, 2012). Doctors, with years of specialized education and experience, approach cases from a clinical perspective, and public members, she writes, remind doctors of the patients' views.

State law establishes the regulatory structure and requirements of boards

Washington, like all states, must strike a balance between the advantages of having many boards and the advantages of having few. Having more boards provides more flexibility and makes it easier for providers to be judged by their peers; having fewer boards makes it easier to achieve consistency between professions.

In Washington, 37 medical professions are regulated by 17 boards and commissions, while 46 more are regulated by DOH under the authority of the Secretary of Health.

The Department of Health plays an important role

Until 2008, Washington's Department of Health (DOH) regulated and supported both BOMS and MQAC through its Health Systems Quality Assurance (HSQA) Division. In that year, MQAC became independent and gained full authority over its own dedicated employees, including complaint intake staff, investigators and lawyers, and its budget. DOH continues to provide BOMS' personnel: most of the staff positions, including investigators and attorneys, serve multiple boards at the same time. Both boards are funded by the fees paid by their licensees.

Both MQAC and BOMS are served by the DOH website, which is the main online resource for people who wish to learn about, search for, and file complaints about all medical and osteopathic doctors or physician assistants.

The Uniform Disciplinary Act facilitates consistent procedures between professions

One tool used by Washington to improve consistency between the 83 individual professions is the Uniform Disciplinary Act (RCW 18.130). All healthcare providers must comply with the many chapters and sections of the Act, not only the physicians and physician assistants regulated by MQAC and BOMS but professionals such as nurses, dentists, pharmacists, and acupuncturists regulated by other boards. It spells out 25 infractions that are considered "unprofessional conduct," from "any act involving moral turpitude, dishonesty or corruption" and "incompetence, negligence or malpractice" to taking bribes and kickbacks. There are limits: boards can review complaints relating to poor medical care, but not poor bedside manner; suspected fraud, but not billing disputes. It also requires regulatory bodies to establish procedures that "ensure substantially consistent application" of the Act, including sanctioning schedules that serve as guidelines on the severity and duration of disciplinary actions.

A national organization offers "best practices" for state boards

The Federation of State Medical Boards (FSMB) is a national membership organization to which all the medical and osteopathic boards belong. Its board is made up of members of state boards, and it has its own staff.

To achieve the goal of adequate professional competence and conduct, FSMB recommends a state's medical practice act contain certain elements. It publishes two sets of guidance for state medical boards: *The Essentials of a State Medical and Osteopathic Act* and *Elements of a State Medical and Osteopathic Board*. As their titles suggest, the first publication serves as a blueprint for an effective medical practice act; the second provides additional guidance that may help better protect the public by ensuring the board is properly configured to deliver quality healthcare. For example, *Essentials* recommends that boards should have control over their staff; *Elements* lists the positions that should exist on a board's staff.

The disciplinary processes MQAC and BOMS use are similar

A normal practice of regulatory boards is to use panels or committees, composed of at least three members, to make specific decisions on behalf of the overall board. Instead of a standing committee, both MQAC and BOMS use panels called Case Management Teams (CMTs) to decide whether or not to investigate complaints. The composition of CMTs vary from meeting to meeting, with board members attending as their schedules permit.

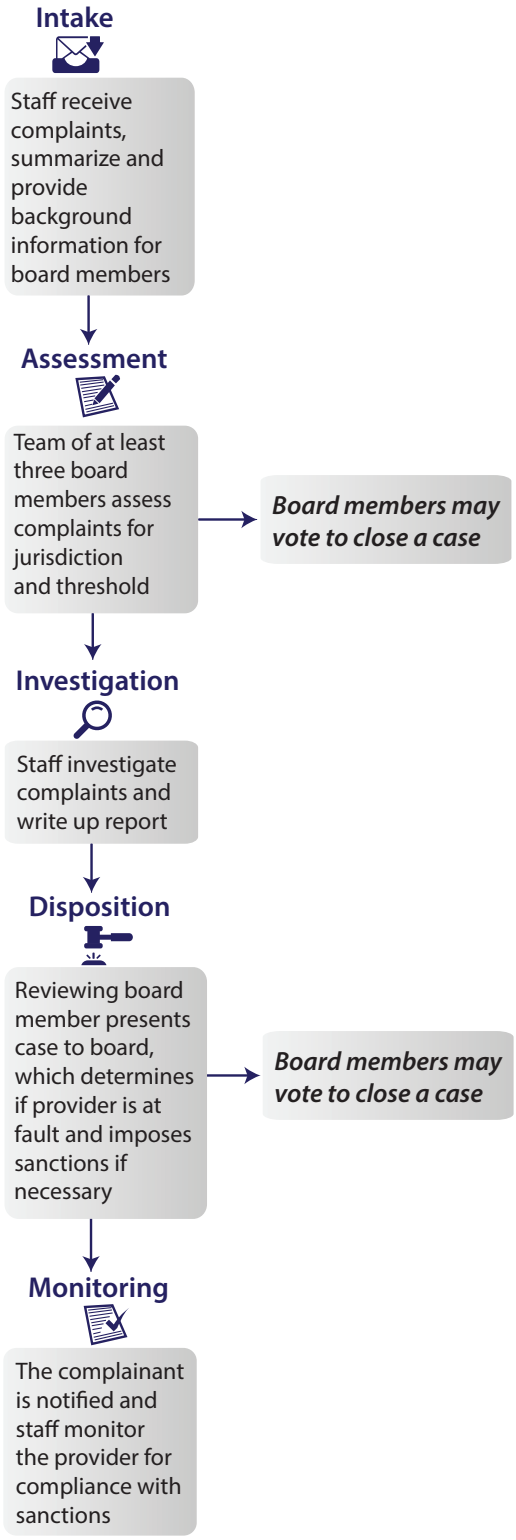
MQAC and BOMS employ similar processes to manage the complaints they receive, as illustrated in **Exhibit 4**. After a complaint is processed by intake staff, it is assessed by a CMT. There are expectations of timeliness for complaint assessments. If a patient is in "imminent danger," the assessment must take place within five days; all other assessments must be processed within 21 days. The CMT must determine whether the complaint is within the board's jurisdiction, as defined by the Uniform Disciplinary Act, and if it merits investigation. Medical expertise is sometimes useful at this stage, but complaints usually do not provide enough information for even experts to make a judgment about the quality of care. Rather, the decision is based on whether the alleged action is a violation described in the Act and is credible. If the complaint does not meet these standards, the CMT will vote to close the case.

If the CMT votes to open the case, a staff investigator is assigned. When the investigation is completed, the resulting report is sent to a member of the board, designated the "Reviewing Board Member" or "Reviewing Commission Member." When the case involves clinical issues, the case is usually assigned to someone whose specialty matches the issue of the case; when the board does not have such a specialist, an outside doctor may be contracted to serve as reviewing member. The reviewing member presents the facts of the case to the remaining members of the board, and may make a recommendation on disposition. The board decides whether there was a violation of the law and what type of discipline, if any, is needed. Many cases involve deciding whether the provider met the "standard of care," and this judgment requires medical expertise, but all members are allowed to vote regardless of expertise.

Complaints occasionally result in disciplinary sanctions. There are many different sanctions available through the Uniform Disciplinary Act, and those imposed depend on the nature and severity of the complaint. Discipline often includes a combination of different sanctions, such as:

- Fines
- Inspections (announced or unannounced)
- Additional education
- Practice restrictions
- Required evaluation
- Writing a relevant paper
- Delivering a relevant presentation
- Appearances before the board
- License probation
- License revocation

Exhibit 4 – Complaint investigation process



In many cases, discipline is not so much a tool for punishment as an opportunity for education. This is often the case when a provider has made a single mistake but is otherwise considered competent. Sanctions in such cases may require the provider to research the problematic issue and write a paper or give a presentation to his or her peers. In other situations, a sanction may include in-person visits by an investigator to verify the provider is making adequate changes to their practice.

Sanctions typically last a year for minor infractions, and up to five years for more severe infractions. Board staff monitor the imposed sanctions on behalf of the board until they are completed and verify that the provider adequately addresses each sanction. The boards are responsible for ensuring any imposed sanctions are completed.

Washington's courts impose certain restraints on issuing sanctions

In most states, to rule there was a violation, a board must find there is a "preponderance of evidence," the standard recommended by the FSMB in its *Essentials of a State Medical and Osteopathic Act*. Washington's Supreme Court, however, requires that state regulatory bodies meet a higher standard of proof, "clear and convincing," which can make it more difficult for the boards to take action against a provider.

Scope & Methodology

To determine whether the disciplinary activities of MQAC and BOMS supported the legislative intent to ensure quality healthcare and protect the public, we compared Washington state regulations and board policies, procedures and processes to best practices. We also analyzed more than 8,600 complaints received by the boards between January 1, 2009, and September 30, 2014, including a review of 330 physical case files, selected using a random sample.

Best practices

The audit used various best practices to assess the disciplinary-related functions of the two boards. The criteria used includes selected practices within the audit scope from the following sources:

- Federation of State Medical Boards
  - *Essentials of a State Medical and Osteopathic Practice Act*, April 2015
  - *Elements of a State Medical and Osteopathic Board*, April 2015
- National Association of State Auditors, Comptrollers and Treasurers
  - *Carrying Out a State Regulatory Program*, March 2004
- U.S. Department of Justice
  - Federal Register Vol. 76, No. 117. *Policy Guidance to Federal Financial Assistance Recipients Regarding the Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, June 2002

A full listing of the best practices used, including the comparison results, is in **Appendix C**.

To analyze whether the boards disciplinary activities were meeting legislative intent, we categorized the best practices into seven areas and then assessed to what extent the boards used the practices. The seven areas are:

- Composition and role of the state medical board
- Adequacy of investigations
- Enforcement of sanctions
- Transparency of processes
- Public visibility of the boards
- Timeliness of processes
- Consistency of complaint assessment

Our audit compared these and other state regulatory best practices to Washington state regulations and board policies, procedures and processes.

In the area of visibility, we conducted additional analysis. For people to file a complaint, they must know where to direct the complaint. We wanted to know whether the boards adequately promoted their existence and purpose. We reviewed recent complaint trends and analyzed the demographics of the ZIP codes where complaints originated, testing to see whether the boards reach all areas of Washington and all the state's residents, regardless of income, education and use of languages other than English.

Outside the scope of this audit

Our audit did not assess whether the decision to investigate any single complaint was correct, nor whether the final disposition of complaints was correct. Because the audit scope was related to the boards' disciplinary processes, we also did not examine their licensing functions or educational requirements.

Audit performed to standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with Generally Accepted Government Auditing Standards (December 2011 revision) issued by the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains more information about our methodology.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the State Auditor's Office will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time, and location (www.leg.wa.gov/JLARC). The State Auditor's Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion.

Audit Results

Question: Do the processes of MQAC and BOMS support the legislative intent of the Uniform Disciplinary Act to ensure quality healthcare and protect the public through their disciplinary activities?

Answer in brief

We found the state's medical practice regulations and the disciplinary processes of both the Medical Quality Assurance Board (MQAC) and the Board of Osteopathic Medicine and Surgery (BOMS) meet the legislative intent of quality healthcare and public safety. The state's laws incorporate many of the regulatory best practices and guidelines suggested by experts in the field; both boards follow most of the best practices we identified, conducting investigations in response to complaints lodged by members of the public.

However, the existence of two boards conducting essentially identical work creates the potential for inconsistent treatment of complaints, and contributes to inefficiencies that could be avoided by merging the two organizations. We also identified issues in law that the Legislature might address to offer more disciplinary flexibility to the boards, as well as practical activities that each board can undertake to improve data management and processes. We discuss selected practices throughout the report, and a full comparison is in Appendix C.

The seven areas we examined:

- Composition and role of state medical boards
- Adequacy of investigations
- Enforcement of sanctions
- Transparency of processes
- Public visibility of the boards
- Timeliness of processes
- Consistency of complaint assessment

Washington's laws lay groundwork for effective boards, but disparities between MQAC and BOMS raise concerns

MQAC and BOMS serve very similar professions, review similar issues, and operate in similar regulatory environments; nonetheless, they regulate very different numbers of providers, and their boards differ in size and composition. We found multiple ways in which MQAC and BOMS differ in the way they manage their affairs and regulate their providers:

- **Board size and composition:** Best practice calls for 25 percent public members. MQAC's structure follows best practice, with six (29 percent) public members on its 21-member board, while BOMS has only one (14 percent) public member on its seven-member board.
- **Timeliness of complaint assessment:** MQAC's larger board, meeting more frequently, is able to assess 95 percent of cases within mandated timeframes, while BOMS assessed cases within its deadlines 78 percent of the time in the 21 months ending September 2014.
- **Rates of complaint investigation:** BOMS opens proportionally fewer investigations, including closing some cases when MQAC would open one.
- **Control over budget and staffing:** MQAC controls its budget and staffing, including legal counsel and dedicated clinical investigators; BOMS does not and shares resources with more than 70 other professions.
- **Representation of physician assistants:** MQAC includes them as board members; BOMS does not.

BOMS has proportionally fewer public members on its board than MQAC

The Federation of State Medical Boards (FSMB) recommends at least 25 percent of a board be public members. Currently, MQAC has six public members, about 29 percent of its 21-member board, while BOMS has one public member, only about 14 percent of its seven-member board. This places BOMS as the fifth-lowest in the nation in public membership. The range of public members on state boards with at least one public member is from 11 percent in South Dakota to 47 percent in California. On average, we found that medical boards with at least one public member included about 25 percent public members. Only two state boards, in Alabama and Louisiana, have no public members.

This limited representation means that public members of BOMS have less input on the decision to open an investigation during the complaint assessment process. Due to the much smaller size of BOMS and its lower proportion of public members, we found that the public was represented at just over half (53 percent) of BOMS' assessments, while at least one public member attended nearly all (99 percent) of MQAC's complaint assessments. In fact, more than 60 percent of MQAC assessment meetings had equal numbers of public members and clinical members present. The current composition of BOMS, with only one public member, makes similar public representation impossible. The public is thus chronically under-represented during one of a medical board's key activities: the assessment of patient complaints.

The boards resolve complaints within target times, but BOMS misses assessment targets in one-fifth of cases

When a complaint is filed, it is important to quickly review and assess it to minimize the risk to public safety and provide timely resolution to the complainant. We found that, overall, both boards resolved complaints in a timely manner, with most investigations and dispositions completed within target timeframes. However, their intake and assessment processes were not as reliable.

Both boards require that a complaint be assessed within 21 days. MQAC meets the targets more frequently than BOMS, as its greater number of members allows for more frequent meetings. We found BOMS did dramatically improve its assessment times during the latter half of the audit period – from 32 percent on-time in 2009 through 2012 to 78 percent in 2013 and 2014. BOMS managers told us that, due to the low volumes of complaints received, it is not practical for its CMTs to meet more often than every other week to improve assessment timelines even further.

MQAC also showed improvement across the audit period, from 93 percent on time in 2009-2012 to 95 percent in 2013 and 2014; they attribute performance improvements to having gained sole control over the complaint intake process.

BOMS investigates a lower percentage of complaints than MQAC, and declines to investigate complaints MQAC would likely open

Our analysis of more than 8,600 complaints made from 2009 to 2014 showed that MQAC investigated 68 percent of complaints it received. BOMS investigated 57 percent: 11 percentage points fewer cases than MQAC.

We reviewed 53 complaints that BOMS decided not to investigate, and found four which, based on our review of about 200 complaints made to MQAC and the resulting assessment decision, would have been investigated by MQAC. For

each of these complaints, we found similar cases that were opened by MQAC. In fact, one of them was considered by both boards; MQAC voted to investigate while BOMS voted not to. Because of concerns about patient privacy, we are not publishing details of these complaints.

We do not claim to know why the investigation rates are different. Nor do we claim that one board is right and the other is wrong. However, the risk of not opening a valid investigation – public safety is jeopardized – is greater than investigating an unsubstantiated complaint – wasted time and resources for state and provider.

MQAC controls its budget and staffing, which gives it more flexibility to protect the public

FSMB recommends a medical board have its own dedicated staff, including administrative and legal staff and clinical investigators. Until recently, DOH provided all staffing services for both MQAC and BOMS through its Health Systems Quality Assurance (HSQA) division, and controlled both of their budgets. In 2008, the Legislature authorized MQAC to begin a five-year experiment to determine whether it was more effective to control its own budget and staffing. At the end of the experiment, MQAC and DOH reported to the Legislature that autonomous control permitted it to better regulate its providers, and as a result, better protect the public.

The report stated that the most important distinction of autonomy was MQAC's ability to "design a fully integrated business model where investigators and staff attorneys work side-by-side, dedicated to Commission work alone, and develop the expertise necessary to regulate the complex multi-specialty medical profession." The report also included a letter from FSMB expressing support for MQAC's continued independence to the Legislature. BOMS was not included in the experiment and continues to share HSQA staffing and budget resources with more than 70 professions.

Physician assistants are regulated by – and represented on – MQAC, but not BOMS

Physician assistants, medical or osteopathic, are regulated by either MQAC or BOMS. Physician assistants are represented by two members on MQAC, but are not represented on BOMS. During the 2015 legislative session, a bill supported by the Washington Osteopathic Medical Association would have increased BOMS' size and added a physician assistant seat on the board, but the bill did not pass. If it had done so, with only 59 osteopathic PAs in Washington, the Board might have found it difficult to fill the seat.

The state could improve consistency and timeliness of complaint resolution by merging BOMS with MQAC

In 2009, Governor Gregoire issued two executive orders to eliminate boards and commissions, noting in both that "the existence of unneeded boards and commissions can lead to a lack of accountability and create confusion and unnecessary regulatory burden on executive agencies and the public." The public showed their desire for more streamlined government services when Initiative 900 was passed directing the State Auditor's Office to conduct performance audits that include identification of duplicative services and make recommendations to eliminate them.

Studies of osteopathic practice show that much of what osteopathic doctors now do is the same as medical doctors, including prescribing medicines and performing surgery. A 2006 article in the *Journal of the American Osteopathic Association* noted that "there is nothing in any of the various iterations of osteopathic principles that would necessarily distinguish osteopathic from allopathic [medical] physicians in any fundamental sense." However, when patients or their representatives wish to lodge a complaint about a healthcare provider, they may find their complaints treated differently depending upon which board governs their physician.

Consistent application of the laws governing medical practice is a keystone of Washington's regulatory framework. The Uniform Disciplinary Act (UDA) requires that boards and commissions create procedures to ensure substantially consistent application of the UDA, including a universal sanctioning schedule for all health professions. While these efforts decrease the risk of inconsistency between boards and commissions, they do not eliminate it. Having two boards performing very similar work for two very similar professions introduces the additional and unnecessary risk of inconsistency. In a 2013 report to the Legislature, DOH noted "inconsistent standards, practices and outcomes even among very similar professions such as allopathic [medical] and osteopathic physicians." A merger of the two boards would eliminate this inconsistency, but agency management expressed concerns about possible consequences to the osteopathic profession if the legislature merged the boards.

Would merging the two medical boards harm the practice of osteopathic medicine in Washington?

Thirty-six states regulate medical and osteopathic doctors through a composite medical board. We reviewed these states' osteopathic associations, related regional osteopathic associations, and national osteopathic associations and found no advocacy for separating these boards. Any advocacy supporting the distinction of osteopathic medicine was primarily related to osteopathic professionals lobbying their government to ensure their profession is represented equally.

At least two associations, in Colorado and Missouri, created grassroots advocacy programs that formalize these efforts. In Massachusetts, the association lobbied successfully to include osteopathic doctors in legislation originally written to only apply to their professional counterparts. Finally, a survey of ten composite state boards, and five of the states' osteopathic associations, found no negative opinions related to inclusion of MDs and DOs on the same board, except in Texas, which at the time lacked osteopathic representation on their composite board; this has since been corrected.

We found no correlation between states' recent DO population, or rate of change, and whether the state used composite or separate boards. Based on our analysis and recent studies, the factor that most explains how many osteopathic doctors practice in a state is whether it has an osteopathic medical school.

How would a merger affect board composition?

MQAC and BOMS group physicians together based on their medical degree. Both MDs and DOs specialize in areas such as cardiology, plastic surgery or psychiatry. Specialties such as psychiatry and cardiology are much more different than the practices of MDs and DOs with the same specialty.

In its guide to osteopathic medicine, the American Association of Colleges of Osteopathic Medicine states, "While allopathic [medical] doctors, MDs, are almost universally recognized as being fully licensed physicians, most Americans would have difficulty defining an osteopathic physician. In fact, many patients visit DOs every day without realizing they are receiving medical care from an osteopathic physician."

Despite this, MQAC regulates all MDs, whether they are cardiologists, plastic surgeons, pediatricians or psychiatrists, and BOMS likewise regulates all DOs, also regardless of specialty. Physician assistants are regulated with their respective doctors, a legislative decision that is common but not mandatory, as six states regulate PAs separately. A physician assistant license is a different credential than an MD or DO, so both boards are already designed to regulate multiple professions, in addition to the varying specialties within the professions. A merger of the boards would not require a major shift in how they operate, except for two issues: it would give osteopathic PAs a place on the board that regulates them and it would affect the workload of osteopathic physicians seated on the newly merged board. Due to the previous pilot project involving MQAC, administrative mechanisms are already in place to support giving BOMS the same autonomous control that MQAC enjoys.

A merger would significantly change the workload of osteopathic physician board members

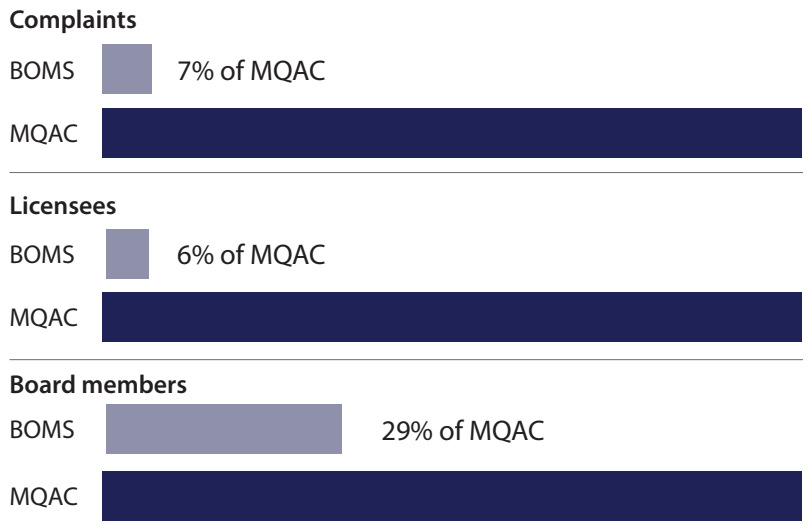
BOMS, with its fewer licensees, receives far fewer complaints than MQAC, as shown in **Exhibit 5**. As a result, it has a much smaller assessment and review workload than MQAC (see **Exhibit 6**); one so modest that it is difficult to justify the need for a separate board. If the osteopathic workload were absorbed into MQAC, with three osteopathic members added to MQAC's current structure, the overall review workload for each member of the new board would likely lessen.

We determined that osteopathic membership on a composite board should be about 10 percent. We found that states with a composite board and at least one osteopathic board member had an average of 10 percent osteopathic membership on the board. If Washington represents osteopathic physicians on a merged board with a minimum of 10 percent representation, this would add three osteopathic members to the current MQAC board, resulting in a workload of about 63 complaints per year per board member.

This is significantly higher than a current BOMS board member's workload, but lower than the current MQAC members' workload. If the board size remains constant but complaints rise with the growth in state population, we estimate that by 2026, the workload would increase to about 84 complaints per member per year.

Exhibit 5 – BOMS compared to MQAC

Fewer complaints, fewer licensees, fewer members



Source: Department of Health.

Exhibit 6 – Per-member workload would decrease in a new merged board

Source: Department of Health.

Concerns about negative impacts to the osteopathic profession appear unfounded

BOMS management shared concerns about the possibility of losing the distinctiveness of their profession, and also physician representation of osteopathic doctors (DOs) in the state if the boards were merged. While valid, these issues have successfully been dealt with before during other, similar mergers (detailed in the sidebar). While both professions would be regulated by the same board, DOs would still retain their unique credentials and also be represented by osteopathic professionals on the new composite board. Issuing multiple, differing licenses should not be problematic, as the boards already issue multiple license types for both physicians and PAs.

While having separate boards might have made sense a century ago, we believe the risk of inconsistent treatment of the public's complaints is greater than the benefit of a separate board for osteopathic providers. One consolidated board, with osteopathic representation, would deliver more consistent consideration of complaints and so better serve the public.

The boards could benefit from law or rule changes

Washington's standard of proof is higher than that required of most other state medical boards

Most states' medical boards need only establish a "preponderance of evidence" to show that a provider committed a violation. However, in 2001, Washington's Supreme Court issued an opinion requiring Washington medical boards to meet a higher standard of proof, "clear and convincing," because discipline may affect a provider's ability to make a living. While this offers more protection for medical providers, this may make it more difficult for boards to protect the public and take action against a provider.

In cases where the standard of proof is not met, but boards observe possible indicators of misconduct, they have no legal method to communicate these concerns to the provider. Instead, they can only suggest to the provider that even though discipline wasn't applied, they could still take the opportunity to improve their practices. This is a lost opportunity for the boards to protect the public by improving the provider's practice.

One possible solution to this problem, recommended by the FSMB, is issuance of a "Letter of Concern." Although patient safety advocates say it could result in less-transparent actions by the boards and could be used when reportable disciplinary action should be taken, such letters would allow the board to communicate concerns to the provider, even when the standard of proof for sanction is not met. These letters are considered non-disciplinary and are not reported to national repositories for such information. MQAC previously requested this authority (calling it a "Letter of Guidance"), but the Legislature has, so far, declined to grant it.

At the time of writing, the American Osteopathic Association is merging its college accreditation function into the Accreditation Council for Graduate Medical Education, creating a single accreditation for all medical schools whether for DOs or MDs. During this process, osteopathic representation is ensured by including osteopathic doctors on the merged board of directors and on an existing review committee.

Two new osteopathic-specific committees were also formed. Doctors from both professions participated in the study to determine whether a merger was appropriate.

Washington's list of unprofessional conduct violations closely matches FSMB recommendations, but gaps exist

Washington's Uniform Disciplinary Act lays out 25 violations that constitute unprofessional conduct, and administrative code lays out additional rules, created by regulatory entities. The FSMB recommends a state's medical practice act establish 58 different violations, many of which are already covered in Washington law or code, either explicitly or implicitly. Some items from FSMB's list are not currently in Washington's laws or codes. For example, FSMB suggests that a physician's failure to protest inappropriate managed care denials by insurers should be considered an offense, but this definition of unprofessional conduct is not included in state regulations.

The FSMB also recommends that inadequate record management should be considered an offense. This is not explicitly listed as an offense in the Act or any rules or policies, but the boards do take action against providers who do not keep adequate records, under the broad authority granted by the UDA. To reduce the risk of future inconsistency, the boards, together with the Legislature, should decide whether state law should be changed to better reflect the FSMB recommended definition for unprofessional conduct.

Whether or not the boards are merged, both could improve the ways they communicate with patients

During our comparison of best practices to the ways in which both boards address visibility and transparency, we identified several opportunities for improvement:

- How boards communicate their presence and purpose to the public
- How they use technology, such as a website, to facilitate communication
- How they interact with people with limited proficiency in written English
- How they interact with people who have filed complaints

It is important that boards clearly and effectively communicate with the public as well as their licensees. The public must know how to file a complaint – a process that should be as simple as possible – and also be aware of disciplinary actions taken against medical professionals. If patients do not know who regulates a medical professional, they may send their complaints to the wrong organization, such as the Washington State Medical Association, a county health department or a federal agency, and it may not be investigated.

The first step is to make their presence and purpose clear to patients

The Legislature intends that all residents have the ability to file a complaint against their medical providers. It is the boards' responsibility to ensure as many people as possible understand how to do so. The boards have taken steps in the last few years to increase their visibility, including increasing outreach efforts to medical and osteopathic schools, restarting a newsletter, hosting a medical conference, and opening active social media accounts. Most of these efforts, however, serve medical providers rather than the general public. To reach the public, the boards increased the number of press releases issued about disciplinary actions, which regularly earn media coverage, increasing public awareness that they can file a complaint.

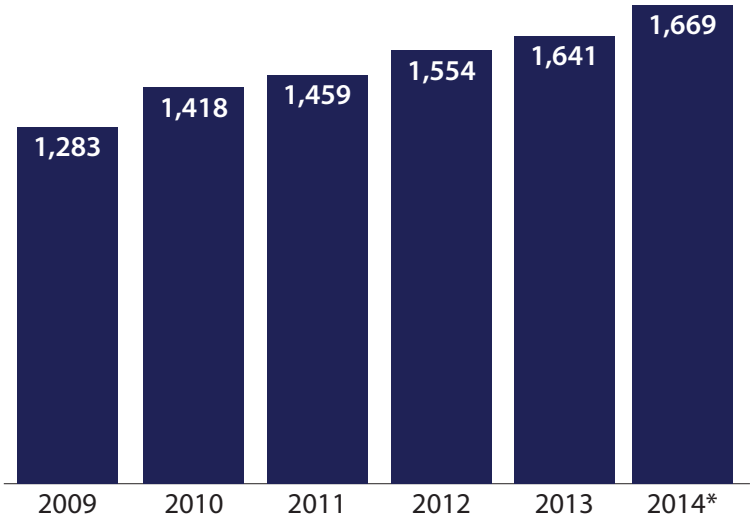
Public awareness of the boards appears to be increasing, but more can be done

As shown in **Exhibit 7**, the number of complaints steadily increased from 2009 to 2014, suggesting the boards' outreach efforts may have had a positive impact on the boards' visibility.

We analyzed complaints made during the audit period and found no significant variation in submitted complaints by indicators such as language, level of income and education. This shows that the boards appear to reach demographic groups in the state equally.

That said, we cannot know the number of complaints not submitted or the percentage of people who did not know how to file a complaint. It is important for the boards to take every reasonable step to increase public awareness of the boards.

Exhibit 7 – Number of complaints considered by MQAC and BOMS combined



Source: Department of Health data provided to State Auditor's Office.
*Note: *Extrapolated from nine months of data.*

When complaints are submitted to the wrong organization, MQAC and BOMS must count on the outside organization to forward the complaint quickly, which can delay or prevent consideration of that complaint. For example, one complaint in our sample was sent to HSQA but involved a doctor regulated by MQAC. It took more than four months for the complaint to be delivered to the right board after the complainant followed up, even though both are part of DOH. While this case is not representative, it illustrates possible delays when complaints are submitted to the wrong entity. During our audit, we also found evidence that some Washington providers advise patients to complain to The Joint Commission, a national nonprofit organization which accredits and certifies health care organizations and programs, rather than the Department of Health.

The Department of Health requires healthcare facilities to post information about patient rights and where to complain about healthcare providers. However, when we asked the boards for information about this, MQAC staff reported they were unsure whether they had this authority.

California requires medical providers, not just medical facilities, to display posters or distribute written materials telling patients about the state's medical board and its purpose. Staff at the Medical Board of California estimated a 10 percent increase in complaints each year since the requirement was enacted.

Example of California's notice

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

The website does not provide a simple resource for the public to know how to complain or to get information about providers

DOH's website offers the public information about healthcare providers, including how to file a complaint. However, the site is difficult to use and in 2016 received a poor ranking in a review of medical board websites by Consumer Reports – 39th out of 50 states. We found that the process to file a complaint on the website is unclear and confusing, and may result in someone submitting a complaint to the wrong board.

Searching for a healthcare provider is not much easier. To look up a doctor, a person must know at least the first letter of the provider's first name, which not all doctors use professionally. To refine a list of providers, the only option is to restrict the search to a provider's specific credential. If a user is looking for a medical doctor, she or he must know to search for "physician and surgeon" and then choose from 11 possibilities.

A provider's profile shows whether disciplinary action has been taken against them, but the only way for the public to determine the specific offense is to read attached legal documents. If someone does not do this, the profile does not differentiate between, for example, a doctor accused of sexual misconduct and a doctor accused of administering the wrong dose of medication. Both boards already write summaries of the misconduct for their press releases and newsletters, but those summaries are not attached to a provider's profile.

FSMB recommends that state medical boards put enough information on their websites to allow patients to select a provider. Several states do this, including Oregon. However, as shown in **Exhibit 8**, Washington's online physician profiles lack much of what the FSMB recommends, including medical education, criminal history, disciplinary actions taken by hospitals and other state disciplinary actions. The website could become a much more valuable resource to help people find providers by using information already available in DOH's system, subject to what is allowed by law.

Exhibit 8 – Washington's online physician profiles do not provide the public with all recommended information

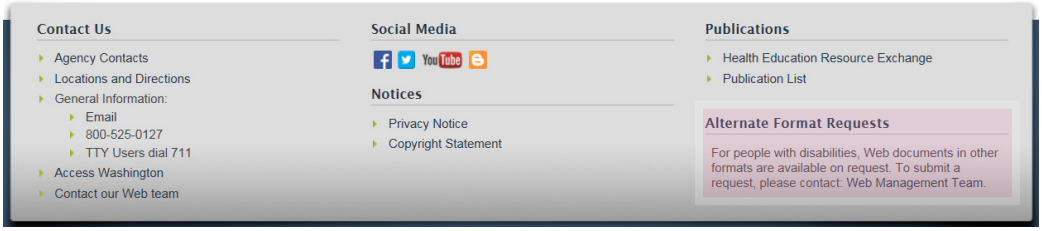
Recommended by FSMB	Included in Washington physician profiles
Demographic information	Limited – Only name and birth date provided
Medical education	No
License information	Yes
Criminal convictions	No
Malpractice history	No
Disciplinary history	Partial – Does not include actions from hospitals or other state boards. The nature of offense is available only by reading legal documents attached to the profile.

Source: Federation of State Medical Boards and Washington DOH Provider Credential Search website.

The boards and DOH need to improve accessibility for non-English speakers

Despite efforts to increase public awareness of the boards, we found non-English speakers are not adequately served by DOH's website, either on its general page or the MQAC and BOMS subsidiary pages (these page addresses are spelled out in the sidebar). We found no reference to materials in other languages; as shown in **Exhibit 9**, the only assistance available is aimed at people with disabilities. Without readily available materials in a language they understand, non-English speakers are at a disadvantage, and may not submit their complaints properly – or at all. The complaint form is available in Spanish, but a consumer must click through four pages in English to find it.

Exhibit 9 – The DOH website does not provide information to non-English speakers, although it does offer other formats for people with disabilities



Both MQAC and BOMS rely on DOH for web content, and staff told us they have no control over the translation services provided on the website. When asked about this, the boards' management said it was too expensive to translate the website because of the number of languages spoken in Washington. The federal government provides guidelines on how to address the issue of accommodating non-English speakers. This guidance suggests that common written materials to always translate may include complaint forms, intake forms with the potential for important consequences, notices of disciplinary action and written notices of rights.

We noted that inexpensive technology is already used by other governmental agencies. For example, Google Translate can convert websites into more than 100 languages. While not recommended for all situations, it is good for initial forms of contact, is readily available, easy to use and free of charge.

Both boards have translators available for verbal interactions

Both boards make an effort to serve non-English speakers by other means. For example, they provide telephonic interpreters. Also, when responding to complainants after an investigation decision, both boards include information about obtaining interpreter services in many different languages so non-English speakers are adequately served in the investigative and disposition processes.

DOH's general page URL:
www.doh.wa.gov/LicensesPermitsandCertificates/FileComplaintAboutProviderorFacility/HealthProfessionsComplaintProcess

MQAC general page URL:
www.doh.wa.gov/LicensesPermitsandCertificates/MedicalCommission

BOMS general page URL:
www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewRenewor Update/OsteopathicPhysician

Google Translate is already used by several Washington agencies, including the Governor's Office and the state's main website, Access Washington.

Once a decision is reached about a complaint, the boards must communicate results to both the provider and the complainant

Whichever side of a complaint someone is on – the unhappy patient or the accused provider – the matter is important to them, and likely highly sensitive and personal in nature. It is essential that boards communicate clearly with both parties throughout the complaint process. The Legislature recognizes this and requires boards to notify respondents and complainants when a complaint is received or finalized. Both MQAC and BOMS must also follow Executive Order 05-03, requiring them to use clear language, officially called "Plain Talk," when communicating with the public.

When a doctor was sanctioned, MQAC did not consistently notify the complainant

In 2011, as a result of patient advocacy work, the Legislature passed a law intended to increase transparency of medical board actions. In part, the new law required boards to notify complainants and respondents anytime a complaint was closed, regardless of the end result. Previously, complainants were only required to be notified if a complaint resulted in formal discipline. Despite the new law, we found MQAC notified complainants about 73 percent of the time that a complaint resulted in any type of discipline; BOMS always did so. Both boards do take steps to notify the general public when a doctor is disciplined – such as updating the provider's license status on DOH's website and issuing a press release – but MQAC did not always notify the person who filed the complaint.

When we examined form letters sent during the audit period, we found they could be confusing and incomplete. For example, many letters reported that the complaint did not fall under the UDA, without a clear explanation why it did not. Letters also contained jargon or poorly worded language that could confuse recipients, such as noting that BOMS "has closed this case because No Whistleblower," or "The Board has closed this case because of billing and fee disputes except as designated by disciplining authority." Both were legitimate reasons not to open a case, but the resulting letters did not follow Plain Talk standards.

> *"The Department of Health, Osteopathic Physician & Surgeon License Board has closed this case because No Whistleblower."*
>
> *"The Board has closed this case because of billing and fee disputes except as designated by disciplining authority.*
>
> *~ Excerpts from letters sent to complainants*

Both boards are already working to improve written communication

Staff from both boards reported they are already updating their communications. By further improving these form letters, both organizations can better communicate with providers and the public. When we spoke with HSQA's director of legal services, he noted the public wants to know why a complaint was closed "and they don't speak bureaucrat."

Both boards could better monitor their processes

In addition to the specific issues raised above, we identified other areas that the boards could improve using best practices related to monitoring staff and systems.

The boards generally enforced sanctions, but MQAC staff did not properly conduct unannounced inspections

BOMS and MQAC have an array of disciplinary actions available to them, including requiring inspections of a provider's practice. These visits are usually scheduled. Less commonly, the board specifies that the inspection must be unannounced. We found MQAC staff regularly did not enforce these board orders, until a news story shed light on the issue.

> *I have been requested by the Compliance Officer to do an unannounced compliance review on Dr. Jones before June 2nd. I would like to coordinate this "unannounced" review with you in hopes that it can be done without too much trouble and that Dr. Jones will be in the clinic on the selected day and hour and not scheduled to see patients. Any and all help that you might be able to provide would be greatly appreciated.*
>
> *~ Excerpt from email sent by MQAC to a doctor's lawyer (doctor's name has been changed), May 17, 2012*

We identified one BOMS case and seven MQAC cases that required unannounced practice reviews. BOMS staff complied with the order, staging surprise practice reviews for the doctor. In the seven cases where MQAC specified unannounced reviews, staff did not comply. In each case, MQAC staff notified the provider of the review by email (see the quote in the sidebar) and participated in setting a time for the visit. In one such email, staff acknowledged the review was supposed to be unannounced. Supervisors reviewed the resulting reports, which specified the visits were to be unannounced, but still approved them.

MQAC members became aware of this issue in fall 2014, after a news story on one such case. The person who arranged all but one of the MQAC reviews no longer works for the board, but supervisors who approved the reports do. Staff acknowledged they were bound to follow the letter of the Commission's orders, but told us that unannounced visits presented practical problems (see sidebar '*Unannounced practice visits*'). For this reason, staff decided whether an unannounced visit was actually necessary, regardless of the actual orders. Staff told us that the board is no longer ordering unannounced visits unless deemed absolutely necessary to verify improvements were made and also that they now follow all board orders.

Unannounced practice visits present practical problems

Doctors practicing solo or in small clinics could be absent if an investigator arrived unannounced, resulting in wasted time and resources, particularly in more remote areas of the state. If the provider was there, he or she likely had patients scheduled and an unannounced visit would disrupt patients' appointments.

At larger clinics or hospitals, reviews were often more complicated and required many employee interviews, particularly if the review required them to retrieve records, so unannounced visits may take longer to produce results.

Implementing regulatory best practices would help several data issues we identified

A regulatory best practice is to review program-related information, including checking data reliability and verifying staff follow procedures. We found both boards could improve the above-noted deficiencies in enforcement and timeliness by implementing these practices. Such improvements would increase data consistency across all professions at DOH, as this is a primary reason why the Integrated License and Regulatory System (ILRS) was put in place.

Compliance staff track data about sanctions outside of ILRS

Once sanctions are imposed, boards are responsible for making sure providers comply with them. We found that compliance staff do not reliably track and update sanctions in ILRS, with the consequence that data in this system is often unreliable or out of date. While officers track compliance in systems outside of ILRS, this is problematic for two reasons:

- Current, accurate information is essential to monitor compliance status
- The data in ILRS is also used across DOH, including for performance measures, accurate comparisons between professions and to feed the agency's website

Neither board has accurate data to show how timely complaints are assessed

We found that neither board had accurate information about how quickly they assessed complaints. ILRS auto-fills the "Received" date field with the current date, if a user does not manually enter one. As a result, about 20 percent of the cases we reviewed had incorrect complaint-received dates, with a median difference of four days between actual receipt and recorded receipt. In all these cases, the system indicated the complaint was received later than it actually was, skewing performance data such that it appeared the boards were both assessing complaints faster than they actually were. (We adjusted data on timeliness presented earlier in the report to correct for this effect.) Without an accurate picture of their performance, the boards cannot easily identify if improvements are needed.

BOMS has already made intake process improvements

HSQA intake staff, who process complaints for BOMS, reported that they implemented a quality assurance process in spring 2014. This process includes having supervisors verify the "Received" date in their system matches the complaint's date stamp. While this is a positive step, we noted errors with the "Received" date shortly after HSQA implemented the new process. Our audit did not examine complaints made after September 2014, so we cannot say whether the problem persists.

Conclusion

While having separate boards might have made sense historically, we believe the risk of inconsistent treatment of the public's complaints is greater than the benefit of a separate board for osteopathic providers. One consolidated board, with osteopathic representation, would deliver more consistent consideration of complaints and so better serve the public.

Recommendations

The Medical Quality Assurance Commission and the Board of Osteopathic Medicine and Surgery generally do a good job of meeting legislative intent to protect the public by using education and discipline to improve the practice of medicine in Washington. However, we identified areas of improvement for both boards, including recommendations for statutory changes to the Legislature:

We recommend the Legislature:

1. Merge BOMS and MQAC into one board by adding three osteopathic physicians to the commission.
2. Ensure a minimum of 25 percent public members on the state medical boards, whether this is two separate entities or one merged board.
3. Modify the Uniform Disciplinary Act so all healthcare professionals must post information in a prominent location about where to file complaints.

We recommend MQAC and BOMS (or the merged board recommended above) work with the Legislature to:

4. Determine whether the statutory definition of unprofessional conduct should better reflect the Federation of State Medical Boards guidelines. In doing so, consider the overall impact to healthcare-related professions if the UDA is changed.
5. Work with the Legislature to determine whether the UDA should allow the disciplinary authority to issue a Letter of Concern in situations where the boards cannot meet the standard of proof, but enough evidence exists to show informal reporting to the provider could improve public safety. In doing so, consider the overall impact to healthcare-related professions if the UDA is changed.

We recommend MQAC and BOMS (or the merged board recommended above) work with DOH to:

6. Improve the usability of their webpages, including addition of a translation tool to the website. In deciding what languages to translate to, consider Department of Justice guidelines for written translations.
7. Improve the Provider Credential Search, with consideration of legal restrictions, including the provider search function, to allow for broader provider searches. In doing so, ensure it includes information recommended by FSMB, such as location, specialty and board certification, summaries of violations and enforcement actions, as well as information that can be voluntarily added by providers such as insurance information and whether new patients are accepted.

We recommend MQAC and BOMS (or the merged board recommended above):

8. Continue to improve correspondence by incorporating Plain Talk principles into their communications with complainants and respondents.
9. If the Legislature does not modify the UDA, expand outreach to the public, specifically by using their rulemaking authority to require that all providers post information in a prominent location about where to file complaints.

10. Regularly evaluate whether staff are following policies and procedures, including whether they are accurately entering data into the Integrated Licensing and Regulatory System.
11. Modify current performance measurement activities to regularly evaluate the nature and volume of complaints, the adequacy and consistency of enforcement actions, as well as how well the boards are meeting their mission to protect the public.

We recommend MQAC:

12. Modify procedures to ensure complainants are sent letters at the end of all cases.

Agency Response

STATE OF WASHINGTON

November 4, 2016

The Honorable Troy Kelley
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor Kelley:

Thank you for the opportunity to respond to the State Auditor's Office (SAO) performance audit report on the medical disciplinary practices of the Medical Quality Assurance Commission (MQAC) and the Board of Osteopathic Medicine and Surgery (BOMS). The Office of Financial Management worked with MQAC, BOMS, and the Department of Health to provide this coordinated response.

The audit was designed to determine whether the investigative and related processes of MQAC and BOMS support the legislative intent of the Uniform Disciplinary Act to ensure quality healthcare and protect the public through their disciplinary activities. We are pleased the audit concludes that we are, indeed, meeting this intent. Dedication to public safety is the foundation of our actions and decisions.

We disagree with the SAO's recommendation to merge BOMS and MQAC based on this performance audit. The audit scope and objectives were not designed to determine if the two should be consolidated or if merging the boards would improve patient safety. Whether Washington should have one board or two is a complex question. It affects licensees, patients and many stakeholders. The two years the SAO worked on this audit were not spent assessing those complexities. We believe the evidence presented does not support this recommendation.

The performance audit did not examine the philosophical, specialty mix, and geographic distribution differences in how allopathic and osteopathic doctors practice. The audit neither obtained nor assessed input from key stakeholders in the allopathic or osteopathic communities or consult with medical experts. In general, we recognize efficiencies may result through consolidation. However, this audit neither addressed nor demonstrated whether these efficiencies outweigh any potential negative effects.

The SAO found that, with the current structure, both MQAC and BOMS are meeting their legislative mandates. Each conducts high-quality investigations. Each ensures both complainants and respondents receive the due process to which they are entitled.

As the audit notes, there are always areas for improvement. These recommendations were considered in light of initiatives underway or planned. Efforts to improve our website, conduct outreach through social media, and engage patient advocacy groups are underway. We continually strive to find and implement better, more effective and efficient ways to serve the citizens of Washington.

Sincerely,

John Wiesman
Secretary
Department of Health

David Schumacher
Director
Office of Financial Management

Melanie de Leon
Executive Director
Medical Quality Assurance Commission

Blake Maresh
Executive Director
Board of Osteopathic Medicine and Surgery

cc: David Postman, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Matt Steuerwalt, Executive Director of Policy
Roselyn Marcus, Assistant Director, Office of Financial Management
Scott Merriman, Legislative Liaison, Office of Financial Management
Rich Roesler, Acting Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
Warren B. Howe, Chair, Medical Quality Assurance Commission
Catherine Hunter, Chair, Board of Osteopathic Medicine and Surgery
Martin Mueller, Assistant Secretary, Department of Health

OFFICIAL STATE CABINET AGENCY RESPONSE TO THE PERFORMANCE AUDIT ON MEDICAL DISCIPLINE IN WASHINGTON – NOVEMBER 4, 2016

This coordinated management response to the State Auditor's Office (SAO) performance audit report received on October 11, 2016, is provided by the Washington State Department of Health (DOH), the Medical Quality Assurance Commission (MQAC), the Board of Osteopathic Medicine and Surgery (BOMS), and the Office of Financial Management.

SAO PERFORMANCE AUDIT OBJECTIVES:

The purpose of SAO's audit was to answer the following question:

- Do the investigative and related processes of MQAC and BOMS support the legislative intent of the Uniform Disciplinary Act (UDA) to ensure quality healthcare and protect the public through their disciplinary activities?

SAO RECOGNITIONS:

1. The two medical disciplinary boards are protecting the public and meet the legislative intent of quality healthcare and public safety.
2. DOH's Health Services Quality Assurance division has implemented a process to improve the letters it sends to complainants and respondents.
3. MQAC has made changes to ensure compliance staff follow board orders.

SAO FINDINGS:

1. BOMS investigates a lower percentage of complaints than MQAC. SAO found four cases where BOMS appeared to have jurisdiction but did not investigate complaints; MQAC opened similar complaints. This is not necessarily wrong, but is an inconsistency between the boards.
2. BOMS does not meet complaint assessment performance targets that are set in WAC as frequently as MQAC; BOMS does not (*independently)* control its budget and staffing; BOMS does not provide representation to the physician assistants it regulates.
3. The definition of "unprofessional conduct" in state law is missing some items laid out in the Federation of State Medical Boards' (FSMB) model medical practice act. One notable suggestion by FSMB is that failure by a provider to protest an inappropriate managed-care denial. While both boards use their rule-making authority to expand their definition of "unprofessional conduct," these rules are not reflected in the Uniform Disciplinary Act and so may not apply to other healthcare-related professions.
4. MQAC did not always notify complainants of the case outcome when discipline was warranted. Only 16 out of 22 complainants were informed of the case outcome when their complaint resulted in discipline.
5. The boards outreach to the public is limited to press releases, listservs, and performance reporting. Despite current DOH guidelines on how to implement the patient rights act, the boards do not require that providers tell patients how to complain to the boards, resulting in

patients being misdirected by providers or not notified at all. Current DOH guidelines only apply to selected facilities, so sole practitioners and small clinics are not required to post this information.

6. DOH's website is confusing and does not include translation tools.
7. DOH's Provider Credential Search provides limited information and has limited provider search functions.
8. Washington's standard of proof is higher than recommended by the FSMB, making it more difficult to prove a complaint is legitimate.
9. BOMS and MQAC staff do not use ILRS as intended, including inaccurate data entry and reliance on shadow systems.
10. Current performance management does not adequately evaluate the efficiency and effectiveness of the boards' disciplinary activities.

SAO Recommendation 1: We recommend the Legislature merge BOMS and MQAC into one board by adding three osteopathic physicians to the commission.

STATE RESPONSE: Merging MQAC and BOMS could significantly affect both licensees and patients. It is not a decision to be made without carefully analyzing and considering the effects. The audit was not designed to determine if merging the boards would improve patient safety, and the evidence presented does not support this recommendation.

One of the SAO's key pieces for supporting consolidation is an analysis showing that MQAC opened cases for investigation at a higher rate than BOMS. This analysis averaged the aggregated percentage of cases opened for investigation over several years. Disaggregation of that data, by year, shows that in the most recent period reviewed, BOMS opened cases at a higher rate than MQAC. No analysis was done to better understand what factors accounted for the variations in case rates.

We strongly disagree that cases should be opened at a certain rate. By law and practice, each case must be assessed on its own merits. To assert that MQAC and BOMS should open the same percentage of cases — similar to meeting a quota — is in direct opposition to this. It makes "meeting the numbers," not patient safety, the focus.

SAO also cites four cases in which BOMS appeared to have jurisdiction, but did not investigate complaints, believing that MQAC would do so. Each case is assessed on its own merits by the commission or board members. To assume a different outcome based on auditor opinion — after the fact — is speculation.

Additionally, while the audit noted that 35 states and territories have composite boards, it did not acknowledge that the largest states in terms of population and licensee counts often regulate using separate boards. According to the 2014 Federation of State Medical Boards Census of Licensed Physicians, nearly 450,000, or 49 percent, of the nation's 900,000 physicians are regulated in states with separate boards. Further, the most recent state to consolidate boards was Hawaii nearly two decades ago; recent attempts in Vermont, Oklahoma and Arizona have been unsuccessful.

How medical regulation and discipline are structured clearly and directly affect public safety. There is no one-size-fits-all answer. The question of whether two boards or one is most effective has been raised before. Opinions differ on this subject even among MQAC, BOMS and DOH. However, we are united in our belief that, in the interest of public safety, the decision on whether the boards should remain separate or be merged should not be made based on this audit.

Action Steps and Time Frame:

- Not applicable.

SAO Recommendation 2: We recommend the legislature ensure a minimum of 25 percent public members on the state medical boards, whether this is two separate entities or one merged board.

STATE RESPONSE: MQAC already meets this recommendation. BOMS agrees that additional public membership could be of benefit. In 2015 and 2016, the Legislature considered but did not pass House Bill 1275, which would add two physicians, one physician assistant, and one public member to BOMS. DOH and BOMS will again propose the bill for consideration by the 2017 Legislature.

Action Steps and Time Frame:

- DOH has submitted agency request legislation for the upcoming session for review and approval. *Completed.*

SAO Recommendation 3: We recommend the Legislature modify the UDA so all health-care professionals must post information in a prominent location about where to file complaints.

STATE RESPONSE: MQAC and BOMS agree that public outreach and engagement are effective, and they routinely engage in such efforts. Efforts to improve our website, conduct outreach through social media, and engage patient advocacy groups are underway. This audit provides no evidence to support the idea that a rule such as the one recommended — which would affect all professions under the concept that similarly situated people are to be treated similarly — would be more effective at improving public safety. Stakeholder feedback designed to fully understand the potential impacts on the patient-practitioner relationship would be critical before contemplating such a change. The audit did not address these considerations.

Action Steps and Time Frame:

- Not applicable.

SAO Recommendation 4: We recommend MQAC and BOMS work with the Legislature to determine whether the statutory definition of unprofessional conduct should better reflect the Federation of State Medical Boards guidelines. In doing so, consider the overall impact to healthcare-related professions if the UDA is changed.

STATE RESPONSE: The UDA now provides both MQAC and BOMS with ample flexibility to fulfill their mandates. MQAC and BOMS disagree with the changes suggested by SAO. As SAO notes, these changes would impact all 80-plus health professions currently subject to the UDA while

offering no analysis of how the Federation of State Medical Boards' guidelines would affect enforcement in these other professions.

One example cited by SAO relates to physicians protesting managed-care denials by insurers. Neither MQAC nor BOMS has jurisdiction over insurers. Further, whether a denial is inappropriate is more often a matter of opinion than of fact. Successful enforcement of this provision would require that more weight be given to the subjective opinion of a board member (commissioner) or a board panel than the guidelines used by a managed care company or health insurer. Indeed, these guidelines are typically the product of hundreds of hours of literature review and discussions with experts to determine evidence-based and best practices.

Action Steps and Time Frame:

- Not applicable.

SAO Recommendation 5: We recommend MQAC and BOMS work with the Legislature to determine whether the UDA should allow the disciplinary authority to issue a Letter of Concern in situations where the boards cannot meet the standard of proof, but enough evidence exists to show informal reporting to the provider could improve public safety. In doing so, consider the overall impact to healthcare-related professions if the UDA is changed.

STATE RESPONSE: While we agree that having an alternative to discipline would be beneficial, the recommendation suggests the ability to impose a form of discipline without having met the burden of proof established by the Washington Supreme Court. We therefore disagree with the recommendation as presented. We fully support statutory solutions that are nondisciplinary and that improve quality outcomes, such as educational programs or outcome data that allow for early notification and intervention. We welcome discussions with stakeholders to that end.

Action Steps and Time Frame:

- Not applicable.

SAO Recommendation 6: We recommend MQAC and BOMS work with DOH to improve the usability of their webpages, including addition of a translation tool to the website. In deciding what languages to translate to, consider Department of Justice guidelines for written translations.

STATE RESPONSE: We agree that we need to improve accessibility for non-English speakers. We are implementing best practices to increase access for customers with limited English proficiency. This includes adding information about the availability of language assistance (telephonic interpretation) in the top 15 languages spoken in our state. We also plan to create a Spanish-language homepage that will allow Spanish speakers to navigate our content.

We have assessed certain free or low-cost translation tools as an option. We decided not to include them because:

- The accuracy of translation can't be guaranteed.
- Non-English speakers are unfamiliar with how to use some of the tools.

- Non-English speakers come to our website using Google and other search engines, and content translated in certain tools will not appear in the search.
- Our agency has had experience with the negative consequences of poorly translated information. Imprecise translations can have health and safety implications.

Improving accessibility can come in many forms, and MQAC, BOMS and DOH are exploring and discussing various solutions to that end.

Action Steps and Time Frame:

- Post the availability of language assistance on the DOH website. *By October 21, 2016.*
- Establish a Spanish homepage on the DOH website. *By January 31, 2017.*

SAO Recommendation 7: We recommend MQAC and BOMS work with DOH to improve the Provider Credential Search, with consideration of legal restrictions, including the provider search function, to allow for broader provider searches. In doing so, ensure it includes information recommended by FSMB, such as location, specialty and board certification, summaries of violations and enforcement actions, as well as information that can be voluntarily added by providers such as insurance information and whether new patients are accepted.

STATE RESPONSE: MQAC and BOMS agree that improving the ease of use and information available in the Provider Credential Search is beneficial. The department's Health Services Quality Assurance division is in the process of collecting requirements to replace the core system it uses for credentialing and enforcement activities, including the provider credential search function. The tentative timeline for implementing this new system is mid-2020. In the interim, the division is completing a rework of the provider credential search user interface to make it more user friendly.

It should be noted that the provider search function is a tool for efficient public disclosure for more than 80 professions. It was neither designed nor intended to be a one-stop shop for provider information. Moving to a platform that provides more information to the consumer, and is populated with more information voluntarily furnished by licensees, may be beneficial and is an effort that MQAC supports. It is a significant undertaking, however, and would need to be researched further, including assessing the effect on other professions.

Action Steps and Time Frame:

- Rework the provider credential user interface to improve usability. *By January 31, 2017.*
- Consider changes to improve the ease of use of the provider credential search as part of an overall system replacement project due to be in place by mid-2020. *By 2020.*

SAO Recommendation 8: We recommend MQAC and BOMS continue to improve correspondence by incorporating Plain Talk principles into their communications with complainants and respondents.

STATE RESPONSE: In 2013, MQAC, BOMS and DOH recognized that communications with complainants and respondents could be improved, and we implemented an initiative do so. We appreciate SAO's acknowledgment of the improvements we have made over the past few years.

As a part of our improvement efforts, we routinely assess the quality and accuracy of our communications with complainants and respondents.

Action Steps and Time Frame:

- Not applicable.

SAO Recommendation 9: We recommend MQAC and BOMS modify procedures to ensure complainants are sent letters at the end of all cases.

STATE RESPONSE: Both MQAC and BOMS already send letters to complainants at the end of cases. In the SAO's review of more than four years of cases, it found six instances, out of about 8,600 cases reviewed, where we were unable to prove that a letter had been sent to a complainant.

Action Steps and Time Frame:

- Not applicable.

SAO Recommendation 10: If the Legislature does not modify the UDA, we recommend MQAC and BOMS expand outreach to the public, specifically by using their rulemaking authority to require that all providers post information in a prominent location about where to file complaints.

STATE RESPONSE: MQAC and BOMS agree that public outreach and engagement are effective, and we frequently engage in such efforts. We do not agree the evidence we have been provided supports the idea that a rule such as the one recommended — which would affect all professions under the concept that similarly situated persons are to be treated similarly — would be more effective at improving public safety. Today, MQAC has a workgroup composed of its governor-appointed public members to assess visibility and outreach. Recommendations from that group are expected in the third quarter of fiscal year 2017.

Action Steps and Time Frame:

- Not applicable.

SAO Recommendation 11: We recommend MQAC and BOMS regularly evaluate whether staff are following policies and procedures, including whether they are accurately entering data into the Integrated Licensing and Regulatory System.

STATE RESPONSE: MQAC and BOMS already evaluate on a regular basis whether staff members follow policies and procedures in accordance with internal controls and the collective bargaining agreement. The separation of business units serves to reinforce this effort. When noncompliance is revealed, the issues and associated staff members are engaged and, when necessary, dealt with according to policy.

MQAC, BOMS and DOH are aware of the issue with the Integrated Licensing and Regulatory System that requires staff members to manually override certain activity dates. This and other items will be evaluated when requirements are gathered for the replacement of the credentialing and enforcement system, scheduled for implementation in 2020.

Action Steps and Time Frame:

- Consider data input issues as part of an overall system replacement project due to be in place by 2020. *By 2020.*

SAO Recommendation 12: We recommend MQAC and BOMS modify current performance measure activities to regularly evaluate the nature and volume of complaints, the adequacy and consistency of enforcement actions, as well as how well the boards are meeting their mission to protect the public.

STATE RESPONSE: MQAC, BOMS and DOH all have several performance metrics and highly trained staff members dedicated to performance management. Their roles include improving how we identify and use data to measure performance. Periodic review and deliberation on these measures are an important and regular part of their business. Because every complaint must be assessed on its own merits, we do not agree that the SAO's idea of consistency is a goal to strive for. We do welcome suggestions for metrics that will help drive and ensure desired outcomes.

Action Steps and Time Frame:

- Not applicable.

Auditor Response

We appreciate the response to our audit recommendations. In the Department of Health agency action plan and the formal response letter from the Governor's Office, we have noted several issues that require follow-up. These include incorrect calculations, misunderstanding of the efforts undertaken by the auditors, and misinterpretation of audit recommendations. We will communicate these issues in detail to the Department of Health and to the Governor's Office.

Appendix A: Initiative 900

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments. Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Audit Results section of this report.

I-900 element		Addressed in the audit
1.	Identify cost savings	**No.** We recommend a merger of two boards, but don't anticipate substantial cost savings, if any.
2.	Identify services that can be reduced or eliminated	**Yes.** We recommend consolidating the two boards and the functions of their staffs.
3.	Identify programs or services that can be transferred to the private sector	**No.** Oversight of health professions is a public safety function that is typically not administered by the private sector.
4.	Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**Yes.** We identified an overlap in programs.
5.	Assess feasibility of pooling information technology systems within the department	**No.** We did not assess pooling information technology systems.
6.	Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**Yes.** The audit examined the complaint assessment functions and made recommendations to improve the consistency of those functions.
7.	Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**Yes.** The audit includes multiple legislative recommendations.
8.	Analyze departmental performance, data performance measures, and self-assessment systems	**Yes.** The audit reviewed performance data and measures to determine whether complaints are processed in a timely and consistent manner.
9.	Identify relevant best practices	**Yes.** The audit includes a comparison to best practices.

Appendix B: Methodology

The scope of this audit

The decision whether to investigate a complaint made to the MQAC or BOMS is typically made by a mix of clinical and public members. Complaints rarely include enough information to require medical expertise, so we analyzed these decisions to check for consistency, transparency and timeliness. We did not examine disciplinary decisions or the licensing processes of the boards.

We worked from a dataset of 8,050 MQAC cases and 557 BOMS cases, which were all cases considered by the boards' CMTs from January 1, 2009, to September 30, 2014. From the dataset, we drew random samples, stratified by the end result, of the cases from both boards, and requested the physical case files from the Department of Health.

Figure 1 – The number of cases analyzed in our stratified random sample

	MQAC	BOMS
Cases closed without investigation	59	53
Cases closed without sanction, after investigation (including cases where complainant did not sign whistleblower waiver)	59	52
Cases closed with sanctions imposed by board (stipulation, agreed order, default order or voluntary surrender)	62	21
Cases closed after hearing	9	3
Cases closed due to withdrawal of complaint	10	2

We collected information from each case, including dates the complaint was received and processed; who sent the complaint (the patient, the hospital, another state's medical board) and how; whether the respondent was identified in the complaint; how many previous complaints had been lodged against the respondent; the severity of the alleged injury; the alleged issues assigned to the case; and whether notifications were sent to the complainant and respondent. We also judged whether the investigation provided enough information for a board member to make a determination about the case, and whether the letters were clear, correct and effective.

Adequacy of investigations

Among the 330 case files we viewed, 218 were for cases in which an investigation was conducted. We reviewed the materials that the investigator prepared for the reviewing member, and assessed whether the information gathered was complete, clear and sufficient for the board to make an informed decision. We noted whether the complainant, patient and respondent were interviewed as part of the investigation. We also interviewed the chief investigators for both boards about the policies, procedures and practices, whether written or informal, that investigators follow.

Transparency

While reviewing the case files, we noted the nature of communication between the board and the complainant and respondent, including whether the appropriate letters were sent. We judged whether the letters conform to Washington's Plain Talk standards for clarity and whether they conformed to English grammar.

Timeliness of processes

We reviewed the time elapsed for each step of the intake, assessment, investigation and disposition processes, and compared them to the targets established by the Department of Health. We also compared the dates of receipt and completion of investigation in the electronic records to what was recorded on the physical case file.

Visibility

To determine whether the boards were reaching all populations in the state, we requested a list of complaints with the origin ZIP code and the source. We eliminated all cases from outside Washington and those that did not come from patients, family or friends. We then used census data to calculate the number of complaints per capita generated by each ZIP code area (after consolidating post office box-only ZIP codes into their surrounding geographic areas). We used a regression analysis to determine whether characteristics of the ZIP code had an apparent effect on the number of complaints per capita. The characteristics tested included education levels, median income, use of languages other than English, whether the area is considered medically underserved, the rate of health insurance coverage, and the size of the incarcerated population.

Adequacy of enforcement

Among the 330 case files we viewed, 94 cases resulted in discipline. We reviewed the legal orders for what discipline was required, and noted whether the files contained evidence that the discipline was carried out (for example, in some cases where the license was surrendered, the physical license was in the file). Where that evidence was not in the file, we used the Integrated Licensing and Regulatory System (ILRS) to compare recorded actions with the expectations laid out in the order.

For unannounced inspections, we identified relevant cases by searching ILRS. We then reviewed the orders to determine which cases called for unannounced practice reviews. We then requested the compliance files for those cases to check whether there was evidence of pre-arrangement of appointments.

Appendix C: Best Practices Comparison

We compared best practices, drawn from the Federation of State Medical Boards and the National Association of State Auditors, Comptrollers and Treasurers, against Washington laws and regulations and the policies, processes and practices of MQAC and BOMS. We noted whether a written policy is in place, and whether we observed it actually put into practice.

FSMB = Federation of State Medical Boards, **NASACT** = National Association of State Auditors, Comptrollers and Treasurers

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
State Board Makeup & Powers					
The following should be required to report to the Board promptly and in writing any information that indicates a licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine; and any restriction, limitation, loss or denial of a licensee's staff privileges or membership that involves patient care: (1) all licensees licensed under the act; (2) all licensed health care providers; (3) the state medical associations and its components; (4) all hospitals and other health care organizations in the state, to include hospitals, medical centers, long term care facilities, managed care organizations, ambulatory surgery centers, clinics, group practices, coroners, etc; (5) all chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.; (6) all liability insurance organizations; (7) all local medical/osteopathic societies; (8) all local professional societies; (9) all state agencies; (10) all law enforcement agencies in the state; (11) all courts in the state; (12) all federal agencies (e.g., DEA, FDA, and CMS); (13) all peer review bodies in the state; and (14) resident training program directors. (FSMB Essentials, Section (XIII)(B)(1-14))	YES	YES	YES	YES	None
Malpractice insurance carriers, the licensee's attorney, a hospital, a group practice, and the affected licensees should be required to file with the Board a report of each final judgment, settlement, arbitration award, or any form of payment by the licensee or on the licensee's behalf by any source upon any demand, claim, or case alleging medical malpractice, battery, dyscompetence, incompetence, or failure of informed consent. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within 30 days). (FSMB Essentials, Section (XIII)(D))	YES	YES	YES	YES	None
To assure compliance with compulsory reporting requirements, specific civil penalties should be established for demonstrated failure to report (e.g., up to $10,000 per instance). (FSMB Essentials, Section (XIII)(G))	YES	YES	YES	YES	None
Range of Actions: A range of progressive disciplinary and remedial actions should be made available to the Board. (FSMB Essentials, Section (IX)(A))	YES	YES	YES	YES	None
The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions, singly or in combination, as the nature of the violation requires and to promote public protection. (FSMB Essentials, Section (IX)(AA))	**Partial**	**Partial**	**Partial**	**Partial**	5
Examination/Evaluation: The Board should be authorized, at its discretion, to require professional competency, physical, mental, or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids, tissues, hair, or nails. (FSMB Essentials, Section (IX))(C))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
Grounds for Action: The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:					
(1) Fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license; (2) Cheating on or attempting to subvert the medical licensing examination(s); (3) The commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of (a) misdemeanor whether or not related to the practice of medicine and any crime involving moral turpitude; or (b) a felony, whether or not related to the practice of medicine. The Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust. (4) Conduct likely to deceive, deceive, defraud, or harm the public; (6) Making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment, or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind; (7) Representing to a patient that an incurable condition, sickness, disease, or injury can be cured; (8) Willfully or negligently violating the confidentiality between physician and patient except as required by law; (9) Professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes negligence, as determined by the board; (10) Being found mentally incompetent or of unsound mind by any court of competent jurisdiction; (11) Being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety; (12) Practice or other behavior that demonstrates an incapacity or incompetence to practice medicine; (13) The use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine; (14) Giving false, fraudulent, or deceptive testimony while serving as an expert witness; (15) Practicing medicine under a false or assumed name; (16) Aiding or abetting the practice of medicine by an unlicensed, incompetent or impaired person; (17) Allowing another person or organization to use his or her license to practice medicine; (18) Commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way; (19) Habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability; (21) Prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes; (22) Knowingly prescribing, selling, administering, distributing, ordering, or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations, or guidelines for use of controlled substances and the management of pain as promulgated by the Board; (23) Prescribing, selling, administering, distributing, ordering, or giving any drug legally classified as a controlled substance or recognized as an addictive drug to a family member or to himself or herself; (24) Violating any state or federal law or regulation relating to controlled substances; (26) Obtaining any fee by fraud, deceit, or misrepresentation; (27) Employing abusive, illegal, deceptive, or fraudulent billing practices; (28) Directly or indirectly giving or receiving any fee, commission, rebate, or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations, or associations; (29) Disciplinary action of another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment) based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section; (30) Failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction, peer review body, health care institution, professional or medical society or association, governmental or law enforcement agency, or court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section; (31) Failure to report or cause a report to be made to the Board any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely, or has an alcohol or drug abuse problem; (32) Failure of physician who is the chief executive officer, medical officer, or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in (31); (33) Failure to report to the Board surrender of a license limitation or other authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society has surrendered the authority to utilize controlled substances issued by any state or federal agency, or has agreed to a limitation to or restriction of privileges at any medical care facility while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section; *This entry continued on the following page*	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
continued from previous page: (34) Any adverse judgment, award, or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section; (35) Failure to report to the Board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section; (38) Failure to furnish the Board, its investigators, or representatives information legally requested by the Board or failure to comply with a Board subpoena or order; (39) Failure to cooperate with a lawful investigation conducted by the Board; (40) Violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board; (41) Engaging in conduct calculated to, or having the effect of, bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board; (42) Failure to follow generally accepted infection control procedures; (43) Failure to comply with any state statute or board regulation regarding a licensee's reporting responsibility for HIV, HVB, seropositive status or any other reportable condition or disease; (44) Practicing medicine in another state or jurisdiction without appropriate licensure; (45) Conduct which violates patient trust, exploits the physician-patient relationship, or violates professional boundaries; (47) Providing treatment or consultation recommendations, including issuing a prescription via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided; (48) Violating a Board formal order, condition of probation, consent agreement, or stipulation; (49) Representing, claiming, or causing the appearance that the physician possesses a particular medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not true; (50) Failing to obtain adequate patient informed consent; (51) Using experimental treatments without appropriate patient consent and adhering to all necessary and required guidelines and constraints; (52) Any conduct that may be harmful to the patient or the public; (53) Failing to divulge to the Board upon legal demand the means, method, procedure, modality, or medicine used in the treatment of an ailment, condition, or disease; (54) Conduct likely to deceive, defraud, or harm the public; (55) The use of any false, fraudulent, or deceptive statement in any document connected with the practice of the healing arts including intentional falsifying or fraudulent altering of a patient or medical care facility record; (56) Failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results, and test results; (57) Delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience, or license to perform them; (58) Using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records, or without having periodic analysis of the study and results reviewed by a committee or peers; and (59) Failing to properly supervise, direct, or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation, or practice protocols. (FSMB Essentials, Section (IX)(D))	YES	YES	YES	YES	None
(20) Failing or refusing to submit to an examination or any other examination that may detect the presence of alcohol or drugs upon Board order or any other form of impairment; and (46) Failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service, or failure to refer to an appropriate provider within such actions are taken for the sole purpose of positively influencing the physician's or the plan's financial wellbeing. (FSMB Essentials, Section (IX)(D)(20 & 46))	✖	✖	✖	✖	4
(25) Signing a blank, undated, or predated prescription form; and (37) Improper management of medical records, including failure to maintain timely, legible, accurate, and complete medical records and to comply with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, of HIPAA; (FSMB Essentials, Section (IX)(D)(25 & 37))	✖	YES	✖	YES	4
(5) Disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; (FSMB Essentials, Section (IX)(D)(5))	YES	YES	✖	✖	4
(36) Failure to provide pertinent and necessary medical records to another physician or patient in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient regardless of whether the patient owes a fee for services; (FSMB Essentials, Section (IX)(D)(36))	✖	YES	✖	YES	4

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relationship with an independent entity whose program meets standards set by the Board. (FSMB Essentials, Section (XI)(1))	YES	YES	YES	YES	None
The medical practice act should provide for the Board to license and regulate physician assistants. (FSMB Essentials, Section (XVIII))	YES	YES	YES	YES	None
The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions. In the course of an investigation, the Board's authority should include the ability to issue subpoenas to licensees, health care organizations, complainants, patients, and witnesses to produce documents or appear before the Board or staff to answer questions or be deposed. The Board should have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is incumbent upon the subpoenaed party to seek a motion to quash the subpoena. (FSMB Essentials, Section (X)(A))	YES	YES	YES	YES	None
The Board should be authorized to use preponderance of the evidence as the standard of proof in its role as trier of fact for all levels of discipline. (FSMB Essentials, Section (X)(C))	✖	✖	✖	✖	4
Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee because of such an informal conference and agreed to in writing by the Board and the licensee should be binding and a matter of public record. However, license revocation and suspension should be held in open formal hearing, unless executive session is permitted by the State's open meetings law. The holding of an informal conference should not preclude an open formal hearing if the Board determines such is necessary. (FSMB Essentials, Section (X)(D))	YES	YES	YES	YES	None
The Board should be authorized to summarily suspend or restrict a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend or restrict a license by means of a vote conducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion. (FSMB Essentials, Section (X)(E))	YES	YES	YES	YES	None
The Board should be authorized to issue a cease-and-desist order and/or obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating any provision of the medical practice act. Violation of an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve those enjoined from criminal prosecution, civil action, or administrative process for violation of the medical practice act. (FSMB Essentials, Section (X)(F))	YES	YES	YES	YES	None
The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts: (A) The practice of medicine is a privilege granted by the people acting through their elected representatives; (B) In the interests of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary for the government to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine; (C) The primary responsibility and obligation of the state medical board is to act in the sovereign interests of the government by protecting the public through licensing, regulation and education as directed by the state government. (FSMB Essentials, Section (I)(A,B & C))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:					
Develop and adopt its budget; (FSMB Essentials, Section (III)(B)(26))	YES	YES	✖	✖	1, 2
Develop and adopt policies and guidelines related to medical practice, other health care professions, and regulation; (FSMB Essentials, Section (III)(B)(3))	YES	YES	YES	YES	None
Establish appropriate fees and charges to ensure active and effective pursuit of its legal responsibilities; (FSMB Essentials, Section (III)(B)(25))	YES	YES	✖	✖	1, 2
Promulgate rules and regulations; (FSMB Essentials, Section (III)(B)(1))	YES	YES	YES	YES	None
Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity. (FSMB Essentials, Section (III)(C))	YES	YES	YES	YES	None
The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three). (FSMB Essentials, Section (III)(D))	YES	YES	YES	YES	None
Members of the Board should receive appropriate compensation for services and reimbursement for expenses at the State's current approved rate. (FSMB Essentials, Section (III)(E))	YES	YES	YES	YES	None
A member of the Board should be subject to removal only when he or she: (1) ceases to be qualified; (2) is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction; (3) is found guilty of malfeasance, misfeasance or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction; (4) is found mentally incompetent by a court of competent jurisdiction; (5) fails to attend three successive Board meetings without just cause as determined by the Board or, if a new member, fails to attend a new members' training program without just cause as determined by the Board; (6) is disciplined for violations of the medical practice act; or (7) is found in violation of the conflict of interest/ethics law. (FSMB Essentials, Section (III)(F)(1-7))	YES	YES	YES	YES	None
All physician members of the Board should hold full and unrestricted medical licenses in the jurisdiction, should be persons of recognized professional ability and integrity, and should have resided, practiced in the jurisdiction long enough to have become familiar with policies and practice in the jurisdiction (e.g., five years). (FSMB Essentials, Section (III)(G))	YES	YES	YES	YES	None
The Board should include public members who: (1) are not licensed physicians or providers of health care; (2) have no substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board; (3) have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board; (4) are residents of the State; and (5) are individuals of recognized ability and integrity. (FSMB Essentials, Section (III)(H)(1-5))	YES	YES	YES	YES	None
The Board should be authorized to appoint committees from its membership. (FSMB Essentials, Section (III)(I))	YES	YES	YES	YES	None
To effectively perform its duties under the Act, the Board should also be authorized to hire, discipline, and terminate staff, including an executive secretary or director. It should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney. (FSMB Essentials, Section (III)(I))	YES	YES	✖	✖	1, 2

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
The Board should conduct, and new members should attend, a training program designed to familiarize new members with their duties and the ethics of public service. (FSMB Essentials, Section (III)(J))	YES	YES	YES	YES	None
Travel, expenses, and daily compensation should be paid for each Board member's attendance, in or out of state, for education or training purposes approved by the Board and directly related to Board duties. (FSMB Essentials, Section (III)(K))	YES	YES	YES	YES	None
Telephone or other telecommunication conference should be an acceptable form of Board meeting if the president/chair alone or another officer and two Board members believe the Board's business can be properly conducted by teleconference. The Board shall be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system. (FSMB Essentials, Section (III)(L))	YES	YES	YES	YES	None
As part of this process [management analysis and reporting], management would be expected to do the following types of things on a periodic basis:					
Monitor the regulated industry for changes that may impact the public's health, safety, or welfare, or that could otherwise affect the regulatory program. (NASACT, Management Analysis and Reporting Process: Section (1))	YES	YES	YES	YES	None
Evaluate the nature and volume of complaints and of violations identified during inspections/investigations. (NASACT, Management Analysis and Reporting Process: Section (2))	✖	✖	✖	✖	13
Evaluate the extent to which program staff complied with agency policies and procedures in carrying out their responsibilities. (NASACT, Management Analysis and Reporting Process: Section (4))	✖	✖	✖	✖	11, 12
Evaluate the reliability of the program data compiled and maintained by the agency. (NASACT, Management Analysis and Reporting Process: Section (5))	✖	✖	✖	✖	12
Evaluate how efficiently the agency is carrying out its responsibilities, including a review of any duplicative regulation that may be provided at different levels of government. (NASACT, Management Analysis and Reporting Process: Section (6))	✖	✖	✖	✖	13
Propose or adopt needed changes in laws, regulations, standards, policies, processes, sanctions, fees, etc., to help ensure the regulatory program is operating as intended and accomplishing its purpose. (NASACT, Management Analysis and Reporting Process: Section (7))	YES	YES	YES	YES	None
Investigate complaints as needed to determine whether problems exist, and how serious they are. (NASACT, Monitoring: the Complaint-Handling Process: Section (5))	YES	YES	YES	YES	None
Specify the number or severity of violations or "occurrences" that should trigger each level of sanction, and any applicable timeframes. Again, immediate action should be taken if the violations or problems found threaten life or health. (NASACT, Enforcement Process: Section (2))	YES	YES	YES	YES	None
Establish an administrative process for appealing these sanctions. (NASACT, Enforcement Process: Section (3))	YES	YES	YES	YES	None
The Board shall consist of enough members to appropriately discharge the duties of the Board at least 25% of whom should be public members. (FSMB Elements, Section ((D)(1)(a))	YES	YES	✖	✖	1, 2
The Board should be of sufficient size to allow for recusals due to conflicts of interest. (FSMB Elements, Section ((D)(1)(b))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		
	Policy	Practice	Policy	Practice	Recommendation
The membership of the Board shall be drawn from as many different regions of the State, as many different specialties as possible, and should reflect the licensee population. (FSMB Elements, Section (2)(a))	YES	YES	✖	YES	2
No member of the Board, acting in that capacity or as a member of any Board committee, shall participate in the deliberation, making of any decision, or the taking of any action affecting his or her own personal, professional, or pecuniary interest, or that of a known relative or of a business or professional associate. (FSMB Elements, Section (G)(6))	YES	YES	YES	YES	None
The Board's staff may include, but need not be limited to, the following: (a) an executive director, (b) one or more assistant executive directors, (c) one or more medical consultants, (d) office and clerical staff, (e) one or more attorneys, (f) one or more investigators who shall be trained in and knowledgable about the investigation of medical and related health care practice, and (g) experts and consultants. (FSMB Elements, Section (I)(2)(a-g))	YES	YES	✖	✖	1, 2
Adequacy of investigations					
Board Authority: The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions. In the course of an investigation, the Board's authority should include the ability to issue subpoenas to licensees, health care organizations, complainants, patients, and witnesses to produce documents or appear before the Board or staff to answer questions or be deposed. The Board should have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is incumbent upon the subpoenaed party to seek a motion to quash the subpoena. (FSMB Essentials, Section (X)(A))	YES	YES	YES	YES	None
Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:					
Develop policies for disciplining or rehabilitating physicians that demonstrate inappropriate sexual behavior with patients or other professional boundaries violations. (FSMB Essentials, Section (III)(B)(19))	YES	YES	YES	YES	None
Institute actions in its own name and enjoin violators of the medical practice act. (FSMB Essentials, Section (III)(B)(20))	YES	YES	YES	YES	None
Issue subpoenas, subpoenas duces tecum, administer oaths, receive testimony, and conduct hearings. (FSMB Essentials, Section (III)(B)(17))	YES	YES	YES	YES	None
Receive, review, and investigate complaints including sua sponte complaints. (FSMB Essentials, Section (III)(B)(13))	YES	YES	YES	YES	None
Review and investigate reports received from entities having information pertinent to the professional performance of licensees. (FSMB Essentials, Section (III)(B)(14))	YES	YES	YES	YES	None
As part of a good inspection [investigation] process, the agency would be expected to: Maintain a record of the monitoring process and its results, and make those results available to inspectors [investigators] for future inspections [investigations] so they are aware of the licensee's inspection [investigation] history and past violations. (NASACT, Monitoring: the Inspection Process: Section (11))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
Evaluate the extent to which program staff complied with agency policies and procedures in carrying out their responsibilities. (NASACT, Management Analysis and Reporting Process: Section (4))	✖	✖	✖	✖	11, 12
Evaluate the reliability of the program data compiled and maintained by the agency. (NASACT, Management Analysis and Reporting Process: Section (5))	✖	✖	✖	✖	12
Investigate complaints as needed to determine whether problems exist, and how serious they are. (NASACT, Monitoring: the Complaint-Handling Process: Section (5))	YES	YES	YES	YES	None
Evaluate how efficiently the agency is carrying out its responsibilities, including a review of any duplicative regulation that may be provided at different levels of government. (NASACT, Management Analysis and Reporting Process: Section (6))	✖	✖	✖	✖	13
Conduct inspections [investigations] in a timely, efficient, and effective manner. (NASACT, Monitoring: the Inspection Process: Section (7))	YES	YES	YES	YES	None
Allowing the regulated person/entity to provide additional information that may have a bearing on the inspector's [investigator's] findings. (NASACT, Monitoring: the Inspection Process: Section (8)(b))	YES	YES	YES	YES	None
Document the results of the inspection/investigation, including any violations found and how serious they are. (NASACT, Monitoring: the Inspection Process: Section (8))	YES	YES	YES	YES	None
Having a supervisor review the results of the inspector's [investigator's] work to ensure that it was conducted in a way that is consistent with applicable laws, regulations, and agency policies, and that any conclusions and recommendations are based on clear and sufficient evidence. (NASACT, Monitoring: the Inspection Process: Section (8)(c))	YES	YES	YES	YES	None
The Board's staff may include, but need not be limited to, the following: (a) an executive director, (b) one or more assistant executive directors, (c) one or more medical consultants, (d) office and clerical staff, (e) one or more attorneys, (f) one or more investigators who shall be trained in and knowledgable about the investigation of medical and related health care practice, and (g) experts and consultants. (FSMB Elements, Section (I)(2)(a-g))	YES	YES	✖	✖	1, 2
Consistency of Assessment					
The Board should be authorized to appoint committees from its membership. (FSMB Essentials, Section (III)(I))	YES	YES	YES	YES	None
Screening out complaints that have no merit on their face or that the agency has no jurisdiction over. For valid complaints that are outside the agency's jurisdiction, procedures should be in place for referring them to or notifying the appropriate agency (ies). (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(f))	YES	YES	YES	YES	None
Maintain a record of the monitoring process and its results, and make those results available to inspectors [investigators] for future inspections [investigations] so they are aware of the licensee's inspection [investigation] history and past violations. (NASACT, Monitoring: the Inspection Process: Section (11))	YES	YES	YES	YES	None
Set guidelines/requirements for which complaints need action, and how quickly complaints should be handled (will depend on the type and severity of the problems alleged). (NASACT, Monitoring: the Complaint-Handling Process: Section (3))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
Evaluate the extent to which program staff complied with agency policies and procedures in carrying out their responsibilities. (NASACT, Management Analysis and Reporting Process: Section (4))	✖	✖	✖	✖	11, 12
Screen complaints against these guidelines to identify those needing action, and assign them to someone to review or investigate. (NASACT, Monitoring: the Complaint-Handling Process: Section (4))	YES	YES	YES	YES	None
Evaluate the reliability of the program data compiled and maintained by the agency. (NASACT, Management Analysis and Reporting Process: Section (5))	✖	✖	✖	✖	12
Evaluate how efficiently the agency is carrying out its responsibilities, including a review of any duplicative regulation that may be provided at different levels of government. (NASACT, Management Analysis and Reporting Process: Section (6))	✖	✖	✖	✖	13
Track and oversee complaints to ensure that they are being addressed appropriately and that things don't slip through the cracks. (NASACT, Monitoring: the Complaint-Handling Process: Section (7))	YES	YES	YES	**Partial**	11
Maintain a record of the complaints received, the investigation results, and any actions taken. (NASACT, Monitoring: the Complaint-Handling Process: Section (8))	YES	YES	YES	YES	None
Transparency					
Provide written translation and oral interpreters for individuals with limited english proficiency. (DOJ Guidance Regarding Limited English Proficient Persons, 02-15207)	✖	**Partial**	✖	**Partial**	6
All the Board's final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the Board Action Data Bank of the FSMB of the United States within 30 days of the action being taken, to any other data repository required by law, and to the media. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the FSMB of the United States and to any other data repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act. (FSMB Essentials, Section (X)(G))	YES	YES	YES	YES	None
Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:					
Acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and to the physician, and inform them of the final disposition of the matters reported. (FSMB Essentials, Section (III)(B)(21))	YES	✖	YES	✖	9
Share investigative information at the early stages of a complaint investigation with other Boards. (FSMB Essentials, Section (III)(B)(16))	YES	YES	YES	YES	None
Allowing complaints to be submitted formally (i.e., in writing or electronically), or informally through a complaint-intake process (i.e., in person or over the phone). (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(b))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
Collecting at least the minimum information needed to take the appropriate initial action on the complaint. (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(d))	YES	YES	YES	YES	None
Making information available on the agency's website or through some other source so members of the public will know that the complaint-handling process exists and how to use it. This information can include the requirements that exist for people operating within the regulated industry, a description of the agency's complaint-handling process, and complaint forms, if applicable. (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(a))	YES	YES	YES	YES	None
Providing for complaints to be called in after regular business hours. (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(c))	YES	YES	YES	YES	None
Taking anonymous complaints when there's a good reason to do so. (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(e))	YES	YES	YES	YES	None
Evaluate the extent to which program staff complied with agency policies and procedures in carrying out their responsibilities. (NASACT, Management Analysis and Reporting Process: Section (4))	✖	✖	✖	✖	11, 12
Evaluate the reliability of the program data compiled and maintained by the agency. (NASACT, Management Analysis and Reporting Process: Section (5))	✖	✖	✖	✖	12
Evaluate how efficiently the agency is carrying out its responsibilities, including a review of any duplicative regulation that may be provided at different levels of government. (NASACT, Management Analysis and Reporting Process: Section (6))	✖	✖	✖	✖	13
Document the results of the inspection/investigation, including any violations found and how serious they are. (NASACT, Monitoring: the Inspection Process: Section (8))	YES	YES	YES	YES	None
Maintain a record of the complaints received, the investigation results, and any actions taken. (NASACT, Monitoring: the Complaint-Handling Process: Section (8))	YES	YES	YES	YES	None
The Board shall present to the Governor, the Legislature and the public, at the end of each fiscal year [Washington presents biennially], a formal report summarizing its licensing and disciplinary activity for that year. (FSMB Elements, Section (M)(1))	YES	YES	YES	YES	None
Visibility					
Provide written translation and oral interpreters for individuals with limited english proficiency. (DOJ Guidance Regarding Limited English Proficient Persons, 02-15207)	✖	**Partial**	✖	**Partial**	6
All the Board's final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the Board Action Data Bank of the FSMB of the United States within 30 days of the action being taken, to any other data repository required by law, and to the media. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the FSMB of the United States and to any other data repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act. (FSMB Essentials, Section (X)(G))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:					
Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards (FSMB Essentials, Section (III)(B)(27))	✖	Partial	✖	Partial	3, 10
Provide the public with a profile of all licensed physicians; (FSMB Essentials, Section (III)(B)(9))	YES	YES	YES	YES	None
A licensee's profile shall contain, but not be limited to:					
Demographic information: (1) name and license number, (2) gender, (3) business or practice address, and (4) birthdate. (FSMB Elements, Section (M)(2)(a))	✖	Partial	✖	Partial	7
Medical Education - (1) medical school(s)' name, address, year of graduation and degree; and (2) post-graduate training program(s)' name, address, years attended, and year completed. (FSMB Elements, Section (M)(2)(b))	✖	✖	✖	✖	7
License and Board certification information: (1) license status, (2) license type, (3) original license date, (4) license renewal date, (5) specialty and type of practice, and (6) board certification by a certifying authority recognized by the Board. (FSMB Elements, Section (M)(2)(c))	✖	Partial	✖	Partial	7
Criminal Convictions: A description of any conviction of a felony or a misdemeanor involving moral turpitude within the last five years, including cases with a deferred adjudication or expungement. (FSMB Elements, Section (M)(2)(d))	✖	✖	✖	✖	7
Malpractice History: (1) The number of awards or judgments within the past 10 years; (2) When the number exceeds 3, the number of demands, claims, and/or settlements paid by the licensee or on behalf of the licensee in the past 5 years; and (3) A statement that malpractice payments do not necessarily demonstrate the quality of care provided by a physician, and that the Board independently investigates all reports of payment in malpractice cases, which will appear in the licensee's disciplinary history if the Board completed the investigation and took disciplinary action. (FSMB Elements, Section (M)(2)(e))	✖	✖	✖	✖	7
Disciplinary actions: (1) All disciplinary actions taken by the Board; (2) A brief description of the reason for a disciplinary action; (3) All disciplinary actions taken by other state medical/osteopathic boards and a brief description of the reason for discipline if available; (4) All disciplinary actions taken by hospitals; (5) An explanation of the types of discipline the Board takes and its effects on the licensee's ability to practice; and (6) A statement that hospitals may take disciplinary actions for reasons that do not violate the governing statutes. (FSMB Elements, Section (M)(2)(f))	✖	Partial	✖	Partial	7
Allowing complaints to be submitted formally (i.e., in writing or electronically), or informally through a complaint-intake process (i.e., in person or over the phone). (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(b))	YES	YES	YES	YES	None
Collecting at least the minimum information needed to take the appropriate initial action on the complaint. (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(d))	YES	YES	YES	YES	None
Making information available on the agency's Web site or through some other source so members of the public will know that the complaint-handling process exists and how to use it. This information can include the requirements that exist for people operating within the regulated industry, a description of the agency's complaint-handling process, and complaint forms, if applicable. (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(a))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
Providing for complaints to be called in after regular business hours. (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(c))	YES	YES	YES	YES	None
Taking anonymous complaints when there's a good reason to do so. (NASACT, Monitoring: the Complaint-Handling Process: Section (1)(e))	YES	YES	YES	YES	None
Evaluate the extent to which program staff complied with agency policies and procedures in carrying out their responsibilities. (NASACT, Management Analysis and Reporting Process: Section (4))	✖	✖	✖	✖	11, 12
Evaluate the reliability of the program data compiled and maintained by the agency. (NASACT, Management Analysis and Reporting Process: Section (5))	✖	✖	✖	✖	12
Evaluate how efficiently the agency is carrying out its responsibilities, including a review of any duplicative regulation that may be provided at different levels of government. (NASACT, Management Analysis and Reporting Process: Section (6))	✖	✖	✖	✖	13
The Board shall present to the Governor, the Legislature and the public, at the end of each fiscal year [Washington does biennially], a formal report summarizing its licensing and disciplinary activity for that year. (FSMB Elements, Section (M)(1))	YES	YES	YES	YES	None
Enforcement					
Evaluate the adequacy and consistency of inspections [investigations] and enforcement actions, and their effectiveness in protecting the state's citizens and resources from harm. (NASACT, Management Analysis and Reporting Process: Section (3))	✖	✖	✖	✖	13
Evaluate the extent to which program staff complied with agency policies and procedures in carrying out their responsibilities. (NASACT, Management Analysis and Reporting Process: Section (4))	✖	✖	✖	✖	11, 12
Evaluate the reliability of the program data compiled and maintained by the agency. (NASACT, Management Analysis and Reporting Process: Section (5))	✖	✖	✖	✖	12
Formally notify these people/entities of the enforcement actions that are going to be applied, the basis for the enforcement action(s), the applicable timeframes, and their right to appeal. (NASACT, Enforcement Process: Section (5))	YES	YES	YES	YES	None
Evaluate how efficiently the agency is carrying out its responsibilities, including a review of any duplicative regulation that may be provided at different levels of government. (NASACT, Management Analysis and Reporting Process: Section (6))	✖	✖	✖	✖	13
Take appropriate, consistent, and timely enforcement actions that address the violations cited against these people/entities (including collecting any fines levied). (NASACT, Enforcement Process: Section (6))	YES	✖	YES	YES	11, 12
Follow-up as needed (i.e., through written reports, the inspection [investigation] process, special investigations, etc.) to determine whether the problem has been corrected or whether additional enforcement action is needed. (NASACT, Enforcement Process: Section (7))	YES	YES	YES	YES	None

Practice	Present at MQAC		Present at BOMS		Recommendation
	Policy	Practice	Policy	Practice	
Track and oversee the enforcement actions taken to ensure that they are being addressed appropriately and that things don't slip through the cracks. (NASACT, Enforcement Process: Section (8))	YES	YES	YES	YES	None
Maintain a record of the enforcement actions taken. (NASACT, Enforcement Process: Section (9))	YES	YES	YES	YES	None
Timeliness					
The Board should be authorized to appoint committees from its membership. (FSMB Essentials, Section (III)(I))	YES	YES	YES	YES	None
Set guidelines/requirements for which complaints need action, and how quickly complaints should be handled (will depend on the type and severity of the problems alleged). (NASACT, Monitoring: the Complaint-Handling Process: Section (3))	YES	YES	YES	YES	1, 2
Evaluate the extent to which program staff complied with agency policies and procedures in carrying out their responsibilities. (NASACT, Management Analysis and Reporting Process: Section (4))	✖	✖	✖	✖	11, 12
Evaluate the reliability of the program data compiled and maintained by the agency. (NASACT, Management Analysis and Reporting Process: Section (5))	✖	✖	✖	✖	12
Evaluate how efficiently the agency is carrying out its responsibilities, including a review of any duplicative regulation that may be provided at different levels of government. (NASACT, Management Analysis and Reporting Process: Section (6))	✖	✖	✖	✖	13
Take appropriate, consistent, and timely enforcement actions that address the violations cited against these people/entities (including collecting any fines levied). (NASACT, Enforcement Process: Section (6))	YES	✖	YES	YES	11, 12
Conduct inspections [investigations] in a timely, efficient, and effective manner. (NASACT, Monitoring: the Inspection Process: Section (7))	YES	YES	YES	YES	None
Track and oversee complaints to ensure that they are being addressed appropriately and that things don't slip through the cracks. (NASACT, Monitoring: the Complaint-Handling Process: Section (7))	YES	YES	YES	**Partial**	11
Allowing the regulated person/entity to provide additional information that may have a bearing on the inspector's [investigator's] findings. (NASACT, Monitoring: the Inspection Process: Section (8)(b))	YES	YES	YES	YES	None

Appendix D: Glossary

Alleged issue – A classification of what the complaint is about, assigned by staff before the complaint is given to the Case Management Team. There are 94 different alleged issues classifications for medical complaints, and a complaint usually contains more than one.

Assessment – The process of determining whether to investigate a complaint, carried out by a Case Management Team.

Below threshold – Not rising to the level that is worthy of investigation. Most often, a complaint is considered "below threshold" because the complaint is about something that is not a violation, for example, a doctor being rude.

Board of Osteopathic Medicine and Surgery (BOMS) – The volunteer board in charge of licensing and discipline for osteopathic doctors and osteopathic physician assistants. The board has seven members, of which one is a public member.

Clear and convincing – The standard of evidence or proof required to take action against a licensee. It is greater than the "preponderance of evidence" standard in civil trials, but less than the "beyond reasonable doubt" standard of criminal trials. The courts have not defined what constitutes "clear and convincing," but some members of the boards use 75 percent as a rule of thumb (as opposed to 51 percent for preponderance).

Case Management Team (CMT) – A panel, composed of at least three board members of either MQAC or BOMS, that meets to decide whether complaints warrant investigations. MQAC's panel meets weekly, BOMS' generally meets every other week. Both have rotating members. The CMT also can act on behalf of the full board or commission, for example to approve changes to settlements. When a complaint is urgent, a panel can be convened to consider just that complaint. Expedited panels are necessary because court decisions do not allow staff to use the board's authority in an investigation without specific authorization, even in emergencies.

Health Systems Quality Assurance (HSQA) – The division of the Department of Health that handles licenses and discipline for all regulated healthcare providers except those regulated by designated boards. HSQA provides the staff, including lawyers and investigators, for BOMS and most other boards but not MQAC or the Nursing Care Quality Assurance Commission.

Integrated License and Regulatory System (ILRS) – The computer software used by HSQA to track complaints, cases and licensees.

Intake – The process in which a complaint is received and prepared for assessment.

Jurisdiction – The areas in which the board and commission have power, defined by the Uniform Disciplinary Act and limited to their licensees.

Member – An appointee to MQAC or BOMS. Most are clinical members, meaning a doctor or PA regulated by the board. Other are from outside the regulated profession; referred to as "public members," they are meant to represent the public interest and are often lawyers.

Medical Quality Assurance Commission (MQAC) – The volunteer board in charge of licensing and discipline for medical doctors and PAs. The board has 21 members, of which six are public members. It includes psychiatrists, but not doctors who do not have MD degrees, such as podiatrists.

Reviewing Commission Member (RCM) – A member assigned to study a case that has been investigated and present it to the other members for a decision. Members are sometimes assigned a case during investigation if their expertise will help the investigator. They can recommend a disposition, but sometimes bring the facts of the case and ask the other members what should be done.

Uniform Disciplinary Act – The law that lists infractions for which clinical providers (doctors, physician assistants, nurses, counselors, etc.) can be disciplined, and the process for disciplining them. It specifies that providers can be disciplined for "unprofessional conduct," which comprises 25 infractions, from "any act involving moral turpitude, dishonesty or corruption" and "incompetence, negligence or malpractice" to taking bribes and kickbacks.