SUMMARY OF CHANGE REQUESTS
Schedule 10
FY 2008-09

Department of Regulatory Agencies
Total Number of Decision Items: 2 prioritized, 3 non-prioritized
Total Number of Base Reduction Items: 0

Priority #	Title	Total $$$	FTE	GF	CF	CFE	FF
1	DOR - Add 1.0 FTE for Board of Medical Examiners Complaints	72,915	1.0		72,915		
2	DOR - License Records Management Funding	89,706	1.0		89,706		
DECISION ITEM SUBTOTAL		162,621	2.0	0	162,621	0	0

Priority #	Title	Total $$$	FTE	GF	CF	CFE	FF
NP-1	Statewide Vehicle Replacement	(67,972)			(67,972)		
NP-2	Statewide C-SEAP Program Funding	1,122		40	946	117	19
NP-3	Commisson for the Deaf and Hard of Hearing Cash Fund	31,116			31,116		
BASE REDUCTION ITEM SUBTOTAL		(35,734)	0.0	40	(35,910)	117	19
		0					
TOTAL		126,887	2.0	40	126,711	117	19

DEPARTMENT OF REGULATORY AGENCIES FY 2008-09 BUDGET REQUEST

Schedule 11 – Summary of Supplementals

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DEPARTMENT OF REGULATORY AGENCIES FY 2008-09 BUDGET REQUEST

Schedule 12 – Summary of Budget Request Amendments

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DEPARTMENT OF REGULATORY AGENCIES FY 2008-09 BUDGET REQUEST

Change Requests

Schedule 13
Change Request for FY 08-09 Budget Request Cycle

Decision Item FY 08-09 ☑ **Base Reduction Item FY 08-09** ☐ **Supplemental FY 07-08** ☐ **Budget Request Amendment FY 08-09** ☐

Request Title: Board of Medical Examiners Complaint Management
Department: Regulatory Agencies
Priority Number: 1 of 2
Dept. Approval by: D. Ng **Date:** 10/12/07
OSPB Approval: [signature] **Date:** 10/14/07 for 11/1/7

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	12,643,453	12,966,828	0	12,966,828	12,921,113	72,915	12,994,028	0	12,994,028	75,934
	FTE	157.30	169.50	0.00	169.50	170.10	0.90	171.00	0.00	171.00	1.00
	GF	0	800	0	800	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	12,384,851	12,707,126	0	12,707,126	10,461,789	72,915	10,534,704	0	10,534,704	75,934
	CFE	258,602	258,602	0	258,602	2,459,324	0	2,459,324	0	2,459,324	0
	FF	0	0	0	0	0	0	0	0	0	0
(9) Division of Registrations Personal Services	**Total**	10,664,552	10,677,567	0	10,677,567	10,982,897	69,001	11,051,898	0	11,051,898	75,000
	FTE	157.30	169.50	0.00	169.50	170.10	0.90	171.00	0.00	171.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	10,664,552	10,677,567	0	10,677,567	8,782,330	69,001	8,851,331	0	8,851,331	75,000
	CFE	0	0	0	0	2,200,567	0	2,200,567	0	2,200,567	0
	FF	0	0	0	0	0	0	0	0	0	0
(9) Division of Registrations Operating Expenses	**Total**	1,310,501	1,285,915	0	1,285,915	1,269,589	3,759	1,273,348	0	1,273,348	779
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	1,310,501	1,285,915	0	1,285,915	1,269,589	3,759	1,273,348	0	1,273,348	779
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(1) Executive Director's Office Hardware/Software Maintenance	**Total**	668,400	1,003,346	0	1,003,346	668,627	155	668,782	0	668,782	155
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	800	0	800	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	409,798	743,644	0	743,644	409,870	155	410,025	0	410,025	155
	CFE	258,602	258,602	0	258,602	258,757	0	258,757	0	258,757	0
	FF	0	0	0	0	0	0	0	0	0	0

Schedule 13
Change Request for FY 08-09 Budget Request Cycle

Decision Item FY 08-09 ☑ **Base Reduction Item FY 08-09** ☐ **Supplemental FY 07-08** ☐ **Budget Request Amendment FY 08-09** ☐

Request Title: Board of Medical Examiners Complaint Management

Department: Regulatory Agencies **Dept. Approval by:** **Date:**

Priority Number: 1 of 2 **OSPB Approval:** **Date:**

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10

Letternote revised text: Add the requested amount to the total that "shall be from the Division of Registrations Cash Fund".

Cash Fund name/number, Federal Fund Grant name: Division of Registrations Cash Fund, #189

IT Request: ☐ Yes ☑ No

Request Affects Other Departments: ☐ Yes ☑ No **If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Department of Regulatory Agencies
Priority Number:	1 of 2
Change Request Title:	Board of Medical Examiners Complaint Management

SELECT ONE:
☒ Decision Item FY 08-09
☐ Base Reduction Item FY 08-09
☐ Supplemental Request FY 07-08
☐ Budget Request Amendment FY 08-09

SELECT ONE:
Supplemental or Budget Request Amendment Criterion:
☒ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☐ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request:

The Department requests $72,915 Cash Funds (Division of Registrations Cash Fund) and 1.0 FTE General Professional V @ 0.9 FTE in the first year to manage and expedite high priority and complex complaints received by the Board of Medical Examiners.

Background and Appropriation History:

MEDICAL BOARD PROTECTS PUBLIC FROM UNSAFE PRACTITIONERS

The mission of the Colorado State Board of Medical Examiners (Board) is public protection through effective licensure and enforcement. Specifically the Board is charged with assuring public protection to the citizens of the state of Colorado from incompetent, unethical, and unsafe practitioners, and is empowered by the Medical Practices Act (the Act) to enforce a minimum level of quality in the delivery of health care services by physicians. The Board seeks to achieve this goal by setting and enforcing basic standards of competence, and carries out the licensure and enforcement of medical practitioners. In particular, Board enforcement requires the review of

complaints and information and, after investigatory and adjudication processes, the discipline of practitioners when appropriate.

APPROPRIATION HISTORY

The Medical Board is funded in the Personal Services, Operating, Legal Services, and Hearings line items within the Division of Registrations. Most recently, the board spent $1,375,241 during FY 05-06, which includes $692,528 in personal services, $91,319 in operating, $501,807 in legal services, and $89,586 in hearings.

The Board has a staff of 8.3 FTE as follows:

Medical Board Staff	**FTE**	
	FY 07-08	**FY 08-09**
Program Director	**1.0**	**1.0**
Enforcement Staff		
Initial Investigations: 1.0 FTE General Professional II; 1.5 FTE Administrative Assistant III	**2.5**	**2.5**
Unit Management and Support: 1.0 General Professional V; 1.0 FTE Admin Assistant III; 0.8 FTE Program Asst I	**2.8**	**2.8**
Licensing/Office Support Staff	**2.0**	**2.0**
	8.3	**8.3**

The Program Director is responsible for oversight of the entire program. The enforcement staff includes 1.5 FTE at the Administrative Assistant III level and 1.0 FTE at the General Professional II level who are responsible for complaint review, case set-up and processing, the initial investigation of the complaint, and the preparation of monthly board inquiry panel meeting agenda packets and meeting follow-up. The enforcement staff also includes 1.0 FTE at the General Professional V level responsible for overall management and supervision of the enforcement unit and for compliance monitoring of licensees on probation with the Board; 1.0 FTE at the Administrative Assistant III level to

provide administrative support to the enforcement unit; and 0.8 FTE at the Program Assistant I level responsible for the review, processing and follow-up of the mandatory license renewal questionnaire, which requires physicians to disclose conduct that may constitute a violation of the statute. The 0.8 FTE also is responsible for initiating reviews of disciplinary actions taken by other state medical boards that involve physicians also licensed in Colorado. Finally, the 2.0 FTE licensing staff conduct the Board's licensing and office support activities, including the processing of all applications in which possible license denial issues have been identified, all applications for international medical graduates, Olympic Training Center physicians and Distinguished Foreign Teaching Physicians, budget management and general office support.

The Board is the biggest consumer of legal services within the Division. This is due to the number of actions taken each year against physicians and the fact that physicians are most often represented by legal counsel, which can cause resolution to become protracted and more expensive. Also, many physicians receive $25,000 in legal defense for complaints filed with the Board as part of their liability insurance coverage, which also can be a disincentive to early resolution of a complaint. However, case resolution once the Panel makes a determination that a violation has occurred is not relevant to this request. **The focus of this request is on the front-end process in identifying and expediting cases for action by the Medical Board that are the most likely to adversely impact public safety.**

PUBLIC PROTECTION OCCURS THROUGH COMPLAINTS AND DISCIPLINARY ACTION

A key way in which the Board protects the public is through its complaint and disciplinary process, in which the Board receives and initiates complaints against alleged offenders of the Act. A complaint is an allegation of wrongdoing against a licensed physician that, if true, constitutes a violation of the Act and warrants disciplinary action against the physician. Complaints are received from a variety of sources including patients, healthcare professionals and entities, and insurance carriers. The complaint process includes a period of initial investigation, followed by Board review. Board

review can result in dismissal of the complaint, referral to a physician expert or referral for further investigation by the Division's professional investigations staff, followed by Board action. In general, from receipt to resolution this process can take more than 180 days, depending on the circumstances. Complaints that are more straightforward (typically involving a single patient, a single physician, and a single allegation) are usually resolved between 90 to 180 days. Complaints that are complex can involve multiple patients and patterns of misconduct and generally involve an important public safety component. These complaints, which are critical from the standpoint of the Board's mission of public protection, often take in excess of 180 days.

Resolution of complaints takes two forms: dismissal of the complaint, or disciplinary action taken by the Board. Disciplinary action ranges from: letters of admonition (equivalent to formal censure); stipulated agreements (in which the licensee must agree to conditions and/or restrictions on their practice); suspensions (in which a licensee cannot practice for periods of time); and license revocations (in which a licensee loses the right to practice). Most disciplinary actions involve a period of probation in which the physician must comply with certain terms and conditions to continue to practice medicine. Additionally, the Board can issue Cease and Desist Orders or pursue injunctive action against individuals engaging in the unlicensed practice of medicine.

The following chart, which shows Board action is required in a three-year average of 14.6% of jurisdictional complaints, summarizes these statistics for the last three years:

Summary of Actions Taken By Medical Board

Year	Complaints	Revocations (1)	Suspensions (2)	Stipulations (3)	Letters of Admonition	Other Actions (4)	Total Actions	% of Complaints	Jurisdictional Complaints	% of Jurisdictional Complaints
FY 04-05	1,080	5	22	66	27	12	132	12.2%	865	15.3%
FY 05-06	1,110	3	9	50	31	6	99	8.9%	865	11.4%
FY 06-07	1,039	3	23	44	56	4	130	12.5%	755	17.2%

(1) Revocations include voluntary surrender of license. (2) Suspensions are those actively served. Includes summary suspensions, agreements to cease practice in lieu of suspension and interim cessations of practice. (3) "Stipulations" replaces the previous category of "Probations." Stipulations may or may not include probation. (4) Other Actions include but are not limited to Revocations held in abeyance or stayed and Suspensions held in abeyance or suspended.

General Description of Request

The Department requests 1.0 FTE (General Professional V) @ 0.9 FTE during the first year to resolve a key bottleneck in the complaint and disciplinary process that is causing the Board to fall short of its standards in resolving cases in a timely fashion, and consequently compromising its effectiveness in protecting the public. Specifically, the requested FTE would be tasked with managing and expediting high priority and complex complaints received by the Board of Medical Examiners in order to maximize the timely referral of matters for Board action.

INITIAL INVESTIGATION & COMPLEXITY AFFECT SPEED OF COMPLAINT RESOLUTION

As mentioned in the background information above, a central element in the Board's ability to protect the public is the complaint and disciplinary process. When the Board receives or initiates a complaint, Board staff conducts an initial investigation into the allegations by issuing a subpoena for medical records if necessary, receiving a response from the physician licensee (generally referred to as the respondent), and consulting with medical experts. The results of this critical process – performed by 1.5 Administrative Assistant FTE and 1.0 GP II FTE – triage complaints into those that appear to be standard priority complaints and those that are high priority or complex complaints that appear to identify conduct that poses a greater threat to public safety.

The time frame for this initial investigation varies. The Act requires that a respondent be given thirty days to respond to the complaint, and this requirement impacts the time frame in which the complaint will be ready for Board review based on when the response is received and the deadline for the next scheduled Panel meeting. More importantly from the standpoint of this request, the time frame is influenced by the complexity of the complaint: initial investigation for straightforward complaints – which require only the respondent's response prior to ultimate Board action – are typically able to be presented

to the Panel within **90 days of receipt of the complaint**. On the other hand, initial investigation of high priority or complex complaints – which require records to be subpoenaed, a physical/mental evaluation and/or an expert to review the case – take **longer than 90 days** to complete the initial investigation. Approximately ten to fifteen percent of the total jurisdictional complaints – approximately 75 to 130 cases based on the statistics cited previously – are in the high priority or complex case categories as described in this request. Experience has shown that there is a greater likelihood that these cases involve physicians who pose a greater risk to public safety.

Until recently, complaints received by the Board were processed in the order of receipt. The only exception that was typically made was when a complaint disclosed conduct that required emergency action to protect the public health, safety or welfare (reference 24-4-104(4), CRS). However, the Division recently adopted policy 80-22, which establishes definitions for high priority complaints and standard priority complaints and the deadlines associated with each complaint type. The language of this policy is included at the end of this document. The complex cases that are the primary focus of this request will usually not meet the definition of a high priority case at first blush. However, these cases will convert to a high priority case if significant risk to the public is identified in the initial investigation but the Board needs the FTE that is the subject of this request to be able to perform that analysis.

THE BOARD'S MISSION OF CONSUMER PROTECTION REQUIRES THAT CASES BE RESOLVED AS EXPEDITIOUSLY AS POSSIBLE

While the amount of time required for each complaint is often subject to the specifics of the case, **public protection requires that all matters before the Board be analyzed, reviewed, and resolved as timely and efficiently as possible.** The reason for this is that all pending cases – until they are resolved by Board action – negatively affect public protection in the following specific ways:

- Each day a case is unresolved potentially permits an incompetent or negligent physician to remain in practice without proper oversight or restrictions;
- Each day a case is unresolved increases the difficulty in obtaining relevant and needed records and x-rays, which are sometimes lost, misplaced or destroyed
- Each day a case is unresolved increases public dissatisfaction with the length of time taken to resolve complaints
- Each day a case is unresolved increases inquiries from both physicians and the public regarding case status, resulting in staff resources being needed to respond to these inquiries, which diverts staff from other duties.

The current statutory and legal structure determines how quickly a case can be moved through the process. This time frame is outlined in general terms below:

Activity	**High Priority Case**	**Standard Priority Case**	**Complex case but not a high priority as defined in Division policy**
Complaint received and processed	5 days	14 days	14 days
Depending on the complexity may need to subpoena records to determine who needs to be investigated	n/a	n/a	30 days if needed
If case involves mental or physical disability issue, order physician to undergo evaluation by the Colorado Physician Health Program	14 to 60 days	60 to 120 days	60 to 120 days
Waiting to receive response from physicians	30 days	30 days	30 days
Depending on physician's response it may be necessary to issue a subpoena for records at this point in the process	30 days if needed	30 days if needed	30 days if needed
Depending on the issues identified, the case may need review by physician expert, who must be located and retained	7 to 30 days	7 to 30 days	7 to 30 days

Process ESPO for expert	2 days	2 days	2 days
Get case to expert	1 day	1 day	1 day
Wait for expert to review case and issue report. This will vary greatly depending on the experts availability and the complexity and number of records to be reviewed and the number of cases to be reviewed	30 to 120 days	30 to 120 days	60 to 120
Receive report from expert, review for completeness and prepare for Panel	5 days	14 days	5 to 14 days
To Panel for review and decision (this will vary based on when the report came in and when the next panel meeting is scheduled)	14 to 30 days	14 to 30 days	14 to 30 days
Total number of days if no evaluation, subpoena or expert is needed	**54 to 70 days**	**72 to 88 days**	**Not applicable; this information is required in complex cases**
Total number of days if subpoena and expert are needed	**124 to 253 days**	**142 to 271 days**	**172 to 301 days**
Total number of days if physical/mental evaluation and subpoena needed	**68 to 130 days**	**132 to 208 days**	**132 to 208 days**

The table above establishes timeframes based on a range of different circumstances. Under the most typical circumstance (cases involving subpoenas and experts), these timeframes range from 124 days for a high priority case requiring subpoenas and experts, to 301 days for a complex case in need of subpoenas and experts. The midpoint of the range equals 212.5 days.

The midpoint of the range represents the status quo and does not provide sufficient public protection. Each case carries with it inherent public safety risks for every day it is open. Further, 180 days represents the shortest possible timeframe for the most difficult cases. Because timely resolution of these complex cases is one of the most important aspects for public protection, this minimum time standard of 180 days is the appropriate benchmark. When cases exceed 180 days, resolution becomes increasingly difficult because relevant and needed records and x-rays are sometimes lost, misplaced or destroyed, witnesses may not be able to be located and the public loses confidence in the Board's ability to fulfill its mission of public protection.

Typically, physicians who are disciplined by the Board are suspended or enter into a stipulated agreement involving conditions and/or restrictions on practice. Until such cases are resolved,, these physicians could potentially be harming the public , and therefore delays must be avoided. The three year average for suspensions (18) and stipulations (53) show that in an average of 71 cases annually, the public was at significant risk until resolution was reached.

Therefore, the Board's target is that complaints are to be ready for Panel review and action within six months of the receipt of the complaint.

PROBLEM: HIGH PRIORITY AND COMPLEX CASES FREQUENTLY EXCEED THIS SIX-MONTH TARGET BASED ON INCREASES IN COMPLAINT VOLUME AND COPMLEXITY

The chief problem surrounding this request is that many complaints – particularly the high priority and complex types – are taking longer than this six month period to reach the Panel for action, and the bottleneck in the process is the amount of resources available for the initial investigation period. Specifically, the Board estimates that there are approximately **100 cases per year that exceed this timeframe**, almost all of which fall into the high priority or complex case categories. This is attributable to several factors, including increases in case volume and case complexity.

First, complaint volume is increasing steadily, and staffing – specifically staffing for initial investigations, which is critically important for routing every complaint that comes in – has not kept pace with complaint volume. Over the last decade the number of complaints received by the Board has increased by over 50%, and continues to grow. In FY 95-96, the Board received 761 complaints and in FY 2005-06 the Board received 1,110 complaints, with a high point of 1,162 complaints reached in FY 03-04. Over the ten-year period, this represents a complaint increase of 46%. Nevertheless, Board staff has not increased over that time, resulting in an increase in the average number of complaints that one FTE handles from 304 complaints in FY 95-96 to 444 complaints in FY 05-06, based on 2.5 FTE in the enforcement section who perform this role.

Importantly, in addition to processing over 1,100 complaints per year, these 2.5 FTE also prepare 24 agenda packets per year that consist of 1,000 to 1,500 pages each, and are required to complete the follow up assignments from each of these 24 meetings.

Secondly, while there has been an increase in the number of complex complaints simply because of the increase in volume, several trends are increasing the complexity of cases, including:

- The changes in the healthcare delivery system have contributed to an increase in the complexity of cases that Board staff must address. The old concept of one physician being solely responsible for a patient's care and the outcome of that care is no longer valid. In the current system, it is commonplace for a case before the Board to involve not only the primary physician, but also physician specialists who were consulted regarding specific aspects of the patient's care, as well as "hand-offs" of patients between physicians, such as the hand-off of the emergency room physician to the hospitalist or the hand-off from one physician in the group practice to another physician in the practice who is assuming care over the weekend. These types of scenarios create complex and confusing patterns of care that the Board and the staff must sort out to determine responsibility as well as the actual fact pattern in each case.

- Increasing complexity is also driven by the legal/tort system. For example, hospital peer review cases that come to the Board's attention typically include boxes of medical records, hearing transcripts and consultant reviews that require a higher level of expertise to sift through to determine the issues that must be addressed as part of the Panel's review process. The tort (malpractice) system often results in the Board receiving highly emotional cases that involving experts with divergent opinions and, again, voluminous records that must be evaluated and analyzed.

As such, case complexity places an increased burden on Board staff. The Board is fortunate to have experienced staff reviewing and processing the majority of complaints the Board receives. However, there is approximately ten to fifteen percent of the case load that falls into the high priority and complex categories described above, and these cases are also the most likely to experience delays because they are complicated, voluminous, and require significant time to sort through all the documents to determine the issues relevant to the Board's jurisdiction. Also, in those complex cases that involve multiple physicians, the coordination of those cases requires additional time and attention to detail. Currently, the only person on staff who has the expertise to evaluate these complex cases is the Board's Program Director, who is a physician assistant and an attorney. However, as the chief administrator for the Board, she does not have sufficient time to devote to these cases. If the Board is to fulfill its mission of public protection then it must find a way to better handle these cases to assure that process is timely and instills public confidence in the Board.

INTERNAL REMEDIES TO MITIGATE INCREASING CASE VOLUME AND COMPLEXITY HAVE BEEN EXHAUSTED

In response to increases in case volume and complexity, existing staff has been forced to manage the increase by restructuring some internal processes, both manually and electronically. From a resource standpoint, shifting Division resources in FY 02-03 enabled the Board to dedicate an additional 0.5 FTE on its staff to complaint processing. Additionally, the Board continues to examine ways to streamline existing processes and find efficiencies, and has been successful in this regard as it is able to process more complaints with less staff than other state medical boards of comparable size.

However, the problem with an increasing number of complaints and increasingly complex complaints without an associated increase in FTE is that it takes longer to conduct the initial investigation, and this development is simply beyond the power of the Board to address internally. Further, there is added priority to resolve the problem given the transition to specific benchmarks and goals that are easily understood by the public, in addition to the Board's own priority on limiting case duration to 6 months in order to

ensure public protection. As previously stated, the benchmark established by the Board is that a case is considered backlogged when it has been with Board staff for more that six months. Currently, the Board has 50 to 60 cases each month that fit this criteria, and based on new cases crossing this threshold even as old cases are ultimately resolved, the Board estimates that the backlog volume is **approximately 100 cases annually.** Complicating this is that on average approximately 50% of the backlogged cases fall into the complex category as described above.

REQUESTED STAFF WILL REDUCE BACKLOG TO MINIMUM LEVELS

The Board proposes adding 1.0 FTE for the purpose of managing and expediting the high priority and complex cases for the Board. Adding the additional FTE would allow those cases involving issues that pose a significant risk to public protection to be removed from the general caseload and be attended to by a professional level staff member who has the expertise to analyze the issues and take the appropriate steps to assure that the case is moved through the process as efficiently as possible. With additional focused resources to address high priority cases as defined in Division policy 80-22 and complex cases as described above, annually it is expected that the added staff will identify and steward a sufficient amount of cases through the initial investigation process such that the annual backlog will drop to 50 cases in the first fiscal year. The ongoing backlog **will be reduced by at least 50 percent within this timeframe,** thereby cutting in half the risk of compromised regulation created by excessive case timeframes.

Ultimately, the backlog will drop to the minimum possible level. It is unknown how many cases may naturally exceed the Board target of 180 days simply because the Board has not had resources to maximize completion of all cases involving controllable circumstances. Staff experience suggests the percentage of cases in which specialized or unavoidable circumstances create excessive delays outside of the control of staff may range between 10-20%. Examples of specialized or unavoidable delays are: experts failing to adhere to time commitments even with follow up from Board staff; multiple subpoenas being required to obtain all necessary information; the need to expand cases to include other physicians that are involved in the patient care; and the need for multiple

experts and expert coordination because the case(s) involve multiple medical specialties. However, the resources provided pursuant to this request are sufficient to resolve all controllable matters of timing, and this is expected to significantly decrease the case backlog.

In order to be successful in resolving the problem, the requested FTE must have two key areas of expertise:

- **Medical expertise** that will allow the FTE to more efficiently and effectively review and analyze complex cases involving voluminous records and information, identify potential violations, obtain any additional records and documentation that are needed, hire the appropriate physician expert to render an opinion in the case so that the case is ready to come before the Panel in a shorter period of time. Adding staff at the Administrative or Program Assistant classifications would not provide this;
- **Administrative expertise** to organize the file and records for the physician expert hired by the Board to review the case. The time the expert takes to conduct his or her review and provide a written opinion is a key factor in whether the case moves through the process in a timely fashion. To have an FTE that can provide assistance to the expert in terms of file organization and issue identification is critical to reducing the time it takes a case to be ready for review by the Panel. These improvements will result in decreasing the backlog and providing more effective public protection. Because of the importance of this new position to DORA's and the Division's overall strategic plan, it is the expectation that this FTE will initially report to the Program Director.

Adding the additional FTE described above would allow those cases involving issues that pose a significant risk to public protection to be removed from the Board's general caseload and be attended to by a professional level staff member who has the expertise to analyze the issues and take the appropriate steps to assure that the case is moved through the process as efficiently as possible.

The following points further elaborate and summarize the before and after impacts of this request and the efficiencies expected:

- Presently, there are approximately 100 complex complaints that exceed the 180-day timeframe annually, and the Decision Item request will permit the Division to reduce this number by 50 cases within the first year – a reduction of 50%.

- It is expected that improvement will be continual until the minimum possible level of 180-day-plus cases is met. While this level is not known, the low end of the estimated range for such cases is 10% of the current backlog of 100 – or 10 per year. Assuming resolution up to this level, the Decision Item's impact will be to ultimately reduce the annual number of cases exceeding 180 days by 90%.

- While the request will undoubtedly have a positive impact on the other 655 total matters presented to the board in a given year, these cases are presently completed within the desired timeframe. The focus of this request is on the 100 cases that exceed 180 days.

- In general, the average completion time for all cases would be such that 180 days would be the maximum of the range. This trims between 73 and 121 days from the range of time it takes to complete various types of cases.

With regard to the efficiencies, the Department believes this position would in particular impact the following: complaint receipt and processing; identifying cases sufficiently complex to need subpoena records; waiting to receive a response from physicians; follow-up subpoena work and physician expert work related to a physician's initial response; waiting for expert review of a case; follow-up in the event of report incompleteness; and ensuring prompt Panel review at the next meeting. Each of these processes is itemized in the table on page 7 of the request.

COMPARISONS TO OTHER STATES SUGGEST COLORADO IS UNDER-STAFFED

When compared to other state medical boards, the Board's resources have not kept pace. Only 16 other states have fewer medical board complaint specialists than Colorado, and those include less-populated states such as Wyoming, Rhode Island, Nebraska, and Alaska, according to the Federation of State Medical Boards.[1] Arizona, which has about the same number of physicians as Colorado, employs five times the number of full-time complaint specialists with an annual budget twice that of Colorado's Board.[2]

Consequences if Not Funded:

If the request is not funded, the length of time to investigate complaints will continue to grow and the risk to the public will grow as well because physicians who pose a threat to patients will be able to continue to practice without restriction.

[1] Arthur Kane & Allison Sherry, Prescription for Conflict, The Denver Post, March 8, 2004, at A1.
[2] Id.

Calculations for Request:

Summary of Request FY 08-09	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	FTE
Total Request	$72,915	$0	$72,915	$0	$0	0.9
Division of Registrations Personal Services	$69,001	$0	$69,001	$0	$0	0.9
Operating Expenses	$3,759	$0	$3,759	$0	$0	
Hardware/Software Maintenance	$155	$0	$155	$0	$0	

Summary of Request FY 09-10	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	FTE
Total Request	$75,934	$0	$75,934	$0	$0	1.0
Division of Registrations Personal Services	$75,000	$0	$75,000	$0	$0	1.0
Operating Expenses	$779	$0	$779	$0	$0	
Hardware/Software Maintenance	$155	$0	$155	$0	$0	

Assumptions for Calculations:

Calculations by Long Bill Line Item - All amounts Cash Funds	**FY 08-09 Total**	**FTE**	**FY 09-10 Total**	**FTE**
Salary, General Professional V, Grade H51, FY 07-08 Range Minimum	$60,687	1.0	$65,964	1.0
PERA @ 10.15%	$6,160		$6,695	
AED @ 1.60%	$971		$1,055	
AED @ 0.50%	$303		$330	
Medicare @ 1.45%	$880		$956	
Total Personal Services	**$69,001**	**1.0**	**$75,000**	**1.0**
Capital Outlay (Furniture) is $2,021 per OSPB guidelines	$2,021			
PC equipped with a shared printer and standard office software is $959	$959			
Telephone service is $279/FTE per the Department's existing system	$279		$279	
Annual operating expenses @ $500/FTE	$500		$500	
Total Operating Expenses	**$3,759**		**$779**	
Hardware/Software Maintenance (annual maintenance is $155/FTE)	**$155**		**$155**	
Total	**$72,915**	**0.9**	**$75,934**	**1.0**
Non-add items				
Short-term Disability @ .16% (.00155)	$107		$116	
Health/Life/Dental Insurance @ $5,383 per Employee	$3,726		$3,726	
Indirect Cost @ $11,773 per FTE	$11,773		$11,773	
Workers' Compensation @ $108 per FTE approx.	$108		$108	
Risk Management @ $112 per FTE approx.	$112		$112	

Impact on Other Government Agencies: None

Cost Benefit Analysis:

The total cost of this request is $72,915 and 1.0 FTE @ 0.9 FTE in the first year. The request is designed to expedite case processing and enhance public protection, and its beneficial impact is more effective and timely public protection and increased confidence in the Board and government in general. These benefits are not quantifiable from a cost-benefit standpoint, considering the Medical Board is required to handle all cases and will do so regardless of the success of this request. This request permits the cases to be resolved more quickly, which enhances Board enforcement.

However, the fact that the request will permit matters to be resolved more quickly does have the benefit of more promptly limiting injury to the public. This request assumes that the Board will resolve an estimated 50% of an estimated backlog of 100 cases within the first 12 months. Further the request assumes that the time to complete the initial investigation and submit to the final Panel for review will be reduced by an average of 60 days. Therefore, the economic value of resolving cases is estimated to be driven by 50 cases being reduced by an average of 60 days each, which translates to 60 days of accelerated public protection, or a total increase 3,000 days overall.

Additionally, the following table shows a comparison of the costs required to achieve this benefit, establishing the request as the less expensive of two available options:

Annual Cost to State	**Cost**	**Differential**
Decision Item Request – 1,800 hours of General Professional V	$72,915	
Centralized investigations staff to resolve these cases @ 1,800 hours	$105,372	$32,457

In addition to the goal of reducing the backlog of cases by 50 percent in the first year, listed below are the qualitative benefits of this request:

- More timely public protection by identifying cases that pose a significant risk to the public sooner
- Better achieve DORA's strategic plan by resolving all consumer complaints in a more timely and efficient manner because this FTE will allow current Board staff to focus on the standard priority complaints, which will lead to more timely resolution
- Facilitate a more efficient expert review process, which would result in the reviews being conducted in a more timely fashion and thus more timely resolution
- Ability to return physicians to practice sooner thereby reducing disruption to patients and access to care
- Improved public perception of the regulatory process
- Complaints filed by the public are resolved more in a more timely fashion
- Facilitate a more efficient expert review process, which will lead to improved expert satisfaction with the process and a greater likelihood that the expert will agree to assist the Board in future cases
- Increased consumer satisfaction with the complaint process
- More responsive communication regarding consumer and professional rights and responsibilities
- Assist in assuring that the delivery of medical services is meeting rigorous standards and fostering quality medical care
- Attract and retain the best qualified board members by providing them with timely and complete case information upon which decisions can be made
- Provide enhanced board member satisfaction by giving the members better organized and more clearly focused information on the complex cases they must evaluate
- Create a higher level of satisfaction with the attorneys who represent physicians by making the process more timely, efficient and focused

Implementation Schedule:

Task	Month/Year
FTE Hired	July 1, 2008
Protocol Adopted for New FTE's complaint duties	July 1, 2008

The Board would hire the FTE as soon as the authorization to do so was effective. Since the FTE would be working for an existing program the overarching rules, policies and procedures are in place. It is anticipated that minor changes to internal processes would be made to accommodate this new position within the organizational structure.

Statutory and Federal Authority:

Title 12, Article 36, Part 1, CRS
Specifically 12-36-118, CRS, outlines the complaint and disciplinary process as follows:

12-36-118. Disciplinary action by board - immunity.

(1) (a) The president of the board shall divide those members of the board other than the president into two panels of six members each, four of whom shall be physician members.

(b) Each panel shall act as both an inquiry and a hearings panel. Members of the board may be assigned from one panel to the other by the president. The president may be a member of both panels, but in no event shall the president or any other member who has considered a complaint as a member of a panel acting as an inquiry panel take any part in the consideration of a formal complaint involving the same matter.

(c) All matters referred to one panel for investigation shall be heard, if referred for formal hearing, by the other panel or a committee of such panel. However, in its discretion, either inquiry panel may elect to refer a case for formal hearing to a qualified

administrative law judge in lieu of a hearings panel of the board, for an initial decision pursuant to section 24-4-105, C.R.S.

(d) The initial decision of an administrative law judge may be reviewed pursuant to section 24-4-105 (14) and (15), C.R.S., by the filing of exceptions to the initial decision with the hearings panel which would have heard the case if it had not been referred to an administrative law judge or by review upon the motion of such hearings panel. The respondent or the board's counsel shall file such exceptions.

(2) Investigations shall be under the supervision of the panel to which they are assigned. The persons making such investigation shall report the results thereof to the assigning panel for appropriate action.

These passages have been added, relocated, and modified since the statute's inception in 1951.

Performance Measures:

DORA's strategic plan includes the following outcomes:

- Consumer complaints are resolved in a timely and efficient manner.
- Businesses and professionals can access the regulatory process in a timely and efficient manner.

Division Policy 80-22 sets forth the following requirements for high and standard priority complaints:

1. Complaints will be considered "high" priority cases if they possess one or more of the following elements:
   a. The agency has objective and reasonable grounds to believe that the public health, safety, or welfare imperatively requires emergency action, and the licensee is in the state and is believed to be actively practicing.
   b. The complaint involves a felony conviction on the part of the licensee.

c. The respondent has been revoked or suspended by a board in another jurisdiction.

d. The agency has objective and reasonable grounds to believe that the licensee has been guilty of a deliberate and willful violation of the statute or rules, and the licensee is in the state and is believed to be actively practicing.

2. The prioritization for "high" priority cases will be as follows:

a. **Case opened** within **5 days** of **complaint received/initiated.**

b. **20/30 day letter** within **5 days** of **complaint received/initiated.**

c. **Complainant Letter** within **5 days** of **Case Opened.**
Referral to Board, Referral to Director or Referral to OI should occur within **40 days** of the **complaint received/initiated.**

d. **Referral to ESP** should occur within **5 days** of any board meeting or Director review.

e. **Referral to OAG** should occur within **5 days** of any board meeting or Director review.

f. All follow up from a board meeting or Director review should be completed within **14 days** of the meeting or review (dismissal, LOC, LOA referrals, stipulation processing).

g. All **LOAs** should be processed on the internal database **23 days** after the letter has been sent to the respondent.

1. Complaints will be considered "standard" priority cases if they do not possess one or more of the situations defined in Policy 80-22(A)(1) above.

2. The prioritization for "standard" priority cases will be as follows:

a. **Case opened** within **14 days** of **complaint received/initiated.**

b. **20/30 day letter** within **14 days** of **complaint received/initiated.**

c. **Complainant Letter** within **14 days** of **Case Opened.**

d. Referral to Board, Referral to Director, Referral to OI or referral to a consultant should
occur within **60 days** of the **complaint received/initiated.**

e. **Referral to ESP** should occur within **14 days** of any board meeting or Director review.

f. **Referral to OAG** should occur within **14 days** of any board meeting or Director review.

g. All follow up from a board meeting or Director review should be completed within **14 days** of the meeting or review (dismissal, LOC, LOA referrals, stipulation processing).

h. All **LOAs** should be processed on the internal database **23 days** after the letter has been sent to the respondent.