PUBLIC TESTIMONY SUMMARY

I-900 STATE AUDITOR'S PERFORMANCE AUDIT:

Department of Health
Health Professions Quality Assurance
(8/21/2007)

As Heard by the Joint Legislative Audit & Review Sub-Committee on I-900 Performance Audits on September 26, 2007

The performance audit being discussed at this hearing was conducted solely and independently by the office of the State Auditor, under the authority of legislation approved by the voters in Initiative 900. The State Auditor is elected directly by the people of the State of Washington and operates independently of the Legislature and the Joint Legislative Audit and Review Committee. Staff to the Joint Legislative Audit and Review Committee prepare a summary of public testimony on State Auditor reports. These summaries are for informational purposes only and do not serve as an assessment by committee staff of the findings and recommendations issued by the State Auditor, nor do they reflect a staff opinion on legislative intent.

Title:	**Department of Health** **Health Professions Quality Assurance**
Audit Scope and Objectives:	The audit was conducted from November 2006 through July 2007. The auditors analyzed data from July 1, 2005, through June 30, 2007, and, when appropriate, analyzed data from previous two-year budget cycles. The audit lists nine objectives identified in a May 2006 letter from the Governor to the State Auditor requesting this review, as well as the nine objective elements listed in Initiative 900.
SAO Findings: The report has 13 findings:	**SAO Recommendations:** The report has 60 recommendations to the Office of Health Professions Quality Assurance or the Department of Health, as well as a set of recommendations to the Legislature. The specific recommendations to the Legislature are spelled out below.
1. The state's governance structure involving the Office of Health Professions Quality Assurance (HPQA) and the Boards and Commissions responsible for regulating health care professions does not promote effective performance management.	• The Legislature should amend the Written Operating Agreement statute (RCW 43.70.240) between HPQA and the boards and commissions to require the agreements to include negotiated performance-based provisions. The amendment should include 1) a requirement that the written agreements are reviewed annually and revised as needed to continually drive performance to protect the public's interests; 2) set an effective date as a deadline for these agreements to be revised and to become operational; 3) require the results of the key performance measures be posted on the Web sites of HPQA and each board and commission.

SAO Findings (cont):	SAO Recommendations (cont):
2. Credentialing process inconsistencies and control weaknesses leave the potential for unqualified individuals to practice in Washington and leave citizens at risk.	• The report has four recommendations to the HPQA with regard to this finding. • The Legislature should eliminate the registered counselor credential as it currently exists. • For all registered professions, the Legislature should review and modify as needed existing laws that allow individuals to be credentialed with no educational or experience requirements.
3. Weaknesses in internal controls over the background check process and lack of national criminal background checks can expose the public to serious risk.	• The report has five recommendations to HPQA with regard to this finding. • The Legislature should give the Department [of Health] the statutory authority to access WSP [Washington State Patrol] criminal background information, particularly non-conviction data (WACIC and ACCESS). • The Legislature should give the Department [of Health] the statutory authority and associated resources to access the FBI database for national background checks and require HPQA to conduct national background checks on all credential holders.
4. Changes in the complaint management process are needed to more accurately assess complaints and to improve responses to complainants.	• The report has 10 recommendations to HPQA with regard to this finding.
5. HPQA's efforts to improve public education regarding citizens' rights to file complaints about credential holders with HPQA are insufficient.	• The report has four recommendations to HPQA with regard to this finding.
6. Investigations of complaints are delayed by process issues and compromised by staffing shortages and internal control deficiencies.	• The report has 10 recommendations to HPQA with regard to this finding. • The Legislature should provide additional tools for obtaining records, documents and other evidence. These tools could include authorization to issue citations and fines for failure to provide documents in a timely manner.
7. Deficiencies in the disciplinary (legal) process have led to inconsistent and delayed discipline of practitioners who engage in unprofessional conduct or provide below standard of care.	• The report has four recommendations to HPQA with regard to this finding. • The Legislature should adopt a law 1) requiring a deadline by which the sanction guidelines must be adopted; 2) authorizing the Secretary to discipline all professions for misconduct, while the boards and commissions continue to discipline standard-of-care violations; 3) indicate that any board or commission not adopting sanction guidelines by the deadline could be subject to losing its disciplinary authority and becoming an advisory committee.
8. The compliance process does not ensure that practitioners who have been disciplined comply with the terms of their sanctions.	• The report has five recommendations to HPQA with regard to this finding.
9. DOH and HPQA oversight needs improvement to ensure that the credentialing and the regulatory processes are performing as intended.	• The report has three recommendations to HPQA with regard to this finding.
10. The DOH internal audit function is understaffed and does not perform evaluations of HPQA to identify and report deficiencies that could impede HPQA's ability to achieve its goals.	• The report has three recommendations to the Department of Health with regard to this finding.

SAO Findings (cont):	SAO Recommendations (cont):
11. Legacy information systems do not enable HPQA to effectively and efficiently license health practitioners, manage consumer complaints and monitor compliance with disciplinary action.	• The report has six recommendations to HPQA with regard to this finding.
12. HPQA's disaster recovery plans and business continuity plans are not fully developed.	• The report has three recommendations to HPQA with regard to this finding.
13. Hard copy files related to licensing and investigations are not physically secure.	• The report has three recommendations to HPQA with regard to this finding.
Agency Response in Audit Report?	Yes; Appendix M contains a joint response from the Department of Health and the Office of Financial Management.
Legislative Action Requested?	Yes.

Staff Summary of Testimony from Audited Agencies:

An outside look is extremely important. Patient safety is the first priority. The audit suggests important changes, some of which the Department of Health has begun and some of which will require the Legislature's help. The Department agrees with most of the recommendations; where the Department does not agree, it offered a different opinion. We approached the audit with the perspective of this being a partnership. The 13 findings and 67 recommendations result in 65 actions. Of these, 47 are already done or are in process with current budget and staffing resources; eight require changes to the law; seven require additional resources not currently available; and three are started with current resources but need additional resources or legislation. We began work on changing health profession regulation back in 2005. The Governor's and Legislature's approval of resources for a new data system and additional staff are appreciated. We also appreciate the audit's recognition that some of the changes made in recent years are best practices.

Staff Summary of Testimony from Other Parties:

We share the concern regarding the lack of requirements for Registered Counselors in private practice and have been working to establish a set of professional standards. It is essential to 1) eliminate the current credential as it stands, but not eliminate the professionals who have been practicing ethically and responsibly in this category; 2) set standards for non-licensed counselors; 3) educate the public; and 4) protect consumer choice.

There are many portions of the audit that are helpful. We support the emphasis on patient safety. There are two audit items that do not have an accurate or documented basis. The auditors cited three cases as evidence that the Medical Quality Assurance Commission did not follow sanction guidelines. In fact, the developing guidelines were not presented to the Commission at the time these cases were settled. The recommendation that the Secretary of Health discipline for misconduct while the professions discipline standard of care would be unique, and there is no evidence to support the recommendation. We urge the Legislature to reject this recommendation.

The Legislature has established in statute the responsibilities for the Medical Quality Assurance Commission; however, all resources for carrying out these responsibilities are assigned to the Department of Health. This situation has resulted in friction between the Commission and the

Department. During the seven months that the auditors were working, there was a great deal of interaction with the Department but minimal time spent with the Commission. The audit was held in secret from June until August while the Department's concurring responses were incorporated. This privilege was not extended to the boards and commissions, and their views are not in the report. The recommendation regarding the split in disciplinary authority is not supported by findings and analysis. However, it does mirror the Department's stated position on legislation from last session. We are disappointed in the audit and hope the Legislature will be aware that there is another side to the story.

We congratulate the Auditor's Office for the thorough and extensive review. We support most of the findings and recommendations of the audit. There are two recommendations that we do not agree with and believe are unsubstantiated. First, the recommendation to split investigations of complaints weakens the work of the Medical Commission. We do not find the recommendation supported in the report or by the authorities referenced in the report. It is difficult to separate personal misconduct from standard of care issues. Second, the recommendation to standardize sanctioning guidelines used by every profession would prevent the Medical Commission from disciplining physicians based on each case's unique set of facts. We do not see how this one-size-fits-all approach improves health care discipline when there are 57 very different health professions. The Legislature should enact most of the reforms recommended by the Auditor, but the reforms should apply to a new independent Medical Commission that is no longer a part of the Department of Health.

Agencies Testifying:

Department of Health (Mary Selecky, Secretary, and Laurie Jinkins, Assistant Secretary)

Other Parties Testifying:

Verne Gibbs, Washington Professional Counselors Association
Judy Tobin, Washington Medical Quality Assurance Commission
Frank Hensley, Washington Medical Quality Assurance Commission
Tim Layton, Washington State Medical Association