# Patient Safety Improvement Task Force Recommendations to the Secretary of Health

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Prepared by the Health Systems Quality Assurance Division and the Center for Facilities, Risk, and Adjudication

**DOH 699-002**

Washington State Department of Health

# Contents

# Executive Summary

In December 2021, the Secretary of Health, Dr. Umair Shah, convened the Patient Safety Improvement Task Force (task force) to develop recommendations to improve the disciplinary process for sexual misconduct cases. Dr. Shah asked the task force to consider two goals:

**Goal 1:** Reduce the overall timeframe to process sexual misconduct cases.
**Goal 2:** Inform the public earlier about disciplinary cases, to help the public to make better informed decisions when selecting a health care provider.

Task force members included representatives from the Department of Health (DOH), Office of the Attorney General (AGO), Washington Medical Commission (WMC), Nursing Care Quality Assurance Commission (NCQAC), Chiropractic Quality Assurance Commission (CQAC), Board of Massage, and Board of Physical Therapy, along with two members from outside the disciplinary process to represent health care provider and patient perspectives. Overall, 30 individuals participated in the task force and provided input on how to achieve the secretary's goals.

The task force met several times between December 2021 and January 2022. DOH facilitated these meetings and drafted a report summarizing the resulting recommendations. The task force reviewed the draft report, after which DOH shared a revised draft with 38 stakeholder organizations for additional comment. Stakeholders included health care provider associations, labor unions, and organizations that work on the issues of patient advocacy, sexual assault prevention, and equity.

Based on discussion and feedback from the task force, DOH identified 18 specific recommendations and grouped them into 9 topic areas:

**Topic 1:** Reduce target timelines and strengthen management oversight of sexual misconduct cases.
**Topic 2:** Expedite board and commission review of sexual misconduct cases.
**Topic 3:** Streamline the process for contracting with experts.
**Topic 4:** Modify disciplinary procedures and agreements.
**Topic 5:** Transition from paper to digital disciplinary files.
**Topic 6:** Research long-term policy changes.
**Topic 7:** Create specialized sexual misconduct teams.
**Topic 8:** Inform the public when a provider is under investigation.
**Topic 9:** Provide public education on the Provider Credential Search verification system and the process for filing a complaint against a provider.

DOH facilitators encouraged the task force to think creatively and present bold ideas for improving patient safety. The task force also discussed the potential cost, feasibility, and timing of some recommendations; however, more work is needed to prioritize and resource these initiatives for implementation.

The recommendations in this report do not necessarily represent the conclusions of every individual on the task force, but our hope is that they approximate consensus and convey the nuance that was revealed during the process. Acting on these recommendations will require thoughtful collaboration and compromise among a diverse and independently governed community of partners.

# Introduction

Analysis of case timelines over the past five years revealed that the Department of Health (DOH), profession-specific boards and commissions, and the Office of the Attorney General (AGO) took an average of 332 days to resolve sexual misconduct complaints, while a subset of cases that went to adjudication took significantly longer. Sexual misconduct cases are legally complex and must follow a rigorous administrative process, however there may be opportunities to implement short and long-term changes that reduce the average timeframe for case resolution.

As required by law, DOH posts information about legal actions on the Provider Credential Search feature of the DOH website, including statements of charges, settlement agreements, and final adjudicative orders. DOH also updates the Provider Credential Search and issues a news release when a provider's license is summarily suspended. However, under current DOH policy, information about whether a provider is under investigation is only accessible through a Public Records Act (chapter 42.56 RCW) disclosure request. It is possible that DOH, boards and commissions can find ways to share information about sexual misconduct cases earlier in the process and better educate the public about provider credential verification and the process for filing a complaint.

### *The Task Force*

The task force members included representatives from the Department of Health (DOH), Office of the Attorney General (AGO), Washington Medical Commission (WMC), Nursing Care Quality Assurance Commission (NCQAC), Chiropractic Quality Assurance Commission (CQAC), Board of Massage, and Board of Physical Therapy. Additionally, DOH invited two members from outside the disciplinary process to represent health care provider and patient perspectives.

The task force convened four times between December 2021 and January 2022. DOH facilitated these virtual meetings. The purpose of the meetings was to bring together a diverse group of individuals representing the full spectrum of the disciplinary process—including technical experts and decision-makers who can influence process and procedure within their organization—for a series of collaborative problem-solving workshops. Together, this group identified root causes, generated ideas for potential solutions, and developed a set of recommendations for DOH leadership to consider. Using notes from the virtual meetings, DOH drafted the recommendations and sent them to the task force in February 2022 for further review.

### *The Disciplinary Process*

The Uniform Disciplinary Act (UDA) (chapter 18.130 RCW) provides the legal and policy framework for the regulatory oversight of health professions in Washington. The Secretary of Health and boards and commissions regulate over 500,000 health care providers in 85 different professions. Each profession has a disciplinary authority that makes decisions in disciplinary cases. The Secretary of Health is the disciplinary authority for 47 professions, including medical assistants, massage therapists, and agency affiliated counselors. Boards and commissions are the disciplinary authority for 37 professions including physicians, nurses, chiropractors, dentists, and pharmacists.

The disciplinary process is made up of five major components:

1. Complaint intake and assessment
2. Investigation
3. Case disposition/legal action
4. Adjudication
5. Compliance

The process is generally the same for both Secretary-regulated professions and board and commission-regulated professions, with the exception that board and commission-regulated professions require a panel of three board or commission members for decision-making at each step of the process. There are several factors during complaint intake, investigation, legal action, and adjudication that can result in a case being delayed.

To provide a sense of scale, DOH, boards and commissions processed 35,128 total complaints during the 2019-2021 biennium, investigated 8,349 of those complaints, and took 1,827 disciplinary actions[1].

### *The Recommendations*

The task force held several meetings and provided written feedback that resulted in the following recommendations, organized by topic, and listed under the corresponding project goal. Topics and recommendations are numbered for reference, but the numbering does not indicate priority.

Each recommendation included in this report is expected to contribute to improving patient safety. However, it is difficult to know at this stage how much an individual recommendation will contribute relative to others. These ideas are presented conceptually, and many of them involve system-wide policies and procedures that require close coordination between DOH offices, AGO divisions, and 17 boards and commissions. It is likely that partners will need to implement multiple recommendations to see results on a large scale across all 85 licensed health professions.

While the primary focus of the task force was to improve the process for sexual misconduct cases, many of these recommendations would have a broader impact within the disciplinary process and could lead to reduced timeframes for other cases as well.

[1] 2019-2021 Uniform Disciplinary Act Report

# Recommendations

## *Goal 1: Shorten the timeframe for resolution of sexual misconduct cases*

### *Topic 1: Reduce target timelines and strengthen management oversight for sexual misconduct cases*

Timelines for resolving disciplinary cases under the Secretary's authority are currently established in chapter 246-10 WAC, with model procedural rules for boards in chapter 246-11 WAC. Secretary authority cases have a performance measure target that aims for 77% of cases completed within the timelines allocated for each stage of the processes except adjudication. The timelines are:

- 21 days for intake and assessment
- 170 days for investigation
- 140 days for case disposition
- 180 days for adjudication

One of the primary recommendations of the task force was to find ways to reduce these target timelines for sexual misconduct cases specifically. Reducing target timelines would help resolve cases faster but would require increased staffing to allow employees with sexual misconduct cases to have smaller caseloads and prioritize those cases.

With reduced timelines, the task force also recommended that DOH strengthen management oversight by improving an existing review process at the supervisor level and elevating more cases to DOH and AGO leadership when they exceed established timelines. Improving the case tracking system to provide more timely and actionable data on the status of sexual misconduct cases would further strengthen the process.

#### Recommendation 1.1: Reduce target timelines for sexual misconduct cases to prioritize and increase resources for those cases

Reducing target timelines can be accomplished in many ways, up to and including rulemaking. There are also opportunities to reduce procedural timelines that are not defined in rule but exist in DOH policy or interagency agreements. Regardless of the method, the desired outcome is to shorten the amount of time that sexual misconduct cases are considered "within timelines" from a management perspective and give these cases the highest priority when moving through each phase of the disciplinary process. Cases that exceed timelines at any phase will receive enhanced management oversight (EMO), and DOH will administer the EMO process more frequently and consistently for sexual misconduct cases (see recommendation 1.2).

**Recommended action:** Convene a workgroup to establish shorter timelines for sexual misconduct cases. DOH should lead this effort and work closely with boards, commissions, and the Office of the Attorney General (AGO) to establish new targets and performance measures. This group should research best practices and set high standards; evaluate the resource requirements for implementation; pilot reduced timelines; update agency procedures; and consider rule changes to formalize the new timelines.

### Recommendation 1.2: Improve Enhanced Management Oversight (EMO) practices in DOH

WAC 246-14-030 requires Enhanced Management Oversight (EMO) of cases that exceed target timelines and notation of the reason for delay. The rule does not specify how EMO should be implemented. Any case that exceeds timelines at DOH receives an "EMO" label in the disciplinary tracking system. Supervisors should meet regularly with employees to discuss cases in EMO status, identify roadblocks, and develop a plan to overcome obstacles impacting those cases.

Task force members found that EMO occurs inconsistently across teams at DOH and would benefit from process improvement. Ensuring that EMO meetings are held regularly and increasing the frequency of those meetings for sexual misconduct cases should strengthen accountability for resolving cases within timelines.

**Recommended action:** Continue support for the following actions identified early in this project:

- Health Law Judges (HLJs) in CFRA will hold monthly EMO meetings for sexual misconduct cases in adjudication and have HLJs report out on status of pending cases for awareness, feedback, best practices and next steps. [Note: these meetings will occur internally within CFRA and are separate from the EMO process in HSQA, due to ex parte contact prohibitions].
- HSQA leaders will strengthen the EMO process to ensure supervisors and employees have visibility and accountability for all sexual misconduct cases exceeding timelines; supervisors in HSQA will hold EMO meetings every other week, review all cases exceeding timelines, identify and remove barriers, and verify that employees are taking appropriate action to resolve issues.

### Recommendation 1.3: Hold additional leadership meetings to raise awareness and accountability for longstanding sexual misconduct cases

The task force identified that managers, division leadership, and agency leadership need better data and more frequent interactions to address issues with sexual misconduct cases earlier and understand the big picture of how these cases are progressing as a cohort. Leadership meetings should focus on cases beyond target timelines and those not progressing well through EMO review at the supervisor level.

**Recommended action:** Establish a meeting process to ensure leadership visibility and accountability for sexual misconduct cases exceeding WAC timelines; respective offices within HSQA and CFRA will each develop internal reports delineating sexual misconduct cases that are over their office's respective timelines; leaders will attend a standing monthly meeting to discuss options to resolve the 10 oldest cases on each report and come prepared to remove any roadblocks.

### Recommendation 1.4: Develop a dashboard approach to collecting, evaluating, and reporting data on the status of sexual misconduct cases

As it stands, the variation and method of reporting case disposition status by profession is not consistent. DOH, boards and commissions need the ability to easily measure all factors influencing case timelines, such as expert review, board and commission meeting schedules, and extensions due to settlements. Standardizing certain elements of the agency's data collection and reporting could help provide a clearer picture of individual and collective progress on sexual misconduct cases.

**Recommended action:** Explore whether the new Health Enforcement and Licensing Management System (HELMS) will include these capabilities. DOH should also gather information on disciplinary performance measures when researching best practices in other states (see recommendation 6.4).

### *Topic 2: Expedite board and commission review of sexual misconduct cases*

Passage of HB 1103 in 2007 required health profession boards and commissions to refer sexual misconduct cases to the Secretary's authority, except when the case involves clinical expertise or standard of care issues (RCW 18.130.062). Because many sexual misconduct cases *do* involve clinical expertise and standard of care issues, boards and commissions retain jurisdiction over two-thirds of cases (from 2017 to 2021, boards and commissions referred 30% of sexual misconduct cases to the Secretary). Reducing procedural delays and applying efficiencies to the board and commission review process could significantly positively impact timeframes for sexual misconduct cases. Additionally, expanding the size of some boards and commissions—along with increasing the pool of pro tem members—would ensure availability for hearing panels and faster approval of disciplinary action.

#### Recommendation 2.1: Develop and implement strategies to expedite board and commission review of sexual misconduct cases

Task force members made several suggestions related to this recommendation, including:

- Contact the assigned Reviewing Board/Commission Member (RBM/RCM) within days of panel authorization for sexual misconduct investigations instead of waiting until the investigation is over. The investigator and RBM/RCM can review complaints before any investigation has started and formulate an investigative plan up front. The RBM/RCM would provide clinical perspective early in the process and minimize the need for additional investigation later.
- Once investigations are completed, the case manager should assign the case to an RBM/RCM and ask them to evaluate and present at the next available board/commission panel call, rather than waiting for a regularly scheduled board/commission meetings to authorize disciplinary action. Panel calls require fewer members and occur every 1-2 weeks, whereas regular board/commission meetings can be several weeks apart.
- Case managers could create proactive meeting schedules to meet emergently as sexual misconduct cases move through the process, similar to what is done for summary action panels.

**Recommended action:** The Office of Health Professions and Office of Investigative and Legal Services should work with boards and commissions to create and promote process improvement efforts for case management procedures.

#### Recommendation 2.2: Enhance the capacity of boards and commissions by expanding the pool of pro tem members, filling existing vacancies, and implementing an active legislative proposal

DOH had the opportunity to propose agency request legislation (SSB 5753) that passed the 2022 legislature and was signed into law on March 31, 2022. The bill modifies membership and quorum requirements for the Dental Quality Assurance Commission, Veterinary Board of Governors, Board of Physical Therapy, Board of Massage, Examining Board of Psychology, Pharmacy Quality Assurance

Commission, and Board of Nursing Home Administrators. It addresses quorum issues by expanding membership and requiring only a simple majority. Many board and commission members will also receive higher compensation, aiding in overall recruitment and retention. In addition to implementing SB 5753, the task force also recommended the following improvements:

- Add an additional board and commission member to hearing panels. The Nursing Care Quality Assurance Commission already schedules four panel members and assumes one will likely be absent. This strategy should be considered by other boards and commissions, although it may be challenging for those with fewer members.
- Appoint more pro tem members and ensure they receive competency training around sexual misconduct and trauma-informed practices.
- Explore the possibility of creating a pool of specially trained public pro tems that can fill in for panels specific to sexual misconduct across multiple boards and commissions.
- Staff emergency case management teams with pro tem members and include one full board/commission member as chair.

**Recommended action:** The Office of Health Professions should work with HSQA leadership, DOH Human Resources, boards, commissions, and the Governor's office to develop pools of candidates interested in serving on boards and commissions, identify opportunities to accelerate recruitment and improve retention of members, increase the pool of pro tems, and utilize pro tems more strategically to compensate for absences and recusals.

### *Topic 3: Streamline the process for contracting with experts*

Experts are hired to provide an opinion on cases that involve clinical knowledge or standard of care issues. Most cases that go to adjudication require experts. Obtaining an outside expert as a consultant or to provide hearing testimony can increase case timelines by weeks to months depending on the profession. The process needs to be reviewed and the time it takes for approval of a contract within DOH needs to be shortened. Staff also have difficulty locating qualified experts in the fields required, such as experts willing and able to perform psychological evaluations in rural areas. Some professions utilize one or two experts for all sexual misconduct cases, and if they are not available, it can significantly slow the case.

#### Recommendation 3.1: Explore strategies to accelerate the contracting process for hiring experts for disciplinary cases

**Recommended action:** The Office of Investigative and Legal Services and the Office of Health Professions should work with the DOH Contracts Unit to identify sources of delay and find opportunities to reduce processing time for contracting with experts.

#### Recommendation 3.2: Expand the pool of experts available to consult and testify, especially for professions with a relatively low number of experts

When boards and commissions rely on a small number of experts, their availability is a factor in case timelines. Having a larger pool of vetted experts to draw upon could decrease case timelines across the board. Several years ago, HSQA tried contracting with Medical Consultant Networks (MCN) so MCN

could identify an expert from those under contract with MCN. At the time, this did not result in wide use of MCN service due to their inability to provide experts in the variety of disciplines needed, so the contract was never renewed. Other services may be available now that more closely meet our needs.

**Recommended action:** The Office of Health Professions and the Office of Investigative and Legal Services should pursue opportunities to expand the pool of experts available to consult on cases for all professions, including through consultant networks.

### *Topic 4: Modify disciplinary procedures and agreements*

The task force identified several areas where operating procedures and/or legal proceedings can delay the timely resolution of disciplinary cases. Delays are a complex subject, and it is worth noting that all parties involved in sexual misconduct cases are invested in resolving cases with due haste. There is a natural tension in the legal process between building a robust case and bringing cases to a swift conclusion. Patient safety requires not only an expedient process, but also an effective one with due process for providers and legal outcomes that assure no further misconduct is committed. Recognizing this complexity, the task force began exploring process changes that would help reduce excessive or unintended procedural delays involving sexual misconduct cases. These ideas range from small changes in office protocols to broader policy initiatives that would require legislation to implement.

#### Recommendation 4.1: Assess and implement a broad range of time-saving procedural efficiencies within each phase of the disciplinary process

Below is a list of initial task force suggestions that could save time and improve performance in managing sexual misconduct cases throughout their lifecycle:

Intake/Assessment

- Complete the Whistleblower Waiver process prior to assessment for investigation (Washington Medical Commission is already doing this).
- Involve the Assistant Attorney General (AAG) when a new investigation is authorized if there is already a related case with the AGO.

Investigation

- Involve the AAG earlier in the process if there are issues related to obtaining evidence or if clinical issues are involved where an expert will be needed.
- Bring the AAG into the team early in the investigation especially if a summary suspension is being considered.

Case Disposition

- In appropriate cases, issue Statements of Charges (SOCs) early if no expert support is required and then amend the SOC later with the standard of care issues that would need an expert opinion.
- Engage with experts earlier in the process and request shorter response times for expert review, perhaps seven days for sexual misconduct cases.

- Include the AAG reviewing sexual misconduct SOCs in the Office of Investigative and Legal Services check-in meetings during pending review to address questions earlier.

Adjudication

- Develop expectations for HLJs to require that all Motions to Continue be filed in writing and filed prior to a conference call (this would likely require a legislative change).
- Identify cases involving sexual misconduct (irrespective of how they are charged) prior to setting a date for the initial scheduling conference; involve the HLJ at that juncture to hold a status conference and set a case schedule.
- Reduce the amount of time it takes for an order to be issued after a hearing.
- Set internal timelines for staff attorneys to engage in settlement discussions to prevent later delays in adjudication.

Overall Process

- Require AAGs and staff attorneys to consult with Executive Directors and/or Office Directors before pursuing actions that will extend timelines for sexual misconduct cases, such as amending SOCs and not opposing continuances.
- For sexual misconduct cases, only have the AAG draft and finalize pleadings to avoid multiple writers and hand offs.
- Follow up sooner and more consistently with cases that are on hold pending criminal trial and consider creating a new code in the licensing system to track these cases.

**Recommended action:** DOH should engage with boards, commissions, and AGO partners to further assess procedural changes identified by the task force, along with identifying any new opportunities for efficiency. This effort should rely on empirical data, as available, to help identify delays and determine the right level of decision-making needed to acquire resources and implement solutions. DOH and partners should immediately implement any changes identified as "just-do-its".

### Recommendation 4.2: Update the service level agreement between DOH and the AGO

Procedural and process improvements related to the workflow between DOH and AGO should be memorialized in a revised agreement between the two organizations. This updated agreement should specify the timeframes for each organization's work on disciplinary cases with a goal of reducing the overall time required to resolve sexual misconduct cases.

**Recommended action:** DOH and AGO leaders should revise the current memorandum of understanding and establish a new agreement for service.

## *Topic 5: Transition from paper to digital disciplinary files*

There are multiple points in disciplinary case processing where delays occur due to copying paper files, duplication of the copying work, and file transmission via US mail or another carrier. The Medical and Nursing commissions have already successfully transitioned to a mostly digital file management system. At DOH, the HSQA and CFRA divisions have taken incremental steps toward scanning and cloud-based file sharing but currently lack the resources to make significant strides away from paper. Moving to

digital files would achieve several important positive outcomes for the entire disciplinary process, including resolving sexual misconduct cases more quickly.

**Recommendation 5: Transition to a paperless process for managing disciplinary and adjudicative files, which would benefit the entire DOH workflow, including faster resolution of sexual misconduct cases**

Digital file management increases productivity by providing immediate access to documents and information; allows multiple users to access the same file at once; reduces operating costs by reducing the amount of paper consumed, stored, shipped and mailed; promotes security by providing digital backups, restricted access, eliminating paper files leaving the office, and reducing privacy breaches; and lowers the organization's consumption of valuable resources and its overall carbon footprint. This transition can occur incrementally and would positively impact timelines for all disciplinary cases, including sexual misconduct cases.

**Recommended action:** Seek funding for a project to transition from paper to digital file management throughout the disciplinary and adjudicative workflow. HSQA and CFRA will assess whether it is feasible to begin implementing some elements of this transition right away if they only require procedural changes or routine IT maintenance and operations support.

### *Topic 6: Research long-term policy changes*

The task force needs to better understand how to leverage statutes, rules, and policy interpretations to improve sexual misconduct case timeframes and protect patients throughout the process. The task force identified the following recommendations for conducting additional research in this area.

**Recommendation 6.1: Research additional regulatory tools to remove a provider from practice during the legal process while sexual misconduct cases are litigated**

**Recommended action:** Conduct research on the following subjects:

- Explore opportunities to utilize summary suspension more frequently under current law to be more assertive in protecting patients. This could look like a new risk assessment method specific to sexual misconduct allegations.
- Develop a policy research brief on using Interim Stipulated Orders and/or Agreements Not to Practice. This is an option in Oregon (677.410 Voluntary limitation of license) and while it does not speed up the legal process, it takes the practitioner out of practice or restricts them during the process and protects the public while the process is underway.

**Recommendation 6.2: Research ways to clarify when sexual misconduct cases should be referred to the Secretary, along with WAC changes that would further clarify and refine definitions of sexual misconduct across all disciplinary authorities**

**Recommended action:** Conduct research on the following subjects:

- RCW 18.130.062, the statute that requires boards and commissions to refer sexual misconduct cases to the Secretary, can be difficult to interpret from an AAG perspective. How much of a

problem is this, and how can we address it? Does lack of clarity around when to transfer negatively impact the timely resolution of cases?

- Determine if/when bifurcating sexual misconduct allegations from standard of care or other non-sexual misconduct allegations would be feasible and shorten case timeframes
- Explore WAC changes would clarify and refine definitions of sexual misconduct for DOH and boards and commissions
- Categorize degrees of sexual misconduct in WAC similar to criminal law (i.e., first degree, second degree, third degree) to allow for better prioritization of case urgency

**Recommendation 6.3: Research board and commission delegation of authority to Executive Directors (EDs) to approve additional steps of the disciplinary process for sexual misconduct cases**

**Recommended action:** Conduct research on the following:

- Explore statutory changes that would include delegation to EDs to approve some steps in the process. EDs in other states appear to have more authority over discipline for some professions. The benefit of delegating would be quicker decision making about investigations and legal action when board and commission members are not available. There would still be limits to the EDs authority and changes would need to be carefully considered.

**Recommendation 6.4: Research the regulation of health profession sexual misconduct in other states**

**Recommended action:** Conduct research on the following:

- Research other states and jurisdictions for best practices and innovative approaches related to sexual misconduct cases. Develop recommendations for improving policies in Washington. [Note: DOH has a legal intern currently gathering information from other states on this topic.]

### *Topic 7: Create specialized sexual misconduct teams*

Creating a team of specially trained employees dedicated to sexual misconduct cases was a popular suggestion among the task force. Sexual misconduct cases are currently processed by the same teams who process all incoming complaints, investigations, legal actions, and adjudicative proceedings. Although all investigators are required by current law (RCW 18.130.062) to undergo training on trauma-informed interview skills, the task force believes a more specialized approach to managing sexual misconduct cases has the potential to improve current practices and reduce timelines. Some of this could be accomplished by restructuring existing teams, while other enhancements—such as specialized legal training and additional staff support—would require new funding.

**Recommendation 7: Research and recommend a strategy for creating one or more specialized units that only manage sexual misconduct cases**

The task force discussed a variety of potential strategies to achieve this outcome. One possibility is to have DOH and partner commissions reassign staff within their respective offices. Another is creating a combined unit of investigators from DOH, Medical and Nursing Commissions that would collaborate on commission authority cases. The task force also suggested that centralizing all sexual misconduct

investigations within DOH—including commission cases—could be an efficient strategy; DOH investigators could work with a reviewing commission member as a consultant when a case has standard of care issues. These ideas require further exploration and possible statutory changes, but the general concept is supported and has the potential to increase productivity, enhance performance monitoring, reduce the timeframe for sexual misconduct case completion, and facilitate process improvement for sexual misconduct cases over time.

**Recommended action:** Research and recommend a shared strategy among DOH and the independent commissions for creating dedicated sexual misconduct teams. DOH and partner commissions should consider where these teams would be best situated within each organization; additional staffing required under the new model; how to ensure communication and collaboration if teams are cross-divisional; determining the role of adjudication in this strategy; and identifying resources to support and develop these teams once they are established.

## *Goal 2: Make information about sexual misconduct cases available to the public earlier in the process*

### *Topic 8: Inform the public when a provider is under investigation*

The task force was asked to find ways of making information about sexual misconduct cases available to the public sooner to protect patients from inadvertently seeing providers who are under active investigation for sexual misconduct. As required by law, DOH currently posts information on the Provider Credential Search feature of its website when statements of charges have been filed; when matters have been resolved by stipulation to informal discipline; and when final adjudication occurs. The public is also made aware of cases when summary action is taken on a license through Provider Credential Search and a standalone news release. However, under current practice, people wanting to know whether a provider is under investigation for misconduct (i.e., suspected but not yet charged) do not have easy access to this information. Complaints are protected from public disclosure under RCW 18.130.095(1)(a) until the time a decision is made whether to investigate. Investigations are publicly disclosable (with redactions), but the public is not widely aware of this fact, and the public disclosure process can be lengthy.

To address this problem, the task force considered how and when it might be necessary to post information about investigations on the Provider Credential Search so that any interested person could run a search on a provider to see if an investigation is currently active. The information could be removed if the investigation resulted in no charges. Nothing in law precludes DOH from posting information to the Provider Credential Search indicating a provider is under investigation. This could be done specifically for sexual misconduct cases, or for all cases under investigation. The task force discussed the merits of posting this information as well as the potential for harm to a provider's reputation and employment, which could occur even if an investigation does not result in any charges. Due to the complexity of this topic, the task force concluded that more research is needed.

### Recommendation 8: Research the risks, benefits, and alternatives for adding investigative information to the online Provider Credential Search and prepare a recommendation for DOH leadership

**Recommended action:** Develop an options-based policy research brief that evaluates the issue from the perspective of both patient safety and impacts to health care providers. Propose alternative courses of action for agency leadership to consider.

## *Topic 9: Provide public education on the Provider Credential Search system and the process for filing a complaint against a provider*

The task force considered ways to educate the public about how to check a provider's disciplinary status using the Provider Credential Search tool and how to file a complaint against a provider. Provider Credential Search is not well advertised on the agency's website or promoted in search results, and some users find the interface difficult to navigate. For example, if a provider has discipline on their record, a user cannot see what that discipline was for (e.g., sexual misconduct) without opening and reading through the attached legal pleadings. The Provider Credential Search has the potential to be a valuable resource for patients who are seeking providers they can trust, and there may be opportunities to enhance this tool by raising awareness and improving the user experience.

Additionally, the DOH complaint intake program would benefit from increasing public awareness and removing barriers to access. Currently, the complaint intake webpage is difficult to find if a person has no prior understanding of the process, and to date, there has not been widespread public education to encourage patient access to the complaint process. Raising awareness of the Provider Credential Search could help empower more patients in Washington to evaluate their providers using readily available information.

task force members expressed some concerns with this approach, including the risk of increasing public hostility to the health care sector at a time when there are critical workforce shortages. Providers on the task force commented that most health care workers in Washington have gone above and beyond during the pandemic and may react negatively to this kind of messaging from the state. It was also acknowledged that there are existing private sector services for evaluating health care providers, along with patient advocacy organizations, meaning DOH is not the sole source of information for patients. These factors should be considered in the development of any public education strategies.

### Recommendation 9: Seek new funding for DOH to launch an ongoing, sustained public education effort to increase awareness around the Provider Credential Search and the process for filing a complaint against a provider

**Recommended action:** With resources allocated, the DOH Center for Public Affairs would implement public education. Activities would include contracting for audience research, developing all needed outreach and education messages and materials, translating web content into other languages, and completing web upgrades to improve accessibility and navigation.

## *Items for further inquiry*

Some ideas the task force generated were technically out of scope for this project, yet still potentially valuable for improving DOH's handling of sexual misconduct cases. Such ideas are listed below and should be considered for further inquiry:

- Develop a list of victim advocates and other resources to share with patient survivors of sexual misconduct.
- Hire mental health counselors in DOH to assist boards, commissions, programs, survivors, and anyone else who needs help related to sexual abuse and/or licensee sanctions.
- Locate experts in the neurobiology of trauma to explain or testify about survivor behaviors such as delays in reporting.
- Additional advanced training on issues and sensitivities regarding sexual misconduct for all staff, investigators, board and commission members, and pro tems.

## *Stakeholder feedback on Task Force recommendations*

In early March 2022, DOH shared the draft task force recommendations with a select group of stakeholders for comment, including health care provider associations, labor unions, and organizations that work on the issues of patient advocacy, sexual assault prevention, and equity. The report was distributed to thirty-eight organizations; ten responded with comments on the draft.

### *Summary of feedback*

Stakeholders were generally supportive of the task force's recommendations under Goal 1: reducing timeframes for case resolution. Some argued that if the recommendations under Goal 1 were implemented effectively, there would be little need for the recommendations under Goal 2—informing the public earlier in the process—since the state would charge providers more quickly and the public would be informed sooner as a result.

Recommendations under Goal 2 were more controversial, with most stakeholders strongly opposed to informing the public when an investigation is opened on a provider (Topic 8). The fear is that proactively sharing investigation status on Provider Credential Search could harm a provider's reputation even if that investigation does not result in disciplinary action. A few comments, though, did support the concept of releasing investigation status and suggested that DOH could do more to disseminate information about sexual misconduct allegations prior to formal action. Disagreement among stakeholders on this topic reflected similar division within the task force itself.

Comments in support of informing the public when a provider is under investigation suggested that cases authorized for investigation have already undergone enough scrutiny to warrant posting, assuming they are removed later if the investigation does not result in charges. Comments also suggested that it would be inconsistent to only post sexual misconduct investigations, and that DOH should consider posting the investigative status of all cases.

Comments opposed to sharing investigative status online warned that the harm to a provider's reputation and livelihood could be irreparable, even if the information is eventually removed. If this policy were enacted, DOH would need to place high emphasis on alerting the public when an investigation does not result in charges against a provider.

Most stakeholders appreciated the task force's conclusion that further research and engagement are needed on Topic 8 before making a policy decision.

Topic 9—providing public education on the Provider Credential Search and complaint process—also generated mixed opinions. Stakeholders, like the task force, considered the potential negative impact this kind of messaging could have on providers during a particularly stressful time for the workforce due to the COVID-19 pandemic and ongoing staffing shortages. However, commenters also noted that transparency and accountability should be a priority, and that it is possible for DOH to support health care workers and promote patient safety resources at the same time.

Other themes reflected in stakeholder feedback include:

- The need for accountability and performance measures around process improvement efforts, such as enhanced management oversight and expediting board and commission review of

sexual misconduct cases; DOH business practices should be specific, well documented, and include expected timeframes for corrective action.

- Concern about unconscious bias among pro tems and expert witnesses due to lack of racial, ethnic, or gender representation, and/or lack of training in trauma-informed practices around sexual misconduct, in terms of both survivor and perpetrator behaviors.
- Concerns about utilizing expert witnesses who specialize in sexual misconduct but lack clinical knowledge of the respondent's profession; this concern would also apply to the idea of creating a centralized pool of board/commission pro tem members for sexual misconduct cases
- Questions about putting some administrative cases on hold while law enforcement agencies pursue criminal charges. Stakeholders wondered whether there are situations where DOH should avoid pausing the administrative case.
- Support and enthusiasm for DOH to go paperless, with some concern about associated costs.
- Support for conducting additional research on regulatory tools to remove providers from practice during the legal process for sexual misconduct cases.
- Concern about delegating authority to Executive Directors to authorize additional steps in the disciplinary process, since many EDs are not health care providers.
- In the long-term, it may help to apply a transformational lens to this work and take steps toward becoming a trauma-informed system, similar to what San Francisco Department of Public Health has done over the past decade; in the short-term, at least consider investing in trauma-informed behavioral health training for all disciplinary staff, board and commission members, and experts.

## *Conclusion*

Many of the preceding recommendations would require new resources to successfully implement. Work such as reducing target timelines, transitioning to paperless files, and creating specialized sexual misconduct teams would need to be thoroughly scoped, and staffing/IT resource proposals would need to be developed before funding can be sought and changes implemented.

DOH has also identified modest staffing increases that would benefit disciplinary operations outside this project and will follow standard processes to pursue these resources. Adjudicative Services and the Office of Investigative and Legal Services are two areas where increased staffing would help reduce caseloads and build administrative capacity.

The DOH project sponsors would like to thank members of the task force and all those who have given their time and expertise to develop these recommendations. We would also like to acknowledge the hundreds of dedicated public servants within DOH, boards, commissions, and partner agencies who commit themselves each day to the important and difficult work of ensuring patient safety. We offer these recommendations in the spirit of continuous improvement and guided by the DOH values of equity, engagement, and innovation.


Washington State Department of
Health