STATE OF NEW HAMPSHIRE
BOARD OF MEDICINE

PERFORMANCE AUDIT REPORT
APRIL 2008

To The Fiscal Committee Of The General Court:

We have conducted an audit of the Board of Medicine to address the recommendation made to you by the Legislative Performance Audit and Oversight Committee. We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to provide a reasonable basis for our findings and conclusions. Accordingly, we have performed procedures we considered necessary in the circumstances.

The purpose of the audit was to determine how efficiently and effectively the Board of Medicine has administered its operations and regulatory responsibilities according to State law, administrative rule, policy and procedure, and best practice. The audit period includes State fiscal years 2002 through 2006.

This report is the result of our evaluation of the information noted above and is intended solely for the information of the Board and the Fiscal Committee of the General Court. This restriction is not intended to limit the distribution of this report, which upon acceptance by the Fiscal Committee is a matter of public record.

Office Of Legislative Budget Assistant

April 2008

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ABBREVIATIONS

AA	Anesthesiologist Assistant
APA	Administrative Procedures Act
APU	Administrative Prosecutions Unit, NH Department Of Justice
ARSP	Alternate Registered Supervisory Physician
CFR	Code Of Federal Regulations
CLA-F	Common License Application Form
CME	Continuing Medical Education
DHHS	Department Of Health And Human Services
DO	Doctor Of Osteopathy
DOJ	Department Of Justice
G&C	Governor And Council
IT	Information Technology
LOC	Letter Of Concern
LPAOC	Legislative Performance Audit And Oversight Committee
MA	Medical Assistant
NHMS	New Hampshire Medical Society
NHSPA	New Hampshire Society Of Physician Assistants
OIT	Office Of Information Technology
PA	Physician Assistant
PAAC	Physician Assistant Advisory Committee
PEP	Physician Effectiveness Program
PHP	Physician Health Program
RFP	Request For Proposal
ROI	Report Of Investigation
RSA	Revised Statutes Annotated
RSP	Registered Supervisory Physician
RTK	Right To Know Law
SFY	State Fiscal Year
SSN	Social Security Number

STATE OF NEW HAMPSHIRE
BOARD OF MEDICINE

SUMMARY

Purpose and Scope

This audit addresses how efficiently and effectively the Board of Medicine administered its operations and regulatory responsibilities. The audit period encompasses State fiscal years (SFY) 2002 through 2006.

Background

The Legislature created the Board in 1897 to ensure physicians possessed the training and skills necessary to practice safe and effective medicine. The Board regulates allopathic (Doctor of Medicine or MD) and osteopathic (Doctor of Osteopathy or DO) physicians and physician assistants (PA). The Board's major functions include examining and investigating license applicants, licensing qualified applicants, denying licenses to unqualified applicants, monitoring licensee competency, investigating complaints against licensees, imposing disciplinary sanctions against licensees not meeting established standards, and assessing and collecting civil penalties against persons engaged in the unauthorized practice of medicine. In SFY 2005, 5,793 physicians were licensed by the Board. In SFY 2006, the first year the Board implemented biennial physician license renewal, the Board reported reinstating 14 licenses and issuing 2,339 physician license renewals, 371 new physician licenses, 250 temporary physician licenses, and 139 training licenses. Three hundred thirty-one physician assistants were licensed in SFY 2006: 300 were renewals and 31 were new licenses.

Results In Brief

We found weak or nonexistent management controls in many of the Board's regulatory and administrative operations. While the Board has limited ability to influence and oversee day-to-day activities given its voluntary nature and the demands of regulating the profession, it is overly reliant on institutional memory and lacks written policies and procedures and administrative rules in many areas. In 14 of the 34 observations we issued (41 percent), we found inadequate or questionable compliance with statutory requirements, including requirements to file statements of financial interests, term limits and residency requirements for members, and quorum requirements. The relationship between the Board, the Medical Review Subcommittee (MRSC), and the Department of Justice (DOJ) is not defined in writing. Further, the DOJ responded to many observations we issued to the Board.

The Board's organizational rules and unique rules of practice address neither the MRSC nor the PA Advisory Committee (PAAC). Board rules inadequately detailed the use of licensee social security numbers, did not reflect statute when requiring disclosure of arrests and indictments, were expired for part of the audit period, provided erroneous references, and were not comprehensive. The Board also undertook informal rule making.

We found inconsistencies in license processing, incomplete renewal applications not handled according to rule, and no provisions for issuing administrative licenses to physicians not providing patient care. The Board did not always adhere to statute and administrative rule in licensing and relicensing physicians and produced an inaccurate official record in one case.

Statute provided for the physician continuing medical education program to be administered by the New Hampshire Medical Society and the program was not controlled by the Board. PAs are required to practice under the supervision of a licensed physician but no follow-up is conducted when the Board receives indication a supervisor has discontinued a relationship with a PA.

The Board can make improvements in several areas of complaint management. Unless the Board obtains information from other sources, such as other states' courts, licensing bodies, or national repositories of disciplinary information, relying on biennial physician renewal may result in the Board not receiving potentially negative information about licensees for two years. The Board lacks administrative rules and formal policies and procedures codifying its current practices for handling anonymous complaints and the Board's investigative processes require clarification and codification in administrative rule, policy, and procedure. Rules do not establish a process for particular types of investigations, define who must be contacted during the course of an investigation, or define what information should be reviewed by investigators to reach sufficiency for a Board decision. Further, subpoenas are issued in a manner contrary to rule.

Our analysis of Board files and data demonstrated 21 percent of cases during the audit period were not investigated and no final action was taken. Further, we found cases where, because there was no contact between the Board and a licensee under investigation, no letter closing the case was sent to the licensee following final Board action. The time taken for final Board action on investigated complaints increased during the audit period, the number of cases lasting 180 days or more increased, and the Board has not established time standards for case processing. Sanctions are meted out based on the institutional memory of Board members rather than relying upon written guidelines or data. The Board issued confidential systems letters to administrators of healthcare facilities in the State without statutory authority, administrative rules, policy and procedure, or guidelines controlling the process thus effectively extending the scope of the Board's responsibilities into an area regulated by another agency.

Cash and checks received by staff were not deposited daily as required by statute and were instead secured in a locked closet until deposited. The Board collected $854,000 in revenue in excess of the statutory limit of 125 percent of its program costs and collected nearly $53,000 from licensees and members of the public for publications without a fee structure adopted in administrative rule. The Board procured over $73,100 in expert medical review services, other personal services, and technology service during the audit period using procurement practices inconsistent with State policy and procedure. The Board expanded the Physician Health Program to include physician assistants without concurrent expansion of the statutory fee collection to support the program. The Board exercised inadequate oversight of the Physician Effectiveness Program (PEP), did not generate a required biennial PEP Fund report, and did not implement policies and procedures to ensure proper Fund deposits. In total, the Fund was under-funded by $183,000 during the audit period.

The Board lacks a comprehensive information management program, record keeping and destruction polices and procedures, and adequate information technology controls. Databases and technology do not provide the Board adequate management information and both licensing and disciplinary databases contain blank and erroneous data. Information security is inadequate and the Board has not prepared a business continuity and contingency plan to minimize disruption of essential operations.

STATE OF NEW HAMPSHIRE
BOARD OF MEDICINE

RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
1	11	No	The Board improve management controls; exert broader control over operations; budget funds to hire an executive director; ensure an appropriate ethical tone is maintained; conduct a risk assessment; promulgate necessary administrative rules; and develop and implement policies and procedures.	Board – Concurs In Part
2	14	Yes	The Legislature consider amending the Code of Ethics to explicitly prohibit nepotism and clarify dependent, misuse of position, and private interest. The Board exert more oversight of the hiring process and discontinue the practice of hiring family members of current employees. The Division of Personnel promulgate administrative rules to regulate part-time employment by the Executive Branch.	Board – Concurs In Part DAS – Concurs In Part
3	18	Yes	The Legislature consider amending RSA 15-A to prohibit members participating when statements of financial interest are not filed timely. The Board improve compliance with requirements for filing statements of financial interest and develop policies and procedures.	Board – Concurs In Part
4	20	Yes	The Legislature consider amending statutes to clarify residency requirements for the Department of Health and Human Services member and membership terms for the Board and Medical Review Subcommittee (MRSC).	Board – Does Not Concur
5	24	No	The Board improve adherence to quorum requirements and develop and implement policies and procedures.	Board – Concurs In Part
6	27	No	The Board structure its relationship with the MRSC in administrative rules and develop and implement policy and procedure.	Board – Concurs In Part
7	31	Yes	The Board seek amendment to RSA 328-D to include at least one public member for the Physician Assistant (PA) Advisory Committee (PAAC) and remove the language requiring New Hampshire Society of Physician Assistants nominations of PAs for PAAC membership.	Board – Concurs In Part

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
8	33	No	The Board establish with the Department of Justice (DOJ) the terms and conditions of their relationship in a formal memorandum of agreement and promulgate administrative rules adding structure to its relationship with the MRSC and DOJ.	Board – Concurs
9	37	Yes	The Legislature consider providing the MRSC authority to conduct public sessions. The Board conduct meetings according to RSA 91-A.	Board – Concurs In Part
10	41	Yes	The Legislature consider what polling methods are acceptable and provide the Board authority to use such methods. The Board discontinue conducting public proceedings via poll except where explicit authority is provided and codify its practices in administrative rules and policy and procedures.	Board – Concurs In Part
11	47	No	The Board amend administrative rules to conform to statutory requirements including creating organizational rules and rules of practice for the PAAC and MRSC.	Board – Concurs In Part
12	52	No	The Board seek statutory amendment to delete dated administrative rule requirements; promulgate necessary administrative rules; and review policy statements, informal procedures, and decisions reached in Board meetings and codify such requirements in administrative rule.	Board – Concurs In Part
13	55	Yes	The Board seek statutory to promulgate administrative rules permitting action with less than quorum.	Board – Does Not Concur
14	57	No	The Board develop and implement licensing and relicensing policies and procedures, administrative medicine administrative rules, and implement a systematic monitoring process to ensure its operations are efficient and effective.	Board – Concurs
15	60	No	The Board discontinue using informal procedures, adhere to statute and administrative rule, develop and implement policies and procedures, periodically review its operations and the functioning of staff, and seek legal counsel to determine how to address the missteps in this matter.	Board – Does Not Concur

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
16	63	No	The Board comply with statute; follow its own administrative rules; and codify unwritten practices into administrative rules, policies, and procedures.	Board – Concurs
17	64	Yes	The Board seek legislative changes to control physician continuing medical education by aligning program administration under the Board, promulgate necessary administrative rules, and develop policies and procedures.	Board – Concurs
18	67	No	The Board develop policy and implement procedures to ensure terminations of PA supervision are investigated, inform PAs who have lost a supervisor of their professional status, and periodically review licensing data to locate and correct erroneous entries.	Board – Does Not Concur
19	70	No	The Board promulgate administrative rules requiring reporting all allegations of misconduct by all licensees within 30 days and timely review and appropriately act on all such allegations.	Board – Concurs
20	71	No	The Board comply with its administrative rules to waive procedures when handling anonymous complaints.	Board – Does Not Concur
21	73	No	The Board clarify investigative processes; codify administrative rules for investigations; develop policies and procedures for investigators; designate investigators; and investigate all allegations of potential misconduct.	Board – Does Not Concur
22	78	No	The Board comply with its administrative rules when issuing subpoenas.	Board – Concurs In Part
23	80	No	The Board implement a management information system to support its needs, including providing case duration data, establish a case duration standard, and improve case processing time.	Board – Concurs
24	84	No	The Board develop and implement policy and procedure for tracking disciplined licensees; develop and implement disciplinary guidelines; and promulgate administrative rules.	Board – Concurs In Part
25	85	No	The Board issue systems letters to the Bureau of Health Facilities Administration.	Board – Concurs In Part

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
26	88	No	The Board ensure every complaint received is formally closed; ensure the licensee is duly informed; and promulgate administrative rules and comprehensive, written polices and procedures.	Board – Concurs
27	90	No	The Board deposit receipts daily; develop and implement receipt and refund polices and procedures; collect permitted amounts; periodically review and adjust licensing and other fees; and charge authorized fees.	Board – Concurs
28	93	No	The Board follow State procurement policy when obtaining consultant services and develop and implement policy and procedure.	Board – Concurs In Part
29	96	No	The Board follow State procurement policy when obtaining technology support services and develop and implement policy and procedure.	Board – Concurs
30	97	No	The Board ensure the Physician Health Program contractor operates the physician effectiveness program according to statute, comply with statutorily established management controls, and complete Fund reports biennially.	Board – Concurs
31	98	No	The Board ensure funds are deposited into the Physician Effectiveness Program Fund, report Fund activity consistently, and develop and implement policy and procedure.	Board – Concurs
32	100	No	The Board develop and implement a comprehensive records management program and policies, distribute pertinent performance information, and promulgate necessary administrative rules.	Board – Concurs In Part
33	103	Yes	The Board determine its data management and reporting needs, prioritize its needs, assess the complaint database management system, and perform a cost-benefit analysis. The OIT review its support to the Board. The Legislature consider repealing the provision of RSA 329:14, V(a), requiring training licenses be separately recorded from full physician licenses.	Board – Concurs OIT – Concurs
34	108	No	The Board Develop and implement a business continuity plan to facilitate recovery of core Board functions.	Board – Concurs In Part

SCOPE, OBJECTIVES, AND METHODOLOGY

This performance audit evaluated the New Hampshire Board of Medicine (Board). In June 2006, the Fiscal Committee approved a joint Legislative Performance Audit and Oversight Committee (LPAOC) recommendation to conduct a performance audit of the Board. We held an entrance conference with the Board on November 1, 2006. The LPAOC approved the audit scope on May 8, 2007. We concluded field work on October 10, 2007.

This audit addressed the following question: **How efficiently and effectively has the Board of Medicine administered its operations and regulatory responsibilities during the audit period, State fiscal years (SFY) 2002 through 2006?** In auditing the Board's practices, we adhered to generally accepted *Government Auditing Standards* promulgated by the U.S. Government Accountability Office. We assessed the effectiveness and compliance with the Board's rules, policies, and procedures by evaluating how the Board manages its administrative responsibilities, licenses regulated professionals, enforces professional standards, and disciplines regulated professionals who do not conform to applicable standards.

Our audit work included structured interviews with current and former Board, Medical Review Subcommittee (MRSC), and Physician Assistant Advisory Committee (PAAC) members; interest groups; current and former Board administrative staff; and Department of Justice (DOJ) staff with Board-support responsibilities. We reviewed Board documents and reports; State and federal laws; State and federal administrative rules; Board polices and procedures; executive orders; Attorney General Opinions; previous audits; and articles in the press. We examined certain aspects of 12 other states' boards; materials from the Federation of State Medical Boards, the National State Auditors Association, the American Medical Association, and numerous other entities; and licensing and disciplinary files. We attended 12 Board meetings as well as one meeting each of the MRSC and PAAC. We also analyzed Board financial, licensure, and disciplinary data, developing descriptive statistics and examining trends; and reviewed Board contract-related materials.

Our review did not include conclusions regarding quality of care issues nor did we substitute auditor judgment for the judgment of the Board in adjudicatory decisions. We assessed whether the process to arrive at decisions was consistent, efficient, and effective when compared to best practice, statute, administrative rule, policy, and procedure.

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REGULATING THE PROFESSION OF MEDICINE

Medicine is a regulated profession due to the potential harm to the public if an incompetent or impaired physician practices. In 1897, the Legislature created what would become the New Hampshire Board of Medicine to ensure physicians possessed the training and skills necessary to practice safe and effective medicine. Each of the other 49 states, the District of Columbia, and the U.S. territories have medical practice acts defining the practice of medicine and delegating enforcement to a medical board.

The Board regulates allopathic (Doctor of Medicine or MD) and osteopathic (Doctor of Osteopathy or DO) physicians and Physician Assistants (PA). The Board's major functions include examining and investigating license applicants; licensing qualified applicants; denying licenses to unqualified applicants; monitoring licensee competency, medical knowledge, and ability to practice safely and ethically; receiving and investigating complaints against licensees; imposing disciplinary sanctions against licensees not meeting established standards; and assessing and collecting civil penalties against persons engaged in the unauthorized practice of medicine. The Board meets monthly in Concord and may meet more frequently if warranted.

In SFY 2006, the first year the Board implemented biennial physician license renewal, the Board reported reinstating 14 licenses and issuing 2,339 physician license renewals, 371 new physician licenses, 250 temporary physician licenses, and 139 training licenses. Three hundred thirty-one physician assistants were licensed in SFY 2006: 300 were renewals and 31 were new licenses. In SFY 2006, the Board's net revenue was $799,538 while net expenditures were $600,148. Figure 1 illustrates the logical connections between the statutory responsibilities of the Board and its main functions.

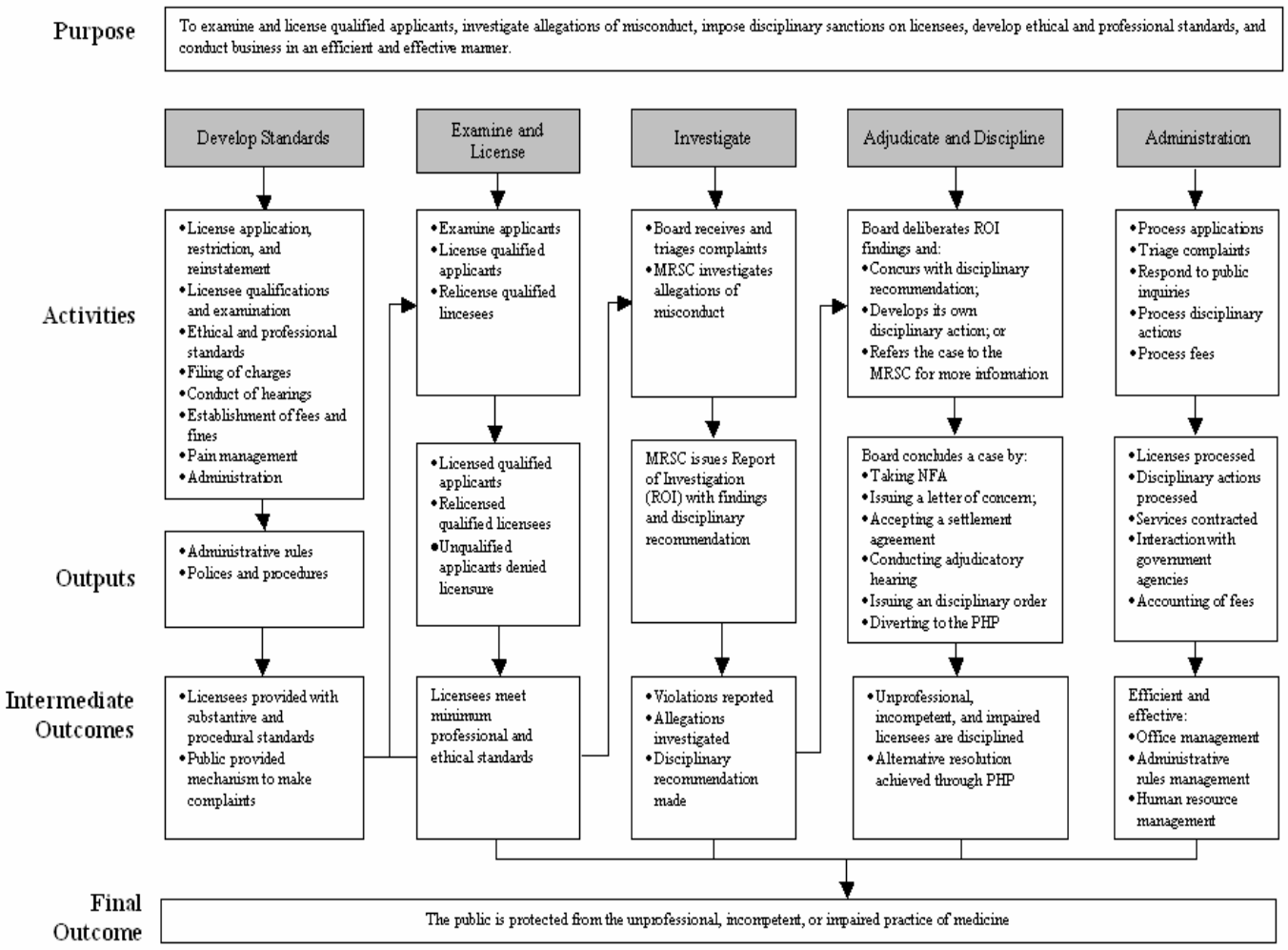
ORGANIZATION, STAFFING, AND ADMINISTRATION

The Board is administratively attached to the Department of Health and Human Services (DHHS) which provides human resource management and training to six full-time and one part-time Board employee. The Board makes regulatory decisions and undertakes contracting and procurement, hires staff, and promulgates rules independent of the DHHS.

The Board consisted of nine members during the audit period including five physicians, one PA, the DHHS Commissioner or Medical Director, and two public members (RSA 329:2). The Governor and Council (G&C) appoint the non-DHHS Board members to no more than two consecutive five-year terms (RSA 329:4, II). The Board is supported by the Medical Review Subcommittee (MRSC) and the Physician Assistant Advisory Committee (PAAC)(RSAs 329:17, V-a and 328-D:9). Non-DHHS Board members and members of the committees are volunteers. Board and MRSC members receive $100 for meetings and activities lasting two or more hours in a day plus official travel expenses (RSA 329:5). PAAC members receive $50 per day plus their official expenses (RSA 328-D:9).

Figure 1

Board of Medicine Logic Model



Source: LBA analysis.

In SFY 2006, full-time Board staff included an administrator, two license clerks, and an administrative secretary who perform daily operations including processing applications and issuing licenses; a fraud investigator who investigates complaints against licensees; and an executive secretary. During the audit period, the Board also employed one part-time license clerk, two interns, and contracted with a physician to act as the MRSC Administrator. Board staff also supported three other licensing boards: Optometry, Nursing Home Administrators, and Podiatry. We found issues related to the Board's: hiring practices, financial disclosures, membership eligibility, and ensuring a meeting quorum was obtained.

As a State agency, the Board is responsible for developing and implementing the management controls integral to efficient and effective operation, to ensure reliable financial reporting, and to comply with applicable laws and regulations. The Board is responsible for developing the detailed policies and procedures to operationalize the controls necessary to: aid mission accomplishment, improve accountability, minimize operational problems through effective stewardship of public resources, provide reasonable assurance it achieves its goals, and help safeguard public resources.

Observation No. 1

Improve Management Controls

There are five components of management control including the control environment, risk assessment, control activities, information and communications, and monitoring. The Board requires improvement in each area.

Control Environment

The control environment includes management's philosophy, operating style, organizational structure, assignment of responsibility and authority, and integrity and ethical values.

The Board is limited in its ability to influence and oversee day-to-day activities given its voluntary nature and the demands of regulating the profession. By necessity, the Board relies on staff to conduct day-to-day activities and conduct State government business such as purchasing, rule promulgation, and human resource management. Increasing Board oversight of full-time staff, while necessary to ensure proper supervision, is problematic given the competing professional demands placed on Board members. However, the State's Board of Nursing and Pharmacy Board employ executive directors and in 2000, 75 percent of other states' physician licensing boards employed executive directors. Further, some other states attach licensing boards to professional licensing bureaus or divisions to provide centralized support services.

Risk Assessment

We found the Board has not conducted a risk assessment. Consequently, there was no clear assessment of where State resources may be unnecessarily exposed to risk. Cash handling procedures, dedicated fund management, and procurement practices require improvement. The Board lacks adequate controls over information and information systems, potentially jeopardizing the confidentiality and integrity of licensing and disciplinary data.

Control Activities

The Board overly relies on institutional memory and lacks written policies and procedures. Management control principles and best practice guide the Board to promulgate detailed, written policies and procedures. State law requires the Board to promulgate administrative rules, which we found insufficient or nonexistent in many areas, leading to inefficiencies in core Board functions such as investigations and the relationship between the Board and its two statutory

committees. Further, significant sections of rules expired during the audit period, potentially compromising their enforceability, and the Board did not consistently follow its own rules in certain instances. We also found statute provides for control of physician continuing medical education by a third party without adequate Board oversight. The Board lacks a process to monitor whether its rules, policies, and procedures are appropriate and whether the services it delivers are efficient and effective.

Fourteen of the 34 observations we issued (41 percent) demonstrate inadequate or questionable adherence to statutory requirements. Some actions were taken in nonpublic meetings, which may be contrary to State law as we discuss in Observations No. 9 and 10. The Board has also extended its regulatory activity beyond what statute permits and has utilized inadequate procurement practices. We also found a former Board member, while representing the Department of Health and Human Services on the Board, had issued a directive to Department personnel to forward to him Board-related documents sent to the Department, including investigative materials. This directive potentially created a breach of the firewall between Board adjudicatory activity and the investigative activity of the Medical Review Subcommittee and the Administrative Prosecutions Unit.

Further, Board staff support three other professional licensing boards: Nursing Home Administrators, Optometry, and Podiatry. There is no formal agreement between the various boards detailing staff support, no mechanism to track staff hours in support of each board, and no assurance each board pays proportionate shares of staff salaries, benefits, and other costs.

Information And Communication

As we discuss in Observations No. 32, 33, and 34, the Board lacks adequate controls over its information and communications systems. This has resulted in Board operations based on limited data, incomplete and inaccurate public reporting, and compromised information security and data integrity.

Monitoring

Regulatory body best practice indicates the Board should establish a systematic process for analyzing program-related information including complaint type and volume; the adequacy, consistency, and effectiveness of enforcement actions; program staff compliance with Board policies and procedures; program data reliability; and Board efficiency. We found no systematic approach undertaken by the Board to review its operations and activities.

Recommendations:

We recommend the Board improve management controls by:

- **exerting broader control over the operation of the Board, Board staff, statutory committees, and staff of other agencies working on the Board's behalf;**
- **budgeting funds to hire a professional public administrator as an executive director to oversee day-to-day Board operations;**

- **ensuring an ethical tone appropriate for a State professional licensing body is maintained;**
- **conducting a risk assessment and implementing risk mitigation efforts to control State assets;**
- **promulgating necessary administrative rules across the breadth of Board operations to include its subordinate committees and processes used by the Board, its committees, Board staff, and staff of other agencies working on behalf of the Board;**
- **developing and implementing detailed, written policies and procedures for operating the Board, its committees, and Board staff;**
- **formalizing an agreement with other boards supported by Board of Medicine staff, developing and implementing a system to track costs by board, ensuring board payments for staff support are equitable, and evaluating the relationship on an ongoing basis; and**
- **developing and implementing a plan to identify, collect, and use management data detailing Board performance.**

Board Response:

The Board concurs in part.

The Board concurs with some of the recommendations but not necessarily with the content of the Observation itself.

The Board has responded in more detail to each of the comments in this Observation through its other responses. The auditors' attention is directed to those responses. To elaborate on specific recommendations, the Board concurs that hiring an Executive Director may contribute to a significant improvement in operations, a goal important to the Board. Conversely, the Board questions whether the cost in effectuating this recommendation would outweigh the costs saved. The Board proposes that a candidate for such Executive Director position could be a physician or other professional with an understanding of the MRSC and the investigative process as well as a detailed understanding of the administrative process, State agency budgeting and management systems and the Board of Medicine's statutes and rules. The Board recognizes that it does not currently track the time staff spends supporting the three other licensing boards, although, again, the Board questions whether the costs associated with implementing a mechanism to track the respective expenses would outweigh the associated cost.

The Board is also striving to create a tracking mechanism to enhance consistency of board action; as stated previously the creation of this repository of information will require a significant investment of time and resources. Finally, the Board objects to any suggestion in this Observation that its members or personnel lack "integrity and ethical values." Identifying areas where the Board could improve management or administrative controls does not demonstrate a lack of ethics or integrity on the part of the Board and any suggestion to that effect is neither warranted nor constructive.

Observation No. 2

Address Risk To Operations Resulting From Employing Relatives

The Board has demonstrated a pattern of hiring family members of current employees. Employing relatives of current employees, in addition to raising the possible appearance of impropriety or a conflict of interest, can limit the effectiveness of management controls when the dynamics of familial and supervisor/subordinate relationships commingle, especially in a small office like the Board of Medicine with six full-time and one part-time employee.

During the audit period, the father of a full-time employee was hired to work part-time for the Board. The mother of this same employee was hired on a full-time basis prior to the audit period. In September 2007, after the audit period, the daughter of this same employee was hired into a part-time position, replacing the father who left State service. The children of two other full-time employees were hired as part-time summer interns.

During the audit period, there were no State statutes or statewide rules or policies that specifically addressed nepotism, generally defined as favoritism based on kinship, in the employment of family members.

On April 2, 2008, the Executive Branch Ethics Committee issued Advisory Opinion 2008-001 that addressed the question of whether a department head or other supervisor within a prospective employee's chain of command could participate, directly or indirectly, in the hiring of a family member. The Committee concluded "an executive branch official has a duty to recuse himself or herself from the selection of a candidate to fill a vacancy when his or her spouse or dependent family member is a candidate for the position. An executive branch official also has a duty to recuse himself or herself from supervising a spouse or dependent family member." In its analysis, the Committee further noted, "because there may be a non-pecuniary conflict with other family members, the same recusal process…should be utilized."

The Advisory Opinion went on to state the Code of Ethics (RSA 21-G:21-35) does not currently define family relationships other than a spouse or dependent that may give rise to a conflict of interest, although the Committee recognized "there may be private interests other than pecuniary ones that could well come into consideration and violate the Ethics Code." The Committee specifically urges "those individuals with hiring and supervisory authority to be mindful of the possible appearance of impropriety or a conflict of interest when dealing with hiring and supervision involving family members." The Opinion also notes a lack of clarity in the Code of Ethics regarding the definitions of a conflict of interest and misuse of position (the latter being so broad as to be unenforceable), and points out the State does not have an anti-nepotism statute.

Executive Branch Ethics Committee Advisory Opinion 2008-001 is contained in Appendix B.

Recommendations:

We recommend the Legislature consider amending the Code of Ethics to explicitly prohibit nepotism in the hiring, promotion, and supervision of State employees.

We further recommend the Legislature consider clarifying the language in the Code of Ethics, including the terms dependent, misuse of position, and private interest, to ensure State officials and employees can effectively use the Code as a guide to ethical behavior, and to ensure the language is sufficiently explicit to allow for its intended application.

We recommend the Board discontinue the practice of hiring family members of current employees since an effective segregation of supervisory responsibility is likely not possible given the small size and make up of its office staff. We also recommend the Board exert more oversight of the hiring process to ensure the fairness intended by the State's personnel system is achieved.

We recommend the Division of Personnel promulgate administrative rules to regulate part-time employment by the Executive Branch to ensure State entities hire part-time employees in a manner that provides "fair and equal opportunity to all qualified persons to enter State employment on the basis of demonstrated merit and fitness as ascertained through fair methods of selection", the process required to be provided to applicants for full-time employment as described in N.H. Admin. rule Per 101.01 (c).

Board Response:

The Board concurs in part.

State law statutes and administrative rules in New Hampshire do not specifically prohibit relatives from working in the same State agency. The Division of Personnel's administrative rules do not address this issue. While the practice may be barred by law from most agencies of the Federal Government; it is fairly prevalent in New Hampshire state agencies. In light of its lawfulness and the frequency of its occurrence in this state, the observation's insinuation of wrongdoing by the Board is unfair.

Unlike the hiring for full-time positions, the Division of Personnel's administrative rules do not require the public postings of part-time positions. The observation discusses three part-time hirings made during the audit period. Two of these hirings were for temporary part-time summer-intern positions. First, all of these hirings were lawful and in accordance with all applicable administrative rules. Second, the Board recognizes that New Hampshire's population demographic generates a high probability of state employees being known to or otherwise related to other employees. Third, there has been no question about the quality of the performance of these employees.

The observation also reviews the hiring of an individual that occurred well outside the time period covered by the audit. (The audit period ends in June 2006, the employment began in

September 2007). This hiring was also lawful and in accordance with all applicable administrative rules.

The Board will consider developing a relevant policy for future Board employees.

Department Of Administrative Services Response:

DAS concurs in part.

As per Personnel Rule 101.01, the purpose of the Rules of the Division of Personnel shall be to implement RSA 21-I:42-58. The Rules are designed to address human resource processes and procedures for classified employees. The Rules also provide a regulatory framework for other types and classifications of employment.

RSA 21-I:58 speaks to appeals of permanent employees. In the case of the Appeal of Higggins-Brodersen and McCann, the Board stated:

> *"In reviewing RSA 21-I:58, it is clear to us that the legislature intended to confer upon State employees a specific right of appeal to the Board based upon permanent status. Permanent employees have completed a working-test period and have been recommended for permanent appointment by the proper authority. See N.H. Code of Admin. Rules, Per 101.26. The term "permanent" reflects a degree of mutual commitment between employer and employee and an expectation that their relationship will be long-term. It is quite reasonable for the legislature to accord employees holding permanent status greater opportunity to challenge personnel decisions affecting them.*

Although there have been arguments that the Rules should apply equally to everyone – full and part-time, it is not supported by law. Of particular note is the following statue:

> ***98-A:7 Application of Statute. –*** *Such part or parts of the rules and regulations of the personnel commission promulgated under RSA 98, as may be inconsistent with the provisions of this chapter shall be repealed to the extent of such inconsistency.*

Although this makes reference to the personnel commission and RSA 98, it still carries the requirement for repealing rules that may be inconsistent with the statutes.

In addition, below are specific legislative enactments that directly address the rights and benefits available to part-time employees. As such, one could not "apply" the rules equally to full-time and part-time employees as such application would, in many instances, contradict what the statutes provide.

The law makes a point of differentiating between full-time and part-time employees, defining them as follows:

> ***98-A:1 Terms Defined. –*** *The following terms shall be construed as follows: I. "Temporary appointment" shall mean an appointment made to fill a temporary position on a full-time basis for the period of appointment. II. "Seasonal appointment" shall mean an appointment made to fill a seasonal position on a full-time basis for the period of appointment. A seasonal appointment is one which may reasonably be anticipated as likely to recur each year for a varying number of months. III. "The equivalent of 6 months or more" shall mean the equivalent of 130 or more regularly scheduled work days, not necessarily consecutive, provided that whenever an employee of the racing commission or greyhound racing commission is employed on any day on a per diem basis he shall be deemed to have worked one day. IV. "Full-time basis" shall refer to employment calling for not less than 37-1/2 hours work in a normal calendar week or calling for not less than 40 hours work in a normal calendar week with respect to positions for which 40 hours are customarily required. V. "Part-time basis" shall refer to employment calling for less than 37-1/2 hours work in a normal calendar week or calling for less than 40 hours work in a normal calendar week with respect to positions for which 40 hours are customarily required.*

Seniority is another example. In the rules, seniority is defined as the length of continuous, full-time employment in the classified service, which is consistent with the law, which provides for seniority credit for full-time employment only when one has attained permanent status, which can only be earned through full-time work.

> ***98-A:5 Seniority. –*** *A permanent temporary or permanent seasonal employee shall accumulate seniority from year to year.*

In RSA 98-A:2, below, there is no legislative requirement for hiring part-time employees from registers, only "temporary appointments" and "seasonal appointments," both of which are considered to be full-time as described above. The law also addresses in 98-A:3 when a position is made permanent.

> ***98-A:2 Requirements. –*** *All temporary appointments to state service shall be made in the first instance from appropriate state personnel registers. If applicants from such registers are not available any individual meeting the minimum qualifications of the position may be certified by the director of personnel. Seasonal appointments shall be made from the appropriate state personnel register. If after the director of personnel has made a reasonable effort to certify eligible's for seasonal appointments from an existing eligible register, he shall find it impracticable to make a certification he may authorize the seasonal appointment to be made of an individual designated by the appointing authority.*

> ***98-A:3 Position Made Permanent. –*** *Any person appointed under a temporary appointment or any person appointed under a seasonal appointment who works the equivalent of 6 months or more, not necessarily consecutively, in any 12-month period shall be deemed to be respectively a permanent temporary employee or a permanent seasonal employee and entitled to all the rights and benefits of a permanent employee in the classified service of the state.*

> ***98-A:6 Working on a Part-Time Basis. –*** *An individual working on a part-time basis shall not be eligible to utilize either sick or annual leave but at each anniversary of employment should the total working time during the preceding year amount to the equivalent of 6 months or more he shall be paid all accumulated annual leave not in excess of those allowed by Per 307.03 of the rules of the division of personnel.*

Observation Conclusion: The Personnel Rules apply to those full-time employees in the state classified system – they do not apply to unclassified or non-classified executive branch employees. Specific to filling existing vacancies and notwithstanding the existence or promulgation of rules regarding part-time employment, the Division of Personnel only has authority over the hiring process and procedure but not over the hiring decision. Specific to conflicts of interest in hiring and supervision conflicts of interest, many agencies address this issue with specific agency policy detailing what is a conflict of interest and how it is handled. The rules do not address policies.

Recommendation Response

We do not recommend implementing a statewide nepotism policy. The PELRB, Case No. P-0719-20, Decision No 2006-075 (Hampton Police Association Complainant v. Town of Hampton Respondent), found that the employer could not unilaterally adopt a nepotism policy where there was a past practice that allowed for hiring relatives. They also found that adopting such a policy, even where it applied to prospective hiring decisions, constituted an unfair labor practice. The Town was ordered back to the table to negotiate. Left to negotiations, there are no guarantees that a statewide nepotism policy would be identical or consistent with a merit system.

Amendment of the Code of Ethics, particularly as it might apply to authorizing or auditing the appointment, compensation or benefits eligibility to one's own family member seems to be a more viable solution to addressing these types of issues and situations. In addition, the Code of Ethics applies equally to all employees of the state including part and full-time, classified and unclassified, as well as board and commission members. Once there is an amendment to the Code of Ethics, the new language should be distributed to all state employees, announcing the new language and standards of conduct.

Observation No. 3

Improve Compliance With Statute Requiring Members Submit Statements Of Financial Interests

Members of the Board and its statutory subcommittees have not consistently complied with requirements to file statements of financial interests. RSA 21-G:5-a, I, applicable to the Board and its statutory subcommittees, required "Every member…file by July 1 of each year a verified written statement of financial interests…unless the member has already filed a statement in that calendar year." RSA 21-G: 5-a, II, stipulated, "No member shall be allowed to enter into or continue the member's duties, unless the member has filed a statement of financial interests…." Members of the Board and its statutory subcommittees should have filed 103 statements during the audit period but did not file 75 percent of the

statements, filed 11 percent of the statements late, and filed 15 percent of the statements timely.

RSA 21-G:5-a, in effect for 98 percent of the audit period, was repealed effective June 2, 2006 by Chapter 21:10, II, Laws of 2006. Its replacement, RSA 15-A, was effective June 2, 2006 and requires a statement of financial interest be filed by the third Friday of January or within 14 days of assuming public duty. RSA 15-A:7 states, "Any person who knowingly fails to comply with the provisions of this chapter or knowingly files a false statement shall be guilty of a misdemeanor."

Recommendations:

We recommend the Legislature consider amending RSA 15-A to prohibit members from participating in public business until such time as they have filed statements of financial interest.

We also recommend the Board improve compliance with requirements for filing statements of financial interest and develop detailed, written policies and procedures binding on members of the Board, its statutory committees, and any ad hoc committees formed to facilitate timely and accurate filing.

Board Response:

The Board concurs in part.

The Board concurs that members of the Board and its subcommittees have not consistently complied with requirements to file statements of financial interests. The Board will improve compliance by adopting new procedures:

1. *Prior to the regularly scheduled December meeting of the Board, the MRSC, and the PAAC, the administrator of each will mail to each member with the pre-meeting packet, a copy of the most current financial interest form available on the State's website.*
2. *The administrators for the Board, the MRSC, and the PAAC, will collect the completed forms at the regularly scheduled December and January meetings. The administrators will keep a log of members that have returned completed forms.*
3. *The administrators will forward all completed forms to the Secretary of State for filing no later than the third Friday in January.*
4. *The administrators will not process a member's per diem compensation or travel expenses reimbursement allowable to the member under RSA 329:5, until such time as the member returns a completed form to the administrator for filing with the Secretary of State or the member proves that he or she filed the statement in accordance with RSA 15-A.*

The Board does not concur that lack of compliance in filing statements of financial interests renders Board decisions open to question. One who holds an office under an appointment giving

color of title may be a de facto officer, although his or her appointment is irregular or invalid. State v. Boiselle, 83 N.H. 339 (1928); Jewell v. Gilbert, 64 N.H. 13 (1886). Under this doctrine, "one who assumes a public officer under color of an election or appointment illegal in fact is a de facto officer, and his official acts are valid as to third persons when they are not from their nature or by express statutory enactment void." Boiselle, 83 N.H. at 339. If an individual is elected or appointed to fill an office that exists by law, and discharges his or her official duties, the individual is considered a de facto officer, and his or her acts are valid, notwithstanding his or her being ineligible or otherwise not possessing all the necessary qualifications of the office. Jewell, 64 N.H. at 13. The doctrine has been applied in New Hampshire to give legal effect to acts performed, under color of law, by persons unqualified to commit the acts, with the goal of protecting the public's reliance on officer's authority and ensuring the orderly administration of government. Id. Accordingly, failure to file timely statements of financial interests does not affect the validity of these officials'votes or affect their ability to comprise a quorum during the time period in question.

Observation No. 4

Clarify Statutory Eligibility Requirements

Appointments for several members of the Board and its subcommittees may be inconsistent with statute. State law requires non-physician appointees to the Board be residents of the State for at least five years (RSA 329:3). The ex officio Department of Health and Human Services member did not meet residency requirements.

Statute specifies Board members may serve two consecutive five-year terms (RSA 329:4, II) and MRSC members may serve no more than two, three-year terms (RSA 329:17, V-a). Unless exempt, whenever statute provides for appointment to a position on a board for a term of stated and limited duration, a term of the position, not of the appointee is created (RSA 21:33-a, I). This provides for static start and end dates of positional terms. Appointments to fill vacancies are for the unexpired term (RSA 21:33-a, II) and candidates may be appointed at any time during the term; however, the term will end on a fixed date (RSAs 21:34 and 21:33-a, III). Three members of the Board and one member of the MRSC have served or are serving for the balance of an unexpired term in addition to two consecutive five-year terms.

Statutory limits for Board members of two consecutive, five-year terms (RSA 329:4, II) and MRSC members of two, three-year terms (RSA 329:17 V-a) indicate the Legislature intended to limit Board and MRSC members' service to ten and six years respectively. Board members will have served between two and 32 months and the MRSC member will have served 34 months beyond those limits.

Recommendations:

We recommend the Legislature consider amending statute to clarify:

- **residency requirements of the ex officio DHHS member of the Board;**

- **whether Board and MRSC members can serve beyond ten and six years, respectively; and**
- **whether hold-over status and serving unexpired terms affect tenure.**

Board Response:

The Board does not concur.

Absence of Residency Requirements for the DHHS Member.

The Board does not concur that the Department of Health and Human Services member did not meet residency requirements, because the residency requirements for non-physician appointees to the Board are not applicable.

During the audit period, the department of health and human services came to employ an individual in the position of the chief medical director of the department who was not a resident of New Hampshire. This member's out-of-state residency status had no bearing on the propriety of his appointment to the Board of Medicine. RSA 329:4, I clearly designates the board member position that is reserved to the commissioner or the medical director as an ex officio position. Black's Law Dictionary defines ex officio as meaning "by virtue of the office; without any other warrant or appointment than that resulting from the holding of a particular office." Black's Law Dictionary 575 (6th ed. 1990). See also State v. Brandt, 31 N.W.2d 5 (Minn. 1948) (stating that an ex officio member is a member of a board "by virtue of his office, and without further warrant or appointment.") (citations omitted). Unlike other Board members, it is uncontroverted that neither the commissioner of the department of health and human services nor the medical director of the department of health and human services are appointed to the Board of Medicine by the Governor and Executive Council. See RSA 329:4, II. In fact, the statute creating the commissioner/medical director position on the Board of Medicine explicitly excludes the medical director from needing further warrant or appointment. See RSA 329:4, I. As an ex officio member, the only qualification for this Board member is that he or she hold the position of commissioner or medical director, which no one disputes occurred in this instance.

Members of the Board and Members of the Medical Review Subcommittee are Serving Statutorily Permitted Terms.

The Board does not concur that members of the Board or MRSC have served beyond their statutorily authorized terms. Both RSA 329:4, II (Board) and RSA 329:17, V-a (MRSC) provide for appointments to positions "for a term of stated and limited duration," which require "approval or confirmation of such an appointment by the governor and council." See RSA 21:33-a. Where neither statute contains an exemption to RSA 21:33-a, both statutes will be construed in accordance with RSA 21:33-a and with RSA 21:34.

Board members and MRSC members who have served, or are serving, more than ten and six years respectively, are serving terms in accord with applicable State law. RSA 21:33-a states "[t]hat the language in such statute creating a term of stated and limited duration shall create a term of position, not of the appointee thereto…". The date an appointee to the Board or the

MRSC is confirmed by the Governor and Council is the date that member's term commences. However, that date does not necessarily coincide with the start date of the "term of position." There are numerous reasons why the commencement date of a "term of appointee" may be different from the commencement date of a "term of position." The most common reason is that the immediate predecessor-member resigned from the board prior to the expiration of the "term of position," or the immediate predecessor-member was "heldover" after the completion of the final "term of position" until a successor was appointed and qualified. See RSA 21:33-a, III. In either case, a gap of time would be created between the immediate predecessor-member's last date of service in his or her "term of appointment" and the final date of the "term of position." This gap of time has been called by the legislature either an "unexpired term," "unexpired portion," or "unexpired balance." See RSA 21:33-a, II and III; RSA 21:34 (hereinafter referred to as "unexpired term").

In accordance with New Hampshire law, the Governor and Council must appoint board members to fill these gaps in "terms of position" before the board members may be appointed to a "new"' term. See RSA 21:33-a, II and III; RSA 21:34; see also RSA 329:4, II. None of these statutes state explicitly that filling the unexpired term of a predecessor be considered a full term for the purposes of counting it towards the successor's commission of two terms. See Khabbaz v. Commissioner, Soc. Sec. Administration, ___ N.H. ___ (decided August 9, 2007) (The Supreme Court will "interpret legislative intent from the statute as written and will not consider what the legislature might have said or add language that the legislature did not see fit to include.") (citing Chase v. Ameriquest Mortgage Co., 155 N.H. ___ (decided February 21, 2007)).

In fact, members of the Board and MRSC are eligible, in accordance with New Hampshire law, to serve in their appointments longer than "ten and six years respectively." In total, a Board member could be "commissioned for a term equal in length to the unexpired balance of the term of his predecessor," serve for "2 consecutive terms," and then continue to serve "until his successor is appointed and qualified." See RSA 21:34; RSA 329:4, II; RSA 21:33-a, III. For example, during the audit period, one public Board member, whose "term of position's" last date was October 14, 2006, resigned from the Board in March 2006. The governor and council confirmed a successor for this public member position on the Board on July 19, 2006. In accordance with RSA 21:34, the unexpired term at the time of confirmation equaled twelve weeks, from July 19 through October 14, 2006. That member could therefore be appointed to serve the twelve weeks and two consecutive five-year terms.

In 1993, the New Hampshire Attorney General rendered an opinion on precisely this issue when interpreting similar provisions in RSA 21-N:10, III:

> *The statute provides that no member may serve "more than two consecutive terms." It is silent as to whether the limitation applies when a member has served for one full and one partial term. While the statute does not state explicitly that the term limitation is for two complete consecutive terms, that appears to us to be the best interpretation of the statute. The statute does provide that "[t]erms of office of members shall be for five years." Furthermore, it is not inconsistent with the obvious legislative intent to limit the number of terms to be served to read into the statute a condition that it be for two complete terms.*

1993 WL 556404 (N.H.A.G.), at 3 (1993). "Since that time, records of the Deputy Attorney General's Office indicate that the same advice has been provided orally to the Governor's Office in 2002 in relation to a different administrative board." Memo from Bud Fitch, Deputy Attorney General to Legislative Auditors, dated September 2007. Thus, in the example above, after the public member served a portion of the successor's prior term (12 weeks) and one full term of position (5 years), that member would still be eligible for a second full term (5 years).

For further discussion and analysis of the legislative enactment of "two consecutive terms" as being "inconsistent with this general policy approach to construe the limit to be one term plus any portion of a second term," please see Memo from Bud Fitch, Deputy Attorney General to Legislative Auditors, dated September 2007.

With the limited exception noted above, the Governor and Council have the sole authority to appoint Board members. As such, creating additional Board policies and procedures regarding appointments would not be appropriate. In any event, where the members of the Board and the MRSC have not exceeded their statutory terms, such additional policies and procedures are unnecessary.

Finally, even assuming for the sake of argument that members who had exceeded their statutory terms participated in making decisions, the Board does not concur that these decisions are consequently open to question. One who holds an office under an appointment giving color of title may be a de facto officer, although his or her appointment is irregular or invalid. State v. Boiselle, 83 N.H. 339 (1928); Jewell v. Gilbert, 64 N.H. 13 (1886). Under this doctrine, "one who assumes a public officer under color of an election or appointment illegal in fact is a de facto officer, and his official acts are valid as to third persons when they are not from their nature or by express statutory enactment void." Boiselle, 83 N.H. at 339. If an individual is elected or appointed to fill an office that exists by law, and discharges his or her official duties, the individual is considered a de facto officer, and his or her acts are valid, notwithstanding his or her being ineligible or otherwise not possessing all the necessary qualifications of the office. Jewell, 64 N.H. at 13. The doctrine has been applied in New Hampshire to give legal effect to acts performed, under color of law, by persons unqualified to commit the acts, with the goal of protecting the public's reliance on officer's authority and ensuring the orderly administration of government. Id. Accordingly, irregularities in the appointment of these members does not affect the validity of their votes or their ability to comprise a quorum during the time period in question.

LBA Rejoinder:

Statute states "All appointed members…shall be residents of the state, regularly licensed to practice medicine and shall have actively been engaged in the practice of their profession within the state for the last 5 years. The other members of the board shall have been residents of the state for at least 5 years (RSA 329:3)."

Observation No. 5

Improve Adherence To Quorum Requirements

The Board and its statutory committees have not consistently complied with statutory requirements affecting quorum. Unless specifically stated otherwise, a majority of Board or committee members constitutes a quorum. A quorum is an essential underpinning to the Right-to-Know Law as a quorum's definition is intertwined with the definition of a meeting and public proceeding and a quorum is required for a meeting to occur and a body to act. To enter nonpublic session, a quorum must meet and have a roll-call vote as a precursor (RSA 91-A:3, I(b)).

From the beginning of the audit period, the Board consisted of nine members (RSA 329:2, I) and quorum was five members. On June 23, 2006 the Board grew to ten members (Chapters 61:1 and 61:4, Laws of 2006) and the required quorum increased to six. From the beginning of the audit period through June 23, 2006, the MRSC consisted of seven members (RSA 329:17, V-a) and the required quorum was four. On June 23, 2006, the MRSC grew to nine members (Chapters 249:2 and 249:4, I, Laws of 2006); the required quorum increasing to five. During the audit period, the PAAC consisted of four members (RSA 328-D:9) and quorum was three.

As we discuss in Observation No. 3, the Board and its committees must submit the statements of financial interest required by RSA 21-G:5-a and RSA 15-A but did so inconsistently. As we discuss in Observation No. 4, statutes governing term limits and eligibility requirements applicable to members of the Board and its committees need clarification. During the audit period, noncompliance with these requirements may have affected members' ability to participate in public business. The Board may have met without a valid quorum in 51 months of the 60 month audit period (85 percent), the MRSC may have met without a valid quorum in 56 months of 60 months (93 percent), and the PAAC may have met without a valid quorum in 59 months of 59 months where it had a meeting scheduled (100 percent). Further, as Table 1 illustrates, non-attendance of PAAC members led to numerous actions being taken without a physical quorum and in some cases with only one member present.

The Board relies upon institutional memory and lacks written policies and procedures, including policies and procedures designed to ensure compliance with quorum requirements. The Administrator indicated in some instances, business was moved without a quorum to avoid delays in processing licenses. Statute provides the authority to act to the Board and its committees. Statute requires a quorum and compliance with other statutes affecting quorum. Not complying with these requirements may unnecessarily subject decisions reached during affected meetings to question.

Table 1

PAAC Attendance-Based Quorum Issues, SFYs 2002 Through 2006

Noncompliance	Number Of Meetings Affected	Percent Of Meetings Affected
No Physical Quorum:	27	46
Nonpublic Session Without Physical Quorum:	17	29
Nonpublic Session With One Member:	2	3
Recommend Board Issue Or Reinstate A License Without Physical Quorum:	25	42
Recommend Board Issue Discipline Without Physical Quorum:	9	15
Discussions Of Investigations Without Physical Quorum:	17	29
Discussion Of Investigations With One Member:	2	3

Source: LBA analysis.

Recommendation:

We recommend the Board, MRSC, and PAAC improve adherence to quorum requirements and the Board develop and implement policies and procedures to ensure quorum requirements are met by all bodies.

Board Response:

The Board concurs in part.

The Board concurs that the PAAC has lacked a quorum at regularly scheduled meetings due in part to vacancies and poor attendance. Given the significant difficulty the Board has experienced in filling vacancies on the PAAC, overall poor attendance, the expense incurred in staffing the PAAC and the PAAC's secondary advisory role, the Board will be seeking a legislation to repeal the statute creating the PAAC.

Nevertheless, the Board and the MRSC have adhered to quorum requirements. During the time of the audit, the relevant statutes provided that the Board consists of 9 members and the MRSC of 7 members. In ordinary circumstances a quorum of a majority of the Board and MRSC would be 5 and 4 respectively. Here, however, there was a contrary directive expressly declared. The Board of Medicine's validly enacted administrative rules delineate the method of computing the number of board members necessary to constitute a quorum:

> *Necessary Quorum. Except as otherwise provided by law, a quorum shall not be required to conduct a hearing or receive information, but final decisions shall be made only by the affirmative vote of a majority of the board members* ***eligible to participate in the matter in question****.*

Med 105.02 (emphasis added). "Rules and regulations promulgated by administrative agencies, pursuant to a valid delegation of authority, have the force and effect of laws." State v. Elementis Chem., 152 N.H. 794, 803 (2006) (citation omitted).

Although Board members have been very conscientious in attending regularly scheduled monthly Board meetings, one or more members are often recused. In accordance with statute, one member of the Board of Medicine also attends the regularly scheduled monthly MRSC meetings. See RSA 329:17, V-a ("The subcommittee shall consist of one member of the board of medicine and 6 other persons…"). Accordingly, as this Board member is privy to the investigative functions of the MRSC in certain matters, this member is automatically recused from the same matters when they come before the Board in its adjudicative function. Generally, Board members must recuse themselves from matters "because of self interest, bias or prejudice." Black's Law Dictionary 1277 (6th ed. 1990) (defining 'recusal'). In accordance with the Med 105.02, as more than one Board member may be recused on a given matter before the Board, and therefore ineligible to participate in the matter in question, the necessary quorum on such given matter may have been less than five.

In addition, as discussed in the response to Observation No. 4, members of the Board and members of the MRSC have not exceeded their term limits and complied with other eligibility requirements. Accordingly, the Board does not concur that these members may not have count towards the Board and MRSC's respective quorum requirements. Members of the Board and MRSC who had not filed their financial statements of interests were authorized to act pursuant to the de facto officer doctrine. Accordingly, the Board also does not concur that that these members may not have counted towards the Board and MRSC's respective quorum requirements.

LBA Rejoinder:

The Board suggests Med 105.02, which explicitly applies to hearings and receipt of information, allows the Board to hold regular meetings, which are defined in RSA 91-A, without quorum. The rule conflicts with RSA 91-A and rules cannot undo statute.

THE MEDICAL REVIEW SUBCOMMITTEE

The MRSC is the investigative arm of the Board designed to investigate complaints and other information concerning possible licensee misconduct. The MRSC is chaired by a member of the Board and consists of physicians and public members. The MRSC reports to the Board when it concludes an investigation. In addition to the MRSC-specific concerns discussed in Observations No. 3, 4, 5, 6, and 8 we also found the Board should expand its control of the MRSC in several areas.

Observation No. 6

Expand Control Over Relationship With The Medical Review Subcommittee

While the MRSC is a subordinate element of the Board, its members view it as a peer body. The relationship between the Board and the MRSC is not formally defined in administrative rule or policy. As we discuss in Observation No. 9, the Board and MRSC intermittently meet to discuss interoperation of the two bodies. During these meetings, interrelations and mechanics between the Board and MRSC are discussed. However, this appears to be inadequate and we noted the following areas of disconnect between the bodies.

Investigative Process

There is no clear definition of "complete investigation." The MRSC generally concludes an investigation with a report of investigation (ROI). The content of the ROI has not been formally defined. There is no clear path between what the Board sees in the ROI and what the MRSC recommends in the ROI. Since the only information available to the Board when making a disciplinary decision is the ROI, the MRSC tries to make ROIs sufficiently complete and the Board has to rely on the MRSC to sufficiently complete its work. At times, Board members believe they do not get sufficient information, while the MRSC sees all the information related to a case.

Board members reported ROIs may: 1) contain extraneous materials, 2) not stick to the facts, 3) not clearly address historical information, and 4) not clearly address whether the case warranted a "3 in 5" investigation, leading to confusion at the Board and warranting a clarification from the MRSC. A "3 in 5" review is required on a licensee with any combination of three reservable claims, written complaints, or actions for medical injury in a consecutive five-year period (RSA 329:17, III-a). In one case, where a complaint was made against an MRSC member, we could find no documentation indicating an investigation was completed, no ROI or other concluding documents for the case, no recommendation from a case reviewer or other investigator, and no recommendation from the MRSC to the Board on case disposition.

Further, the investigative process appeared so unclear due to questions regarding appropriate procedures, and exacerbated by the lack of rules and written policy and procedure, that the Administrative Prosecutions Unit (APU) had to provide a presentation on the process to the Board.

Communication Process

Board communication with the MRSC needs improvement in substance and timeliness to coordinate the different branches of work. If there is communication between the Board and MRSC, it is in written form. Memoranda may directly flow from the APU to the Board or from the MRSC to the Board. The current system of communication between the two groups lengthens case processing. Further, as we report in Observations No. 23, 32, and 33 there is no process to track cases, exacerbating communications issues when cases pass back-and-forth between the Board and MRSC.

Separation between the Board and MRSC is necessary to segregate the adjudicative from the investigative/prosecutorial function and maintain due process protections. However, disagreements between the Board and the MRSC could be solved by MRSC case presentations to the Board, at least in complex cases.

Guidance To The MRSC

The Board has not provided the MRSC with written guidelines defining its expectations and requirements. The MRSC establishes the DOJ's limits in carrying out its investigative and prosecutorial duties. The MRSC sets the tone of a settlement agreement's penalties, tasking the APU to obtain punishments. Further, the MRSC provides "manageable" amounts of information to the Board in ROIs and the MRSC does not delete important information, from their perspective. Compounding the lack of rules, policy, and procedure surrounding the MRSC, MRSC members who serve as investigators are not formally trained as the Board has not established baseline training requirements. The Board, however, does employ a trained investigator and has limited access to a DOJ investigator for complex cases.

Consequently, it is difficult for Board members to understand the MRSC's role and work methods. The relationship between the MRSC and the Board has been strained, with the Board questioning MRSC recommendations. The MRSC takes issue with questions posed by the Board and the MRSC pushes back when the Board does not concur with its recommendation. ROIs have been supplemented or modified, and some cases reinvestigated, resulting in letters of concern issued to licensees being rescinded because they were based on incomplete investigations. We also noted a case where the APU accepted a voluntary surrender of a license without Board involvement while the Board was moving to an emergency suspension, indicating the MRSC and APU may not always be working within the Board's intent.

The Board is the final authority on matters within its scope of responsibility and has ultimate responsibility for its actions and those of its supporting committees and staff. Board members reported they need to trust the MRSC has diligently carried out an investigation and all related matters are fully examined. With no administrative rules, policy, or procedures for the MRSC to follow, there is no basis for the Board, the PAAC, or the public to evaluate the quality of the MRSC's work. Relying on expensive and time-consuming hearings to reinvestigate a case instead of detailing how the MRSC should conduct its business, what information it must provide to the Board, and building management controls to ensure the process is followed, is wasteful and inefficient.

Recommendations:

We recommend the Board structure its relationship with the MRSC in administrative rules, including:

- **establishing the purpose and scope of the MRSC's statutorily and administratively established responsibilities;**
- **provide MRSC-specific definitions;**
- **set forth the nature and requirement of all formal and informal procedures;**

- **establish timelines for investigations;**
- **designing flexibility in the system to ensure unique circumstances can be accounted for and timelines adjusted with proper cause shown;**
- **procedures to be followed when a sitting member is under investigation;**
- **detailing required information for Board review to include a standardized ROI format and minimum content, establishing what a complete investigation looks like, providing the Board with adequate information to make a decision; and**
- **training required for investigators.**

We further recommend the Board develop and implement detailed, written policy and procedure detailing these processes.

Board Response:

The Board concurs in part.

The Board concurs that its rules and policies do not set out the specific process that the Medical Review Subcommittee ("MRSC") follows. The Board has taken note that some board members are confused about the responsibilities of the MRSC relative to the Board. The Attorney General Administrative Prosecution Unit ("APU") provides regular trainings to Board members. The APU also provides new members with a manual detailing the statutes, rules and case law that they will need to know. The Board will take steps to supplement the manual with a section outlining the roles of the MRSC, the APU and the Board in the disciplinary process.

The Board concurs that at times, the MRSC must supplement its Report of Investigation ("ROI") to address questions that the Board raises. However, the Board does not concur that investigations and ROI's should be standardized. The Board also does not concur that investigators lack training. To the contrary, the investigators are highly trained and have extensive experience conducting investigations.

Investigative Process

As discussed in the Board's response to Observation No. 21, the investigative process must be flexible. As written, the rules allow for that flexibility while ensuring that the investigation focus on obtaining sufficient information to enable the Board to determine whether to bring the physician before the Board in the context of a disciplinary hearing.

"The type, form and extent of an investigation shall be determined by the need to examine acts of possible misconduct." Med 210.04(b).

By necessity, the investigative process must be flexible and responsive. The course of an investigation is guided by the facts that are gathered. The next steps in an investigation depend upon the information gathered and the questions raised in the previous steps. The investigation must focus on obtaining and scrutinizing very specific and unique facts because the question ultimately to be determined is whether the doctor's actions or conduct was negligent, grossly negligent, or incompetent. RSA 329:17, VI. Thus, the Board's rules are written to enable

necessary flexibility "to secure the just, efficient and accurate resolution of all board proceedings." Med 201.01.

Although flexible, the overall investigative process is orderly and in accord with the statute and administrative rules. When the Board receives a complaint, it initially reviews it to determine whether it should dismiss the complaint, consolidate it with another similar action or sever the issues raised in the complaint. Med 205.02(d); Med 209.01; Med 209.02. Unless the Board dismisses the complaint, the Board refers the complaint to the Medical Review Subcommittee ("MRSC") to conduct an investigation. RSA 329:17, V-a; see Med 210.04(c). By design, the Board is not involved with the investigation. The MRSC, with its five physicians, reviews medical records and might ask for the licensee under investigation to respond to the allegations in the complaint. RSA 329:18, VII; Med 210.04(c). If it is necessary to collect information and interview witnesses outside of the immediate medical setting at the core of the complaint, the MRSC investigator and/or the APU investigator is used. From all of the information gathered, the MRSC makes a "recommendation as to whether further board action should be taken on the allegations in question." Med 210.04(c).

Communication Process between the Board and the MRSC

Following its investigation, the MRSC provides a recommendation to the Board as to whether a disciplinary action should be pursued. Like the investigation itself, the content of the ROI is directly dependent upon the allegations raised in the complaint and the unique facts uncovered during the investigation. Therefore, the content of the ROI should not be regimented as it could interfere with the MRSC's ability to effectively communicate the information that it found to be most significant in making its recommendation.

Next, it is essential that the information provided to the Board be limited to that which is necessary for the Board to decide whether to pursue a disciplinary adjudication. The standard is that the MRSC provides the Board with "sufficient information to make fair and reasoned decisions." Med 201.01. The purpose of the investigation report is for the MRSC to make a "recommendation as to whether there is a reasonable basis to conduct further disciplinary proceedings." Med 210.04(d). At this stage the Board's role is to review the investigation report for the limited purpose of deciding, "whether further board action should be taken on the allegations in question." Med 210.04(c). For the MRSC to provide anything more at this stage in the process could render the Board unable to remain the unbiased trier of fact during the hearing.

"An impartial tribunal is an essential element of a fair hearing." Appeal of Dell, 140 N.H. 484, 492 (1995). The investigative process is intentionally designed to segregate the Board from the case review and information gathering phase. This separation ensures that the Board receives only enough information to determine whether a complaint against a physician warrants a hearing. Through the adjudicatory hearing, the Board will receive information submitted as evidence for the purpose of determining whether the physician engaged in misconduct. Given that a physician's reputation and livelihood are at stake, it is critical that the Board enter the hearing phase able to impartially hear and consider the facts and testimony from both sides of the controversy.

Understandably, the Board might have questions from time to time. In such cases, the MRSC supplements the information it provided to the Board to answer its question.

LBA Rejoinder:

As we discuss in Observation No. 26, Board records show 21 percent of complaints received were not investigated, were never closed, and were never reviewed by the Board. This does not demonstrate an orderly process is followed.

THE PHYSICIAN ASSISTANT ADVISORY COMMITTEE

The four-member PAAC advises the Board on utilization, licensure, and discipline of PAs, and cooperates with the Board in adopting PA-related administrative rules. The Committee by statute consisted of two licensed PAs nominated by the New Hampshire Society of Physician Assistants and two licensed physicians who supervised PAs. Committee members are appointed by the Board to no more than two, three-year terms (RSA 328-D:9). In addition to the PAAC-specific concerns discussed in Observations No. 3, 5, and 18, the Board did not appoint members to the Committee as specified in statute.

Observation No. 7

Improve Management Of Physician Assistant Advisory Committee Membership

The PAAC "shall consist of 2 physician assistants licensed under [RSA 328-D] and nominated by the New Hampshire Society of Physician Assistants" (NHSPA) and two physicians who supervise PAs, all of whom are appointed by the Board (RSA 328-D:9). However, the Board only intermittently requests nominations from the NHSPA for PAAC membership and does not consistently use the Society's nominations when received. The PAAC supports the Board's mission to protect the public while the Society promotes and advocates for the profession. Providing the NHSPA the statutory role to nominate PAAC members may unnecessarily provide too much weight to the perspective of a single advocacy group. Importantly, neither the New Hampshire Medical Society nor other interest group has a similar role in Board or MRSC member selection (RSAs 329:2 and 329:17, V-a).

Further, while statute provides for no public members on the PAAC, both the Board and MRSC have public members and best practice demonstrates public membership on regulatory bodies is desirable to provide dispassionate judgment. An additional public member would also increase PAAC membership, possibly helping the Committee avoid the quorum issues we discuss in Observation No. 5.

Recommendations:

We recommend the Board consider seeking amendment to RSA 328-D to include at least one public member for the PAAC and remove the language requiring New Hampshire Society of Physician Assistants nominations of PAs for PAAC membership.

Board Response:

The Board concurs in part.

The relevant statutes in effect during the audit period were contained in the practice act regulating physician assistants. See RSA ch. 328-D. The physician assistant advisory committee (PAAC) was established to "serve in an advisory capacity to the board [of medicine]." RSA 328-D:9. The statute provided that four committee members serve at any given time. RSA 328-D:9. Two of these members must be physicians and two of these members must be physician assistants. The Board has had great difficulty in identifying physicians willing to volunteer to be appointed to this committee as terms expire. Due to the length of vacancies in filling the volunteer committee member positions, the poor attendance at committee meetings overall, the expense of staffing the PAAC, the PAAC's secondary advisory role, and the concerns raised in Observations No. 5 and 9, the Board has begun seeking legislation to repeal RSA 328-D:9, the statute creating the PAAC. Part of this repeal would include language, as suggested in the Audit's Recommendation in this Observation, to "remove the language requiring New Hampshire Society of Physician Assistants nominations of PAs for PAAC membership."

In light of the Board's efforts outlined above, the Board does not concur that a legislative amendment to include a public member on the PAAC would resolve the failure of the PAAC to meet its statutory obligations. Finally, the legislature enacted a statutory amendment in 2001 that added to the Board of Medicine "one member selected to represent physician assistants regulated by the board" (RSA 329:2, I), further obviating the continuing need for the PAAC.

THE DEPARTMENT OF JUSTICE

The DOJ supports the Board by providing counsel to the Board from the Bureau of Civil Law and providing investigative and prosecutorial services in professional misconduct cases from the Administrative Prosecutions Unit (APU), a component of the Consumer Protection and Antitrust Bureau. The organizational separation between the two bureaus serves to ensure due process in Board proceedings. The DOJ also provides training to Board members on their adjudicative responsibilities. However, there is no agreement with the DOJ detailing the terms and conditions of the investigative and legal support provided to the Board nor is the value of the relationship established except in the biennial budget. The relationship between the Board and DOJ has at times been an obstacle to efficient operation.

Observation No. 8

Exercise Independent Board Authority

The Board is administratively attached to the Department of Health and Human Services and is independent of the Department (RSAs 329:2, III and 21-G:10, I(a)). However, the DOJ exerts considerable influence over the Board's actions. The nature and structure of the relationship between the two entities is not documented or codified in administrative rules or written agreement.

Each Board member we interviewed expressed concern with the relationship between the Board and the DOJ, noting a trend over their tenure where the DOJ controlled more and more of the relationship between the two bodies. Further, medical values and legal values do not always align, leading to tension between the two bodies.

Investigative And Prosecutorial Functions

The DOJ exerts substantial control over the disciplinary process with the APU, exercising a significant degree of latitude in carrying out its investigative and prosecutorial duties. The MRSC-established limits appear to be the APU's primary guide in conducting investigations and seeking settlement. However, the Board and the MRSC relationship with the DOJ is not formally structured, nor is there formal guidance on investigations or discipline. Further,

- There is no compliance with a standing Board request to review proposed settlement agreements before respondents sign them.
- In 13 of 58 cases (19 percent) where the Board returned a recommendation to the MRSC, the Board perceived the settlements reached were inadequate punishment for the violations. While the APU cannot change Board actions, two Board members stated some settlement agreements were presented like an "ambush" and a final action. We observed this sentiment in two Board meetings. DOJ staff asserted any further Board involvement with the settlement agreement process might jeopardize the firewall between adjudicative and prosecutorial-investigative functions essential to due process.
- Settlement agreements have been rejected by the Board and requested substantive changes resisted by the APU. A former Board president reported when the Board insists on going ahead with a case, the APU had at times not aggressively prosecuted cases or declined to take a requested Board action. We observed this dynamic in two Board meetings.
- No formal process exists for the Board to seek review of APU decisions at a higher level of the DOJ should the Board be dissatisfied.

These factors combine and place the Board in a situation where it must decide to proceed to a hearing, incurring major cost in the process, or accept a proposed settlement agreement. Consequently, according to two Board members, case decisions are sometimes based on what the DOJ will do versus what the Board believes should be done. We also observed this dynamic in two Board meetings.

In eight of 58 cases (14 percent) where the Board returned a recommendation to the MRSC, we found Board dissatisfaction with the time taken by the APU to return the cases. Our file review indicates case processing time increased during the audit period. One long-serving Board member noted delays in some cases of up to six months. In addition to some delays resulting from the legal process we found:

- No mechanism to track and prompt responses from the DOJ and measure performance.
- The amount of support provided is based on resources available from the DOJ, not an assessment of Board needs.
- The current system of communication, solely relying on passing memoranda between the Board and the MRSC and the APU, further lengthens the process.

Further, the Board has not promulgated comprehensive administrative rules detailing the investigative process, establishing investigative timelines, establishing disciplinary guidelines, specifying what information it wants after an investigation, or structuring the relationship between the Board and the MRSC and between the Board and the APU. This leaves significant latitude for the MRSC and the APU.

Board Counsel

The Board expressed a need for increased availability of assigned counsel or for dedicated counsel to improve timeliness. The DOJ has provided the Board with a part-time attorney supporting several other State boards and agencies. According to one Board member, in theory, counsel is an advocate for the Board but in practice works for the DOJ. Further:

- Board counsel does not always attend adjudicative hearings.
- Board counsel does not attend the entire Board meeting resulting in delays, time wasted in discussion without counsel, and Board indecisiveness.
- Administrative staff and Board members must write orders as counsel reportedly will not – an inefficient process due to the lack of legal training on the part of members and staff.
- There is no mechanism to measure Board counsel performance.

The Board hires consultants or others to efficiently carry out investigations. However, special legal counsel may only be hired on the recommendation of the Attorney General (RSAs 329:18, II and 332-G:3). This was allowed on a temporary basis in two instances during the audit period.

Best practice suggests regulatory Boards should exercise their regulatory responsibilities independently, not based on constraints in legal support.

Recommendations:

We recommend the Board establish with the DOJ the terms and conditions of their relationship in a formal memorandum of agreement. This agreement should:

- **be based on anticipated service needs, not past utilization;**
- **specify roles for APU staff;**
- **specify timelines for provision of services and create a mechanism to track cases throughout their lifecycle;**
- **be flexible to ensure unique circumstances can be accounted for and timelines adjusted with proper cause shown;**
- **establish concretely the content of reports and what materials must be considered as a minimum when completing a report;**
- **create an appeal process between the two agencies; and**
- **account for customer satisfaction measurement by the DOJ of the services it provides the Board to ensure mutual goals are met.**

We further recommend the Board:

- **pursue DOJ approval to obtain authority to hire additional legal support when the Board deems it necessary;**
- **seek Governor and Council approval of supplemental budget requests for investigative and legal support when necessary; and**
- **promulgate administrative rules adding structure to its relationship with the MRSC and APU to include requiring MRSC presentations of complex cases to the Board to inform its decision making while ensuring the necessary protections between the adjudicative and prosecutorial processes are in place.**

Board Response:

The Board concurs.

Investigative and Prosecutorial Functions

The majority of Board of Medicine members have not served on the Medical Review Subcommittee (MRSC), and as a result, the Board members themselves do not have a thorough understanding of the process involved in reaching settlement agreements. Additionally, members of the MRSC have far greater details in the amount of information available to them in the process of investigating cases. At the conclusion of an investigation, the members of the MRSC will draft a Report of Investigation which will detail the areas the MRSC members believe should be a part of the settlement agreement and convey this information to the Administrative Prosecutions Unit (APU) attorneys. The APU relies on the information and recommendations provided by the MRSC members when negotiating a settlement agreement with licensees and their attorneys.

The Board will, over the next year, work to promulgate administrative rules adding structure to its relationship with the MRSC and the APU. The Board will endeavor to develop guidelines for the MRSC, specifically as to what the Board expects to be included in the Reports of Investigation sent to the Board.

The Board concurs that additional guidance on the investigation process and resultant recommendations for discipline should be more structured. The Board has been reviewing various forms of tracking mechanisms whereby the Board, the MRSC, and the public may compare allegations investigated and sufficiently proven versus discipline approved or imposed by the Board, whereby ensuring the standardization of discipline in similar cases. A tracking mechanism based on severity of outcome or behavior, risk to the patient, risk of the procedure, etc. may allow members of the MRSC to review final outcomes from past cases and make recommendations for cases under investigation with greater uniformity. Creating this tracking mechanism is an arduous task that the Board has been striving to achieve; the Board has committed to spend the necessary amount time to create a reliable model that will be most effective in its implementation.

A licensee's signature on a settlement agreement is not the final act in the negotiation. After a licensee agrees to the terms of the settlement agreement (by signing the document) it is brought before the Board. The Board may accept or reject the terms of a settlement agreement in whole or in part. Upon rejection of any part of a settlement agreement, the Board may explain in writing, the reasons for rejection. The APU is then obligated to renegotiate an agreement. If a settlement agreement cannot be reached between the APU and the licensee, the APU will prepare a Notice of Hearing for the Board to accept or reject.

The APU prosecutes licensee disciplinary cases before the Board of Medicine according to Chaptered Law 0162 (SB501, session 1998). "The attorney general is hereby authorized to hire an assistant attorney general for investigating and prosecuting disciplinary actions before the board of medicine pursuant to RSA 21-M:9, II(u)." This law also requires the Board to provide the funding for these services. It has happened where the Board has rejected APU's recommendation for no further action against a licensee and the Board has requested a hearing on the matter. Attorneys must adhere to the New Hampshire Rules of Professional Conduct and cannot prosecute a case without evidence. Moreover, the Board must not issue a Notice of Hearing, publicizing information that may be detrimental to a licensee and the licensee's practice, where there is no grounds to believe that an allegation against a licensee can be proven by a preponderance of the evidence to the Board in a disciplinary hearing. The APU prosecutes cases before the Board, upon request, where the allegations of misconduct can be proven, are likely to be proven, or have a sufficient modicum of evidence of unprofessional behavior. In cases where the APU refuses to prosecute cases upon request, the APU provides the Board with a written statement detailing the reasons for refusal. The Department of Justice is working on a procedure whereby the DOJ can review cases in which the Board is insistent on prosecution after a written refusal by the APU.

<u>Board Counsel</u>

The Board is currently working to ensure that their counsel attend all of its meetings, write orders, and attend all administrative proceedings, including hearings.

A Memorandum of Understanding was recently approved by the Board, signed by the Board President, and returned to the Office of the Attorney General. The memorandum provides for the Board to pay for an increased number of hours of legal support to add efficiency to Board

actions, improve timeliness of Board decisions, and to allow the Board to concentrate on greater organization of decision making.

ADMINISTRATIVE PROCEDURE

The functioning of State government rests on delegated and enumerated powers. Agencies can exercise only the authority the Legislature delegates to them. The Legislature invested in the Board quasi-legislative, executive, and quasi-judicial authority by permitting it to adopt binding administrative rules, regulate the profession of medicine, and adjudicate matters properly before it. While affecting the separation of powers between the functions of the three branches of government, these limited delegations are necessary for efficiency as the Legislature cannot legislate a solution to every problem in a complex and constantly evolving profession and the courts cannot adjudicate every contested matter or license application. The administrative procedures developed impact significantly the control and performance of agencies and consequently affect the public.

To avoid the accumulation of too much power, limit agency overreach, and maintain popular control, the Legislature constrained the Board in at least two ways. The Board must conform to the Administrative Procedures Act (APA) detailed in RSA 541-A, which integrates public and Legislative oversight and due process into Board procedures, as well as the Right-to-Know (RTK) Law (RSA 91-A), requiring the Board act publicly, helping balance disproportionate access to information which inherently exists between agencies and the public, and furthering the application of due process to agency activities. These statutes are to be followed for the Board to carryout its regulatory function and affect private parties. When agencies do not fully meet the requirements of the APA and RTK, an imbalance in the separation of powers may occur.

Public Access And The Right To Know

The purpose of the State's Right-to-Know Law is to ensure, to the greatest extent possible, public access to the actions, discussions, and records of all public bodies, and their accountability to the people (RSA 91-A:1). The administrative rule process, by requiring public and Legislative oversight further ensures openness by allowing interested parties to take part in a process which ultimately concludes in some form of regulation affecting the public. The Board demonstrated a tendency towards conducting business in nonpublic ways, resolving matters using informal and nonpublic procedures.

Observation No. 9

Improve Conformity With Right-to-Know Requirements When Conducting Meetings

Board Retreats

The Board held three retreats and one special meeting during the audit period. Attendees included the Board, the MRSC, Board counsel, APU attorneys, and Board staff. Retreat topics included how to improve Board-MRSC communications; the complaint process; the settlement

agreement process; disciplinary options; the role of APU attorneys; streamlining processes; testifying at Board hearings; the effect of case law on disciplinary actions; and orientation packets for new members.

While transcripts or recorded minutes of these meetings do not exist, agendas and follow-up documents demonstrate the attendees mentioned, and later made refinements to, Board-MRSC communications by using case status updates; mentioned, and later adopted changes to, the settlement agreement process; and agreed on the utility of voluntary surrender of licenses. The retreats were not considered meetings by the Board however some portions of them may fit into the definition of a public meeting.

Board Meetings

A review of Board minutes indicate certain actions occurred in nonpublic session, including discussing and publicizing a request for proposal, voting to pay an incumbent service provider on an interim basis pending completion of the procurement process, guidelines for drafting orders, forwarding a memorandum on amending RSA 329 to the Attorney General, drafting hearing evidence procedures, the format of letters of concern, and receiving and tabling of an informational letter regarding ground breaking for a facility. These matters may have more properly been taken up in public session.

The MRSC meets in nonpublic session monthly. A review of the Committee's minutes reveals no formal meeting being called to order, no roll-call vote to enter non-public session taken, and no statement on the authority to enter non-public session being provided. The minutes further indicate the Committee undertook potentially non-confidential matters in its nonpublic sessions, including the director of the Physician's Health Program (PHP) speaking about the program and the Committee mentioning the content of financial disclosure letters issued to physicians with ownership interests in health-related facilities, meeting dates and times, a retreat with the Board, and dictation of reports of investigation.

PAAC Meetings

The PAAC advises the Board on matters pertaining to the utilization of physician assistants and the body's action is required to accomplish its statutory responsibilities. During the audit period, the PAAC consisted of four members (RSA 328-D:9) and the required quorum was three. During the 60-month audit period, the PAAC held 59 meetings, 27 without a quorum being physically present (46 percent) and three with only one member present (five percent). The PAAC recommended to the Board licensing action in 25 months (42 percent) without a quorum present, including the three months only one member was present. During these meetings, the PAAC also entered nonpublic session without a quorum present in 17 months (29 percent), and entered nonpublic session with only one member present in two months (three percent). The PAAC discussed investigations of alleged licensee misconduct in 17 months (29 percent), including two months where only one member was present, and recommended Board action on allegations, including issuing discipline, in nine months (15 percent) without a quorum being present.

In order to act, the PAAC must meet according to RSA 91-A with a quorum of the members. Without a quorum, the PAAC cannot act. To enter nonpublic session, a quorum must meet and have a roll-call vote as a precursor (RSA 91-A:3, I(b)).

Noncompliance with the Right-to-Know Law undermines "Openness in the conduct of public business…" and compromises "…the greatest possible public access to the actions, discussions and records of all public bodies, and their accountability to the people."(RSA 91-A:1) Further, RSA 91-A noncompliance may unnecessarily expose Board actions to invalidation or other relief a court may fashion should such actions be challenged (RSA 91-A:8, II, and 91-A:8, III).

Recommendations:

We recommend the Legislature consider providing the MRSC authority to conduct public sessions to address non-confidential matters.

We recommend the Board ensure its meetings and those of its statutory committees are held according to the requirements of RSA 91-A.

Board Response:

The Board concurs in part.

The Board concurs that over the multi-year period covered by the audit, there have been a few isolated incidents where the Board discussed items in nonpublic session that should have been in the public session. The Board has taken note of these instances and will take steps to ensure that similar incidents are avoided in the future.

The Board takes its obligations under the Right to Know law very seriously. The Board must balance the public's right to know with individuals' rights to the privacy, including the privacy of individual's medical records, and the specific confidentiality obligations set forth in RSA chapter 329.

Board "Retreats"

The three retreats conducted by the Board during the audit period were essentially mini-training sessions conducted in conjunction with the Office of the Attorney General for all Board and subcommittee members and staff. They pertained to both the adjudicatory and investigatory functions of the Board. The Observation correctly notes that "[a]ttendees have included the Board, the MRSC, Board counsel, Administrative Prosecutions Unit (APU) attorneys, and Board staff." These mini training sessions have occurred with irregular frequency (once a year or every other year) based upon member turnover and perceived need by either Board counsel or the APU attorneys. The topics at these retreats were limited to topics that are appropriate in training sessions. Board actions or pending matters were not discussed or acted upon. As such, these sessions were not "meetings" within the purview of the Right to Know law, and the public was rightfully excluded. See RSA 91-A:2 ("meeting" means "the convening of a quorum… to discuss or act upon a matter of matters over which the public body has supervision, control,

jurisdiction or advisory power."). Because the appellation "retreat" is likely to be misinterpreted, the Board will consider discontinuing its use of this term. The Board will also continue to be vigilant to ensure that no Board business is discussed or conducted at any such sessions.

MRSC Meetings

The Board does not concur that the MRSC did not comply with the RSA chapter 91-A, because the specific statutes governing the MRSC exclude this subcommittee from the Right-to-Know law. The statutory language in RSA 329:29 creates a specific exemption to the Right-to-Know law for all the work the MRSC conducts; therefore, the MRSC does not conduct meetings under the Right to Know law. "Where two statutory provisions conflict, the specific statute controls over the general one." Petition of Ann Crane, 132 N.H. 293, 298 (1989) (quoting Appeal of Plantier, 126 N.H. 500, 510 (1985)). RSA 329:29 is very specific about including all "proceedings, records, findings and deliberations," as well as how each member "deliberates, decides or votes on any matter" as confidential and privileged and not available for use in any other proceeding; accordingly, it is not subject to the provisions of RSA chapter 91-A.

To hold otherwise would create illogical results. First, to interpret that the MRSC's meetings are "meetings" as defined by the Right-to-Know law could necessitate even motion to enter nonpublic session, and the vote on such motion, required by RSA 91-A:3, I(b) to be conducted in non-public. The Supreme Court has objected to "interpret[ing] statutory language in a literal manner when such a reading would lead to an absurd result." Cayten v. New Hampshire Dept. of Envtl. Services, ___ N.H. ___ (decided March 15, 2007) (citing In re Guardianship of E.L., 154 N.H. 292, 300-01 (2006)). Second, assuming for the sake of argument that the MRSC violated RSA 91-A by failing to make motions and roll call votes, there would be no remedy and these violations are purely technical, because "[a]ll proceedings" of the MRSC are "confidential and privileged and shall not be used or available for use or subject to process in any other proceeding." RSA 329:29. An interpretation of these conflicting statutes that would require the MRSC to develop a procedure to take the perfunctory steps of entering and exiting non-public sessions and sealing minutes that, by law, cannot be unsealed, would elevate form over substance. Thus, the only logical reading of RSA 329:8, RSA 329:18, I and RSA 329:29 is that MRSC meetings are exempt from the Right-to-Know Law.

PAAC Meetings

The relevant statutes in effect during the time of the audit provided for four members on the physician assistant advisory committee; hence, a quorum of the PAAC is three members. See RSA 328-D:7. The Board has had great difficulty in identifying physicians willing to be appointed to this committee as terms expire. Due to the length of vacancies, poor attendance overall, the expense of staffing the PAAC, the PAAC's secondary advisory role, and the concerns raised in Observation No. 9, the Board will be seeking legislation to repeal the statute creating the PAAC.

LBA Rejoinder:

The conclusion that MRSC meetings are exempt from the Right-to-Know Law is overly broad and undoes the letter and intent of RSA 91-A. Importantly, we do not recommend the Committee publicly act on investigation-related matters; just those matters the Board or PAAC would have to act on in public. The response does not address the substance of the actions detailed in the Observation and discussions the MRSC undertook still appear to be matters which should be conducted publicly. These matters appear to be appropriate and necessary so it seems illogical to conclude the MRSC should not undertake these matters. It should, nonetheless, do so publicly.

Observation No. 10

Improve Methods Of Polling Members When Conducting The Public's Business

A public proceeding is "the transaction of any functions affecting any or all citizens of the state."(RSA 91-A:1-a, I)

Telephone Polls

We found evidence the Board conducted 15 telephone polls during the audit period and moved business before the Board by this method. The Executive Branch has used telephone polls to conduct public business for over 20 years. There is neither statutory authority to conduct such polls nor a prohibition against them. No administrative rule or formal policy exists detailing necessary processes for conducting polls. Informal criteria for conducting telephone polls include:

- some harm must result from untimely Board action compelling the Board to act before its next scheduled meeting,
- no quorum of members can meet concurrently - an administrator contacts members separately to solicit a response on a specific question,
- no discussions of an issue can occur,
- the polling administrator records the votes, and
- ratification of the poll occurs at the next meeting of the body for the action to be effective.

In reviewing the Board's polling activity, the records were not sufficiently clear to determine whether most of these informal criteria were met. We could determine from regular meeting minutes the Board did not consistently ratify poll results, as detailed in Table 2. Without ratification, poll results are not binding. We also found polls were conducted using a combination of methods to include mailing of memoranda, telephone contact, and electronic mail.

The Right-to-Know Law excludes isolated conversations among Board members outside of public meetings, unless the conversations were planned or intended to discuss matters relating to

official business and decisions were made during the isolated conversation. Board members may use such conversations to circumvent the spirit of the Right-to-Know Law; therefore, if official deliberations occur, a decision is made, or the gatherings occur on a regular basis, a court may determine they constitute meetings under the Right-to-Know Law. Using telephone polls seems contrary to the intent of RSA 91-A as they do not occur by chance, do not appear to be isolated conversations, and are not social in nature. Additionally, lacking formal guidance on the telephone poll process creates the unnecessary risk the Board may inconsistently comply with the few procedural requirements reported to exist.

Emergency Meetings

RSA 329:7 permits the President of the Board to call an emergency meeting when required by an imminent peril to the public health or safety. These meetings may be conducted telephonically with a quorum of Board members and have the same effect as other Board meetings when properly ratified. Based on Board records, a February 15, 2005 emergency license suspension was the only emergency matter before the Board during the audit period. Statute requires the President "employ whatever means are available to inform the public that a meeting is to be held. The minutes of the meeting shall clearly spell out the need for the emergency meeting."(RSA 91-A:2, II) This matter was addressed by a telephone conference for which we could find no evidence the Board complied with the requirements of either RSA 329:7 or RSA 91-A:2, II, including convening a quorum, publishing a notice, or ratifying the decision made. We did find a summary of the action taken.

Table 2

Board Ratification Of Telephone Polls, SFYs 2002 Through 2006

Actions Taken	Poll Date	Ratified Date
Vote On Postponing Of Hearing	May 16, 2006	Jun 6, 2006
Approve Full Licensure For Reinstatement Of Retired Licensee	July 26, 2005	None
Consider Voluntary Agreement Not To Practice	July 22, 2005	August 3, 2005
Postpone Hearing	May 20, 2004	None
Request For Postponement Of Hearing	July 1, 2004	None
Request For Postponement Of Hearing	February 26, 2004	None
Issue Notice Of Apparent Liability To One Expired Licensee	January 22, 2004	None
Issue Notice Of Apparent Liability To Second Expired Licensee	January 22, 2004	None
Approve Settlement Agreement	September 25, 2003	None
Approve Motion To Delay Hearing	September 27, 2003	None
Approve First Motion To Continue	August 27, 2003	None
Approve Second Motion To Continue	August 27, 2003	None
Issue A License Where Questions On Qualifications Were Raised	February 13, 2003	None
Consider Continuing A Hearing	January 6, 2003	January 8, 2003
Show Cause Order To Deny Renewal Application And Move To Hearing	October 9, 2001	None
Total Without Evidence Of Ratification		**12**
Percent Without Evidence Of Ratification		**80**

Source: LBA analysis.

Telephonic Meetings

Telephone conferences where a quorum of the Board participates constitute meetings under RSA 91-A. RSA 91-A:2 requires notice, participation of a quorum of members, drafting and making meeting minutes available, and public access. Meetings requiring nonpublic session must comply with additional requirements including:

- statutory authority to conduct a nonpublic session (RSA 91-A:3, I(a)),
- a motion must be properly made and seconded to enter nonpublic session (RSA 91-A:3, I(a)),
- the motion must state the specific exemption justifying nonpublic session (RSA 91-A:3, I(b)),
- the vote on a motion to enter nonpublic session must be by roll call and requires a majority concur (RSA 91-A:3, I(b)),
- all discussions held and decisions made must be confined to the matters set out in the motion (RSA 91-A:3, I(c)), and
- minutes must be kept and made publicly available unless two-thirds of the members vote to keep the minutes confidential, concluding publication would likely affect adversely the reputation of any person other than a member of the Board or render the proposed action ineffective (RSA 91-A:3, III).

During the audit period, the Board conducted two telephonic meetings. Table 3 details Board compliance with statutory requirements for these meetings, including nonpublic session requirements.

Table 3

Board Compliance With Statutory Requirements While Conducting Telephonic Meetings, SFYs 2002 Through 2006

Actions Taken	Date	Evidence Supporting The Board: Created Minutes	Made Public Notice	Met With Quorum	Provided For Public Access	Cited Authority To Enter Non-Public Session	Properly Entered Non-Public Session	Held A Roll Call Vote To Enter Non-Public Session	Two-Thirds Voted To Seal Non-Public Session Minutes
Issue Notice of Hearing	August 30, 2005	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Discuss Physician Applications	November 30, 2002	No	No	Yes	No	Yes	Yes	Yes	Yes
	Percent Compliant	**50**	**0**	**100**	**50**	**100**	**100**	**100**	**100**

Source: LBA analysis.

During the audit period, the Board lacked a systematic monitoring and quality review process to ensure efficient and effective operations. The Board relies upon institutional memory and lacks written policies and procedures, including policies and procedures designed to ensure Board compliance with RSA 91-A and other statutory or procedural requirements. Further, not ensuring complete compliance with RSA 91-A may unnecessarily expose Board actions to the risk of invalidation or other relief a court may fashion should the Board's actions be challenged (RSA 91-A:8, II, and 91-A:8, III).

Recommendations:

We recommend the Legislature consider what methods of polling members of the Board are acceptable when they conduct public proceedings and provide statutory authority for the Board to conduct public business using acceptable methods.

We recommend the Board discontinue conducting public proceedings via poll except for emergencies where explicit statutory authority is provided under RSA 329:7 or when a meeting conforming to the Right-to-Know Law is held. The Board should codify its practices in administrative rules and written policy and procedures. Each should ensure statutorily required procedural safeguards are observed.

Board Response:

The Board concurs in part.

Telephone Polls

The Board does not concur that it does not have the authority to conduct telephone polls in certain insular and limited circumstances. Telephone polls are a necessary function of bodies, such as the Board of Medicine, that meet infrequently. Oftentimes, the Board is required to vote on procedural issues that, by their very nature, cannot wait until the following Board meeting. The most common example of such an issue is a request to continue a hearing.

If the Board were not able to rule on such a procedural motion by conducting a telephone poll prior to the following meeting, there could be adverse consequences for the parties, counsel, witnesses and the Board, including considerable waste of time and resources. There could also be potential due process implications. In addition, the party seeking the continuance would be in jeopardy of contempt of a prior Board order scheduling their appearance by failing to appear.

As illustrated in the table provided with Observation No. 10, over half (9 of 15) of the telephone polls conducted by the Board of Medicine during the audit period where of the nature described above.

When properly conducted, telephone polls do not violate the language, intent, or spirit of the Right-to-Know law. The board's administrator is the person who receives the procedural motion at the board's office. The board's administrator then telephones each of the board members in turn. The board's administrator reads the procedural motion and asks the board member one

single question: whether he or she votes to grant or deny the relief requested. The board's administrator checks off the board member's answer in the appropriate column of a preprinted table, ends the telephone call and dials the next member in turn. As the administrator telephones to poll each board member individually, no deliberation or discussion occurs among board members.

A tally of the votes on the board's administrator's table does not constitute a vote of the board. The parties are all notified that subsequent to a telephone poll of the board on a certain date, the requested procedural relief is either granted or denied. The parties are also clearly notified, in writing, that such decision is not final and will only become final subject to ratification by the board at their next regularly scheduled meeting. A 1985 New Hampshire Opinion of the Attorney General delineates the sequence of a telephone poll and its use by the Governor and Council. It discusses the telephone poll approval of an action, followed by a later ratification of the telephone poll approval. This action effectively allows for a body to make an interim decision on an issue subject to a time constraint that is not conducive to their regularly scheduled meetings. Further it allows for the body to later deliberate and discuss the issue in accordance with the Right-to-Know law. Subsequent to discussion, the body may disregard its interim decision and vote in a manner contradictory to the telephone poll. The Opinion concluded that "to the extent that the Governor and Council does not subsequently ratify its telephone approval, the telephone poll would be null and void," and it would be as if the body had never taken action. N.H. OP. A.G. 85-57 (May 21, 1985).

As Observation No. 10 states: "The Executive Branch has used telephone polls to conduct public business for over 20 years." In addition to the implicit or explicit approval of telephone polls set forth in the Opinions of the Attorney General, the New Hampshire Supreme Court has reviewed proceedings wherein decisions were made with the use of telephone polls. The Court did not comment adversely on the fact that an issue was addressed by telephone poll. See, e.g., New Hampshire Opinion of the Attorney General, 85-171 (December 24, 1985); New Hampshire Opinion of the Attorney General, 85-57 (May 21, 1985); In re Appeal of Stanton, 147 N.H. 724, 726 (2002); Appeal of Catholic Medical Center, 128 N.H. 410, 412 (1986). See also Supreme Court Administrative Rule 39. In Appeal of Catholic Medical Center, the Court stated that the plaintiffs were not denied due process where they were not provided prior notification and a board denied their request for rehearing "as result of a telephone poll of the board members." Id.,128 N.H. 412, 416 (the issues before the court never directly questioned the legitimacy of telephone polls).

Finally, Observation No. 10 identifies a number of telephone polls after which the board failed to ratify its interim decision. While procedurally the Board should vote on ratification of the telephone poll, failure to do so makes the interim decision based on the telephone poll "null and void," and it would be as if the Board had never taken action. N.H. OP. A.G. 85-57 (May 21, 1985). As a practical matter, when voting on the procedural issue of postponing a hearing, by the time the Board has convened to vote on ratification of the postponement, such vote has become a moot point. Nonetheless, the Board will take steps to ensure that its polls are ratified at the next regularly scheduled meeting by immediately including the subject of the poll on the agenda for the next meeting.

Emergency Meetings

The Board does not concur and states that it complied with both RSA 329:7, RSA 91-A:2 and all relevant statutes and rules. The Board's statute states that the Board may conduct emergency meetings.

At the outset, the Board does not concur that the "February 15, 2005 emergency license suspension was the only emergency matter before the Board during the audit period." The Board had considered other emergency matters, however, these were considered during regular Board meetings and did not necessitate emergency meetings under RSA 329:7. Moreover, the Board's minutes substantiate that the Board did follow the applicable laws and rules for the February 15, 2005 emergency session. First, in accordance with RSA 91-A:2, II, the Board was not required post a notice of the emergency meeting. Second, the Observation states in the negative that "we could find no evidence that the Board complied with the requirements," however, there is no evidence or reason to believe that the Board did not comply. The Board may indeed have posted a notice of this meeting. In the normal course of business, the Board does not routinely keep copies of notices posted and thus no copy for the February 15, 2005 emergency meeting is available at this time. Third, the Board minutes concerning individuals who are in the process of adjudicatory proceedings are kept on an ongoing basis and are amended subsequent to each board action. The Board's March 2007 agenda and minutes concerning the February 15 emergency meeting clearly note who moved to table a request for an emergency suspension, who seconded this motion, and that the Board voted in favor of tabling the motion. Finally, even if the Board did not explicitly ratify this vote at the next regularly scheduled meeting, which it apparently did, the Board's vote to accept the March 2007 minutes containing the February 15 vote could also be construed as ratification. Regardless, the spirit and intent of the Right-to-Know law was preserved in the agenda and minutes.

Telephonic Meetings

The New Hampshire Board of Medicine, comprised of volunteer members, has been quite diligent in carrying out its public protection mission and fulfilling its legislative mandate in accordance with its statutory practice act. The Board's infrequent use of telephonic meetings has not violated either the spirit or the intent of the Right-to-Know law. On occasion, an issue may arise before the Board that cannot wait until the next regularly scheduled board meeting; conversely, the Board cannot produce a quorum to attend a meeting in person at the Board's offices because of the competing demands of the professional and personal schedules of these volunteer Board members. On such occasions, the Board may convene a telephone conference which fully complies with the Right-to-Know law.

As stated in Table 3 of Observation No. 10 , the Board only conducted two (2) such meetings during the audit period. In 2002, the Board complied with most of the additional requirements. Although the Board failed to meet one of the procedural requirements for the 2002 meeting, it did fully comply in its later 2005 telephonic meeting. The Board does not keep posted notices of past board meetings. Thus, a reference to the Board not making public notice of its 2005 meeting is not supported. The Board believes it did comply and continues to comply, with the Right-to-Know law to the best of its abilities.

The Board does concur that it should create written procedures of the steps its administrator or its members should take to conduct a telephonic meeting or a telephone poll, when one is required.

LBA Rejoinder:

The Board provides no evidence the Legislature ever envisioned it would have the authority to conduct telephone polls. The Board's discussion on the necessity of procedures to move its business via something other than a meeting fails to address Legislative forethought in providing it authority to do so as in RSA 329:7, when an emergency exists. Further, according to the Board, even the informal, uncodified procedures do not need to be followed because the issues they deal with become moot at times.

ADMINISTRATIVE RULES

The Legislature provided the Board authority to promulgate binding administrative rules (RSA 541-A). Rules are generally applicable regulations, standards, or other statements adopted to implement, interpret, or make specific the statutes enforced or administered by the Board. Rules prescribe or interpret Board policy, procedure, or practice requirements binding on the public and employees of other State agencies (RSA 541-A:1, XV). Rules allow the Board to develop procedures, "fill in the details" between statute and the practices needed to achieve its statutory purpose, and "…establish specific rules of conduct and the procedures by which the Board regulates the medical profession in New Hampshire." Rules provide greater certainty and regularity in Board action and the rule making process provides public and Legislative oversight over Board rule promulgation (RSAs 541-A:11; 541-A:13; and 541-A:22, II).

Rules must be specific. Rules requiring further clarifications or interpretations to be understood are not sufficiently detailed. Unadopted rules are invalid and may not be enforced (RSA 541-A:22, I). Consequently, rule making is a key underpinning of administrative procedure and due process. RSA 541-A:16, I(b), requires the Board adopt rules of practice setting forth the nature and requirement of all formal and informal procedures available and RSA 329:9, XVI, requires rules necessary for the proper administration of the Medical Practice Act be adopted. However, the Board has been overly reliant on informal procedures.

Observation No. 11

Improve Adherence To Requirements Governing Administrative Rules

Organizational Rules And Rules Of Practice Did Not Address The Board's Two Statutory Subcommittees.

RSA 541-A:16, I(a), requires the Board adopt in rule "a description of its organization, stating the general course and method of its operations and the methods by which the public may obtain information or make submissions or requests." Organizational rules include the purpose and scope, definitions, and a description of the agency's structure and functions whether established

by statute or administratively by the agency. The rules should detail the areas under Board control; cite all statutory rule making authority; describe the effect of the Board's authority on the public; how the public can best deal with the Board; and procedures to obtain public documents and other information under RSA 91-A. The rules must cover adjudicative proceedings, the rulemaking processes, the format and procedure for filing petitions for declaratory rulings, and a description of all forms and instructions used.

The Board has two statutory sub-organizations: the PAAC and the MRSC (RSAs 328-D:9 and 329:17, V-a). Each body has an effect on the public as well as on licensees. Neither committee is discussed in the Board's organizational rules and unique rules of practice do not exist for either body. This is concerning as our interviews with Board members demonstrated most have little knowledge of the PAAC or the MRSC's existence and little understanding of their functions, unless they served on one of those bodies. Public knowledge and understanding of their role is likely to also be questionable if many Board members lack a full understanding.

Board Rules Inadequately Detail Use Of Social Security Numbers

Board rules, Med 301.03(a)(3), require physician applicants for licenses provide their social security number (SSN) "required pursuant to 45 CFR Part 60.8." The federal rule states for each action taken, the Board must report to the National Practitioner Data Base a "…physician's or dentist's Social Security number, if known, and if obtained in accordance with section 7 of the Privacy Act of 1974"(45 CFR 60.8(b)(4)). The federal rule does not require submission of SSNs, the collection of which is prohibited by federal and State law unless a specific exemption applies (Section 7, P.L. 93-579 (a)(1) and RSA 541-A:22, III(h)). However, other federal and State law impose a requirement on applicants for professional license to submit SSNs for specific purposes. The Board must disclose whether submission is voluntary or mandatory and for what purpose the SSN is requested or required. The Board must also apply other protections to SSNs.

Board rules do not appear to comply with Section 7 of the Act. The Board uses several application forms and the current forms for physician applicants for full licensure (the Common License Application Form or CLA-F) appear to comply with section 7 of the Act by providing citations for required and requested submission and stating their purposes. CLA-F was only implemented by the Board in February or March, 2007 according to staff and older forms had no citations or use statements. Board forms for PA applicants, PA reinstatement, physician camp licenses, physician license reinstatement, physician locum tenens license, and visiting physician license do not appear compliant, lacking citations and purpose statements. Further, rules governing PAs do not require submission of SSNs.

Board Rules Should Reflect Statute When Requiring Disclosure Of Arrests And Indictments

RSA 332-A:1 restricts licensing questions by prohibiting licensing agencies from asking "any question concerning whether [an applicant] has been arrested or indicted for a crime." The Board may ask whether the applicant has ever been convicted of a crime (RSA 332-A:1 and 651:5, X(c)). Board rules require disclosure of whether physician applicants were ever a defendant in a criminal proceeding and the circumstances of the proceeding (Med 301.03(a)(19)), in apparent conflict with statute. Conversely, PA licensure rules require applicants submit a statement

regarding conviction of a felony or misdemeanor (Med 604.01(a)(10)), which appears to conform to statutory requirements.

Significant And Weighty Sections Of Board Rules Expired During The Audit Period.

During the audit period, the Board's rules complied with 70 percent of the governing statutory requirements from SFY 2002 through SFY 2004. In SFY 2005 and 2006, however, compliance dropped to 33 percent and 32 percent respectively as major sections of rules expired. Gaps in administrative rules may unnecessarily subject Board actions to question and potential legal appeal. Board actions taken under expired rules may be invalid to the extent they are not enforceable by statute.

Several sections were expired for over nine months of the audit period to include application procedures for regular licenses and special licenses. Several sections were expired for almost 13 months of the audit period to include the entire section regulating continuing medical education (CME) which also affects license renewal requirements, procedures for filing disciplinary charges, disciplinary proceeding procedures, and fines. The majority of rules related to PAs were expired for over 15 months of the audit period. Several Board members reported no process to review rule expiration and indicated the Administrator is relied upon to track the rules.

Erroneous References Within Board Rules

Several sections of Board rules make erroneous references including:

- Med 205.02(m) which specifies "A complaint which raises substantial issues of professional misconduct which may warrant disciplinary sanctions shall be granted by incorporating those issues into a notice of hearing which commences a disciplinary hearing pursuant to Med 501.04." Med. 501.04 did not exist.
- Med 106.01(b)(2), which defines Board-committees and permits committees to retain consultants pursuant to "Med 329:18 II." This section did not exist in Board rules. RSA 329:18, II, permits the Board to utilize paid consultants or others to support its operation.
- Chapter Med 100, which cites as its statutory authority RSAs 329:9; 326-B:2,V(e); 326-B:10; and 541-A:2. However, RSA 326-B:2, V(e), did not exist and RSA 326-B:10 establishes the State's Joint Health Council and contains no Board rule making language.
- Med 205.02(b)(4) which requires complaints be signed and dated as required by Med 204.01 (a). Med 204.01(a) did not address dates and signatures, Med 204.02(a) did and may be the intended reference in Med 205.02(b)(4).

Board Rules Are Fixed To Dated Materials

Med 103.01 details the composition of the Board stating the Board "consists of 8 members…" Since Sept. 9, 2001, the Board has consisted of nine members and since June 23, 2006, ten. The Board need not reiterate statute in its rules. Also, Med 501.02(h) requires licensees adhere to the

Principles of Medical Ethics - Current Opinions With Annotations (2004-2005) adopted by the American Medical Association which is published biennially. The Board could refer to the *Principles* by title without reference to specific dated materials.

Recommendations:

We recommend the Board amend its administrative rules to conform to statutory requirements including:

- **organizational rules and rules of practice for the PAAC and MRSC;**
- **rules reflecting statutory quorum requirements;**
- **rules conforming to federal and State law when requesting or requiring SSNs and in using SSNs to include: 1) requiring both physician and PA applicants submit SSNs, 2) stating whether submission is mandatory or voluntary, 3) stating for what the SSN will be used, 4) ensuring SSNs are used only for permissible purposes, 5) ensuring SSNs are protected, and 6) also indicate the effect of nondisclosure; and**
- **rules limiting physician licensing questions to whether an applicant has been convicted of a crime.**

We further recommend the Board correct erroneous references; discontinue referencing to materials which change frequently; and develop policy and implement procedures designed to ensure rules remain current, are reviewed regularly, and reflect operating practices.

Board Response:

The Board concurs in part.

Amendments to Administrative Rules

The statute referenced in this Observation, RSA 541-A:16, I(a), provides that each agency shall "adopt as a rule a description of its organization, stating the general course and method of its operations and the methods by which the public may obtain information or make submissions or requests." The Board's rules contain all of this information, including the method by which the public may obtain information. The Board's rules also address matters under the Board's control, cite to rulemaking authority, cover adjudicative proceedings, address the procedure for filing petitions for declaratory rulings, and address a host of other subjects in accord with RSA 541-A. The purpose of administrative rules is to fill in the "details to effectuate the purpose of the statute." State v. Elementis Chem., 152 N.H. 794, 803 (2005) The Board is not required to anticipate every type of misconduct in which any of its licensees might engage and create administrative rules to address each possible situation. See Appeal of Plantier, 126 N.H. 500, 512 (1985). The Board believes it has struck a proper balance with respect to the level of detail in its administrative rules.

Social Security Numbers

While the Physician Assistant (PA) rules do not require social security numbers, applicable statutes so require submission of social security numbers. Although it might be a better practice to detail this request in a rule, the federal and state statutory requirements requiring this information may well obviate the need for such an administrative rule. The Board, in its request and subsequent use of applicants' or licensees' social security numbers, is fully compliant with applicable state and federal law. The Board, however, will review the application forms for the different license types and, to the extent possible strive to create greater uniformity among them and will include the requisite disclosure statements pertaining to social security numbers on the application forms.

Criminal Disclosure Statements

The Board does not concur that the requests for disclosure of criminal information on its applications do not conform with statutory requirements. RSA 329:12 requires applicants for licensure to be of good professional character and RSA 329:2, II authorizes the Board to examine and investigate applicants to assure that they comply with the above. In addition, RSA 329:11-a requires all Board of Medicine applicants to submit a criminal history record check, which includes arrests, indictments and convictions. This statue was enacted in 2007.

Finally, the Board notes that RSA 651:5 states that in license applications, the applicant may be questioned "in terms such as 'Have you ever been arrested for or convicted of a crime that has not been annulled by a court?" RSA 651:5, X(c). Thus, State law contemplates that there may be situations where applicants for particular licenses may be questioned regarding prior arrests.

Rule Expiration

While the Board generally concurs that it is better to have current administrative rules, the absence of administrative rules does not remove, negate or diminish the Board's legislatively prescribed statutory authority and/or power to act. As the expiration of rules has been a systematic problem for most of the Title 30 professional and occupational licensing boards, the law was amended during the audit period in part to assist these types of boards. Under current law, the 100 chapters of rules do not expire, and the greater part of the 200 chapters will likewise not expire. It is the Board's expectation that this measure will allow it re-promulgate its other rules, that are subject to expiration, in a more timely manner.

Erroneous References

The Board concurs that erroneous and outdated references within its rules should be corrected.

Dated Materials

The Board concurs in part. The rules need not reiterate statutory provisions. Administrative rules, by their nature, are for filling in the "details to effectuate the purpose of the statute." State v. Elementis Chem., 152 N.H. at 803. Requiring the Board to reiterate statutory requirements

could lead to confusion and contrary requirements as noted in this section. Further, JLCAR has recommended the Board explicitly state within its rules the specific editions of volume of its code of ethics. The Board has acted accord with the instruction of JLCAR.

LBA Rejoinder:

The Board's rules include neither the MRSC nor the PAAC, a description of their organization, the general course and method of their operations, and the methods by which the public may obtain information or make submissions or requests from them.

Observation No. 12

Expand Administrative Rules To Address All Procedures Affecting Licensees And The Public

Board administrative rules did not contain all the procedures available or used, which affect licensees and the public.

Specified Rules Not Adopted

The Board has not adopted required rules in certain areas including:

- The time and place of applicant examination (RSA 329: 9, III(a); RSA 329:10, I), the requirement to give the examination in the English language (RSA 329:10, I); the requirement tests be available twice per year (RSA 329:10, I); details on other testing procedures (RSA 329:10, I); establishing the passing grade for an applicant (RSA 329: 9, III(c)); the disposition of examination papers (RSA 329: 9, III(d)); and examination security measures (RSA 329: 9, III(e)). The requirement for these rules, however, may be outdated.
- The circumstances under which restricted licenses are to be issued (RSA 329: 9, VIII) and the procedures for appropriate pain management (Chapter 268:2, Laws of 2000 and RSAs 329: 9, XV-a and 318-B:10, IX).
- Detailing record keeping related to physician assistants (RSAs 328-D:10, I(i) and 328-D:11), the role of staff during disciplinary and enforcement proceedings (RSAs 541-A:30-a, III(g) and 541-A:16, I(b)(2)), and retention schedules for decisions and orders (RSA 541-A:30-a, III(l) and RSA 541-A:16, I(b)(2)).
- Use of controlled substances in managing chronic pain(RSA 329:9, XV-a).
- Detailing hospital and other healthcare facility reporting of licensee discipline or adverse actions (RSA 151:6-b).

The Board Has Undertaken Informal Rule Making

The Board developed and published guidelines for general use by licensees, without codifying in rule, the conditions under which licensees may administer Ethylenediamine Tetraacetic Acid (EDTA) and internet and telephone prescribing. During Board meetings, the Board also

established guidelines or took actions affecting licensees or the public, without codifying in rule or by declaratory rule:

- Requiring an applicant for licensure complete a continuous academic year in a residency program to qualify for a license.
- Lifting restrictions on a licensee two months early and without a public hearing on the changed restrictions.
- Agreeing to amend a licensee's National Practitioner's Data Base entry.
- Extending the timeframe for completing continuing medical education and denying a similar request in another case.
- Changing licensing questions.
- Establishing who may receive copies of final orders and settlement agreements without charge, who must pay for copies, and setting the rate to be charged.
- Letter of concern format.
- Adopting a protocol waiving the requirement of then Med. 303.01(d), which specified the number of attempts allowed a physician to pass a national exam, for physicians who pass the American Boards and requiring an interview with applicants requesting such waivers.
- Allowing a licensee to renew for one year when rule and law required biennial renewal.
- Rescinding and removing letters of concern from licensee files.

The Board published articles in its periodic newsletter clarifying procedures licensees must follow, without codifying the procedures in rule or declaratory ruling:

- How to answer the renewal application question regarding informal investigations.
- Physician self-prescribing and prescribing for family members.
- Internet prescribing.
- Financial disclosures.

Ad hoc policymaking can be confusing for licensees, the public, and the Board itself. Enforcing these requirements may lead to inconsistent Board regulatory activities and may be contrary to Legislative intent. Licensees and the public may not be aware a specific procedure or recourse is available without legally binding rules.

Recommendations:

We recommend the Board consider seeking statutory amendment to delete outdated rule requirements related to applicant examinations. We further recommend the Board promulgate administrative rules detailing:

- **healthcare facility reporting of disciplinary and adverse actions;**
- **the circumstances under which restricted licenses are to be issued;**
- **the procedures for appropriate pain management;**
- **record keeping related to PAs;**
- **the role of staff during disciplinary and enforcement proceedings;**

- **retention schedules for decisions and orders;**
- **the conditions under which licensees may administer EDTA;**
- **the use of controlled substances in the management of chronic pain;**
- **internet and telephone prescribing;**
- **physician self-prescribing and prescribing for family members; and**
- **financial disclosures.**

We further recommend the Board review policy statements, informal procedures, and decisions reached in Board meetings but which are not adopted in rule, determine which should remain Board policy, and codify such requirements in administrative rule.

Board Response:

The Board concurs in part.

"[B]ecause administrative agencies act in a quasi-judicial capacity, agencies inherently have limited jurisdiction to apply strong and dominant public policy as expressed in controlling statutes, regulations, common law, and other applicable authority, to address matters necessary to resolve questions arising within the scope of their jurisdiction." Amalgamated Transit Union, Local 717, *144 N.H. 325, 327-28 (1999)(citing* Gould v. Director, NH Div. Of Motor Vehicles, *138 N.H. 343, 347 (1994)). Most of these actions identified in this Observation constitute actions of the Board in its quasi-judicial capacity. In this capacity, the Board has authority to address matters necessary to resolve questions arising within the scope of its jurisdiction.*

In addition, "[p]romulgation of a rule pursuant to RSA chapter 541-A is not necessary to carry out what statute authorizes on its face." E.g., Smith v. NH. Board of Examiners of Psychologists, *138 N.H. 548, 553 (1994).*

Finally, "informational" and "explanatory" material in the Board's newsletter falls within the exception in RSA 541-A:1, XV.

The Board does concur that it should and will consider seeking legislative repeal of outdated portions of RSA 329 that reference rulemaking.

LBA Rejoinder:

Despite the Board's quasi-judicial role, it remains subject to RSA 541-A and it is overly reliant on informal procedures. In applying general criteria to an individual and specific circumstance, the Board exercises its quasi-judicial responsibilities. When setting generally applicable policy, the Board must exercise its administrative responsibilities and promulgate administrative rules. Rules are essential elements of management control and add consistency to agency operations.

While rules are not necessary to enforce what statute authorizes, the Board has not delineated where statute authorizes the many actions taken. Further, the Board does not address where statute directs it to adopt rules but it has not. RSA 541-A:1, XV(b) exempts

informational pamphlets, letters, or other explanatory material which refer to a statute or rule without affecting its substance or interpretation. The Board's "explanatory material" did not conform to this exemption.

Observation No. 13

Seek Statutory Authority To Promulgate Rule Permitting Action With Less Than Quorum

The Board's rules appear to permit action with less than a quorum. Med 105.02, states "Except as otherwise provided by law, a quorum shall not be required to conduct a hearing or receive information, but final decisions shall be made only by the affirmative vote of a majority of the board members eligible to participate in the matter in question."

Adjudicative hearings conducted by boards are also public meetings under RSA 91-A and must conform to meeting and quorum requirements. Unless specifically stated otherwise, a majority of Board or committee members constitutes a quorum. This is derived from RSA 21:15 which specifies "Words purporting to give a joint authority to 3 or more public officers shall give such authority to a majority of them, unless otherwise expressly declared." However, contested cases reportedly may be decided by less than a quorum, provided the meeting has been opened with a quorum of the body's members. The Board rule is silent on having a duly opened meeting in order to carry out this function and may not meet the intent of the Right-to-Know Law and quorum laws by allowing decisions be made by less than a quorum without a duly convened meeting first being opened.

Recommendations:

We recommend the Legislature consider whether Board promulgation of rules permitting action with less than a quorum are acceptable.

We further recommend the Board seek statutory authority to promulgate administrative rules permitting action with less than a quorum.

Board Response:

The Board does not concur.

RSA 21:15 defines quorum as: "[w]ords purporting to give a joint authority to 3 or more public officers shall give such authority to a majority of them, unless otherwise expressly declared." The Board's administrative rules, expressly declare otherwise in Med 105.02. "Rules and regulations promulgated by administrative agencies, pursuant to a valid delegation of authority, have the force and effect of law." State v. Elementis Chemical, 152 N.H. 794, 803 (2005). Rules promulgated pursuant to the APA are presumed lawful and constitutional. Moreover, "it is well settled that an administrative agency must follow its own rules and regulations." Greenland Conservation Commission v. New Hampshire Wetlands Council, ___ N.H. ___ (December 19, 2006) (citing Appeal of Town of Nottingham, 153 N.H. 539, 554-55 (2006)). Where Med 105.02

has not been declared unlawful by the New Hampshire Supreme Court, the Board continues to follow this rule as well as the Board's other obligations under RSA 329 and applicable principles of due process in adjudicatory proceedings.

LICENSING

According to statute, the Board licensed and relicensed physicians annually until July 1, 2002, when RSA 329:16-a was changed to require biennial relicensing. The Board did not, however, implement biennial relicensure until 2006. In licensing physicians the Board relies upon the Federation of State Medical Boards, Federation Credentials Verification Services, to verify applicants' core documents such as birth certificates, diplomas, licensing examination results, and internships or residencies. Among the requirements which must be met to renew a license, physicians must take a specified number of hours of Continuing Medical Education (CME), a program administered by a third party with no management control exercised by the Board.

PAs are licensed and relicensed annually (RSA 328-D:5). The Board requires physician applicants pass one of several available examinations (Med 303.01(a)) and requires PA applicants pass an initial examination administered by the National Commission on Certification of Physician Assistants and continue to hold a valid national certificate (Med 604.01(a)(7)). Table 4 summarizes available licensing data for the audit period.

Table 4

Licensing Actions, SFYs 2002 Through 2006

Licensing Action	State Fiscal Year (SFY)				
	2002	**2003[1]**	**2004**	**2005**	**2006[2]**
Renewal - Physician	4,215	4,550	4,590	4,765	2,339
New - Physician	333	335	383	406	371
Non-renewal - Physician	213	N/A	118	232	250
Temporary - Physician	142	N/A	189	236	250
Training - Physician	133	134	120	141	134
Reinstatements - Physician	23	20	13	13	14
Subtotal - Physician	**5,059**	**N/A**	**5,413**	**5,793**	**3,358**
Renewal - PA	245	268	266	311	300
New - PA	44	40	47	31	31
Subtotal - PA	**289**	**308**	**313**	**342**	**331**
Total	**5,348**	**N/A**	**5,726**	**6,135**	**3,689**

Note: [1] Unpublished Board data. N/A means information was not available.
[2] The Board reported the license renewal cycle for physicians changed from annual to biennial in SFY 2006.

Source: Unaudited Board data.

Observation No. 14

Improve Administration Of Licensing

We reviewed 205 licensing files and found administration of the Board's licensing function should be improved in several areas:

License Processing Inconsistencies

We found various inconsistencies in license processing activities during our file review:

- Board rules (Med 305.01(c)(10)) require applicants for a courtesy license provide the dates during which the applicant will be practicing and provide verification of those dates be received directly from the New Hampshire healthcare facility at which the applicant will be practicing. In one of six cases (16.7 percent), this was not done.
- Drug Enforcement Administration certification required by Board rule was not always provided (Med 301.03(a)(28)) nor did staff require it be submitted. We found four of 19 cases (21 percent) did not contain Drug Enforcement Administration certification and there was no evidence follow-up was undertaken to ensure the Board obtained the required certification.
- The Board must approve or deny an application within 120 days of receipt. The Board did not comply with this requirement in three of 21 new applicant cases (14.3 percent).

We found incomplete renewal applications were not handled according to rule. Board rules (Med 401.03 (c) and 608.01(c)) require an incomplete renewal application or one not including the renewal fee "be returned [to the applicant] unprocessed." This was not done. The Board generates a deficiency list and provides feedback to the applicant to obtain required materials, similar to the process used for new licensees under Med 301.02, (c). Specific deficiencies we found during our file review included:

- Board rule (Med 401.02(c)) requires licensees submit "Proof of completion of the continuing education requirements…" This was not done in 162 of 164 cases (98.7 percent) of the physician cases we reviewed.
- Board rules require PAs provide, upon renewal application, information on their place of employment and on disciplinary or malpractice allegations against them (Med 608.01(b)). In one of 13 cases (7.7 percent), this was not done.
- Board rules require PAs provide upon renewal application, a copy of current professional certification (Med 608.01(b)(5)). In one of 13 cases (7.7 percent), this was not done.
- Board rules (Med 401.03(b)(5)) require a listing of other states in which a physician renewal applicant currently holds an active license. This was not done in two of 164 cases (1.2 percent).
- Med 401.03(b)(12) requires renewal applicants indicate whether their hospital privileges had been lost, denied, or restricted in any way during the preceding licensure period. In one of 164 cases (0.6 percent) this was not done.

- Following unwritten procedures for mailed in applications, licensing staff annotated receipt of fees by writing the check number next to the fee printed on the form. We could find no annotation of receipt of fees in 29 of 164 cases (17.7 percent).
- We found two instances (one percent) where license information for a similarly named licensee was placed in the wrong licensee's file.

Inadequate follow-up on deficiencies in licensing is concerning as the Board relies on staff to vet applications. Once vetted, applications are placed onto a consent list and approved by the Board, usually without discussion.

Administrative Medicine

There are no provisions in New Hampshire to issue administrative licenses to physicians who do not provide patient care. No Board rules detail a mechanism to ensure licensees practicing administrative medicine are competent should they return to providing patient care. The renewal application form does not require licensees affirm they have actively practiced medicine. Unless another state takes some action, such as restricting a license to administrative medicine, and reports their action, the Board may not know a licensee conducts administrative medicine. In one case, a physician had been practicing administrative medicine for ten years in another state and had been issued a full, unrestricted New Hampshire license. In this case, another state's medical board issued a restricted license reflecting the practice of administrative medicine and this was reported to a national database, making the Board aware of the matter after fully licensing this physician a year prior. This physician retains an unrestricted license in New Hampshire. As we discuss in Observation No. 12, the Board has not promulgated administrative rules detailing the circumstances under which restricted licenses are to be issued.

Training License Oversight

The Board issues training licenses for seven years, unless the application specifies a shorter period. Other than the initial license, the licensee does not have to renew the training license unless the training period exceeds seven years. During the training period, the Board exerts no other formal oversight of the licensee, relying on the training institution to report professional competency issues under its informal guidelines, which, as we discuss in Observation No. 12, are not codified as required by statute in administrative rule. The effectiveness of the facility reporting process is questionable, the Board is responsible for monitoring licensees to ensure they maintain competency, and others licensed by the Board are required to renew licenses and provide information which might result in an investigation either annually or biennially.

Other Administrative Inconsistencies

The Board continued to refer to certain license types, in both verbal and written communication, using terms deleted from use by rule during the audit period. With Board rule changes effective September 6, 2003, visiting professor licenses and camp licenses became special licenses and locum tenens licenses became courtesy licenses. On April 10, 2004, a new license was created in rule called a temporary license. While these changes in rule occurred in September 2003 and April 2004 staff, Board application forms and databases still refer to the old terms. Using terms

not found in statute or rule may confuse new Board staff and the public at large, particularly when using current Board statute and rules.

The Board has no systematic monitoring process ensuring its operations are efficient and effective. The Board relies on institutional memory and has no written policies and procedures.

Recommendations:

We recommend the Board:

- **Develop and implement comprehensive, written policies and procedures detailing processes staff are to follow while administering licensing and relicensing.**
- **Follow-up with licensees to obtain Drug Enforcement Administration certification required by rule.**
- **Handle incomplete applications according to rules.**
- **Approve or deny applications within 120 days of receipt as required by statute.**
- **Develop and implement policy, procedure, and administrative rules dealing with administrative medicine, to include establishing how many are licensed in the State and mechanisms to ensure competency should they return to regular practice.**
- **Combine all licensing data into one database.**
- **Standardize licensing terminology consistent with law and rules.**
- **Exert additional oversight of training licensees to include annual or biennial relicensure as other professionals are required to complete.**
- **Consider modifying the physician relicensure form to provide space for staff to annotate receipt of fees rather than following the informal procedure of annotating the check number on the form.**
- **Develop and implement a systematic monitoring process to ensure its operations are efficient and effective.**

Board Response:

The Board concurs.

The Board concurs that improvements are needed in the administration of licensing within the Board's office. The Board will direct the Administrator to develop appropriate policy for Board staff to follow to facilitate compliance with the Board's statutory and administrative requirements. The Board will review this policy on an annual basis. Moreover, the policy will be updated to reflect current practices of the Board. The Board also concurs that all licensing data should be combined into one database as set forth in the response to Observation No. 33 and that all Board communications should reflect current terminology for uniformity purposes.

Many applications for licensure require investigations of prior lawsuits and/or disciplinary actions imposed by other jurisdictions. The Board is cognizant of the current time constraints set forth by statute. The Board will review whether a statutory modification is appropriate where the

statutory timeframe for action on licensure would be inappropriate for applications in which the licensee has had prior writs, claims, or disciplinary actions in other states.

In accordance with the Observation recommendations, the Board accepts that training licenses should be issued for a shorter period than seven years. The Board will review the appropriate timelines for re-licensure and will initially study whether a biennial renewal cycle for such licenses is appropriate.

Not all physicians that practice medicine prescribe controlled substances, therefore, not all applicants will have a DEA certificate.

Observation No. 15

Adhere To Statute And Administrative Rules When Licensing Physicians

We found the Board did not always adhere to statute and administrative rule in licensing physicians and produced an inaccurate official record. In one of six (17 percent) new license applications before the Board in one month, we found:

- The physician applying for the new license had a discrepancy in the application.
- The application went before the Board at this regularly scheduled meeting and the applicant was not granted a license at this meeting.
- The applicant and the applicant's supervisor telephoned Board staff and the Board president about the issue.
- The applicant and others faxed letters, dated the day after the Board meeting, evidently clarifying the issue in question on the application.
- The Administrator contacted Board members via electronic mail to solicit their vote on licensing this applicant two days after the Board meeting.
- There was no Board meeting held between the original meeting date and the following month's regularly scheduled meeting.
- No poll results were found in the applicant's file nor were the minutes or results of the poll mentioned in the subsequent month's Board meeting minutes. Poll results were subsequently obtained.
- The Board never ratified the poll.
- Board minutes, accepted at the following month's regularly scheduled meeting, and the letter notifying the applicant of the award of the license, show the applicant was awarded the license at the original Board meeting.

Statute stipulates:

- The Board may make no final decision concerning a new applicant until it has received all required third-party certifications and no license will be granted if the Board finds the applicant does not possess the necessary educational, character, and other professional qualifications to practice medicine (RSA 329:14 II). The Board

denied licensure at the original meeting and faxes dated after that date demonstrate the Board did not possess needed information to establish qualification at its meeting.

- The Board act as a body when licensing physicians (RSA 329:14, III). The electronic mail poll after-the-fact and the lack of poll ratification at the next scheduled meeting demonstrate no final, official act by the Board was undertaken to approve this license.
- The Board carry out public business in a public proceeding (RSA 91-A). The electronic mail poll after-the-fact and the lack of required poll ratification at the next scheduled meeting demonstrate no meeting after the original meeting occurred where the Board could undertake to approve this license.
- The Board produce and maintain a true record of all of the Board's official acts (RSA 329:8). The Board minutes, the letter notifying the applicant of license award, the faxes dated after the original meeting, and the electronic mail poll dated after the original meeting demonstrate a true record was not maintained on this matter. A review of the official record would lead one to conclude the licensee was licensed at the original meeting and no other actions were taken.

As we discuss in Observation No. 10, the Executive Branch concludes conducting polls of public bodies in other than public meetings is permissible under certain circumstances and after following certain procedures. However, in licensing this physician, the Board did not follow these informal procedures, demonstrating how, once permitted, informal procedures can lead to other informal procedures, compromising the original Legislative intent to conduct public business in specific ways, and compromising the integrity of the licensing process for physicians.

Further, it is a violation of State law to knowingly make a false entry in anything kept by the government for information or record (RSA 641:7, I).

Recommendations:

We recommend the Board:

- **discontinue using informal procedures to carry out public business;**
- **adhere to statute and administrative rule when licensing physicians;**
- **develop and implement detailed, written policies and procedures to ensure statute and rule are followed;**
- **periodically review its operations and the functioning of staff to ensure law, rule, policy, and procedure are followed; and**
- **seek legal counsel to determine how to address the missteps in this matter.**

Board Response:

The Board does not concur.

The New Hampshire Board of Medicine is a quasi-judicial board with specific authority delegated to it by the state legislature. RSA chapter 329 empowers the Board, among other

things, to review license applications and to accept or reject such applications, in whole or in part.

When considering an application, the Board must review an applicant's compliance with a myriad of requirements ranging from the ministerial (such as verifying the Board's receipt of a copy of the applicant's transcript or noting whether an applicant's raw examination score is within the passing range preset by the Board) to the discretionary (such as evaluating an applicant's letters of recommendation). Whereas discretionary functions are necessarily tasks which only actual Board members can perform, the Board may delegate certain ministerial functions to its administrative staff. Hence, in a situation where the Board has reviewed the contents of an application and has performed its discretionary evaluation but has found the application to be lacking in an item of ministerial import, it would not be impermissible for the Board to vote to approve the license with a condition that the applicant provide this item to the Board's staff. The Board may then delegate, to its staff, the ministerial task of reviewing the applicant's compliance in supplementing the application with the requisite information. Because of the ministerial nature of the condition set by the Board, upon the applicant's compliance, the Board's staff may issue the license without further action by the Board.

The Observation states "the Board may make no final decision concerning a new applicant until it has received all required third-party certifications…." However, it is permissible and indeed reasonable for the Board to make a conditional decision, which subsequently becomes final upon satisfaction of the condition, where nature of the condition is something that does not require the exercise of any discretion or judgment by the Board. For example, if the decision concerns a new application and the sole reason for tabling or denying the application is the omission of a ministerial document known to exist but absent from the application, the Board could reasonably approve the application conditioned upon the particular item being produced in satisfactory time and manner. To require otherwise could significantly interfere with the Board's obligation to comply with the timeliness guidelines reviewed in Observation No. 14 and unnecessarily delay licensure of qualified applicants, particularly where the Board only meets on a monthly basis. A decision by the Board approving a license subject to a ministerial condition precedent need not be subsequently reviewed by the Board if such ministerial submission is received by the Board's staff. Accordingly, the Board need not ratify such decision in later Board meeting or by poll. Nevertheless, although not required to use this process, if the Board does elect to use the telephone poll process in the future, it will endeavor to comply with all required procedural steps.

As the Board has been compliance with the applicable laws, rules, policies and procedures in this matter, it does not concur with the recommendation.

LBA Rejoinder:

The Board's file for this case demonstrates:

- **No affirmative Board vote took place during the Board's public or nonpublic sessions.**

- **The Board president agreed to poll the Board to approve the license two days after the Board met.**
- **Seven members were polled two days after the Board's public meeting. One member's response to the electronic mail poll suggests the member was confused about what the poll was about, but still voted to license the applicant. The remaining six voted to "approve" the applicant's license.**
- **Another Board member recognized the necessity to ratify the vote at the next meeting.**
- **The Board administrator was polling members "to try to get [the applicant's] license approved."**

Further, the materials provided after the Board's public meeting were essential for at least four members to make their decision to award the license, demonstrating the action take was not "ministerial" in nature.

Two other applicants were not granted a license at this meeting. There is no evidence they were provided the same consideration as the physician approved after-the-fact.

Observation No. 16

Adhere To Statute And Administrative Rules When Relicensing Physicians

The Board did not consistently adhere to statute and administrative rules in certain cases. Effective July 1, 2002, "Every person licensed to practice…" medicine was required "…to apply to the board on a biennial basis for renewal"(RSA 329: 16-a; Chapter 228: 6, Laws of 2001). In an effort to reduce workload, the Board implemented an unwritten policy, contrary to statute, which required licensees who were originally licensed in an odd year to renew for two years and licensees originally licensed in an even year to renew for one year, then biennially in subsequent renewal years. This approach resulted in half of the physician licensees being licensed biennially, consistent with the statute, but the other half of the physician licensees not duly licensed.

One licensee originally licensed in an odd year, and who should have been relicensed for two years, from July 1, 2003 through June 30, 2005, requested an exception. The Board granted the licensee's request to renew his license for one year, not two as required by statute and its own unwritten procedure. This licensee also was an elected State official.

We found no authority for the Board to waive statutory licensing requirements and then not apply its own unwritten policy consistently to all licensees. As this policy was not an administrative rule, there was no mechanism established to handle requests for exceptions nor would any other licensee be aware of such an opportunity, since the Board never publicized its procedures. Furthermore, we found no other licensee made a similar request.

In a subsequent renewal year, the Board granted a request from the same elected State official to waive Continuing Medical Education (CME) requirements. Board administrative rules require, "No wavier petition shall be granted which does not propose a specific timetable for completing

specific courses…"(Med 402.03(b)). The petition did not propose a specific timetable for completing specific courses and therefore did not meet the requirements of the rule for a waiver and should not have been granted. Nonetheless, the Board granted a six-month extension to obtain required CME credits for license renewal.

Recommendations:

We recommend the Board comply with the laws it enforces; follow its own administrative rules; and codify unwritten practices into administrative rules, policies, and procedures to provide adequate safeguards ensuring Board dealings with licensees who are also government officials, are beyond reproach in fact and appearance.

Board Response:

The Board concurs.

The Board will comply with the recommendations made in this Observation.

Observation No. 17

Improve Controls Over Administering Physician Continuing Medical Education

RSA 329:16-g delegates responsibility for verifying physicians meet State CME requirements to the New Hampshire Medical Society (NHMS), resulting in inadequate government controls over the CME program including: 1) no State agency reviews CME audits, 2) rule-making has effectively been delegated to the NHMS, and 3) no mechanism to ensure the NHMS charges no more than 125 percent of the actual cost of providing the service.

Non-government Administration Of Physician CME Program

We examined CME administration by 17 physician licensing boards in 12 other states, as well as other regulated health professions in New Hampshire, and found the Society's role in CME administration is unique. We found one board does not have CME requirements and the remaining 16 boards (94 percent) require licensees substantiate CME completion directly to the board when renewing their licenses. No other states we examined delegated this responsibility to a non-governmental organization. One state formally involves its medical society in CME administration by permitting it to certify CME completion for its members. Licensees in this other state may, however, directly submit their CME documentation to the regulatory board. Further, we found the Board has taken a hands off approach to CME administration, and Board staff direct all CME-related inquiries and verification-related matters to the NHMS. We found neither physician assistants and other professions the Board's staff support, nor other medical-related regulatory boards in New Hampshire, use their professional associations to administer continuing education requirements and certification. Best practice suggests licensees should directly submit to their regulatory agencies a renewal form and supporting documents demonstrating the licensees meet continuing educational and professional qualifications.

Further, RSA 329:16-g, requires an approved CME program continue the education of a licensee in his or her field of practice and be certified by a national, state, or county medical society or college or university approved by the Board. Regulatory body best practice suggests accreditation standards should be related directly to educational program quality and not be restricted to a select number of providers, as well as the regulatory board determining which programs and providers are acceptable. The NHMS accredits CME programs, sets and administers quality standards, establishes criteria for program evaluation, and certifies accredited providers meet and maintain standards. Initial accreditation is reportedly approved for two years costing $2,000 and re-accreditation is for a four-year term costing $2,000. We found the Board is not involved in overseeing or approving these programs and associated standards. While the Board may approve CME programs on a case-by-case basis when petitioned by individual licensees, the NHMS is the only source for physician CME verification and program accreditation in the State.

CME Audits

The Board is required to examine licensees and advance the development of continuing professional education and other requirements demonstrating licensee professional competence. Licensees are required to prove they complete 150 hours of CME at least every three years (Med 402.01(a)). The 16 other state physician licensing boards we examined require licensees attest to CME completion to their boards when renewing their licenses. These 16 boards ensure the integrity of the CME program and licensee compliance with the CME requirement by auditing a sample of between one and 25 percent of licensees. However, RSA 329:16-g requires the NHMS audit all physician CME reports annually and requires the Board accept NHMS verification of CME. New Hampshire is unique as the Board neither audits the licensee's CME records nor reviews the third party's audit of the reported CME, taking a hands-off approach.

CME Requirements And Program Implementation For License Renewal Are Inconsistent

Board rules require licensees use a form provided by the Board to report their CME and stipulate the form is part of the renewal application. RSA 329:16-d requires the Board mail a license renewal application on or before March 1 of a licensee's renewal year. License renewal forms do not mention or require applicants to verify their CME status. In addition, the Board does not mail the CME reporting form along with the renewal application, disconnecting relicensure from CME requirements. Further, 1) although required by statute to be a Board form and the CME form is presented as a Board form, it is actually a NHMS form; 2) Board rules require licensees report CME annually by December 31 but the NHMS allows licensees to report by February 28; 3) there is no record of CME completion in a licensee's file; and 4) the Board's CME reporting rule was not updated to reflect the 2004 change in timelines from annual to biennial renewal. A Board member stated some licensees want the Board to handle CME due to potential reporting errors and questions on how to correct errors or omissions. This same Board member stated it was unclear who interprets issues or decides to award or not award CME in a given situation when questions arise.

Physician CME Fees

Licensed New Hampshire physicians are required to pay $30 per year to the NHMS, a special interest group, to provide CME verification to the Board, whether they are members of the NHMS or not. Charges are not to exceed 125 percent of the actual cost of providing the service (RSA 329:16-g). Other states we examined neither administer physician CME through their medical society nor charge an additional fee for reporting CME. Estimates indicate the NHMS may have received over $329,000 in fees related to this program during the audit period. We found no Board or other State agency oversight of CME charges supporting the program to ensure no more than 125 percent is charged. We found no explanation for why the Medical Society is permitted to make 25 percent over the cost of the program nor could we locate other private entities receiving a statutory profit margin of 25 percent.

Board efforts to resume CME program operation reportedly led to disagreement between the Board and the Medical Society. This resulted in statutory changes formally assigning CME administration to the NHMS, ostensibly to recover costs it incurred administering CME in the past. Board staffing inadequacies reportedly restricted its ability to manage CME in the past. However, physician renewals are now conducted biennially, reducing demands on Board staff time. Sampling can reduce the number of audits required to reasonably ensure licensee compliance, and requiring licensees retain documentation for a specified time period can reduce the physical needs associated with data storage.

Recommendations:

We recommend the Board seek legislative changes to achieve necessary control over physician CME administration to include:

- **direct Board program operation,**
- **directly conducting audits of statistically significant samples of physician licensees upon relicensure,**
- **ensuring the program's costs and charges are reviewed to ensure appropriateness, and**
- **ensuring authorized CME providers are not unnecessarily restricted.**

We further recommend the Board develop necessary administrative rules describing Board and licensee responsibilities and detailed, written policies and procedures providing staff guidance on the process.

Board Response:

The Board concurs.

The Board of Medicine concurs with this recommendation. Historically, the Board has taken significant steps to conform with the recommendations in this observation with little success due to circumstances beyond its control. On January 5, 2000, the Board voted unanimously to contact the New Hampshire Medical Society to inform it that the Board would be assuming

responsibility for monitoring the continuing medical education (CME) requirements for physicians effective July 1, 2000. Shortly after the Board advised the New Hampshire Medical Society, the Medical Society contacted a sponsor and lobbied for the introduction of HB 511. HB-511, which was approved by the legislature effective September 3, 2001, provided that the New Hampshire Medical Society would continue to manage licensees' CMEs until January 1, 2007.

The Board recognizes that the Medical Society has diligently, effectively and fairly run the CME program. The Medical Society has purchased software and updates to monitor physician CMEs and has requested that it be allowed to continue running the CME program after January 1, 2007. At the time of this request, the Board did not have the resources, including the computer hardware or software or manpower, to take over this program. It was also within the Board's understanding that if the question went back to the legislature the decision would be the same. Nevertheless, the Board concurs with the detailed information and analysis provided in this observation and expects that these findings will be provided to the Legislature to allow it to make an informed decision about CME implementation and monitoring, which the Board believes should be subject to greater supervision and oversight by the Board.

Observation No. 18

Improve Oversight Of Physician Assistant Licensing

PAs are required to practice under the supervision of a licensed physician (RSA 328-D:1, III and Med 602.03(b)). Completed supervision agreements are required as a condition of licensure and relicensure (Med 602.03(b), 604.01(a)(4), and 608.01(b)(3)) and incomplete renewal applications shall not be accepted by the Board and by rule are to be returned, unprocessed, to the applicant (Med 608.01(c)). Delegation agreements are the authority for a PA to provide medical care and must be signed by the PA, registered supervisory physician (RSP), and all alternate registered supervisory physicians (ARSPs)(Med 602.03).

We found of the 368 PAs active in the State based on SFY 2006 data, seven (1.9 percent) had discrepancies either in RSP or ARSP data. Five cases listed the RSP and ARSP as "none." Staff stated these discrepancies were likely due to the PA relocating and not having new supervising physicians. PAs without supervising physicians are not eligible to practice. However, no follow-up is conducted when the Board receives indication a supervisor has discontinued a relationship with a PA. The Board waits until the relicensure cycle commences in December of each year, unless wrongdoing is reported. File review revealed in four cases the supervising physicians terminated the supervisory relationship with the PA. The fifth case was a data entry error, which staff reportedly corrected. There was no clarification of the conditions leading to the terminations of the supervisory relationships.

ARSP data were blank for one PA and listed as "N/A" for a second. A review of each file showed:

- *Case 1*. The ARSP was listed as "N/A" in this case. The PA was relicensed without the ARSP data being provided. The RSP listed was a Physician Assistant Advisory Committee (PAAC) member and was the member who made the motion to approve this license. This leads to questions on the propriety of such action and whether the physician PAAC member should have been recused in this case. Staff contacted the PA and the PA has ARSPs and will provide the Board with the required data.
- *Case 2*. The ARSP was listed as blank in this case. Documents from 2001 list the primary and alternate supervisor as the same physician. Other alternates were indicated elsewhere in the file. Subsequent documents indicate the PA was employed and resided out-of-State but maintained a New Hampshire license and residence. The PA was not apparently working or under active supervision by the listed New Hampshire physician while out-of-State. Staff referred this case to the Board investigator for resolution.

Recommendations:

We recommend the Board develop policy and implement procedures to ensure terminations of PA supervision are investigated and ensure some mechanism is in place to inform PAs who have lost a supervisor of their professional status. We further recommend the Board develop policy and implement procedures to periodically review licensing data to locate erroneous entries and resolve the source of error.

Board Response:

The Board does not concur.

The administrative rules regulating physician assistants were modified and adopted in their present form in July 2006. Prior to that time, specifically during the period subject to this audit, the administrative rules were unclear and ambiguous as to whether a physician assistant (PA) was, in fact, required to provide information regarding the PA's alternative registered supervisory physician (in addition to a registered supervisory physician) at the time of license renewal. The administrative rules promulgated in July 2006 have clarified this issue and the board currently requires a PA to provide the information of two physicians.

Observation No. 18 lists a 1.9% error rate in approving PA licenses during the audit period because these PA license renewals contained the information of the registered supervisory physicians (RSPs) but not the alternate registered supervisory physicians (ARSPs). As stated above, the Board's acceptance of a PA license renewal which listed an RSP but failed to list an ARSP was not contraindicated by the administrative rules in effect at the time. In any event, although in light of the secondary nature of listing the ARSP, the diminutive impact such an error has on the public health, welfare and safety of the citizens of the State of New Hampshire, the issue has been resolved. The Board is without sufficient information to comment on the two specific cases mentioned in Observation No. 18.

LBA Rejoinder:

The Board does not explain why it does not concur with our recommendation to:

- **Develop policy and implement procedures to ensure terminations of PA supervision are investigated.**
- **Develop policy and implement procedures to ensure some mechanism is in place to inform PAs who have lost a supervisor of their professional status.**
- **Develop policy and implement procedures to periodically review licensing data to locate erroneous entries and resolve the source of error.**

The Board should possess "sufficient information to comment on the two specific cases" discussed in Observation No. 18, as we discussed both with staff, and our representation in the Observation was arrived at with Board staff.

COMPLAINTS AND INVESTIGATIONS

The Board provides a toll-free telephone line for consumers to request physician information and obtain help filing complaints. By law, complaints must be made in writing, and the Board accepts and acts on anonymous complaints in some instances. Statutes require Clerks of the Superior Court report the filing and disposition of medical injury actions and the felony conviction of licensed health care providers, providers of professional liability insurance report reservable claims against licensees, health care facility administrators report disciplinary or adverse actions against a licensee, and professional societies consisting of licensees report disciplinary actions taken against licensees (RSAs 329:17, 499:10-a, and 151:6-b).

RSA 329:17, VI, and 328-D:6 authorize the Board to investigate and take disciplinary action against licensees who provide false information, practice medicine while impaired, display incompetence, engage in dishonest or unprofessional conduct, are grossly or repeatedly negligent, allow an unlicensed person to practice, fail to provide adequate aseptic or radiological safeguards, dishonestly advertise or make deceptive public statements, willfully or repeatedly violate statute or Board rules, are convicted felons, or fail to maintain adequate medical records. Investigatory files, including complaints not warranting disciplinary action, are not public records (RSA 329:8). Complaints are kept on file in the event future complaints indicate a pattern of conduct warranting disciplinary action. Statute requires the Board conduct an investigation of licensees, called a "3 in 5" review, with any combination of three reversible claims, written complaints, or actions for medical injury in a consecutive five-year period (RSA 329:17, III-a).

Complaints are received by staff before assignment to an MRSC member or support staff to investigate. The length and nature of Board investigations varies with the complexity of the complaint, but the Board reports investigations are completed within six months on average, although some may linger for more than five years. Table 5 summarizes available complaint data for the audit period.

Table 5

Complaints Received, SFYs 2002 Through 2006

Complaints	State Fiscal Year (SFY)				
	2002	**2003**	**2004**	**2005**	**2006**
Complaints Filed	196	Not Published[1]	209	147	150
Malpractice Writs	256		196	169	132
Complaints - Other Sources	43		67	91	95
Total	**495**		**472**	**407**	**377**

Note: [1] The Board did not publish SFY 2003 data.
Source: Unaudited Board data.

We found several areas of complaint management where the Board can make improvements.

Observation No. 19

Implement Reporting Of Allegations Of Misconduct Information Timely

On July 1, 2002, Chapter 228:6, Laws of 2001 changed physician relicensing from an annual to biennial requirement. The renewal application is used, in part, to obtain potentially negative information about a licensee based on self-reporting. Under RSA 329:16-f, licensees must report address changes within 30-days, however under the current statutory and regulatory construct, a licensee must report out-of-State discipline or other allegations only upon relicensure, which may be nearly two years after the incident. Unless the Board obtains information from other sources, such as other states' courts, licensing bodies, or national repositories of such information, the change to biennial renewal has extended reporting of potentially essential information to the Board from one to two years.

Staff did report they would likely learn, once another state's licensing board completed any related investigation, if that investigation resulted in a public discipline; however, given the gravity of some allegations it seems inappropriate to risk waiting nearly two years before becoming aware of them.

Recommendations:

We recommend the Board promulgate administrative rules requiring the reporting of all allegations of misconduct by all licensees within 30 days, establishing a system to standardize collection of reports, and creating a mechanism to timely review and appropriately act on all such allegations.

Board Response:

The Board concurs.

The Board will follow the recommendations of the auditors and will strive to develop and promulgate these administrative rules in the upcoming year.

The Board will review the appropriate course of action in seeking an amendment to RSA 329 necessitating licensees to disclose final disciplinary action imposed by any other jurisdiction within 30 days. The Board will then modify its administrative rules accordingly concerning the requirements to report such disciplinary action.

Observation No. 20

Follow Rules When Handling Anonymous Complaints

The Board lacks administrative rules and formal policies and procedures codifying its current practices for handling anonymous complaints. During our file review, we found ten anonymous complaints. Based on current practice, all complaints, regardless of whether the complainant is known or not, go directly to the MRSC or other investigator to be investigated without Board review. Board rules:

- define a complaint as a written allegation of professional misconduct against a licensee (Med 201.02(b));
- require complaints be in writing and filed with the Board (Med 205.02(a));
- require complaints contain the name and address of the complainant, the name and business address of the licensee against whom the complaint is directed, the specific facts and circumstances believed to constitute professional misconduct, the date, and the complainant's signature (Med 205.02(b) and Med 204.01(a)); and
- establish a document is considered filed when it is actually received and conforms to the requirements of the Board's rules (Med 204.01 (a)).

By definition, an anonymous complaint lacks a named complainant, would not be signed, and could not conform to Board rule requirements. However, Board rules allow for suspending or waiving procedural rules, potentially allowing for accepting anonymous complaints (Med 201.04). Unless the Board waives procedural requirements related to complaint filing by motion, documents not conforming to rules should not be accepted for filing. In practice, we found no motions to suspend the rules in Board minutes.

Recommendation:

We recommend the Board comply with its administrative rules to waive procedures when handling anonymous complaints or codify its current anonymous complaint handling practices.

Board Response:

The Board does not concur.

The Board does not concur and states that it has the authority to act on anonymous complaints by virtue of RSA 329:17. RSA 329:17 gives the Board the authority to undertake disciplinary or non-disciplinary remedial proceedings "upon its own initiative." RSA 329:17, I, I-a. When the Board receives an anonymous complaint, it effectively acts upon its own initiative when it decides to investigate the allegations.

Likewise, the administrative rules do not require the Board to dismiss a complaint that fails to include the complainant's name. Even if the Board were to dismiss an anonymous complaint for failing to conform to filing requirements under Med 205.02(b)(1), the rules provide that the Board can nevertheless continue to pursue the claim of its own initiative. Med 205.02(e). The rules further provide that in such cases, the board "shall make a decision on the pending matter without considering the noncompliant information, unless the board notifies the parties that it has waived the rule." Med 201.03(b). Therefore, the Board need not waive an administrative rule to conduct an investigation on matters initially brought to the Board's attention as an anonymous complaint.

To require the Board to take steps to waive a rule that has no impact on either the complainant or the respondent would be contrary to the direction that "[t]hese rules shall be construed to secure the just, efficient and accurate resolution of all board proceedings." Med 201.01. Moreover, the rules provide that "[t]he board, upon its own initiative . . . shall suspend or waive any procedural requirement or limitation imposed by this chapter upon reasonable notice to affected persons when it appears that the proposed waiver or suspension would be lawful, and would be more likely to promote the fair, accurate and efficient resolution of issues properly pending before the board than would adherence to a particular procedural rule or rules." Med 201.04. In the case of an anonymous complainant, there are no "affected persons" at the time of accepting the complaint. The respondent is not noticed by the complaint. Med 204.03(a) ("Complaints against licensees shall be filed with the board without service upon the licensee against whom the allegations are made."); see 205.02(c). This waiver rule is intended to help ensure that the Board is able to focus on substantive issues rather than be distracted by matters that are purely procedural in nature. To add procedures to waive the rules requiring the name and address of the complainant would merely add to the administrative and procedural burden of the Board and its staff. It would do nothing to "promote the fair, accurate and efficient resolution of issues." Med 201.04; see Med 201.01.

Finally, it appears that one reason the administrative rules require the complainant's name and address is to afford the complainant with the ability to participate in the process. RSA 329:18, VIII; Med 205.02(d)(3), (g)(1) and (j). In particular, the rules give the complainant the ability to correct or supplement the information in the complaint, to comment on any proposed settlement or, with the Board's approval, to intervene in a disciplinary hearing. Med 205.02(d)(3), (g)(1) and (j). On the other hand, it is important to recognize that some complainant might find it necessary to act anonymously for quite legitimate reasons. For instance, a coworker or employee might fear retaliation. A patient might similarly fear a sort of retaliation inasmuch as

physicians are often viewed as the person with power and authority. When the complainant is anonymous, the complaint is viewed with greater skepticism. However, because the Board has the authority to initiate investigations on its own accord, the Board has the authority to call for an investigation when it believes that the allegations merit further inquiry.

Observation No. 21

Clarify And Codify Investigative Process

The Board's investigative processes require clarification and codification in administrative rule, policy, and procedure. The investigative process is a core element of the Board's responsibilities. State law and Board administrative rule direct the Board to take investigative action including: 1) conducting investigations, 2) assigning investigators, 3) referring matters to the MRSC, 4) issuing subpoenas, and 5) determining the nature of investigation needed. In practice, however, the process is ad hoc, as the Board lacks rules, and written and detailed policies and procedures addressing the MRSC and investigative practice.

Preliminary Investigation

Board investigations can be formal or informal and examine any matter within its jurisdiction (Med 201.02(g)). The Board is supposed to review all complaints first to determine whether the allegations, if true, are within the Board's jurisdiction to investigate. In practice, we found Board staff screened complaints, referred them to the MRSC which typically conducted investigations, and closed some complaints without MRSC investigation or Board action. Rules do not establish how a complaint is reviewed for jurisdiction and validity, or how staff may close cases.

Statute and rule provide the Board discretion to determine the form of investigation used, based on the need to examine acts of possible misconduct (RSA 329:18, III and Med 210.04(b)). When investigating acts of misconduct, higher levels of formality should be attained in the investigation, and as case complexity increases so should the formality of the investigation. Neither statute nor Board administrative rules provide details on when and how formal and informal Board investigations are to be conducted.

Informal Investigations

General practice usually demonstrates an informal investigation does not follow strict procedures; may be a preliminary investigation; does not rely on subpoenas to obtain information; may lead to formal investigation, informal settlement, or other disposition; and is used when the potential punishment, were allegations found to be true, is minor. In practice, the Board does not use informal investigations as preliminary investigations to establish jurisdiction or determine whether further informal or formal investigation is needed. Of the 144 investigated cases we reviewed, six of seven cases which resulted in discipline, and all of the 29 cases resulting in a letter of concern, were the result of informal investigations.

Board rules permit informal investigations at any time without a Board order (Med 210.04(a)). Informal investigations may include requests for additional information from the complainant, including medical records, and face-to-face meetings with "interested persons" (RSA 329:18, VII, and Med 210.01(b)). The Board may subpoena relevant medical and pharmacy records and obtain medical, pharmacy, and billing records from licensees, other health care providers, and other entities involved in health care (RSAs 329:18, IV(a) and 329:18, V). Rules do not define what is required to constitute a complete informal investigation.

Further, we found in one case, the Board investigator conducted unannounced visits to a licensee's business during an investigation. Administrative inspections should only be conducted when a licensee is aware of the inspection or there is a Board order. The Board did not provide information related to the frequency of such visits and lacks administrative rule, policy, and procedure detailing when such investigations are permissible, whether they require a formal order, and how such inspections should be conducted.

Formal Investigations

Formal investigations are more complex than informal investigations. General practice usually demonstrates formal investigations follow codified procedures; are initiated by formal order; are required to issue subpoenas to obtain testimony and other evidence; may lead to informal settlement, case closure, or contested case proceedings; and are used when the potential punishment, were the allegations found to be true, is major. Under statute and Board rules, formal investigations appear more structured than informal investigations, permitting the Board to administer oaths; preserve testimony; and issue subpoenas for witnesses, documents, and other items (RSA 329:18, IV(a) and Med 210.02(a)). The Board must issue a formal investigation order detailing: the statutory or regulatory authority, statutes or rules violated, subject of the investigation, general nature of the conduct being investigated, investigator, expected completion date, special authority conferred upon the investigator, and other necessary provisions (Med 210.02(b)).

The Board has not defined when and how to conduct formal investigations, nor could Board staff describe when one should be used, deferring to the Department of Justice assigned counsel to address the matter. Further, the Board does not require formal investigations when the potential punishment, were the allegations found to be true, is major.

Converting Informal Investigations Into Formal Investigations

Board rule requires the Board to convert an informal investigation to a formal investigation "at anytime" by issuing an order (Med 210.02(b) and 210.04(a)). Board rules neither define under what circumstances the Board *should* convert informal investigations into formal investigations nor when investigators *must* seek a Board order for conversion.

Assignment Of Investigation

Statute and rule require the Board assign investigators to particular investigations. The Board may use a member of its staff, an attorney, any other person, or a committee of persons to

conduct an investigation (RSA 329:17, V-a, and Med 210.03). Board rules do not assign, as a matter of course, any one person or entity investigative responsibility on the Board's behalf. No rules detail how to hand over an investigation to the MRSC. We found no referrals were made by the Board. Complaints were routinely referred to the MRSC by staff without Board involvement.

Minimum Content Of Investigations

Board rules require investigators contact persons and examine health care records and other documents "reasonably necessary" to make a recommendation whether further board action should be taken on allegations (Med 210.04(c)). Rules do not establish a process for particular types of investigations, define who must be contacted in the course of an investigation, or define what, as a minimum, should be reviewed to reach sufficiency for a Board decision. There is no policy or procedure on this matter to aid investigators, or define what a report of investigation must contain to permit the Board to make informed conclusions.

Communication During Investigative Process

There is no discussion in statute or rule of what notice the Board should provide to respondents, complainants, or other key parties. There is little information readily available for licensees, complainants, and the public generally explaining Board investigative practice. The Board's website provides primarily the only details on investigative practices. Further, licensees against whom complaints have been lodged may never hear from the Board during an investigation, even after the Board has taken final action.

The Board has ultimate responsibility for all actions taken in its name by investigators. It should exercise control over this important function to ensure investigations are conducted consistently and fairly, using clearly defined processes. Board rules rely on vague terms and lack clarity, suggesting less than full compliance is acceptable, and imply case-by-case definitions apply with unstated criteria. Rules must be specific to implement, interpret or make specific a statute enforced or administered by the Board. Rules requiring clarification or interpretation lack sufficient detail and lead to ad hoc rulemaking, the enforcement of which is prohibited by RSA 541-A:22, I.

The lack of clear administrative rules and publicly available policies and procedures may have a number of potentially negative consequences: 1) licensees and complainants may not be fully aware of procedures they must participate in, 2) the investigative process could change without the Board's knowledge or approval, and 3) unclear authority for investigators could compromise proceedings. Improved administrative rules, policies, and procedures can structure the process, set guidelines and parameters, establish minimum standards, and help assure fairness.

Recommendations:

We recommend the Board clarify its investigative processes and codify administrative rules for investigations, including rules:

- **For using preliminary investigations to determine jurisdiction, establish probable cause, and recommend further Board action.**
- **Defining the authority of investigators to conclude non-jurisdictional cases and how investigators must proceed in non-jurisdictional cases.**
- **Requiring formal investigations in complex cases and in cases where the allegations, if true, could result in discipline.**
- **Specifying when to convert informal investigations into formal investigations.**
- **Detailing what materials must be reviewed and who should be interviewed during an investigation.**
- **Defining what completed formal and informal investigations should entail, as a minimum, to establish sufficient grounds for the Board to make a determination.**
- **Detailing milestones in the investigative process.**
- **Identifying when notice to the respondent and complainant is warranted. In long-duration cases, the Board should provide periodic updates to key parties.**
- **Clarifying the responsibilities and authority of MRSC members, APU investigators and attorneys, the Board investigator, other Board staff, and Board members, including use of administrative inspections in formal investigations.**

We further recommend the Board develop detailed, written policies and procedures for all investigators, and follow rule and law by designating investigators and ensuring all allegations of potential misconduct are thoroughly investigated.

Board Response:

The Board does not concur.

Investigative Process

The Board does not concur that the investigative process should be more detailed and codified. An investigation is conducted to determine whether the facts alleged in a complaint are sustainable such that disciplinary action might be warranted. As such, it is the complaint and the facts unique to the complaint that drive the investigation. Therefore, the investigative process must be flexible.

"The type, form and extent of an investigation shall be determined by the need to examine acts of possible misconduct." Med 210.04(b). Although flexible, the overall investigative process is orderly and in accord with the statute and administrative rules. The Medical Review Subcommittee ("MRSC") conducts the investigation. RSA 329:17, V-a; see Med 210.04(c). By design, the Board is not involved with the investigation. The MRSC, with its five physicians, reviews medical records and might ask for the licensee under investigation to respond to the allegations in the complaint. RSA 329:18, VII; Med 210.04(c). If it is necessary to collect information and interview witnesses outside of the immediate medical setting at the core of the complaint, the MRSC investigator and/or the APU investigator is used. From all of the information gathered, the MRSC makes a "recommendation as to whether further board action should be taken on the allegations in question." Med 210.04(c).

Throughout the investigative process, the MRSC as a unit directs the investigations. Each month, the MRSC meets. Each MRSC member provides an update on the case he or she is reviewing. The other members ask questions and provide input. Once the investigation is complete, the case reviewer and the investigator provide the entire MRSC with a written report of findings and conclusions. In addition, the case reviewer presents the case to the MRSC for discussion. Only then, does the MRSC derive a recommendation for the Board. Through this process, the MRSC is able to look at a complaint and pursue an investigation from several perspectives, anticipate and analyze issues and obstacles and then, as a body, provide the Board with a report as to whether there is reasonable basis to conduct further disciplinary proceedings and recommend whether the Board should initiate a hearing on the matter. Med 210.04(c), (f). Although the rules do not prescribe that a report of the investigation must be prepared for informal investigations, all investigations conclude with a report.

Formal vs. Informal Investigations

The Board has sole discretion to decide whether an investigation will be formal or informal. RSA 329:18, III; Med 210.04(a). Nevertheless, investigations begin as "informal" investigations by interviewing persons, gathering data and requesting medical records. Med 210.01. A formal investigation might involve subpoenaing documents or recording testimony under oath. RSA 329:18, IV; Med. 210.02. These powers are available to the Board only in the context of a formal investigation. RSA 329:18, IV(a). Therefore, the formal process is used when the investigator is unable to obtain necessary information through informal means.

Communications During the Investigative Process

Pursuant to statute, the Board is under no obligation to provide the respondent with notice of an investigation. In fact, the statute explicitly provides that the Board "may conduct investigations on an ex parte basis." RSA 329:18, III; Med 210.04(d).

Moreover, an investigation is not adjudicatory. The due process protections referenced on pages 1-2 of Observation No. 21 are not triggered during the investigation phase. At this stage, the MRSC is merely gathering information. Any such information, like the complaint itself, is confidential. Due process protections will be triggered if the Board decides, after reading the investigation report, to proceed with a disciplinary hearing.

Contrary to Observation No. 21, it is imperative that the Board not control the investigative process as it could taint the fair hearing process. The purpose of the investigation is for the MRSC to gather sufficient information to make a "recommendation [to the Board] as to whether there is a reasonable basis to conduct further disciplinary proceedings." Med 210.04(e); Med 210.04(c); RSA 329:17, V-a. At this stage the Board's role is to review the investigation report for the limited purpose of deciding, "whether further board action should be taken on the allegations in question." Med 210.04(c). For the MRSC to provide anything more at this stage in the process could render the Board unable to remain the unbiased trier of fact during the adjudicatory hearing.

"An impartial tribunal is an essential element of a fair hearing." Appeal of Dell*, 140 N.H. 484, 492 (1995). The investigative process is intentionally designed to segregate the Board from the case review and information gathering phase. This separation ensures that the Board receives only enough information to determine whether a complaint against a physician warrants a hearing. Through the adjudicatory hearing, the Board will receive information submitted as evidence for the purpose of determining whether the physician engaged in misconduct. Given that a physician's reputation and livelihood are at stake, it is critical that the Board enter the hearing phase able to impartially hear and consider the facts and testimony from both sides of the controversy.*

LBA Rejoinder:

The investigative process is flexible to the point there is little structure to it at all. The Board rejects the opportunity to exercise control over this important function and ensure investigations are conducted in a consistent and fair manner, within a clearly defined process, by structuring the investigative process to avoid repetitive steps and unnecessary delays or by defining a complete investigation and the format of an ROI.

The Board is the final authority on matters within its scope of responsibility and has ultimate responsibility for its actions and those of its supporting committees and staff. Requiring Board members and the public to trust the MRSC has diligently carried out an investigation and all related matters are fully examined with no administrative rules, policy, or procedures for the MRSC to follow appears unreasonable.

Observation No. 22

Improve Management Of Subpoenas

The Board does not comply with its own rules when issuing subpoenas. According to RSA 329:18, IV(a), the Board may issue subpoenas only in formal investigations or adjudicatory hearings, except subpoenas issued pursuant to RSA 329:18, V. Our file review contained one formal investigation conducted by the Board, and subpoena authority was delegated to select staff by the Board in this single case by formal order.

RSA 329:18, V, permits the Board to subpoena medical, pharmacy, or billing records related to medical diagnosis or treatment from its licensees, other health care providers, health care facilities, health insurance companies, health maintenance organizations, and medical and hospital service corporations licensed or certified in New Hampshire. Records must be related to matters within the Board's regulatory authority. According to Med 206.08(a) "Subpoenas for the attendance of witnesses or the production of evidence in board investigations or adjudicatory proceedings shall be issued only upon the order of the board." Our file review found 95 cases, totaling 156 subpoenas, where subpoenas were issued by Board staff without a Board order or documented delegation of subpoena issuing authority. Table 6 details our findings.

Table 6

Subpoenas Issued In Informal Investigations Without Board Order, SFYs 2002 Through 2006

	SFY					
	2002	**2003**	**2004**	**2005**	**2006**	**Audit Period**
Total cases reviewed	37	37	36	37	37	184
Cases where subpoenas did not conform to rule	10	18	23	17	27	95
Percent	27	49	64	46	73	52
Total subpoenas without order	12	25	39	38	42	156

Source: LBA analysis of Board files.

Government agency compliance with laws is a fundamental expectation and core management control.

Recommendation:

We recommend the Board comply with its administrative rules when issuing subpoenas.

Board Response:

The Board concurs in part.

The Board of Medicine is cognizant of the statutes and regulations related to subpoenas and intends to comply therewith.

RSA 329:18 allows formal and informal investigations. While the Board may declare a formal investigation and order the MRSC or its staff to issue subpoenas in a particular matter, this is not required in every instance, and in fact would not be the usual or optimal practice in most investigations. In order for the MRSC to carry out its investigatory function on behalf of the Board, of necessity and consistent with RSA 329 and the requirements of due process, the Board must delegate the day-to-day functions of running the investigation to the MRSC. This includes issuing subpoenas for records in the ordinary course. If the MRSC were not able to act between Board meetings, it could not complete timely investigations. In addition, involving the Board in the investigation would run afoul of the required separation of functions. The Board, as the adjudicator, is limited in its ability to obtain information regarding the investigation outside of a narrow well-established process at appropriate intervals in the adjudicatory process.

The New Hampshire Board of Medicine is made up almost entirely of volunteer members. The Board of Medicine historically has and is continuing to utilize all its available resources to satisfy the statutory goal of licensing and disciplining medical providers as appropriate. Nothing in the Board's delegation of the function of issuing subpoenas to its legislatively created investigatory body and staff compromises the Board's authority or its decision-making process. Nevertheless, in order to balance the obligations set forth above and address the auditor's

concerns, the Board, as of March 2008, has instituted a process of authorizing or ordering the MRSC and its staff and counsel to issue subpoenas as appropriate in all pending investigations on a regular basis at its monthly meetings. The Board will also explore whether a statutory change would further facilitate the timely and appropriate issuance of subpoenas by the MRSC or its staff.

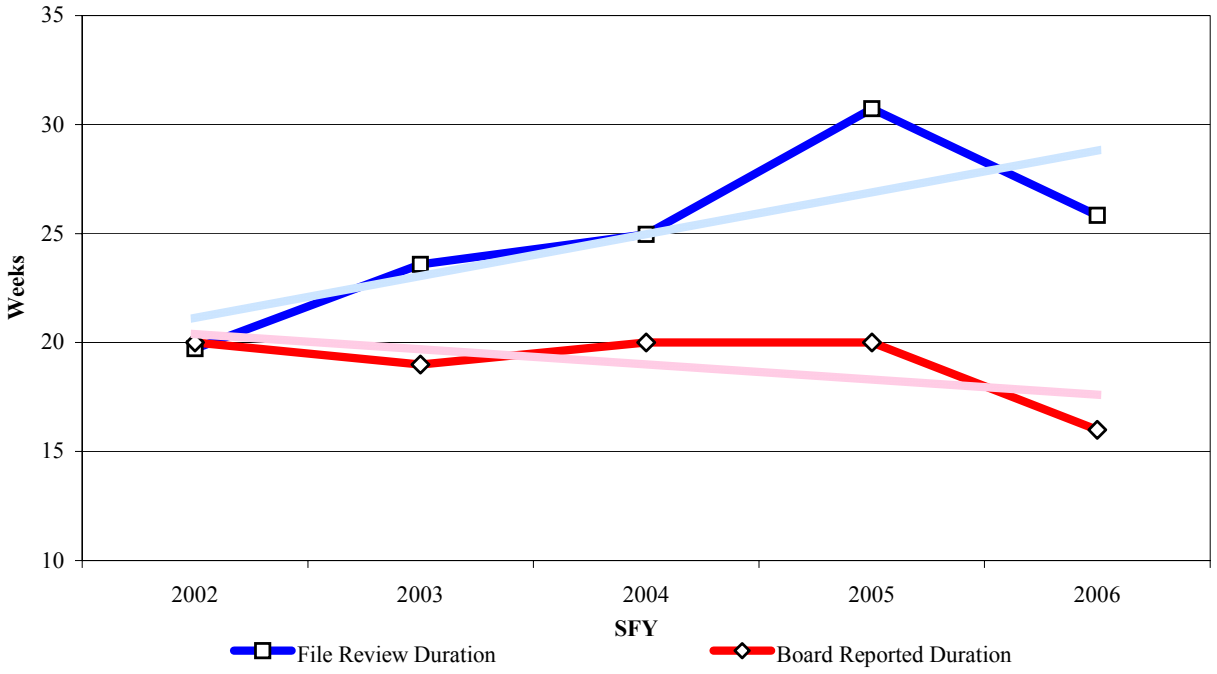
Observation No. 23

Improve Timeliness Of Complaint Resolution

The time taken for final Board action on investigated complaints is increasing. Our review of Board disciplinary files demonstrates case processing time has increased, contrary to the Board's public reports claiming investigated case processing time decreased during the audit period. Figure 2 illustrates the average case processing times for investigated cases based on our file review and the duration according to Board Annual Reports provided to Governor and Council.

Figure 2

Board Reported Investigation Duration Compared To Case Processing Time Based On File Review, SFYs 2002 Through 2006

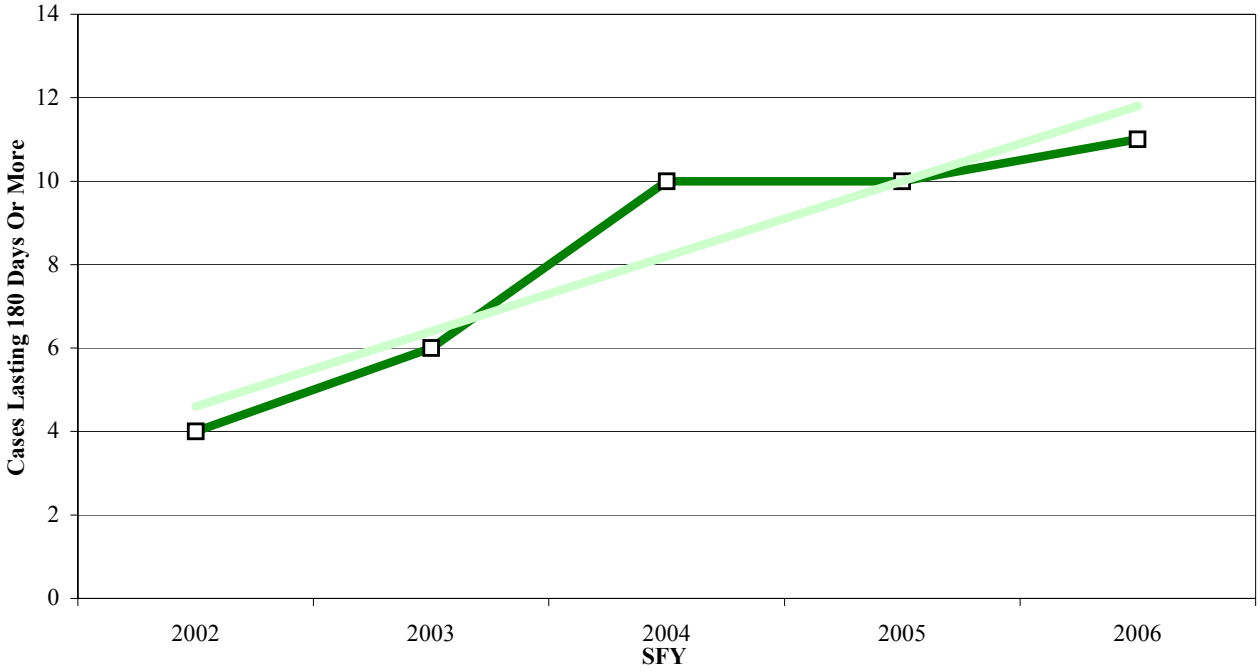


Source: LBA analysis of Board of Medicine disciplinary files and annual reports.

Additionally, the number of cases taking 180 or more days to close is increasing. Figure 3 illustrates the observed trend during the audit period.

Figure 3

Cases Lasting 180 Days Or More, SFYs 2002 Through 2006



Source: LBA analysis of Board of Medicine disciplinary files.

The Board has not established time standards for case processing, established formal steps within the process, or collected data regarding the timeliness of each step, limiting analysis of where delays may exist or where changes in processing times have occurred during the audit period. Consequently, complaints are taking longer to conclude. The Board has a duty to timely resolve matters before it. Lengthy case resolution may undermine due process.

Recommendations:

We recommend the Board:

- **Implement a management information system to support its needs, including providing case duration data.**
- **Identify steps within the case management process, collect data on timeliness of each step, and consider in which elements of the case management process efficiencies might be gained.**
- **Redesign elements of the case management system to improve efficiency.**
- **Establish a case duration standard against which to measure future performance.**

- **Routinely track and report case duration data.**
- **Improve timeliness of case processing.**

Board Response:

The Board concurs.

The Board concurs that timeliness of complaint resolution is essential. The Board also recognizes, however, that a thorough and impartial evaluation of complaints, that includes all relevant and available information, combined with reasoned deliberation is equally important.

A variety of factors outside the control of the Board or the MRSC can effect the timeliness of complaint resolution. For example, there may be delays, sometimes months, in obtaining the medical records or other necessary information due to circumstances not of the Board's own making. Following assignment and review by an MRSC member, the MRSC may conclude that additional information is required or additional witnesses should be interviewed, which might prolong the process. Delays can arise from witness unavailability, lack of an expert consultant, a need for information from another licensing jurisdiction or law enforcement, pending litigation, lack of cooperation from a licensee or a host of other factors. Having said that, it is important to track timing in order to determine whether delays are in fact caused by unavoidable circumstances.

The Observation reports on the combined lengths of investigations and adjudicative proceedings in the aggregate. For a more accurate review of the timeliness of complaint resolution, the Board recommends reviewing the length of cases in a manner that considers the median and mean timeframes segregated into categories based upon case result: no further action, letters of concern, settlement agreements and hearings. It would also be helpful to separate the investigatory and adjudicative phases.

The Board concurs that implementing a system to evaluate the progress of investigations remaining beyond a reasonable number of months is appropriate. The Board will explore this issue with OIT along with other IT recommendations from the auditors.

DISCIPLINE

The MRSC, with the support of Board and DOJ staff, evaluates complaints, medical records, a licensee's response to complaint allegations, statements, and any additional information to determine whether there is evidence of licensee misconduct. Board action is required to resolve all complaints. Upon completion of an investigation, the MRSC reports to the Board its recommendations which may include no further action (NFA), a confidential letter of concern (LOC), additional investigation, approval of a settlement agreement, or a disciplinary hearing. When an investigation finds a complaint warrants disciplinary action, the Administrative Prosecutions Unit (APU) may attempt to reach a settlement agreement or the Board may issue a notice of hearing to begin the public hearing process on the allegations. The complainant has an opportunity to participate in the hearing process which also provides the respondent due process.

Although investigations are confidential, once a disciplinary proceeding begins, documents and evidence can become public. The Board can issue discipline in cases where a licensee evidences gross or repeated negligence.

Discipline may include a reprimand; license suspension, limitation, restriction, or revocation; requiring a licensee submit to care or treatment; requiring a licensee participate in a program of continuing medical education in areas of deficiency; requiring a licensee practice under the direction of another physician; and administrative fines. The severity of the discipline is based on numerous factors including the seriousness of the offense, prior disciplinary actions, and potential harm to the public, but the Board retains broad discretion in deciding appropriate punishment. The Board's decision can be appealed to the Supreme Court under RSA 541.

In addition to disciplinary action, the Board may take non-disciplinary, remedial, or no action against a licensee. In issuing an NFA letter to a licensee, the Board: 1) determines the complaint does not rise to the level of professional misconduct, 2) does not find the complaint credible, or 3) decides not to begin immediate disciplinary action but does not resolve the merits of the complaint. The Board may issue a non-disciplinary confidential LOC when it finds insufficient evidence to support disciplinary action but believes the licensee should modify or eliminate certain practices, which, if continued, might result in future Board action. Recommendations in an LOC are not enforceable. Non-disciplinary, remedial action can include license suspension, limitation, restriction, or revocation; requiring a licensee submit to care or treatment in the Physician Health Program (PHP), or requiring a licensee practice under the direction of another physician.

Complaints are maintained in a confidential investigatory file for future use should additional information about the complaint be received or if new complaints are filed against the licensee. A "3 in 5" review is required on a licensee with any combination of three reservable claims, written complaints, or actions for medical injury in a consecutive five-year period (RSA 329:17, III-a). Table 7 summarizes available disciplinary and non-disciplinary data for the audit period.

Table 7

Disciplinary And Non-Disciplinary Actions,
SFYs 2002 Through 2006

Action	State Fiscal Year (SFY)				
	2002	**2003**	**2004**	**2005**	**2006**
Discipline	33	Not Published[1]	19	16	19
Letter of Concern	44		76	52	57
No Further Action	418		377	339	301
Total	**495**		**472**	**407**	**377**

Note: [1] The Board did not publish SFY 2003 data.
Source: Unaudited Board data.

Observation No. 24

Improve Management Of Discipline

Board members expressed a desire to ensure sanctions for offenses are consistent with past practice. Currently, sanctions are meted out based on the institutional memory of Board members rather than relying upon written guidelines. Disciplinary sanctions guidelines are a tool to promote consistency in discipline issued by the Board. Best practice suggests the Board should develop standard criteria regarding: the types of violations which generally occur, how serious violations are, the types of corrective actions needed for each type of violation, when corrective actions must be taken, and the consequences of not taking required corrective action. Professional licensing agencies in New Hampshire and other states regulating medicine and related fields have developed disciplinary sanctions guidelines intended to inform licensees and the public of the penalties associated with licensee misconduct. Also, the State's judicial system uses sentencing guidelines to provide a framework for administering punishment.

Recommendations:

We recommend the Board develop and implement comprehensive, written policy and procedure detailing the tracking of disciplined licensees; develop and implement disciplinary guidelines based on analysis of past practice; and clarify the role of the MRSC and the APU in overseeing discipline, promulgating administrative rules to codify their respective roles.

Board Response:

The Board concurs in part.

In anticipation of this Observation, the Board has already begun to track Board actions, both disciplinary action and non-disciplinary Letters of Concern. This tracking mechanism is categorized into subjects: ethics, negligence, communication, and adverse outcome. It is the Board's intent to include information retroactively, at least for the preceding two or three years, to create a more complete and accurate database. The Board recognizes, however, that the practice of medicine is not only a science but an art as well. Therefore, a tracking mechanism can be for guidance only as it could not foretell whether a licensee should or should not be disciplined based on the raw data of action or inaction. The Board aspires to create a tracking mechanism from which the Board, the MRSC, and the public could review simple fact patterns of cases and the final discipline, similar to institutional memory. Some of this information is also already currently published in the Board's regular newsletter. However, as the specific facts of each case, licensee, and patient are different, it will be the MRSC's thorough investigation and the Board's adjudication of each individual case combined with the guidance of the tracking mechanism that will ultimately dictate the corrective and/or necessary disciplinary action.

The Board does not concur that adopting additional administrative rules regarding the role of the MRSC and the APU will address the consistency issue raised in this Observation and therefore do not concur with this recommendation.

Observation No. 25

Issue Systems Letters To Bureau Of Health Facilities Administration

The Board issued confidential systems letters to administrators of healthcare facilities in the State without statutory authority. Systems letters are issued to a hospital or a healthcare facility advising the facility of what the Board determines to be a broad systems error or circumstance potentially placing patients in danger. Systems letters do not address any specific physician error. Systems letters are not disciplinary action and there is no follow-up or enforcement. Systems letters are not forwarded to other authorities and are reported to be confidential under RSAs 329:8; 329:17, VII-a; and 91-A:5, IV.

The Board could not quantify how many letters were issued during the audit period, referring audit staff to the Board's minutes. A review of Board minutes revealed at least seven instances where some form of letter to an administrator of a healthcare facility was recommended. This included at least four instances where letters were issued to administrators who were not Board licensees.

The Board reported deriving authority to issue systems letters from RSA 329:17, VII-a, and the *Appeal of Rowan*, 142 N.H. 67 (1997). RSA 329:17, VII-a, states "The board may issue a nondisciplinary confidential *letter of concern* to a *licensee*…" when "…the board believes the *physician* should modify or eliminate certain *practices*," which "may result in *action against the licensee's license*." [emphasis added] This section provides the Board clear authority to issue letters of concern to *licensees* related to their *practices* but no apparent authority to issue *facilities* or persons not licensed by the Board letters related to the *practices* of employees. A review of the *Appeal of Rowan* reveals a discussion on the Board's authority to discipline a licensee and the Board's authority over the practice of medicine by individuals and how the Board files contempt charges. It does not appear to draw a broader circle permitting the Board to exit from the Board-individual licensee relationship and undertake oversight of healthcare facilities, systems, and organizations. There are no Board administrative rules, policy and procedure, or guidelines establishing authority to issue these letters or other controls over the process.

RSA 151 provides for development, establishment, and enforcement of basic standards of care and treatment in hospitals and other healthcare facilities to ensure safe and adequate treatment. The Department of Health and Human Services (DHHS) administers this chapter through the Bureau of Health Facilities Administration which inspects and licenses facilities; investigates violations, in part, for trends in patient care which have the potential to adversely affect the health of patients; and suspend or revoke a facility's license (RSAs 151:6, I; 151:6-a; and 151:7). The Bureau is responsible for overseeing healthcare systems within facilities and is the appropriate recipient of a complaint about an inadequate system of care in a healthcare facility. The Board may not have an adequate understanding of the Bureau's role in regulating healthcare facilities.

In undertaking systems monitoring, the Board effectively extended the scope of its responsibilities into an area regulated by another agency with no apparent authority, no ability to

investigate, no follow-up mechanism, and no method to mete out discipline. RSA 151:13 requires the DHHS report "any information relative to acts which appear contrary to accepted professional practices to the appropriate professional licensing board." but Board systems letters are not disseminated to anyone other than the named recipient. RSA 151:16 provides for penalties for violations of the chapter where Board systems letters have no binding effect. This results in limiting distribution of information needed to ensure quality care systems are in place in regulated facilities and eliminating any potential follow-up action or the imposition of penalties where warranted.

Recommendation:

We recommend the Board discontinue issuing systems letters to individual health facility administrators and instead issue system letters to the Bureau of Health Facilities Administration for appropriate follow-up.

Board Response:

The Board concurs in part.

The Board concurs that, when the Board learns of systems errors or circumstances that create a potential danger to patients of healthcare facilities, the Board should refer such systems-related issues to appropriate licensing authorities under RSA 151. The Board will ensure that these system-related issues are so reported in the future. However, the Board also believes issuing confidential systems letters to healthcare facilities is consistent with RSA 329 and does not usurp the authority of the Department of Health and Human Services to regulate facilities under RSA 151. In light of the specific provisions of RSA 329:29 regarding communications between the medical review subcommittee and hospital quality assurance committees, the Board will also re-evaluate its current practice of issuing systems letters from the Board to hospital supervisory personnel, and consider instituting in the alternative, a practice of issuing systems letters from the medical review subcommittee directly to a facility's quality assurance committee.

The Board issues confidential systems letters to hospitals or other health care facilities advising them of what the Board believes to be "systems" errors or circumstances, which, if left unaddressed, may place patients in danger or lead to violations of RSA 329 and result in disciplinary action against individual licensees. The Board's authority to send such letters derives from both the language and purposes of RSA 329. RSA 329 should be interpreted to effectuate its purposes. Appeal of Rowan, 142 N.H. 67, 74 (1997). "[T]he primary purposes of RSA chapter 329 are to ensure a high quality of medical care and to protect the public from persons unfit to practice medicine." Id. (quotations omitted); see also RSA 329:18 (Board may investigate possible misconduct by licensees and applicants for licensure, unauthorized practice of medicine, and other matters within the scope of RSA 329).
Consistent with these purposes, RSA 329:17 has broad reporting requirements for superior courts, insurers, hospitals and health care facilities, and medical societies to report to the Board information regarding actions against licensees, and in some instances, other medical care providers. See RSA 329:17, II-V. The statute specifically provides that the medical review subcommittee "may provide information to a hospital committee organized to evaluate matters

relating to the care and treatment of patients or to reduce morbidity and mortality, in accordance with RSA 151:13-a, and subject to the privileges and immunities set forth in that section." RSA 329:29; see also RSA 329:29 (records of medical review committee are confidential and privileged); RSA 329:18 (investigations and information gathered in investigations exempt from public disclosure).

RSA 329 does address specifically the Board's authority to send confidential letters of concern to individual licensees and to use those letters as evidence in subsequent disciplinary proceedings. See RSA 329:17, VII-a. Nevertheless, the lack of a reference to healthcare facilities in that particular provision does not lead to the conclusion that legislature intended the Board to not be able to also communicate directly with the facilities regarding potential dangers to their patients and potential violations of RSA 329. Where the Board does not take disciplinary action directly against facilities, there would be no need to include a similar provision regarding systems letters in the statute.

RSA 151:2, I, sets forth the specific facilities that are required to be licensed by the Bureau of Health Facilities. RSA 15:2, II, sets forth a list of facilities that are not required to be licensed under that chapter. Specifically excluded from such licensing are "physicians' offices and related facilities" and "community health clinics," among others. Given the purpose of the Board in protecting patients, ensuring a high quality of care, and the authority granted in RSA 329:17, V-b and RSA 329:29, the Board regards system letters as particularly appropriate to those facilities not otherwise regulated under RSA chapter 151. The Board concurs that system letters for facilities that are governed by RSA chapter 151 must be addressed to the Bureau of Health Facilities with a copy to the specific facility.

LBA Rejoinder:

The Board asserts in essence because it is not prohibited from doing so, it may regulate facilities. The Board asserts it may use the MRSC to communicate "systems issues" and redefines the statute by concluding "facilit[ies]," not just hospitals, will be the recipients of letters in its future scheme. The Board further proposes to undertake regulation of health care facilities not included in the scope of RSA 151, to include physician's offices, despite its statutory mandate to "[e]xamine and investigate persons who apply for the authority to practice medicine in New Hampshire and license to those who are found qualified" and "[i]nvestigate and examine existing licensees and commence disciplinary action concerning licensees in accordance with the standards of this chapter."(RSA 329:2, II(a) and II(b)) The Legislature provided the Board no criteria for regulating facilities.

If the Legislature intended the Board to have a role in the operation of hospitals and other facilities, it would have so stated. Further, the Board has not 1) promulgated administrative rules to effectuate investigations of facilities of any type, 2) defined "systems" errors, 3) defined what "systems letters" are and under what conditions they will be issued, or 4) provided for appeal. Additionally, investigations not resulting in a public hearing are confidential under the Board's statute and the Board may be compromising its own confidentiality requirements by communicating to facility administrators the substance of issues uncovered.

Observation No. 26

Formally Close All Cases

We found complaints registered with the Board do not always receive final disposition. Our file review and Board data demonstrated some cases are suspended by staff and some cases are essentially, but not formally closed. RSA 329:18-a, III, provides the Board authority to dispose of allegations by settlement, default, or consent order; by issuing an order of dismissal for failing to state a proper basis for adverse action; or by summary judgment order based upon undisputed material facts. Board rule permits dismissal for failing to state a cause of action, alleging a time-barred cause of action, or failure of the complainant to respond to a request for further information or otherwise cooperate with an investigation or hearing (Med 205.02 (d)). While there is no role for staff in making final disposition in matters before the Board, we found four cases where a matter was apparently dismissed by staff and no formal and final action was taken by the Board:

1. *Case 1*. We found no final action on this case in the file or in Board minutes. The Report of Investigation (ROI) concluded the Board does not investigate such matters, as it was a billing issue. The case was referred to the Board by the Department of Justice (DOJ) and the ethical definition is included in file, clearly indicating fraud violates medical ethics. The Board adopted medical ethics as a standard of licensee behavior. The case was "closed" by no further action after 251 days with no Board involvement or final notice to the licensee.
2. *Case 2*. We found no final action on this case in the file or in Board minutes. There was no ROI in the file and it was unclear whether the case was referred to the DOJ.
3. *Case 3*. We found no final action on this case in the file or in Board minutes. We found this case was not investigated according to the file. Handwritten notes in the file explain "dropping" the case by complainant and the case was "not investigated." *Case 4*. We found no final action on this case in Board minutes. We found documentation in the file indicating staff determined the case would not be investigated or placed on the MRSC agenda, stating "We usually hold these types of cases for 2 or 3 months – giving [the complainant] the impression (false as it may be) that we are diligently reviewing his concerns."

In addition to these examples identified during file review, our analysis of Board files and data demonstrated 21 percent of cases during the audit period were not investigated and no final action was taken. We found no rule, policy, or procedure detailing this process. Table 8 summarizes our findings.

Table 8

Cases Without Final Action, SFY 2002 Through 2006

	SFY					
	2002	2003	2004	2005	2006	Audit Period
Total Files Reviewed	37	37	36	37	37	184
No Final Action	13	12	2	7	5	39
Percent	35	32	6	19	14	21

Source: LBA analysis of Board files.

Further, we found cases where, because there was no contact between the Board and a licensee under investigation, no letter closing the case was sent to the licensee following final Board action. These cases remain in the Board's files and could factor into future Board investigations such as "3 in 5" investigations required by statute on licensees with any combination of three reservable claims, written complaints, or actions for medical injury in a consecutive five-year period (RSA 329:17, III-a). It is unclear whether due-process is ensured when Board staff terminate investigations without the Board arriving at a final conclusion and making a final decision on each matter, or when licensees who have been investigated are not informed of the outcome of the investigation and not informed all investigation-related materials are retained by the Board for future use in potential disciplinary proceedings.

Recommendations:

We recommend the Board ensure every complaint received is formally closed. If such matters are to be available for consideration in future investigations or hearings, the Board should ensure the licensee is duly informed. We further recommend the Board promulgate administrative rules and comprehensive, written polices and procedures to codify and structure this process.

Board Response:

The Board concurs.

The Board concurs that all complaints relating to the care of licensees should be investigated and formally closed. The Board notes that there has been considerable improvement since 2003.

Case 1 involved a case of a patient receiving care at one medical facility and later care at another medical facility with differing amounts billed to the patient's insurance company. All bills were found to be for appropriate codes, billing amounts were merely different. There was no allegation or evidence of fraud presented either in the complaint or in any billing record. Investigation of the amount a licensee bills for an individual code or procedure is not appropriate or necessary for the Board; moreover, it is not within the scope of the Board's authority. Nonetheless, while the result in this matter was inconsequential, the Board will instruct its staff to forward all cases to the Board for final action.

The Board concurs that it should draft a policy or rules that would allow the MRSC to consolidate and thereby close 'cases' where an additional complaint is received from the same complainant without new or additional information to the same allegation. The MRSC investigators will work with the Board to update the administrative rules or create a written policy that reflects the current practices.

BUSINESS FUNCTIONS

The Board staff conduct business functions largely independent of other State agencies. In carrying out the business of the Board, the staff handle cash and checks; contract for technology system support, legal services, and other professional services; and arrange for leased office space. We found several areas requiring improvement.

Observation No. 27

Improve Management Controls Over Cash And Check Handling, Revenue, And Fees

Management controls provide reasonable assurance agency operations are effective and efficient, financial reporting is reliable, and laws and regulations are followed. The degree to which an agency uses control activities to effect management control can determine its success in meeting its mission, goals, and objectives. Controls such as rules, policies, and procedures are critical tools in helping an agency meet its objectives and protect the public's interests.

Cash And Check Handling

RSA 6:11, II, requires agencies to deposit daily on-hand funds in excess of $100. According to the Board Administrator, one staff member endorses checks while another staff member makes deposits. Staff attempt to make deposits daily, but during periods of heavier work load, deposits are made weekly. Cash and checks received, but not deposited immediately, are secured in a locked closet until deposited. In one instance, we observed documents demonstrating the Board had stored licensing fees totaling $22,500 before making a deposit.

While we found evidence the Board has used proper refunding procedures in some instances, we also found two instances where licensees sent the Board checks for $300, which were not deposited and were subsequently returned to the licensees after 20 and 51 days respectively. We also observed an unendorsed check for $300 in a disciplinary file, which had been there for four years. We observed Board staff accepting cash, holding it on the premises, and not consistently providing receipts for cash payments. Improper cash and check handling provides an opportunity for potential loss through fraud, physical loss, and loss of interest.

Collection In Excess Of Statutory Authority

State law permits the Board to charge fees covering the full cost of its programs, or 125 percent of program direct costs, whichever is greater (Chapter 130, Laws of 2001; Chapter 318, Laws of

2003; and Chapter 176, Laws of 2005). The Board has collected revenue in excess of 125 percent of its cost to administer its programs in each year of the audit period and totaling over $854,000. Table 9 details revenue, expenditures, and excess funds during the audit period.

In collecting revenue in excess of the permitted 125 percent, the Board may be overcharging its licensees for the cost of administering the Board. The Department of Health and Human Services (DHHS) financial administrator responsible for the Board reported the overage was factored into the budget in the event a major case came up and funds were required for an adjudicative hearing; effectively creating a contingency fund without authority.

Table 9

Net Board Revenue, Expenditures, And Excess Revenue, SFYs 2002 Through 2006

	2002	2003	2004	2005	2006
Net Revenue	$799,486	$924,688	$814,299	$704,449	$799,538
Net Expenditures	$422,160	$462,929	$510,803	$554,634	$600,148
Revenue As Percent Of Expenditures	189	200	159	127	133
Revenue Required To Recover 125 Percent Of Expenditures	$527,700	$578,661	$638,504	$693,293	$750,185
Amount In Excess Of Required Revenue	$271,786	$346,027	$175,795	$11,156	$49,353

Source: Unaudited Board data.

No Administrative Rules For Collecting Certain Fees

State law requires the Board to adopt administrative rules establishing fees (RSA 329: 9; Chapter 130, Laws of 2001; Chapter 318, Laws of 2003; and Chapter 176, Laws of 2005). Through administrative rules the Board establishes policy, procedure, or practice requirements binding on persons outside the Board, whether members of the general public or personnel in other agencies. Consequently, the Board may only charge fees for items promulgated in administrative rule and charging for items not codified in rule is contrary to Legislative intent. However, the Board requires licensees and members of the public to pay fees for documents such as replacement pocket licenses for licensees or licensee lists, without the fee structure being adopted in administrative rule. During the audit period, the Board collected nearly $53,000 from these types of fees. The fee schedule is detailed in Table 10.

Table 10

Board Fees Charged Without Adoption In Administrative Rule

Item	On Requestor-Provided Disk	List Or On Requestor-Provided Labels
Full Physician List	$ 100	$ 200
In-State Physician List	$ 50	$ 100
Physician List, One Specialty	$ 10	$ 20
Physician List, One County	$ 25	$ 50
Physician Assistant List	$ 25	$ 50
Physician Or Physician Assistant Replacement Pocket License	$ 20	

	Copy Of Laws	Copy Of Rules	Copy Of Laws And Rules
Physician	$ 3.00	$ 7.25	$ 10.25
Physician Assistant	$ 1.25	$ 1.50	$ 2.75

Source: LBA analysis of Board data.

Recommendations:

We recommend the Board:

- **establish procedures to comply with State law requiring depositing receipts daily when they exceed $100 to reduce the risk of loss, theft, or misappropriation;**
- **develop and implement receipt and refund polices and procedures;**
- **collect amounts permitted by State law by periodically reviewing and, if necessary, adjusting its licensing and other fees; and**
- **only charge fees authorized by statute and permitted in duly adopted administrative rules as required by State law.**

Board Response:

The Board concurs.

The Board concurs that policies and procedures should be developed consistent with State law. The Board will review policies and procedures adopted by similarly situated New Hampshire state agencies and strive to adopt such policies in accordance with the Observation recommendations.

Observation No. 28

Improve Consultant Procurement Practices

Statute permits the Board to retain expert witnesses, special legal counsel, or other qualified persons to assist with investigations and adjudicatory proceedings (RSAs 329:18, II, and 332-G:3). Individual physicians and at least one consulting firm have been employed to provide medical expertise in a discipline not available on the Board or MRSC. Other services were also procured to support Board operations including stenographic and legal services. According to data provided by the DHHS, the Board procured over $47,500 in medical expert review services and over $18,700 in other personal services during the audit period. Board personal services procurement inconsistently followed State policy and procedure.

The Board lacks formally adopted policies or procedures controlling personal services procurement, relying instead on informal procedures. State policy requires the Board obtain Governor and Council (G&C) approval for all personal services contracts with a cumulative value by service type within a fiscal year of $2,500 or more, including amendments, and reporting all contracts valued $2,499 and under to G&C on a quarterly basis. We reviewed Board and MRSC minutes and DHHS-provided expenditure data and found:

- Two SFY 2006 purchases, one for $2,925 in medical expert review services from a single vendor split into three increments and one purchase of $3,964 of stenographic services from a single vendor split into seven increments, neither with evidence of G&C review.
- A SFY 2005 purchase of $3,325 in expert review services from a single vendor in a single purchase with a retroactive G&C request including a contract, exhibits, and a resume submitted after the services were provided and an invoice submitted.
- A SFY 2003 purchase of $2,655 in expert review services from a single vendor split into six increments with no evidence of G&C review.
- Three SFY 2002 purchases, one for $3,573 in expert review services from a single vendor split into two increments; one for $2,718 in services from a private law firm split into three increments, and one for $7,112 in stenographic services from a single vendor split into five increments, including one single purchase of $2,835, with no evidence of G&C review.

State policy requires the Board use competitive bidding by obtaining three telephone quotes for contracts under $1,000, obtaining three written quotes for contracts valued between $1,000 and $2,000, or publishing a request for proposal in a statewide newspaper for three consecutive days for contracts valued over $2,000. When procurement was by sole source or contract award was not to the lowest bidder, State policy requires the Board provide justification. Board staff reported expert medical reviewers were nominated or referred by MRSC members and nominees being selected by the MRSC Administrator or the MRSC as a body when the Administrator is recused. Staff then telephonically contact the nominee and request a review of the case, offering a fee of $150 per hour, not to exceed $2,499. Staff reportedly review the nominee's complaint history and physical location within the State to avoid conflicts of interest. We found no evidence of competitive procurement or justification for using non-competitive procurement.

State policy requires the Board obtain Division of Personnel approval for personal services contracts over $2,499 and include a resume of the service provider for contracts over $500. We reviewed the 14 available procurement files for SFY 2005 and 2006 and found one resume (seven percent). Statute requires nonresident vendors and residents doing business under a name other than their own provide evidence of registration with the Secretary of State and provide evidence of their authority to execute and be bound by a contract. The Board contracted with an out-of-State expert review corporation not licensed to conduct business in New Hampshire twice during the audit period and we found no certificates of authority or evidence of registration.

State policy requires the Board use a long form contract (P-37) for purchases of any value or a short form contract for purchases under $2,500. Board staff report medical consultants must sign and return a form indicating acceptance of the Board's conditions, provided in a letter describing the general requirements of the review and case documentation if the reviewer accepts. We reviewed the 14 available procurement files for SFYs 2005 and 2006. Of ten files which should have contained contracts, only three documents with features of a contract were located (30 percent). In reviewing other services procured, we found no contracts.

Board staff indicated their procurement process was used with the knowledge of the Departments of Administrative Services and Health and Human Services. Citizens demand high standards of the State procurement system and those operating it. To maintain high public accountability standards, policies and procedures implementing controls designed to manage risks are developed. By avoiding established State procurement policy, the Board unnecessarily increased its exposure to risk.

Recommendations:

We recommend the Board follow State procurement policy when obtaining consultant services and develop and implement written, detailed policy and procedures regulating the acquisition and provision of consultant services.

Board Response:

The Board concurs in part.

The Board intends to develop and implement written, detailed policies and procedures regulating the acquisition of consulting services.

The Board concurs that it should comply with State procurement policies with respect to personal service contracts for stenographic and private legal services.

The Board concurs that an expert review services agreement should comply with the requirement of a resume for providers with reviews costing over $500. Compliance with certain other components of the standard personal services procurement process, however, is often not practical or appropriate. Medical Review Subcommittee (MRSC) members select experts based on geographic location, potential conflicts of interest, specialty, and reputation when needed for specific and insular cases. In the same manner that it would not be appropriate to engage an

expert witness for purposes of litigation by a competitive bid process, such a process is often not applicable here. For example, the investigations discussed in MRSC meetings are statutorily confidential. See RSA 329:29. Publication of the criteria needed in certain medical specialties to assist the MRSC in an investigation, as required by the state procurement process, would contravene confidentiality requirement. Timing of the investigation may also not permit a lengthy procurement process. In some instances the MRSC must engage the services of an expert licensed in a state other than NH, particularly in specialty areas where there are few physicians licensed in NH or the local physicians have conflicts or decline to participate. Given the nature of the consultation, a physician licensed in another state may not be required to register to do business in NH under state corporate law. RSA 5:18-a only requires registration to in NH where required by other applicable business entity statutes.

It is impossible to know, in advance, if there will be a need for additional expert services in other separate cases in that specialty during the same fiscal year. When the MRSC has another case that requires outside review which happens to be of the same or similar medical specialty, if the medical expert's quality of review was excellent and the expert's hourly rate was comparable to those of experts in that specialty, the MRSC is likely to seek the review of the same expert. It is possible that multiple reviews on separate and distinct insular cases by the same reviewer could lead to that reviewer receiving over $2,499 in one fiscal year. The Board views this as being compliant with the law. It is impossible to know in advance the number of cases in any given specialty, the hours required, if the specialist would have conflicts of interest, or geographically where the case to be reviewed would be located.

The Board concurs that changes need to be made in the process of choosing legal and stenographic services, and that state law must be followed. The Board concurs in part with the recommendations on expert reviewers. The Board will create written policies and procedures concerning contract with medical expert reviewers.

LBA Rejoinder:

Many agencies, including the Board, have unique contracting requirements, yet G&C regulations constitute a binding set of requirements all State agencies must follow to ensure expenditures of public funds are adequately controlled.

Several expert reviewers are frequently used by the Board within and across fiscal years. Contracting procedures allow for multiple year contracts and can provide for an upper limit of service with an hourly rate. The Board should examine its historical use of expert reviewers, to uncover trends in the disciplines used most frequently. Indefinite delivery, indefinite quantity contracts could be negotiated for an indefinite quantity of services during a fixed period, including base and option years. The Board could place service orders to meet case-specific requirements.

Observation No. 29

Improve Technology Service Procurement

We found the Board's technology service procurement methods during the audit period did not conform to State policy. Management controls are an integral component of any organization's management. Controls provide reasonable assurance Board operations are effective and efficient and comply with applicable laws and regulations.

Effective information technology management is critical to achieving useful, reliable, and continuous recording and communication of information. The Board's technology needs are supported in part by the Office of Information Technology (OIT). However, complaint and discipline database maintenance and other technology-related services were provided by a contractor during the audit period. The Board expended over $6,900 during the audit period on database and other technology-related services.

State policy requires the Board:

- Use competitive bidding by obtaining three telephone quotes for contracts under $1,000, obtaining three written quotes for contracts valued between $1,000 and $2,000, or publishing a request for proposal in a statewide newspaper for three consecutive days for contracts valued over $2,000. When procurement was by sole source or a contract award was not to the lowest bidder, State policy requires the Board provide justification. We found no evidence of competitive procurement or justification for using non-competitive procurement.
- Ensure nonresident vendors and residents doing business under a name other than their own provide evidence of registration with the Secretary of State and provide evidence of their authority to execute and be bound by a contract. We found Board procurements did not conform to this requirement.
- Use a long form contract (P-37) for purchases of any value or a short form contract for purchases under $2,500. No contracts are available, reportedly destroyed when other documents were shredded.

Obtain Office of Information Technology approval for technology-related procurements over $250. We reviewed Board technology service procurements and found this threshold avoided by breaking purchases into increments below this threshold at least 12 times during SFYs 2004 through 2006.

As stated in Observation No. 28, Board staff indicated their procurement process was used with the knowledge of the Departments of Administrative Services and Health and Human Services. Citizens demand high standards of the State procurement system and those operating it. To maintain high public accountability standards, policies and procedures implementing controls designed to manage risks are developed. By avoiding established State procurement policy, the Board unnecessarily increased its exposure to risk.

Recommendations:

We recommend the Board follow State procurement policy when obtaining technology support services and develop and implement written, detailed policy and procedures regulating the acquisition and provision of technology support services.

Board Response:

The Board concurs.

The Board concurs that it has not followed State-contracting policy when procuring technology support services. Until 2006, the Board did not have consistent technology support from the Office of Information Technology (OIT). OIT, in fact, stated that administrative licensing boards, such as the Board of Medicine, were "last on the list" for technology support services. In order to comply with its statutory mandate as set forth in its practice act, RSA ch. 329, the Board was forced to find alternative technology support outside of the Office of Information Technology.

The Board has recently begun, and expects to continue, to work in cooperation with the Office of Information Technology to improve compliance with the State contracting policies.

Observation No. 30

Operate The Physician Health Program According To Statute

RSA 329:13-b, V(b), requires the Board allocate $30 from each physician license renewal fee to a non-lapsing fund within the Office of the State Treasurer, called the physician effectiveness program (PEP) Fund. RSA 329:13-b, V(a), also authorizes the Board to contract with other organizations to establish a program to assist and monitor impaired physicians. The Board contracts with the New Hampshire Medical Society (NHMS) to meet this requirement using what is called by the Society the Physician Health Program (PHP).

The SFY 2003-2004 contract identified physicians as being eligible for the PHP. The SFY 2005-2006 contract included expanding services to physician assistants. No concurrent expansion of the statutory fee collection to support the program or expansion of the scope of the program itself was made.

Other than outlining contract requirements and receiving confidential quarterly reports on program participants, the Board has no administrative oversight of the PEP despite RSA 6:12-e requiring the Fund Administrator file a biennial report on the Fund with the State Treasurer beginning in January 2004. The Board Administrator, also the Fund Administrator, has not generated such a report. The State Treasurer's current practice, however, is to send fund information to agencies managing dedicated funds and have them confirm the information. Neither the Treasurer's Office nor the Administrator knew who confirmed the fund information in 2005. By not fulfilling management's responsibility in reporting Fund information to the Treasurer as required by statute and generally overseeing the program, there is a lack of financial

and administrative control over the PHP. By expanding program scope without expanding the funding base, physicians may bear a disproportionate share of the burden of sustaining program infrastructure.

Recommendations:

We recommend the Board ensure the contractor operates the physician effectiveness program according to statute. If the Board wishes to allow professionals not statutorily included in the program to use its services, it should seek to amend RSA 329:13-b, V (b) to include those licensees and obtain proportional funding from these professionals.

The Board should comply with statutorily established management controls and ensure the Fund Administrator generates biennial Fund reports. If the Board wishes to continue to have the Treasury Department report Fund information, it should seek to amend RSA 6:12-e to reflect current practice. Further, the Board should develop policy and procedure to provide program oversight.

Board Response:

The Board concurs.

The Board will comply with the recommendations made in this Observation. The Board will direct its Administrator to initiate the process by contacting the Treasury Department.

Observation No. 31

Improve Physician Effectiveness Program Fund Administration

The Board Administrator is also the Administrator of the PEP Fund. We found the Administrator was unaware of this responsibility, did not generate the required biennial Fund report for SFY 2005 (RSA 6:12-e), and did not implement policies and procedures to ensure proper Fund deposits. Effective July 1, 2004, Chapter 263:1, Laws of 2004, established the PEP Fund, which "is to be kept distinct and separate from all other funds." It also increased the allocation of fees into the Fund from $20 to $30 for each license renewal. An expense line was not added to the Board's budget to accommodate the PEP program until SFY 2006.

According to the Board's Annual Report, in SFY 2005 the Board renewed 4,765 physicians, which means it should have deposited in the Fund $30 from each renewal, totaling $142,950. However, according to the State Treasurer-generated report on the Fund, revenue for SFY 2005 totaled $5,340, a difference of $137,610. In SFY 2006 the Board renewed 2,399 physicians and should have deposited $30 from each renewal into the Fund, totaling $70,170. Only $24,780 was deposited, a difference of $45,390. In total, the fund has been under-funded by $183,000 during the audit period as detailed in Table 11.

Improper Fund administration lessens the public's assurance the Board's finances are reported accurately and consistently. Further, it may unnecessarily jeopardize the financial stability of a program established to aid physicians impaired or potentially impaired by mental or physical illness, and designed to protect the public.

Table 11

Expected And Reported PEP Fund Revenue, SFYs 2005 And 2006

	State Fiscal Year		
	2005	2006	Total
Expected Fund Revenue	$ 142,950	$ 70,170	$ 213,120
Reported Fund Revenue	5,340	24,780	30,120
Difference Between Expected And Reported Revenue	$ 137,610	$ 45,390	$ 183,000

Source: LBA analysis of unaudited fund revenue.

Recommendations:

We recommend the Board ensure the Board Administrator deposits the required funds from each renewal application fee into the Fund and reports fund activity consistently. We further recommend the Board develop and implement detailed, written policy and procedure governing Fund accounting.

Board Response:

The Board concurs.

The Board concurs that it is obliged to "allocate $30 from each physician license renewal fee it collects to the fund for the physician effectiveness program." RSA 329:13-b, V(b). The Board also notes, from Table 11 in the Observation that the physician effectiveness program (PEP) fund has been under-funded in the past. The Board will take measures to ensure that the Board and its staff is aware of its responsibility to allocate a portion of renewal fees to the PEP fund and to generate any necessary budget reports.

INFORMATION AND COMMUNICATION

For the Board to operate and control operations, it must have relevant, reliable, and timely operational and financial data to help determine whether the Board is meeting accountability goals and using State resources effectively and efficiently. Pertinent information should be identified, captured, and distributed as frequently as needed in a useable format. The Board lacks a comprehensive information management program.

Observation No. 32

Develop And Implement Information And Records Management Program

Statute requires the Board establish and maintain an economical and efficient records management program to support the public's right to know; protect the State's legal and financial rights and the rights of those affected by the Board; and preserve records supporting the interest of the State and posterity (RSAs 91-A:1; 91-A:4; 5:25; 5:33, I; 5:33, II; and 329:8). Best practice suggests the Board maintain secure and complete records related to its regulatory responsibilities and State employees familiar with Board operations stated the Board should permanently retain everything or almost everything it handles.

A record illustrates an event occurred or a decision was made and records management is a series of policies and procedures organizing, securing, providing access, and regulating the disposal and perpetuation of records. The only Board recordkeeping and data destruction policies are a policy on maintaining medical records obtained during investigations, a policy codified only in Board minutes. Otherwise, the Board lacks recordkeeping and destruction polices and procedures.

As we discuss in Observations No. 10, 18, and 28, the Board lacks minutes detailing several meetings and adequate contract-related records. Board staff report receiving guidance from other agencies on retention requirements but this appears to have been inconsistent with State policy. All records made or received by public officials are the property of the State and may not be disposed of except as provided by law (RSA 5:37). RSA 5:38 permits destruction of records without permanent or historical value four years from their making. However, RSA 329:8 requires Board records be preserved and RSA 91-A:2, II, makes minutes permanent Board records. State Archives policy allows contract-related materials terminated in 1999 to be destroyed in 2006. This underscores the necessity of written policy and procedures to structure agency work and not to rely on past practice or word-of-mouth to make business decisions.

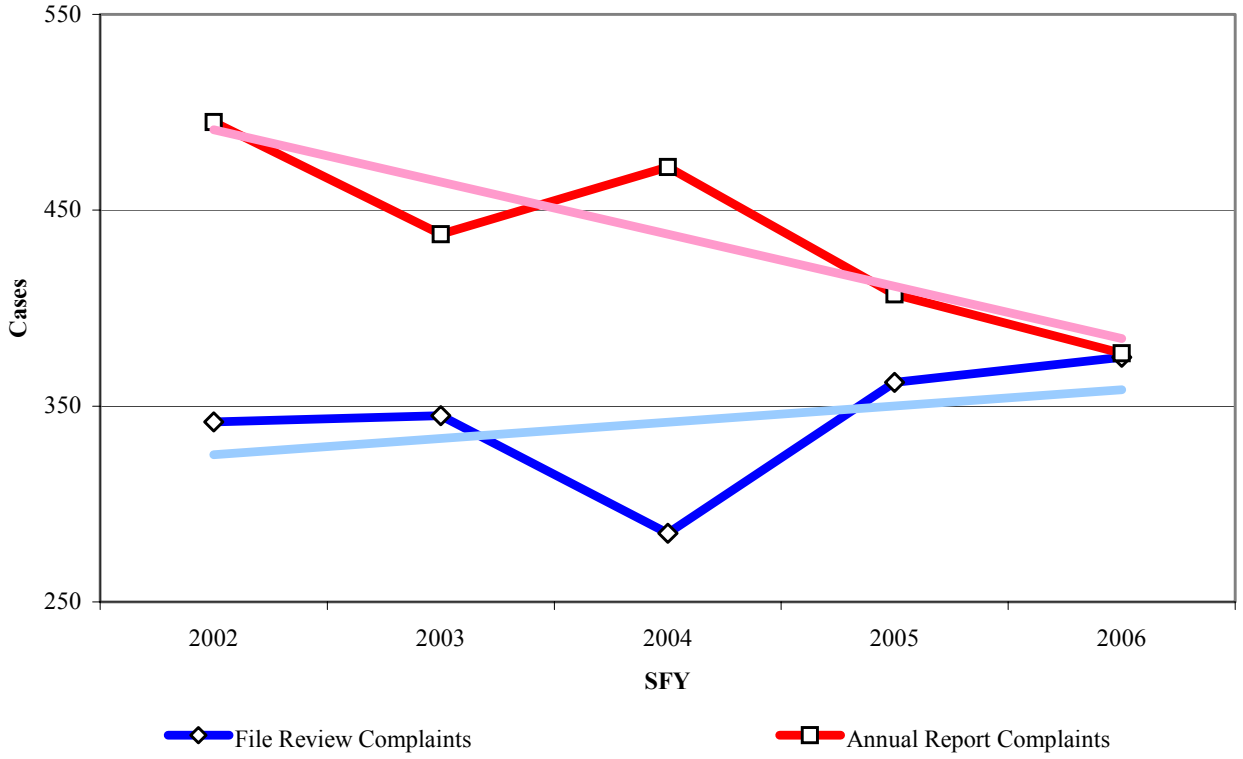
Hardcopy records are relied upon by the Board for most of their licensing and disciplinary actions. Staff reported relying on an ad hoc system of electronic and hard copy records in carrying out daily functions, indicating opportunities to gain efficiencies by consolidating data into one electronic repository. Board staff reported conducting manual file reviews to obtain basic management information for annual reporting to the Governor and Council. Further, our review of electronic and hardcopy records indicate the Board has significant opportunity to improve the comprehensiveness and completeness of its records. We requested hardcopy files based on electronic records for our file review. Upon Board staff review the hardcopy files were found not to exist. We also found blank and invalid data files in both licensing and disciplinary databases maintained by Board staff. Based on this review, we estimate over two percent of Board electronic complaint cases do not have an actual corresponding hardcopy record.

As we discuss in Observation No. 33, the Board's electronic complaint and disciplinary database does not support the Board's data needs. We examined Board public reporting of certain data and compared it with other Board data, uncovering discrepancies. Reportedly, investigations last less than eight weeks on average but durations vary with case complexity. As illustrated in Figure 2,

there were discrepancies in case duration as reported by Board in Annual Reports submitted to the Governor and Council when compared to our file review-generated data. Further, when comparing Board reported cases to other Board data, we found while reporting a decrease in complaints publicly, Board data indicate complaints actually increased during the audit period. Figure 4 illustrates this discrepancy.

Figure 4

Annual Report Complaints Compared To File Review, SFYs 2002 Through 2006



Source: LBA analysis of Board annual reports and data.

The President of the Board reported tracking trends informally; however, six Board members reported not knowing how many complaints are received per year, or whether the Board tracks complaint trends. One member stated a preference to see more statistics regarding discipline, and another reported the Board could be more efficient with proper use of technology.

Recommendations:

We recommend the Board develop and implement a comprehensive records management program ensuring records with historical and legal value are retained, all records are

safeguarded against loss or alteration, and record retention schedules consistent with State policy are established and followed.

We also recommend the Board:

- **identify, collect, analyze, and distribute pertinent performance information to support efficient management;**
- **consolidate hardcopy and electronic information management systems;**
- **ensure publicly reported data match Board records;**
- **continually monitor and improve information quality;**
- **develop and implement related policies and procedures; and**
- **promulgate necessary administrative rules.**

Board Response:

The Board concurs in part.

For record keeping, retention requirements, and destruction policies and procedures, the Board of Medicine adheres to RSA 329:8 and RSA ch. 5 and accompanying administrative rules relative to retention/destruction schedules. Where this statute and rules are silent, as the Board is administratively attached to the Department of Health and Human Services, it also relies on that agency's advice on retention policies.

The Board currently uses a paper system for Board and/or MRSC business, but is attempting to shift to an entirely electronic system. Due to budgetary constraints this process has been slow. The Board concurs that this transition should be completed expeditiously.

The Board is unable to comment specifically. The Board does not believe that its records support an estimate that over two percent of Board electronic complaint cases do not have an actual corresponding hardcopy record.

The observation described an apparent discrepancy in reported duration versus the duration found in the review of some files. Again, the Board is unable to comment on this review, as it is unclear from the observation what specific circumstances gave rise to the alleged discrepancy. For example, it is possible that additional investigation occurred following the preparation of reports.

The observation described an apparent discrepancy between reported complaints versus the complaints determined by an audit of files. The transition to electronic filing may account for some of this allege discrepancy. In any case, for State Fiscal Year 2005, the two lines converge, and the reported and reviewed numbers of complaints appear identical. The Board of Medicine's office strives to maintain accurate reporting statistics while continuing to improve on the performance of the daily operations of the Board within its budgetary constraints.

The Board concurs with the recommendations. The Board will develop and implement a comprehensive records management program. The Board will work with the Office of

Information Technology to consolidate paper and electronic information management systems. These objectives have been discussed at several Board meetings and the Board has discussed the best method to implement these goals. The Board has concluded, in part, that completion of this process will require additional resources. The Board will seek additional funding or resources to support this effort.

Observation No. 33

Improve Information Technology Management

The Board lacks adequate controls over its information technology (IT) systems. IT controls include security, management, data control, and system software acquisition and maintenance. Effective IT management is critical to achieving useful, reliable, and continuous recording and communication of information. Technology can support an efficient and economical records management program.

General And Application Controls Lacking

General and application controls over computer systems are interrelated. General controls support the functioning of application control, and both help ensure complete and accurate information processing. We found general and application controls lacking and the Board lacks adequate system documentation and comprehensive policies for its IT systems. We also found:

- Physical security of IT assets was inadequate.
- Separation of incompatible duties was limited. Consequently, licensing staff could create, edit, and delete licensing records without management knowledge, affording inadequate protection against inadvertent corruption or malicious use of data. Further, two staff had unrestricted access to all systems, again creating the situation where data could be corrupted or compromised without management knowledge.
- Procedures for disposal of hardware were inadequate as equipment was surplussed without potentially sensitive data being removed by Board staff.
- No policies on appropriate use of State computers and the Internet were developed.
- As we discuss in Observation No. 34, disaster preparation and recovery lacked planning and resourcing.

Databases And Technology Do Not Provide Adequate Management Information

Controls should be installed at an application's interfaces to ensure inputs received are valid and outputs are correct and properly distributed. An example is computerized edit checks built into a system to review the existence, format, and reasonableness of data. We found the Board's databases do not have such controls resulting in blank and erroneous data in both the licensing and complaint-discipline databases.

The Board's physician licensing database captures basic information on full licenses issued and we found areas of data inadequacies to include blank data or data outside a valid range. Error

rates ranged from 0.1 to 0.7 percent for select data fields. Staff indicated some errors were due to system failures while others were data entry errors. Staff further reported correcting these issues once identified. The physician assistant licensing database similarly functioned as generally expected with error rates in select data fields of 1.4 to 1.9 percent as discussed in Observation No. 18. However, other license types are not included in the Board's electronic database, compromising the completeness of the database. Board staff maintain hardcopy, hand written indices on other license types issued by the Board, such as temporary, resident training, and camp licenses.

The Board's complaint-discipline database is dysfunctional, incapable of providing management information or even permitting generation of basic descriptive statistics on key events such as dates complaints were received and closed. As a result, the Board must rely on their collective memory or rely on the memory of individual, long-serving Board members to recall prior enforcement actions. Staff undertake manual counting to assemble information for annual reporting and other management information needs. Staff reported correcting data entry errors, but also reported system glitches leading to losses or corruption of data. Further, all relevant data are not entered into the database, with dummy data used as placeholders and blank fields occurring in significant percentages of the database. Once again, all license types are not maintained in this database, with disciplinary data for licensees possessing other than full licenses being manually maintained by staff.

Consequently, the Board lacks adequate information systems for routinely managing and reporting on complaint and discipline activity. Implementing an effective information management system could provide the Board data on case types processed and their resolution, facilitating consistency in Board decision-making. Such information could also provide the Board measures of efficiency and timeliness of investigations.

Inadequate Security

Information security is inadequately maintained. Information system control activities include security program planning and access security. Access security control can include firewalls restricting system access, frequent changes of passwords, and deactivation of former employees' passwords and should protect Board systems and networks from inappropriate and unauthorized use. We found:

- Inadequate password procedures were used, including using "password" as a user password. Access privileges for former employees were not timely removed from systems. Board staff reported correcting both deficiencies following discussions with the audit team.
- The Board relied on electronic mail in conducting its business. Draft materials, including Board orders, letters of concern, reports of investigation, and other, sensitive or confidential materials which are protected under statute were e-mailed among Board members, staff, and Department of Justice staff supporting Board operations. Messages were not encrypted and messages transited State and commercial electronic mail service providers potentially subjecting these messages to misrouting or compromise.

- The Board's server was shared with another board, which was located in the same leased building as the Board of Medicine. Staff from the other board could access Board of Medicine licensing and disciplinary databases. Not only did this arrangement reportedly reduce server efficiency but it also potentially compromised the integrity of the databases. While there were no reported or known instances of database compromise, the Board lacked the ability to determine whether an intrusion occurred. The database has suffered several instances where data were lost or corrupted due to unknown causes.

Reported Inadequate Support

The Board's technology needs are generally supported by the Office of Information Technology (OIT). The OIT assembled the hardware architecture currently supporting the Board, which maintains licensing and complaint-discipline databases on its server. However, Board staff report inadequate support from the OIT, resulting in its reliance on a contractor to develop and administer Board databases. We question whether a functional system will be implemented under the current management approach, given reported problems with the complaint and discipline database occurring over a two-year period, as well as the absence of a plan to implement a functional system.

Recommendations:

We recommend the Board improve information technology general and application controls by:

- **securing its server so only authorized Board of Medicine staff may utilize the system;**
- **improving physical security of IT assets;**
- **separating incompatible duties and developing robust controls where this is not possible due to staffing limitations;**
- **removing potentially sensitive data from IT systems before surplussing;**
- **implementing password policies ensuring individual passwords for each employee, password security, and terminating former employee access;**
- **developing policy on appropriate use of State IT systems and the Internet;**
- **discontinuing the use of non-secure e-mail to conduct confidential business, and**
- **adding necessary controls to ensure quality data are entered, including drop-down boxes, filters, and routine reviews for missing or illogical data.**

We recommend the Board consolidate all licensing data into one electronic database and all complaint and disciplinary data into a second database, discontinuing reliance on multiple manual indices and records.

We recommend the Board:

- **determine its data management and reporting needs,**
- **develop a plan for prioritizing those needs,**

- **identify limitations in providing useful information, and**
- **assess the complaint database management system and perform a cost-benefit analysis to determine whether its current system can support Board management data needs.**

The Board should ensure the OIT is incorporated into this process, including assessing whether a commercial-off-the-shelf system might better meet its needs. We further recommend the OIT review its support to the Board of Medicine and ensure needed system improvements are implemented timely.

We recommend the Legislature consider repealing the provision of RSA 329:14, V(a), requiring training licenses be separately recorded from full physician licenses, allowing the Board to fully merge and automate its databases.

Board Response:

The Board concurs.

The Board concurs that general and application controls over information technology (IT) systems need improvement. Physical security of IT assets needs improvement. Secure data should only allow creation, deletion, and editing with limited access by secured login. Password use with secure login and password change would be appropriate to ensure identification of source if information is changed or contaminated.

Ideally licensing and public databank information should be maintained in one database. A separate database should be developed with confidential information involving complaints, claims, writs, and the investigation of those cases. The Board also concurs that combining records regarding training licenses with other licensing information in any newly developed IT system may assist the Board in fully automating and merging the licensing database. The Board will consider seeking a legislative modification of RSA 329:14, V(a) as part of that process if necessary.

The development of a valid electronic format for categorizing and retrieving information related to the MRSC investigation and Board decisions poses some significant challenges. The final actions and dispositions of complaints are not readily categorized under one or two word headings, as they are very fact specific. A listing by subject may not provide enough information to be useful for recall and comparison purposes. For example, in evaluating adverse outcomes in the performance of medical procedures or surgery, there may be facts or circumstances that distinguish each case. Risk factors for complications can include age of patient, medical condition, prior surgeries, urgency of the procedure, and even location of the services. Adequacy of informed consent, severity of the complication, whether there was a delay in diagnosis, and a host of similar factors may warrant different consideration by the Board.

Nevertheless, the Board recognizes the need to preserve institutional memory and ensure consistent and fair treatment of licensees. The Board has, in public session, discussed the development of a systematic approach to the categorization of the confidential cases investigated by the MRSC and subject to final action by the Board. The development of a systematic method

to categorize, with a "decision tree" to aid in identifying similar cases, would be of value, but is a complex task. With a volunteer Board meeting once a month, a project like this can be expected to take several years.

In the short term, the Board concurs that funding should be sought for improvement of information technology (IT) systems. Targeted areas should include restricting access, better password systems, and timely removal of former employee access. The Board will explore options with the Office of Information Technology, including consideration of a "commercial-off-the-shelf" system. Final implementation of any OIT solution will require identification of a funding source and, most likely, appropriation of additional funds by the Legislature.

Office Of Information Technology Response:

We concur.

The Office of Information Technology (OIT) shall work cooperatively with the Board of Medicine on the issues identified in this observation to ensure adequate controls and business processes are put in place.

General and Application Controls Lacking

OIT has several statewide policies in place to address many of the control issues identified in this observation. OIT will educate the Board of Medicine staff on the business need for these controls. These policies control processes such as Data Storage and Release, Media Sanitation, Mobile Devices User Accounts, and Passwords. OIT has several internal policies that it can provide to the Board on IT systems management and appropriate use of state resources. The policies include access authorization, facility security network and server configuration, and computer usage.

Databases and Technology Do Not Provide Adequate Management Information

OIT administers an enterprise licensing solution that may provide a cost-effective means for the Board to address the inadequacies of its current system. OIT will work with the Board to identify the various license types, business processes, and workflow requirements necessary to issue, renew, investigate, and discipline its licensees. OIT will work with the Board to assess commercial-off-the-shelf licensing applications to address those business requirements while ensuring the necessary controls are in place. In addition to the business needs identified, the application shall allow for enforcement of unique user names and complex password management and separation of incompatible responsibilities

Inadequate Security

OIT will implement strong password requirements for network and domain access. Because application level enforcement may not be possible for the licensing databases, OIT will educate the Board on security and confidentiality issues. OIT will work with the Board to identify business requirements for secure, confidential email communications.

Reported Inadequate Support

The Board's application and network infrastructure pre-date OIT. The current biennium added staff to assess agency needs and provide desktop support but application and network support provided by OIT continues to be on a best effort basis. The application selected by the Board to improve it licensing system will impact the level of support OIT is able to provide under its current funding mechanism. Increased support may require additional funding at the agency level.

Observation No. 34

Develop A Business Continuity And Contingency Plan

The Board has not prepared a business continuity and contingency plan to minimize disruption of essential operations in the event of a physical disaster or other foreseen or unforeseen disturbances. The Board lacks a comprehensive records management program. A parallel program is a plan to ensure business continuity and survivability of essential data.

The Board has no plan to recover electronic or hardcopy records or methods to reconstitute its essential functions. The purpose of a business continuity and contingency plan is to document recovery strategies, plans, and policies and procedures necessary to implement a recovery process for essential technology and other resources so the Board may continue to fulfill its public protection function. Further, statute requires the Board make and maintain records containing adequate and proper documentation to furnish information to protect the legal and financial rights of the State and of persons affected by the Board's activities (RSAs 5:33, II, and 329:8).

The Board's server resides in the Board's offices along with all other, non-archived hardcopy licensing and disciplinary records. Hardcopy records are relied upon by the Board for much of their licensing and disciplinary activity. Electronic data are reportedly backed-up daily but not stored off-site. This consolidation of Board records with no method to recover essential information poses significant risk should the Board's offices or technology systems suffer a catastrophic event.

A business continuity plan is intended to minimize operational downtime by providing documented and tested policies and procedures to follow in the event of system failures. A well-designed plan includes tested recovery strategies and plans as well as policies and procedures intended to implement an efficient and effective system recovery. Best practice recommends

back-up data be stored in a secure location off-site and a waterless gas-based fire suppression system be used for server areas.

Recommendation:

We recommend the Board develop and implement a written business continuity plan, in coordination with the Office of Information Technology and State Archives, to minimize the effects on Board operations in the event of an technology system failure or physical disaster at the Board's offices. The plan should include written procedures for recovering and carrying out core Board functions such as licensing, complaint management, and investigations until technology systems and office facilities are restored. Procedures should also address a process for storing database back-ups and essential duplicate hardcopy records off-site.

Board Response:

The Board concurs in part.

The Board concurs that the risk of information loss is present. To reduce this risk, the Board has taken all available steps that are within its budget. For example, the Board's Administrator physically removes a hard copy of the data available on electronic storage to a location off-site on a weekly basis. The Board has reviewed additional steps that would further reduce or effectively eliminate such risk; these steps include transition from paper to electronic filing. As a practical matter, such transition would require at least two or three added FTEs, and additional hardware, including computers and back-up technology systems. The Board will continue to strive to reduce information loss within its budgetary constraints. As it has in the past, the Board will seek additional funding or resources to support this effort.

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OTHER ISSUES AND CONCERNS

In this section, we present issues not developed into formal observations, but we consider noteworthy. The Legislature and the Board of Medicine may wish to consider whether these issues and concerns deserve further study or action.

Review Application Of Administrative Gloss

Administrative gloss is a case law-based legal doctrine applied by the courts with origins in disputes over local zoning ordinances. The doctrine concludes: 1) where an ordinance is ambiguous, 2) the agency responsible for enforcement has reasonably and consistently interpreted the ordinance, 3) the agency has applied its interpretation in similar situations over several years, and 4) the promulgating legislative body has not interfered with the interpretation, then the agency interpretation becomes de facto law. Legislative action is required to change the agency-made law as the agency cannot without violating the administratively glossed legislative intent. State agencies have applied administrative gloss to State law and the Board and DOJ continue this practice. Administrative gloss erodes Legislative authority.

The Legislature provided Executive Branch agencies a formal process in the Administrative Procedures Act (RSA 541-A or APA) to be used in cases where statutes require further clarity. The APA is to be followed before agencies affect the public either through rules or through orders after an adjudication. By applying administrative gloss at the State level, the APA is avoided and its purpose undermined because the Executive Branch now has a method to "fill in the details" without the formal and public procedures required for rules or orders. Administrative gloss provides a third, uncodified path for the Executive Branch to affect the public, encroaching on Legislative power and inhibiting due process as there is no public or Legislative oversight over the process.

The functioning of State government rests on delegated and enumerated powers. Agencies can exercise only the authority the Legislature delegates to them. The effect of the application of administrative gloss, which claims statutory vagueness, reaches beyond the enumerated powers and is based on a canon of statutory construction, for which "there is an equal and opposite canon." A "cynical view might hold principles of interpretation arise when necessary to support the result sought by the interpreter" concludes a 2000 New Hampshire Bar Journal article. The quasi-independent Board, by utilizing informal and nonpublic legal advice to develop and subsequently use procedures not permitted in statute and resting instead on precedence; using these procedures to affect licensees and the public; avoiding public disclosure and meetings; and applying administrative gloss, may have exceeded its delegated authority.

We suggest the Legislature examine the application of this doctrine by the Executive Branch.

Osteopathic Physician Board Member

The Board now consists of ten members, five are physicians or surgeons, one is a physician assistant (PA), one is the Commissioner or the Medical Director of the Department of Health and Human Services, and three are public members. Doctors of Osteopathy (DO) are not provided representation on the Board. In 2006 four other states' boards we reviewed include a DO member. Two other states we reviewed have separate boards specifically dedicated to regulating DOs. In 2006 PAs in New Hampshire numbered 371 licensees and DOs numbered 258. PAs are provided statutory representation on the Board while DOs are not.

We suggest the Legislature consider amending RSA 329 to include a DO member on the Board.

Notify Supervising Physicians Of Physician Assistant Malpractice

Board rules define a supervisory physician (RSP) as a physician who is responsible for the supervision and performance of a PA (Med 601.08). Board rules further define supervision as the exercise of control and direction over the services of a PA (Med 601.09). The Board requires RSPs to sign a contract assuming responsibility for supervision of PAs professional activities. However, the Board does not notify the RSP when a supervised PA is under investigation or receives a letter of concern.

We suggest the Legislature consider amending RSA 329 to permit confidential reporting of PA malpractice to supervising physicians.

Regulation Of Medical Assistants

Medical assistants (MA) are not regulated in the State. Medical assistants perform administrative and clinical tasks in offices of physicians, podiatrists, chiropractors, and other health practitioners. Postsecondary medical assisting programs are offered in vocational-technical high schools, postsecondary vocational schools, and community and junior colleges. Programs usually last either one or two years and result in either a certificate or associate degree. Duties vary and may include taking medical histories, recording vital signs, explaining treatment procedures, collecting specimens, performing basic laboratory tests, instructing patients about medications and special diets, preparing and administering medications, authorizing drug refills, drawing blood, removing sutures, and changing dressings. Some states regulate MAs but the Board has promulgated no formal rule or policy for physicians and physician assistants in New Hampshire on the subject.

We suggest the Legislature consider to what extent MAs should be regulated and subsequently assign regulatory responsibility.

Proactively Establish Continuing Medical Educational Requirements

CME is a recognized tool for physician learning and change. Two Board members stated the Board could and should require licensees to take a certain number of hours of CME in specific areas. One Board member noted there has been an issue with licensee communication skills and felt the Board should require licensees take CME in communications. Four of the 11 other states' boards we reviewed require licensees take CME in certain areas and nationally, 21 boards similarly require specific CME which included: geriatric and end-of-life care, human immunodeficiency virus care, risk management, domestic violence, pain management, and infectious diseases.

We suggest the Board consider proactively using administrative rules to require CME in areas where trends demonstrate potential need.

Centralization Of Professional Licensing Board Support And Administrative Oversight

We found significant gaps in both the administration of the Board's operations and the administrative processes used by the Board. Many issues rest with the administrative support provided to the Board. Others hinge upon the voluntary nature of the Board itself, limiting, among other things, the ability of the Board to oversee and supervise its own administration. Necessarily, the Board's regulatory decisions should remain independent. However, administrative support does not have to be decentralized as it is now for the Board to receive necessary support and remain independent in its adjudicatory and regulatory decisions. Nationally, nearly 31 percent of other states' boards were located within a larger licensing department, division, bureau, or office in 2000. Further, we note at least two states reported cost savings as a result of consolidating regulatory board support.

We suggest the Legislature consider whether centralizing regulatory board support and administrative oversight could improve accountability and efficiency without compromising independent adjudicatory and regulatory decision-making.

Anesthesiologist Assistants

The anesthesiologist assistants (AA) function under the direction of an anesthesiologist. AAs are not PAs. AAs assist in developing and implementing an anesthesia care plan; collect preoperative data; take health history; insert intravenous, arterial, and special catheters; perform airway management; and administer drugs for induction and maintenance of anesthesia. Approximately 700 anesthesiologist assistants practice nationwide in 16 jurisdictions, under formal licensure in ten jurisdictions and under physician delegation in the other six, including New Hampshire. All are under the purview of the respective state medical board.

No Regulation In New Hampshire

Nationally, the AA profession is growing. Some view AAs as trained professionals capable of safe delivery of anesthesiology while others do not. No Board rule defines the critical elements of the profession such as scope of practice, prescriptive authority, supervision, and liability. AAs practice under the informal principle of physician delegation which is also not defined in New Hampshire. Physician delegation has different meanings among jurisdictions with some requiring AAs meet educational standards without providing for licensure. No such requirements exist in the State. The only formal regulation is by a third-party certification body which is not recognized by the Board. Licensure, conversely, would more clearly define the AA profession. The national trend is for medical boards to regulate providers like AAs.

Inappropriate Licensure

The Board inappropriately licensed an AA as a PA without meeting the statutory and regulatory requirements for PA licensure. AAs and PAs are not the same educationally; PAs being broadly educated medical professional while AAs focus on anesthesiology, and are tested and certified by different national bodies. PAs are required by statute to have graduated from a training program approved by the Committee on Allied Health Education and Accreditation or other Board-approved accrediting agency and to pass a Board approved national proficiency examination (RSA 328-D:3). Board rules recognize only the National Commission on Certification of Physician Assistants as a certifying body for PAs (Med 601.04). There are no rules detailing any requirements for AAs.

The Board was advised in 1995 by the Department of Justice that while this individual "may have been…inadvertently licensed after the effective date of RSA 328-D:3 (January 1, 1990) there is no method…by which the Board may continue licensure of someone who does not hold a current national certification." The Board was advised a "legislative change is necessary" by the Department. Licensing documentation in the file also demonstrates the Board's reliance on institutional knowledge. The licensee made note on the license application to "check with" a former Board member about the application "if there is any question" on the license.

We suggest the Legislature consider formally regulating AAs and subsequently delegate regulatory authority.

We suggest the Board issue PA licenses only to qualified physician assistants.

Relationship With Expert Reviewers And Supervisors

The Board could not tell us whether expert reviewers and persons who agree to supervise a licensee under the terms of a settlement or other agreement are 1) contractors to the State, 2) if the State bears any responsibility to indemnify expert reviewers and supervisors should their evaluations be challenged, 3) what liability is involved if expert reviewers or supervisors provide erroneous evaluations, and 4) whether the State bears any responsibility to the licensee if an expert reviewer or supervisor provides an erroneous evaluation and the Board implements or

takes additional disciplinary action as a result. These relationships are largely ad hoc in nature and as we discuss in Observation No. 28, there are no substantive contracts assigning responsibilities or risk for expert reviewers. Further, there are no statutes, rules, or policy detailing the Board's relationship with either expert reviewers or supervisors. The lack of clarity on the relationships may constitute risk to the State and to these individual service providers.

We suggest the Board define its relationship with these informal service providers in administrative rule and ensure identification and mitigation of associated risks to protect both the State and individuals.

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CONCLUSION

This report details a number of gaps in the Board of Medicine's management controls affecting its ability to efficiently and effectively administer its operations and regulate the profession of medicine in the State. We found several areas of Board operation require improved adherence to statutes and rules including licensing and relicensing physicians and physician assistants. Another area of non-compliance includes the Administrative Procedure Act, where we found Board administrative rules to be inadequate or absent in several core areas. This has led to the use of informal, often nonpublic, procedures to accomplish core Board functions including licensure, relicensure, and investigations. Further, Board procedural and substantive rules do not reflect either of the Board's statutory committees and the Board could enhance its independence by clarifying its relationship with the Department of Justice. We also found problems with the Board's hiring practices and instances where the Board may have undertaken public proceedings in private. The Board could benefit from increased transparency of its operations and clearly codified procedures.

The Board lacks detailed, written policies and procedures leading to inadequate control of financial and administrative operations, licensing, and investigations. Not all malpractice complaint cases are closed by the Board, other cases are not investigated, and subpoenas are issued in a manner contrary to Board rules. There is no Board oversight of the physician continuing medical education program supporting relicensure. We found avoidance of contracting requirements for professional and technology support services, inadequate control over the Board's sole dedicated Fund, and excessive fees collected. The Board lacks a records management program and does not collect or analyze data in several important areas including discipline and the duration of investigations.

Board management is responsible for exercising control over its operations. Given the voluntary nature of the Board and the regulatory demands on it, which make increased Board oversight problematic, we have recommended the addition of an executive director to help improve management control at the Board. Without adequate attention to management controls, to include administrative rules and written, detailed policy and procedure, there can be little assurance future Board operations will not continue the conditions we found leading to the significant observations contained in this report.

APPENDIX A
BOARD OF MEDICINE RESPONSE TO AUDIT

New Hampshire Board of Medicine
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April 9, 2008

RICHARD J MAHONEY CPA
DIRECTOR OF AUDITS
OFFICE OF LEGISLATIVE
BUDGET ASSISTANT
STATE HOUSE ROOM 102
CONCORD NH 03301

Dear Mr. Mahoney:

The Board of Medicine ("Board") would like to thank you for performing the performance audit and for making recommendations for change. The Board appreciates your efforts. The Board, however, has little control over many of the changes recommended. For example, the Board definitely needs IT support and updates with great urgency, yet this has been a low priority for the agencies charged with such support. Certainly, the summary sheets very helpful and valuable as it provides the Board with a roadmap for the necessary additional actions the Board should take.

The Board and the Medical Review Subcommittee ("MRSC") members take this opportunity to remind the LBA and the readers of this audit that the members each volunteer an average of 100-200 hours a year. We are volunteers dedicated to the practice of medicine and committed to assure that the medical services provided are effective and of a quality consistent with the standard of care within the medical profession, and to safeguard the citizens of New Hampshire against harm which may be caused by unqualified, impaired, or unlicensed practitioners.

On a conservative budget, our administrator strives to operate the Board of Medicine with an outdated information system. The Office of Information Technology has agreed to support the needed transition to a more secure and updated system.

With regards to osteopathic members, M.D. and D.O. degrees and training are very similar. D.O. licensees are welcome to apply for consideration for Board positions. Diversity of geography, specialty and gender are encouraged in applicants of the MRSC and the Board. The Board would be happy to welcome a D.O. to the Board, as it has in the past, but would consider the specialty and experience of the physician to be more important than the type of degree.

I look forward to our meeting on April 8 to discuss the draft audit report. Please note, I have submitted my resignation as President effective May 7, 2008. I shall continue to serve on the Board until my successor is appointed and qualified in accordance with RSA 329:4, II. Should you have need for further information in the future, please contact Dr. James Sise, M.D.

Sincerely,

Kevin R. Costin, P.A.
Board President

KRC/pt

APPENDIX B
EXECUTIVE BRANCH ETHICS COMMITTEE ADVISORY OPINION 2008-001

STATE OF NEW HAMPSHIRE
EXECUTIVE BRANCH ETHICS COMMITTEE

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Advisory Opinion

2008-001

Question Presented

May a department head or other supervisor within a prospective employee's chain of command participate, directly or indirectly, in the hiring of a family member?

If it is determined that such employment is permissible, what, if any, limitations or obligations do the ethics statutes place on the department head or supervisor participating in the hiring process or supervision of their family member as an employee? If it is determined that such employment is not permissible, what effects, if any, would such a determination have on the department head, supervisor, or family member so hired?

Summary Answer

An executive branch official who serves as a department head or supervisor must recuse himself or herself from a hiring process when either a spouse or a dependent family member is a candidate for employment within the official's department.

Likewise, an executive branch official should not directly participate in any supervisory decisions regarding an employee who is a spouse or a dependent family member.

A department head or supervisor who violates the ethics statutes may be charged with a misdemeanor or may face disciplinary action. RSA 21-G:34. In the event that an individual who is a spouse or a dependent family member of a department head or supervisor is employed by the State in a process where the department head or supervisor

was improperly involved in the hiring decision, the ethics statutes do not impose a consequence on the person hired.

The ethics statute does not currently define other family relationships that may give rise to a conflict of interest under these circumstances.

Facts

An individual who is a spouse or family member of an executive branch department head or supervisor seeks employment with the State in the department where the family member serves. Individuals who are members of the same family, some of whom are dependents, are employed by the same department of State government. Over time one family member may be promoted or transferred into a supervisory role over the other.

Legal Authority

RSA 21-G:21, II; RSA 21-G:22; RSA 21-G:23; RSA 21-I:52

Analysis

RSA 21-G:22 prohibits executive branch officials from participating "in any matter in which they, or their spouse or dependents, have a private interest which may directly or indirectly affect or influence the performance of their duties." This section therefore precludes hiring, promotion and supervisory decisions from being made with regard to a spouse or dependent.

The conflict of interest statute, RSA 21-G:22, requires executive branch officials to avoid conflicts of interest. A conflict of interest is a "situation, circumstance or financial interest which has the potential to cause a private interest to interfere with the proper exercise of a public duty." RSA 21-G:21, II. Although the Legislature has not defined this further as it relates to non-dependent family members or spouses, the Committee recognizes there may be private interests other than pecuniary ones that could well come into consideration and violate the Ethics Code. For instance, if the family member hires their, brother or aunt out of loyalty or affection, they are allowing their private interest, their relationship with that individual, to interfere with their proper exercise of a public duty, in this case, of conducting a fair and impartial hiring process.

In describing the common law on conflict of interest, the New Hampshire Supreme Court has described the restriction as follows:

> In New Hampshire the requisite personal interest has been defined as a pecuniary interest which is immediate, definite, and capable of demonstration; not remote, uncertain, contingent and speculative, that is, such 'that men of ordinary capacity and intelligence would not be influenced by it.

> *Marsh v. Town of Hanover*, 113 N.H. 667, 673 (1973)(internal citations and quotations omitted).

A spouse or dependent family member has a personal financial interest in employment. Therefore, a decision to fill a vacancy where the decision maker's spouse or dependent family member is a candidate for the position is a situation which has the potential to cause the private interest to interfere with the proper exercise of the public duty to select the most suitable candidate.

Once employed by the State, the spouse or dependent family member has a personal financial interest in retaining that job, obtaining pay increases, and promotions. Therefore, a supervisory decision to discharge or retain, to change compensation for, or to promote a spouse or dependent family member has the potential to cause the private interest to interfere with the proper exercise of the public duty to make supervisory decisions in the best interest of the people of the State.

A department head or supervisor is required by RSA21-G:22 not to participate in such hiring or supervisory decisions, therefore, recusal is required. Recusal means not participating in deliberations, making recommendations, giving advice, considering resumes or evaluations, or in any other way assuming responsibility for or participating in any aspect of the work or decision-making relating to filling the vacancy or supervising the spouse or dependent family member. Recusal from supervision will typically require establishing an alternative supervisor for the spouse or dependent family member. Likewise, because there may be a non-pecuniary conflict with other family members, the same process as discussed above should be utilized.

The ban on a department head or supervisor participating in the decision to hire or supervise a spouse or dependent family member does not bar that person from seeking or obtaining employment with the department. The Human Rights law, RSA chapter 354-A, prevents discrimination in employment based on marital status and discrimination generally based on familial status. While New Hampshire courts have not addressed the question, the Minnesota Supreme Court has found that an anti-discrimination statute very similar to RSA chapter 354-A prohibits enforcement of an employer's anti-nepotism rule. *Krafi v. State*, 284 N.W. 2d 386, 387 (Minn. 1979).

New Hampshire's legislature has not established an explicit anti-nepotism law. The United States and several states have adopted explicit anti-nepotism laws. 5 U.S.C. § 3110; Missouri Constitution Article VII §6; Louisiana LSA-R.S. 42:1119. These and other anti-nepotism statutes reflect significant policy choices with some limited to immediate family and others extending out to four degrees of consanguinity. Some prohibit only immediate supervisory relationships while others bar any form of employment within the same department.

RSA 21-I:52 prohibits the consideration of political considerations or the receipt of any other consideration in hiring, compensation, and promotion decisions to positions in the classified service. It does not apply to positions outside the classified service and it does not include familial relations as a prohibited consideration.

In light of the presence of the Human Rights statute and the absence of an explicit anti-nepotism statute, extending the prohibition on conflict of interest beyond a requirement of recusal for the department head or supervisory family member is a policy decision properly made by the legislature.

The misuse of position statute, RSA 21-G:23, prevents an executive branch official from using "his or her position with the state to . . . secure governmental privileges or advantages for others." Each time anyone is employed by the State some executive branch official has used his or her position to secure a governmental privilege, employment, for another. Until the legislature clarifies what improper conduct is necessary to make the securing of a governmental privilege for others unethical, it would be an unjustifiable conclusion that this statute prevents a department head or supervisor from participating in decisions regarding the employment or supervision of a family member.

A department head or supervisor who violates the ethics statutes may be charged with a misdemeanor or may face disciplinary action. RSA 21-G:34. Furthermore, departments are authorized by RSA 21-G:27 to establish supplemental ethical codes. Executive branch officials should review their department ethics code to determine if a more restrictive departmental anti-nepotism code applies.

Conclusion

An executive branch official has a duty to recuse himself or herself from the selection of a candidate to fill a vacancy when his or her spouse or dependent family member is a candidate for the position. An executive branch official also has a duty to recuse himself or herself from supervising a spouse or dependent family member.

Although RSA 21-G:30, I (c) only addresses spouse and dependents, the Committee recognizes that other family relationships could present conflicts as well with respect to non-pecuniary interests. The Committee does urge those individuals with hiring and supervisory authority to be mindful of the possible appearance of impropriety or a conflict of interest when dealing with hiring and supervision involving family members.

This Advisory Opinion is issued by the Executive Branch Ethics Committee on April 2, 2008, pursuant to RSA 21-G:30, I (c).

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