



# **The Colorado Board of Medical Examiners and The Colorado Nursing Board**

## **Performance Audit**

**November 2001**

**Submitted to:  
The Office of the Colorado State Auditor**

**Prepared By:  
Sjoberg Evashenk Consulting, LLC  
455 Capitol Mall, Suite 700  
Sacramento, California 95814**

**LEGISLATIVE AUDIT COMMITTEE  
2001 MEMBERS**

*Representative Fran Coleman*  
**Chairman**

*Senator Jack Taylor*  
**Vice-Chairman**

*Senator Norma Anderson*  
*Representative Glenn Scott*  
*Senator Stephanie Takis*  
*Senator Ron Tupa*  
*Representative Val Vigil*  
*Representative Tambor Williams*

**Office of the State Auditor Staff**

*Joanne Hill*  
**Acting State Auditor**

*Larry T. Gupton*  
**Deputy State Auditor**

*Heather Sanchez*  
**Legislative Auditor**



**STATE OF COLORADO**

Joanne Hill, CPA  
Acting State Auditor

**OFFICE OF THE STATE AUDITOR**

(303) 866-2051  
FAX(303)866-2060

Legislative Services Building  
200 East 14th Avenue  
Denver, Colorado 80203-2211

November 1, 2001

Members of the Legislative Audit Committee:

We respectfully submit the results of our performance audit of the Colorado Board of Medical Examiners and the Colorado Board of Nursing at the Department of Regulatory Agencies. We conducted this audit pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government.

This report was prepared on behalf of the Office of the State Auditor by Sjoberg Evashenk Consulting, LLC, and includes our findings, conclusions, and recommendations, and the responses from the Board of Medical Examiners, the Board of Nursing, the Division of Registrations, the Department of Regulatory Agencies, and the Office of the Attorney General.

Sincerely,

Joanne Hill  
Acting State Auditor

---

## TABLE OF CONTENTS

---

	PAGE
<b>REPORT SUMMARY</b> .....	1
<b>Recommendation Locator</b> .....	5
<b>OVERVIEW</b> .....	9
 <b>FINDINGS AND RECOMMENDATIONS</b>  	
<b>CHAPTER 1. LICENSING OF PHYSICIANS AND NURSES</b> .....	13
<b>The Boards' Licensing Activities Comply With Laws     And Regulations</b> .....	13
<b>Self-Disclosure Requirements for Licensure Renewal Differ Between     the Two Boards</b> .....	19
<b>The Nursing Board Can Improve the Effectiveness of Nurse Aide     Background Checks</b> .....	20
<b>Other States Conduct Background Checks for Nurses and Physicians</b>	22
<b>CHAPTER 2. COMPLAINT INVESTIGATION PROCEDURES</b> .....	25
<b>Improved Case Management Systems Would Benefit Both     Boards' Enforcement Activities</b> .....	25
<b>Documentation in Complaint Files Can Improve</b> .....	29
<b>Reengineering Project Recommends Business Process Changes</b> .....	32
<b>Complaint Processes Lack Performance Measures</b> .....	34
<b>Current Automated Case Tracking System Includes Stale Data</b> .....	38

	<b>PAGE</b>
<b>Tracking Referred Enforcement Cases Is Difficult .....</b>	<b>40</b>
<b>Additional Attorney General Funding Achieved the Goal of Reducing Nursing Board Case Backlog .....</b>	<b>44</b>
<b>Board Actions Can Prevent Development of Another Backlog .....</b>	<b>45</b>
<b>CHAPTER 3. PROBATION MONITORING .....</b>	<b>49</b>
<b>The Medical Board Needs to Better Enforce Probationary Requirements .....</b>	<b>49</b>
<b>The Medical Board Needs to Strengthen Controls Over Practice Monitoring .....</b>	<b>51</b>
<b>The Nursing Board Adequately Monitors Its Probationers .....</b>	<b>54</b>



Joanne Hill, CPA  
Acting State Auditor

**Colorado State Board of Medical Examiners  
Colorado Board of Nursing  
Performance Audit  
November 2001**

**Authority, Purpose, Scope**

This performance audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the Office of the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit focused on the regulatory responsibilities, operations, and activities of the Board of Medical Examiners and the Board of Nursing. A contractor, Sjoberg Evashenk Consulting, LLC, performed the audit work. To determine the effectiveness and efficiency of the two boards' operations, the auditors interviewed representatives from both boards, the Attorney General's Office, the Division of Registrations' Complaints and Investigations Section, and medical and nursing board staff from other selected states. Auditors also assessed and tested the boards' goals and objectives, key functions and procedures, and results of activities in the areas of licensure, complaint resolution, enforcement, and discipline. The audit work, performed from April to October 2001, was conducted according to generally accepted government auditing standards.

**Better Case Management Tools and Process Improvements Would Enhance Medical and Nursing Board Activities**

The Department of Regulatory Agencies mission is to serve the public through responsible regulation and the vigorous and fair enforcement of Colorado law. Within the Division of Registrations, the Board of Medical Examiners and the Board of Nursing seek to protect the public by effective licensure and enforcement of the specified healthcare professionals under the boards respective jurisdictions. Generally, each board evaluates applicants for medical or nursing licensure, grants licenses to qualified candidates, investigates complaints against licensees and, as appropriate, metes out disciplinary actions and oversees the resolution of cases.

Our review reveals that the Board of Medical Examiners and the Board of Nursing both consistently fulfill the respective statutory responsibilities bestowed upon them. Generally, we found both boards demonstrate compliance with laws and regulations in their respective licensure, complaint and enforcement activities and that they perform these functions typically in a timely manner. Complaints and related enforcement efforts are also handled consistently and in the public's best interest. We believe that the two boards could provide enhanced services and operate more efficiently with an improved case management system and by implementing some process milestones and performance measures.

*For further information on this report, contact the Office of the State Auditor at (303) 866-2051.*

## **Mandate Self-Disclosure as a Requirement for License Renewal**

Both the Medical Board and the Nursing Board require all candidates seeking initial licensure to self-disclose any information relating to potentially unacceptable conditions such as a criminal history or substance abuse issues. Board staff review this information to determine if the applicant has any issues that could prohibit licensure under the practice act. In addition to the disclosures provided in the initial licensure packet, the Medical Practice Act also requires licensees seeking renewal to complete another self-disclosure questionnaire. As a result, every two years, physicians and physician assistants are required to self-report any potentially unacceptable information that could impact the application for renewal. However, the Nurse Practice Act requires only initial applicants to self-disclose this type of information—license renewals do not require such disclosures. Thus, the Nursing Board may continue to renew the license for individuals who may develop criminal histories, substance abuse problems, or other matters that would endanger their ability to maintain a license under the practice act. **We recommend that the Nursing Board work with the Department to seek statutory changes that mandate renewal applicants to complete a self-disclosure form.**

## **Self-Disclosure Requirements Differ Between the Two Boards**

Issues came to our attention at the Nursing Board involving the requirement of lifetime background checks for nurse aides. One issue involves lifetime background checks of nurse aide candidates. Under current practices, nurse aide applicants obtain background checks using private contractors. These checks are intended to identify any history of criminal activity throughout an applicant's life and are based on names and birth dates. However, some contracted background checks do not adequately identify criminal history. In fact, we found seven instances where nurse aide applicants self-reported criminal histories but the formal background checks missed this information. Our tests of these same seven candidates through the Colorado Bureau of Investigation and the Judicial Department identified histories in four of the seven instances. Thus, it appears that the self-reporting process is more effective in identifying potentially disqualifying matters than the formal contracted or state-performed background checks.

The Colorado Bureau of Investigation (Bureau) indicates that fingerprint checks through Colorado's database are more accurate than background checks because this method eliminates the possibility of improperly identifying records belonging to others having the same name and birth date. However, according to the Nursing Board, even Bureau reviews have limitations; the Bureau's database may not include arrests and convictions in states other than Colorado and its search may not fully disclose conviction information. The Bureau maintains that the most effective method in identifying criminal histories is running fingerprints through national databases but this requires specific statutory authority to ensure confidentiality and to gain national access.

The other issue we identified relates to Colorado's requirement for lifetime background checks of nurse aide applicants—physicians, physician assistants, practical and registered nurses, and psychiatric technicians are not required to submit such a report. Rather, these other nursing and healthcare professional applicants need only self-report any criminal history on licensure application forms or by completing a questionnaire; the boards conduct follow-up research on those positive responses indicating potentially unacceptable conditions for licensure. **We recommend that the process be improved by requiring nurse aide candidates to obtain background checks through the Colorado Bureau of Investigations. Further, the board should consider adopting fingerprint screenings if a higher level of investigation is needed.**

### **Improved Case Management Systems Would Benefit Both Boards**

Our review of operations and activities revealed a few issues related to the complaint processes at both the Medical Board and the Nursing Board. Specifically, in our review of selected cases at both boards, we found instances where certain documents were difficult to locate in the files. Also, the case management systems used by both boards are not always up-to-date, as some of the cases we selected for review from the open status had actually been closed and not reclassified. We believe that the boards are completing the appropriate steps and obtaining the requisite evidence, but management controls and staff accountability could be strengthened by ensuring that all complaint files are complete and board activities fully documented. **Therefore, we recommend that the boards adopt procedure and document checklists to ensure that all files are complete and include all relevant documents.**

The boards lack a comprehensive system to track and monitor complaint and enforcement activities. Staff rely primarily on manual case files and an automated case management system with limited functionality. Therefore, we find that the boards would benefit from an improved case management system that would allow managers to proactively make assessments of compliance with rules and regulations using target dates, better monitor case progress, and allocate resources using real-time management information. Furthermore, by taking steps to mutually establish budgets and timeframes with external experts, the Division of Registrations' Complaints and Investigations Section, and the Attorney General's Office, the boards could more comprehensively monitor and track complaints through every aspect of the process. While we recognize that the Division's business process reengineering project envisions a division-wide case management system, it is essential that the Division and each board remain vigilant to ensure that any new system include the elements essential to the respective boards needs. **We recommend that, as the Division's business process reengineering project proceeds, the boards ensure that the appropriate action triggers, milestones, and performance measures are incorporated into any new case management system.**

## **The Medical Board Needs to Better Enforce Probationary Requirements**

Particular to the Medical Board's enforcement activities, we identified opportunities for improved monitoring and oversight. In the area of selecting practice monitors, we found that in two of our sampled cases monitors were not in place when the licensee's disciplinary probationary period began. As a result, up to seven months of licensee activities early in the probation period were not monitored and the board did not require that once monitors were in place that they go back and review the practice period that was missed. Moreover, while we found that the majority of case files sampled included most of the required monitoring reports, little evidence exists that staff actually reviewed them. Thus, the system has a weakness in an essential oversight component intended to assure the licensee complies with the terms of probation and that his or her practices are not endangering patients. **We recommend that the board not allow the probation period to begin until an approved practice monitor is in place. Moreover, the board can improve controls by requiring staff to initial and date monitoring reports upon review.**

## **Summary of Agency Responses**

The agencies agreed with all of our recommendations. Their responses are located in the audit report.

---

## RECOMMENDATION LOCATOR

---

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	20	The Department of Regulatory Agencies should seek statutory changes to the Nurse Practice Act that would mandate the Nursing Board to design a questionnaire and require all licensees seeking to renew their license to self-disclose any potentially unacceptable information.	Department of Regulatory Agencies	Agree	01/01/03
2	22	The Board of Nursing should improve its background check process for nurse aides by: a. Requiring candidates to use the Colorado Bureau of Investigation background check process. b. Considering requiring checks using fingerprints if a higher level of investigation is needed to ensure a more accurate investigation.	Board of Nursing	Agree	Upon Release of the Criminal History Task Force Report
3	30	Any case management system used or adopted should include process checklists specific to each board's activities to ensure documents are added to files, steps are completed, and staff are accountable for their actions.	Division of Registrations	Agree	6/30/03
			Board of Medical Examiners	Agree	01/01/02
			Board of Nursing	Agree	01/01/02

---

## RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
4	33	The Board of Medical Examiners and the Board of Nursing need to work closely with the Division of Registrations and follow the progress of the initiatives taken in response to the reengineering project to ensure that any system developed within that project include placeholders for inserting all relevant documents, such as complaint, 30-day letter, and the licensee response so that the automated case files include appropriate documentation.	Division of Registrations	Agree	06/30/03
			Board of Medical Examiners	Agree	06/30/03
			Board of Nursing	Agree	06/30/03
5	36	The Board of Medical Examiners and the Board of Nursing should: a. Review their respective complaint intake processes to understand the cause of long time lags to send out the initial acknowledgments and licensee response letters and initiate controls to assure the prompt completion of these steps. b. Establish performance goals for certain components of the complaint process to ensure that the case moves forward in a timely manner.	Board of Medical Examiners	Agree	01/01/02
			Board of Nursing	Agree	11/30/01
6	37	The Board of Medical Examiners and the Board of Nursing should work closely with the Division of Registrations to ensure that the new case management system includes triggers to monitor key aspects of complaint resolution and discipline and to automate rote processes such as automatically sending out standard correspondence and notifications.	Division of Registrations	Agree	6/30/03
			Board of Medical Examiners	Agree	06/30/03
			Board of Nursing	Agree	06/30/03

## RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
7	39	Board of Medical Examiners and Board of Nursing staff should take proactive measures to ensure that resolved cases are properly reclassified. Moreover, the Board of Medical Examiners and the Board of Nursing should ensure that only clean and accurate data are moved to the new system.	Board of Medical Examiners	Agree	Ongoing
			Board of Nursing	Agree	Ongoing
8	42	As each case is referred to the external experts, the Division of Registrations' Complaints and Investigations Section, or the Attorney General's Office, the Board of Medical Examiners and the Board of Nursing staff should initiate a process to assign mutually agreed to "budgets" or estimated timelines. The individual boards should set intermediate milestones or checkpoints to prompt proactive check-in calls to appropriate external groups. These timelines should be incorporated into the case file. At predetermined points, staff should contact the respective entity and obtain a brief update of the case status. Any new case management system should facilitate online updates, and staff should adjust the time schedule as appropriate.	Division of Registrations	Agree	01/01/02
			Board of Medical Examiners	Agree	01/01/02
			Board of Nursing	Agree	01/01/02
			Office of the Attorney General	Agree	01/01/02
9	43	The Board of Medical Examiners and the Board of Nursing should ensure that the Division of Registrations' reengineering project considers communications and information sharing needs between Division functional units, such as the Complaints and Investigations Section, and the regulatory boards. This may entail a process to grant access or share case information in the instances where work is being conducted by more than one of the entities within the Division.	Board of Medical Examiners	Agree	06/30/03
			Board of Nursing	Agree	06/30/03

---

## RECOMMENDATION LOCATOR

---

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
10	46	To ensure that the Office of the Attorney General continues to obtain the appropriate and timely disciplinary outcome on behalf of the Board of Nursing for all referred cases, both the Board of Nursing and the Office of the Attorney General should closely monitor the volume and resolution process of referred cases. Further, both entities need to ensure frequent communication of all issues that may affect the timely resolution of enforcement actions.	Board of Nursing	Agree	01/01/02
			Office of the Attorney General	Agree	01/01/02
11	51	The Board of Medical Examiners needs to improve controls over receiving and reviewing treatment monitoring reports by requiring staff to ensure their receipt and to initial and date reports upon review.	Board of Medical Examiners	Agree	11/01/01
12	53	To ensure the protection of patients, the Board of Medical Examiners should not allow physicians to continue to practice until the licensee has obtained an approved practice monitor. In addition, the probation period should not begin until the approved practice monitor has been obtained.	Board of Medical Examiners	Agree	10/01/01

---

---

# Overview

---

With a budget of over \$17 million annually, the Colorado Department of Regulatory Agencies (Department) is responsible for 28 boards and licensing programs created by the Colorado Legislature with the intent to ensure the competency of licensees and thus protect the public. Through the regulation of over 230,000 licensees in more than 30 professions and occupations, the boards and licensing programs within the Department share the following set of goals: to identify and license qualified practitioners; to conduct investigations and inspections to ensure compliance with generally accepted standards of practice, conduct or safety; to restrict or revoke licenses when generally accepted standards are not met; to communicate effectively to inform, educate, verify, and advise; and, to administer regulatory programs efficiently.

## **The Board of Medical Examiners Licenses Physicians and Physician Assistants**

The Board of Medical Examiners (Medical Board) regulates the practice of medicine of more than 14,000 physicians and physician assistants as of June 30, 2001. The Medical Board is authorized by and its responsibilities and practices are delineated primarily under the Medical Practice Act, Section 12-36-101 C.R.S. The original 9-member state Medical Board, established under the Medical Examiners Act passed by the Colorado General Assembly in 1881, set educational standards by developing a state medical examination and enforced these standards for nearly 100 years. Under existing law, the Medical Board no longer develops and conducts licensure examinations for physicians; rather like many professions, it relies on national examination processes.

The modern Medical Board focuses its attention on evaluating and granting licensure to practice medicine to qualified candidates, and when necessary and appropriate, issues discipline of varying degrees to physicians violating provisions of the Medical Practice Act. Moreover, the 13-person Medical Board through its oversight and efforts of its 11 staff members, assures that physicians on probation remain competent to safely practice medicine, provides information to the public regarding the status of physicians' licenses, and regulates categories of non-physician practitioners, specifically, licensed physician assistants.

State law and board regulations promulgate rigorous standards for practicing medicine in Colorado. Licensure candidates must provide a variety of documentary evidence to

support eligibility claims, including graduation from an approved medical school, specified postgraduate training, and passing one of the specified national examinations. The board stipulates slightly different and additional requirements for individuals graduating from medical schools outside of the United States or Canada. For all candidates, eligibility for licensure includes more than education, experience, examination and paying the fee; they must also "self-report" on a variety of issues including criminal history, drug or alcohol abuse, and mental or behavioral issues.

Colorado also licenses physician assistants (PAs). PAs may undertake specified activities "which constitute the practice of medicine" including the prescribing of controlled substances. Physician assistants must work under the "personal and responsible direction and supervision" of a physician. Physicians have various responsibilities over the activities of PAs including reviewing the chart of every patient seen within seven working days.

To attain PA certification individuals must be 21 years of age, successfully complete a board approved educational program for physician assistants, and pass a national certification examination or other board-approved examination. While application questions and requirements are not as rigorous or comprehensive as those included in the physician application packet, nonetheless, PAs must also provide specific data related to past activities such as investigations or disciplinary actions taken against them, as well as disclosing any violations of law. In addition, applicants must explain any behavior or mental or physical condition that could impact their competency or ability to practice medicine safely, and disclose any issues related to excessive use of controlled substances or alcohol.

For the Fiscal Year 2001, the Medical Board was allocated approximately \$1.77 million for its operations and support, which is completely funded through licensing fees. Medical Board revenues for the same fiscal year were estimated at \$1.95 million. Organized into areas of compliance, administration, licensing, and complaints, the staff implements the directions of the board. Functionally, the Medical Board staff reviews licensure applications and renewals; takes complaints from the public, hospitals, peer doctors, legal actions, and others; manages the activities required to complete investigations; and provides recommendations and support to board members. It conducts its complaint and enforcement activities in conjunction with external medical experts, the Division's Complaints and Investigations Section, and the Attorney General's Office.

## **The Nursing Board Regulates Nurses, Nurse Aides and Psychiatric Technicians**

Regulating the practice of over 76,000 licensees in four categories during Fiscal Year 2001, the Board of Nursing (Nursing Board) is responsible for protecting the health and safety of the public. Its 18.5 full-time equivalent staff provide the support to oversee the licensure, enforcement and discipline of registered nurses, licensed practical nurses, certified nurse aides, and licensed psychiatric technicians. Moreover, the Nursing Board is responsible for the inspection of 30 nursing education programs and 200 nurse aide programs. For the Fiscal Year 2001, its budget was over \$2.8 million, which is completely funded through licensing fees. Revenues for the same year were estimated at \$3.2 million. Both the Nursing Board and the Medical Board base their fees on anticipated expenses; when revenues exceed actual expenses, the excess revenues remain with the boards and are considered in setting rates for the following year.

Originating in 1905 as the State Board of Nurse Examiners, it was established to examine, license and revoke licenses of registered nurses or "RNs". In the late 1950s the original statute was repealed and reenacted giving the board additional powers and expanding the board membership from five to nine. The new statute adopted the definition of professional nursing promulgated by the American Nurses Association and empowered the board to accredit and approve the course of study of the professional nursing education programs in the state. In 1973, the code was again amended and expanded nursing scope of practice to include diagnosis and other areas.

The core of the current Nurse Practice Act was enacted in 1980 and replaced the registered nurse statute and the licensed practical nurse statute. Revising the scope of practice for both groups, the act defined the profession in broad terms to allow independent nursing and delegated medical functions. While the 1980 law specified that the board list nurses meeting qualifications as advanced practice nurses, it wasn't until 1994 that the board was required to develop a registry and title for these advanced practitioners.

The Nursing Board regulates practical nurses, registered nurses, nurse aides, and psychiatric technicians in Colorado. State law and board regulations define the scope of practice for each of these groups. The board defines the scope of practice of professional nursing for RNs as including "the performance of both independent nursing functions and delegated medical functions" and considers registered nurses to be independent practitioners, including individuals listed on the advanced practice registry. Further, it states two factors limit the independent scope of nursing practice: 1) the task or practice

must be within the field of nursing; and 2) the RN must possess the specialized knowledge, judgment, and skill required to complete the task or job undertaken. RNs are not required to practice under physician oversight.

Unlike RNs, practical nurses, also known as trained practical nurses, licensed vocational nurses, or licensed practical nurses (LPNs), must perform under the supervision of a dentist, physician, podiatrist, or RN, licensed by the state. The law characterizes their responsibilities as "caring for the ill, injured, or infirm, in teaching and promoting preventive health measures, in acting to safeguard life and health, or in administering treatments and medications prescribed by a legally authorized dentist, podiatrist, physician or physician assistant implementing a medical plan." To be licensed in Colorado, RNs and LPNs must meet educational requirements specific to the respective practice and successfully complete the related national examinations with passing scores.

Nurse aides also work under the supervision of other licensed healthcare professionals. Regulations require Certified Nurse Aide candidates to complete either a nurse aide training program or five semester credits of nursing fundamentals and to successfully pass a state-approved and administered standardized competency examination. Nursing and psychiatric technician students meeting specific course-work and credit-hour requirements are eligible to take the certified nurse aide examination as are Licensed Psychiatric Technicians.

Colorado is one of four states that licenses psychiatric technicians and licenses are awarded in two specialty areas: care of the developmentally disabled, and care of the mentally ill. State law defines the practice as performing "interpersonal and technical skills," including the administering of selected treatments and selected medications prescribed by a licensed physicians or dentists, caring for, observing, and recognizing the symptoms and reactions of a mentally ill patient or developmentally disabled individual. To obtain the Licensed Psychiatric Technician "LPT" credential, individuals must complete a state approved training program and successfully pass the state administered examination.

---



---

# Licensing of Physicians and Nurses

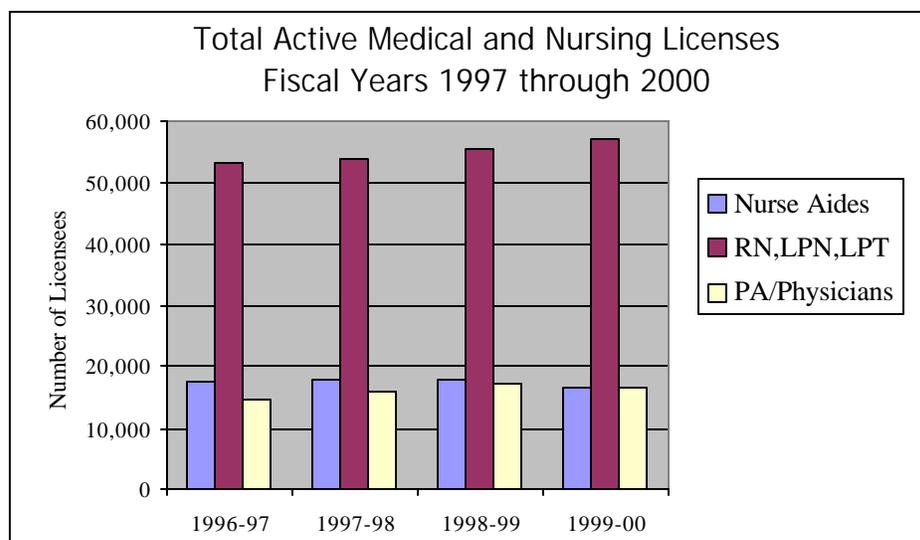
## Chapter 1

---

### The Boards' Licensing Activities Comply With Laws and Regulations

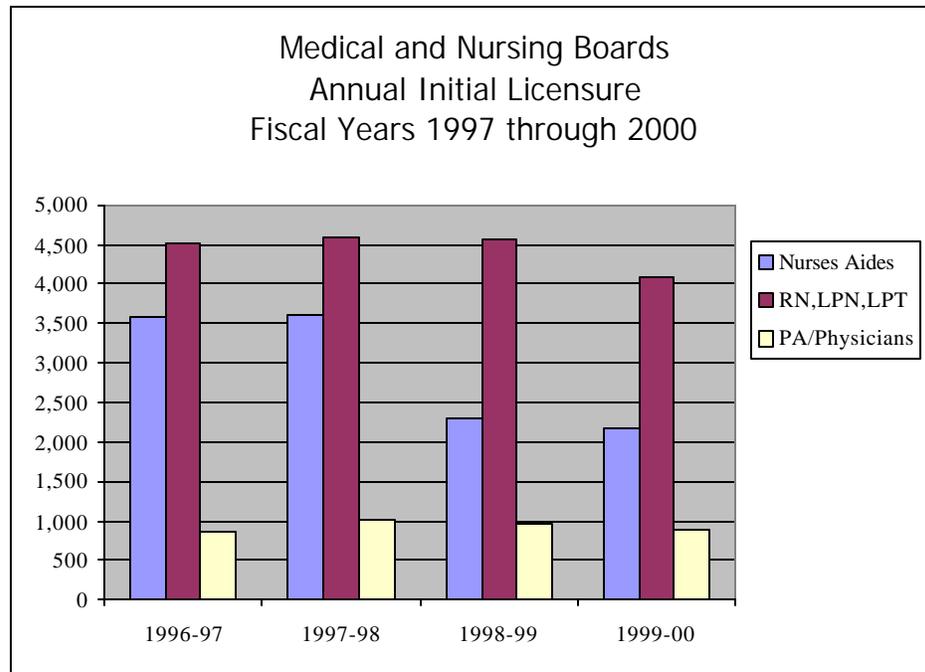
State law provides for the Medical Board and the Nursing Board to license and certify specified healthcare professionals. Both boards award initial licenses and certifications and conduct renewal processes as required under regulation. While state laws and regulations delineate the varied scope of practice for each of the categories of licensure, the processes followed by the two boards are quite similar. In reviewing these processes, we find that the licensing activities of both the Medical Board and the Nursing Board comply with the respective rules and regulations over those functions. Our tests of a cross-section of license applications and renewals from both boards show that the applicants reviewed met the eligibility requirements, files contained the required documents validating licensure, each application was approved or denied within an appropriate time period, and licenses were conferred only to qualified applicants.

**Figure 1**



Overall, the number of individuals holding active medical and nursing licenses in Colorado has grown moderately, about 5 percent, over the past four years with virtually no growth during the past year. Both the Medical and the Nursing Boards expect these trends to continue. They project that the numbers of licensees at both boards will remain relatively flat for the Fiscal Years 2001 and 2002. Colorado's licensing patterns seem to track with general nursing trends nationally—during a similar period the number of registered nurses and nurse aides nationwide increased at a slightly lower rate, about 3.7 percent with a 0.9 percent growth between 1998 and 1999. Within the various nursing licensing groups, the numbers tended to fluctuate year to year.

**Figure 2**



In total, the Medical Board initially licensed 897 doctors and physician assistants in Fiscal Year 2000. The Nursing Board initially licensed 4,089 registered nurses, licensed practical nurses, and psychiatric technicians, and certified 2,180 nurse aides during Fiscal Year 2000.

The Nursing Board typically combines licensing activity and statistics for registered nurses, licensed practical nurses, and psychiatric technicians. From 1997 through 2000, registered nurses comprised around 80 percent of the total, with licensed practical nurses making up approximately 18 percent and psychiatric technicians the remaining 2 percent of the total.

State law and regulations specify the eligibility requirements for each group of healthcare professionals regulated by each board. The education, experience, and examination requirements vary significantly to appropriately encompass and match the scope of practice of each group of licensees.

Processes for initial licensure by both boards have many similarities. All applicants must provide the appropriate fee. In addition, candidates submit licensure applications directly to the appropriate board—packets include a variety of data from verification of education to disclosures related to criminal histories and substance abuse. Whereas the Medical Board obtains much of this information through a series of forms, the Nursing Board uses a questionnaire. A variety of information such as criminal history, substance or alcohol abuse issues or other potentially unacceptable conditions is obtained through these processes. Thus, a "yes" response to certain questions may indicate a potential inhibitor to licensure. Board staff conduct follow-up inquiries on self-reported information that may limit or prohibit licensure. While our review found both boards consistently follow-up on "yes" answers provided on the self-reporting questionnaire, neither have processes to verify "no" responses to these questions.

Renewal processes at both boards also require staff to undertake similar activities. Licensees send renewals to the boards' agent bank in a lock-box. The Nursing Board, however, will also accept renewals sent directly to the board or delivered to the board's offices by the licensee. The agent bank records and deposits the licensee fee and forwards the application packet to the appropriate board. Upon receipt of the initial and renewal packets, board staff review the forms and related documents for completeness and to assess the adequacy of the information provided.

Both boards track their respective rates for approving and denying initial licenses. Licensure may be denied for a variety of reasons such as criminal activities, unacceptable behavioral matters, and poor practice records in other states. While each group of licensees vary, at the Nursing Board the denial rate for registered and practical nurses remains below one-half of one percent. Nurse aides' denial rate is higher, but as Table 1 indicates, has gone down steadily over the past four years.

**Table 1:**

<b>Board of Nursing - Denial of Licenses Fiscal Year 1997 through 2000</b>				
<b>License Type</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
LPN	0.09%	0.09%	0.11%	0.15%
RN	0.33%	0.13%	0.22%	0.29%
Nurse Aide	4.07%	2.67%	2.19%	1.88%

We were unable to obtain national statistics for nursing denial rates—most data maintained nationally relates to examination passing rates, which is not comparable to licensure rates. Therefore, we cannot conclude on the reasonability of the Nursing Board’s rate of licensure denial.

The Medical Board also tracks its rate of denials for physicians and physician assistants. Over the past four years the denial rates have ranged between 1.27 percent to 2.23 percent. Similar to the situation we found for nurses, we were unable to obtain national denial rates for doctors nor can we determine the reasonableness of Colorado’s rates.

The timing for license renewal varies depending upon the practice areas. Currently the renewal periods are staggered between odd and even years and occur at different times during these years. Licenses “expire” on the renewal date, but board policy provides a two-month grace period. Renewal applications must be submitted prior to the expiration date and during this period the boards process and renew the licenses. The following two tables detail the expiration dates for licenses overseen by the Medical and Nursing Boards.

**Table 2:**

<b>Board of Medical Examiners License Renewal Schedule</b>			
<b>Type</b>	<b>Licensure Period</b>	<b>Expiration Date</b>	<b>Year</b>
Physician	24 months maximum	May 31	Odd
Physician Assistant	24 months maximum	January 31	Even

**Table 3:**

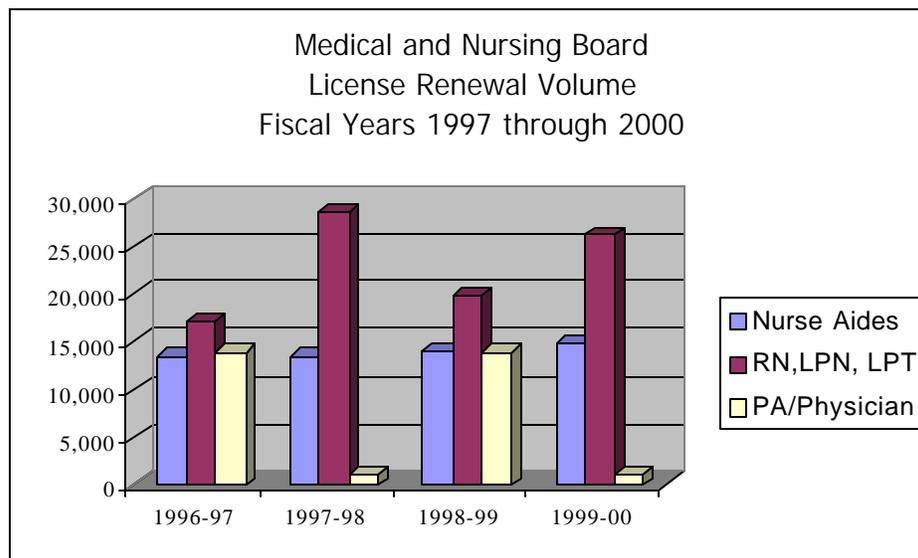
<b>Board of Nursing License Renewal Schedule</b>			
<b>Type</b>	<b>Licensure Period</b>	<b>Expiration Date</b>	<b>Year</b>
Registered Nurse	24 months maximum	September 30	Even & Odd <sup>1</sup>
Practical Nurse	24 months maximum	June 30	Even
Nurse Aide	24 months <sub>2</sub> maximum	January 31	Even
Psychiatric Technician	24 months maximum	March 31	Odd
<sup>1</sup> Half the Registered Nurses are licensed in even years and the other half in odd years. <sup>2</sup> Prior to January 2000, Nurse Aide certificates were renewed annually; new policy requiring biennial began January 31, 2000.			

Although the “same-day” renewal process for half if not all those in each practice group creates significant workload peaks at both boards, the processes followed appear to sufficiently handle these spikes. Our review did not discover issues such as late-processing, backlogs, or significant overtime by staff at either entity. Although the Medical Board has renewals for physicians and physician assistants staged in opposite years, the bulk of the renewals occur in odd numbered years—nearly 14 times greater volume than in even years—when physician licenses expire. We found the board staff plan for this workload spike and reallocate the resources within the licensing unit and obtain assistance from administrative staff to meet its performance measures. Of the renewals that we sampled, all applications filed by the specified due date were appropriately processed in a timely manner.

The Nursing Board is responsible for licensing more than 76,000 individuals. Until a recent change in rules, nurse aides’ certificates were renewed annually. Current regulations now allow a biennial renewal for nurse aides, comparable to the other groups of healthcare professionals. In the “even” years when these licenses expire, the board’s renewal workload virtually doubles. However, under the prior annual renewal cycle the board’s processes sufficiently met this workload challenge and the new rules actually should provide a reduction in board efforts in the long run since nurse aides will renew every two years rather than every year. Moreover, it appears that the staggering of the four categories of licensing and certification throughout the year allows the board staff to sufficiently plan and reallocate resources as the peak periods arise. We found all renewals

reviewed were appropriately processed well within the 60-day grace period allotted for renewals.

**Figure 3**



Notes: In January 2000, the Nursing Board changed the renewal of nurse aides from annual to biennial. Thus no renewals will occur in the 2000-01 fiscal year. Physician and physician assistant renewals occur in alternating years—physicians in May of odd years, physician assistants in January of even years.

Neither board expects the volume of initial or renewal of licenses to materially increase over the next few years. As such, rules and regulations remaining constant, both find that current resource allocation should be sufficient to meet the near-future workload demands.

Our review of licensing activities at both boards revealed no exceptions—all application and renewal files examined included required documentation and reflected staff review. For those applicant files where “yes” answers to questions could deem the candidate ineligible or unacceptable for licensure, we reviewed the files in depth and found staff at both boards handled these cases consistently, and where appropriate, issued formal complaints initiating the investigation process.

## **Self-Disclosure Requirements for Licensure Renewal Differ Between the Two Boards**

Both the Medical Board and the Nursing Board require all candidates seeking initial licensure to self disclose any information relating to potentially unacceptable conditions such as a criminal history or substance abuse issues. Board staff review this information to determine if the applicant has any issues that could prohibit licensure under the practice act. Board staff conduct initial inquiries to follow-up on “yes” answers provided by applicants that may limit or prohibit licensure. This process involves such activities as interviewing the candidate, obtaining and reviewing legal documentation related to a crime or infraction (such as “driving under the influence”), and researching issues related to prior disciplinary actions or a treatment program. At the Medical Board, in many instances where individuals truthfully disclose conditions or situations potentially unacceptable under the practice act, the board staff prepare a “complaint” against those individuals. In severe instances, the board may deny the application outright. Upon filing the formal complaint, the application then enters the complaint and enforcement process for resolution. Nursing Board application questionnaire disclosures indicating unacceptable conditions most likely will result in denying licensure.

In addition to the disclosures provided in the initial licensure packet, the Medical Practice Act also requires licensees seeking renewal to complete another self-disclosure questionnaire. As a result, every two years, physicians and physician assistants are required to self-report any potentially unacceptable matter that could impact the application for renewal. The truthful disclosure of this information gives the Medical Board an update about these licensees and the opportunity to investigate those licensees who may have violated the provisions of the practice act. However, the Nursing Board rules require only initial applicants to self-disclose this type of information —license renewals do not require such disclosures. As a result, the Nursing Board may continue to renew the license for licensees who may develop criminal histories, substance abuse issues or other issues that would endanger their ability to maintain a license under the practice act.

Nursing Board representatives indicated that the main reason for the lack of a self-disclosure questionnaire for those licensees seeking renewal is the workload that would be generated from such self-disclosure. According to a representative of the board, the board receives approximately 52,000 applications for license renewals and it does not have the necessary staff to investigate all the potential “yes” answers on a self-disclosure form. However, the representative also conceded that the board does not have any way of

determining if a renewal applicant has developed an issue that would inhibit their ability to maintain a license other than if a complaint is filed against the licensee. This endangers the public safety by allowing licensees who may no longer meet the requirements of the practice act to obtain a renewal. The Nursing Board should seek legislative approval to develop procedures similar to those included in the Medical Practice Act that require renewal applicants to complete a self-disclosure form.

---

### **Recommendation No. 1:**

The Department of Regulatory Agencies should seek statutory changes to the Nurse Practice Act that would mandate the Nursing Board to design a questionnaire and require all licensees seeking to renew their license to self-disclose any potentially unacceptable information.

#### **Department of Regulatory Agencies Response:**

Agree. The Department of Regulatory Agencies will seek a statutory change to the Nurse Practice Act to require the Board of Nursing to develop a self-disclosure questionnaire to mail with license renewal notices.

---

## **The Nursing Board Can Improve the Effectiveness of Nurse Aide Background Checks**

In each of the four groups licensed or certified by the Nursing Board, applicants must pay a fee, pass a uniform examination, and submit an application to the board. However, to become a Certified Nurse Aide the applicant must also obtain a lifetime background check. These checks are intended to identify any history of criminal activity throughout an applicant's life and are based on names and birth dates. None of the other licenses issued by the Medical or Nursing Boards require such a background report. A nurse aide applicant's background check may be completed by any private contractor approved by the Nursing Board. To gain board approval, the contractor must submit an application and meet board criteria and be re-approved every two years. Once an agency has obtained approval, the Nursing Board provides specific procedures to be performed in conducting

an acceptable lifetime background check. The board also stipulates the requirements of the final report submitted on behalf of the applicant.

Nurse aides and all other applicants for other initial nursing licenses must submit specified information or a completed questionnaire to the board “self-reporting” any prior criminal history. These questionnaires cover a variety of issues ranging from felony, misdemeanor, and petty offenses to chemical dependency and psychological disorders.

A nurse aide disclosing prior criminal offenses, or if one is discovered through the lifetime background check, is not immediately disqualified. Specifically Section 24-5-101, C.R.S. provides that a prior felony may not exclude an individual from certification—it is however, considered as an indicator of moral standing and, thus, can preclude the applicant from certification. If the board believes that the applicant is of good moral character, regardless of a prior offense, provided that they meet all other provisions, the applicant can be approved for certification.

While performing our review, we discovered seven instances where nurse aide applicants’ self-reported prior criminal offenses but the background checks did not identify these crimes. Several of these offenses involved indiscretions or circumstances such as domestic violence and driving under the influence (DUI) that may preclude the applicant from licensure. None of these seven individuals were approved by the Nursing Board to practice in Colorado. While it is unclear why the private contractors did not identify these criminal activities, the Colorado Bureau of Investigation (Bureau) did indicate that searches might be complicated due to “stolen” identities or when individuals share names and birth dates. Further, we were told that although private contractors can obtain statewide law enforcement data from the Bureau they would need to pay \$10 to obtain this service.

In the seven cases we reviewed, the applicants informed the Nursing Board of their criminal history so the board had appropriate data to determine the acceptability of the candidates for certification. However, if the applicants had not honestly reported, the Nursing Board would have most likely issued them a certificate.

To determine whether the criminal histories would be disclosed if background checks were conducted by the Colorado Bureau of Investigation, we submitted these same seven applicants to them for review. The Bureau’s review identified two candidates with felonies, and two others with items on their histories classified as “not releasable” or activity that is likely to be sealed by a court. The other three individuals disclosing a criminal history were not identified through the Bureau’s search.

While it appears that under the current system in Colorado, self-reporting for nurse aides is more accurate than the contractor-produced lifetime background checks, the Nursing Board still runs the risk that candidates will not honestly disclose criminal histories. A more effective alternative, according to the Colorado Bureau of Investigation, is fingerprint cards for applicants that allow searches of statewide databases. However, according to the Nursing Board, even Bureau reviews have limitations; the Bureau's database may not include arrests and convictions in states other than Colorado. The Bureau maintains that the most effective method in identifying criminal histories is running fingerprints through national databases. To access national fingerprint databases, the State would need to pass a statute requiring the search and the statute must include appropriate provisions to protect privacy and retain the confidentiality of the information.

## **Other States Conduct Background Checks for Nurses and Physicians**

We contacted other nursing and medical boards to determine whether background or fingerprint checks are required for licensure. We found that three of the four nursing boards contacted in other states require background checks of all nursing applicants. Only one does not require background checks for its nurses; the three other states require background checks for all categories of nurses licensed. Further, in these three states, background checks are conducted by state entities: either the State Department of Public Safety, the State Bureau of Investigations, or in-house. Also, one state runs fingerprint cards for all licensees against various databases that provide the board with any out of state criminal history. On the other hand, we found that for the five states we contacted regarding physician licensure, only one required background checks. The Criminal History Task Force convened in accordance with recent legislation, is reviewing the issue of criminal background checks in the statewide context of public safety policy. The Nursing Board should ensure that issues related to individuals under its regulatory jurisdiction are included in the deliberations of the task force. Nevertheless, Colorado should improve the process for currently required background checks for nurse aide applicants.

---

### **Recommendation No. 2:**

The Board of Nursing should improve its background check process for nurse aides by:

- a. Requiring candidates to use the Colorado Bureau of Investigation background check process.

- b. Considering requiring checks using fingerprints if a higher level of investigation is needed to ensure a more accurate investigation.

### **Board of Nursing Response:**

Agree. The Board of Nursing believes that criminal background checks enhance public protection. We believe the existing system used to conduct criminal history can be improved. Section 12-38-108(1)(k)(VII)(1) & 12-38.1-104 C.R.S., requires that criminal background checks include information on convictions. State Board of Nursing rules and regulations require lifetime criminal conviction histories and an out-of-state criminal background search in each state/county where the applicant resided outside of Colorado as indicated by the data, using all names and aliases of the nurse aide. CBI information pertains to arrests and convictions in Colorado only. The Board is committed to improving the accuracy and efficiency of the process, including requiring fingerprints. The Board will work closely with and consider the recommendations of the state's Criminal History Task Force.

---

---

---

# Complaint Investigation Procedures

## Chapter 2

---

### Improved Case Management Systems Would Benefit Both Boards' Enforcement Activities

Performing under similar provisions of law and regulation to protect the public from unsafe medical practices, the Medical Board and the Nursing Board operate complaint and enforcement functions. Our review of these activities reveals that overall the boards appropriately and diligently conduct the various activities involved with receiving complaints; establishing case files, developing evidence, and taking appropriate action. However, we believe that an improved case management system would enable the boards to conduct these processes more efficiently and effectively.

Both boards receive complaints related to activities of their respective licensees. As regulators, the boards must review the complaints within their jurisdiction and bring each to resolution. Over the past 10 years the boards have received thousands of complaints and meted out hundreds of disciplinary actions. Specifically, since 1992, the Medical Board has received 7,759 complaints, or an average of 776 per year, within its jurisdiction and has taken 898 disciplinary actions. Since 1992, the Board of Nursing has received a total of 6,809 complaints, or an average of 680 per year. During that same period, the Board took 3,726 actions (not including 144 Letters of Concern issued during Fiscal Years 2000 and 2001). As the statistics convey, not all complaints result in disciplinary action—some complaints logged do not constitute a practice act violation, are not credible, or lack sufficient evidence.

Disciplinary actions fall into categories at each board that correlate to the activities of the individuals regulated. There are several actions common to both boards:

- License Revocation – The board formally takes action to revoke a license and the individual is prohibited from practicing in the state.
- Surrender of License – Similar to revocation except the licensee voluntarily surrenders (or in the Nursing Board's term "relinquishes") his or her license before the board formally takes action against them.

- Suspension – The board moves to suspend the licensee from practicing for a prescribed period of time or until completion of certain treatment or activity. The boards may also tie suspensions to probation periods.
- Probation – Discipline includes a probationary period during which the licensee must comply with certain conditions to continue to practice. Such conditions may include, but are not limited to, practice monitoring by a board-approved peer or by a supervisor, treatment monitoring by an approved licensee or entity, and restrictions on practice.
- Letter of Admonition – These letters are board actions admonishing certain behaviors. Admonitions are public documents and a permanent part of a licensee's file.

Table 4 and Table 5 illustrate the types and volume of actions taken by both boards.

**Table 4**

<b>Board of Medical Examiners Complaints Received and Actions Taken 1997 through 2001</b>					
	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Total Jurisdictional Complaints Received	800	928	846	867	870
Actions:					
Revocation	7	7	2	7	1
License Surrender/Retirement	15	12	12	7	9
Suspension with/without Probation	23	13	11	12	10
Probation/Practice Limitations <sup>1</sup>	23	17	29	24	15
Letter of Admonition	33	18	25	19	21
License Granted w/ Probation Limits	8	4	2	2	9
License Denied After Hearing <sup>3</sup>	0	1	0	1	0
Injunction/Stipulated Agreement <sup>2</sup>	1	1	0	3	2
<b>Total Actions</b>	<b>110</b>	<b>73</b>	<b>81</b>	<b>75</b>	<b>67</b>
Source: Information provided by the Board of Medical Examiners.					
<sup>1</sup> Includes only those cases without suspension.					
<sup>2</sup> Formal actions taken against an unlicensed individual practicing medicine.					
<sup>3</sup> License awards or denials are typically not part of the enforcement process. License denials in the enforcement process most often relate to physicians seeking licensure in Colorado after being licensed in another state or jurisdiction.					

As part of our audit work we requested that the Medical Board provide an explanation of the downward trend in the number of disciplinary actions taken over the last five years. A representative from the Medical Board indicated that several factors may contribute to the trend. The representative noted that the board is primarily a reactive body that is dependent upon receiving complaints as opposed to seeking out violations. Consequently the board believes that some of the decline may be attributable to the case mix for that particular year and the fact that the board simply did not refer as many cases because formal disciplinary action was not warranted by the facts of the case. Another factor may be the fact that the Colorado Physician Insurance Company (COPIC) now provides physicians with legal defense for complaints filed with the Medical Board. This has significantly increased the life of a disciplinary action filed against a physician and has required the board's legal staff to expend greater resources to resolve cases. The Medical Board representative noted that despite the fact that cases are more aggressively defended, the board's determination that a physician's conduct violated the practice act has been consistently upheld. Finally, the representative informed us that the Medical Board has experienced increased turnover in its legal staff which has slowed the resolution process. In addition, the complexity of the cases continues to grow as healthcare and medical practice evolves. The Medical Board representative noted that the board continues to work with the Attorney General's Office to overcome these obstacles and resolve cases as expeditiously as possible.

The Nursing Board exercises similar disciplinary actions for registered nurses, practical nurses and psychiatric technicians. It separately categorizes and tracks actions related to nurse aides. In Table 5 we have combined the results for all four groups of licensees.

Table 5

<b>Board of Nursing Complaints Received and Actions Taken 1997-2001</b>					
	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Total Jurisdictional Complaints Received	776	734	768	624	630
Actions:					
Licensed Revoked/Relinquished	125	108	107	132	91
Board Ordered Summary Suspension <sup>1</sup>				7	12
Suspension	77	100	56	72	41
Probation <sup>2</sup>	91	77	104	97	41
Letter of Admonition	103	75	74	75	46
Letter of Concern <sup>3</sup>				88	56
Other Actions	1	19	14	1	4
Total Actions	397	379	355	472	291
Dismissed	342	397	305	304	192
Source: Information provided by the Board of Nursing					
<sup>1</sup> Board of Summary Suspensions are summary suspensions that have been ordered by the board. However, these may have been mediated and referred to the Office of the Attorney General. Via mediation, the final outcomes of the 7 board ordered summary suspensions in Fiscal Year 2000 are as follows: 1 agreement to cease practice with a subsequent suspension; 4 relinquishments; 1 stipulated indefinite suspension with a specific term of suspension; and 1 suspension. Via mediation, the final outcomes of the 12 summary suspensions in Fiscal Year 2001 are as follows: 2 revocations; 1 stayed revocation; 5 surrendered licenses; 2 suspensions; and 2 licenses were summarily suspended at the time of this data collection. This data was not collected in this manner prior to Fiscal Year 2000.					
<sup>2</sup> Probation - Statutory authority does not exist for certified nurse aides. Figures for this action only include registered nurses, practical nurses, and psychiatric technicians.					
<sup>3</sup> Letters of Concern - Statutory authority for this action began in July, 1999. Statutory authority does not exist for this action against certified nurse aides. Figures for this action only include registered nurses, practical nurses, and psychiatric technicians.					

As Table 5 shows, the numbers of disciplinary actions taken by the Board of Nursing decreased significantly between Fiscal Year 2000 and Fiscal Year 2001. Nursing Board representatives indicated that the board implemented two decision items between Fiscal Year 1999 and Fiscal Year 2001 to help eliminate an existing backlog of cases at the Attorney General's Office and to allow the Nursing Board to develop new programs such as the Early Neutral Intervention Program which can lead to the quicker resolution of cases. At the same time, the board received statutory authority to issue a Letter of Concern which is a confidential notification outlining the board's concerns and also implemented the panel system which splits the Nursing Board into two panels each of which can hear and decide disciplinary actions. The Nursing Board representatives believe

that these variables impacted the board's data related to discipline. For example, the addition of two FTE attorneys plus supporting staff at the Attorney General's Office for 1999 and 2000 lead to an increased number of actions as the existing backlog was cleared. Finally, the Nursing Board representatives informed us that with all the new variables impacting the board during the last few years, it is difficult to make any cause and effect statements based on purely descriptive statistics.

At both boards, the complaint process begins with the receipt of a written complaint. Complaints are received from a variety of sources including patients, healthcare professionals, or insurance carriers. The first determination made by board staff is whether or not the complaint is within its jurisdiction. For example, the complaint must be a violation of the nurse or medical practice acts and must involve a Colorado licensee. If staff determine that the complaint falls under the board's jurisdiction, a "30-day letter" is issued to the licensee. The licensee must respond to the 30-day letter by providing information detailing the issues surrounding the complaint. Once staff receive the response, the complaint is taken before a panel consisting of half of the respective board members. At that time, the panel decides how to proceed. It may dismiss the action if it lacks credible evidence of an infraction; send the case the Division's Complaints and Investigations (C&I) Section for general investigation or to an outside consultant for expert review; or take disciplinary action through the Attorney General's Office or through the board itself. If an investigation is undertaken, the investigating entity prepares a report submitting the findings to the board. Based upon these results, the board decides whether to pursue disciplinary action or to dismiss the case.

## **Documentation in Complaint Files Can Improve**

In reviewing the complaint process for both the Medical Board and the Nursing Board, we identified six discrete attributes to test and assess the adequacy and timeliness of complaint processing. At each of the boards, we selected two samples of enforcement cases: one sample from the cases classified as closed and a second sample from cases classified as open. For each selected case we examined the files and related documentation and interviewed appropriate staff to fully understand the steps taken in each case and to assess the consistency of process and procedure. During our review we noted instances that do not themselves constitute exceptions to the rules, regulations, and processes, but if remedied would contribute to a stronger and more efficient and effective administration of the respective enforcement activities.

We sampled 51 cases from Medical Board files and 42 cases at the Nursing Board to determine whether staff appropriately complete all steps in the complaint processes. We ascertained whether files had documents reflecting the complaint, sending of the letter requesting licensee response (“30-day letter”), the response to the 30-day letter, records of referring cases to external groups such as the Division’s Complaints and Investigations (C&I) Section and the Attorney General’s Office, and a record of the outcome of the case, if appropriate.

Generally, the case files at both boards included the appropriate evidence that relevant rules and regulations were followed in processing the complaint. Further, board actions suggest that cases are treated uniformly and with appropriate due process. However, during our review we encountered some difficulty in locating certain documents in files. This issue caused confusion in our review process.

While we believe that both the Medical Board and the Nursing Board fulfill their respective responsibilities for investigating and resolving complaints, maintaining complete case files is a key component in management controls and staff accountability. Therefore we find that controls and accountability can be improved, whether files are manual or electronic, by incorporating a checklist delineating all the related actions, procedures, and documents involved in resolving complaints. Staff should be required to log-in and date all pertinent documents and other records gathered during the course of the complaint review. Additionally, checklists should include the date and contemporaneous notes describing the various activities and contacts as they take place. Checklists would also allow, at any point in time, management to query the file to determine activities completed and obtain an indication of the current status of any case.

---

### **Recommendation No. 3:**

Any case management system used or adopted should include process checklists specific to each board's activities to ensure documents are added to files, steps are completed, and staff are accountable for their actions.

#### **Division of Registrations Response:**

Agree. The Division’s current licensing system is outdated and does not have the capability to support an automated checklist function. As a result, the staff for the Board of Nursing and the Board of Medical Examiners developed manual checklists for various processes to ensure documents are added to files, steps are completed, and staff is accountable for their actions. In order to address the

recommendation without delay, both Boards will review and revise their current checklists to help ensure that complete case files are maintained.

The Division's long-term solution is replacement of the licensing system. The Division is already in the process of purchasing a new licensing system. The Request for Proposal (RFP) has been released and selection of a vendor will be completed within the next few months. The Division recognizes the need for any replacement licensing system to include an automated case management system with the ability to process checklists specific to each Board's activities. The RFP outlines the need for a robust system that fully supports the Division's business functions and a high priority has been placed on system requirements related to the complaint intake process. The Division is expecting full implementation of the new licensing system by June 2003.

Looking ahead to the future, the Business Process Reengineering (BPR) Project proposed the idea of a "paperless office" whereby any documents received by the Division would be scanned and imaged to the computer. The complaint intake process would benefit greatly by this technology. The actual complaint case files would be accessible on the computer rather than a paper file. This would increase the efficiency at which the Division operates. It would eliminate valuable time spent handling paper and sharing paper files and decrease the likelihood of misplaced or lost documents. However, the necessary resources identified to implement this technology were well outside of the funding the Division received to replace the licensing system.

### **Board of Medical Examiners Response:**

Agree. The Board of Medical Examiners does employ checklists for many of its disciplinary processes for the reasons described in this report. A checklist will be developed and implemented by year-end to replace the current complaint log to improve the documentation of staff activities with respect to each complaint filed and to ensure that all necessary documents are received and filed.

### **Board of Nursing Response:**

Agree. Due to statutory changes effective July 1999, procedures for the processing of cases changed. These processes necessarily resulted in changes in the case filing system. Consequently, those who review case files compiled prior to and after July 1, 1999 may experience confusion in locating documents.

The Board of Nursing has unique checklists for each of the multiple types of complaints received. For example, the Board has checklists for abandonment cases, diversion program cases, advanced practice cases, and no violation cases, as well as standardized checklists for routine 30-day letters and referrals to the Complaints and Investigations Section (C&I) or Attorney General's Office (AGO). Staff log and date pertinent documents and other records gathered during the course of the complaint review using several case-type specific checklists. However, the checklists do not clearly delineate when a response from a licensee is not received. The Board will review existing checklists to ascertain whether they can be enhanced. The Board has an established Records Management Team devoted to continuously evaluating and improving case records.

---

## **Reengineering Project Recommends Business Process Changes**

Several years ago, the Division of Registrations (Division) identified the need to replace its existing automated licensing system, ARMS. After conducting a study in 1999 to determine the feasibility of replacing the system, the Division decided that before procuring a new system it should first review its existing business processes division-wide—thus in early 2001, it procured a vendor to conduct a business process reengineering of the Division's activities. This multi-step project included objectives to achieve efficiencies and improvements in the Division's business performance, determine best practices that can be applied to other Department of Regulatory Agencies activities, develop steps to achieve Colorado's "e-Government" vision, and identify a "robust automated solution" to support the Division's business practices. This project will impact all regulatory boards at the Department of Regulatory Agencies including the Medical and Nursing Boards since they use the Division's automated licensing and case tracking system.

During the over six month project, the contactor produced a number of reports addressing areas including "As Is" business practices, preparing a "To Be" business model, outlining enabling technology, and providing comments and recommendations for "seeing it through." The reengineering project recommends sweeping changes to the way the Division and the individual boards conduct business. It's "new business model" recommends standardizing and consolidating many activities across the many boards within the Division. In addition, the contractor delineates the elements of a "replacement licensing system."

It is unclear at this point the ramifications of the reengineering project to the structure and operations of the Nursing Board and the Medical Board. However, looking to the future, it is important that the boards ensure that any new system consolidates the boards' case records and activities into one integrated case management system. The system should be designed not only to improve staff and process accountability, but should include the various elements needed to generate valuable management information for administering the programs, allocating resources, and fulfilling the boards' mission and fiduciary responsibilities to residents.

---

### **Recommendation No. 4:**

The Board of Medical Examiners and the Board of Nursing need to work closely with the Division of Registrations and follow the progress of the initiatives taken in response to the reengineering project to ensure that any system developed within that project include placeholders for inserting all relevant documents, such as the complaint, 30-day letter, and the licensee response so that the automated case files include appropriate documentation.

#### **Division of Registrations Response:**

Agree. In order to assist with further development and implementation of the BPR Project recommendations, the Division initiated a Change Management Team that will develop and recommend a plan for transitioning the Division from the current business model to a new business model and oversee implementation of approved changes. The Change Management Team is working very closely with all boards and programs within the Division, including the Board of Nursing and the Board of Medical Examiners. In addition, there is strong integration between the Team and selection and implementation of the replacement licensing system.

The RFP for the replacement licensing system specifies that the vendor must complete Joint Application Development (JAD) sessions with Division staff. These sessions are intended to ensure that the replacement licensing system will provide automated support for each board's and program's unique business rules and requirements. This would include placeholders for inserting all relevant documents.

#### **Board of Medical Examiners Response:**

Agree with Division of Registrations' response.

---

## **Board of Nursing Response:**

Agree. The Board of Nursing is committed to working closely with the Division of Registrations to ensure that any system developed will include placeholders for inserting all relevant documents so that the automated case files include appropriate documentation. Board of Nursing staff is actively involved in the selection of the replacement licensing system

---

## **Complaint Processes Lack Performance Measures**

Our testing of complaints at each board also included assessing the timeliness of the complaint processing from receipt to resolution. Our testing of files at both boards reveals that those steps within the control of each board such as sending out letters to complainants and the 30-day letter to the licensees; the gathering of documentation; and referrals to external experts, the Division's Complaints and Investigations Section, or the Attorney General's Office, generally occur within timeframes appearing reasonable. Because neither board nor state laws and regulations establish timeframes or process goals for completing the various steps, we analyzed each activity and ascertained whether the average time typically taken to complete each step appeared reasonable, and if so, applied that timeframe as a measure to the cases tested.

Our sample of 38 Nursing Board cases and 51 Medical Board cases convey:

1. The Nursing Board sent 30-day letters within an average of 28 days of complaint date and at the Medical Board this activity took an average of 27 days.
2. The resolution of cases ranged widely—at the Nursing Board, one case was dismissed within 12 days of complaint receipt while another case took 1,504 days to resolve, resulting in a Letter of Concern. Overall, the 24 resolved Nursing Board cases included in our sample took an average 363 days.
3. At the Medical Board case resolution times ranged from 59 days for one dismissed case to 743 days for a case resulting in license surrender. For the 29 resolved Medical Board cases that we reviewed, the overall average was 239 days in elapsed time.

4. Of our sample cases, the Nursing Board sent 17 cases to the Division's C&I Section. Of those cases where C&I investigations were complete, time ranged from 21 to 272 days.
5. The Medical Board sent 14 of our sample cases to C&I and 6 were complete—investigation time ranged from 173 days to 329 days.
6. The Attorney General's Office's efforts on behalf of the Nursing Board ranged from 98 days to 1,112 days for six Nursing Board cases in our sample and from 87 to 687 days for the seven cases completed for the Medical Board.

We interviewed staff at both boards, the Attorney General's Office, and at the Division's C&I Section to understand their respective roles in the complaint resolution process and to obtain reasons why some cases take so long to complete. The individuals we spoke with conveyed similar information, generally indicating that each case is unique and only the steps are similar, not the circumstances. Any number of issues can prolong the case. For example, licensees can be difficult and purposefully prolong the effort; investigators may experience difficulties in obtaining evidence or locating witnesses; or there may be related legal proceedings, such as an on-going malpractice suit, that impact the ability of the State to proceed.

Within each board's control, however, is the initial process to acknowledge the complaint and to notify the licensee of the complaint and obtain pertinent case information. The acknowledgment to the complainant should occur upon complaint receipt and the letter to the licensee, "the 30-day letter" should come shortly after the staff initially consider the complaint. We identified, however, certain instances at both the Medical Board and the Nursing Board where a long period of time elapsed between the complaint receipt and the boards' conveyance of these two letters. In most of the cases we reviewed these letters went out within a few weeks of complaint receipt; we identified a few cases at each board where the letters were delayed due to efforts to first obtain additional information, complete a medical evaluation, or divert the individual into a rehabilitation program. One Medical Board case in our sample took unusually long for the 30-day letter to be sent to the licensee suggesting a potential weakness in the intake process—possibly this case was misplaced for a time. The boards should work closely with the Division in the reengineering process to ensure that any new case management system includes triggers to monitor key processes and to automate rote processes such as automatically sending out standard correspondence and notifications.

While the two boards believe that their respective section strategic plans provide performance measures, we believe more can be done. Presently board staff can track the

complaint though the process, but these efforts are reliant on manual processes and individual efforts. We recognize that the nature of investigations and due process proceedings are not uniform. However, certain aspects of the process, under the board staff control, are suited to automated processes and performance goals. For example, time measures for opening case files, sending out the complainant acknowledgment letter and the 30-day letter to the licensee could be established along with tickler notifications for staff to follow-up on 30-day responses not submitted on time. Further, board staff could work with the external agencies to establish estimated budgets for each referred case estimating completion—these dates can be adjusted as the circumstances around the issue unfold. In conjunction with the estimated budgets, board staff could establish interim milestones to proactively check on cases at either the external consultants, Attorney General's Office, or the C&I, obtain status reports and update the expected completion date. By establishing “working” budgets and interim milestones, board staff can ensure that cases are appropriately moving forward and could potentially speed up the resolution process.

---

### **Recommendation No. 5:**

The Board of Medical Examiners and the Board of Nursing should:

- a. Review their respective complaint intake processes to understand the cause of long time lags to send out the initial acknowledgments and licensee response letters and initiate controls to assure the prompt completion of these steps.
- b. Establish performance goals for certain components of the complaint process to ensure that the case moves forward in a timely manner.

### **Board of Medical Examiners Response:**

Agree.

- a) Board staff has, and will continue to, evaluate their intake processes to ensure that inquiry letters to physicians and acknowledgment letters to complainants are sent out as quickly as possible. There are often valid reasons that a complaint may need to be held to subpoena additional information from other parties so that a complete inquiry letter to the licensee can be sent. Additional controls will be implemented by year-end to ensure that undue delays are eliminated.

- b) While performance goals currently exist for many components of the complaint process, Medical Board staff will establish additional performance goals for those complex and unusual complaints which require procedural steps beyond the standard process. These additional goals will help to ensure that cases move forward in a timely manner.

### **Board of Nursing Response:**

Agree.

- a) The Board of Nursing uses various Division-wide baseline data available to it in establishing performance expectations and goals. These performance expectations are reflected in the Division's and the Board of Nursing's Section Plan as well as individual employee performance plans. Acknowledgment of receipt of a complaint is sent within 3 business days. Until recently, routine 30-day letters were sent within 10 business days. However, the Board recently implemented a pilot study in which all 30-day letters are sent out monthly on a pre-determined schedule that corresponds with the Board's meeting schedule, rather than upon receipt of the complaint. All letters sent out monthly have the same due date. This pilot will be evaluated for improved staff efficiency, including a less complex tickler system.
- b) The Board of Nursing will evaluate the need for additional performance and quality indicators. The Board has an established Continuous Quality Improvement (CQI) team that can conduct the evaluation. Additionally, the Board implemented a procedure to generate computerized monthly reports on open cases to ensure they are moving as expeditiously as possible. Staff will follow up with consultants, investigators, attorneys, and other appropriate parties as necessary. These monthly reports will be in addition to existing quarterly case status reports and the existing ongoing contact with staff of C&I and the AGO.

### **Recommendation No. 6:**

The Board of Medical Examiners and the Board of Nursing should work closely with the Division of Registrations to ensure that the new case management system includes triggers to monitor key aspects of complaint resolution and discipline and to automate rote processes such as automatically sending out standard correspondence and notifications.

### **Division of Registrations Response:**

Agree. The Request for Proposal (RFP) has been released and selection of a vendor will be completed within the next few months. The Division recognized the need for any replacement licensing system to include an automated case management system that includes triggers to monitor key events within the complaint intake, complaint resolution and discipline processes. The RFP outlines the need for a robust system that fully supports the Division's business functions and a high priority has been placed on system requirements related to tracking the complaint and disciplinary status and alerting the user to generate correspondence based on changes to that status.

The BPR Project identified several system requirements for routine correspondence to be generated without human intervention. However, within the enforcement business function automatic correspondence without human intervention was not identified as a system requirement due to the nature of this business function. The system would be required to maintain templates for standard types of correspondence. The Division is expecting full implementation of the new licensing system by June 2003.

### **Board of Medical Examiners Response:**

Agree with Division of Registrations' response.

### **Board of Nursing Response:**

Agree. Consistent with the previous response to recommendation No. 4, the Board of Nursing is committed to working closely with the Division of Registrations to ensure that the new replacement licensing system and the case management system include triggers to monitor key aspects of complaint resolution and discipline and to automate rote processes such as automatically sending out standard correspondence and notifications. However, 30-day letters cannot be categorized as a rote process. The Board of Nursing is implementing a new process to ensure that these letters become more individualized to the unique aspects of the case. This process is being implemented to improve efficiency, timeliness, and cost-effectiveness in the formal investigative and AGO stages of a case.

---

---

## Current Automated Case Tracking System Includes Stale Data

In addition to certain documentation and process delay issues, we also found that the case tracking system used by both boards, ARMS, included closed cases within its database of open case files. Specifically, 44 percent of Nursing Board and 12 percent of Medical Board cases selected for review and classified as open, had previously been resolved and were closed. This issue is primarily “housekeeping” in nature and does not negatively impact the operations of either board. However, not properly classifying cases does result in overstated numbers of open cases and may create confusion when assessing workload or tracking a specific case.

Although conducting computer operations to identify cases needing to be purged or reclassified from the open case database is desirable, the Division’s reengineering process, intended to streamline processes and provide improved systems for case management, should first be considered. The boards should determine the probability and timing of any new system and assess the short and long-term benefits of cleaning up the existing ARMS. If a new system is not forthcoming in the foreseeable future, the boards should consider updating the system. Nonetheless, the boards must ensure that data are accurate before converting over to any new case management system.

---

### Recommendation No. 7:

Board of Medical Examiners and Board of Nursing staff should take proactive measures to ensure that resolved cases are properly reclassified. Moreover, the Board of Medical Examiners and the Board of Nursing should ensure that only clean and accurate data are moved to the new system.

### Board of Medical Examiners Response:

Agree. The Medical Board has taken and will continue to take proactive measures to ensure that resolved cases are properly documented in the ARMS system. Because of the eccentricities of ARMS, this is an ongoing process which Board staff carries out quarterly to verify case status and correct any errors in status. We agree with the recommendation that it is necessary to take these proactive measures to ensure proper classification of cases on the computer system and to ensure that only clean and accurate data are moved to the new system. We will continue to be vigilant in this regard.

## **Board of Nursing Response:**

Agree. The Board of Nursing established an internal Continuous Quality Improvement (CQI) team approximately two years ago. The team has been developing tickler systems, checklists, desk procedures, and internal training and cross training to ensure the accuracy of a database of over 76,000 licensees, who frequently hold more than one type of nursing license. The aim is to eliminate the types of occurrences referenced in the audit report. The team recently implemented a monthly quality-check scan of the licensing system following monthly actions by the Board's panels to ensure the case status is accurately entered. This team will work closely with the Division to ensure that only clean and accurate data are moved to the new licensing system. Additionally, the Board will work closely with the Division to ensure that the new system has the necessary data fields to track a licensee population that is extremely mobile, has frequent name changes, and hold multiple types of nursing licenses.

---

## **Tracking Referred Enforcement Cases Is Difficult**

The staff supporting both boards have limited responsibilities related to the actual investigation and development of enforcement cases. Much of the case development, investigation, and prosecution is conducted by outside consultants, the Division's Complaints and Investigations (C&I) Section, and/or the Attorney General's Office. Board staff conduct initial reviews of complaints, determine whether the issue is within the board's jurisdiction, obtain the licensee's response to the allegation by sending the "30-day letter," review the licensee's reply, and obtain other pertinent background information. Some staff at the Nursing Board are licensed nurses and apply their expert knowledge and judgment to many cases, often minimizing the need to contract for outside experts.

However, when cases at either board warrant additional expert review, investigative services, or prosecution, then staff refer cases to outside entities. Because referred cases leave the immediate control of board staff, tracking and managing the progress of cases is more challenging. As a result, the boards wait for the outside entities to conduct their work before they take the enforcement case to the next step. Although the boards are technically "clients" of these outside agencies and should be in position to exercise control over these activities, the boards maintain that in reality they have limited influence in getting things done. Because as previously discussed, each case is different and the complexity and nature varies, regardless of attention by the boards or these outside entities, resolution may take long periods of time.

Three places in the enforcement process may require services outside the boards' control. First, some cases require expert evaluation, sometimes in the early stages to ascertain the validity of the complaint, credibility of the evidence, and the strength of a potential enforcement effort, and also later in the process to conduct actual investigations requiring specific expertise. Both boards use a number of medical or nursing experts to conduct these reviews. The second place the board refers enforcement cases to is the Division's Complaints and Investigations (C&I) Section. C&I conducts investigations on behalf of all of the boards within the Division. When a board refers a case, C&I completes an investigation of the allegation and prepares a formal report of its findings. Based upon the C&I results, boards determine the appropriate next action to take, ranging from prosecution of the licensee to dismissal of the issue.

The third place the boards typically use outsiders is prosecution services provided by the Attorney General's Office. In instances where cases are directly referred to the Attorney General or when the investigation is not complete when referred, the Attorney General's Office conducts the investigation and undertakes the prosecutorial activities. Most often, the majority of investigative activity is complete prior to referral and the Attorney General's Office builds a case and proceeds or advises the board as to the appropriate disciplinary action.

Tracking cases referred to other state entities such as C&I and the Attorney General's Office is more difficult for a number of reasons. One difficulty arises from the fact that both C&I and the Attorney General's Office are entities independent of the two boards. Moreover, although there are dedicated resources at both entities to the two boards and the C&I or Attorney General's Office adopt a similar priority, the completion of the work is still subject to workload and the case itself. The situation is further complicated by the unpredictable nature of investigations and prosecutions. The progress of these efforts is impacted not only by the efforts of C&I and the Attorney General's Office but also by factors such as the responsiveness of a licensee, his or her employer, or other group; finding witnesses or needed experts; and conducting settlement discussions or negotiating disciplinary actions. All of these factors can significantly impact the timely resolution of a case.

According to board staff, the medical and nursing experts work directly for them under contract. Being external private contractors, the staff may more readily set expectations and timelines for services. However, when board staff refer cases to C&I and the Attorney General they expect that these agencies will appropriately conduct their work and the board will be notified when the investigation is completed, further action is needed, or a settlement or prosecution is at hand. Other than making notations in the files indicating that cases have been referred to these entities, the current case management process does not include a proactive mechanism to ascertain the status and expected date of completion. Having the ability to easily and proactively track progress of referred cases would ensure

that they do not stay too long at the consultant or other agency, would provide a tickler tool for staff to follow-up on case progress at certain points, and assist in setting board agendas and workload.

Currently, board staff may obtain the status of cases from these outside agencies only by direct inquiry. Given the variety of unpredictable issues affecting the progress of these external services, there is little in the way of industry standards or uniform timeframes for completing investigations or enforcement activities. However, C&I or the Attorney General's Office could be asked to estimate timelines for each case and the individual boards could internally set certain timelines or milestones for tracking purposes. These "budgets" should be mutually agreeable and known to be flexible. By setting periodic checkpoints, staff could prompt proactive status reports from all three external groups, remain reasonably abreast of progress, and ensure that the cases keep moving forward. Moreover, by monitoring cases that are referred to other entities, the boards' may be able to provide more assistance to these investigative and disciplinary processes with the intent to expedite and assist in these efforts. The Medical and Nursing Boards, the Attorney General's Office, and the Division's C&I must operate with the goals to quickly but judiciously move these cases through the enforcement process to fulfill their missions to protect the public from healthcare professionals unfit to practice.

---

### **Recommendation No. 8:**

As each case is referred to the external experts, the Division of Registrations' Complaints and Investigations Section, or the Attorney General's Office, the Board of Medical Examiners and the Board of Nursing staff should initiate a process to assign mutually agreed to "budgets" or estimated timelines. The individual boards should set intermediate milestones or checkpoints to prompt proactive check-in calls to appropriate external groups. These timelines should be incorporated into the case file. At predetermined points, staff should contact the respective entity and obtain a brief update of the case status. Any new case management system should facilitate online updates, and staff should adjust the time schedule as appropriate.

### **Division of Registrations Response:**

Agree. The Division agrees with the recommendation that the Board of Nursing and the Board of Medical Examiners work with the Division of Registrations' Complaints and Investigations Section and the Attorney General's Office to agree on estimated timelines for completion of cases. The Division will meet and communicate on a regular basis with representatives from the Board of Nursing, Board of Medical Examiners, the Complaints and Investigations Section, and the Office of the Attorney General to ensure that all cases are processed in a timely manner.

### **Board of Medical Examiners Response:**

Agree. We agree with the recommendation to work with the Division of Registrations' Complaints and Investigations Section and the Attorney General's Office to agree on estimated timelines for completion of cases. We will continue our quarterly procedure to review with these entities the status of each case and receive progress updates. Further, we will also continue to receive on a quarterly basis written case status reports from the Attorney General's Office and Complaints and Investigations. Medical Board staff will continue their ongoing efforts to work with these entities to ensure to the best of its ability that timelines are met.

### **Board of Nursing Response:**

Agree. The Board believes case status reports are an important aspect of managing cases referred to external agencies. Currently, the Board confers with the Complaints and Investigations Section (C&I) and the AGO on the prioritization of cases referred. The Board also receives nurse and nurse aide case status reports from the AGO and C&I. The Board recently implemented a plan for the monthly review of cases in C&I. The aim of the Board's CQI team is to make improvements, including the identification of more systematic approaches to determine case budgets and timelines. The new licensing system should greatly enhance the ability and efficiency of tracking checkpoints and timelines.

### **Office of the Attorney General Response:**

Agree. The Attorney General's Office currently provides regular status reports on all pending cases to the staff of the Board of Medical Examiners and the Board of Nursing. We also work with Board staff to set budgets and timelines for the progression of cases, and will continue to do so. In addition, the Attorney General's Office will continue to evaluate its case management procedures to ensure that we prosecute cases expeditiously and utilize resources appropriately.

### **Recommendation No. 9:**

The Board of Medical Examiners and the Board of Nursing should ensure that the Division of Registrations' reengineering project considers communications and information sharing needs between Division functional units, such as the Complaints and Investigations Section, and the regulatory boards. This may entail a process to grant access or share case information in the instances where work is being conducted by more than one of the entities within the Division.

### **Board of Medical Examiners Response:**

Agree. The Board of Medical Examiners' staff will work closely with other staff within the Division of Registrations and the Department of Regulatory Agencies to ensure that communication and information sharing needs between the Division's functional units are considered

### **Board of Nursing Response:**

Agree. The Board of Nursing's staff will work closely with other staff within the Division of Registrations and the Department of Regulatory Agencies to ensure that communication and information sharing needs between the Division's functional units are considered.

---

## **Additional Attorney General Funding Achieved the Goal of Reducing Nursing Board Case Backlog**

Often, once the Nursing Board determines that an infraction against the practice act has occurred, the board and licensee can come to agreement as to appropriate disciplinary action. If a licensee and the board cannot agree that an indiscretion occurred or cannot reach a mutually acceptable discipline, the board refers the case to the Colorado Attorney General's Office. The Attorney General's Office will initially attempt to settle the case with the licensee without going before an administrative law judge. If a settlement still cannot be reached, the case undergoes a formal hearing to determine if the licensee violated the practice act.

In 1998, the Attorney General received funding to dedicate two attorney positions for Nursing Board cases to reduce the backlog and meet resource needs. Since 1998, the backlog has successfully been resolved and at the end of Fiscal Year 2001, the Attorney General's Office now carries 81 active Nursing Board and Nurse Aide cases as compared to 216 cases prior to the budget augmentation. Despite the June 30, 2001 termination of the funding for additional resources both entities believe that the backlog is adequately resolved and barring changing circumstances the resources should be sufficient to meet expected enforcement demands.

## **Board Actions Can Prevent Development of Another Backlog**

The Nursing Board has actively worked to reduce the Attorney General's Office caseload and to help retain it at a reasonable level. Specifically, it created processes to enable the settlement of cases before reaching the Attorney General. The two processes, the Alternative Complaint Resolution Process and the Expedited Settlement Process, are designed to allow board staff to work directly with the licensees to reach an expedited resolution. The Alternative Complaint Resolution Process is used for complaint cases that do not pose a threat to the well being of patients and where the licensee agrees that they may have made a mistake. In these cases, nurse practice consultants meet with the licensee to assess his or her nursing skills and knowledge and determine if disciplinary action is necessary. The majority of the complaints handled this way result in either a case dismissal or Letter of Concern, which is a non-public reprimand. During Fiscal Year 2000, the board handled 34 cases using the Alternative Complaint Resolution process.

The Nursing Board uses the Expedited Settlement Process to reach an agreement with the licensee without bringing in the Attorney General's Office to conduct the settlement. After a Nursing Board panel deems that a case warrants disciplinary action, staff decide if it requires Attorney General attention or if the case can be settled through the Expedited Settlement Process. For a case to go through the Expedited Settlement Process the Division's C&I Section or a private consultant must have investigated the case and determined the infraction. If the violation is one that would not result in a suspension or revocation of the licensee under the practice act, then the Nursing Board staff, following statutory guidelines for the applicable punishment, negotiates with the licensee to bring resolution to the case. During the process, the staff may enlist the assistance and expertise of Attorney General's Office staff. If the Nursing Board staff and the licensee cannot agree on a suitable stipulation, the case is forwarded to the Attorney General to be completed under the usual process. In Fiscal Year 2000, there were 48 cases resolved using the Expedited Settlement Process.

In addition to implementing the alternative approaches to case resolution, Attorney General staff credit the Nursing Board for referring more complete cases over the past two years. Specifically, the board has the C & I or a private consultant conduct a more detailed investigation of the cases prior to referring them, thus reducing the amount of work to be done by the Attorney General's staff. As a result, staff find that cases are resolved sooner and require fewer resources to complete.

Beginning July 1, 2001, the Attorney General's Office no longer received the additional funding for the two positions to work Nursing Board cases. Nonetheless, the Attorney General staff indicate that the caseload is at a manageable level and believe they can obtain disciplinary outcomes for the Nursing Board in a timely manner. Moreover, Attorney General staff indicate that the changes made in the Nursing Board enforcement and case management approaches should allow the caseload to remain at a workable level for the foreseeable future. However, many variables affect the enforcement process, including the overall staffing levels at the Attorney General's Office, the Nursing Board, and C&I; the volume of complaints received by board; and other factors that could increase the backlog at any of the three entities.

---

### **Recommendation No. 10:**

To ensure that the Office of the Attorney General continues to obtain the appropriate and timely disciplinary outcome on behalf of the Board of Nursing for all referred cases, both the Board of Nursing and the Office of the Attorney General should closely monitor the volume and resolution process of referred cases. Further, both entities need to ensure frequent communication of all issues that may affect the timely resolution of enforcement actions.

#### **Board of Nursing Response:**

Agree. The Board of Nursing currently monitors the number of cases referred to external agencies on a monthly and cumulative basis. There is ongoing communication on prioritization and timelines for the resolution of cases and on issues that impact the resolution. The Board of Nursing is implementing changes in the Alternative Complaint Resolution Program and Expedited Settlement Process that are designed to enhance the Board's ability to resolve cases prior to referral to the AGO. Additionally, the change to a more focused 30-day letter should assist in ensuring a more detailed investigation of cases prior to referral to the AGO.

#### **Office of the Attorney General Response:**

Agree. The Attorney General's Office currently monitors the number of cases referred to it by the Board of Nursing. In addition, in consultation with the staff of the Nursing Board, the Attorney General's Office sets projected timelines for the resolution of cases, prioritizes cases and communicates concerning issues that

impact the resolution of cases. The Attorney General's Office will frequently communicate with Board staff.

---

---

---

# Probation Monitoring

## Chapter 3

---

### **The Medical Board Needs to Better Enforce Probationary Requirements**

After completing the complaint process and determining disciplinary action is warranted, the physician or physician assistant and the Medical Board may enter into a written stipulation agreement that details the terms of the discipline. The agreement defines the provisions and disciplinary actions the licensee must fulfill in order to retain the license. The stipulation agreements created by the board may include but are not limited to both an education provision and a probationary period with a monitoring requirement. The monitoring can take the form of treatment monitoring—for complaints involving issues such as psychological disorders or substance abuse, or practice monitoring—for complaints involving substandard care or unprofessional conduct. Generally, the monitoring period lasts five years; the licensee may petition the board for less time, but reductions are infrequently approved. The five-year probation period is not unlike that imposed by four of the five other state medical boards we contacted, which ranged from one to ten years. We found that the Medical Board needs to provide better oversight of those physicians on probation.

### **Educational Programs May Be Included in Disciplinary Actions**

Medical Board stipulation agreements may also include a requirement for the licensees to obtain additional training and education through the Colorado Physician Education Program (CPEP). Licensees must pay for these educational services. Once a licensee is referred to the educational program, CPEP performs an evaluation to identify practice or educational weaknesses. CPEP then creates a personalized educational plan for the physician. This learning program may be 6 to 18 months in duration and includes a reassessment at its completion to assess whether the physician has satisfactorily remediated the identified weaknesses.

We selected a sample of 12 individuals from the 100 board licensees currently on probation and one licensee from the 66 stipulations being held in abeyance (these

physicians were not practicing within the State of Colorado.) Within this sample of 13 probation cases, six cases included a CPEP requirement. We verified that in all six cases, files adequately document that the licensees completed the CPEP requirements within the time period specified by the Medical Board.

## **Physicians' Disciplinary Action May Require Treatment Monitoring**

When stipulation agreements require treatment monitoring, the licensee must report to the Colorado Physician Health Program (CPHP). The Medical Board contracts with CPHP to evaluate, refer, and monitor physicians potentially needing programs for chemical dependency, psychological treatment, and other similar treatments. CPHP is paid for through the licensing fees collected by the board and provides its services free of charge to all Colorado licensed physicians and physician assistants. Individuals may report voluntarily to CPHP; however, if CPHP determines that a treatment or dependency issue may inhibit the individual from practicing medicine safely, it notifies the Medical Board and a formal complaint may be issued against the licensee. Upon reporting to the program, CPHP assesses the licensee's condition and may create a treatment plan that includes all of the steps necessary for rehabilitation. The licensee must agree to the plan, and sign it in accordance with the provisions set out in the stipulation agreements. Many physicians continue to practice during the monitoring period—however, those determined to be a danger to patients may not practice until approved to do so. As part of the monitoring, CPHP submits quarterly reports to the Medical Board providing information as to whether the licensee is adhering to the treatment plan and stipulation agreement. Depending on the requirements, the quarterly reports may include dates, results of urine tests, and statements from CPHP regarding the physician's compliance with treatment requirements. Once received, the Medical Board's compliance monitor is tasked to review the reports to ensure that the licensee adheres to the stipulation.

Of the 13 cases selected for our sample, 6 are undergoing a form of treatment monitoring. Only 4 of the 6 required probation reports at the time of our review. For each of these 4, the required quarterly reports are on file without exception, and they appropriately reported on the probationer's status, his or her adherence to treatment, and progress in fulfilling the terms of the stipulation agreements. Moreover, the files we reviewed reveal that the licensees completed all aspects of their individual stipulation agreements within the required time periods. However, there is no documentary evidence to verify that Medical Board staff actually reviewed any of these quarterly reports; thus, the system lacks a final control in the practice monitoring cycle. Because no proof is available to adequately demonstrate that staff review these reports, the board lacks assurance that this step is done timely, if at all.

To strengthen and add accountability to the monitoring process, and to create a sense of responsibility with the staff compliance reviewer, the Medical Board should add an additional control to the process. The board should establish a workload performance measure of a specific timeframe for reviewing submitted treatment and practice monitoring reports and require staff to initial and date these documents. Further, complaint file checklists or logs should reflect the completion of these review activities.

---

### **Recommendation No. 11:**

The Board of Medical Examiners needs to improve controls over receiving and reviewing treatment monitoring reports by requiring staff to ensure their receipt and to initial and date reports upon review.

#### **Board of Medical Examiners Response:**

Agree. The recommendation for dating and initialing treatment monitoring reports will be implemented on November 1, 2001. Medical Board staff currently has a tickler system to trigger when monitoring reports are due and Board staff follows up if reports are not timely received. It is the hope of the Medical Board that the new computer system will allow us to automate this function.

---

## **The Medical Board Needs to Strengthen Controls Over Practice Monitoring**

Most Medical Board stipulation agreements require practice monitoring. This disciplinary action involves appointing a peer clinician to review the probationer's patient case files on a monthly basis and report the results of these reviews to the Medical Board. The licensee must find an individual to serve as the practice monitor, who must then be approved by the board. The board specifies that a practice monitor cannot have too close a relationship to the licensee and must be in good standing with the Medical Board. Further, the monitor must practice in a similar field as the licensee. For example, if the licensee is a cardiologist the practice monitor must also be a cardiologist. For Physician Assistants, the practice monitor generally is a supervising physician.

Once a physician agrees to become a practice monitor, a Medical Board panel reviews his or her qualifications and relationship to the licensee and accepts or denies the candidate. If the board does not approve a practice monitor, the licensee must continue

to seek one that is acceptable to the board. An approved monitor must sign a statement agreeing to all requirements for serving in this role, including monthly reviews of 10 of the licensee's case files. (Five from regular cases and five from cases referred to a hospital.) In conducting such reviews, the practice monitor is ensuring that the licensee took appropriate action in each case. Quarterly, practice monitors submit reports to the Medical Board that include a listing of the case files reviewed with a determination of whether or not the licensee acted appropriately in each case. Quarterly reporting also requires the practice monitor to make a determination of the competency of the licensee.

As a member of the Medical Board's staff, the compliance monitor tracks the receipt of the quarterly reports and reviews them for adequacy. If a required report is not received, the compliance monitor sends out a reminder to the practice monitor. If the report indicates that the licensee is not practicing safely, the compliance monitor notifies the Medical Board and a formal complaint is issued against the licensee. Provided that the report indicates satisfactory efforts, the compliance monitor sends a letter to the practice monitor informing them the report was received and when the next report is due. Further, the compliance monitor's letter may inform the practice monitor of any needed changes or improvements in future reports.

There are a variety of infractions to the Medical Act that warrant disciplinary actions, in particular practice monitoring. Table 6 illustrates the issues identified in our sample of cases.

Table 6

<b>Board of Medical Examiners Physician Indiscretions* Within Sample</b>	
Issue	Number of Cases
Improper Prescribing of Medication	4
Unprofessional Conduct	4
Substance Abuse	3
Mental Illness	2
Physical Disability	1
Substandard Care	1
Sexual Boundary Issues with Patients	1
* Some physicians were placed on probation for multiple issues; therefore, the total does not equal the amount of cases within our sample.	

Using our sample of the 13 probation cases, we found that nine stipulated practice monitoring: the majority of these cases involved unprofessional conduct or improper prescribing of medications. Two of the nine cases had no reports due at the time of our testing. Of the cases reviewed, we found that files included the required reports with the exception of three instances where we identified one report missing from each. In these instances, we found no evidence of correspondence or other Medical Board action concerning the missing reports within the files. The Medical Board believes that the missing reports were received but were misplaced. While the compliance monitor uses an aging report to notify him when reports are due, we find that the missing reports point to a weakness in the process. We consider this a minor exception that should be addressed through a new case management system. As mentioned earlier in this report, the new case management system should include placeholders for all documents and reports and a checklist log to record the receipt of such information.

In our sample of nine cases, we also found two where significant delays occurred in establishing a practice monitor; in one case seven months elapsed before an approved appointment was made, and the other took more than two months to complete the selection process. In these two cases, the Medical Board did not take any compensating action to either “restart the clock” or add elapsed time to the end of the probation period. Further, there were no indications that the practice monitor went back to conduct the review of files from the unmonitored period. We did not find any evidence to suggest that those two licensees without monitors were practicing unsafely during their probationary periods; however, lapses in the Medical Board’s monitoring controls could jeopardize public safety, since the doctors had committed violations that merited practice monitoring.

---

### **Recommendation No. 12:**

To ensure the protection of patients, the Board of Medical Examiners should not allow physicians to continue to practice until the licensee has obtained an approved practice monitor. In addition, the probation period should not begin until the approved practice monitor has been obtained.

### **Board of Medical Examiners Response:**

Agree. The Stipulation and Final Board Order language was revised by the Medical Board’s legal staff to implement this recommendation, effective October 1, 2001.

---

## **The Nursing Board Adequately Monitors Its Probationers**

Similar to the Medical Board, if the Nursing Board determines, or an administrative law judge finds, that a complaint justifies disciplinary action, the board requires the nurse licensee to sign a stipulation agreement. The stipulation may require the licensee to undergo a monitoring period. Like the Medical Board, monitoring can be in the form of treatment or practice monitoring. However, the Nursing Board's typical probationary period is significantly shorter than the Medical Board's. While the Medical Board generally requires five years of probation for both treatment and practice monitoring, the Nursing Board monitoring period usually is two years for practice monitoring and three to five years for treatment monitoring. The duration of this probationary period is similar to those used by two of the four other state nursing boards that we contacted. The other two state boards have no set probationary periods, rather the durations vary as the boards determine the period on a case-by-case basis.

### **Treatment Monitoring Is Also Used by the Nursing Board**

If the licensee's stipulation resulted from a chemical dependency or psychological disorder, the board may require the licensee to undergo treatment monitoring; the Colorado Nurse Health Program (CNHP) provides this service for nurses. A comparable program to the Medical Board's Health Program, CNHP evaluates and monitors registered and practical nurses referred for treatment and is paid for within their licensing fees. Psychiatric Technicians and Certified Nurse Aides are not statutorily included in the CNHP program and do not pay the related increment in their licensing fee.

If a licensee is referred to CNHP, an assessment is completed and an appropriate course of action is determined. The CNHP describes this action or monitoring plan in a contract with the licensee. If the licensee does not agree to the course of action or fails to sign the monitoring plan, the nurse will not be admitted to CNHP for monitoring and the Nursing Board may take additional disciplinary action—which can lead to suspension, revocation, and other penalties. The course of action may require medical treatment, group support meetings, and case management, chosen to address the licensee's problems.

CNHP submits quarterly statistical reports that include statistics on the number of licensees currently undergoing monitoring. Further, should a licensee not adhere to his or her monitoring plan, CNHP will notify the Nursing Board's compliance monitors who

determine if the indiscretion warrants referral to the board for further investigation and possible discipline.

To test the board's processes and procedures over probation activities, we selected 11 cases out of the 97 cases being monitored as of May 2001. Six cases involved some form of treatment monitoring from CNHP; but of these, only four were actively practicing nursing—the other two were out of practice or their license was suspended. Of the licensees actively practicing, one was not admitted to CNHP and the Nursing Board issued a complaint to suspend the nurse's license. For the remaining three, the licensees were adhering to all requirements of their stipulations. Therefore, we found that the Nursing Board and staff acted appropriately in the activities overseeing treatment monitoring cases within our sample.

## **Practice Monitoring Is Often Ordered for Issues Involving Quality of Care**

If the Nursing Board finds a licensee has a standard or quality of care issue, the board may require a practice monitoring probation similar to the Medical Board. In Nursing Board cases, the licensee's supervisor is usually the practice monitor. Together the licensee and supervisor create a plan of supervision that must be approved by board staff and includes the steps deemed necessary to appropriately remediate the identified areas of substandard care. The supervisor is responsible for submitting the quarterly reports to the Nursing Board's compliance monitors, who review them upon receipt. If the reports are late or inadequate, the compliance monitors refer the case to the board for guidance. In these cases, the compliance monitors first will question the practice monitor or call the licensee directly to obtain more information. If staff determine a problem or breach of plan, the compliance monitor may request that the board provide guidance. It is up to the board to determine the need for any further action.

From our sample of 11 probation cases, there were eight cases requiring a practice monitor. In three of the cases, the Nursing Board received inadequate or late reports but in one of these cases, the board ultimately received and accepted additional information. However, in two other cases the Nursing Board did not accept reports and the probation periods were extended. All other case files included the appropriate reports and evidence of staff reviews. Of note, unlike the Medical Board's practices, Nursing Board staff do provide sufficient evidence of reviews and analysis of monitoring reports. In all of the cases sampled, the Nursing Board and its staff consistently and adequately followed probationary policies, procedures, and regulations. The board has only just begun

determining trends related to program success. Between July 1, 1999, and June 30, 2001, 28 complaints were received relating to licensees formally disciplined.

## **Distribution**

### **Copies of this report have been distributed to:**

Legislative Audit Committee (12)

Department of Regulatory Agencies (2)

Division of Registrations (2)

Board of Medical Examiners (2)

Board of Nursing (2)

Office of the Attorney General (2)

Joint Budget Committee (2)

Department of Personnel  
d.b.a. General Support Services  
Executive Director (2)  
State Controller (2)

Honorable Bill Owens, Governor

Office of State Planning and Budgeting (2)

---

Depository Center, Colorado State Library (4)

Joint Legislative Library (6)

State Archivist (permanent copy)

National Conference of State Legislatures

House Business Affairs and Labor

Senate Business, Labor and Finance

Legislative Legal Services

Auraria Library

Colorado State University Library

### **Copies of the report summary have been distributed to:**

Members of the National Legislative Program Evaluation Society

Members of the Colorado General Assembly

National Association of State Auditors, Comptrollers, and Treasurers

**Report Control Number 1408**