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# *2017 NCSBN Discipline Case Management Conference* - Effective Complaint Triage Processes Video Transcript



**Event**
2017 NCSBN Discipline Case Management Conference

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**Presenter**
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- [Jeanine] There's a lot of nurses in the audience, so I want to ask you if you know the difference, how can you tell the difference between a graduate nurse and an experienced nurse? The nurses will get it. The graduate nurse wants everyone to know that they're a nurse. They wear all the pins, they have it on their rear view mirrors, they tell everybody they're a nurse. And the experienced nurse, they don't want anyone to know. You know exactly what I'm talking about. Okay, so we're going to talk about effective complaint triage processing, and we're going to talk about triage practices and also the legal aspects of triage. Now, because we're experienced nurses, we know that we can't just come up with stuff on our own, we have to involve people with greater knowledge, I'll come back to, back to it, there we go. So, the CORE, let's see if we can get there again, CORE stands for commitment, ongoing, regulatory, excellence. There it is. And it is a subcommittee that was comprised of 10 states that were well-known for high performing in their area, and they got together and they came up with this plan of care if you will, from a nurse's perspective, so they have a plan of care. So, a lot of great minds went together to put this together. Why is it important to have a standard plan when you're triaging? Well, it's public protection, right? So we need to do this systematically, we need to do it in unbiased manner, and it needs to be the same every time we do it. So, investigative evidence obtained guides decision making, so we know what's appropriate for all case resolutions. We have limited resources, so we need to use them most efficiently and as effectively as possible. And because investigations and disciplines are the largest expenditure for most nursing boards, we need to get it right or we're going to hear about it. So we can see that nursing is the largest regulated population, and with the 20 boards of nursing that were surveyed, it's about a $57 million budget. And if you think about each investigation, the average is about $2,800 per investigation. So what do we do? We take the wisdom of the experts, we got some guidelines and thresholds for opening up cases, we were able to focus on high risk, high harm cases. We talked about timely complaint resolution and the right outcomes which enhanced public protection, and it's appropriate and defensible, and Emma's going to talk about the defensible side of it, when it comes upon identifying and collecting relevant information and evidence. So what does this plan consist of? Well, it talks first of all about standardizing the online complaint, because everything starts with the actual

complaint. Now if you have a standardized form, you're going to get the same information every time. Most importantly, you're going to get the information about the respondent knowing the contact information, the way that they served or in which the complaint was gained, the guided narrative of who, what, when where and why, get all the information you can, witnesses, contact information, and in some cases uploading information. Again, it informs the complainant of information that's needed, so they know what they need to provide, it's consistent across the board. And because that consistency actually facilitates the ability to timely assess the risk and harm and assigns the priority status, and that simplifies the assignments of the complaint when we're assigning it to an investigator. The second suggestion is that we establish thresholds for opening and assigning complaint investigations. Some issues, or some violations, may be, yeah, they're violations, but maybe they're 10 years old, so they don't really meet that threshold. So if we have a consistent threshold for opening the complaints across the board. For instance, AZBN policy, the Arizona Border Nursing, they have three major areas of actions in other jurisdictions, arrests/convictions and practice related allegations. So in those three areas we have thresholds for each of those areas. You're obviously going to want to establish clear guidelines and policies which outline that complaint intake decision making process, or everybody is following the same rules. You're going to designate a primary person accountable for the receipt an assignment of the complaints, one person doing it all the time makes it more reliable. You're going to assign the case a priority risk level, and that's basically done on the initial information that you have. So we want to make sure that the highest risk to the public gets the highest level of risk assigned. And how do we do that? Nature, severity of the complaint. A priority one is obviously a high harm, it's an imminent threat to the public, something's going to happen if we don't do something. Priority two is the medium risk, medium harm. And priority three being low risk and low harm. So obviously, the higher the risk, the higher the harm, the higher the priority. Priority one risks are going to be, again, those immediate investigations, you want to get them done as soon as possible. Here's some of the violations which may put them in that category. Significant abuse, sexual conduct, significant injury or harm impairment. I'm going to read them all to you. Medium risk, these are ones that are considered priority two. They're important but not necessarily a substantiated danger, diversion of prescription, fraud, and diversion of a drug fraud or prescription, maybe some sexual misconduct or boundary issues. You can see the list there, practicing beyond a scope. And then the third or the low risk, low harm cases, these could be documentation errors where there's no harm, maybe some verbal abuse, abandonment, that kind of thing, sleeping on duty. And some jurisdictions have a priority four, which would be like an educational deficiency. Other plans of care, assign an investigator based on the expertise and capacity. That would be great, if we had a nurse that specialized in everything, but we do the best that we can, and we assign the cases to the investigator that has the most relevant information. Also a good idea to assign multiple complaints on the same licensee, to the same person, where there's really no point in starting over again. So if they have one, two, three complaints, just assign him all to the same person. Likewise, if they have multiple people involved in the same issue, multiple nurses involved in the same issue, that prones to go to the same investigator as well, because the base story stays the same, it's the players that change. And then you're going to standardize the form to document the complaint and triage activity that makes it much easier when you know what direction to go, so which subpoenas need to be sent out, where they were sent, other documents that need to be obtained, and just tracking the information. Make sure that all the licensees or individuals, don't track them by license number but track them by the individuals, and then you also want to track investigative cycle timelines. I'm going to turn it over to the legal side of complaint tracking. - [Emma] So my portion of this presentation, I'm going to talk about the legal theory and analysis that provides a foundation for the triage practices, policies, and processes that we use. And really the point of that is, you're asking why is this important, why is this relevant, particularly for the

non-attorneys is, even if we have the best practices in place, the best policies in place, if you end up getting legal challenges, it really can be a huge detriment to the agency in terms of resource allocation. So even if the agency ends up prevailing in court, the whole process of going through litigation is extremely draining our resources. A court of appeal's case can easily take 100 attorney hours, and pull that attorney, whether it's an assistant attorney general or in-house counsel off of litigating other cases, and that really puts a strain on the agency's ability to protect the public, because cases, including high risk cases that need to be addressed at hearing, are going unaddressed because the agency has become mired in a legal dispute. So, I will be talking about primarily, the Arizona Nurse Practice as a model for this discussion, and I recognize, I didn't know we had international visitors, which is just very exciting. But other states have very different legal practice acts. But I know that some of them are similar, and I'd be interested to hear if other people have different perspectives. I broke my presentation into three parts, the opening, processing, and closing of complaints. I don't like to read my slides, so I'll let you read what's in your materials and I'll embellish on that. Part one is regarding opening complaints. So the legal authority to investigate and just... So there's really no point in opening a complaint. And I apologize if some of this is a little bit basic, but I think just to set the foundation for our discussion, as you all know, there's no point in opening a complaint if ultimately the agency is not going to be able to take action on the complaint even if the allegations are substantiated. So we look at the legal authority that your board has to investigate and discipline found both in the Practice Act and also in case law, and that's where the nexus to practice is, both pieces of that. In Arizona, our Nurse Practice Act has very broad authority to conduct an investigation upon receipt of information. That's the language in our statute, is just upon receipt of information. So that can be either from a public complaining, a patient, or even board staff themselves occasionally will be investigating one issue and will end up discovering other issues, and that's acceptable under the Arizona's statutory framework. And then, the violation itself in the in the... I don't have the complete statutory language there, but what the statute says is that the information indicates that there may have been a violation of the entire Nurse Practice Act. If that occurs, not only can there be an investigation, but the board can take disciplinary action. So in Arizona, our Practice Act, and again, there are different regulatory structures in different jurisdictions, our Practice Act covers both actual and potential harm. So we don't need to wait until a patient is actually harmed before we can take action in our statutes, and that's very helpful because it allows us to take action for things like DUIs. How many of the people here, how many people are working in jurisdictions where you could take action for like a DUI? Is that most of you? Okay, but not all, I see some people are not... How many cannot take action for something that's not directly related to practice? Is there anyone? Okay, so we do have a few. And then in addition to the ability to take action both for potential harm, meaning concerning conduct that hasn't risen to the level of actually hurting anybody yet, we also can take action both for patients, actions that are related to patients, and also in our statute specifically says "or the public." So, I'm going to talk now about the nexus to practice, and what I mean by that is, is the conduct either directly part of the nursing practice, or is it related to the nursing practice? So if nursing practice isn't directly involved, can you still take action? Can you still open a complaint? In Arizona, again, with our statutes, it refers to patients and the public, so yes, we can. And then there are some violations in Arizona that do depend on the practice. We for example have a rule, it's kind of our catch-all rule for practice that makes it a violation for a nurse who is practicing in any other manner that gives the board reasonable cause to believe the health of a patient or the public may be harmed, so that's very broad. And one of the things that we train our investigators is that we only apply that to actual practice cases, so obviously we wouldn't use that violation for DUI, because it wouldn't be defensible in court. Again, that's where we're trying to avoid getting to have to litigate the legality of the board's actions, because we don't want to either not be able to protect the public or to have to use all of those resources. So in

addition to our Nurse Practice Act, that we have this very broad language and we use the term "public," we had a case several years ago that has become a very important case, a seminal case in Arizona that talks about the nexus issue, nexus to practice. And I really enjoy talking about this case because it's so Arizona. I'll get into the facts a little bit. It's kind of harkens to the old Westerns, or the Wild West. The only problem with it is it's set in Buckeye, Arizona instead of Tombstone. That would have made it a little bit better, but... So, Cloude Winters was a certified teacher, certified through the Arizona Board of Education. He was a fairly new teacher, and I don't have personal knowledge of this case, just everything comes from reading it. But we've litigated it and used in a lot of cases. The board ultimately revoked him due to five separate incidents that occurred over about a two year span. And I know, I just kill the suspense here, but we'll get into the facts, they're kind of fun. So, Winters was a teacher, and there's actually nothing in the case that talks about his teaching, so nothing, no criticism of his teaching, no criticism of his conduct at the school, in the classroom, none of that. He was not perhaps your ideal neighbor, however. And I also want to point out that I don't know if any of you have spent...well, I know of some of you have spent quite a bit of time in Arizona, but for those of you who haven't, summer starts in about April, and it ends say in late October, maybe November. So I don't think it's a coincidence that when I go through the incidents you're going to note that all of them occurred between April and October, because we're talking 90s, 100s, 110 plus temperatures, and people get very ornery during that time of year. So the first incident that occurred with Mr. Winters was he had...and I'm going to go through this in detail, and there's a reason, because it really kind of reflects Mr. Winter's conduct issues, and that became a core issue in the case. So the first incident, Mr. Winters had a verbal altercation with a 21-year-old neighbor. That was ultimately dismissed by the Buckeye magistrate court. The second incident, Mr. Winters had complained to the Buckeye police department that a rock was thrown through the front window of his home. Again, we're having some neighbor issues here, I'm thinking having some clan fighting. Later that same evening, and I love the way it's worded in the case, it says that, "Mr. Winters loaded 357 revolver, discharged and damaged the neighbor's air conditioning unit." And it doesn't say he did it, it just said it discharged, it's very interesting how they worded that. And I also again...this is another Arizona thing, or anywhere where it's really, really hot to shoot out your neighbor's air conditioning unit, not particularly kind. And I know May sounds nice in some parts of the country, trust me, it's quite hot. So the third incident was when Winters and a different neighbor had a physical altercation in the street outside their homes. They were both charged with disorderly conduct, that was ultimately dismissed but the court and the board still considered it. Fourth incident, we're still going strong Mr. Winters, he threatened an individual who happened to be an 18-year-old former student of his, they got into a big argument at a convenience store. The prosecutor declined to prosecute, but again, the board and the court still considered that conduct. The fifth incident was my personal favorite, was where Mr. Winters and a neighboring family had, they both had protective orders against each other. And Mr. Winters violated the order of protection by threatening the neighbor's children, he told the children that they had, and this is a quote from the case, "They had better sleep with one eye open." So, he also told the Buckeye chief of police that if nothing was done about this situation, something might happen. So he was sentenced to a supervised probation for that one, and ordered to participate in anger management counseling. So the case went to court, and the board had taken an initial action to revoke the certificate. Mr. Winters argued that his conduct did not affect the operation of the school or adversely affect the teacher-student relationship, because again, nothing happened at the school. But again, he's threatening children, a former student, his dangerous and violent conduct, the physical fights, the discharge of the firearm, the court found that the tendency to react with violence was serious and was enough for the board to go ahead and revoke. So again, that case is helpful to us because it informs how we proceed with those types of cases where there is conduct outside of the practice. Part

two I'm not going to spend a lot of time on, the processing of complaints, because Jeanine did a nice job of reviewing that. The efficiency I think probably as regulators you all get that, and really the question is, how do we get there legally? What is the structure that we use? So in Arizona we use delegated authority, and what I mean by that is that the statutes in Arizona allow the executive director or her designator, meaning other board staff, to make a lot of decisions. And we use the board for guidance, so we use board approved policies, policies that staff develop sometimes after receiving direction from the board on various topics, including triage of course, and sometimes there are policies that the board or staff comes up with and brings to the board and asks for review and approval. And then the staff will implement those policies. And I'm curious, how many people here work for boards that do have such delegated authority to be able to allow staff to make the decision to close or to not open complains? Now, looks like a majority of people. How many here work for boards where every complaint before it can be closed has to go before the board? Okay, interesting. So obviously that's something to consider when looking at the policies. And as Jeanine covered, the bord has policies, and you have one in the back of your materials for this presentation, is our triage or criteria for opening complaints and investigation, we call it the triage policy. And it is, as you'll note, it's very detailed, it's very specific. And the point of that is to make it fair, and make it easy for staff to be able to use it and apply it, and it's also legally defensible because it is standardized. As much as you can, as regulators you know that every case is a little different, you have a Mr. Winters, sometimes you have somebody…you know, you have your routine DUIs too that are pretty straightforward. But we do get routinely challenges at the board, racial allegations, things like that, and being able to show that we are using a standardized process is really helpful when defending those types of allegations. Part three, I will talk about closing complaints. The benefits are fairly obvious, of weeding out those cases that are not as serious, not high risk, not high harm, with our goal being public protection to really be able to focus our limited resources on those cases that are most likely to harm the public and to sort them quickly. But I will be talking about the risks. So what happens if the cases are not processed quickly? And I have some cases from other states here to talk about, a couple of cases from Maryland. Do we have anyone here from Maryland? No? Okay. Well then I can't be corrected when I present the case. So, the cornfield case was, as a woman reading it, very disturbing. It's a medical board case, the physician involved was an OBGYN surgeon who left his female patient unattended while she was under anesthesia, and then he was investigated by the peer review committee at the hospital, and it was determined that he lied to the peer review committee, and he also lied about an equipment failure. The board wanted to take action against his license, and he argued that he had not...first of all, the board had exceeded their timeframe to take action, because in Maryland there's a statute that requires expeditious disposition of complains within 18 months of receipt. And he also argued that there was no nexus to his practice because the allegation was not just that he had provided substandard care, but that he had lied to the peer review committee, and he was arguing, "That's not the practice in medicine, you can't discipline me for that." So there's an interesting discussion in the case about nexus to practice. And what the court ultimately decided was that the peer review process itself is part of the practice of medicine, and that because of that, lying to the committee was a violation of the Nurse Practice Act. Additionally, the court went into a lot of detail about the timeframe and the fact that the board had exceeded the timeframe. The court found that this timeframe is directory versus mandatory, and what that means essentially is that there is no penalty to the board for being late, and the court refused to dismiss the case. What the statute said is this, if the board does not expeditiously dispose of the complaint, that they must provide an explanation for the delay. And the board was able to do so, maybe not to the satisfaction of the physician, but the court found that it did not result in dismissal. Again, so the board came out succeeding in this litigation. However, you can only imagine how many resources were used in the process. The next case is also a

case out of Maryland, because they have this 18 month statute. This case has some different issues though that I thought were informative. I call this the no good deed goes unpunished case, because in this particular case the board was concerned with the physician's practice regarding her forms for patient consent and disclosure. And the board sent this physician a notice explaining their concern and saying, "We're going to close your complaint for now, but we're going to come back in six months, revisit it, to verify that you've made the corrections we're asking you to make." So sure enough, six months later, the board came back and issued a subpoena, this is taken for the forms to verify that the physician had made the corrections that they had directed. And the physician filed a motion to quash the subpoena, and argued that the board had closed the complaint, they had no right to reopen it, and this was merely a fishing expedition. So, the reason is the no good deed goes unpunished, is that, the court found that the board had only closed the complaint for the benefit of the physician. The board did that so that the physician wouldn't have this complaint hanging over her head, so when she went to get credentialing at a hospital, she didn't have to disclose that she had a pending complaint with the board, that's the only reason that they closed it. And they specifically talk about that in the case. And the court found that, again, this 18 months requirement was simply directory, and they refused to dismiss the case, or to quash the subpoena actually in that case. The Cooper case is a case out of Illinois. And it's about a daycare. It was regulation through the Department of Children and Family Services. This daycare operator was cited for having a dangerous daycare, there were insufficient staff ratios, and I believe they didn't have cleaning materials locked up properly and that kind of thing. But it was also boring apparently, they didn't have enough toys, they were cited for not having enough toys for the kids. So the court found that, again in this case there was a requirement for the agency to hold the hearing within 30 days. In this case, again the court found that that was directory because the law did not prohibit the agency from performing after a certain amount of time. It didn't specifically say the case will be dismissed, instead it allowed the daycare operator to continue. The court said in that case that if the timeframe is safeguarding someone's rights, that's when it's mandatory, otherwise it's directory. And the court did get into a discussion, this is partly why I talk about the facts besides they're kind of more interesting than the legal theory sometimes, but the court did say that protecting kids was important, so there was a strong public policy reason not to dismiss the case. Again, risks of closing complaints. Really the issue here is, what if you close these complaints early, because you're being supper efficient, you're closing the complaints early, but then something happens where you need to reopen it. What risks is your agency facing at that point? Are you going to be able to reopen? If you do reopen, are you going to get a legal challenge? Are you going to be able to proceed? Are you going to end up again, mired in litigation? So the times when you might need to reopen, and I'll get into this in more detail, is when you're trying to establish a pattern of conduct, you need to consider if there are limitations to opening them, and if there's any liability to the agency for not acting quickly. So, I think, again, you all probably are very familiar with the concept that a fresh new complaint is easier to litigate or to pursue as both an investigator and as an attorney, because everything is fresh, it's right there, you don't have to go hunting down witnesses, everyone's available, the records are available, you're not trying to find records that are 5, 10 years old that may have been purged or lost, people still remember what happened, all of that, and of course, with older cases, it's the opposite - you can't find people, people don't remember what happened. So obviously there's a huge benefit to trying to get to cases early, but if there's an early closure to a case, what can happen? Well, we have this happen occasionally at our board, and I'm sure you probably do at yours as well, where we may close for example an old DUI, someone applies for a license and they have an old DUI, that wouldn't be something that we would typically investigate. However, if that person then has another DUI, our rule in Arizona requires that we prove that there is a pattern of using, or being under the influence of alcohol, drugs, or similar substance. And again, I'd be

just curious, how many of you have requirement to prove a pattern for substance use disorder or repeated use, or something where you would need more than one incident? Could I see by a show of hands? I'm not seeing a lot of hands, just a few. Okay. So I guess that's pretty unusual. It is sometimes helpful not only to show that to the court to demonstrate the history of substance use disorder, severity of the conduct, severity of the illness, but also when we have for example, patient allegations from a patient who may have dementia, Alzheimer's, some kind of condition or brain injury, something where that patient has...there may be a credibility issue, because it's really hard to determine whether that person, the patient, or a person is accurately reporting. And then we've had this happen before in our board, where we have a patient making allegation very peculiar of a sexual nature against a regulated person, and it's isolated, we don't have any corroboration and the patient either may be elderly and may actually pass away, or may not be completely cognitively intact, and so we really can't proceed, there's just not enough evidence, there's no other witnesses, that type of thing. And then maybe a year later, we get in another one that's almost identical, and there are very specific, factual allegations that are unique to that individual. So then we need to go back and revisit that old complaint to see if we can corroborate the current allegation. And that can be, obviously, as you know, very difficult. I want to talk about this California case, it's Long versus... Oh no, I'm sorry, this is a Massachusetts case, the Board of Registration of Real Estate Appraisers. In this case, the board tried to discipline the licensee as a repeat offender going back and looking at prior conduct. And this is a...you know, maybe it's unique to this particular case, but it was an interesting discussion about how this board tried to bootstrap in that first offense. This real estate, I believe it was an agent, had...it wasn't an appraiser, I'm sorry. He had a 17-year-old OUI conviction that he failed to disclose on his initial application and on subsequent renewal applications, and the board finally found out about it, and then they went back and tried to treat him as a repeat offender. And it's a summary decision, it's a short and it's not binding, but what the court said was that this board could not do that. They could not treat this individual as a repeat offender even though he committed repeated offenses and they could prove it. That there was no dispute about those facts, at least not in the decision. They couldn't just jump ahead in the repeat offender penalty, they had to go back and treat him as a first offender, because they hadn't taken action initially, and presumably, that was because they hadn't caught it. The court in that case also talks about how the board may have imposed a harsher sentence on this individual due to the board's consideration of unadjudicated earlier conduct, meaning that this board even though they're saying now what we...what the board ended up arguing was, we have the right to sanction this individual, we can prove that he's committed these offenses of failing to disclose repeated times. And even though maybe we shouldn't have considered it as a prior offense, that he didn't disclose on his initial application, we should still be able to penalize him. The court said, "You're considering an issue that didn't go through the hearing process, he didn't have an opportunity to defend himself, this wasn't adjudicated, so you should not even be considering it." Some of the...and I'm going to try and wrap up here because I see I'm almost out of time, some defense arguments that may be made to early disclosure, if you want to go back and revisit it our race judicata, which is, essentially means that this case, this complaint was already decided legally. And so in that case, the consideration is, did the complaint go before the board, or was it closed by staff of the administration? Obviously, if there's a hearing, you're going to have a very strong race judicata argument, but even if the case has gone before the full board, does that weaken your case to go back and reopen at that point? There may be estoppel arguments, meaning that at the point the board closed the complaint that the other side was assuming that it wasn't going to be reopened, relied on that. Legal restrictions on reopening previously closed complains that some...well, actually the only state that has that I know of, and if any of you have others, feel free and jump in, an actual limit is California three year limit on taking action. Generally, I did talk about Maryland as well having that discretionary

limitation in Illinois in certain parts of the case. New Mexico has an interesting rule that says that although there is no statute of limitations, that older cases, and I think probably most courts do this anyway, but it specifically says that older cases will be treated differently in terms of the sanction. There's a new Arizona statute that has several exceptions that requires the age of the actual conduct to be no more than four years old before the complaint is filed with the board. So that's not actually a board action, it's more about when the complaint is filed. There are exceptions for medical malpractice in some more of the serious violations, felonies, sexual misconduct, impairment on duty, that type of thing. So what risks are there to the agency for not taking action? And this, again, if you're closing complaints, what type of risks might there be to your agency? This is a California case in which the real estate commissioner failed to take action against a broker who was stealing clients' money. There were multiple clients involved, and they filed a class action negligence lawsuit against the defendant real estate commissioner arguing that the commissioner's failure to act after the investigation was the cause of their injury, the proximate cause of their injury of…so essentially commissioner, had you just revoked this broker, we would not have had our money stolen. And the trial court found that the commissioner was not immune. So a lot of states have immunity for their agencies. The trial court said, not immune. However, the appellate court found that there was no proximate cause. In their analysis they found that, yes, the defendant commissioner had a statutory duty to investigate the broker. And yes, that law was meant to protect the plaintiffs in this case, but the court found that the failure of the commissioner to act was not the proximate cause because there was not a duty to take a specific action, meaning that even though there was an investigation, there was not…and they actually got into the Webster's dictionary definition of investigate, saying that investigate does not mean take action. They're saying even if the commissioner had timely investigated this and had taken action, there's no saying that they would have necessarily revoked, so they would not find for the plaintiffs in that case. They also said that there's a risk to the public. It's bad public policy, not a risk to the public, this is bad public policy to require the commissioner to warn the public because of the reputational harm to the broker. So there's a discussion of that in that case. Okay, I think we've already covered this, and I see that I'm out of time, so I will not cover that slide. I don't know if there are any questions. Thank you.