

**MEDICAL BOARD OF CALIFORNIA**

EXECUTIVE OFFICE
 2005 Evergreen Street, Suite 1200
 Sacramento, CA 95815
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**MEMBERS OF THE COMMITTEE**

Barbara Yaroslavsky,
President
Frank Zerunyan, J.D.,
Vice President
Hedy Chang, Secretary
Richard Fantozzi, M.D.
Gary Gitnick, M.D.
Janet Salomonson, M.D.

**EXECUTIVE COMMITTEE
MEETING****June 18, 2009**

Medical Board of California
 Hearing Room
 2005 Evergreen Street
 Sacramento, CA 95815
 916-263-2389

*Action may be taken on any
 item listed on the agenda.*

AGENDA

1:30 p.m. – 4:00 p.m.
 (or until completion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order
2. Approval of Minutes from the March 25, 2009 Meeting
3. Update on 2009 Legislation – Ms. Whitney
4. Discussion and Approval of Final Draft of Vertical Enforcement Report– Ms. Threadgill
5. Public Comment on Items not on the Agenda
6. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act and to promote access to quality medical care through the Board's licensing and regulatory functions.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Public Meetings Act. The audience will be given appropriate opportunities to comment on any issue before the Board, but the President may apportion available time among those who wish to speak.

For additional information call (916) 263-2389.

NOTICE: *The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request no later than five working days before the meeting to the Board by contacting Cheryl Thompson at (916) 263-2389 or sending a written request to that person at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Requests for further information should be directed to Ms. Thompson at the same address and telephone number*



MEDICAL BOARD OF CALIFORNIA
Executive Office



Executive Committee

**Holiday Inn Capitol Plaza
River View Room
300 J Street
Sacramento, CA 95814**

**Teleconference Location:
UCLA Medical Center
10833 Le Conte Avenue, 44-138 CHS
Los Angeles, CA 90095-1684**

March 25, 2009

MINUTES

Open Session:

Agenda Item 1 Call to Order/Roll Call

The Executive Committee of the Medical Board of California was called to order by the Chair, Dr. Richard Fantozzi at 1:33 p.m. Notice had been sent to interested parties.

Members Present:

Richard D. Fantozzi, M.D.
Hedy Chang
Gary Gitnick, M.D.
Barbara Yaroslavsky
Frank Zerunyan, J.D.

Staff Present:

Barb Johnston, Executive Director
Kimberly Kirchmeyer, Deputy Director
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Kurt Heppler, Department of Consumer Affairs Staff Counsel
Armando Melendez, Business Services Office
Kelly Nelson, Legislative Analyst
Regina Rao, Business Services Office
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Michele Tuttle, Legislative Assistant
Linda Whitney, Chief of Legislation

Members of the Audience:

Yvonne Choong, California Medical Association
Mr. Conway (at Teleconference location)
Frank Cuny, California Citizens for Health Freedom
Rick Keene
John Toth, M.D., California Citizens for Health Freedom
Brian Warren, Department of Consumer Affairs

Agenda Item 2 Approval of Minutes from the November 6, 2008 and December 8, 2008 Meetings

Ms. Yaroslavsky made a motion to approve the minutes from the November 6, 2008 Executive Committee meeting; s/Zerunyan; vote was taken by roll call; motion carried.

Ms. Yaroslavsky made a motion to approve the minutes from the December 8, 2008 meeting; s/Chang; vote was taken by roll call; motion carried.

Agenda Item 3 Legislation

A. 2009 Legislation

Linda Whitney, Chief of Legislation, stated, since this was a teleconference meeting, all votes on Legislation would be taken by voice vote via roll call. With the exception of the actions the Full Board has taken on Board-sponsored bills, Ms. Whitney indicated all positions taken during this meeting would be an action of the Executive Committee, providing the basis for her testimony at hearings during April and early May, until the Full Board has the opportunity to discuss the bills.

AB 501 (Emmerson) – Physician and Surgeons: Limited License

Ms. Whitney directed members to the three Board-sponsored bills, beginning with AB 501 (Emmerson). This bill relates to licensing, and contains a provision for a limited license. Approval from the Full Board has been given to incorporate the fee cap and the expansion of the reserve into this bill, with the author agreeing to take these additions. The use of "M.D." language is out for review, with the language being vetted by interested parties. The UC system supports this concept, but revisions may emerge. Staff is awaiting the input of other entities.

Ms. Whitney introduced a proposed amendment to section 2441 of the Business and Professions (B&P) Code; this provision amends the current section dealing with the waiver of license fee for the disable status category by clearly stating the intent of the amendment is to enhance public protection and not create an undue burden on the licensee; additionally, a licensee who is in disabled status who is not engaged in the practice of medicine for five years or more from the waiver date authorized in this section, would have to establish to the satisfaction of the Board that he or she is qualified to practice medicine safely. Individuals falling into this category could be required to take a clinical examination. This is the same requirement that already exists for any individual who is delinquent for five years. Ms. Whitney asked for permission to incorporate this amendment into the

legislative proposal. Ms. Yaroslavsky made a motion to approve incorporating this amendment; s/Zerunyan. Ms. Yaroslavsky asked for clarification to ensure this proposal would allow doctors with a disability to receive an initial limited license without having to go through the probationary license process, removing the impression the doctor might be under a disciplinary action. Ms. Whitney stated that the bill would accomplish this.

Mr. Zerunyan asked if “disability” was defined anywhere. Mr. Heppler indicated that it was not defined. Mr. Zerunyan was concerned the definition of “disability” might become a subject of litigation in the future and thought it would be helpful if it could be defined and included in the statute.

Mr. Zerunyan also asked how the consumer would know of any limitations on the physician’s license. Ms. Whitney indicated the information would be included on the Board’s website; she was unsure of what information would appear on the actual certificate of licensure that the physician would post on the wall. Given that most consumers aren’t aware of the ability to check their physician’s license on-line, Mr. Zerunyan was still concerned that a patient would be unaware of the limitations on their doctor’s license. Dr. Fantozzi suggested that efforts should be made to make any action or wording consistent with the Americans with Disabilities Act (ADA). In addition to making sure the public was aware of the limitation on the physician’s license, Dr. Fantozzi felt the Board should also make sure the licensee was not put in a prejudiced position. Ms. Whitney indicated she would work with staff attorneys and consultants from the legislature to come up with an agreeable solution.

A vote was taken by roll call and the motion to approve incorporating the amendment of B&P Code Section 2441 into AB 501 carried.

AB 1070 (Hill) – Healing Arts: Discipline: Public Reprimand

Ms. Whitney indicated this bill was the Board’s enforcement enhancement legislation. The bill currently includes B&P Code Section 2227, which is to add an educational condition to a public reprimand recommended by the Administrative Law Judge. The bill incorporates Board approved sections on requiring certified medical records, amendments to B&P Code Section 801.01 malpractice reporting, amending B&P Code Section 2008 so the Board President may serve on panels, and amending B&P Code Section 2425.3 for reporting of convictions at time of renewal. The bill is intended to possibly incorporate the Vertical Enforcement (VE)/Prosecution enhancements, depending on the outcome of the VE Report which is due to the Legislature on July 1, 2009. There will be no language until the VE Report is out and the Board has had an opportunity to meet to discuss the report.

Staff is recommending that B&P Code Section 801.02 be added to this bill. An insurance company informed the Board of a process they are using termed “remedial services”, which is similar to the “Sorry Works” type of system where an apology and possibly a payout is made prior to any filing of a malpractice claim. Staff is proposing language that would allow the Board to receive this information and carry out its duty of consumer protection while ensuring the confidentiality of these remediations.

Ms. Yaroslavsky made a motion to approve adding B&P Code Section 801.02 to AB 1070; s/Chang.

Ms. Whitney indicated this new section would set forth findings as well as protect the remediation that is done, and would require reporting, just as in malpractice settlements, of remediations in the amount of \$30,000 or more to the Board. The Board would be able to look into these remediation actions and take action, if appropriate. Ms. Whitney indicated when the Board receives information based upon B&P Code Section 801.01, only around 5% proceed to accusation. Hence, while most are looked at, only a small number go forward to an actual enforcement action. Nevertheless, in the Board's duty as a consumer protection agency, this is the appropriate thing to do.

A vote was taken by roll call and the motion to approve adding B&P Code Section 801.02 to AB 1070 carried.

AB 1094 (Conway) – MBC: Physician and Surgeon Well-Being

Ms. Whitney indicated this bill is the Board's Wellness Program bill. Dr. Duruisseau met with the Director of Consumer Affairs (DCA), DCA staff, and Board staff on March 10, 2009 to discuss the opposition from last year regarding this bill and the veto. Staff was directed to continue on their legislative analysis that would go to the State and Consumer Services Agency (Agency). Unfortunately, word was received on March 16, 2009 that the Legislative Director at Agency had called the author's office and informed the author the bill would be opposed and most likely vetoed. The author's office informed Board staff the bill would probably be used for another purpose. Dr. Duruisseau requested, as soon as the new Agency secretary was in place, to have a meeting.

Ms. Yaroslavsky asked if the bill was to be used by the author's office for another purpose and the Board would lose the opportunity to forward a wellness bill. Ms. Whitney indicated that the Board would not only lose the opportunity with this bill, but possibly in the future as well. Dr. Fantozzi was curious as to why the administration is announcing, before the bill has gone through the legislative process, that they will veto a bill that has not had an opportunity to be looked at or amended. He felt there was no further action for the Board to take, other than to direct staff to work with the author and keep the Board informed.

Mr. Zerunyan asked if there was a language or drafting issue with the bill, specifically referring to the use of the word "program" in the language which might be perceived as being unnecessary. Ms. Whitney indicated she has not heard from Agency or DCA with regard to this matter; she has been obtaining direction from Dr. Duruisseau as the chair of the Wellness Committee. Dr. Fantozzi offered, as President of the Board, to speak to whomever Ms. Whitney felt was appropriate in order to move the bill forward. Ms. Whitney expressed her hope that a meeting with Agency would identify where their concerns lay with the bill. Brian Warren, DCA Legislative Office, stated the DCA did not take a position on the bill; the bill was dealt with at the Agency level. While many bills were vetoed last year due to the budget issue, this particular bill had a veto message. The "program" issue was not specifically mentioned in the veto message, rather the broader issue of whether it was the Board's charge to have a wellness program and how that program tied to consumer protection. Ms. Whitney stated the Wellness Committee had assembled a package with research tying physician burnout and other issues to patient safety and consumer protection. Dr. Fantozzi reiterated the Wellness bill was never intended to be a program.

No action was requested or taken.

Ms. Whitney introduced three bills dealing with the employment of physicians at hospitals: AB 646 (Swanson), AB 648 (Chesbro), and SB 726 (Ashburn).

AB 646 (Swanson) – Physicians and Surgeons: employment: delete pilot project

Ms. Whitney stated this bill will eliminate the current pilot program and allow for limited direct employment of physicians at rural hospitals and any public or non-profit hospitals. This changes the prohibition on the corporate practice of medicine and allows hospitals to employ physicians. The pilot program the Board evaluated showed very few physicians and hospitals were interested in participating in this program, although there were many restrictions preventing them from participation. There has been no real evaluation of the need for the direct employment of physicians in this manner. Staff is recommending an oppose position on this bill. Mr. Zerunyan made a motion to oppose the bill; Ms. Yaroslavsky seconded the motion.

Ms. Whitney indicated the Committee could vote to “oppose unless amended” to narrow the focus of the physicians who could come into the program, though Ms. Whitney doubted the author would be interested in this amendment. Dr. Fantozzi asked if this is a pilot the Board would be overseeing. Ms. Whitney stated the Board would not necessarily oversee the pilot, but, rather, would receive the information from the hospitals regarding the physicians and would track which physicians were at which hospitals in order to be aware of issues or questions that arise. Dr. Fantozzi asked if this pilot would create workload issues for staff. Ms. Whitney stated without limitations, the additional workload could be significant; with limitations, the workload could be minor and absorbable. Mr. Zerunyan amended his motion to oppose unless amended to limit the parameters of the physicians and the number of hospitals.

During public comment, Yvonne Choong, California Medical Association (CMA), shared that CMA strongly opposed AB 646 and AB 648 for similar reasons. They could only support a continuation of the original pilot program.

A vote was taken by roll call and the motion to oppose unless amended to narrow the focus carried.

AB 648 (Chesbro) – Rural Hospitals: physician employment

Ms. Whitney indicated this bill was basically the same bill as AB 646, except it is specifically for rural hospitals employing physicians. Again, the bill does not have any parameters and staff recommends oppose unless amended to limit the number of participants. Ms. Yaroslavsky made a motion to oppose unless amended; s/Zerunyan; vote was taken by roll call and the motion carried.

SB 726 (Ashburn) – Hospitals: employment of physicians; pilot project revision

Ms. Whitney indicated this bill was a pilot program authorizing acute care hospitals to employ physicians. It is very similar to the pilot program currently in existence, with the difference being that it allows more participants. There are, however, parameters in place limiting participants. Staff recommends support if

amended, looking at the longer operational period for full evaluation to be conducted. Ms. Yaroslavsky made a motion to support if amended; s/Zerunyan.

Ms. Choong, indicated CMA has taken a support if amended position on this bill.

A vote was taken by roll call and the motion to support if amended carried.

Ms. Whitney introduced three bills dealing with the issue of Peer Review: AB 834 (Solorio), SB 58 (Aanestad), and SB 700 (Negrete McLeod). She stated there would be a fourth peer review bill sponsored by CMA which will focus on the 809 sections; however, the language has not yet been amended into the bill and it is not included in the Legislative Packet. Each of the bills focuses on a different aspect of peer review.

AB 834 (Solorio) – Health Care Practitioners: peer review

This bill is sponsored by the California Hospital Association. Currently, there is no language in the bill indicating the bill's intent. The recommendation is to take a watch position. Ms. Yaroslavsky made a motion to watch the bill; s/Chang; vote was taken by roll call and the motion carried.

SB 58 (Aanestad) – Physicians and Surgeons: peer review

Ms. Whitney indicated Dr. Aanestad held two interested parties meetings to discuss the development of this bill and possible amendments to enhance the peer review system. Ms. Yaroslavsky made a motion to watch this bill; s/Zerunyan; vote was taken by roll call and the motion carried.

SB 700 (Negrete McLeod) – Healing Arts: peer review

This bill focuses on possible enhancements for the Board related to peer review. Board staff has been working closely with the author's staff to develop ideas and concepts. Dr. Low participated in the public hearing on the peer review issue, doing an excellent job representing the Board. The current language of the bill is minimal. Ms. Yaroslavsky made a motion to support and continue to work on enhancements to the bill; s/Chang.

Yvonne Choong, CMA, stated CMA is opposed to this bill as it is currently written requiring all minutes of peer review hearings to be submitted.

A vote was taken by roll call and the motion to support and continue to work on enhancements carried.

AB 245 (Ma) – Physicians and Surgeons

Ms. Whitney indicated this bill was included in their packets because many enhancements to public disclosure requirements of the Board may be incorporated into this bill. Ms. Yaroslavsky made a motion to watch this bill; s/Zerunyan; vote was taken by roll call and the motion carried.

AB 252 (Carter) – Practice of Medicine: cosmetic surgery: employment of physicians

This bill, sponsored by the American Society for Dermatological Surgery, codifies a physician's license will be revoked if they violate corporate practice laws and establishes a legal presumption of "knowingly", and makes it a felony for an entity to provide cosmetic medical treatments or contract with physicians for providing these services. The bill attempts to address many of the issues that have arisen in laser hearings and medical spa issues. Ms. Chang made a motion to support this bill; s/Yaroslavsky.

Mr. Zerunyan asked, if the violation of corporate practice law was a felony, could mens rea (the prior intention to commit a criminal act) be made a strict liability. Mr. Heppler indicated the answer to this question would require further research.

Ms. Yaroslavsky asked if we have, in law, doctors who participate knowingly in the unlicensed practice of medicine having their licenses automatically revoked, and, if not, could it be included in this legislation. Ms. Whitney indicated the Board has not supported an automatic revocation, mostly because each case can be different. Nevertheless, this might be an issue the Board could consider at the full Board meeting as a discussion item.

Ms. Whitney stated these issues will have to be worked out in the legislative proceedings, but suggested the Board might want to "watch" the bill at this point and wait for a full Board discussion. Ms. Chang withdrew her motion to support the bill and changed it to a watch position; Ms. Yaroslavsky seconded the motion.

During public comment, Rick Keene, American Dermatological Association, indicated this bill was exactly the same bill the Board supported last year, carried by Assemblyman Nakanishi. In light of the many medi-spas opening with scant oversight, he sees this as a very important public safety move and public policy measure. He asked the Board to take a support position on the bill.

Dr. Fantozzi asked Ms. Whitney to address and provide clarification on the two issues which were raised and bring the bill back to the full Board for discussion.

A vote was taken by roll call and the motion to watch the bill carried.

AB 526 (Fuentes) – Public Protection and Physician Health Program Act of 2009

Ms. Whitney stated this is a place holder bill for the Public Protection and Physician Health Program Act sponsored by the CMA. Staff is working with CMA to understand the direction CMA is taking in developing this program. Ms. Whitney indicated Ms. Yaroslavsky has been involved in the meetings regarding this bill, but language is currently not available to present to the Board. Ms. Yaroslavsky made a motion to take a watch position on this bill; s/Chang.

Mr. Zerunyan stated there was no need to legislate a physician obtaining treatment since there was nothing preventing them from doing so, but, rather, the issue was whether the Board could participate in such a program. He felt the Board had just abandoned such a program for the reason of consumer protection not being

served.

Ms. Choong, CMA, responded the bill was not about treatment, but about monitoring and oversight of physicians post-treatment. She indicated this program is not meant to replace diversion. The physicians the CMA envisions enrolling in this program would not have any disciplinary action against them; it is a pro-active step before the physician begins to have problems.

Mr. Zerunyan stated, from his perspective, the minute you involve the Medical Board, the Board cannot hide or participate in any kind of venue where the names of those individuals are shielded from the public. He presumes there will be no incentive for a physician to participate in any program of this sort if they are not guaranteed to be shielded.

Ms. Choong clarified that the program would not deal with physicians who are already involved with the Board in any way. She indicated this would be a separate program in which participants would be monitored if found they were not participating or meeting the terms of their contract in any way; additionally, language might be inserted into the bill to refer non-compliant physicians to the Board.

Mr. Zerunyan asked who would run this program. Ms. Choong responded that decision has not yet been made. She stated that originally the program was going to be run out of the Department for Public Health, but this was no longer probable. They are currently in negotiations with the State and Consumer Services Agency as a possible home for the program, but, again, this part of the bill was still undecided.

Dr. Fantozzi asked what role, if any, the CMA saw the Board as playing. Ms. Choong responded the Board would have no role, other than in cases where a physician was failing the program and they were believed to be a public danger; in such cases, that individual would be referred to the Board.

Dr. Fantozzi asked if there was a fiscal component to the bill. Ms. Choong responded the CMA envisioned the only way to fund this program in the long term would be through licensing fees. Mr. Zerunyan stated this, in itself, would involve the Board.

A vote was taken by roll call and the motion to take a watch position on the bill carried.

AB 583 (Hayashi) – Health Care Practitioners: disclosure of education and hours

Ms. Whitney indicated this bill is sponsored by the CMA and the California Society of Plastic Surgeons. The bill would require health care practitioners to disclose in writing their license type and the highest level of academic degree to patients and would also require physicians to disclose their board certification. The bill is to address the public's confusion on who they might be seeing and what degree that practitioner holds. Ms. Yaroslavsky made a motion to support the bill; s/Chang.

Ms. Yaroslavsky asked if this disclosure information would be included on the individual's nametag. Ms. Whitney reported this information could also be presented in a handout to the patient. Ms. Yaroslavsky asked if, along with the other required information, the fact that the Board is the licensing and regulatory entity could also be included in the disclosure. Ms. Whitney stated the author could be asked to include this additional disclosure in the bill.

Ms. Yaroslavsky withdrew her motion to support the bill and changed it to support if amended to include information that clarifies for the consumer who the licensing board is, and is more specific about how this information is provided to the consumer. Dr. Fantozzi directed Ms. Whitney to continue to work with the author to resolve these issues of concern.

Mr. Zerunyan stated the bill allows the practitioner to choose one of three methodologies to provide this notice to consumers (via nametag, in writing to the patient during the initial office visit, or in a prominent display in his/her office). He felt that the term "prominent" in the third option needed to be better defined. Additionally, Mr. Zerunyan felt a more uniform system of notification would be preferable and less confusing to consumers.

Ms. Yaroslavsky stated she also questioned the requirement that the physician post the hours when they are in the office. She was unsure of the need for this requirement and asked for clarification. Dr. Fantozzi stated since the CMA supports this bill and does not take issue with this requirement, the Board probably would not have reason to object.

Frank Cuny, California Citizens for Health Freedom, expressed his concern that the health care practitioner be identified by nametag. Even with a posted license on the wall, he stated it can be difficult for the patient to know if the person actually delivering care is a physician, physician's assistant, or a nurse practitioner. A white coat is not enough.

A vote was taken by roll call and the motion to take a support if amended position on the bill carried.

AB 718 (Emmerson) – Prescription Drugs: electronic prescribing

Ms. Whitney reported this bill will require every licensed prescriber or pharmacy to have the ability to electronically transmit prescriptions in California by January 1, 2012. Ms. Whitney questioned whether this date was achievable, particularly for outlying and rural areas. Ms. Yaroslavsky made a motion to support the bill; s/Chang.

Mr. Zerunyan expressed his concern that this was an unfunded mandate.

Ms. Choong stated the CMA opposes this bill; however, it is their understanding that this will not be the final bill since significant amendments are forthcoming.

Ms. Yaroslavsky withdrew her motion to support and changed her motion to a watch position. A vote was taken by roll call and the motion to take a watch position on the bill carried.

AB 721 (Nava) – Physical Therapists: scope of practice

Ms. Whitney stated this bill would authorize a physical therapist (PT) to initiate treatment of conditions within the scope of practice of a PT. Dr. Gitnick made a motion to oppose the bill; s/Chang.

As a physician, Dr. Fantozzi expressed his concern over the ability and expertise of PTs to diagnose certain medical conditions. Further, he was concerned about the PT's self-determination of whether or not a condition requires treatment beyond their scope of practice; he is uncomfortable with leaving this decision at the discretion of the PT. Dr. Gitnick echoed his concerns, stating, as an example, that it would be difficult for a well-trained PT to differentiate between back pain due to a spinal problem versus a kidney stone. He stated this is the physician's role. A PT is not trained to make differential diagnosis; they are trained to treat specific diagnosed events. He felt it was in the patient's best interest that these diagnoses and care decisions remain with the physician.

Ms. Choong, CMA, stated the CMA is opposed to the bill for the reasons Dr. Fantozzi and Dr. Gitnick expressed. Additionally, she indicated the CMA has had discussion with the PTs about this issue and have offered to work with them to amend the language to allow additional visits with the PT before doing a re-referral back to the physician. She stated the PTs are very interested in acting as independent practitioners with direct access. Ms. Choong indicated at their recent lobby day, the PTs stated they were catching things the doctors were missing, implying their ability to diagnosis was higher than that of physicians.

Mr. Zerunyan agreed with the stated concerns; however, he also understands the consumer's frustration with the delay in receiving physical therapy while waiting to get an appointment with their physician in order to obtain a referral. In addition to opposing the bill based on the consumer protection aspect, he also opposes the bill because it is an unfunded mandate.

A vote was taken by roll call and the motion to take an oppose position on the bill carried 4-0 with 1 abstention.

AB 832 (Jones) – Clinic Licensing: minor services

Ms. Whitney reported this bill is the proposed fix to the *Capen v. Shewry* decision which caused problems with the licensing and accreditation of outpatient surgery centers. The Department of Public Health is not issuing licenses to physician owned facilities. Staff recommends a watch position, directing staff to work with the author, sponsor, and interested parties because of the technical issues related to this bill as compared to Senator Negrete McLeod's bill on outpatient settings. Ms. Whitney indicated there are conflicts that need to be sorted out which should be done before the Board moves forward with a position on this bill. Ms. Yaroslavsky made a motion to accept staff's recommendation to take a watch position and to work with the author, sponsor, and interested parties; s/Chang.

Ms. Yaroslavsky asked if this bill would make it optional to license outpatient surgery centers or make it mandatory that they be licensed, and, within that scope of practice, if there would be language requiring doctors to have transfer privileges to nearby hospitals. Ms. Whitney indicated there were technical problems with the bill in that licensure is permissive in one spot and mandatory in another, however, the intent is to include all outpatient surgery settings into the licensing program under the Department of Public Health.

A vote was taken by roll call and the motion to take a watch position on the bill carried.

SB 674 (Negrete McLeod) – Healing Arts: outpatient settings: advertising

Ms. Whitney stated this bill, which covers a variety of subjects, including advertising, outpatient setting accreditation requirements, supervision of laser and IPL device procedures, the wearing of nametags for healthcare professionals and public information, also adds to the definition of outpatient surgery settings to incorporate in vitro fertilization. It amends Health & Safety Code Section 1248. Ms. Yaroslavsky made a motion to support if amended; s/Zerunyan.

A vote was taken by roll call and the motion to take a “support if amended” position on the bill carried.

AB 1116 (Carter) – Cosmetic Surgery: Donda West Law

This bill enacts the Donda West Law and requires a physical examination of patients prior to cosmetic surgery. The examination could be performed by a physician and surgeon, nurse practitioner, physician assistant, or dentist licensed to perform this type of surgery. Ms. Whitney reported this bill was vetoed last year due to budget issues. The Board had previously taken a support position on the bill. Ms. Yaroslavsky made a motion to support the bill; s/Chang.

Dr. Fantozzi expressed concern with the bill’s specification of who would conduct the physical examination; although implied, he wanted to ensure the individual conducting the exam was qualified and accepted responsibility for the exam. He was unsure of the qualification of, for example, dentists to conduct the exam since the underlying issues were the presence of cardiopulmonary disease, nutritional issues, and other factors that go beyond a simple query of how the patient was feeling. Dr. Fantozzi would prefer that the list of those allowed to administer the exam be eliminated.

Dr. Gitnick pointed out that physicians are covered by the Medical Practice Act and are licensed to do almost any procedure in the State of California. He agrees that only qualified individuals should conduct the exam, but was unsure how the Medical Practice Act could force that to happen. Ms. Whitney explained the bill was very specific to those dentists who hold a permit as an oral maxillofacial surgeon and who have a permit to do cosmetic surgery as being eligible to conduct the physical exam prior to cosmetic surgery. Dr. Fantozzi reiterated his concern that even these types of dentists do not have the expertise to diagnose cardiopulmonary illness prior to surgery. It is his belief that a physician should conduct the exam. Ms. Whitney stated the law already allows a dentist with a special permit to do maxillofacial surgery; to say the dentist can no longer do the surgery without prior examination of the patient by a physician would likely not be accepted by the bill’s author. Dr. Gitnick and Dr. Fantozzi indicated they could only agree to an oppose or oppose if amended position on this bill for these concerns.

Ms. Yaroslavsky withdrew her motion to support the bill and changed it to oppose unless amended. A vote was taken by roll call and the motion to take a oppose unless amended position on the bill carried.

SB 132 (Denham) – Polysomnographic Technologists

Ms. Whitney reported the Board had a letter from Senator Denham asking for support of this bill which requires the registration of and qualification requirements for polysomnographic technologists who work in sleep centers under the direction and supervision of a physician. Last year the Board took a neutral position on the same bill. The Respiratory Care Board, the CMA, and the Sleep Society all support this bill. Ms. Whitney indicated there are technical items the Board would like to see included in the bill such as the need for a separation of the registration and application fee and the inclusion of criminal penalties. The Board would be responsible for both the registration and enforcement of these individuals. Ms. Yaroslavsky made a motion to support if amended; s/Chang.

Dr. Fantozzi asked about the anticipated number of registrants, the registration fee, and, hence, the revenue that would be brought forward to support the costs of registration and enforcement. Ms. Whitney stated the estimated number of registrants was 520, and the registration fee would be calculated and negotiated to make the bill revenue neutral.

A vote was taken and the motion to support if amended carried.

SB 294 (Negrete McLeod) – Nurse Practitioners: expand scope of practice

This bill expands the scope of practice for nurse practitioners allowing them to implement standardized procedures, admit patients, order durable equipment, and more. Mr. Zerunyan made a motion to oppose; s/Chang.

A vote was taken and the motion to oppose the bill carried.

SB 389 (Negrete McLeod) – Professions and Vocations: finger printing

Ms. Whitney reported this bill deals with fingerprinting, which is already done by the Board. However, this bill adds a provision requiring everyone who is licensed by a board to be fingerprinted. This bill would satisfy the motion the Board passed in November of 2008 to have fingerprint records for all physicians who are licensed in the State. The Board was going to go through the regulatory process to ensure fingerprinting of all physicians, but now it appears, if this bill moves forward, that will no longer be necessary.

Mr. Zerunyan made a motion to support the bill; s/Chang.

Ms. Choong, CMA, stated the CMA opposed this bill unless amended; they would like to see the exemption of physicians over the age of seventy from the fingerprinting requirement in the belief that it is not a good use of resources. They would also like to see more focus on the other boards who currently are not fingerprinting.

A vote was taken and the motion to support the bill carried.

SB 470 (Corbett) – Prescriptions: labeling

This bill would allow patients to request that their health care provider, when writing a prescription, include the intended purpose of the medication on the prescription label. Mr. Zerunyan made a motion to support the bill; s/Yaroslavsky; motion carried.

SB 638 (Negrete McLeod) – Regulatory Boards: joint committee on operations

Ms. Whitney reported this bill addresses the Sunset Review process. Last year a similar bill, which was not passed, was proposed to revise how the sunset process would take place; instead of going to the Joint Committee on Boards, Commissions, and Consumer Protection, the Sunset Review would go to the Policy Committees. The current bill incorporates these changes and also establishes new sunset dates for various boards and bureaus which have not yet been determined. The Board is currently due to sunset on July 1, 2010; it is the Board's hope that this date will be reset for 2011 or 2012.

Ms. Yaroslavsky made a motion to support the bill; s/Zerunyan; motion carried.

SB 774 (Ashburn) – Nurse Practitioners: scope of practice: define

Ms. Whitney indicated this is a spot bill for language that will be developed regarding the scope of practice for nurse practitioners. Ms. Yaroslavsky made a motion to watch the bill; s/Zerunyan; motion carried.

SB 819 (Senate Business & Professions Committee) – Omnibus: provisions from 2008

Ms. Whitney reported the provisions in this bill were those previously carried in SB 1779 (2008) which was vetoed. She re-confirmed the Board's support of the provisions in the bill. Ms. Yaroslavsky made a motion to support the bill; s/Zerunyan; motion carried.

SB 821 (Senate Business & Professions Committee) – Omnibus: MBC provisions

Ms. Whitney indicated this bill is this year's omnibus legislation which carries three provisions for the Board. Ms. Chang made a motion to "support" the bill; s/Yaroslavsky; motion carried.

SB 92 (Aanestad)

Ms. Whitney provided a handout to Members and to the public of the sections of the 132-page bill that pertain to the Board. This bill is a major health reform bill. Section 1 on page 2 of the handout covered the failure of a physician to conduct a good faith examination as required in the provisions listed in the bill; this would constitute unprofessional conduct and grounds for disciplinary action. There are also sections of the bill that apply to the health care services agreement which would specify that only California licensed health care

professionals may deny or delay authorization for health care services. Hence, it relates to HMOs and insurance carriers. The bill also specifies the primary obligation of the licensee is to the enrollee or the insured. Additionally, the bill includes a provision on medical assistants.

Staff is not asking for a position on this bill at this time. Ms. Whitney stated staff would closely watch this bill and bring it back to the full Board at the May 2009 meeting

Finally, Ms. Whitney reported on a Registered Dispensing Optician (RDO) bill. She stated staff is working with the sponsor to administratively address their issues regarding the renewal and address of record of RDOs. No action was requested or taken.

Agenda Item 4 Public Comment

Hearing no public comment, the meeting was adjourned at 3:20 p.m.

LEGISLATIVE PACKET



EXECUTIVE COMMITTEE MEETING

**Sacramento, CA
June 18, 2009**

**Medical Board of California
Tracker - Legislative Bill File
6/11/2009**

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 120	Hayashi	Peer Review: 809 sections	Senate	Watch	6/1/2009
AB 175	Galgiani	Telemedicine: Optometrists	Sen. Health & Sen. B&P (6/17)	Support	4/21/2009
AB 245	Ma	Disclosure Verification	Senate	Oppose	6/1/2009
AB 252	Carter	Cosmetic surgery: employment of physicians	Sen. B&P (6/8)	Support	
AB 356	Fletcher	Radiological Technology: physician assistants	Senate	Support	4/23/2009
AB 501	Emmerson	Licensing: Limited, Use of M.D., Fee/Fund	Senate	Sponsor/Support	5/26/2009
AB 526	Fuentes	Public Protection and Physician Health Program Act of 2009	Senate	Neutral	6/1/2009
AB 583	Hayashi	Disclosure of Education and Office Hours	Sen. B&P	Support if amended	
AB 602	Price	Dispensing Opticians	Sen. B&P	Watch	3/25/2009
AB 646	Swanson	Physician employment: district hospital pilot project	Senate	Support in Concept	5/5/2009
AB 648	Chesbro	Rural Hospitals: physician employment	Senate	Support in Concept	5/28/2009
AB 718	Emmerson	Electronic Prescribing Pilot Program	Sen. Health & Sen. B&P	Support	5/27/2009
AB 832	Jones	Clinic Licensing: Workgroup	Asm. Approps.	Support if amended	5/5/2009
AB 933	Fong	Workers' Compensation: utilization review	Sen. Lab. & Ind. Rel.	Support	
AB 977	Skinner	Pharmacists: Protocols with Physicians	Asm. Health	Watch	4/23/2009
AB 1070	Hill	Enforcement Enhancements: reporting, public reprimand	Senate	Sponsor/Support	4/22/2009
AB 1116	Carter	Cosmetic Surgery: physical examination prior to surgery	Sen. B&P	Support	
AB 1310	Hernandez	Healing Arts: database	Senate	Support if amended	6/2/2009
AB 1458	Davis	Drugs: adverse events: reporting	Asm. Approps.	Support	5/5/2009

* Board Sponsored Bills

* Two-Year Bills

* Bills for Discussion

**Medical Board of California
Tracker - Legislative Bill File
6/11/2009**

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
SB 58	Aanestad	Physicians and Surgeons: peer review	Sen. Approps.	Watch	5/19/2009
SB 132	Denham	Polysomnographic Technologists (urgent)	Assembly	Support	5/14/2009
SB 389	Negrete McLeod	Fingerprinting	Assembly	Support	6/1/2009
SB 470	Corbett	Prescriptions: labeling	Asm. Health & Asm. B&P	Support	4/30/2009
SB 638	Negrete McLeod	Regulatory Boards: joint committee on operations	Senate	Support	
SB 674	Negrete McLeod	Outpatient settings/Advertising	Assembly	Support	6/1/2009
SB 700	Negrete McLeod	Healing Arts: peer review	Senate	Support	5/20/2009
SB 726	Ashburn	Hospitals: employment of physician; pilot project revision	Assembly	Support in concept	5/6/2009
SB 819	B&P Comm.	Omnibus: provisions from 2008	Assembly	Support MBC provisions	6/1/2009
SB 821	B&P Comm.	Omnibus: MBC provisions	Assembly	Support MBC provisions	5/20/2009

* Board Sponsored Bills

* Two-Year Bills

* Bills for Discussion

AB 245

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:

AB 245

Author:

Ma

Bill Date:

June 1, 2009, amended

Subject:

Disclosure Verification

Sponsor:

Union of American Physicians and Dentists

STATUS OF BILL:

This bill is currently in the Senate.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board (Board) to verify the accuracy of the information posted on its Website regarding enforcement actions or other items required to be posted. This bill would require the Board to remove any expunged convictions within 30 days.

This bill was amended to remove all requirements for verification of information by the Board. This bill was amended to change the number of days the Board has to remove any expunged convictions from the Web site from 30 days to 90 days.

ANALYSIS:

Currently the Board is required to post on its Web site specified information regarding license status, enforcement actions, and specified information reported to the Board. This bill would require the Board to verify all of the information prior to posting it on the website and would require the Board to remove information that is incorrect, inaccurate, or unsubstantiated.

The Board would be required to verify that all of the biographical information on its licensees is accurate. This bill would require the Board to establish a process for addressing complaints received from licensees regarding inappropriate information posted by the Board.

The sponsor states the reason for the bill is due to 31 physicians members who had false reports of medical discipline transmitted to the Board which caused damage to their careers. This is 805 reporting, and to force the Board to verify those reports prior to posting is against the public policy established in the peer review reporting laws. This issue should be dealt with in the peer review bills.

Amendments to the bill taken June 1, 2009 remove all requirements to the Board and increase the number of days that the Board has to remove expunged convictions from the Board's Web site from 30 days to 90 days.

FISCAL: None to MBC

POSITION: Due to the amendments, the Board's opposition may be removed.
Staff Recommendation: Neutral

June 10, 2009

AMENDED IN ASSEMBLY JUNE 1, 2009

AMENDED IN ASSEMBLY APRIL 27, 2009

AMENDED IN ASSEMBLY MARCH 26, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL

No. 245

Introduced by Assembly Member Ma

February 10, 2009

An act to amend Section 2027 of the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 245, as amended, Ma. Physicians and surgeons.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires the board to post certain information on the Internet regarding licensed physicians and surgeons, including, but not limited to, felony convictions, certain misdemeanor convictions, and whether or not the licensees are in good standing. Existing law requires that certain information remain posted for 10 years and prohibits the removal of certain other information.

This bill would require the board to ~~verify the information posted pursuant to those provisions, as specified, and would require the board to immediately remove information discovered to be false and to remove expunged misdemeanor or felony convictions within a specified period of time, posted pursuant to those provisions, within 90 days of receiving notice of the expungement.~~ ~~The bill would also require the board to ensure that the biographical information posted on its Internet Web site regarding licensees is accurate.~~ ~~The bill would also require the board~~

~~to establish a process for addressing complaints from licensees regarding the posting of inappropriate information.~~

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2027 of the Business and Professions
2 Code is amended to read:

3 2027. (a) The board shall post on the Internet the following
4 information in its possession, custody, or control regarding licensed
5 physicians and surgeons:

6 (1) With regard to the status of the license, whether or not the
7 licensee is in good standing, subject to a temporary restraining
8 order (TRO), subject to an interim suspension order (ISO), or
9 subject to any of the enforcement actions set forth in Section 803.1.

10 (2) With regard to prior discipline, whether or not the licensee
11 has been subject to discipline by the board or by the board of
12 another state or jurisdiction, as described in Section 803.1.

13 (3) Any felony convictions reported to the board after January
14 3, 1991.

15 (4) All current accusations filed by the Attorney General,
16 including those accusations that are on appeal. For purposes of
17 this paragraph, "current accusation" shall mean an accusation that
18 has not been dismissed, withdrawn, or settled, and has not been
19 finally decided upon by an administrative law judge and the board
20 unless an appeal of that decision is pending.

21 (5) Any malpractice judgment or arbitration award reported to
22 the board after January 1, 1993.

23 (6) Any hospital disciplinary actions that resulted in the
24 termination or revocation of a licensee's hospital staff privileges
25 for a medical disciplinary cause or reason.

26 (7) Any misdemeanor conviction that results in a disciplinary
27 action or an accusation that is not subsequently withdrawn or
28 dismissed.

29 (8) Appropriate disclaimers and explanatory statements to
30 accompany the above information, including an explanation of
31 what types of information are not disclosed. These disclaimers and
32 statements shall be developed by the board and shall be adopted
33 by regulation.

1 (9) Any information required to be disclosed pursuant to Section
2 803.1.

3 (b) (1) From January 1, 2003, the information described in
4 paragraphs (1) (other than whether or not the licensee is in good
5 standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain
6 posted for a period of 10 years from the date the board obtains
7 possession, custody, or control of the information, and after the
8 end of that period shall be removed from being posted on the
9 board's Internet Web site. Information in the possession, custody,
10 or control of the board prior to January 1, 2003, shall be posted
11 for a period of 10 years from January 1, 2003. Settlement
12 information shall be posted as described in paragraph (2) of
13 subdivision (b) of Section 803.1.

14 (2) The information described in paragraphs (3) and (6) of
15 subdivision (a) shall not be removed from being posted on the
16 board's Internet Web site. Notwithstanding the provisions of this
17 paragraph, if a licensee's hospital staff privileges are restored and
18 the licensee notifies the board of the restoration, the information
19 pertaining to the termination or revocation of those privileges, as
20 described in paragraph (6) of subdivision (a), shall remain posted
21 for a period of 10 years from the restoration date of the privileges,
22 and at the end of that period shall be removed from being posted
23 on the board's Internet Web site.

24 (c) Notwithstanding subdivision (b), the board shall remove an
25 expunged misdemeanor or felony conviction posted pursuant to
26 this section within 30 90 days of receiving notice of the
27 expungement.

28 ~~(d) (1) Notwithstanding subdivision (b), the board shall verify~~
29 ~~the accuracy of information posted pursuant to this section as of~~
30 ~~January 1, 2010, and shall, by April 1, 2010, remove any~~
31 ~~information that the board is unable to verify.~~

32 ~~(2) On and after January 1, 2010, notwithstanding subdivision~~
33 ~~(a), the board shall not post information pursuant to this section~~
34 ~~unless it first verifies the accuracy of that information. The~~
35 ~~verification required by this paragraph shall include, but not be~~
36 ~~limited to, an attempt to verify the information with the licensed~~
37 ~~physician and surgeon who is the subject of the information and~~
38 ~~his or her attorney.~~

39 ~~(3) Notwithstanding subdivision (b), and except as provided in~~
40 ~~paragraph (1), any information posted pursuant to this section that~~

- 1 the board subsequently discovers to be false shall be immediately
2 removed.
3 ~~(c) The board shall ensure that the biographical information~~
4 ~~posted on its Internet Web site with respect to licensed physicians~~
5 ~~and surgeons is accurate.~~
6 ~~(f) The board shall establish a process to completely address~~
7 ~~complaints from licensed physicians and surgeons regarding~~
8 ~~inappropriate information posted by the board pursuant to this~~
9 ~~section.~~
10 ~~(g)~~
11 *(d)* The board shall provide links to other Web sites on the
12 Internet that provide information on board certifications that meet
13 the requirements of subdivision (b) of Section 651. The board may
14 provide links to other Web sites on the Internet that provide
15 information on health care service plans, health insurers, hospitals,
16 or other facilities. The board may also provide links to any other
17 sites that would provide information on the affiliations of licensed
18 physicians and surgeons.

AB 501

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 501

Author: Emmerson

Bill Date: May 26, 2009, amended

Subject: Licensing: Limited, Use of M.D., Fee/Fund

Sponsor: Medical Board of California

STATUS OF BILL:

This bill is currently in the Senate.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a graduate of an approved medical school, who is enrolled in post graduate training in California, to use the initials M.D. only while that post graduate trainee is under the supervision of a licensed physician from that program. It will allow others who hold an unrestricted license to use these initials as long as they are not representing themselves as physicians who are allowed to practice in California.

This bill would allow the Medical Board (Board) to issue an initial limited license to an applicant for licensure who is otherwise eligible for a medical license in California but is unable to practice all aspects of medicine safely due to a disability.

This bill would establish a cap on the licensing fee imposed by the Medical Board. The cap would be fixed by the Board at a fee equal to or less than seven hundred ninety dollars (\$790). This bill would increase the amount of reserve allowed in the Contingent Fund of the Board.

Amendments to this bill further clarify the use of the initials M.D. In addition to graduates of an approved medical school while enrolled in post graduate training in California, a graduate of an approved medical school who has not had their license revoked or suspended may use the initials M.D. as long as they do not represent themselves as a physician who is entitled to practice medicine, do not engage in any of the acts prohibited by Section 2060. All medical schools are in support of this provision.

ANALYSIS:

Amends Business and Professions Code section 2054:

This bill would allow a graduate of an approved medical school, who is enrolled in post graduate training in California, to use the initials M.D. only while that post graduate

trainee is under the supervision of a licensed physician from that program. The post graduate trainee would be permitted to use the initials only while he or she is under the supervision of a licensed physician from that program.

This bill would allow physicians licensed in other states or countries to participate in events in California using the initials M.D. as long as they are not practicing medicine as physicians.

This section was amended to include graduates of approved medical schools who, if issued a license, have not had that license revoked or suspended and persons authorized to practice medicine under Sections 2111 and 2113.

Amends Business and Professions Code section 2088:

Currently the Board does not have the authority to issue a limited medical license at the time of initial licensure. The law allows the Board to issue a probationary license initially with restrictions against engaging in certain types of practice. Although the Board is authorized to limit a license of an existing licensee, there are various individuals who wish to practice in California and are not eligible to obtain a full and unrestricted medical license but can practice safely with a limited license.

All applicants for a limited license would be required to sign a statement agreeing to limit his or her practice to whatever areas are recommended by a reviewing physician who may be recommended by the Board. Several other states have laws that allow for the initial issuance of limited, restricted, or special licenses to address applicants with disabilities. There are qualified applicants who wish to be licensed in California, who will be able to practice safely with a limited license.

Amends Business and Professions Code section 2435:

This bill would establish a cap on the licensing fee imposed by the Medical Board. The cap would be fixed by the Board at a fee equal to or less than seven hundred ninety dollars (\$790). Currently the law requires the fee to be exactly seven hundred ninety dollars (\$790), leaving the Medical Board without the option to lower the fee when needed in order to comply with the limits on the reserve allowed in the Contingent Fund of the Medical Board. The fee cap would allow the Board to adjust the fee as needed.

This bill would increase the amount of reserve allowed in the Contingent Fund of the Medical Board to not less than two months and not more than four months' operating expenditures. The current two month limit on the reserve is rigid in that it limits the Board's ability to implement programs. A reserve fund of two to four months would allow more room to effectively maintain compatibility with the state audit while also allowing the Board to implement programs as necessary.

This bill would require an audit of the Board's financial status to be commenced no later than January 1, 2012 by the Bureau of State Audits. The audit would include the

impact of the 2008 loan to the general fund as well as projections related to expenses, revenues, and reserves. The audit will be funded within existing resources of the 2011-2012 fiscal year and would be required to be completed by June 1, 2012. The audit conducted in 2007 cost \$75,000.

FISCAL: None to the Board until 2011/2012, approximate cost \$100,000

POSITION: Sponsor/ Support

June 10, 2009

AMENDED IN ASSEMBLY MAY 26, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 501

Introduced by Assembly Member Emmerson

February 24, 2009

An act to amend Sections 2054 and 2435 of, and to add Section 2088 to, the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 501, as amended, Emmerson. Physicians and surgeons.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law makes it a misdemeanor for a person who is not licensed as a physician and surgeon *under the act* to use certain words, letters, and phrases or any other terms that imply that he or she is authorized to practice medicine as a physician and surgeon.

~~This bill would authorize a graduate of an approved medical school who is enrolled in a postgraduate training program approved by the board to use certain words, letters, or phrases while under instruction and under the supervision of a licensed physician and surgeon at the training program. The bill would also authorize a graduate of an approved medical school who does not have a valid certificate as a physician and surgeon issued by the board and who is not otherwise authorized to practice medicine in this state to use the initials "M.D." subject to specified conditions.~~

This bill would authorize certain persons who are not licensed as physicians and surgeons under the act to use the words "doctor" or

“physician,” the letters or prefix “Dr.,” or the initials “M.D.,” as specified.

Existing law authorizes the board to issue a probationary license subject to specified terms and conditions, including restrictions against engaging in certain types of medical practice. Existing law authorizes a licensee who demonstrates that he or she is unable to practice medicine due to a disability to request a waiver of the license renewal fee. Under existing law, a licensee granted that waiver is prohibited from practicing medicine until he or she establishes that the disability no longer exists or signs an agreement, under penalty of perjury, agreeing to limit his or her practice in the manner prescribed by the reviewing physician.

This bill would authorize an applicant for a license who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability to receive a limited license if the applicant pays the license fee and signs an agreement, under penalty of perjury, agreeing to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board. By requiring that the agreement be signed under penalty of perjury, the bill would expand the scope of a crime, thereby imposing a state-mandated local program. The bill would authorize the board to require the applicant to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving the limited license.

Under existing law, licensees of the board are required to pay licensure fees, including an initial licensing fee of \$790 and a biennial renewal fee of \$790. Existing law authorizes the board to increase those fees in certain circumstances and states the intent of the Legislature that, in setting these fees, the board seek to maintain a reserve in the Contingent Fund of the Medical Board equal to 2 months' operating expenditures.

This bill would require those fees to be fixed by the board at a maximum of \$790, while retaining the authority of the board to raise those fees in certain circumstances. The bill would state the intent of the Legislature that, in setting those fees, the board seek to maintain a reserve in the Contingent Fund of the Medical Board in an amount not less than 2 nor more than 4 months' operating expenditures. The bill would also require the Bureau of State Audits to commence a review of the board's financial status by January 1, 2012, and to report its findings and recommendations to the Joint Legislative Audit Committee by June 1, 2012, as specified.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2054 of the Business and Professions
2 Code is amended to read:

3 2054. (a) Any person who uses in any sign, business card, or
4 letterhead, or, in an advertisement, the words "doctor" or
5 "physician," the letters or prefix "Dr.," the initials "M.D.," or any
6 other terms or letters indicating or implying that he or she is a
7 physician and surgeon, physician, surgeon, or practitioner under
8 the terms of this or any other law, or that he or she is entitled to
9 practice hereunder, or who represents or holds himself or herself
10 out as a physician and surgeon, physician, surgeon, or practitioner
11 under the terms of this or any other law, without having at the time
12 of so doing a valid, unrevoked, and unsuspended certificate as a
13 physician and surgeon under this chapter, is guilty of a
14 misdemeanor.

15 (b) A holder of a valid, unrevoked, and unsuspended certificate
16 to practice podiatric medicine may use the phrases "doctor of
17 podiatric medicine," "doctor of podiatry," and "podiatric doctor,"
18 or the initials "D.P.M.," and shall not be in violation of subdivision
19 (a).

20 (c) ~~A graduate of an approved medical school who is enrolled
21 in a postgraduate training program approved by the board may use
22 the words "doctor" or "physician," the letters or prefix "Dr.," or
23 the initials "M.D.," while under instruction and under the
24 supervision of a licensed physician and surgeon at that postgraduate
25 training program, and shall not be in violation of subdivision (a).~~
26 (d) ~~Except as provided in subdivision (c), a graduate of an
27 approved medical school who does not have a valid, unrevoked,
28 and unsuspended certificate as a physician and surgeon issued
29 under this chapter and who is not otherwise authorized to practice
30 medicine under this chapter may use the initials "M.D." without~~

1 violating subdivision (a), provided he or she does not do either of
2 the following:

3 (1) ~~Imply that he or she is a physician and surgeon, physician,~~
4 ~~surgeon, or practitioner under the terms of this chapter, or that he~~
5 ~~or she is entitled to practice medicine in this state.~~

6 (2) ~~Represent or hold himself or herself out as a physician and~~
7 ~~surgeon, physician, surgeon, or practitioner under the terms of this~~
8 ~~chapter.~~

9 (c) *Notwithstanding subdivision (a), any of the following persons*
10 *may use the words "doctor" or "physician," the letters or prefix*
11 *"Dr.," or the initials "M.D.":*

12 (1) *A graduate of a medical school approved or recognized by*
13 *the board while enrolled in a postgraduate training program*
14 *approved by the board.*

15 (2) *A graduate of a medical school who does not have a*
16 *certificate as a physician and surgeon under this chapter if he or*
17 *she meets all of the following requirements:*

18 (A) *If issued a license to practice medicine in another*
19 *jurisdiction, has not had that license revoked or suspended by any*
20 *jurisdiction.*

21 (B) *Does not otherwise hold himself or herself out as a physician*
22 *and surgeon entitled to practice medicine in this state except to*
23 *the extent authorized by this chapter.*

24 (C) *Does not engage in any of the acts prohibited by Section*
25 *2060.*

26 (3) *A person authorized to practice medicine under Section*
27 *2111 or 2113 subject to the limitations set forth in those sections.*

28 SEC. 2. Section 2088 is added to the Business and Professions
29 Code, to read:

30 2088. (a) An applicant for a physician's and surgeon's license
31 who is otherwise eligible for that license but is unable to practice
32 some aspects of medicine safely due to a disability may receive a
33 limited license if he or she does both of the following:

34 (1) Pays the initial license fee.

35 (2) Signs an agreement on a form prescribed by the board, signed
36 under penalty of perjury, in which the applicant agrees to limit his
37 or her practice in the manner prescribed by the reviewing physician
38 and agreed to by the board.

39 (b) The board may require the applicant described in subdivision
40 (a) to obtain an independent clinical evaluation of his or her ability

1 to practice medicine safely as a condition of receiving a limited
2 license under this section.

3 SEC. 3. Section 2435 of the Business and Professions Code is
4 amended to read:

5 2435. The following fees apply to the licensure of physicians
6 and surgeons:

7 (a) Each applicant for a certificate based upon a national board
8 diplomate certificate, each applicant for a certificate based on
9 reciprocity, and each applicant for a certificate based upon written
10 examination, shall pay a nonrefundable application and processing
11 fee, as set forth in subdivision (b), at the time the application is
12 filed.

13 (b) The application and processing fee shall be fixed by the
14 board by May 1 of each year, to become effective on July 1 of that
15 year. The fee shall be fixed at an amount necessary to recover the
16 actual costs of the licensing program as projected for the fiscal
17 year commencing on the date the fees become effective.

18 (c) Each applicant who qualifies for a certificate, as a condition
19 precedent to its issuance, in addition to other fees required herein,
20 shall pay an initial license fee, if any, in an amount fixed by the
21 board consistent with this section. The initial license fee shall not
22 exceed seven hundred ninety dollars (\$790). An applicant enrolled
23 in an approved postgraduate training program shall be required to
24 pay only 50 percent of the initial license fee.

25 (d) The biennial renewal fee shall be fixed by the board
26 consistent with this section and shall not exceed seven hundred
27 ninety dollars (\$790).

28 (e) Notwithstanding subdivisions (c) and (d), and to ensure that
29 subdivision (k) of Section 125.3 is revenue neutral with regard to
30 the board, the board may, by regulation, increase the amount of
31 the initial license fee and the biennial renewal fee by an amount
32 required to recover both of the following:

33 (1) The average amount received by the board during the three
34 fiscal years immediately preceding July 1, 2006, as reimbursement
35 for the reasonable costs of investigation and enforcement
36 proceedings pursuant to Section 125.3.

37 (2) Any increase in the amount of investigation and enforcement
38 costs incurred by the board after January 1, 2006, that exceeds the
39 average costs expended for investigation and enforcement costs
40 during the three fiscal years immediately preceding July 1, 2006.

1 When calculating the amount of costs for services for which the
2 board paid an hourly rate, the board shall use the average number
3 of hours for which the board paid for those costs over these prior
4 three fiscal years, multiplied by the hourly rate paid by the board
5 for those costs as of July 1, 2005. Beginning January 1, 2009, the
6 board shall instead use the average number of hours for which it
7 paid for those costs over the three-year period of fiscal years
8 2005–06, 2006–07, and 2007–08, multiplied by the hourly rate
9 paid by the board for those costs as of July 1, 2005. In calculating
10 the increase in the amount of investigation and enforcement costs,
11 the board shall include only those costs for which it was eligible
12 to obtain reimbursement under Section 125.3 and shall not include
13 probation monitoring costs and disciplinary costs, including those
14 associated with the citation and fine process and those required to
15 implement subdivision (b) of Section 12529 of the Government
16 Code.

17 (f) Notwithstanding Section 163.5, the delinquency fee shall be
18 10 percent of the biennial renewal fee.

19 (g) The duplicate certificate and endorsement fees shall each
20 be fifty dollars (\$50), and the certification and letter of good
21 standing fees shall each be ten dollars (\$10).

22 (h) It is the intent of the Legislature that, in setting fees pursuant
23 to this section, the board shall seek to maintain a reserve in the
24 Contingent Fund of the Medical Board of California in an amount
25 not less than two nor more than four months' operating
26 expenditures.

27 (i) Not later than January 1, 2012, the Bureau of State Audits
28 (BSA) shall commence a review of the board's financial status,
29 including, but not limited to, its projections related to expenses,
30 revenues, and reserves, and the impact of the loan from the
31 Contingent Fund of the Medical Board of California to the General
32 Fund made pursuant to the Budget Act of 2008. The BSA shall,
33 on the basis of the review, report its findings and recommendations
34 to the Joint Legislative Audit Committee by June 1, 2012. This
35 review shall be funded from the existing resources of the board
36 during the 2011–12 fiscal year.

37 SEC. 4. No reimbursement is required by this act pursuant to
38 Section 6 of Article XIII B of the California Constitution because
39 the only costs that may be incurred by a local agency or school
40 district will be incurred because this act creates a new crime or

1 infraction, eliminates a crime or infraction, or changes the penalty
2 for a crime or infraction, within the meaning of Section 17556 of
3 the Government Code, or changes the definition of a crime within
4 the meaning of Section 6 of Article XIII B of the California
5 Constitution.

O

AB 526

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 526

Author: Fuentes

Bill Date: June 1, 2009, amended

Subject: Public Protection and Physician Health Program Act of 2009

Sponsor: California Medical Association

STATUS OF BILL:

This bill is currently in the Senate.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Public Protection and Physician Health Committee (Committee) within the State and Consumer Services Agency (SCSA) with the intent of creating a program in California that will permit physicians to obtain treatment and monitoring of alcohol or substance abuse/dependency, or of mental disorder recovery so that physicians do not treat patients while impaired.

This bill was amended to require the Board to increase licensing fees by \$22 for the purposes of funding the physician health program.

ANALYSIS:

This bill would establish the Public Protection and Physician Health Committee. The Committee would be comprised of 14 members and would be under the SCSA. This bill would require that the committee must be appointed and hold its first meeting no later than March 1, 2010. The Committee would be required to prepare regulations that provide clear guidance and measurable outcomes to ensure patient safety and the health and wellness of physicians by June 30, 2010. These rules and regulations shall include:

- Minimum standards, criteria, and guidelines for the acceptance, denial, referral to treatment, and monitoring of physicians and surgeons in the physician health program;
- Standards for requiring that a physician and surgeon agree to cease practice to obtain appropriate treatment services;
- Criteria that must be met prior to a physician and surgeon returning to practice;

- Standards, requirements, and procedures for random testing for the use of banned substances and protocols to follow if that use has occurred;
- Worksite monitoring requirements and standards;
- The manner, protocols, and timeliness of reports required;
- Appropriate requirements for clinical diagnostic evaluations of program participants;
- Requirements for a physician and surgeon's termination from, and reinstatement to, the program;
- Requirements that govern the ability of the program to communicate with a participant's employer or organized medical staff about the participant's status and condition;
- Group meeting and other self-help requirements, standards, protocols, and qualifications;

The Committee would be required to recommend one or more non-profit physician health programs to the SCSA. The physician health programs would be required to report annually to the committee on the number of participants served, the number of compliant participants, the number of participants who have successfully completed their agreement period, and the number of participants reported to the board for suspected noncompliance. The physician health programs would also have to agree to submit to periodic audits and inspections of all operations, records, and management related to the physician health program to ensure compliance.

This bill would require the SCSA, in conjunction with the committee, to monitor compliance of the physician health programs, including making periodic inspections and onsite visits.

This bill would permit a physician to enter into a voluntary agreement with a physician health program that must include a jointly agreed upon treatment program and mandatory conditions and procedures to monitor compliance with the treatment program. The physicians' voluntary participation in a physician health program would be confidential unless waived by the physician.

This bill would prohibit any voluntary agreement from being considered a disciplinary action or order by the Board and would prohibit the agreement from being disclosed to the Board nor to the public. Each participant, prior to entering into a voluntary agreement, would be required to disclose to the Committee whether he or she is under investigation by the Board. If a participant fails to disclose such an investigation, upon enrollment or at any time while a participant, the participant shall be terminated from the program.

Physician health programs would be permitted to report to the committee the name of and results of any contact or information received regarding a physician who is suspected of being, or is, impaired and, as a result, whose competence or professional conduct is reasonably likely to be detrimental to patient safety or to the delivery of patient care. The programs would be required to report to the committee if the physician and fails to cooperate with any of the requirements of the physician health program, fails to cease practice when required, fails to submit to evaluation, treatment, or biological fluid testing when required, or whose impairment is not substantially alleviated through treatment, or who, in the opinion of the physician health program, is unable to practice medicine with reasonable skill and safety, or who withdraws or is terminated from the physician health program prior to completion.

The participating physician in a voluntary agreement would be responsible for all expenses relating to chemical or biological fluid testing, treatment, and recovery as provided in the written agreement between the physician and the physician health program.

This bill would permit, not require, the Board to increase licensing fees to no less than \$22 and not to exceed 2.5% of the license fee. This fee would be expended solely for the purposes of the physician health programs. If the board included this surcharge, it would be collected and transferred to a trust established by this bill. The Board would be required to separately identify, on the licensing fee statement, the amount being collected for the program. If the Board were to opt to increase the licensing fees to fund this program, the bill states that the Board would be allowed to include a statement indicating to licensees that the Public Protection and Physician Health Program is not a program of the Board and that, by collecting this fee, the Board does not necessarily support, endorse, or have any control of or affiliation with the program. The SCSA would be required to contract for a biennial audit to assess the effectiveness, efficiency, and overall performance of the program and make recommendations.

Amendments to this bill taken June 1, 2009 require the Board to increase licensing fees by not less than \$22 or 2.5% of the license fee, whichever is greater, to be used solely for the purposes of the physician health programs.

FISCAL: Unknown

POSITION: Staff Recommendation: Oppose

June 10, 2009

AMENDED IN ASSEMBLY JUNE 1, 2009

AMENDED IN ASSEMBLY APRIL 16, 2009

AMENDED IN ASSEMBLY APRIL 14, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL

No. 526

Introduced by Assembly Member Fuentes

February 25, 2009

An act to add and repeal Article 14 (commencing with Section 2340) of Chapter 5 of Division 2 of the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 526, as amended, Fuentes. Public Protection and Physician Health Program Act of 2009.

Existing law establishes in the Department of Consumer Affairs the Substance Abuse Coordination Committee, comprised of the executive officers of the department's healing arts boards, as specified, and a designee of the State Department of Alcohol and Drug Programs. Existing law requires the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board shall use in dealing with substance-abusing licensees. The Medical Practice Act establishes in the Department of Consumer Affairs the Medical Board of California, which provides for the licensure and regulation of physicians and surgeons.

This bill would enact the Public Protection and Physician Health Program Act of 2009, which would, until January 1, 2021, establish within the State and Consumer Services Agency the Public Protection and Physician Health Committee, consisting of 14 members appointed

by specified entities, ~~and~~ would require the committee to be appointed and to hold its first meeting by March 1, 2010, and would require agency adoption of related rules and regulations by June 30, 2010. The bill would require the committee to recommend to the agency one or more physician health programs, and would authorize the agency to contract, including on an interim basis, as specified, with any qualified physician health program for purposes of care and rehabilitation of physicians and surgeons with alcohol or drug abuse or dependency problems or mental disorders as specified. The bill would impose requirements on the physician health program relating to, among other things, monitoring the status and compliance of physicians and surgeons who enter treatment for a qualifying illness, as defined, pursuant to written, voluntary agreements, and would require the agency and committee to monitor compliance with these requirements. The bill would provide that a voluntary agreement to receive treatment would not be subject to public disclosure or disclosure to the Medical Board of California, except as specified. The bill would ~~authorize~~ *require* the board to increase physician and surgeon licensure and renewal fees for purposes of the act, and would establish the Public Protection and Physician Health Program Trust Fund for deposit of those funds, which would be subject to appropriation by the Legislature. The bill would also require specified performance audits.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature hereby finds and declares that:
2 (a) California has long valued high quality medical care for its
3 citizens and, through its regulatory and enforcement system,
4 protects health care consumers through the proper licensing and
5 regulation of physicians and surgeons to promote access to quality
6 medical care. The protection of the public from harm by physicians
7 and surgeons who may be impaired by alcohol or substance abuse
8 or dependence or by a mental disorder is paramount.
9 (b) Nevertheless, physicians and surgeons experience
10 health-related problems at the same frequency as the general
11 population, and many competent physicians and surgeons with
12 illnesses may or may not immediately experience impairment in
13 their ability to serve the public. It has been estimated that at least

1 10 percent of the population struggles with alcohol or substance
2 abuse or dependence during their lifetime, which may, at some
3 point, impact approximately 12,500 of the state's 125,000 licensed
4 physicians and surgeons.

5 (c) It is in the best interests of the public and the medical
6 profession to provide a pathway to recovery for any licensed
7 physician and surgeon that is currently suffering from alcohol or
8 substance abuse or dependence or a mental disorder. The American
9 Medical Association has recognized that it is an expression of the
10 highest meaning of professionalism for organized medicine to take
11 an active role in helping physicians and surgeons to lead healthy
12 lives in order to help their patients, and therefore, it is appropriate
13 for physicians and surgeons to assist in funding such a program.

14 (d) While nearly every other state has a physician health
15 program, since 2007 California has been without any state program
16 that monitors physicians and surgeons who have independently
17 obtained, or should be encouraged to obtain, treatment for alcohol
18 or substance abuse or dependence or for a mental disorder, so that
19 they do not treat patients while impaired.

20 (e) It is essential for the public interest and the public health,
21 safety, and welfare to focus on early intervention, assessment,
22 referral to treatment, and monitoring of physicians and surgeons
23 with significant health impairments that may impact their ability
24 to practice safely. Such a program need not, and should not
25 necessarily, divert physicians and surgeons from the disciplinary
26 system, but instead focus on providing assistance before any harm
27 to a patient has occurred.

28 (f) Therefore, it is necessary to create a program in California
29 that will permit physicians and surgeons to obtain referral to
30 treatment and monitoring of alcohol or substance abuse or
31 dependence or a mental disorder, so that they do not treat patients
32 while impaired.

33 SEC. 2. Article 14 (commencing with Section 2340) is added
34 to Chapter 5 of Division 2 of the Business and Professions Code,
35 to read:

36
37 Article 14. Public Protection and Physician Health Program

38
39 2340. This article shall be known and may be cited as the Public
40 Protection and Physician Health Program Act of 2009.

- 1 2341. For purposes of this article, the following terms have
2 the following meanings:
- 3 (a) "Agency" means the State and Consumer Services Agency.
 - 4 (b) "Board" means the Medical Board of California.
 - 5 (c) "Committee" means the Public Protection and Physician
6 Health Committee established pursuant to Section 2342.
 - 7 (d) "Impaired" or "impairment" means the inability to practice
8 medicine with reasonable skill and safety to patients by reason of
9 alcohol abuse, substance abuse, alcohol dependency, any other
10 substance dependency, or a mental disorder.
 - 11 (e) "Participant" means a physician and surgeon enrolled in the
12 program pursuant to an agreement entered into as provided in
13 Section 2345.
 - 14 (f) "Physician health program" or "program" means the program
15 for the prevention, detection, intervention, monitoring, and referral
16 to treatment of impaired physicians and surgeons, and includes
17 vendors, providers, or entities contracted with by the agency
18 pursuant to this article.
 - 19 (g) "Physician and surgeon" means a holder of a physician's
20 and surgeon's certificate.
 - 21 (h) "Qualifying illness" means "alcohol or substance abuse,"
22 "alcohol or chemical dependency," or a "mental disorder" as those
23 terms are used in the Diagnostic and Statistical Manual of Mental
24 Disorders, Fourth Edition (DSM-IV) or subsequent editions.
 - 25 (i) "Secretary" means the Secretary of State and Consumer
26 Services.
 - 27 (j) "Treatment program" or "treatment" means the delivery of
28 care and rehabilitation services provided by an organization or
29 persons authorized by law to provide those services.
 - 30 2342. (a) (1) There is hereby established within the State and
31 Consumer Services Agency the Public Protection and Physician
32 Health Committee. The committee shall be appointed and hold its
33 first meeting no later than March 1, 2010. The committee shall be
34 comprised of 14 members who shall be appointed as follows:
 - 35 (A) Eight members appointed by the secretary, including the
36 following:
 - 37 (i) Two members who are licensed mental health professionals
38 with knowledge and expertise in the identification and treatment
39 of substance abuse and mental disorders.

1 (ii) Six members who are physicians and surgeons with
2 knowledge and expertise in the identification and treatment of
3 alcohol dependence and substance abuse. One member shall be a
4 designated representative from a panel recommended by a nonprofit
5 professional association representing physicians and surgeons
6 licensed in this state with at least 25,000 members in all modes of
7 practice and specialties. The secretary shall fill one each of the
8 remaining appointments from among those individuals as may be
9 recommended by the California Society of Addiction Medicine,
10 the California Psychiatrist Association, and the California Hospital
11 Association.
12 (B) Four members of the public appointed by the Governor, at
13 least one of whom shall have experience in advocating on behalf
14 of consumers of medical care in this state.
15 (C) One member of the public appointed by the Speaker of the
16 Assembly.
17 (D) One member of the public appointed by the Senate
18 Committee on Rules.
19 (2) (A) For the purpose of this subdivision, a public member
20 may not be any of the following:
21 (i) A current or former physician and surgeon or an immediate
22 family member of a physician and surgeon.
23 (ii) Currently or formerly employed by a physician and surgeon
24 or business providing or arranging for physician and surgeon
25 services, or have any financial interest in the business of a license.
26 (iii) An employee or agent or representative of any organization
27 representing physicians and surgeons.
28 (B) Each public member shall meet all of the requirements for
29 public membership on the board as set forth in Chapter 6
30 (commencing with Section 450) of Division 1.
31 (b) Members of the committee shall serve without compensation,
32 but shall be reimbursed for any travel expenses necessary to
33 conduct committee business.
34 (c) Committee members shall serve terms of four years, and
35 may be reappointed. By lot, the committee shall stagger the terms
36 of the initial members appointed.
37 (d) The committee shall be subject to the Bagley-Keene Open
38 Meeting Act (Article 9 (commencing with Section 11120) of
39 Chapter 1 of Part 1 of Division 3 of Title 2 of the Government
40 Code), and shall prepare any additional recommended rules and

1 regulations necessary or advisable for the purpose of implementing
2 this article, subject to the Administrative Procedures Act (Chapter
3 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
4 Title 2 of the Government Code). The rules and regulations shall
5 include appropriate minimum standards and requirements for
6 referral to treatment, and monitoring of participants in the physician
7 health program, and shall be written in a manner that provides
8 clear guidance and measurable outcomes to ensure patient safety
9 and the health and wellness of physicians and surgeons. The agency
10 shall adopt regulations for the implementation of this article, taking
11 into consideration the regulations recommended by the committee.
12 (e) The rules and regulations required by this section shall be
13 adopted not later than June 30, 2010, and shall, at a minimum, be
14 consistent with the uniform standards adopted pursuant to Section
15 315, and shall include all of the following:

16 (1) Minimum standards, criteria, and guidelines for the
17 acceptance, denial, referral to treatment, and monitoring of
18 physicians and surgeons in the physician health program.

19 (2) Standards for requiring that a physician and surgeon agree
20 to cease practice to obtain appropriate treatment services.

21 (3) Criteria that must be met prior to a physician and surgeon
22 returning to practice.

23 (4) Standards, requirements, and procedures for random testing
24 for the use of banned substances and protocols to follow if that
25 use has occurred.

26 (5) Worksite monitoring requirements and standards.

27 (6) The manner, protocols, and timeliness of reports required
28 to be made pursuant to Section 2345.

29 (7) Appropriate requirements for clinical diagnostic evaluations
30 of program participants.

31 (8) Requirements for a physician and surgeon's termination
32 from, and reinstatement to, the program.

33 (9) Requirements that govern the ability of the program to
34 communicate with a participant's employer or organized medical
35 staff about the participant's status and condition.

36 (10) Group meeting and other self-help requirements, standards,
37 protocols, and qualifications.

38 (11) Minimum standards and qualifications of any vendor,
39 monitor, provider, or entity contracted with by the agency pursuant
40 to Section 2343.

1 (12) A requirement that all physician health program services
2 shall be available to all licensed physicians and surgeons with a
3 qualifying illness.

4 (13) A requirement that any physician health program shall do
5 all of the following:

6 (A) Promote, facilitate, or provide information that can be used
7 for the education of physicians and surgeons with respect to the
8 recognition and treatment of alcohol dependency, chemical
9 dependency, or mental disorders, and the availability of the
10 physician health program for qualifying illnesses.

11 (B) Offer assistance to any person in referring a physician and
12 surgeon for purposes of assessment or treatment, or both, for a
13 qualifying illness.

14 (C) Monitor the status during treatment of a physician and
15 surgeon who enters treatment for a qualifying illness pursuant to
16 a written, voluntary agreement.

17 (D) Monitor the compliance of a physician and surgeon who
18 enters into a written, voluntary agreement for a qualifying illness
19 with the physician health program setting forth a course of
20 recovery.

21 (E) Agree to accept referrals from the board to provide
22 monitoring services pursuant to a board order.

23 (F) Provide a clinical diagnostic evaluation of physicians and
24 surgeons entering the program.

25 (14) Rules and procedures to comply with auditing requirements
26 pursuant to Section 2348.

27 (15) A definition of the standard of “reasonably likely to be
28 detrimental to patient safety or the delivery of patient care,” relying,
29 to the extent practicable, on standards used by hospitals, medical
30 groups, and other employers of physicians and surgeons.

31 (16) Any other provision necessary for the implementation of
32 this article.

33 2343. (a) On and after July 1, 2010, upon adoption of the rules
34 and regulations required by Section 2342, the committee shall
35 recommend one or more physician health programs to the agency,
36 and the agency may contract with any qualified physician health
37 program. The physician health program shall be a nonprofit
38 corporation organized under Section 501(c)(3) of Title 26 of the
39 United States Code. The chief executive officer shall have expertise
40 in the areas of alcohol abuse, substance abuse, alcohol dependency,

1 other chemical dependencies, and mental disorders. In order to
2 expedite the delivery of physician health program services
3 established by this article, the agency may contract with an entity
4 meeting the minimum standards and requirements set forth in
5 subdivision (e) of Section 2342 on an interim basis prior to the
6 adoption of any additional rules and regulations required to be
7 adopted pursuant to subdivision (d) of Section 2342. The agency
8 may extend the contract when the rules and regulations are adopted,
9 provided that the physician health program meets the requirements
10 in those rules and regulations.

11 (b) Any contract entered into pursuant to this article shall comply
12 with all rules and regulations required to be adopted pursuant to
13 this article. No entity shall be eligible to provide the services of
14 the physician health program that does not meet the minimum
15 standards, criteria, and guidelines contained in those rules and
16 regulations.

17 (c) The contract entered into pursuant to this article shall also
18 require the contracting entity to do both of the following:

19 (1) Report annually to the committee statistics, including the
20 number of participants served, the number of compliant
21 participants, the number of participants who have successfully
22 completed their agreement period, and the number of participants
23 reported to the board for suspected noncompliance; provided,
24 however, that in making that report, the physician health program
25 shall not disclose any personally identifiable information relating
26 to any physician and surgeon participating in a voluntary agreement
27 as provided in this article.

28 (2) Agree to submit to periodic audits and inspections of all
29 operations, records, and management related to the physician health
30 program to ensure compliance with the requirements of this article
31 and its implementing rules and regulations.

32 (d) In addition to the requirements of Section 2348, the agency,
33 in conjunction with the committee, shall monitor compliance of
34 the physician health program with the requirements of this article
35 and its implementing regulations, including making periodic
36 inspections and onsite visits with any entity contracted to provide
37 physician health program services.

38 2344. The agency has the sole discretion to contract with a
39 physician health program for licensees of the board and no
40 provision of this article may be construed to entitle any physician

1 and surgeon to the creation or designation of a physician health
2 program for any individual qualifying illness or group of qualifying
3 illnesses.

4 2345. (a) In order to encourage voluntary participation in
5 monitored alcohol or chemical dependency or mental disorder
6 treatment programs, and in recognition of the fact that mental
7 disorders, alcohol dependency, and chemical dependency are
8 illnesses, a physician and surgeon, certified or otherwise lawfully
9 practicing in this state, may enter into a voluntary agreement with
10 a physician health program. The agreement between the physician
11 and surgeon and the physician health program shall include a
12 jointly agreed upon treatment program and mandatory conditions
13 and procedures to monitor compliance with the treatment program,
14 including, but not limited to, an agreement to cease practice, as
15 defined by the rules and regulations adopted pursuant to Section
16 2342. Except as provided in subdivisions (b), (c), (d), and (e), a
17 physician and surgeon's participation in the physician health
18 program pursuant to a voluntary agreement shall be confidential
19 unless waived by the physician and surgeon.

20 (b) (1) Any voluntary agreement entered into pursuant to this
21 section shall not be considered a disciplinary action or order by
22 the board, shall not be disclosed to the board, and shall not be
23 public information if all of the following are true:

24 (A) The voluntary agreement is the result of the physician and
25 surgeon self-enrolling or voluntarily participating in the physician
26 health program.

27 (B) The board has not referred a complaint against the physician
28 and surgeon to a district office of the board for investigation for
29 conduct involving or alleging an impairment adversely affecting
30 the care and treatment of patients.

31 (C) The physician and surgeon is in compliance with the
32 treatment program and the conditions and procedures to monitor
33 compliance.

34 (2) (A) Each participant, prior to entering into the voluntary
35 agreement described in paragraph (1), shall disclose to the
36 committee whether he or she is under investigation by the board.
37 If a participant fails to disclose such an investigation, upon
38 enrollment or at any time while a participant, the participant shall
39 be terminated from the program. For those purposes, the committee
40 shall regularly monitor recent accusations filed against physicians

1 and surgeons and shall compare the names of physicians and
2 surgeons subject to accusation with the names of program
3 participants.

4 (B) Notwithstanding subparagraph (A), a participant who is
5 under investigation by the board and who makes the disclosure
6 required in subparagraph (A) may participate in, and enter into a
7 voluntary agreement with, the physician health program.

8 (c) (1) If a physician and surgeon enters into a voluntary
9 agreement with the physician health program pursuant to this
10 article, the physician health program shall do both of the following:

11 (A) In addition to complying with any other duty imposed by
12 law, report to the committee the name of and results of any contact
13 or information received regarding a physician and surgeon who is
14 suspected of being, or is, impaired and, as a result, whose
15 competence or professional conduct is reasonably likely to be
16 detrimental to patient safety or to the delivery of patient care.

17 (B) Report to the committee if the physician and surgeon fails
18 to cooperate with any of the requirements of the physician health
19 program, fails to cease practice when required, fails to submit to
20 evaluation, treatment, or biological fluid testing when required, or
21 whose impairment is not substantially alleviated through treatment,
22 or who, in the opinion of the physician health program, is unable
23 to practice medicine with reasonable skill and safety, or who
24 withdraws or is terminated from the physician health program prior
25 to completion.

26 (2) Within 48 hours of receiving a report pursuant to paragraph
27 (1), the committee shall make a determination as to whether the
28 competence or professional conduct of the physician and surgeon
29 is reasonably likely to be detrimental to patient safety or to the
30 delivery of patient care, and, if so, refer the matter to the board
31 consistent with rules and regulations adopted by the agency. Upon
32 receiving a referral pursuant to this paragraph, the board shall take
33 immediate action and may initiate proceedings to seek a temporary
34 restraining order or interim suspension order as provided in this
35 division.

36 (d) Except as provided in subdivisions (b), (c), and (e), and this
37 subdivision, any oral or written information reported to the board
38 pursuant to this section, including, but not limited to, any physician
39 and surgeon's participation in the physician health program and
40 any voluntary agreement entered into pursuant to this article, shall

1 remain confidential as provided in subdivision (c) of Section 800,
2 and shall not constitute a waiver of any existing evidentiary
3 privileges under any other provision or rule of law. However, this
4 subdivision shall not apply if the board has referred a complaint
5 against the physician and surgeon to a district office of the board
6 for investigation for conduct involving or alleging an impairment
7 adversely affecting the care and treatment of patients.

8 (e) Nothing in this section prohibits, requires, or otherwise
9 affects the discovery or admissibility of evidence in an action
10 against a physician and surgeon based on acts or omissions within
11 the course and scope of his or her practice.

12 (f) Any information received, developed, or maintained by the
13 agency regarding a physician and surgeon in the program shall not
14 be used for any other purpose.

15 2346. The committee shall report to the agency statistics
16 received from the physician health program pursuant to Section
17 2343, and the agency shall, thereafter, report to the Legislature the
18 number of individuals served, the number of compliant individuals,
19 the number of individuals who have successfully completed their
20 agreement period, and the number of individuals reported to the
21 board for suspected noncompliance; provided, however, that in
22 making that report the agency shall not disclose any personally
23 identifiable information relating to any physician and surgeon
24 participating in a voluntary agreement as provided herein.

25 2347. (a) A physician and surgeon participating in a voluntary
26 agreement shall be responsible for all expenses relating to chemical
27 or biological fluid testing, treatment, and recovery as provided in
28 the written agreement between the physician and surgeon and the
29 physician health program.

30 (b) In addition to the fees charged for the initial issuance or
31 biennial renewal of a physician and surgeon's certificate pursuant
32 to Section 2435, and at the time those fees are charged, the board
33 ~~may~~ shall include a surcharge of not less than twenty-two dollars
34 (\$22) ~~and not to exceed, or~~ an amount equal to 2.5 percent of the
35 fee set pursuant to Section 2435, *whichever is greater, and* which
36 shall be expended solely for the purposes of this article. ~~If the~~
37 ~~board includes a surcharge, the~~ The board shall collect this
38 surcharge and cause it to be transferred monthly to the trust fund
39 established pursuant to subdivision (c). This amount ~~shall~~ may be
40 separately identified on the fee statement provided to physicians

1 and surgeons as being imposed pursuant to this article. The board
2 may include a conspicuous statement indicating that the Public
3 Protection and Physician Health Program is not a program of the
4 board and the collection of this fee does not, nor shall it be
5 construed to, constitute the board's endorsement of, support for,
6 control of, or affiliation with, the program.

7 (c) There is hereby established in the State Treasury the Public
8 Protection and Physician Health Program Trust Fund into which
9 all funds collected pursuant to this section shall be deposited. These
10 funds shall be used, upon appropriation in the annual Budget Act,
11 only for the purposes of this article.

12 (d) Nothing in this section is intended to limit the amount of
13 funding that may be provided for the purposes of this article. In
14 addition to funds appropriated in the annual Budget Act, additional
15 funding from private or other sources may be used to ensure that
16 no person is denied access to the services established by this
17 program due to a lack of available funding.

18 (e) All costs of the committee and program established pursuant
19 to this article shall be paid out of the funds collected pursuant to
20 this section.

21 2348. (a) The agency shall biennially contract to perform a
22 thorough audit of the effectiveness, efficiency, and overall
23 performance of the program and its vendors. The agency may
24 contract with a third party to conduct the performance audit, except
25 the third party may not be a person or entity that regularly testifies
26 before the board. This section is not intended to reduce the number
27 of audits the agency or board may otherwise conduct.

28 (b) The audit shall make recommendations regarding the
29 continuation of this program and this article and shall suggest any
30 changes or reforms required to ensure that individuals participating
31 in the program are appropriately monitored and the public is
32 protected from physicians and surgeons who are impaired due to
33 alcohol or drug abuse or dependency or mental disorder. Any
34 person conducting the audit required by this section shall maintain
35 the confidentiality of all records reviewed and information obtained
36 in the course of conducting the audit and shall not disclose any
37 information that is identifiable to any program participant.

38 (c) If, during the course of an audit, the auditor discovers that
39 a participant has harmed a patient, or a patient has died while being
40 treated by a participant, the auditor shall include that information

1 in his or her audit, and shall investigate and report on how that
2 participant was dealt with by the program.

3 (d) A copy of the audit shall be made available to the public by
4 posting a link to the audit on the agency's Internet Web site
5 homepage no less than 10 business days after publication of the
6 audit. Copies of the audit shall also be provided to the Assembly
7 and Senate Committees on Business and Professions and the
8 Assembly and Senate Committees on Health within 10 business
9 days of its publication.

10 2349. This article shall remain in effect only until January 1,
11 2021, and as of that date is repealed, unless a later enacted statute,
12 that is enacted before January 1, 2021, deletes or extends that date.

O

AB 1070

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1070

Author: Hill

Bill Date: April 22, 2009, amended

Subject: Enforcement Enhancements: reporting, public reprimand
Sponsor: Medical Board of California

STATUS OF BILL:

This bill is currently in the Senate.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle carrying enforcement enhancements for the Medical Board (Board). This bill finds and declares the importance of the required reporting under Business and Professions Code section 801.01 and makes various technical changes to this section to enhance the Board's ability to effectively protect consumers.

This bill would allow the Board President to sit on a disciplinary panel when the Board does not have a full complement of members. This bill would require all medical records requested by the Board to be certified.

This bill would allow an administrative law judge to recommend that a licensee be issued a public reprimand that includes additional requirements for education and training.

This bill would require all licensees to report to the Board information regarding any specialty board certifications held and his or her practice status. Licensees would be allowed to report his or her cultural background and foreign language proficiencies. Reporting would occur both at the time of renewal or upon initial licensure.

ANALYSIS:

Amends Business and Professions Code section 801.01:

1. Finds and declares the importance of the required reporting under this section for public protection and clarifies the interpretation of the reporting requirements. This is necessary because there are entities that are not reporting, either due to finding ways around it or misinterpreting the law. The Board cannot effectively protect consumers if reporting is not consistent and enforced.

2. Specifies that the University of California is included in the definition of “state governmental agency.” This is a technical amendment to make clear that all state and local hospitals are considered state agencies and are bound by the same reporting requirements.
3. Removes section (e) due to the changes made in (f) rendering (e) duplicative.
4. Requires not only physicians, but the entities with which the physicians are affiliated to send a copy of any report filed to the claimant or his or her counsel. Current law states that the physician is required to send a copy of the report to the claimant. The word ‘entity’ is being added to cover a broader spectrum of individuals who may be reporting. This allows for the burden to be shared by all involved, rather than just the physician.
5. Puts the responsibility for any failure to comply with the reporting requirements on all parties, not just the physician. If an entity, rather than an individual physician, is responsible for making the decision in a case, that entity is responsible for the reporting. However, if the physician is not affiliated with a larger entity, the burden of reporting would be on the physician. Additionally, the fines for failing to comply are increased to not less than five hundred dollars (\$500) and not more than five thousand dollars (\$5,000).
6. Adds that a copy of a judgment must be submitted to the Board to be consistent with the requirement for a copy of an arbitration award.
7. Requires that any entity providing a report to a licensing Board must also notify the licensee that such report is being filed with that Board.

Adds Business and Professions Code section 804.5:

1. Recognizes that various entities are implementing risk management programs in the interest of early intervention to address known complications and other unanticipated events. Prohibits these programs from including provisions that prohibit patients from contacting or cooperating with the Board or from filing or withdrawing a complaint.

Amends Business and Professions Code section 2008:

1. Allows the Board President to sit on a disciplinary panel when the Board does not have a full complement of members. Currently, the Board President is not permitted to sit on a panel. When the Board does not have enough members to fill both panels, usually due to term expirations, it is often the case that Board members must serve on two disciplinary panels at the same time in order to

have a quorum with which to take action. Allowing the Board President to sit on a panel would expedite the process of decision making and reduce the workload for the members who are sitting on more than one panel.

Amends Business and Professions Code section 2225.5:

1. Requires all medical records requested by the Board to be certified. When the Board requests medical records upon initial complaint, certified records are requested but not always provided. The initial review can be performed without certified records, however, if the complaint goes to investigation, the Board will need certified medical records. Currently, the Board often has to request medical records more than once, which prolongs the process of investigation. Requiring the requested medical records to be certified would expedite the process of review and investigation of complaints. The board has a form that can be filled out to certify the records and the provider of the records can ask the board to send its copy service thus reducing the cost to the physician or entity. (form attached)
2. Puts a cap of ten thousand dollars (\$10,000) on the penalty that can be assessed a physician for not complying with the Board's request for medical records. Currently the penalty is one thousand dollars (\$1,000) a day for not complying with the request for medical records. This cap is the same as what is in current law for hospitals.
3. Defines certified medical records as a copy of the patient's medical records authenticated by the licensee or health care facility, as appropriate, on a form prescribed by the board.

Amends Business and Professions Code section 2227:

1. Allows an administrative law judge to recommend the issuance of a public reprimand that includes additional education and training in a proposed decision. Currently, when the Board feels the appropriate level of discipline for a physician is a public letter of reprimand with required training or education, prior to the filing of an Accusation, the Board may issue the physician a public letter of reprimand that includes the additional education or training requirements. However, if the Board has filed an accusation against a physician and the accusation is heard by an administrative law judge, the law does not allow the administrative law judge to recommend a public reprimand to be issued to the physician with a training or education requirement.

Amends Business and Professions Code section 2425.3:

1. Specifies that licensees must report to the Board information regarding any specialty board certifications he or she holds that is issued by a member of the American Board of Medical Specialties or approved by the Board, his or her practice status, and may report his or her cultural background and foreign language proficiency both at the time of renewal and at upon initial licensure. Current law states that a physician must report the required information to the Board at renewal, but does not specify that the physician report the required information to the Board at the time of initial licensure.

FISCAL: None to the Board

POSITION: Sponsor/ Support

June 10, 2009

AMENDED IN ASSEMBLY APRIL 22, 2009

AMENDED IN ASSEMBLY MARCH 31, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL

No. 1070

Introduced by Assembly Member Hill

February 27, 2009

An act to amend Sections 801.01, 2008, 2225.5, 2227, and 2425.3 of *and to add Section 804.5 to*, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1070, as amended, Hill, Healing arts.

(1) Existing law provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California, of physicians and surgeons by the Medical Board of California, and of podiatrists by the California Board of Podiatric Medicine. Existing law requires those licensees, insurers providing professional liability insurance to those licensees, and governmental agencies that self-insure those licensees to report specified settlements, arbitration awards, or civil judgments to the licensee's board if based on the licensee's alleged negligence, error, or omission in practice or his or her rendering of unauthorized professional services.

This bill would specify that these reports must be sent whether or not the licensee was a named party in the underlying claim or action and would limit reports regarding claims or actions to those based on the licensee's alleged negligence, error, or omission in practice in California. The bill would also specify that the reporting requirements apply to the University of California, as specified.

Existing law requires licensees ~~obligated~~ and insurers required to make these reports to send a copy of the report to the claimant or his or her counsel and requires a claimant or his or her counsel who does not receive a copy of the report within a specified time period to make the report to the appropriate board. Existing law makes a failure of a licensee, claimant, or counsel to comply with these requirements a public offense punishable by a specified fine.

This bill would require any entity or person ~~obligated~~ required to make a report to send a copy of the report to the claimant or his or her counsel. ~~The bill would also require an entity that makes a report to notify the licensee within 15 days of the filing of the report.~~

The bill would also make a failure to comply with any of the reporting requirements an infraction punishable by a specified fine. By expanding the scope of a crime, the bill would impose a state-mandated local program.

~~Existing law requires these reports to include certain information, including the name and address of every physician and surgeon or podiatrist who was alleged to have acted improperly.~~

~~This bill would require the reports to include that information with respect to every physician and surgeon or podiatrist who participated in the care or professional services provided to the patient.~~

Existing law ~~also~~ requires ~~the~~ these reports to include *certain information, including* a brief description of the facts of each claim, charge, or allegation, *and the amount of the judgment or award and the date of its entry or service.*

This bill would eliminate the requirement that this description be brief and would require the description to also include the role of each physician and surgeon or podiatrist in the care or professional services provided to the patient, as specified, ~~and a list of the dates of treatment rendered by those persons.~~ *The bill would also require the report to include a copy of the judgment or award.*

(2) *The Medical Practice Act provides for the regulation of physicians and surgeons by the Medical Board of California, and provides that the protection of the public is the highest priority for the board in exercising its licensing, regulatory, and disciplinary functions.*

This bill would prohibit any entity that provides early intervention, patient safety, or risk management programs to patients, or contracts for those programs for patients, from requiring that a patient waive his or her rights to contact or cooperate with the board, or to file a complaint with the board.

~~(2)~~
(3) Existing law authorizes the Medical Board of California to appoint panels from its members for the purposes of fulfilling specified obligations and prohibits the president of the board from serving as a member of a panel.

This bill would allow the president of the board to serve as a member of a panel if there is a vacancy in the membership of the board.

~~(3)~~
(4) Under existing law, a physician and surgeon or podiatrist who fails to comply with a patient's medical record request, as specified, within 15 days, or who fails or refuses to comply with a court order mandating release of records, is required to pay a civil penalty of \$1,000 per day, as specified.

This bill would place a limit of \$10,000 on those civil penalties and would make other related changes, *including providing a definition of "certified medical records," as specified.*

~~(4)~~
(5) Existing law prescribes the disciplinary action that may be taken against a physician and surgeon or podiatrist. Among other things, existing law authorizes the licensee to be publicly reprimanded.

This bill would authorize the public reprimand to include a requirement that the licensee complete educational courses approved by the board.

~~(5)~~
(6) Existing law requires the board to request a licensed physician and surgeon to report, at the time of license renewal, any specialty board certification he or she holds, as specified. Existing law also authorizes a licensed physician and surgeon to report to the board, at the time of license renewal, information regarding his or her cultural background and foreign language proficiency.

This bill would instead require licensees to provide that information at the time of license renewal and immediately upon issuance of an initial license.

Existing law requires a licensed physician and surgeon to also report, at the time of license renewal, his or her practice status, as specified.

This bill would also require that this information be provided immediately upon issuance of an initial license.

~~The bill would also require a licensed physician and surgeon to report to the board, at the time of license renewal, if any civil action has been~~

~~filed or criminal conviction has occurred, as specified, since his or her last renewal or initial licensure, as specified.~~

~~(6)~~ (7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 801.01 of the Business and Professions
2 Code is amended to read:

3 801.01. The Legislature finds and declares that the filing of
4 reports with the applicable state agencies required under this
5 section is essential for the protection of the public. It is the intent
6 of the Legislature that the reporting requirements set forth in this
7 section be interpreted broadly in order to expand reporting
8 obligations.

9 (a) A complete report shall be sent to the Medical Board of
10 California, the Osteopathic Medical Board of California, or the
11 California Board of Podiatric Medicine, with respect to a licensee
12 of the board as to the following:

13 (1) A settlement over thirty thousand dollars (\$30,000) or
14 arbitration award of any amount or a civil judgment of any amount,
15 whether or not vacated by a settlement after entry of the judgment,
16 that was not reversed on appeal, of a claim or action for damages
17 for death or personal injury caused by the licensee's alleged
18 negligence, error, or omission in practice in California, or by his
19 or her rendering of unauthorized professional services, whether or
20 ~~not the licensee was a named party in the claim or action.~~

21 (2) A settlement over thirty thousand dollars (\$30,000) ~~of a~~
22 ~~claim or action, whether or not the licensee was a named party in~~
23 ~~the claim or action, if the settlement is based on the licensee's~~
24 ~~alleged negligence, error, or omission in practice in California, or~~
25 ~~on the licensee's rendering of unauthorized professional services,~~
26 ~~and a party to the settlement is a corporation, medical group,~~

1 partnership, or other corporate entity in which the licensee has an
2 ownership interest or that employs or contracts with the licensee.

3 (b) The report shall be sent by the following:

4 (1) The insurer providing professional liability insurance to the
5 licensee.

6 (2) The licensee, or his or her counsel, if the licensee does not
7 possess professional liability insurance.

8 (3) A state or local governmental agency that self-insures the
9 licensee. For purposes of this section “state governmental agency”
10 includes, but is not limited to, the University of California.

11 (c) The entity, person, or licensee obligated to report pursuant
12 to subdivision (b) shall send the complete report if the judgment,
13 settlement agreement, or arbitration award is entered against or
14 paid by the employer of the licensee and not entered against or
15 paid by the licensee. “Employer,” as used in this paragraph, means
16 a professional corporation, a group practice, a health care facility
17 or clinic licensed or exempt from licensure under the Health and
18 Safety Code, a licensed health care service plan, a medical care
19 foundation, an educational institution, a professional institution,
20 a professional school or college, a general law corporation, a public
21 entity, or a nonprofit organization that employs, retains, or contracts
22 with a licensee referred to in this section. Nothing in this paragraph
23 shall be construed to authorize the employment of, or contracting
24 with, any licensee in violation of Section 2400.

25 (d) The report shall be sent to the Medical Board of California,
26 the Osteopathic Medical Board of California, or the California
27 Board of Podiatric Medicine, as appropriate, within 30 days after
28 the written settlement agreement has been reduced to writing and
29 signed by all parties thereto, within 30 days after service of the
30 arbitration award on the parties, or within 30 days after the date
31 of entry of the civil judgment.

32 ~~(e) If an insurer is required under subdivision (b) to send the~~
33 ~~report, the insurer shall notify the claimant, or if the claimant is~~
34 ~~represented by counsel, the claimant’s counsel, that the insurer~~
35 ~~has sent the report to the Medical Board of California, the~~
36 ~~Osteopathic Medical Board of California, or the California Board~~
37 ~~of Podiatric Medicine. If the claimant, or his or her counsel, has~~
38 ~~not received this notice within 45 days after the settlement was~~
39 ~~reduced to writing and signed by all of the parties or the arbitration~~
40 ~~award was served on the parties or the date of entry of the civil~~

1 judgment, the claimant or the claimant's counsel shall make the
2 report to the appropriate board.

3 ~~(f)~~
4 (e) The entity, person, or licensee obligated *required* to report
5 under subdivision (b) shall send a copy of the report to the claimant
6 or to his or her counsel if he or she is represented by counsel. If
7 the claimant or his or her counsel has not received a copy of the
8 report within 45 days after the settlement was reduced to writing
9 and signed by all of the parties or the arbitration award was served
10 on the parties or the date of entry of the civil judgment, the claimant
11 or the claimant's counsel shall make the report to the appropriate
12 board.

13 ~~(g)~~
14 (f) Failure to comply with this section is a public offense
15 punishable by a fine of not less than five hundred dollars (\$500)
16 and not more than five thousand dollars (\$5,000).

17 ~~(h)~~
18 (g) (1) The Medical Board of California, the Osteopathic
19 Medical Board of California, and the California Board of Podiatric
20 Medicine may develop a prescribed form for the report.

21 (2) The report shall be deemed complete only if it includes the
22 following information:

23 (A) The name and last known business and residential addresses
24 of every plaintiff or claimant involved in the matter, whether or
25 not the person received an award under the settlement, arbitration,
26 or judgment.

27 (B) The name and last known business and residential address
28 of every licensee who participated in the care or professional
29 services provided to the patient was alleged to have acted
30 improperly, whether or not that person was a named defendant in
31 the action and whether or not that person was required to pay any
32 damages pursuant to the settlement, arbitration award, or judgment.

33 (C) The name, address, and principal place of business of every
34 insurer providing professional liability insurance to any person
35 described in subparagraph (B), and the insured's policy number.

36 (D) The name of the court in which the action or any part of the
37 action was filed, and the date of filing and case number of each
38 action.

39 (E) A description or summary of the facts of each claim, charge,
40 or allegation, including the date of occurrence, each and the

1 licensee's role in the care or professional services provided to the
2 patient with respect to those services at issue in the claim, ~~charge,~~
3 ~~or allegation, and a list of the dates of treatment rendered by each~~
4 ~~licensee or action.~~

5 (F) The name and last known business address of each attorney
6 who represented a party in the settlement, arbitration, or civil
7 action, including the name of the client he or she represented.

8 (G) The amount of the judgment ~~and~~, the date of its entry, *and*
9 *a copy of the judgment*, the amount of the arbitration award, the
10 date of its service on the parties, and a copy of the award document,
11 or the amount of the settlement and the date it was reduced to
12 writing and signed by all parties. If an otherwise reportable
13 settlement is entered into after a reportable judgment or arbitration
14 award is issued, the report shall include both the settlement and *a*
15 *copy of the judgment or award.*

16 (H) The specialty or subspecialty of the licensee who
17 ~~participated in the care or professional services provided to the~~
18 ~~patient: was the subject of the claim or action.~~

19 (I) Any other information the Medical Board of California, the
20 Osteopathic Medical Board of California, or the California Board
21 of Podiatric Medicine may, by regulation, require.

22 (3) Every professional liability insurer, self-insured
23 governmental agency, or licensee or his or her counsel that makes
24 a report under this section and has received a copy of any written
25 or electronic patient medical or hospital records prepared by the
26 treating physician and surgeon or podiatrist, or the staff of the
27 treating physician and surgeon, podiatrist, or hospital, describing
28 the medical condition, history, care, or treatment of the person
29 whose death or injury is the subject of the report, or a copy of any
30 deposition in the matter that discusses the care, treatment, or
31 medical condition of the person, shall include with the report,
32 copies of the records and depositions, subject to reasonable costs
33 to be paid by the Medical Board of California, the Osteopathic
34 Medical Board of California, or the California Board of Podiatric
35 Medicine. If confidentiality is required by court order and, as a
36 result, the reporter is unable to provide the records and depositions,
37 documentation to that effect shall accompany the original report.
38 The applicable board may, upon prior notification of the parties
39 to the action, petition the appropriate court for modification of any
40 protective order to permit disclosure to the board. A professional

1 liability insurer, self-insured governmental agency, or licensee or
2 his or her counsel shall maintain the records and depositions
3 referred to in this paragraph for at least one year from the date of
4 filing of the report required by this section.

5 (†)
6 (h) If the board, within 60 days of its receipt of a report filed
7 under this section, notifies a person named in the report, that person
8 shall maintain for the period of three years from the date of filing
9 of the report any records he or she has as to the matter in question
10 and shall make those records available upon request to the board
11 to which the report was sent.

12 (†)
13 (i) Notwithstanding any other provision of law, no insurer shall
14 enter into a settlement without the written consent of the insured,
15 except that this prohibition shall not void any settlement entered
16 into without that written consent. The requirement of written
17 consent shall only be waived by both the insured and the insurer.

18 (j) *Any entity that makes a report pursuant to this section shall,*
19 *within 15 days after filing the report, notify the licensee that the*
20 *report was filed with the appropriate licensing board.*

21 (k) For purposes of this section, “licensee” means a licensee of
22 the Medical Board of California, the Osteopathic Medical Board
23 of California, or the California Board of Podiatric Medicine.

24 SEC. 2. Section 804.5 is added to the Business and Professions
25 Code, to read:

26 804.5. *The Legislature recognizes that various types of entities*
27 *are creating, implementing, and maintaining patient safety and*
28 *risk management programs that encourage early intervention in*
29 *order to address known complications and other unanticipated*
30 *events requiring medical care. The Legislature recognizes that*
31 *some entities even provide financial assistance to individual*
32 *patients to help them address these unforeseen health care*
33 *concerns. It is the intent of the Legislature, however, that such*
34 *financial assistance not limit a patient’s interaction with, or his*
35 *or her rights before, the Medical Board of California.*

36 *Any entity that provides early intervention, patient safety, or risk*
37 *management programs to patients, or contracts for those programs*
38 *for patients, shall not include, as part of any of those programs*
39 *or contracts, any of the following:*

1 (a) A provision that prohibits a patient or patients from
2 contacting or cooperating with the board.

3 (b) A provision that prohibits a patient or patients from filing
4 a complaint with the board.

5 (c) A provision that requires a patient or patients to withdraw
6 a complaint that has been filed with the board.

7 ~~SEC. 2.~~

8 ~~SEC. 3.~~ Section 2008 of the Business and Professions Code is
9 amended to read:

10 2008. The board may appoint panels from its members for the
11 purpose of fulfilling the obligations established in subdivision (c)
12 of Section 2004. Any panel appointed under this section shall at
13 no time be comprised of less than four members and the number
14 of public members assigned to the panel shall not exceed the
15 number of licensed physician and surgeon members assigned to
16 the panel. The president of the board shall not be a member of any
17 panel unless there is a vacancy in the membership of the board.
18 Each panel shall annually elect a chair and a vice chair.

19 ~~SEC. 3.~~

20 ~~SEC. 4.~~ Section 2225.5 of the Business and Professions Code
21 is amended to read:

22 2225.5. (a) (1) A licensee who fails or refuses to comply with
23 a request for the certified medical records of a patient, that is
24 accompanied by that patient's written authorization for release of
25 records to the board, within 15 days of receiving the request and
26 authorization, shall pay to the board a civil penalty of one thousand
27 dollars (\$1,000) per day for each day that the documents have not
28 been produced after the 15th day, up to ten thousand dollars
29 (\$10,000), unless the licensee is unable to provide the documents
30 within this time period for good cause.

31 (2) A health care facility shall comply with a request for the
32 certified medical records of a patient that is accompanied by that
33 patient's written authorization for release of records to the board
34 together with a notice citing this section and describing the
35 penalties for failure to comply with this section. Failure to provide
36 the authorizing patient's certified medical records to the board
37 within 30 days of receiving the request, authorization, and notice
38 shall subject the health care facility to a civil penalty, payable to
39 the board, of up to one thousand dollars (\$1,000) per day for each
40 day that the documents have not been produced after the 30th day,

1 up to ten thousand dollars (\$10,000), unless the health care facility
2 is unable to provide the documents within this time period for good
3 cause. This paragraph shall not require health care facilities to
4 assist the board in obtaining the patient's authorization. The board
5 shall pay the reasonable costs of copying the certified medical
6 records.

7 (b) (1) A licensee who fails or refuses to comply with a court
8 order, issued in the enforcement of a subpoena, mandating the
9 release of records to the board shall pay to the board a civil penalty
10 of one thousand dollars (\$1,000) per day for each day that the
11 documents have not been produced after the date by which the
12 court order requires the documents to be produced, up to ten
13 thousand dollars (\$10,000), unless it is determined that the order
14 is unlawful or invalid. Any statute of limitations applicable to the
15 filing of an accusation by the board shall be tolled during the period
16 the licensee is out of compliance with the court order and during
17 any related appeals.

18 (2) Any licensee who fails or refuses to comply with a court
19 order, issued in the enforcement of a subpoena, mandating the
20 release of records to the board is guilty of a misdemeanor
21 punishable by a fine payable to the board not to exceed five
22 thousand dollars (\$5,000). The fine shall be added to the licensee's
23 renewal fee if it is not paid by the next succeeding renewal date.

24 Any statute of limitations applicable to the filing of an accusation
25 by the board shall be tolled during the period the licensee is out
26 of compliance with the court order and during any related appeals.

27 (3) A health care facility that fails or refuses to comply with a
28 court order, issued in the enforcement of a subpoena, mandating
29 the release of patient records to the board, that is accompanied by
30 a notice citing this section and describing the penalties for failure
31 to comply with this section, shall pay to the board a civil penalty
32 of up to one thousand dollars (\$1,000) per day for each day that
33 the documents have not been produced, up to ten thousand dollars
34 (\$10,000), after the date by which the court order requires the
35 documents to be produced, unless it is determined that the order
36 is unlawful or invalid. Any statute of limitations applicable to the
37 filing of an accusation by the board against a licensee shall be
38 tolled during the period the health care facility is out of compliance
39 with the court order and during any related appeals.

1 (4) Any health care facility that fails or refuses to comply with
2 a court order, issued in the enforcement of a subpoena, mandating
3 the release of records to the board is guilty of a misdemeanor
4 punishable by a fine payable to the board not to exceed five
5 thousand dollars (\$5,000). Any statute of limitations applicable to
6 the filing of an accusation by the board against a licensee shall be
7 tolled during the period the health care facility is out of compliance
8 with the court order and during any related appeals.

9 (c) Multiple acts by a licensee in violation of subdivision (b)
10 shall be punishable by a fine not to exceed five thousand dollars
11 (\$5,000) or by imprisonment in a county jail not exceeding six
12 months, or by both that fine and imprisonment. Multiple acts by
13 a health care facility in violation of subdivision (b) shall be
14 punishable by a fine not to exceed five thousand dollars (\$5,000)
15 and shall be reported to the State Department of Health Services
16 ~~Public Health~~ and shall be considered as grounds for disciplinary
17 action with respect to licensure, including suspension or revocation
18 of the license or certificate.

19 (d) A failure or refusal of a licensee to comply with a court
20 order, issued in the enforcement of a subpoena, mandating the
21 release of records to the board constitutes unprofessional conduct
22 and is grounds for suspension or revocation of his or her license.

23 (e) Imposition of the civil penalties authorized by this section
24 shall be in accordance with the Administrative Procedure Act
25 (Chapter 5 (commencing with Section 11500) of Division 3 of
26 Title 2 of the Government Code).

27 (f) *For purposes of this section, "certified medical records"*
28 *means a copy of the patient's medical records authenticated by*
29 *the licensee or health care facility, as appropriate, on a form*
30 *prescribed by the board.*

31 ~~(f)~~

32 (g) For purposes of this section, a "health care facility" means
33 a clinic or health facility licensed or exempt from licensure
34 pursuant to Division 2 (commencing with Section 1200) of the
35 Health and Safety Code.

36 ~~SEC. 4.~~

37 ~~SEC. 5.~~ Section 2227 of the Business and Professions Code is
38 amended to read:

39 2227. (a) A licensee whose matter has been heard by an
40 administrative law judge of the Medical Quality Hearing Panel as

1 designated in Section 11371 of the Government Code, or whose
2 default has been entered, and who is found guilty, or who has
3 entered into a stipulation for disciplinary action with the board,
4 may, in accordance with the provisions of this chapter:

5 (1) Have his or her license revoked upon order of the board.

6 (2) Have his or her right to practice suspended for a period not
7 to exceed one year upon order of the board.

8 (3) Be placed on probation and be required to pay the costs of
9 probation monitoring upon order of the board.

10 (4) Be publicly reprimanded by the board. The public reprimand
11 may include a requirement that the licensee complete relevant
12 educational courses approved by the board.

13 (5) Have any other action taken in relation to discipline as part
14 of an order of probation, as the board or an administrative law
15 judge may deem proper.

16 (b) Any matter heard pursuant to subdivision (a), except for
17 warning letters, medical review or advisory conferences,
18 professional competency examinations, continuing education
19 activities, and cost reimbursement associated therewith that are
20 agreed to with the board and successfully completed by the
21 licensee, or other matters made confidential or privileged by
22 existing law, is deemed public, and shall be made available to the
23 public by the board pursuant to Section 803.1.

24 ~~SEC. 5:~~

25 *SEC. 6.* Section 2425.3 of the Business and Professions Code
26 is amended to read:

27 2425.3. (a) A licensed physician and surgeon shall report to
28 the board, immediately upon issuance of an initial license and at
29 the time of license renewal, any specialty board certification he or
30 she holds that is issued by a member board of the American Board
31 of Medical Specialties or approved by the Medical Board of
32 California.

33 (b) A licensed physician and surgeon shall also report to the
34 board, immediately upon issuance of an initial license and at the
35 time of license renewal, his or her practice status, designated as
36 one of the following:

37 (1) Full-time practice in California.

38 (2) Full-time practice outside of California.

39 (3) Part-time practice in California.

1 (4) Medical administrative employment that does not include
2 direct patient care.

3 (5) Retired.

4 (6) Other practice status, as may be further defined by the
5 ~~Division of Licensing board.~~

6 (c) (1) A licensed physician and surgeon shall report to the
7 board, immediately upon issuance of an initial license and at the
8 time of license renewal, and the board shall collect, information
9 regarding his or her cultural background and foreign language
10 proficiency.

11 (2) Information collected pursuant to this subdivision shall be
12 aggregated on an annual basis based on categories utilized by the
13 board in the collection of the data, and shall be aggregated into
14 both statewide totals and ZIP-Code code of primary practice
15 location totals.

16 (3) Aggregated information under this subdivision shall be
17 compiled annually and reported on the board's Internet Web site
18 on or before October 1 of each year.

19 ~~(d) A licensed physician and surgeon shall report to the board,
20 at the time of license renewal, if either of the following have
21 occurred since his or her last renewal, or if this is the licensee's
22 first renewal, since his or her initial license was issued:~~

23 ~~(1) He or she has been convicted of a felony or misdemeanor;~~

24 ~~(2) The filing of a civil action alleging unlawful conduct by the
25 licensee, whether or not the licensee was a named party in the
26 action;~~

27 ~~(e)~~

28 (d) The information collected pursuant to subdivisions (a) and
29 (b) may also be placed on the board's Internet Web site.

30 ~~SEC. 6.~~

31 ~~SEC. 7.~~ No reimbursement is required by this act pursuant to
32 Section 6 of Article XIII B of the California Constitution because
33 the only costs that may be incurred by a local agency or school
34 district will be incurred because this act creates a new crime or
35 infraction, eliminates a crime or infraction, or changes the penalty
36 for a crime or infraction, within the meaning of Section 17556 of
37 the Government Code, or changes the definition of a crime within

- 1 the meaning of Section 6 of Article XIII B of the California
- 2 Constitution.

O

TRACKER II

Medical Board of California
2008 Tracker II - Legislative Bills
6/11/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 52	Portantino	Unbilical Cord Blood Collection Program	Senate	06/02/09
AB 82	Evans	Dependent Children: psychotropic medications	Senate	06/01/09
AB 159	Nava	Perinatal Mood and Anxiety Disorders: task force	Asm. Approps.	03/25/09
AB 259	Skinner	Health Care Coverage: certified nurse-midwives: direct access	Asm. Health	
AB 361	Lowenthal	Workers' Compensation: treatment authorization	Sen. L & IR (6/24)	05/14/09
AB 417	Beall	Medi-Cal Drug Treatment Program: buprenorphine	Senate	05/19/09
AB 445	Salas	Use of X-ray Equipment: prohibition: exemptions	Asm. Health	
AB 452	Yamada	In-home Supportive Services: CA Independence Act of 2009	Asm. Hum. S.	
AB 456	Emmerson	State Agencies: period review	Senate	05/28/09
AB 497	Block	Vehicles: HOV lanes: used by physicians	Sen. T&H	05/14/09
AB 520	Carter	Public Records: limiting requests	Asm. Jud.	
AB 542	Feuer	Adverse Medical Events: expanding reporting	Senate	05/05/09
AB 657	Hernandez	Health Professions Workforce: task force	Senate	06/02/09
AB 681	Hernandez	Confidentiality of Medical Information: psychotherapy	Sen. Jud.	
AB 721	Nava	Physical Therapists: scope of practice	Asm. B&P	04/13/09
AB 830	Cook	Drugs and Devices	Senate	04/23/09
AB 834	Solorio	Health Care Practitioners: peer review	Asm. B&P	04/14/09
AB 867	Nava	California State University: Doctor of Nursing Practice Degree	Senate	04/14/09
AB 877	Emmerson	Healing Arts: DCA Director to appoint committee	Asm. Approps.	04/14/09
AB 931	Fletcher	Emergency Supplies: increase amount	Sen. Health	03/26/09
AB 950	Hernandez	Hospice Providers: licensed hospice facilities	Senate	06/02/09
AB 1005	Block	CA Board of Accountancy: live broadcast of board meetings	Senate	04/30/09
AB 1083	Perez	Health Facilities: security plans	Senate	05/26/09

Medical Board of California
2008 Tracker II - Legislative Bills
6/11/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1094	Conway	Disposal of Personal Information	Senate	05/26/09
AB 1113	Lowenthal	Prisoners: professional mental health providers: MFTs	Sen. B&P	05/14/09
AB 1140	Niello	Healing Arts (spot)	Senate	04/14/09
AB 1152	Anderson	Professional Corporations: licensed physical therapists	Senate	05/18/09
AB 1162	Carter	Health Facilities: licensure	Assembly	
AB 1168	Carter	Professions and Vocations (spot)	Assembly	
AB 1194	Strickland	State Agency Internet Web Sites: information	Asm. B&P	
AB 1317	Block	Assisted Oocute Production: advertisement	Sen. Health	05/06/09
AB 1478	Ammiano	Written Acknowledgment: medical nutrition therapy	Asm. B&P	
AB 1518	Anderson	State Government: Boards, Commissions, Committees, repeal	Asm. B&P	05/11/09
AB 1540	Health Comm.	Health	Senate	05/05/09
AB 1542	Health Comm.	Medical Records: centralized location	Senate	05/06/09
AB 1544	Health Comm.	Health Facilities: licensure	Senate	
SB 26	Simitian	Home-generated Pharmaceutical Waste	Sen. Approps.	04/15/09
SB 33	Correa	Marriage and Family Therapy: licensure and registration	Asm. B&P (6/16)	06/08/09
SB 39	Benoit	Torts: personal liability immunity	Asm. Jud. (6/23)	05/13/09
SB 43	Alquist	Health Prof.: cultural and linguistic competency infofmatoin	Assembly	05/19/09
SB 92	Aanestad	Health care reform	Sen. Health	03/11/09
SB 112	Oropeza	Hemodialysis Technicians	Asm. B&P	06/03/09
SB 171	Pavley	Certified Employees: physician assistants: medical certificates	Asm. B&P	05/18/09
SB 186	DeSaulnier	Workers' Compensation: treatment: predesignationof physician	Asm. Ins.	

Medical Board of California
2008 Tracker II - Legislative Bills
6/11/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 238	Calderon	Medical Information: prescription refill requirements	Sen. Health	04/23/09
SB 294	Negete McLeod	Nurse Practitioners	Asm. B&P	06/08/09
SB 303	Alquist	Nursing Facility Residents: informed consent	Assembly	04/27/09
SB 341	DeSaulnier	Pharmaceuticals: adverse drug reactions	Sen. Approps.	05/14/09
SB 368	Maldonado	Confidential Medical Information: unlawful disclosure	Sen. Health	04/01/09
SB 374	Calderon	Health Care Providers: resonable disclosure: reproductive choices	Asm. B&P	04/02/09
SB 395	Wyland	Medical Practice	Senate	
SB 442	Ducheny	Clinic Corporation: licensing	Sen. Approps.	05/06/09
SB 482	Padilla	Healing Arts: Medical Practice	Sen. Jud.	04/14/09
SB 484	Wright	Ephedrine and Pseudoephedrine: classification as Schedule V	Assembly	05/12/09
SB 502	Walters	State Agency Web Sites: information posting: expenditures	Sen. G.O.	
SB 599	Negrete McLeod	Licensing Boards: disciplinary actions: posting	Assembly	05/13/09
SB 606	Ducheny	Physicians and Surgeons: loan repayment	Asm. B&P	03/31/09
SB 620	Wiggins	Healing Arts: osteopaths	Asm. B&P	
SB 630	Steinberg	Health care Coverage: reconstructive surgery: dental	Assembly	06/01/09
SB 719	Huff	State Agency Internet Web Sites: information searchability	Sen. Approps.	
SB 744	Strickland	Clinical Laboratories: public health labs	Assembly	05/21/09
SB 761	Aanestad	Health Manpower Pilot Projects	Asm. Health	05/06/09
SB 762	Aanestad	Professions and Vocations: healing arts	Asm. B&P	05/05/09
SB 788	Wyland	Licensed Professional Clinical Counselors	Assembly	04/29/09
SB 810	Leno	Single-Payer Health Care Coverage	Sen. Approps.	04/23/09
SB 820	B&P Comm.	Consumer Affiars: professions and vocations	Asm. B&P	04/21/09

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA



REVISED DRAFT 6.7.09

REPORT TO THE LEGISLATURE

VERTICAL ENFORCEMENT MODEL

Arnold Schwarzenegger, Governor
Richard D. Fantozzi, M.D., President, Medical Board of California
Barb Johnston, Executive Director, Medical Board of California

June 2009

This ***Report to the Legislature, Vertical Enforcement Model***, was prepared on behalf of the Medical Board of California by Integrated Solutions for Business and Government, Inc. (ISBG), a California certified small business based in Sacramento, California.

ISBG would like to acknowledge and express its sincere appreciation to the dedicated staff of the Medical Board of California and the Attorney General's Health Quality Enforcement Section, whose assistance were critical to the completion of this report. A special thanks to Nancy Smith and Sean Eichelkraut for producing the statistical data upon which the report is based.

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I. EXECUTIVE SUMMARY

The mission of the Medical Board of California “is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board’s licensing and regulatory functions.”

To this end, legislation was enacted into law to assist in streamlining the investigation and prosecution of alleged misconduct by physicians and surgeons (P&S).

Senate Bill 1950 (Figueroa), Chapter 1085, Statutes of 2002, mandated the appointment of an Enforcement Program Monitor (Monitor) to “monitor and evaluate the disciplinary system and procedures” of the Medical Board of California (MBC) for a period of two years. Two reports were required: an initial report of the findings and conclusions no later than October 1, 2003, and a final report prior to March 31, 2005.

In both the Initial and Final Reports of the ***Medical Board of California Enforcement Program Monitor***, the Monitor recommended the vertical prosecution model whereby “the trial attorney and the investigator are assigned as the team to handle a complex case as soon as it is opened as a formal investigation”. The Monitor stated that the vertical prosecution model would improve efficiency and reduce case cycle time and, thereby, ensure the quality and safety of medical care to the people of California.

Subsequently, Senate Bill 231, Chapter 674, Statutes of 2005, was enacted into law codifying the use of the vertical prosecution model effective January 1, 2006. It also required the MBC to report and make recommendations to the Governor and the Legislature on the vertical prosecution model by July 1, 2007.

As mandated, the MBC and the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) implemented the vertical prosecution model for P&S on January 1, 2006. To avoid potential complications that might result from utilizing a different model for the investigation and prosecution¹ of Allied Health Care Professions (AH), cases investigated by the MBC on behalf of sister agencies, MBC and HQES elected to simultaneously implement the vertical prosecution model for AH cases as well. Since not all of MBC’s cases lead to prosecution and a modified model was necessary due to staffing issues, the name of the new model was internally changed to vertical enforcement (VE), although statute still refers to a vertical prosecution model.

The MBC’s ***Report to the Legislature on Vertical Enforcement*** in November 2007, stated that from January 1, 2006 through April 9, 2007, there was an overall decrease of 10 days in the average time to complete an investigation, excluding all cases pending

¹ For purposes of this report, the term “prosecution” refers to an administrative action commenced by the filing of an accusation with the Office of Administrative Hearings, unless the context indicates otherwise.

prior to implementation of the pilot. The report further stated that the statistics showed that the number of cases closed without prosecution was reduced from 145 days to 139 days; obtaining medical records was decreased from 74 days to 36 days; conducting physician interviews reduced from 60 days to 40 days; obtaining medical expert opinions went from 69 day to 36 days; filing of accusations by HQES decreased from 241 to 212 days; and obtaining interim suspension orders or temporary restraining orders decreased from 91 days to 30 days.

Although the initial statistical data from the pilot identified trends which suggested that the VE model can more quickly identify cases for closure, handle certain egregious complaints more expeditiously, and showed a trend of reducing the time frames to complete investigations, the pilot period did not provide sufficient time to address the Monitor's concerns regarding the time to complete prosecutions, since some MBC investigations may take over 12 months to complete and the available statistics at that time only covered a 16 month period.

Consequently, Senate Bill 797 (Ridley-Thomas), Chapter 33, Statutes of 2008, was enacted continuing the VE model until July 1, 2010, and requiring a report by the MBC on the effectiveness of VE model by July 1, 2009. This report is the result of that mandate.

The MBC commissioned Integrated Solutions for Business and Government, Inc. (ISBG) on March 13, 2009, to review data collected by the MBC for the period from January 1, 2005 (pre-VE) through December 31, 2008, and report findings and recommendations.

The statistical conclusions contained in this report are based on data provided to ISBG by MBC. ISBG performed no independent testing or auditing of the provided data to verify its accuracy. Due to the limited scope and time available to complete the report, data separately collected and maintained by HQES was not compared with the data provided by MBC. References to comparisons of data between years, such as the percentage difference between 2005 and 2008, refers to a comparison of the total cases in the indicated years, exclusive of cases in the intervening years.

Because many of the data markers involve comparison of relatively few cases, reference should be made to the applicable underlying data contained in the appendices in determining the significance, if any, of the specific statistical comparisons.

The following table summarizes select results of the review of the provided combined P&S and AH data, showing the percentage increase or decrease in time for the specified data markers between 2005 and 2008.

	(Percentage Increase or Decrease)
	2008 vs. 2005
	(2005 Data Pre VE, 2008 Data Combined VE & Non VE Cases)
Misc. Stats	
Attorney Services Hours Billed by AG	37.71%
Legal Assistant/Paralegal Hours Billed by AG	39.81%
Enforcement Temp Help Hours Worked (excludes Med. Consultants)	86.83%
Enforcement Medical Consultant Hours Worked	4.11%
Average Caseload per Filled Field Investigator Position	no change
	Combined Physician and Surgeon & Allied Health Care Stats
Cases Referred to Investigations	-14.36%
Days Aged from Assigned to Investigator to Closed, No Prosecution	
Average	37.64%
Median	-61.54%
No of Cases	-24.31%
Days Aged from Assigned to Investigator To Referral for Citation/Fine	
Average	75.72%
Median	61.48%
No of Cases	-19.61%
Days Aged from Assigned to Investigator To Referral for Criminal Action	
Average	38.35%
Median	52.22%
No of Cases	-2.63%
Days Aged from Case Submitted to D.O. Medical Consultant to Review Completed	
Average	183.87%
Median	83.33%
No of Cases	569.39%
Days Aged from Assigned to Investigator To Investigation Completed (Referral to AG)	
Average	42.13%
Median	56.83%
No of Cases	11.38%
Days Aged from Assigned to Investigator to All Outcomes	
Average	21.73%
Median	40.65%
No of Cases	-19.00%
Days Aged from Assigned to Investigator to Settlement	
Average	-6.21%
Median	-5.23%
No of Cases	-11.34%
Days Aged from Assigned to Investigator to Disciplinary Outcome	
Average	-0.51%
Median	-1.85%
No of Cases	-9.61%
Days Aged from Completed Investigation to Accusation Filed	
Average	-72.32%
Median	-84.46%
No of Cases	-8.48%
Days Aged from Accusation Filed to Disciplinary Outcome	
Average	-8.75%
Median	-27.29%
No of Cases	-6.08%
Days Aged from Accusation Filed to Accusation Withdrawn/Dismissed Outcome	
Average	16.67%
Median	-23.64%
No of Cases	24.00%
Days Aged from Accusation Filed to Settlement Outcome	
Average	-17.16%
Median	-28.25%
No of Cases	-10.99%
Other Stats	
OAH Initial Hearing Dates Delayed Due to Governor's Executive Order, July - October 2008	
Average Days Delay	119.78
Median Days Delayed	112.00
Number of Cases Delayed	23.00

Since statistical data alone does not fully describe the effectiveness of the VE model, interviews of MBC and HQES staff were conducted from April 9 through 15, 2009. Eleven (11) MBC enforcement staff were interviewed at the management, supervisory and investigative levels, all of whom were present since the onset of VE, with an average of 13 years with MBC. Additionally, 11 HQES staff were interviewed at the management, supervisory, primary and lead levels, all of whom were present since the onset of VE, with an average of 14 years experience with HQES. The following is a synopsis of the interviews:

- All believe that public safety is their number one priority;
- In general, they like their respective professions;
- Most HQES staff indicated that their current caseload is manageable and not much different than prior to VE;
- Most MBC staff stated that their caseload is too heavy;
- Both HQES and MBC are experiencing retention issues;
- MBC continues to experience recruiting problems;
- Both believe that communication between MBC investigators and DAGs increased, but for different reasons;
- The manner in which VE is implemented is inconsistent from one HQES office to another;
- DAGs believe that VE is a vast improvement from the previous Deputy in District Office (DIDO) program; and
- Some MBC investigators believe that, as implemented, VE may be more effective, but is not more efficient.

Although noteworthy efforts were expended by both HQES and MBC staff toward implementation of the VE model and some successes achieved, it is evident that room for improvement exists. Six alternatives are apparent regarding the future of the VE model based on the statistical data and other information gathered to date. Summary of the alternatives are:

- Canceling the VE pilot and resuming the previous method of investigating and prosecuting complaints;
- Continuing the current pilot unmodified for a period of time to gather additional statistical data;
- Transferring MBC investigators to DOJ and consolidating responsibility for the investigation and prosecution of complaints under the AG;
- Transferring responsibility for prosecuting cases to MBC and allowing MBC to hire in-house legal staff necessary to assume these duties;
- Co-location of DAGs and investigators in the same facility; or
- Continuing the pilot with modifications to improve its implementation and assess its effectiveness and success in two years.

The last alternative is the most feasible. This alternative would modify the current pilot with improvements recommended below which are imperative for the VE model to succeed. Furthermore, additional commitment to the VE process by executive

management and every manager and supervisor in each department is essential to the success of this modified VE model.

Summary of the recommendations for a more successful implementation of the VE model are as follows:

Recommendation #1: Zero Tolerance of Negative Communication

While both the MBC and HQES have made considerable progress in their working relationship, additional work is necessary to ensure mutual respect and appreciation for the vital roles each bring to the process and, ultimately, to public protection. Poor interpersonal communications are aggravated by a lack of commonly understood and mutually accepted appreciation of each others' roles and professional contributions towards resolving cases in the VE model. It is recommended that the tone be uniformly set by executive management and every manager and supervisor of both departments that all staff work together as partners in a professional and respectful manner, and that all communications demonstrate mutual respect, courtesy and responsiveness, without exception. Any inappropriate communication must be addressed immediately, fairly and effectively.

Consideration should be given to engaging a knowledgeable outside consultant respected by both MBC and HQES to help identify, isolate and eliminate the cause(s) of such negative communications.

Recommendation #2: Clarity of Roles

It is recommended that clear and consistent direction be provided by top management regarding the roles of DAGs and MBC staff at all levels. Although the VPM identifies the VE team members and their respective roles, many of those interviewed from both departments stated that there needs to be a greater clarity of their respective roles.

The meaning of GC Section 12529.6 wording "under the direction of" must be clearly defined and adhered to in a consistent manner throughout both departments in a manner that emphasizes teamwork and recognizes the unique training, expertise and contributions of all members of the team. If necessary, legislative changes should be sought to provide additional clarity.

Although HQES management stated that it has been HQES' position that MBC is the client, interview responses indicate that this is not clearly understood or accepted. Therefore, management must clarify and ensure a consistent understanding and application of the term, which should be included in the joint training recommended below and incorporated in all appropriate manuals.

Recommendation #3: Consistent and Unified VE Process

Since the VE process varies from one office to the other, it is recommended that there be a consistent and uniform statewide VE process, including appropriate levels of approval, which are adhered to in every office. Exceptions, if any, should have an appropriate basis, be clearly documented and published to avoid the appearance of being arbitrary or unfair. It is also recommended that consideration be given to implementing a single joint manual that includes input from all who are part of the VE process, through a joint task force or committee, to ensure consistency and uniform understanding of the VE model and each person's role in the VE process.

Recommendation #4: Consider Limiting VE to Specified Types or Categories of Cases or Circumstances

The data provided indicates that although there is a decrease in the time to complete a case once it is referred to the AG for prosecution, there is an overall increase in the investigatory phase of cases in the VE model.

As the Monitor noted, the vertical prosecution model is widely and successfully used by law enforcement, district attorney offices and others for specialized or complex cases. In light of the demonstrated increase in the time to complete the investigatory phase that has resulted from inclusion of all cases in the VE model, it is recommended that consideration be given to identifying specific types or categories of cases or circumstances under which VE would likely be of benefit and limit its use to those situations.

A working group consisting of management and staff from both departments should evaluate and recommend the categories of cases, circumstances or guidelines for determining which cases warrant handling in the VE process. In addition, consideration should be given to designating an intake officer(s) in the field offices to determine cases warrant VE handling in accordance with the final guidelines. An outside consultant experienced in vertical prosecution should be considered to assist in this process.

Recommendation #5: Joint Statewide Training

Although MBC management states that joint statewide training has been previously attempted, it is recommended that a mandated joint statewide training for all DAGs and investigators, regardless of their level, experience or past training, be held to assist in team building and ensure a common and consistent knowledge base. Based on the comments received from interviewees, such training should, at a minimum, include:

- Effective and efficient communication;
- Workload prioritization;
- Roles, background and training of investigators, supervisors, lead and primary DAGs and SDAGs, and the needs of each to efficiently and appropriately perform their functions;

- Definition of “client” and “direction”;
- Interviews and interview strategies;
- Obtaining appropriate expert witnesses;
- Subpoena use and preparation;
- Administrative hearing process and investigator’s role at a hearing; and
- The role and purpose of the Central Complaint Unit (CCU).

Recommendation #6: Staffing Vacancies

It is recommended that the departments continue to give priority to resolving current staffing vacancy issues. Areas to pursue include:

- Methods to increase investigators’ salaries;
- Use of overtime pay;
- Use of telecommunication and alternate work schedules; and/or
- Wage subsidization in high turnover, hard to fill vacancy locations.

Consideration should be given to engage a knowledgeable consultant to survey past and current employees to identify and, if appropriate, help resolve areas of dissatisfaction that are contributing to the problem.

Recommendation #7: Common Server

One of the recommendations of the Monitor’s reports and the previous ***Report to the Legislature, Vertical Enforcement***, was to implement an “information technology system interoperable with the current system used at DOJ”. The MBC and AG have agreed to an interoperable database and are in the process of obtaining necessary control agency approvals. Although immediate implementation may consequently not be feasible at this time, there was significant support from many of those interviewed for implementation of a common or shared server accessible to both DAGs and investigators for storage of common documents and their calendars as an interim measure.

It is suggested that a working group of both AG and MBC staff be established to explore an effective and efficient method of sharing documents and information to eliminate repetitive duplication of documents and unnecessary delays in scheduling and rescheduling of subject interviews.

In conclusion, it is recommended that the most prudent course of action at this time is the continuation of the pilot with the modifications contained in Recommendations 1 through 7 to improve the implementation of the VE model, and a reassessment of its success after two years. It is important to note that additional commitment to the VE process by executive management and every manager and supervisor in each department is essential to the success of this modified VE model.

II. INTRODUCTION

BACKGROUND

The mission of the Medical Board of California “is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board’s licensing and regulatory functions.”

The Medical Practice Act as codified in Business and Professions (B&P) Code Sections 2000-2029 establishes the Medical Board of California (MBC) within the Department of Consumer Affairs (DCA) and mandates, in B&P Code Section 2001.1, protection of the public as the highest priority of the MBC in exercising its licensing, regulatory and disciplinary functions.

The MBC’s quality of medical care responsibilities as outlined in B&P Code Section 2004 are: the enforcement of disciplinary and criminal provisions of the Medical Practices Act; the administration and hearing of disciplinary actions; the implementation of disciplinary actions appropriate to findings made by a panel or an administrative law judge; the suspension, revocation, or other limiting of certificates after the conclusion of disciplinary actions; and the review of the quality of medical practice carried out by certified physicians and surgeons under the jurisdiction of the MBC.

In addition, B&P Code Section 2020 requires that the Attorney General act as legal counsel for the MBC for any judicial or administrative proceedings and, pursuant to B&P Code Section 2006, on and after January 1, 2006, redefines statutory references to investigations by the MBC, or one of its divisions, to refer to an investigation directed by employees of the Department of Justice (DOJ).

Government Code (GC) Sections 12529 and 12529.5, effective until July 1, 2010, established the Health Quality Enforcement Section (HQES) within the DOJ, whose primary responsibility is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the MBC, selected other boards and any committee under the jurisdiction of the MBC.

HISTORY

In 2002, the Joint Legislative Sunset Review Committee recommended that the Director of DCA appoint an independent Enforcement Monitor (Monitor) to investigate and evaluate the disciplinary and enforcement policies and procedures of the MBC.

Subsequently, SB 1950 (Figueroa), Chapter 1085, Statutes of 2002, was enacted. Section 2220.1 of the B&P Code was added which mandated the appointment of a Monitor for two years and required the Monitor to report its findings to the Governor and the Legislature. The statute required that the initial report be submitted no later than October 1, 2003, and a final report prior to March 31, 2005. MBC's sunset date was extended from July 1, 2003 to July 1, 2005.

The ***Initial Enforcement Monitor Report*** was submitted on November 1, 2004. In the report, the Monitor recommended a vertical prosecution model whereby an attorney and investigator are assigned as a team to handle complex cases as soon as a case is opened as a formal investigation. The Monitor stated: "In this system, the prosecutor and investigator work together during the investigative phase to develop the investigative plan and ensure the gathering of necessary evidence to prove the elements of the offense and to address anticipated legal defenses; provide legal analysis of the incoming evidence to help shape the direction of the case; prepare subpoenas or help secure search warrants to prod uncooperative subjects or third-party witnesses; deal directly with defense attorneys when issues arise; and address settlement or plea matters, which often appear early in such cases."

With respect to the role of the investigator, the Monitor stated: "In turn, the investigator contributes a peace officer's experience and insight into the investigative plan and case strategy, and performs the field investigative tasks, including identification and location of witnesses and subjects; interviews of witnesses and subjects; obtaining and participating in the review of documentary and technical evidence; accessing criminal history and other databases; identifying and assisting with experts; planning and executing undercover operations; preparation of affidavits and specifications for search warrants, and service of those warrants; arrests and surrenders; witness assistance and evidentiary matters during trial; investigative report preparation; and other tasks usually associated with the work of trained peace officers and professional investigators."

The benefits of vertical prosecution, according to the Monitor, are:

- Improved efficiency and effectiveness arising from better communication and coordination of efforts;
- Reduced case cycle times;
- Improved commitment to cases;
- Improved morale, recruitment, and retention of experienced prosecutors and investigators;
- Improved training for investigators and prosecutors; and
- The potential for improved perception of the fairness of the process.

The Monitor report also recommended that MBC's investigators be transferred to HQES. It is important to emphasize that the Monitor also stated: "It is critical to note that the vertical prosecution model works best where all participants recognize and respect the contributions of all team members, and where attorneys, investigators, and other team members perform the functions for which they are trained and best suited.

Investigators in a vertical prosecution team are responsible for the tasks which are appropriately theirs, including essentially all the field investigative tasks involving witnesses, evidence, and related procedures. Prosecutors in a vertical prosecution team perform the tasks for which they are trained and licensed, including legal analysis and advocacy essential to preparing evidence for trial and presenting that evidence at trial.”

Many of the recommendations outlined in the Monitor’s report were addressed immediately by MBC, however, others required legislation.

Subsequently, SB 231 (Figueroa), Chapter 674, Statutes of 2005, was enacted instituting a two year vertical prosecution pilot, but without transferring the MBC’s investigators to HQES. The GC Section 12529.6 was added requiring that effective January 1, 2006, “each complaint that is referred to a district office of the board for investigation, shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney general to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.”

The legislation also required MBC to report and make recommendations to the Governor and the Legislature on the vertical prosecution model by July 1, 2007. Lastly, the MBC sunset date was extended to July 1, 2008.

The ***Final Enforcement Monitor Report*** was completed on November 1, 2005. As it relates to vertical prosecution, the Monitor once again recommended the full implementation of the vertical prosecution system, including the transfer of MBC’s investigators to HQES after 2007.

On January 1, 2006, the MBC and the HQES implemented a vertical prosecution model. Since not all of MBC’s cases lead to prosecution and a modified model was necessary due to staffing issues, the new model was internally renamed from vertical prosecution to vertical enforcement (VE), although statute still refers to a vertical prosecution model.

Both agencies agreed that the two year VE pilot include three basic elements:

- Each complaint referred to an MBC field office must be simultaneously and jointly assigned to an MBC investigator and a HQES deputy attorney general (DAG);
- The joint assignment must exist for the duration of the case; and
- Under the direction of a DAG, the assigned MBC investigator is responsible for obtaining the evidence required to allow the DAG to advise the MBC investigator

on legal matters such as whether a formal accusation should be filed, dismiss the complaint, or take other appropriate legal action.

In addition, both agencies agreed that at a minimum, the MBC investigator and the assigned DAG would confer at three specific stages of each investigation:

- Upon initial case assignment;
- Prior to the interview with the subject physician; and
- Prior to the submission of case documents for expert review.

As mandated by SB 231, MBC presented its report to the Legislature on the vertical prosecution model on November 2007. The report stated that although there were challenges in implementing the new VE model, there was, during the first 16 months of VE from January 1, 2006 through April 9, 2007, an overall decrease of 10 days in the average time to complete an investigation (exclusive of cases pending prior to implementation of the pilot). The report also indicated that the number of cases closed without prosecution during this period was reduced from 145 days to 139 days; obtaining medical records decreased from 74 days to 36 days; conducting physician interviews declined from 60 days to 40 days; obtaining medical expert opinions decreased from 69 days to 36 days; filing of accusations by HQES decreased from 241 days to 212 days; and the time to obtain interim suspension orders or temporary restraining orders was reduced from 91 days to 30 days.

According to the MBC' report, because of SB 231, HQES augmented their staff with nine new positions to assist with the new VE model, and MBC augmented their staff with four new investigator positions.

The MBC's ***Report to the Legislature on Vertical Enforcement*** on November 21, 2007 included the following recommendations:

- To fully and permanently integrate the VE model in MBC's operations;
- To move forward with co-location of HQES and MBC staff, where appropriate;
- To implement an information technology system that is interoperable with the system used at the Department of Justice; and
- To create a joint MBC and HQES manual similar to the MBC Enforcement Operations Manual (EOM) to incorporate the VE model from the receipt of a complaint until its resolution in any administrative action.

In addition, the report stated that: "Initial statistical data from the pilot period identify trends which suggest the VE model can more quickly identify cases for closure and certain egregious complaints can be handled more expeditiously. The data also suggested progress in reducing the time frames to complete investigations. However, the pilot time frame was insufficient to address the Monitor's concerns regarding the time to complete prosecutions. Since certain MBC investigations can take one year to conduct, the pilot time frame did not provide adequate time to measure the prosecutorial time line of such cases."

On October 13, 2007, the Governor signed Senate Bill 1048 (Committee on Business, Professions and Economic Development), Chapter 588, which extended MBC's sunset date until July 1, 2010.

Subsequently, SB 797 (Ridley-Thomas), Chapter 33, Statutes of 2008, added the following to GC Section 12529.6:

"The Medical Board of California shall do both of the following:

- (1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.
- (2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model."

In addition, SB 797 called for another report to the Governor and the Legislature on the vertical enforcement and prosecution model by July 1, 2009. This report is the result of that mandate.

SCOPE

The primary purpose of this report is to evaluate the VE model by reviewing statistical data on the impact of VE on the investigation and prosecution of complaints referred to MBC's district office enforcement staff for investigation. Because MBC and HQES also jointly processed certain Allied Health Care cases utilizing the VE model, this data is also included in the evaluation in order to account for its impact on workload and provide for a larger data sample.

Interviews of select MBC and HQES staff were also conducted to supplement the statistical data obtained.

Due to time and scope constraints, comparisons with other agencies were not possible in the development of the recommendations. However, references to various other agencies' vertical prosecution processes are included in the ***Report to the Legislature Vertical Enforcement, November 21, 2007***, as well as the Monitor reports.

APPROACH AND METHODOLOGY

Annual statistical data was obtained from MBC for various data markers for the period January 1, 2005 (pre-VE) through December 31, 2008. ISBG performed no independent testing or auditing of the provided data to verify its accuracy. Due to the limited scope and time available for analysis and completion of the report, data

separately collected and maintained by HQES was not compared with the MBC provided data.

References to comparisons of data between years, such as the percentage difference between 2005 and 2008, refers to a comparison of the total cases in the indicated years exclusive of cases in the intervening years. Because many of the data markers involve a comparison of a relatively small number of cases, reference should be made to the underlying data contained in the applicable appendices when determining the significance, if any, of the results of the specific statistical comparisons.

Since data alone can not provide a full understanding of the impact of VE, interviews of select HQES and MBC staff were conducted between April 9 through 15, 2009. Eleven (11) HQES staff were interviewed, all of whom were present since the onset of VE, with an average of 14 years experience with HQES, representing all staffing levels. Additionally, 11 MBC investigative staff were interviewed, all of whom were present at MBC since the onset of VE, with an average of 13 years with MBC, representing all staffing levels. Selection of the interviewed staff was made by HQES and MBC management and included a cross section of geographic locations and journey and supervisory levels from each agency.

III. STAFFING AND CASELOAD

STAFFING

Both MBC and HQES received additional staffing to implement VE.

MBC Staffing

Per MBC's *Report to the Legislature on Vertical Enforcement* in November 2007, MBC had 92 sworn staff positions comprised of 71 investigators and 21 supervisors. On July 1, 2006, based on SB 213, MBC augmented its staff by four investigator positions. Of the 96 authorized positions, it reported an average statewide vacancy rate of 12.3 percent, or 11.6 vacant positions.

In 2007, MBC internally reallocated its sworn probation positions to enforcement positions and redesignated the Rancho Cucamonga probation office to an enforcement district office.

As of May 2009, MBC enforcement field staff consists of 3 Supervising Investigator (Sup) II positions, 12 Sup I positions, and 70 investigator positions, of which 10 are vacant, resulting in a 14 percent investigator vacancy rate. According to interviewed staff, the vacancies are due mainly to retirement, the VE process and workload. In addition, MBC is not receiving lateral transfers from other departments, and the current investigator list is inadequate. They also stated that certain areas, such as Fresno and San Jose, continually experiences difficulties in recruiting and retaining staff.

Between 2005 and 2008, there was a 4.11% increase in the number of hours worked by medical consultants and a 569.39% increase in the number of cases referred for medical consultant review. During this same period, there was a 183.87% increase in the average and 83.33% increase in the median days between submission of a case for DO medical consultant review and completion of the review.

The Governor's Executive Orders also had an impact on timelines. For example, between July and October 2008, 23 Medical Board cases scheduled for OAH hearings were delayed an average of 119.78 days and a median of 112 days.

HQES Staffing

Pursuant to SB 231, HQES augmented its staff by nine DAGs to implement the VE model. According to a roster provided by HQES, this section has one Senior Assistant AG, six Supervising DAGs (SDAG), 45 DAGs (including one vacancy in Sacramento, three Senior Legal Analysts, and two DAG retired annuitants. Based on information obtained during interviews of HQES personnel, the San Francisco Office currently has

the most senior (i.e., HQES experienced) attorney staff of the four HQES offices. It was stated that in the San Diego office, 67 percent of the DAGs have two years or less experience in HQES, and in the Los Angeles office 75 percent of the DAGs have 3 or less years of HQES experience.

It must be noted that not all HQES staff are funded by MBC as they also represent other clients.

With the addition of investigation oversight responsibilities to HQES, between 2005 and 2008 there was a 37.71% increase in the number of attorney services hours and an increase of 39.81% in the number of legal assistant/paralegal hours billed to MBC by the AG. During the same period, there was an 8.48% decrease in the number of completed investigations that resulted in the filing of an accusation.

CASELOAD

Caseload levels vary between HQES and MBC staff.

MBC Caseload

Most MBC staff stated that their caseload is too heavy. The average caseload for senior MBC investigators was estimated by staff interviewed to be between 25-27, and the average for investigators was estimated at approximately 20. Most stated that a preferred workload would be about five cases less.

HQES Caseload

Most HQES staff interviewed reported that their current caseload is manageable and not much different from prior to VE. Even though the DAGs are now responsible for case investigations, administrative caseloads decreased and staffing increased by nine new positions. Currently, most of the personnel interviewed estimated an average caseload of 10-20 administrative cases and 20-30 investigation cases, depending on whether the DAG is acting in a primary or lead role.

RETENTION AND RECRUITMENT

Retention and recruitment of investigators and attorneys have been a challenge, especially in some areas of the state.

MBC

Per MBC's *Report to the Legislature on Vertical Enforcement*, MBC had 96 sworn staff position comprised of 21 supervisors and 75 investigators. Of the 96 authorized positions, MBC indicated it had an average statewide vacancy rate of 12.3 percent, or 11.6 vacant positions in calendar year 2006.

As of May 2009, MBC has 3 Sup II, 12 Sup I, and 70 senior/investigator positions of which 10 are vacant, resulting in a 14.29 percent vacancy rate for senior/investigator positions. According to staff interviewed, the vacancies are due mainly to early retirement, the VE process, and workload. According to supervisory staff interviewed, lateral transfers from other departments are not occurring and the current investigator list is inadequate. Furthermore, it has been extremely difficult to recruit staff for certain areas such as Fresno and San Jose, and there are long standing vacancies in these areas.

Interviewees indicated staff retention problems are mainly the result of the VE process and insufficient staffing levels. Reported perceptions as to the reasons for staff transferring to other departments or retiring early included frustration with the process, multiple approval levels, loss of autonomy, disrespectful attitude and treatment by select DAGs, roles not clearly defined or accepted, conflicting directions and heavy caseloads.

HQES

According to the roster provided by the AG's office, HQES has one Senior Assistant AG, six SDAGs, 45 DAGs (including one vacancy in Sacramento), three Senior Legal Analysts, and two retired annuitant DAGs.

Interviewees indicated that the San Francisco Office has the most senior attorney staff of the four HQES offices. It was stated that in the San Diego office, 67 percent of the DAGs have two years or less experience in HQES, and in the Los Angeles office 75 percent of the DAGs have 3 or less years of HQES experience.

Although HQES management indicates it does not have problems recruiting, retaining or promoting DAGs and that HQES is going through a transition period that explains the presence of newer DAGs, some of the AG personnel interviewed indicated that some DAGs are retiring early or transferring to other departments due to the complexity of cases, the multitude of mandates, lack of authority and the multiple levels of review.

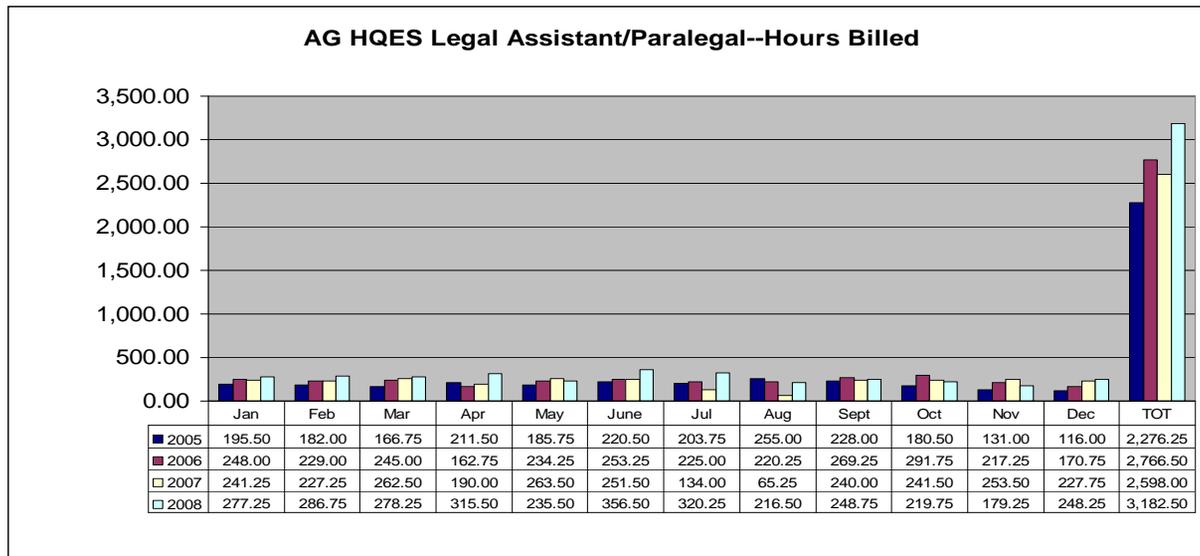
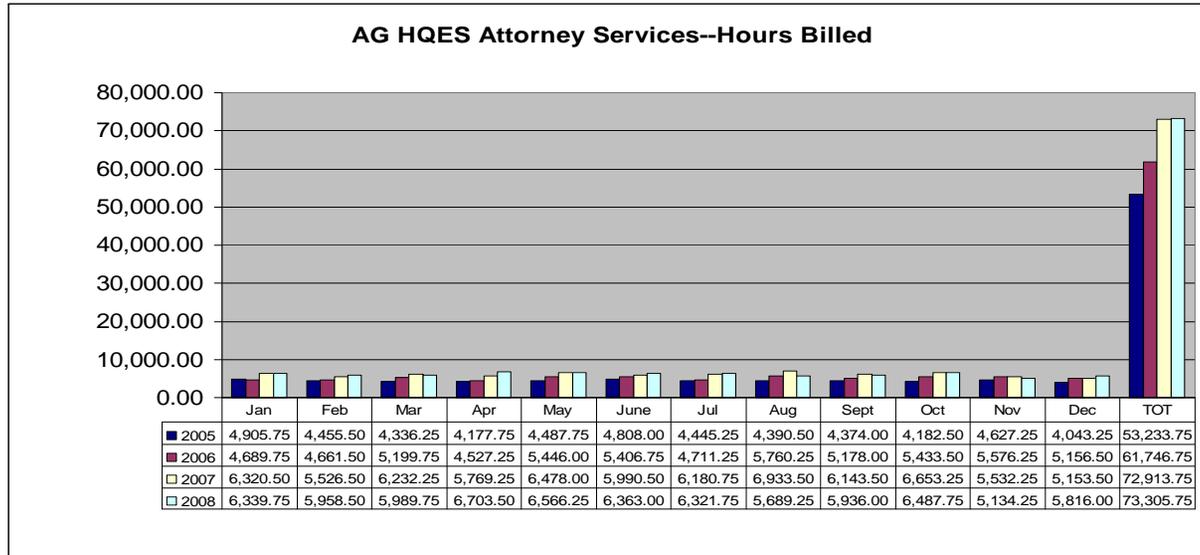
ATTORNEY GENERAL HEALTH QUALITY ENFORCEMENT SECTION ATTORNEY SERVICES HOURS BILLED TO MEDICAL BOARD

Table 3.1 below reports the Attorney General Health Quality Enforcement Section attorney services hours to the Medical Board. Between 2005 and 2008, there was a 37.71% increase in the attorney services hours billed and a 39.81% increase in the legal assistant/paralegal hours billed.

Table 3.1 – Attorney General Health Quality Enforcement Section Attorney Services Hours Billed to Medical Board

	Percentage Difference 2006 to 2007	Percentage Difference 2007 to 2008	Percentage Difference 2006 to 2008	Percentage Difference 2005 to 2008
Attorney Services	18.09%	0.54%	18.72%	37.71%
Legal Asst/Paralegal	-6.09%	22.50%	15.04%	39.81%

Charts 3.1a & b – Attorney General Health Quality Enforcement Section Attorney Services Hours Billed to Medical Board



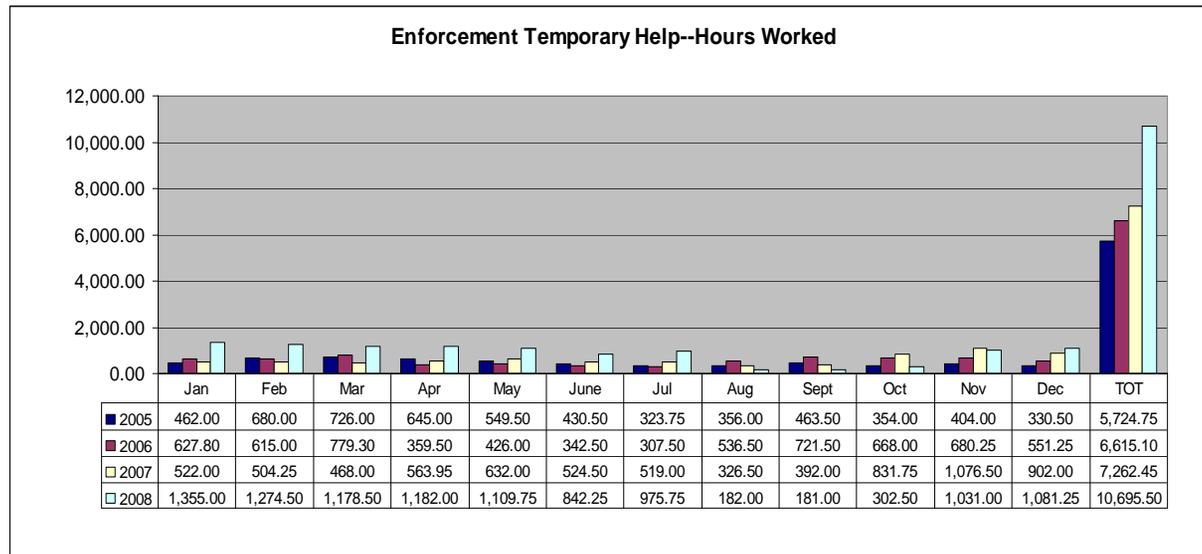
MEDICAL BOARD ENFORCEMENT TEMPORARY HELP HOURS WORKED (EXCLUDES MEDICAL CONSULTANTS)

Table 3.2 below reports the enforcement temporary help hours worked (excluding medical consultants). Between 2005 and 2008, there was an 86.83% increase in the enforcement temporary help hours worked.

Table 3.2 – Medical Board Enforcement Temporary Help Hours Worked (Excluding Medical Consultants)

	Percentage Difference 2006 to 2007	Percentage Difference 2007 to 2008	Percentage Difference 2006 to 2008	Percentage Difference 2005 to 2008
Enforcement Temporary Help Hours Worked	9.79%	47.27%	61.68%	86.83%

Chart 3.2 – Medical Board Enforcement Temporary Help Hours Worked (Excluding Medical Consultants)



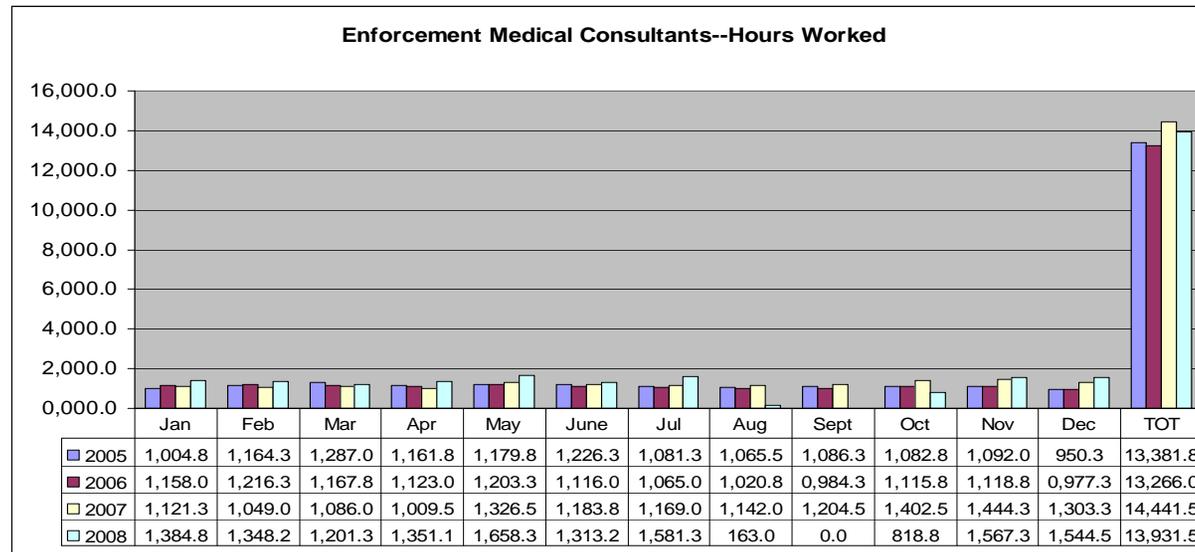
ENFORCEMENT MEDICAL CONSULTANT HOURS WORKED

Table 3.3 below reports the enforcement medical consultant hours worked. Between 2005 and 2008, there was a 4.11% increase in the enforcement medical consultant hours worked.

Table 3.3 – Enforcement Medical Consultant Hours Worked

	Percentage Difference 2006 to 2007	Percentage Difference 2007 to 2008	Percentage Difference 2006 to 2008	Percentage Difference 2005 to 2008
Enforcement Medical Consultant Hours Worked	8.86%	-3.84%	5.02%	4.11%

Chart 3.3 – Enforcement Medical Consultant Hours Worked



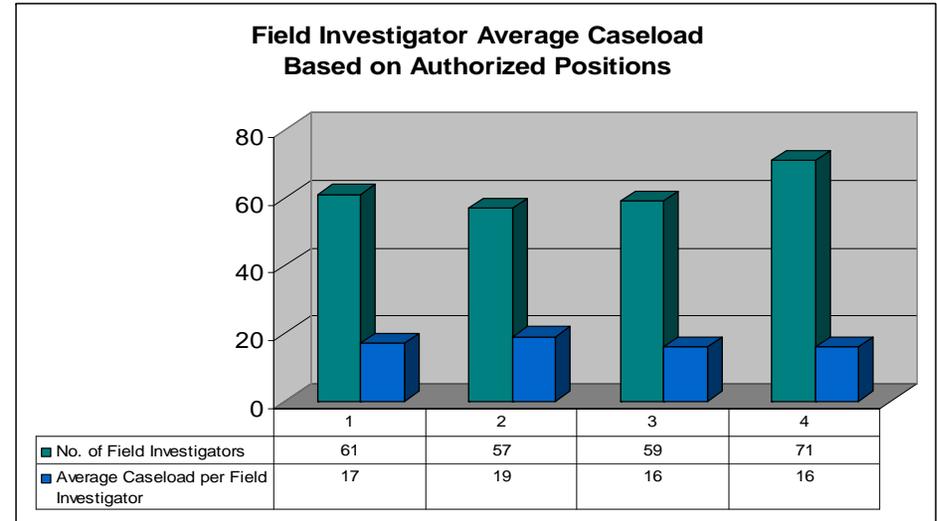
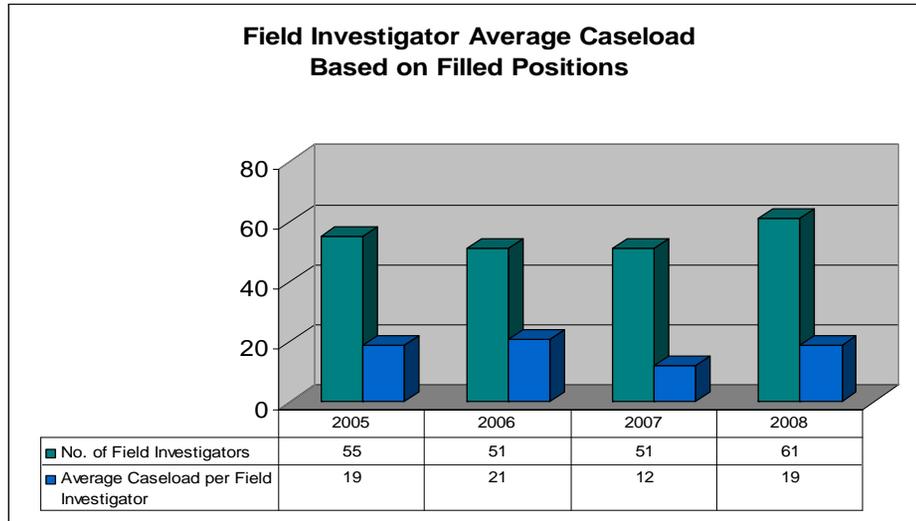
MEDICAL BOARD INVESTIGATORS AND AVERAGE CASELOAD

Table 3.4 below reports the number of Medical Board field investigators and average caseload. Between 2005 and 2008, there was a 10.91% increase in the number of filled investigator positions and a 16.39% increase in the number of authorized positions. During this period, the average caseload per filled field investigator position remained the same, while the average caseload per authorized investigator position decreased 5.88%.

Table 3.4 – Medical Board Field Investigators and Average Caseload

	Percentage Difference 2006 to 2007	Percentage Difference 2007 to 2008	Percentage Difference 2006 to 2008	Percentage Difference 2005 to 2008
No. of Filled Enforcement Field Investigator Positions	0.00%	19.61%	19.61%	10.91%
Avg Cases per Filled Enforcement Field Investigator	-42.86%	58.33%	-9.52%	0.00%
No. of Authorized Enforcement Field Investigator Positions	3.51%	20.34%	24.56%	16.39%
Avg Cases per Authorized Field Investigator Position	-15.79%	0.00%	-15.79%	-5.88%

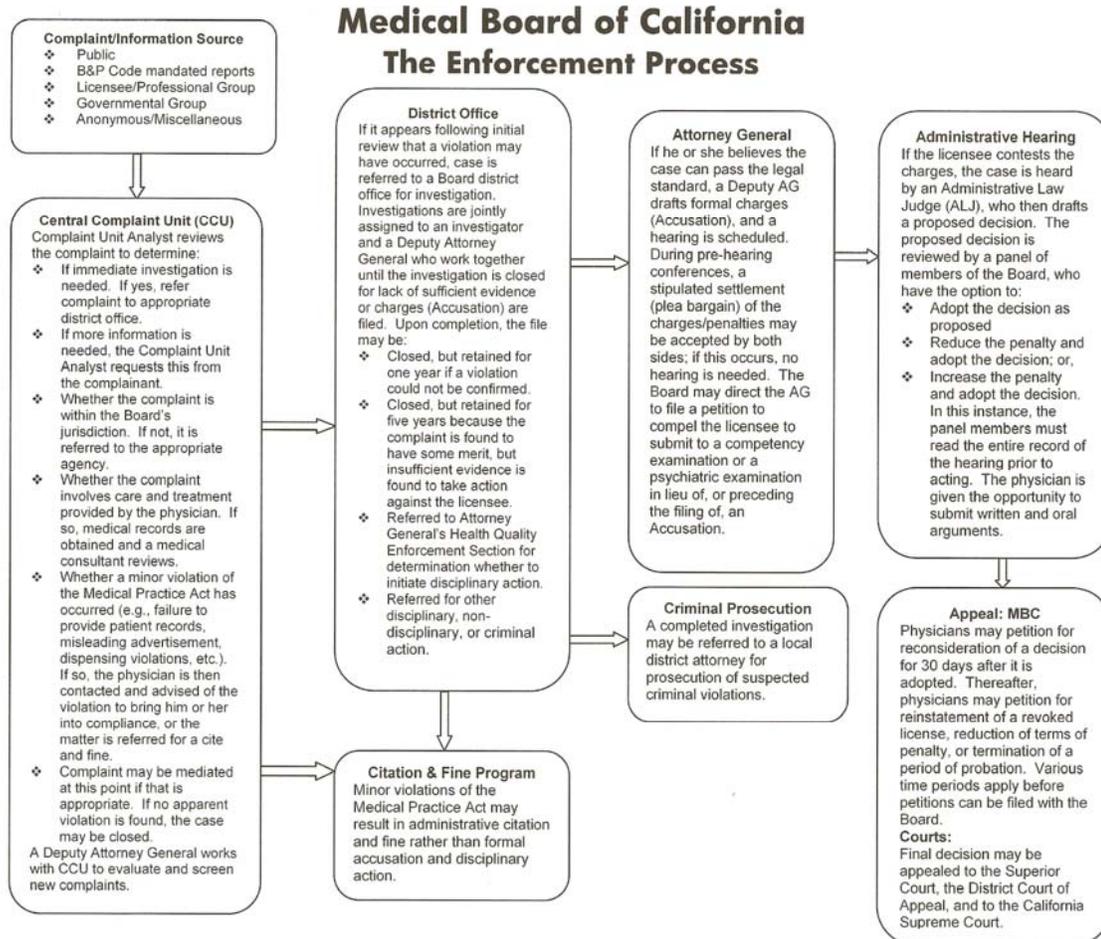
Charts 3.4a & b – Medical Board Field Investigators and Average Caseload



IV. MBC ENFORCEMENT PROCESS

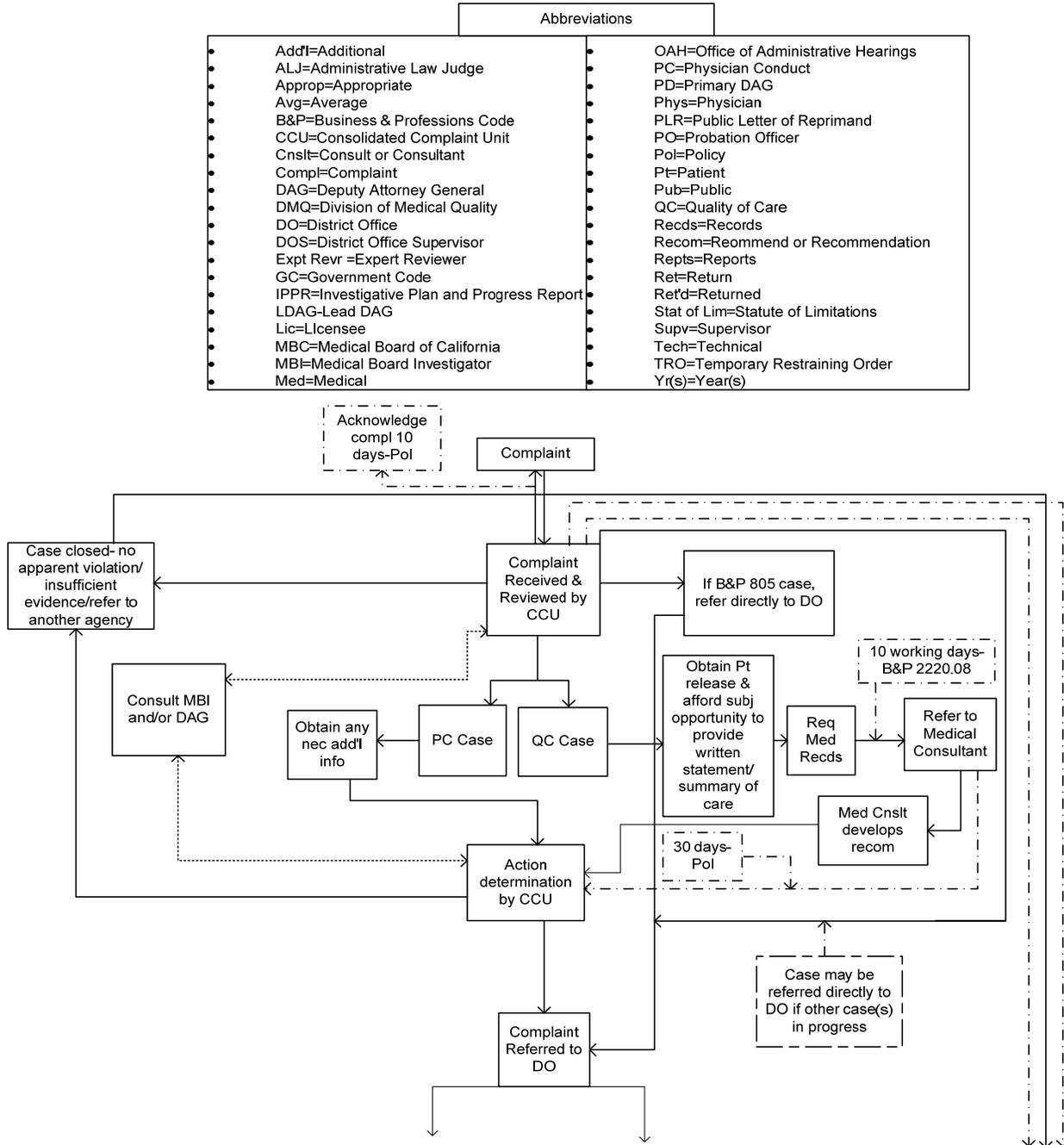
Government Code Section 12529.6(a): “The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.”

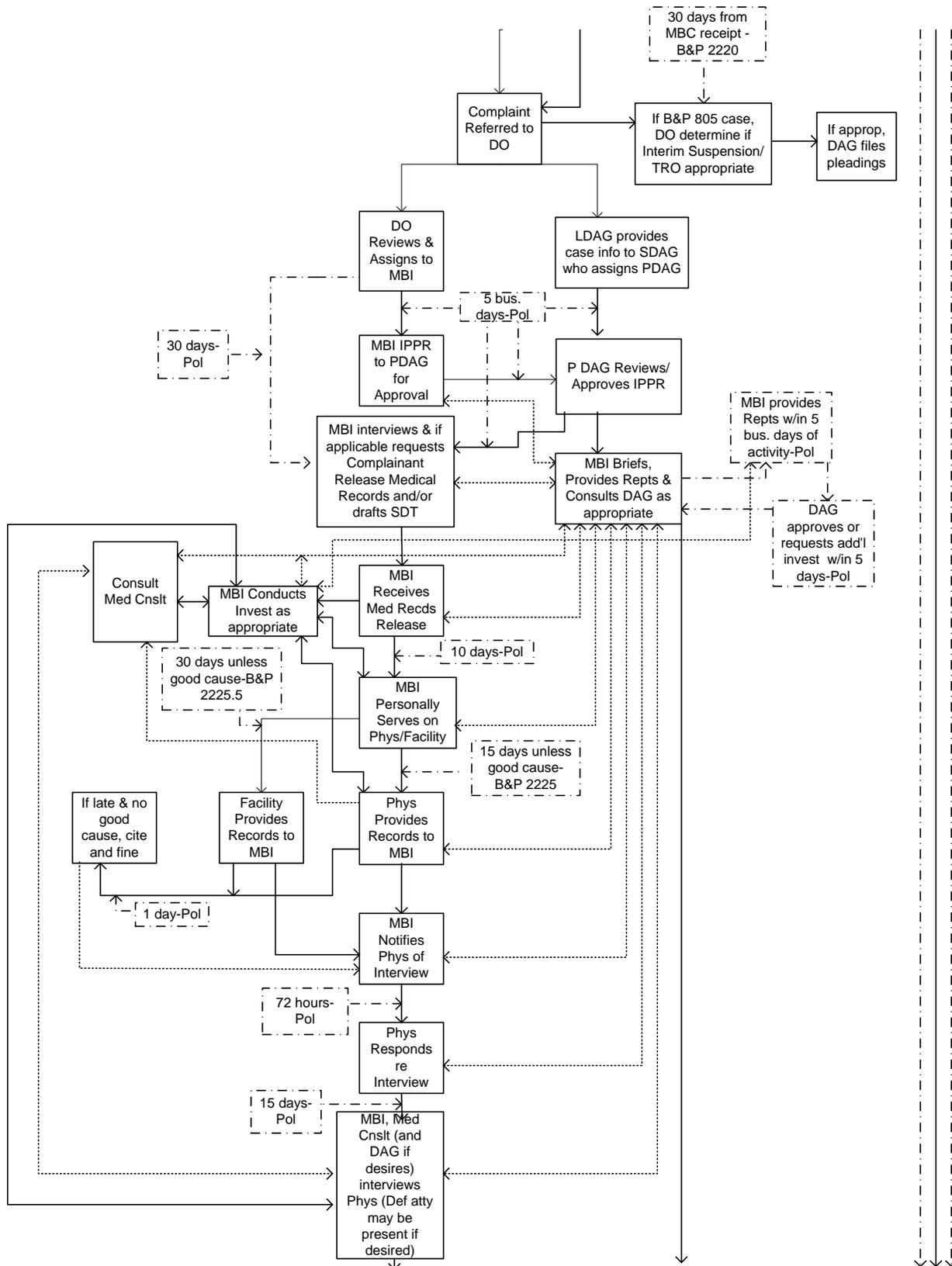
The following chart depicts the MBC enforcement process as published by MBC:

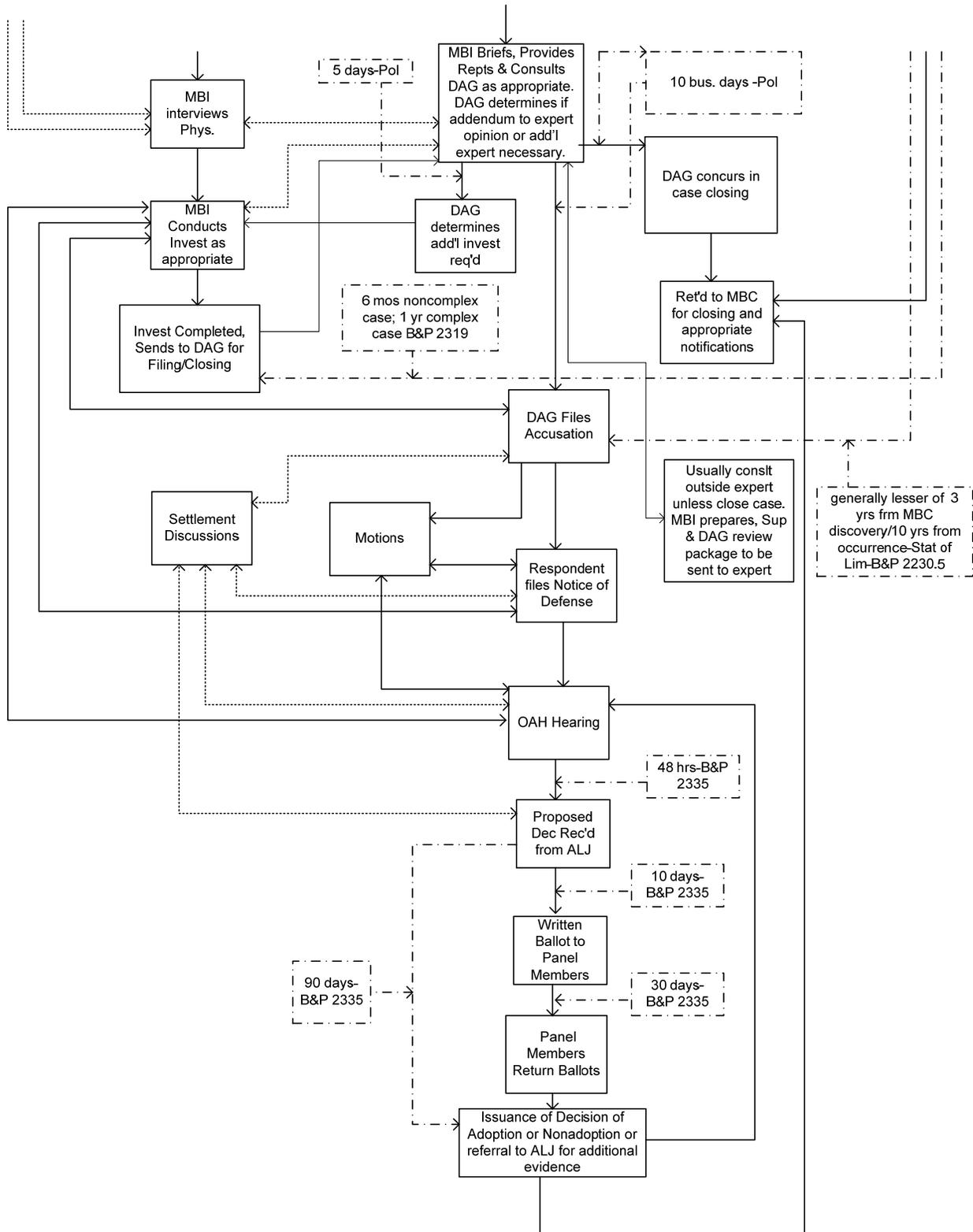


The following flow chart illustrates select steps in the vertical enforcement model utilized in the MBC enforcement:

**Medical Board of California
Enforcement Flow
(Partial)**







V. PRIORITY AND COMPLEX CASES

PRIORITY CASES

Per B&P Code Section 2220.05: “In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority bases, as follows, with the highest priority being given to cases in the first paragraph. . .”

The priorities include:

- Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients;
- Drug or alcohol abuse involving death or serious bodily injury to a patient;
- Repeated acts of excessive prescribing, furnishing, dispensing, or administering controlled substances;
- Sexual misconduct with one or more patients; and
- Practicing medicine while under the influence of drugs or alcohol.

Priority Policy

Pursuant to the above statute and MBC’s ***Enforcement Operations Manual*** (EOM) Section 6.13, MBC investigators are required to prioritize investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Per EOM Section 9.7, when the Sup I/II becomes aware that the public health and safety is at risk, he/she may request the AG’s office to obtain a Temporary Restraining Order (TRO) or an Interim Suspension Order (ISO); or when MBC becomes aware that a physician or surgeon is incarcerated resulting from a felony conviction, request an Automatic Suspension (ASO); or may request the AG make a Penal Code Section 23 (PC 23) court appearance on behalf of MBC.

Pursuant to the HQES and MBC ***Vertical Prosecution Manual*** (VPM), Second Edition, November 2006, the lead DAG is directed to identify those cases in which an ISO or PC 23 appearance is necessary and to notify the SDAG, who designates a primary DAG responsible for the order or appearance. The EOM Section 9.7 indicates that after an ISO is issued the DAG must file an accusation within 15 days or the ISO dissolves. After the accusation is filed, a hearing must be held within 30 days (unless respondent stipulates to a later date) and the Administrative Law Judge (ALJ) must prepare a decision within 15 days.

In accordance with EOM, Section 9.7, when an investigator is aware that there is any criminal proceeding against a licensee, the investigator, together with the Sup I, determines if a PC 23 request for intervention by the AG's Office is warranted. If so, it is presented to the lead DAG and then follows the procedures listed in the VPM.

Per EOM, Section 9.7, after a TRO is issued by the Superior Court, the DAG files an accusation within 30 days and an administrative hearing is scheduled within 30 calendar days of the date the subject requests a hearing. The Administrative Law Judge (ALJ) must render a decision within 15 days following the hearing. Failure to do so may result in the termination of the TRO by the Superior Court.

If a licensee is incarcerated pursuant to a felony conviction, the investigator requests an ASO from a DAG, who, in turn, prepares an ASO notice to the licensee and submits the notice to the MBC Executive Director for signature.

COMPLEX CASES

Pursuant to B&P Code Section 2319, the goal for cases which, in the opinion of the MBC, involve complex medical or fraud issues or complex business or financial arrangements, is no more than one year to investigate.

Complex Case Policy

The MBC's EOM identifies the factors to be taken into consideration in determining if a case is "complex" as follows:

- Multiple patients;
- Fraud/ethical violations/dishonesty cases;
- Unique legal cases;
- Unlicensed corporate practice of medicine;
- Multiple violation cases;
- Cases requiring subpoena enforcement through Superior Court;
- Records needed from more than three providers or locations;
- Drug cases requiring pharmacy audits, undercover operations, two experts, uncooperative patients, search warrants or internet purchases;
- Cases involving impairment of the subject where there is lack of complainant information and/or lack of corroboration;
- Unique patient legal status which requires determining who has the legal authority to authorize the release of the patient's medical records
- Unique medical issues; and
- Cases involving unique patients, subjects or issues.

The MBC's database does not currently distinguish between complex and noncomplex cases. Consequently, this report is not able to make such a distinction in its review or analysis of the provided data.

NOTE REGARDING TABLES AND CHARTS

The following pages present tables and charts that summarize the results of the review of select data markers as a percentage increase or decrease over identified time frames.

Combined data for Physicians and Surgeons and Allied Health Care cases is presented first, followed by the specific data for Physicians and Surgeons cases and the separate data for Allied Health Care cases. Because many of the data markers involve comparison of relatively few cases, the combined Physicians and Surgeons and Allied Health Care data provides a stronger basis for comparison. Nevertheless, because of the relative small sample size, reference should be made to the applicable underlying data contained in the appendices and identified in the charts in determining the significance, if any, of the specific statistical comparisons.

The statistical conclusions contained in this report are based on data provided to ISBG by MBC. ISBG performed no independent testing or auditing of the provided data to verify its accuracy. Due to the limited scope and time available to complete the report, data separately collected and maintained by HQES was not compared with the data provided by MBC. References to comparisons of data between years, such as the percentage difference between 2005 and 2008, refers to a comparison of the total cases in the indicated years, exclusive of cases in the intervening years.

The absence of a percentage increase or decrease in a table indicates that either there is no data applicable or that the denominator was "0" and that no percentage calculation is therefore possible.

Data markers are grouped in accordance within the relevant chapter headings.

Physicians and Surgeons case data excludes out of state and headquarters cases. Allied Health Care case data includes: osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians and licensed midwives.

VI. SUSPENSION ORDERS

Pursuant to the EOM, a Temporary Restraining Order (TRO), Interim Suspension Order (ISO), Automatic Suspension Order (ASO) or PC 23 appearance, as appropriate, may be sought when the public health and safety is at risk or a physician is incarcerated as a result of a felony conviction.

Pursuant to B&P Code Section 2220, the MBC shall investigate the circumstances underlying any report received pursuant to Section 805 within 30 days to determine if an ISO or TRO should be issued.

Per EOM, an investigator should seek a TRO or an ISO when the public health and safety are at risk, such as sexual misconduct, drug or alcohol abuse, mental illness, physical illness affecting competence, criminal activity that involves actual or potential serious injury or harm to the public, multiple acts of gross negligence and/or incompetence, or physicians who fail a professional competency examination.

With regard to a TRO, the DAG must file an accusation within 30 days after a TRO is issued by the Superior Court and schedule an administrative hearing within 30 calendar days of the date the subject requests a hearing. The ALJ must render a decision within 15 days.

With regard to an ISO, after the ALJ issues an ISO, an accusation must be filed within 15 days or the ISO dissolves. After the accusation is filed, a hearing must be held within 30 days (unless respondent stipulates to a later date), and the ALJ must prepare a proposed decision within 15 days.

Pursuant to B&P Code Section 2236.1, a licensee shall be suspended automatically during any time the licensee is incarcerated after a felony conviction. An ASO notice is prepared by the DAG and signed by the MBC Executive Director notifying the licensee of the suspension and of his/her rights to a hearing.

When an investigator becomes aware of any criminal proceedings against a licensee, and the investigator and supervisor determines that a suspension or restriction of the licensee's practice is warranted, a PC 23 order is requested and the DAG represents the MBC at the criminal arraignment or preliminary hearing in the appropriate court.

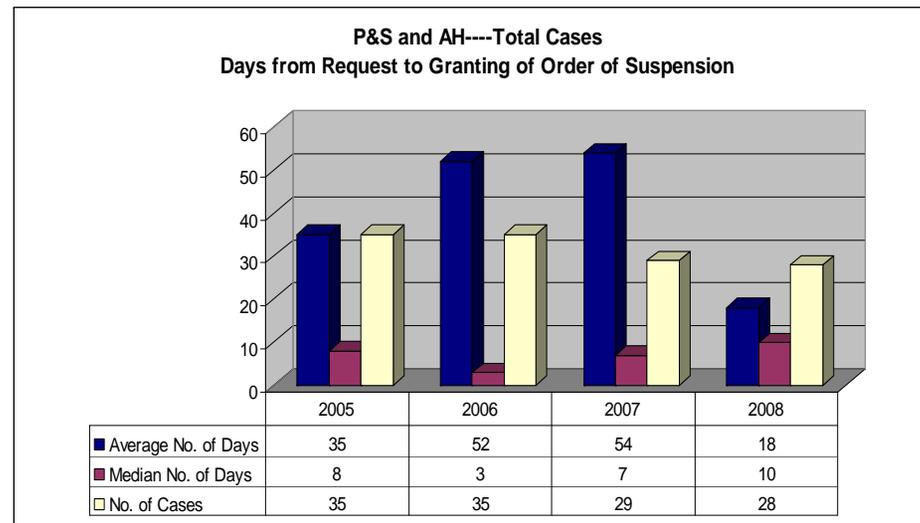
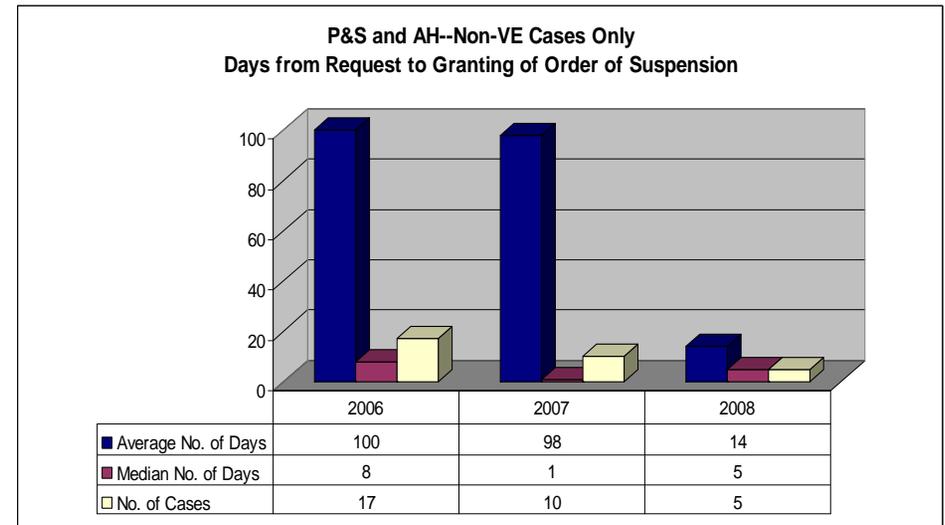
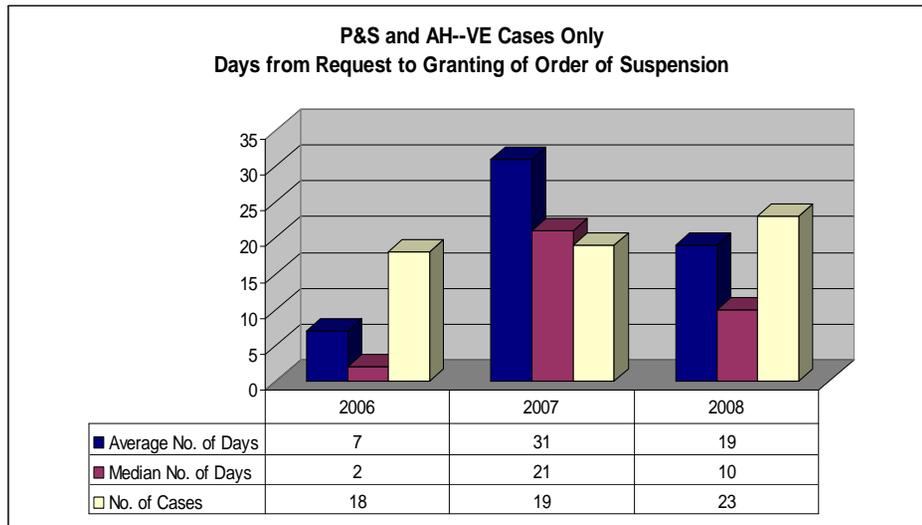
CALENDAR DAYS AGED FROM REQUEST TO SUSPENSION ORDER GRANTED — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 6.1 below reports the average and median calendar days aged from request to suspension order granted for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 48.57% decrease in the average days aged, a 25.00% increase in the median days aged, and a 20.00% decrease in the number of such cases.

Table 6.1 – Calendar Days Aged from Request to Suspension Order Granted for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008	
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Request to Suspension Order Granted																	
Average	3.85%	-2.00%	342.86%	-66.67%	-85.71%	-38.71%	-65.38%	-86.00%	171.43%	-48.57%							
Median (middle record-half are above and half below)	133.33%	-87.50%	950.00%	42.86%	400.00%	-52.38%	233.33%	-37.50%	400.00%	25.00%							
Record Count	-17.14%	-41.18%	5.56%	-3.45%	-50.00%	21.05%	-20.00%	-70.59%	27.78%	-20.00%							

Charts 6.1a, b & c – Calendar Days Aged from Request to Suspension Order Granted for Physicians and Surgeons and Allied Health Cases



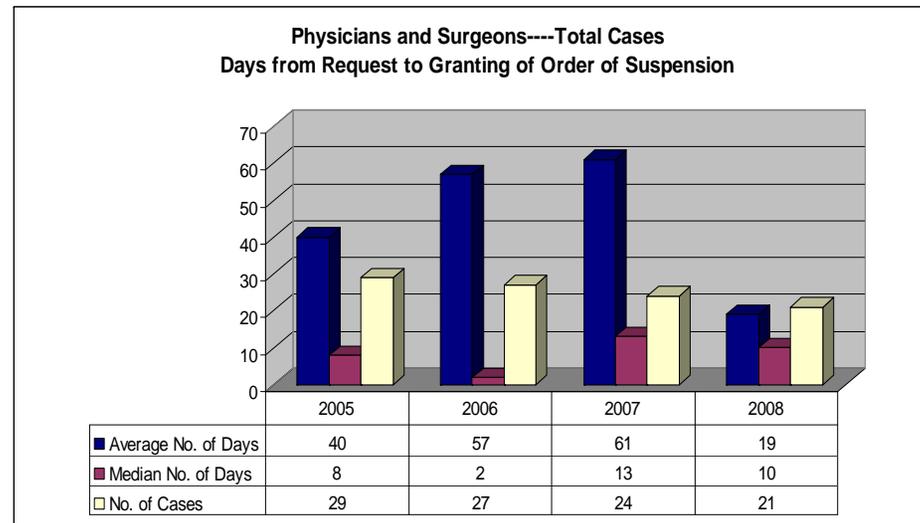
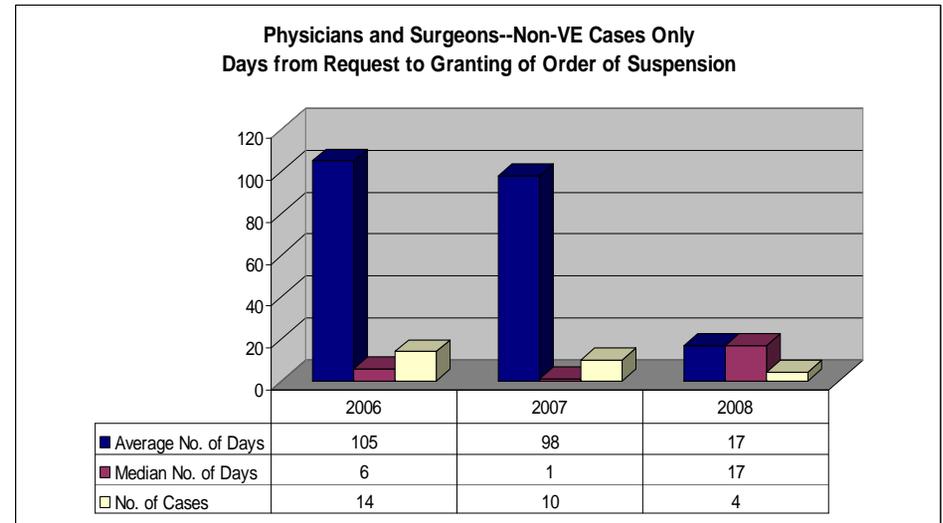
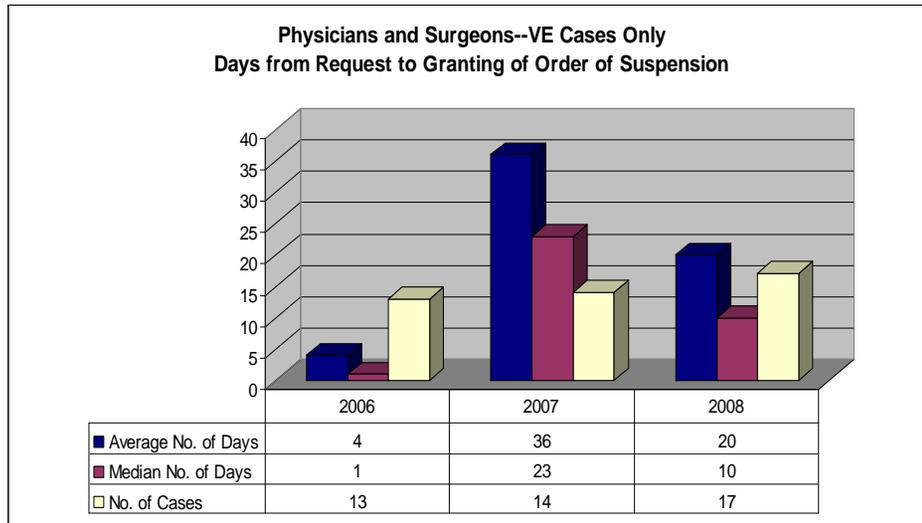
CALENDAR DAYS AGED FROM REQUEST TO SUSPENSION ORDER GRANTED — PHYSICIANS AND SURGEONS

Table 6.2 below reports the average and median calendar days aged from request to suspension order granted for Physicians and Surgeons cases. Between 2005 and 2008, there was a 52.50% decrease in the average days aged, a 25.00% decrease in the median days aged, and a 27.59% decrease in the number of such cases.

Table 6.2 – Calendar Days Aged from Request to Suspension Order Granted for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All			
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending			
Calendar Day Age from Request to Suspension Order Granted																
Average	7.02%	-6.67%	800.00%	-68.85%	-44.44%	-66.67%	-83.81%	400.00%	-52.50%							
Median (middle record-half are above and half below)	550.00%	-83.33%	2200.00%	-23.08%	-56.52%	400.00%	183.33%	900.00%	25.00%							
Record Count	-11.11%	-28.57%	7.69%	-12.50%	21.43%	-22.22%	-71.43%	30.77%	-27.59%							

Charts 6.2a, b & c – Calendar Days Aged from Request to Suspension Order Granted for Physicians and Surgeons Cases



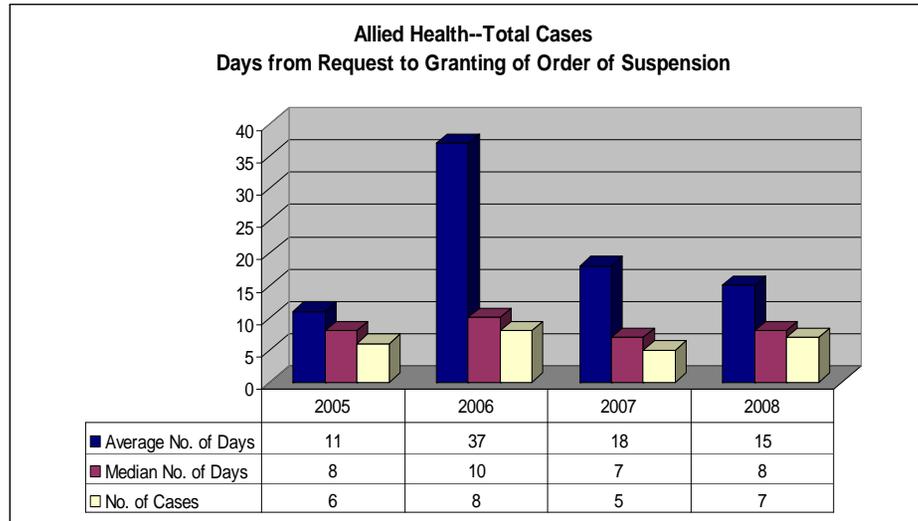
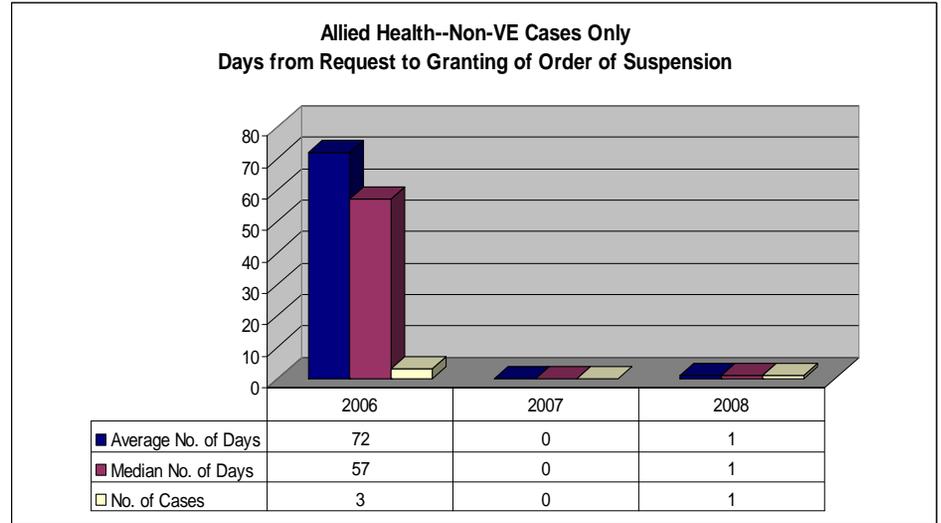
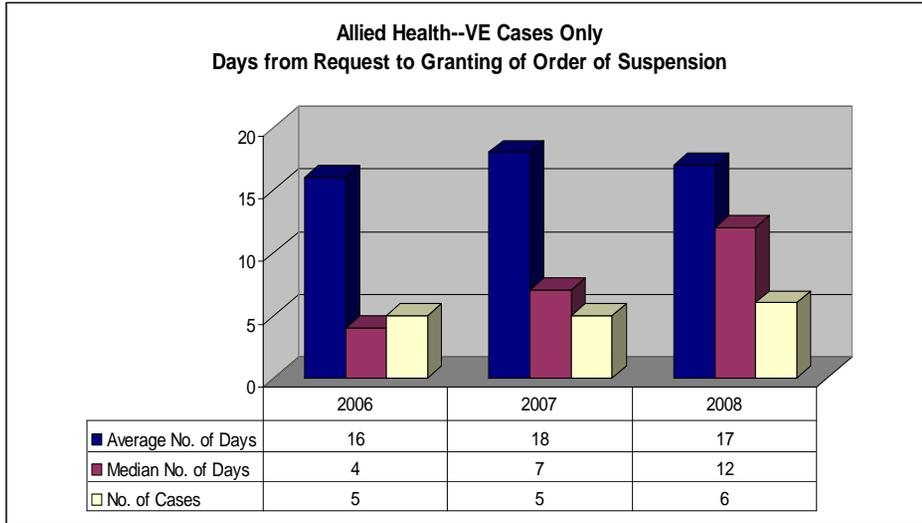
CALENDAR DAYS AGED FROM REQUEST TO SUSPENSION ORDER GRANTED — ALLIED HEALTH

Table 6.3 below reports the average and median calendar days aged from request to suspension order granted for Allied Health Care cases. Between 2005 and 2008, there was a 36.36% decrease in the average days aged, no change in the median days aged, and a 16.67% increase in the number of such cases. There were no such cases pending at year end for any year.

Table 6.3 – Calendar Days Aged from Request to Suspension Order Granted for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008	
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Request to Suspension Order Granted																	
Average	-51.35%	-100.00%	12.50%	-16.67%		-5.56%	-59.46%	-98.61%	6.25%	36.36%							
Median (middle record-half are above and half below)	-30.00%	-100.00%	75.00%	14.29%		71.43%	-20.00%	-98.25%	200.00%	0.00%							
Record Count	-37.50%	-100.00%	0.00%	40.00%		20.00%	-12.50%	-66.67%	20.00%	16.67%							

Charts 6.3a, b & c – Calendar Days Aged from Case Assigned to Investigator to Suspension Order Granted for Allied Health Cases



VII. VERTICAL PROSECUTION - ASSIGNED TO CLOSED, NO PROSECUTION

Per EOM Section 7.1, investigations which are “Closed-No Violations” are closed because of no violation of the law or the case is determined to be non-jurisdictional. Investigations, which are “Closed-Insufficient Evidence”, are closed because insufficient evidence is found to file formal charges.

Per the VPM, in cases which the investigation report recommends closure, the primary DAG must review the proposed closure within 10 business days and indicate either approval or disapproval. If, at any stage of the investigation, the primary DAG concludes that the investigation should be closed, he/she is required to submit a proposal to close to the lead DAG. Within 10 business days, the lead DAG shall review the proposed closure and indicate in writing either approval or disapproval of the proposal.

Per EOM Section 9.3, the MBC has the authority to issue citations and fines to physicians and surgeons as an alternative option to discipline by providing a method to address relatively minor violations of law which would not normally warrant license revocation or imposition of probationary terms. California Code of Regulations (CCR) Section 1364.11 lists the citable offenses which MBC may issue a citation.

Per EOM Section 9.4, the MBC may issue a public letter of reprimand (PLR) by stipulation or settlement after a thorough investigation is conducted, in lieu of filing or prosecuting an accusation.

The following tables and charts detail the average and median time frames from assignment to an investigator to completion without referral for filing of an accusation.

CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO CASE CLOSED, NO PROSECUTION — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

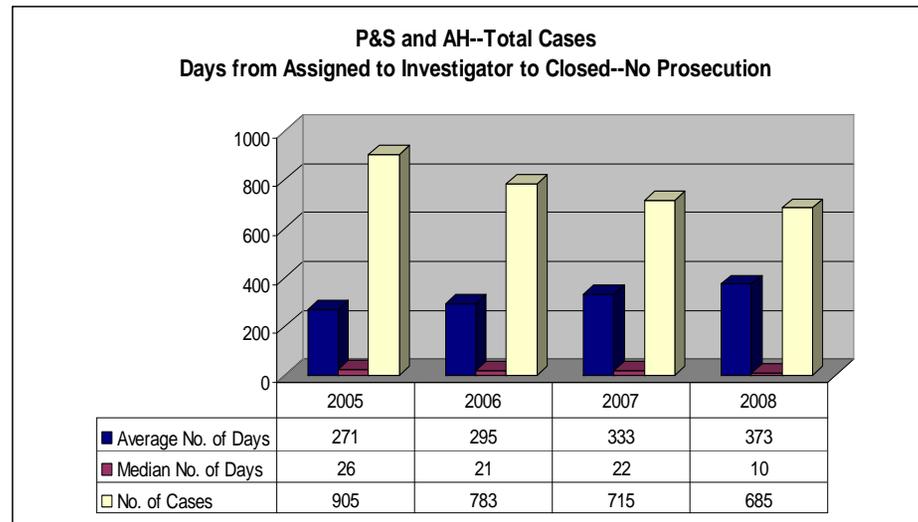
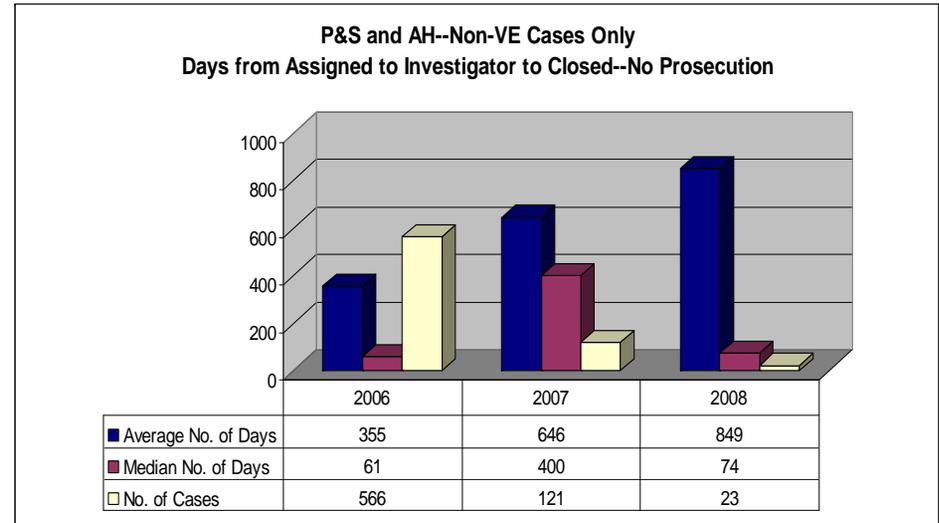
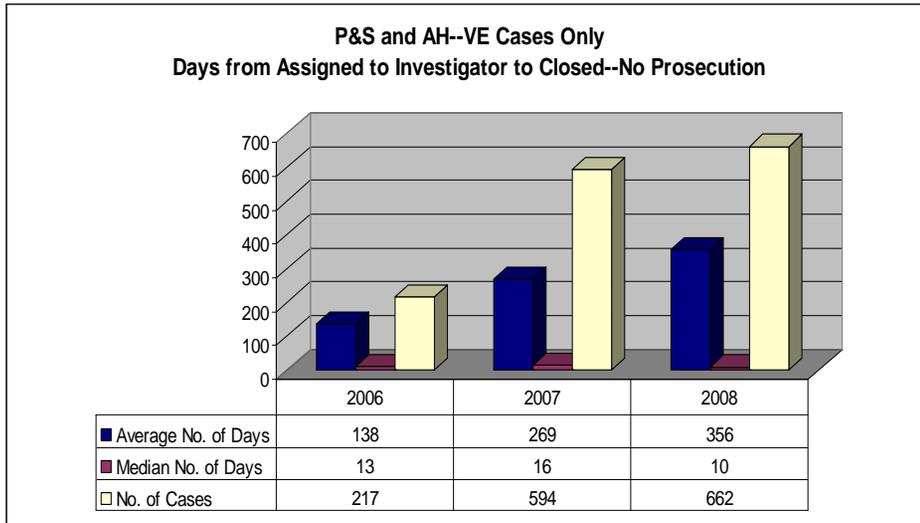
Table 7.1 below reports the average and median calendar days aged from case assigned to case closed with no prosecution for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 37.64% increase in the average days aged, a 61.54% decrease in the median days aged, a 24.31% decrease in the number of such cases and a 12.46% increase in the number of such cases pending at year end. During this period, there was a 14.36% decrease in the number of cases referred to investigations.

Table 7.1 & 7.1a – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending			
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution																				
Average	12.88%		81.97%		94.93%		12.01%		31.42%		32.34%		26.44%		139.15%		157.97%		37.64%	
Median (middle record - half are above and half below)	4.76%		555.74%		23.08%		-54.55%		-81.50%		-37.50%		-52.38%		21.31%		-23.08%		-61.54%	
Record Count	-8.68%	-0.41%	-78.62%	-79.43%	173.73%	23.65%	-4.20%	7.32%	-80.99%	-93.10%	11.45%	12.40%	-12.52%	6.87%	-95.94%	-98.58%	205.07%	38.98%	-24.31%	12.46%

	Per. Dif. 2006 to 2007	Per. Dif. 2007 to 2008	Per. Dif. 2006 to 2008	Per. Dif. 2005 to 2008
Complaints Referred	-13.22%	8.66%	-5.71%	-14.36%

Charts 7.1a, b & c – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons and Allied Health Cases



Charts 7.1d, e & f – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End

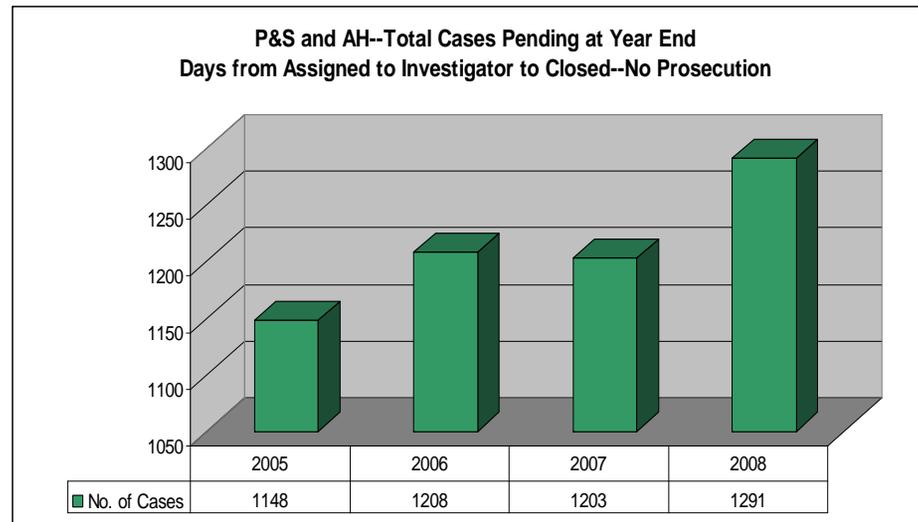
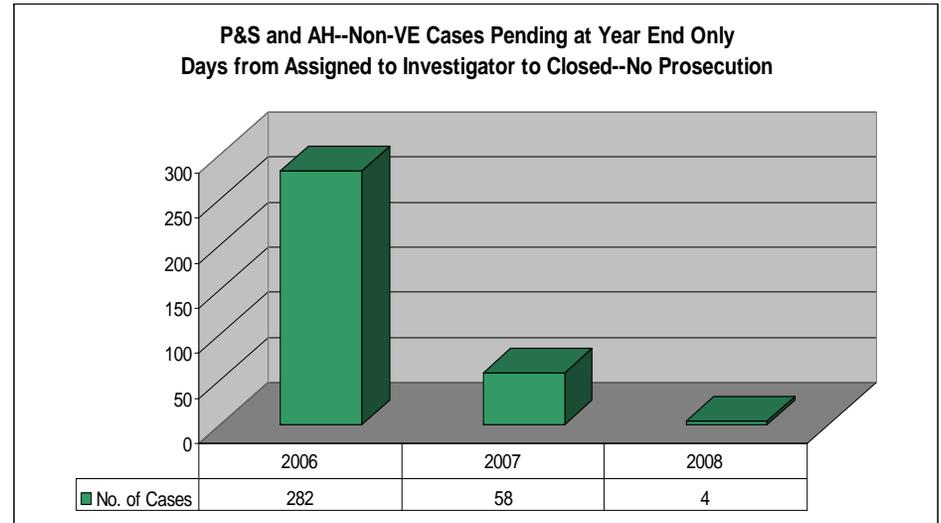
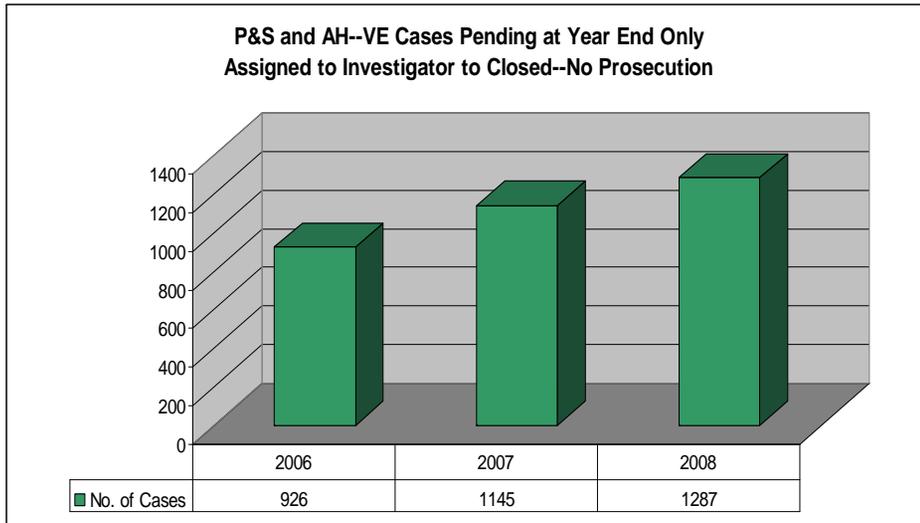
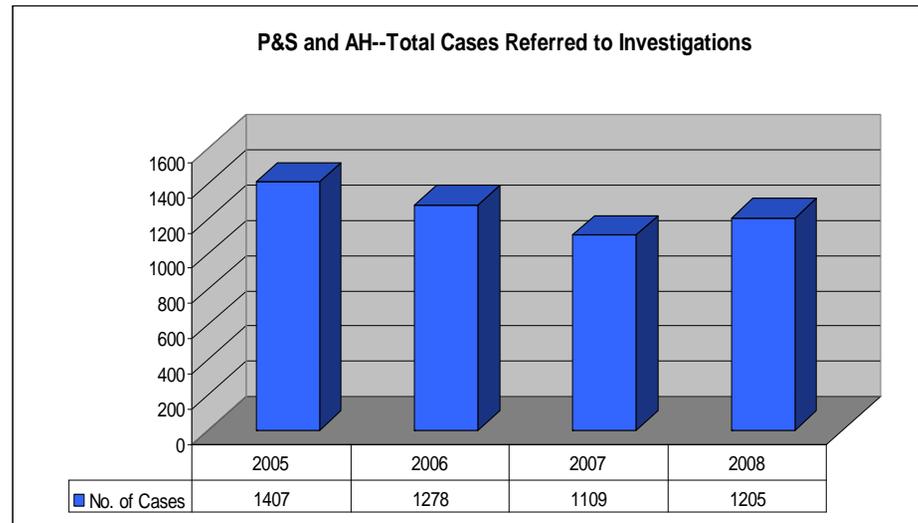


Chart 7.1g – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons and Allied Health Cases — Total Cases Referred to Investigations



CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO CASE CLOSED, NO PROSECUTION — PHYSICIANS AND SURGEONS

Table 7.2 below reports the average and median calendar days aged from case assigned to case closed with no prosecution for Physicians and Surgeons cases. Between 2005 and 2008, there was a 38.01% increase in the average days aged, a 32.94% increase in the median days aged, a 26.36% decrease in the number of such cases and a 10.85% increase in the number of such cases pending at year end. During this period, there was a 14.17% decrease in the number of such cases referred to Investigations.

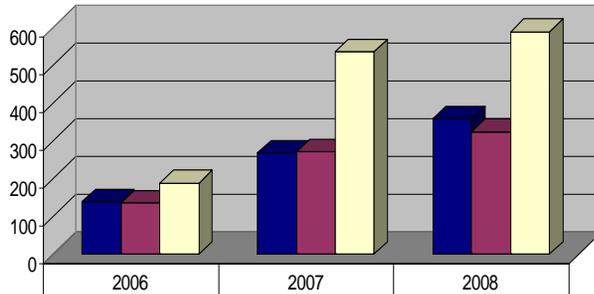
Tables 7.2 & 7.2a – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All							
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending							
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution																				
Average	10.67%	78.55%	93.53%	12.65%	31.05%	33.09%	24.67%	133.98%	157.55%	38.01%										
Median (middle record - half are above and half below)	6.64%	86.05%	101.48%	9.84%	44.50%	19.12%	17.13%	168.84%	140.00%	32.94%										
Record Count	-8.00%	0.00%	-78.86%	-79.18%	183.60%	23.83%	-5.43%	6.14%	-80.56%	-94.12%	9.70%	11.21%	-13.00%	6.14%	-95.89%	-98.78%	211.11%	37.71%	-26.36%	10.85%

	Per. Dif. 2006 to 2007	Per. Dif. 2007 to 2008	Per. Dif. 2006 to 2008	Per. Dif. 2005 to 2008
Complaints Referred	-13.10%	7.27%	-6.78%	-14.17%

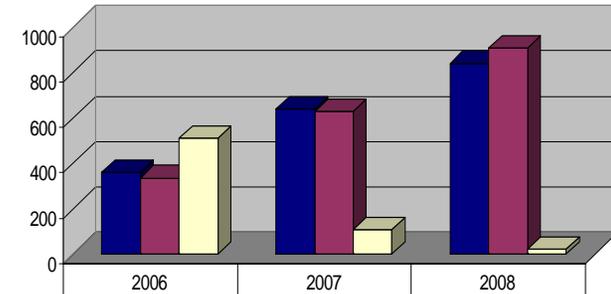
Charts 7.2a, b & c – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons Cases

Physicians and Surgeons--VE Cases Only
Days from Assigned to Investigator to Closed--No Prosecution



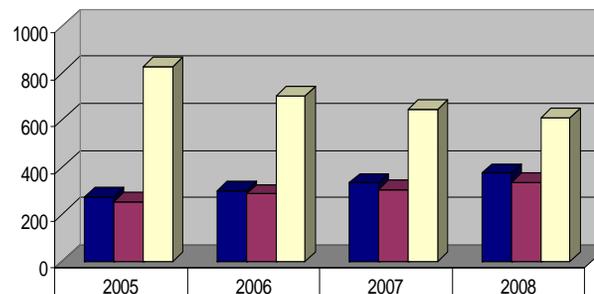
	2006	2007	2008
Average No. of Days	139	269	358
Median No. of Days	135	272	324
No. of Cases	189	536	588

Physicians and Surgeons--VE Cases Only
Days from Assigned to Investigator to Closed--No Prosecution



	2006	2007	2008
Average No. of Days	359	641	840
Median No. of Days	337	627	906
No. of Cases	511	108	21

Physicians and Surgeons--Total Cases
Days from Assigned to Investigator to Closed--No Prosecution



	2005	2006	2007	2008
Average No. of Days	271	300	332	374
Median No. of Days	252	286	305	335
No. of Cases	827	700	644	609

Charts 7.2d, e & f – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons Cases — Cases Pending at Year End

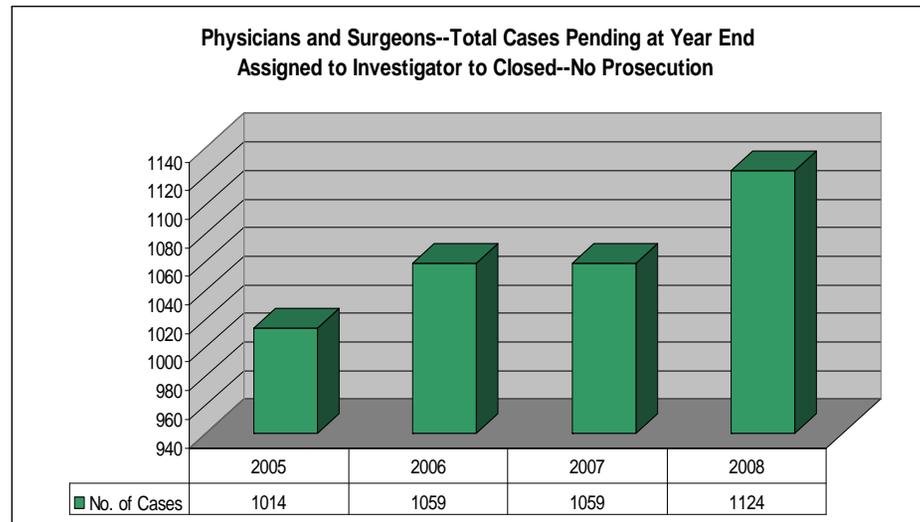
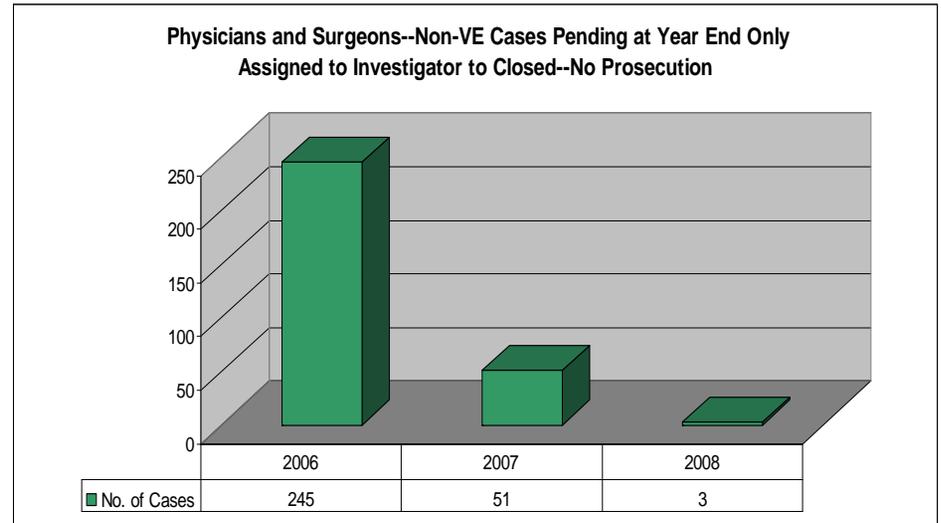
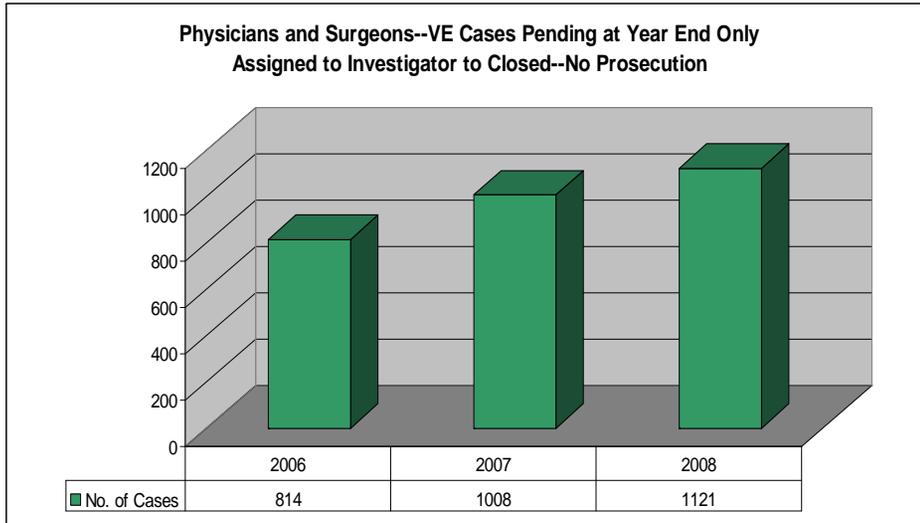
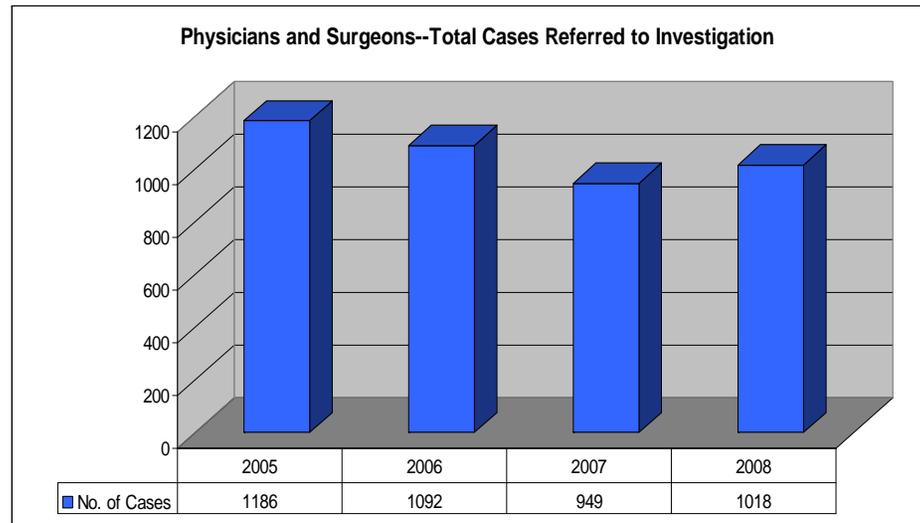


Chart 7.2g – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons Cases — Total Cases Referred to Investigations



CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO CASE CLOSED, NO PROSECUTION — ALLIED HEALTH

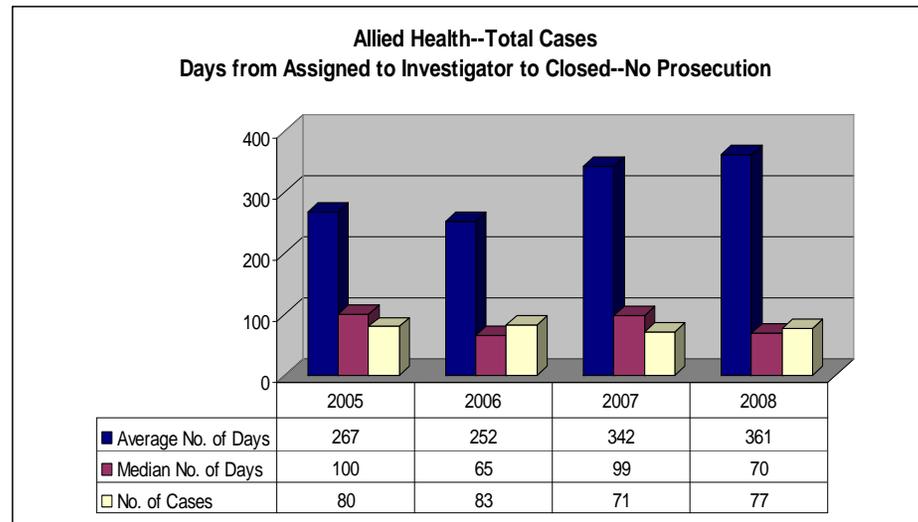
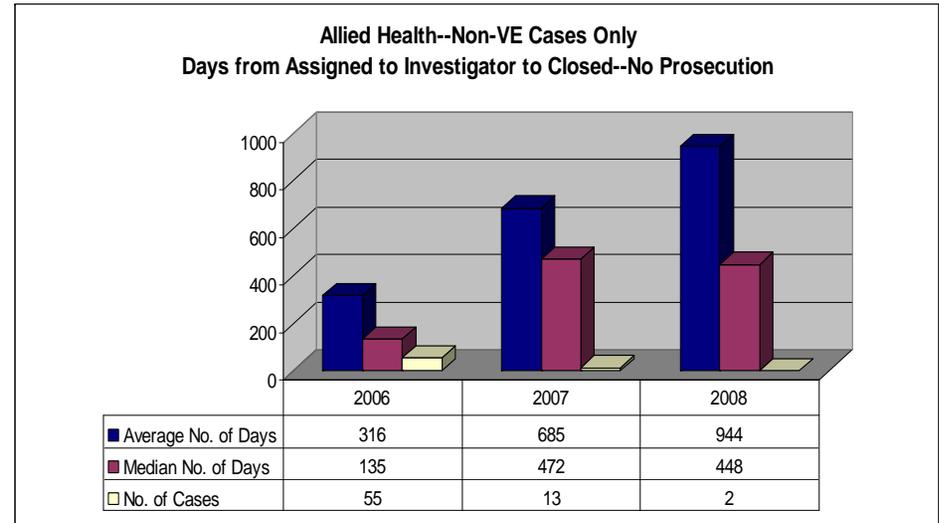
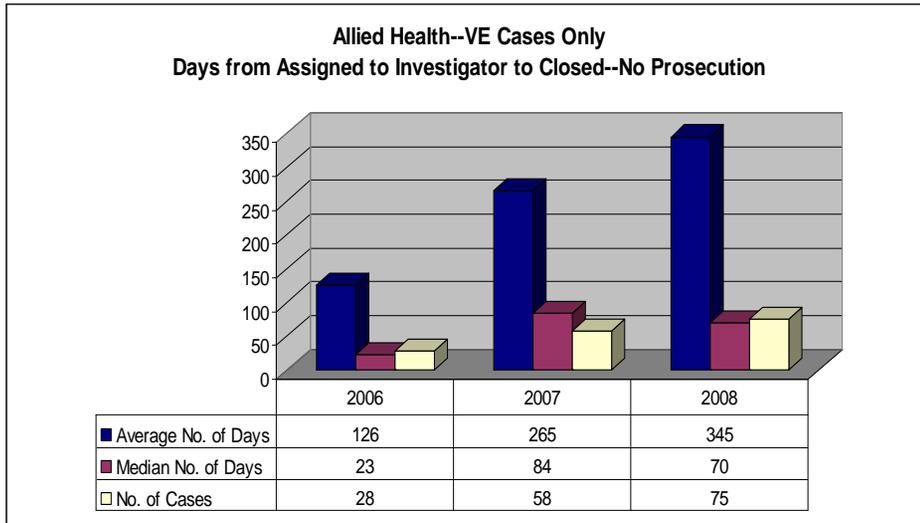
Table 7.3 below reports the average and median calendar days aged from case assigned to case closed with no prosecution for Allied Health Care cases. Between 2005 and 2008, there was a 35.21% increase in the average days aged, a 30.00% decrease in the median days aged, a 3.75% decrease in the number of such cases and an 18.57% increase in the number of cases pending at year end. During this period, there was a 15.38% decrease in the number of cases referred to Investigations.

Tables 7.3 & 7.3a – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage Difference 2005 to 2008	
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All	
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution																				
Average	35.71%	116.77%	110.32%	5.56%	37.81%	30.19%	43.25%	198.73%	173.81%	35.21%										
Median (middle record - half are above and half below)	52.31%	249.63%	265.22%	-29.29%	-5.08%	-16.67%	7.69%	231.85%	204.35%	-30.00%										
Record Count	-14.46%	-3.36%	-76.36%	-81.08%	107.14%	22.32%	8.45%	15.28%	-84.62%	-85.71%	29.31%	20.44%	-7.23%	11.41%	-96.36%	-97.30%	167.86%	47.32%	-3.75%	18.57%

	Per. Dif. 2006 to 2007	Per. Dif. 2007 to 2008	Per. Dif. 2006 to 2008	Per. Dif. 2005 to 2008
Complaints Referred	-13.98%	16.88%	0.54%	-15.38%

Charts 7.3a, b & c – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Allied Health Cases



Charts 7.3d, e & f – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Allied Health Cases — Cases Pending at Year End

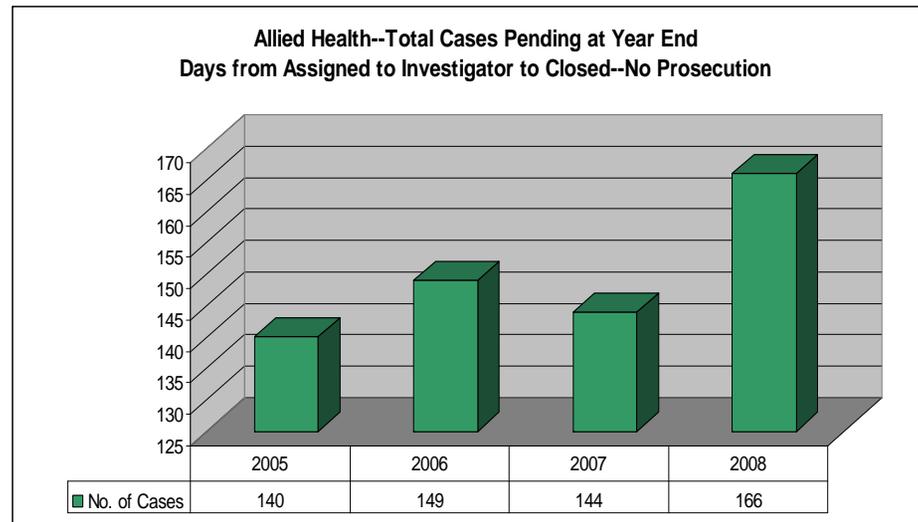
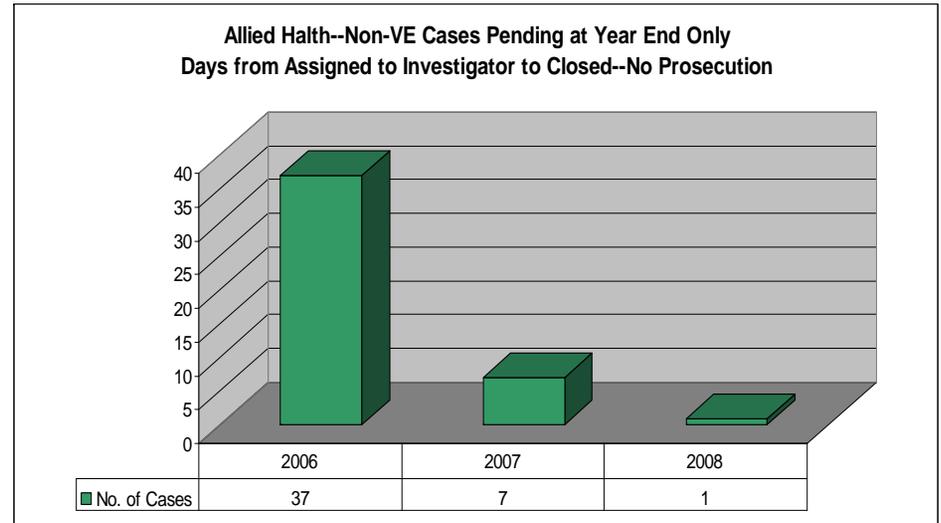
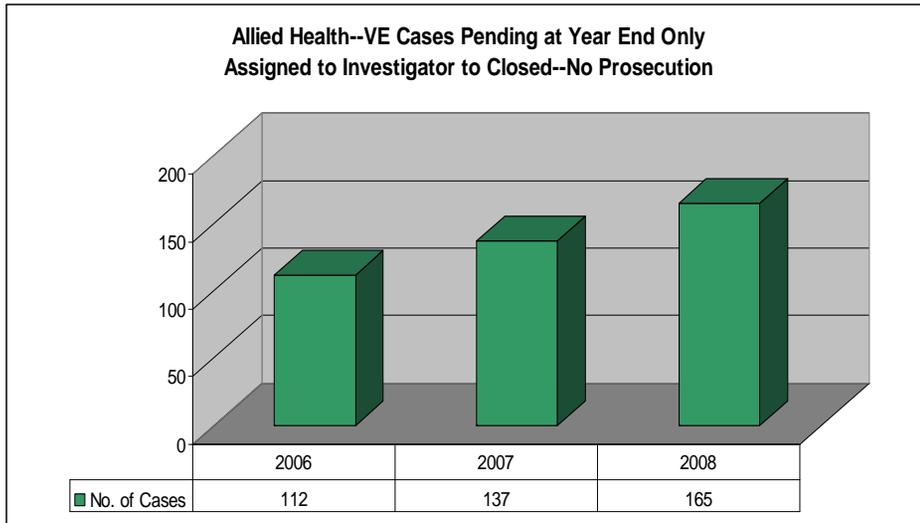
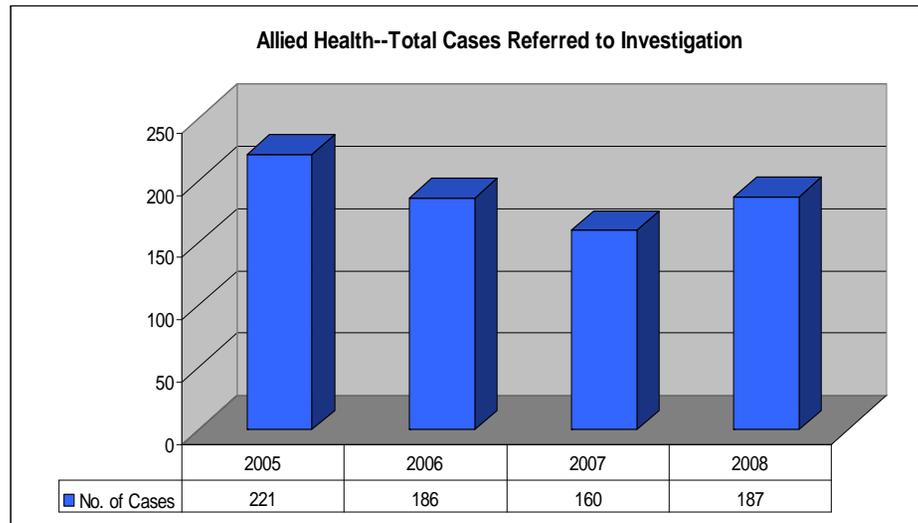


Chart 7.3g – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Allied Health Cases — Total Cases Referred to Investigations



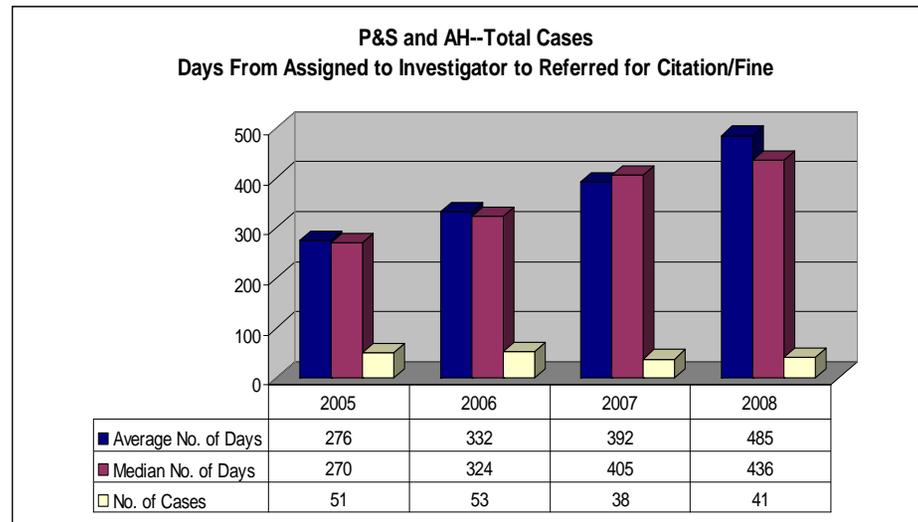
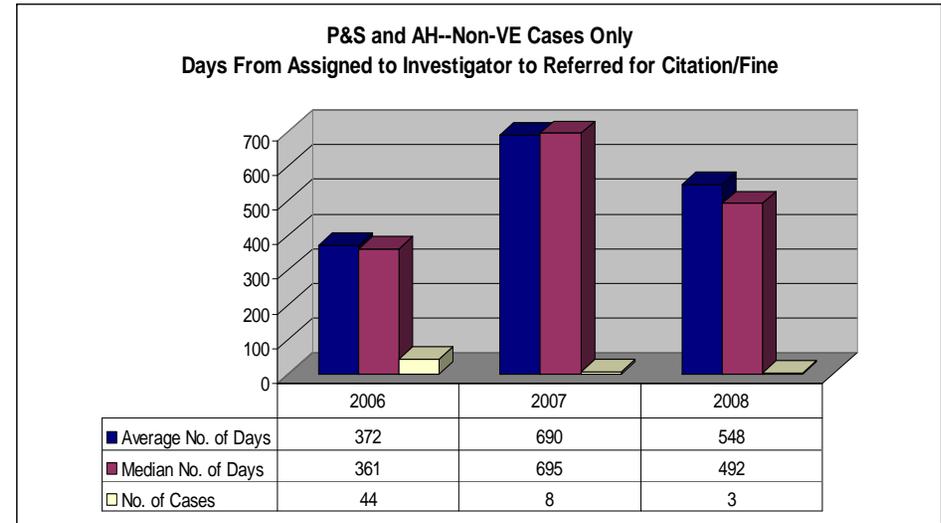
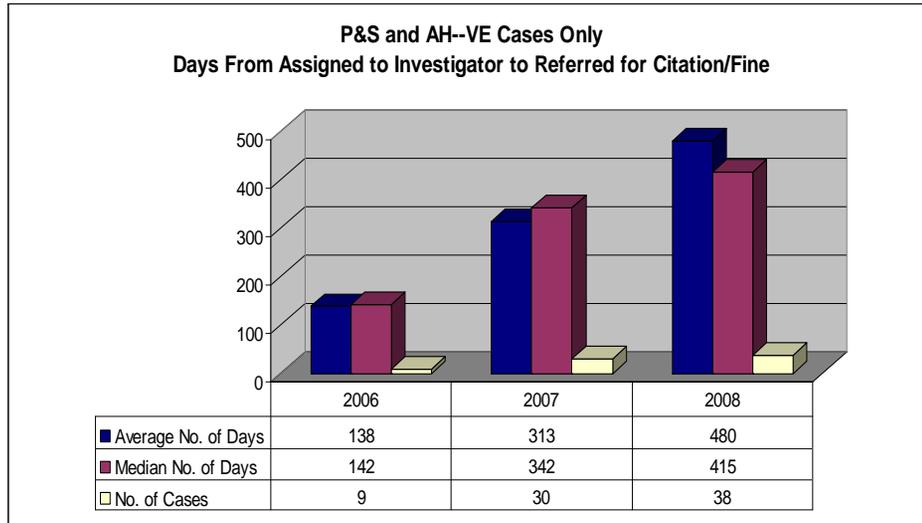
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR CITATION/FINE — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 7.4 below reports the average and median calendar days aged from case assigned to investigator to referral for citation/fine for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 75.72% increase in the average days aged, a 61.48% increase in the median days aged, and a 19.61% decrease in the number of such cases.

Table 7.4 – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008							
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All							
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending							
Calendar Day Age from Investigation Assigned to Referral for Citation/Fine																	
Average	18.07%	85.48%	126.81%	23.72%	-20.58%	53.35%	46.08%	47.31%	247.83%	75.72%							
Median (middle record - half are above and half below)	25.00%	92.52%	140.85%	7.65%	-29.21%	21.35%	34.57%	36.29%	192.25%	61.48%							
Record Count	-28.30%	-81.82%	233.33%	7.89%	-62.50%	26.67%	-22.64%	-93.18%	322.22%	-19.61%							

Charts 7.4a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for Physicians and Surgeons and Allied Health Cases



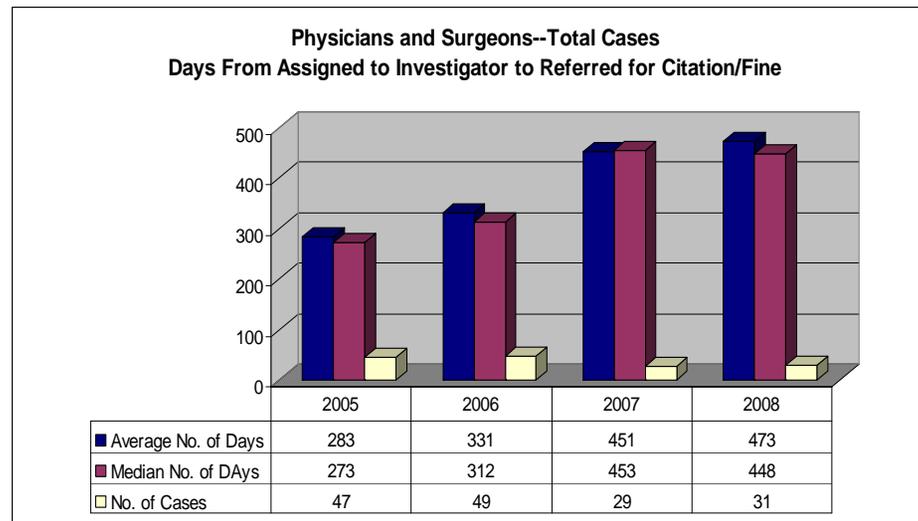
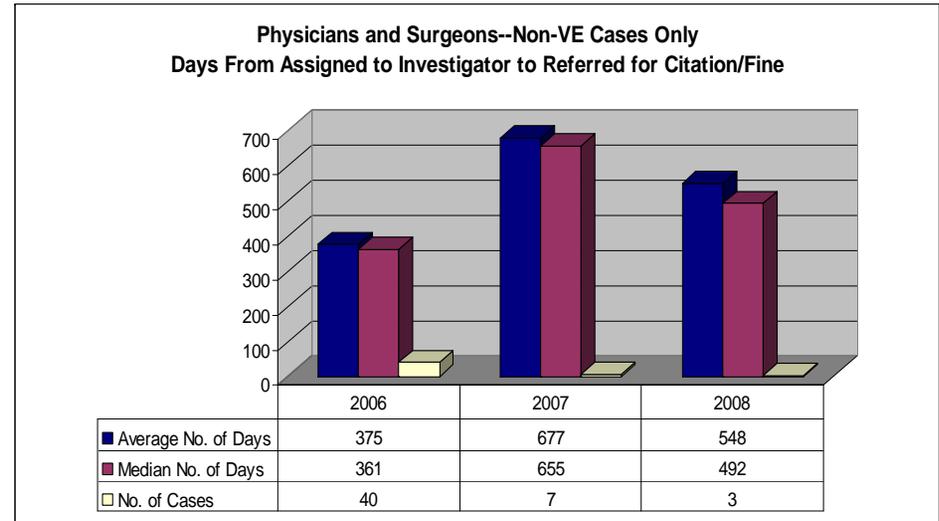
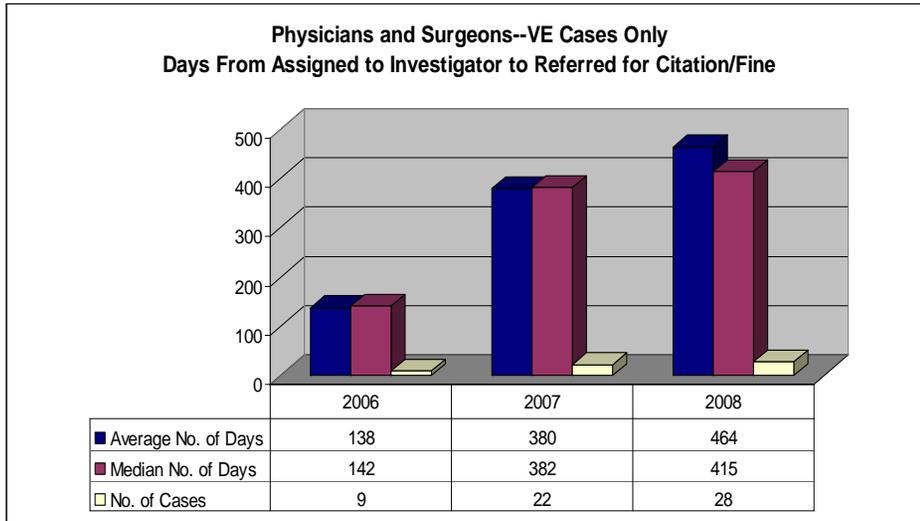
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR CITATION/FINE — PHYSICIANS AND SURGEONS

Table 7.5 below reports the average and median calendar days aged from case assigned to investigator to referral for citation/fine for Physicians and Surgeons cases. Between 2005 and 2008, there was a 67.14% increase in the average days aged, a 64.10% increase in the median days aged, and a 34.04% decrease in the number of such cases.

Table 7.5 – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008		
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All		
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending		
Calendar Day Age from Investigation Assigned to Referral for Citation/Fine												
Average	36.25%	80.53%	175.36%	4.88%	-19.05%	22.11%	42.90%	46.13%	236.23%	67.14%		
Median (middle record - half are above and half below)	45.19%	81.44%	169.01%	-1.10%	-24.89%	8.64%	43.59%	36.29%	192.25%	64.10%		
Record Count	-40.82%	-82.50%	144.44%	6.90%	-57.14%	27.27%	-36.73%	-92.50%	211.11%	-34.04%		

Charts 7.5a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for Physicians and Surgeons Cases



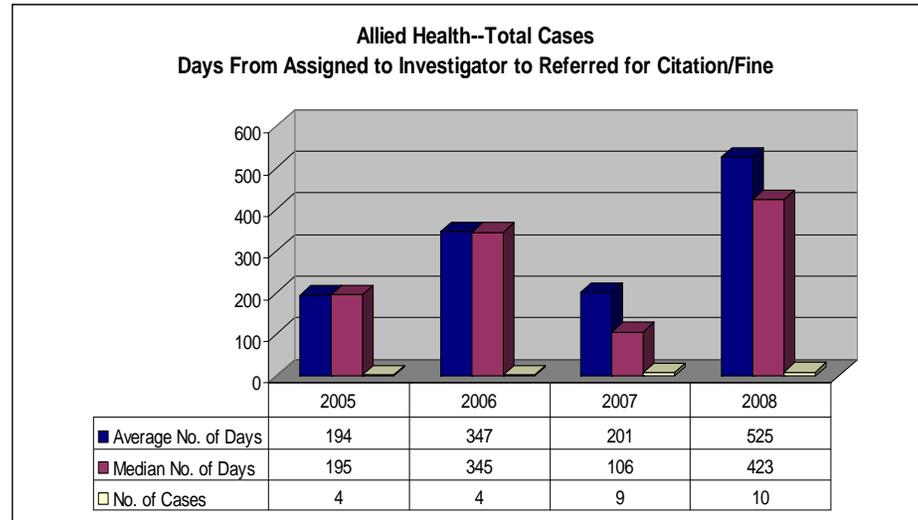
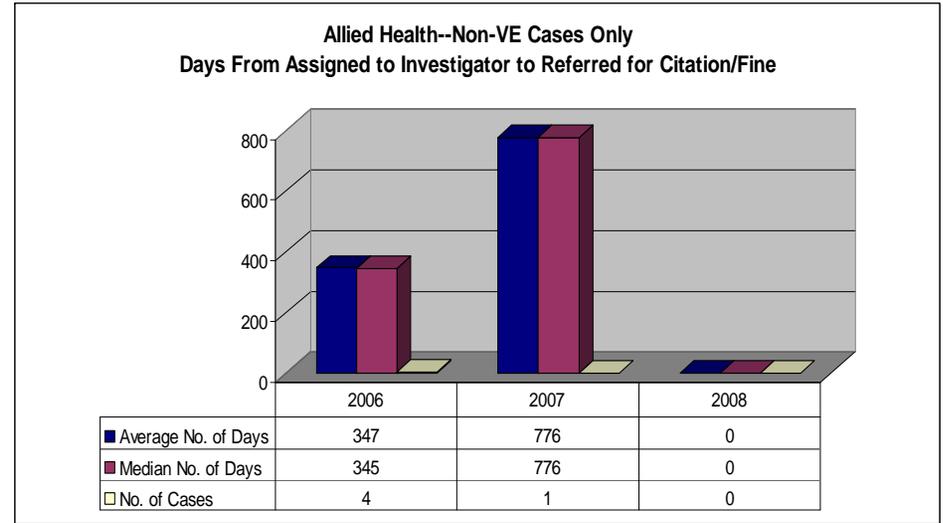
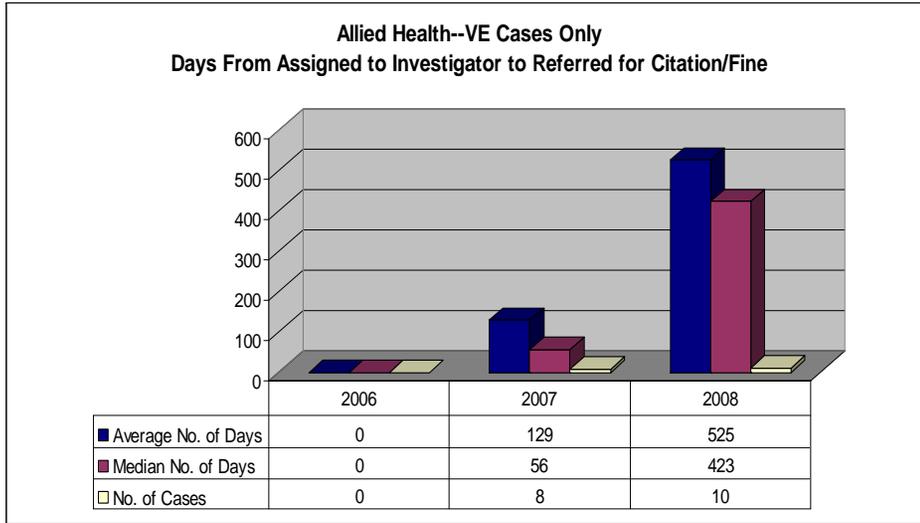
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR CITATION/FINE — ALLIED HEALTH

Table 7.6 below reports the average and median calendar days aged from case assigned to investigator to referral for citation/fine for Allied Health Care cases. Between 2005 and 2008, there was a 170.62% increase in the average days aged, a 116.92% increase in the median days aged, and a 150.00% decrease in the number of such cases.

Table 7.6 – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for and Allied Health Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008									
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All									
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending									
Calendar Day Age from Investigation Assigned to Referral for Citation/Fine																			
Average	-42.07%	123.63%		161.19%	-100.00%	306.98%	51.30%	-100.00%		170.62%									
Median (middle record - half are above and half below)	-69.28%	124.93%		299.06%	-100.00%	655.36%	22.61%	-100.00%		116.92%									
Record Count	125.00%	-75.00%		11.11%	-100.00%	25.00%	150.00%	-100.00%		150.00%									

Charts 7.6a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for Allied Health Cases



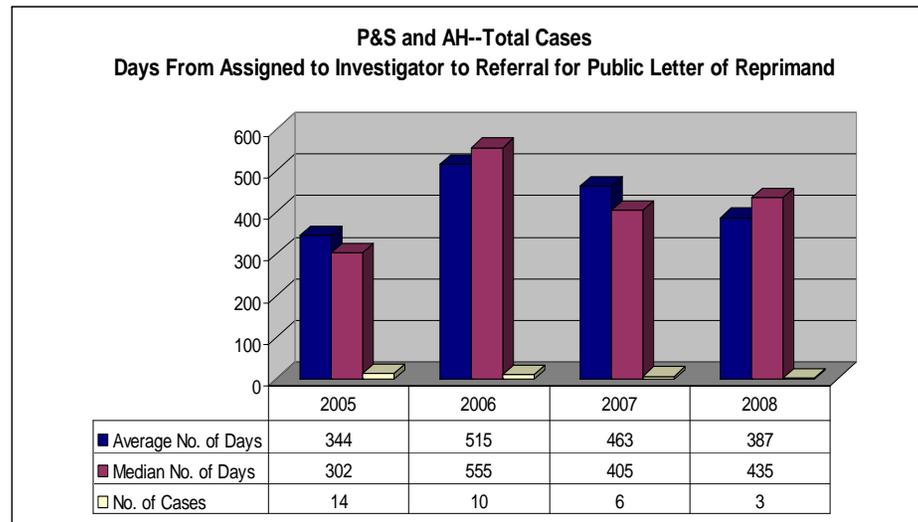
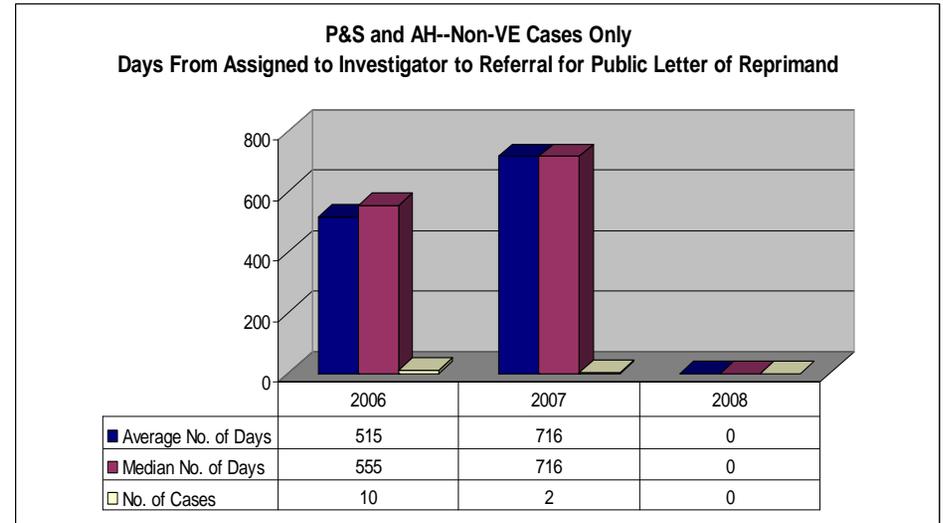
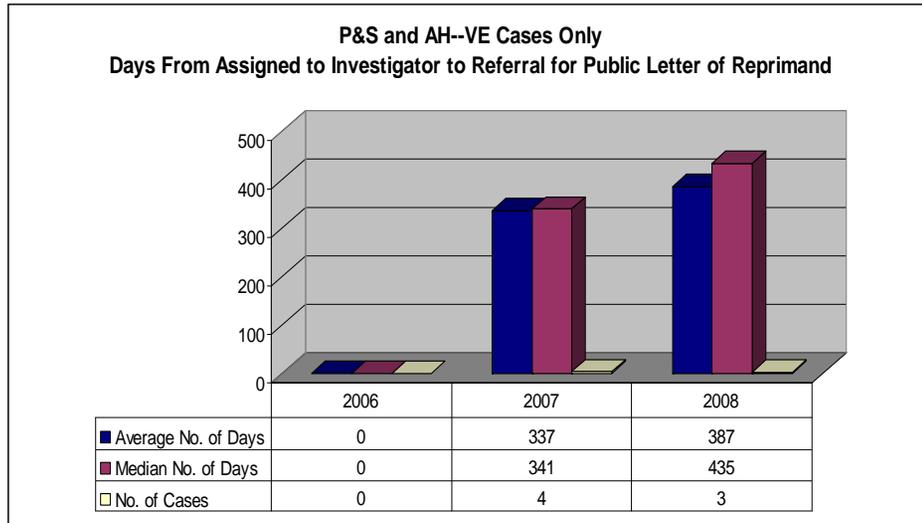
**CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR PUBLIC LETTER OF REPRIMAND
— PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED**

Table 7.7 below reports the average and median calendar days aged from case assigned to investigator to referral for public letter of reprimand for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 12.50% increase in the average days aged, a 44.04% increase in the median days aged, and a 78.57% decrease in the number of such cases.

Table 7.7 – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008	
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Investigation Assigned to Referral for Public Letter of Reprimand																	
Average	-10.10%	39.03%					-16.41%	-100.00%	14.84%					-24.85%	-100.00%		12.50%
Median (middle record - half are above and half below)	-27.03%	29.01%					7.41%	-100.00%	27.57%					-21.62%	-100.00%		44.04%
Record Count	-40.00%	-80.00%					-50.00%	-100.00%	-25.00%					-70.00%	-100.00%		-78.57%

Charts 7.7a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Physicians and Surgeons and Allied Health Cases



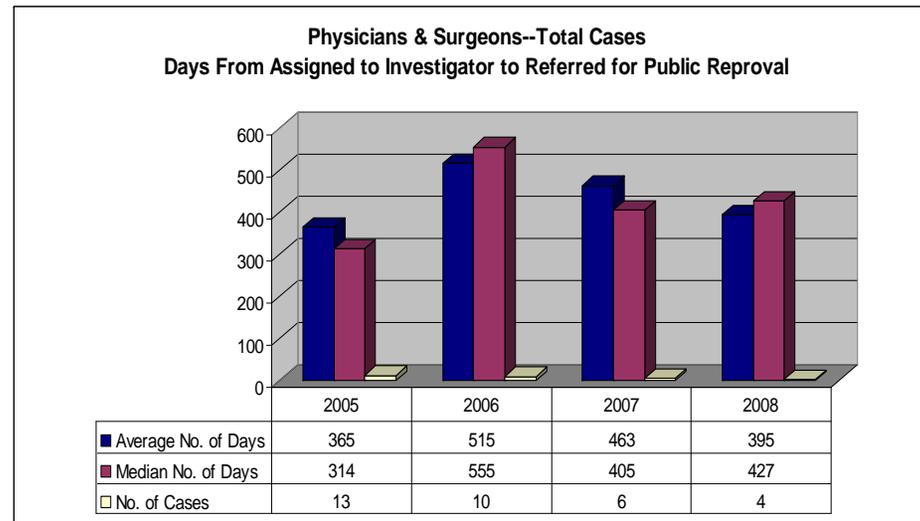
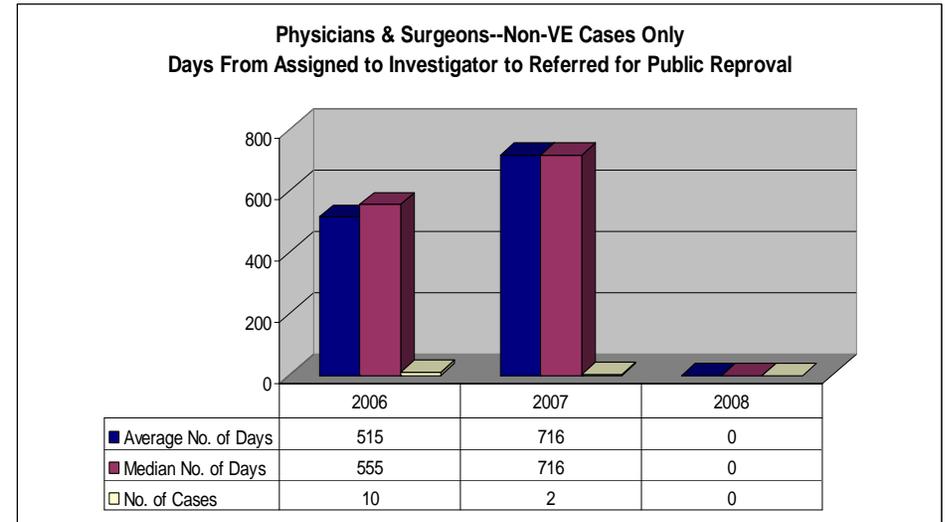
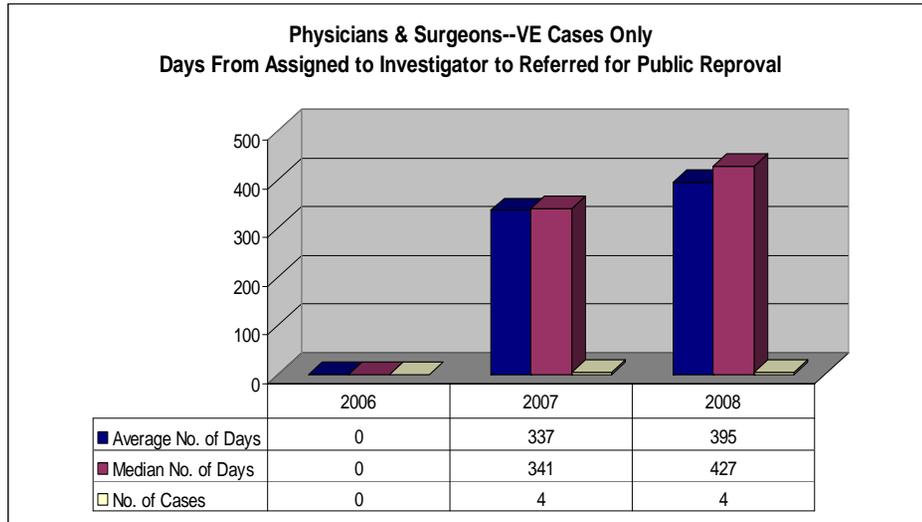
**CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR PUBLIC LETTER OF REPRIMAND
— PHYSICIANS AND SURGEONS**

Table 7.8 below reports the average and median calendar days aged from case assigned to investigator to referral for public letter of reprimand for Physicians and Surgeons cases. Between 2005 and 2008, there was an 8.22% increase in the average days aged, a 35.99% increase in the median days aged, and a 69.23% decrease in the number of such cases.

Table 7.8 – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008	
	All		Not VE		VE	All		Not VE		VE	All		Not VE	VE	All		
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending		
Calendar Day Age from Investigation Assigned to Referral for Public Letter of Reprimand																	
Average	-10.10%		39.03%				-14.69%		-100.00%		17.21%						8.22%
Median (middle record - half are above and half below)	-27.03%		29.01%				5.43%		-100.00%		25.22%						35.99%
Record Count	-40.00%		-80.00%				-33.33%		-100.00%		0.00%						-69.23%

Charts 7.8a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Physicians and Surgeons Cases



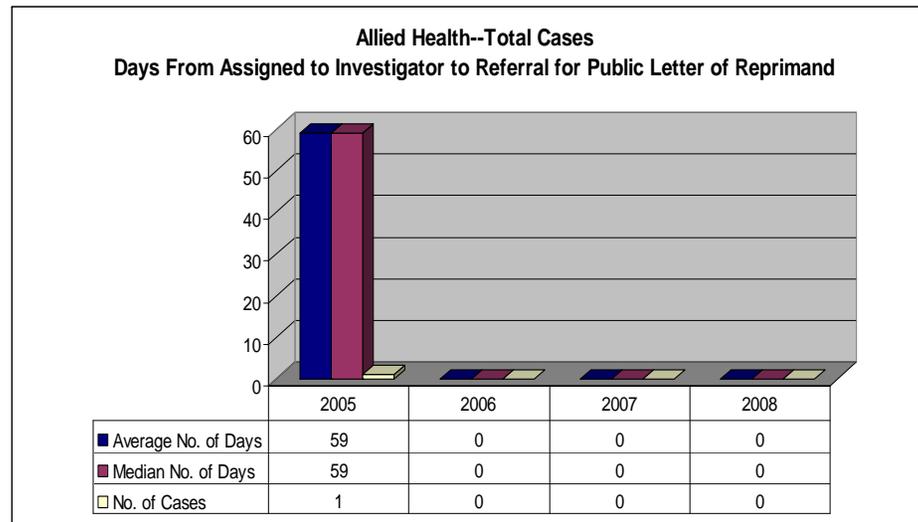
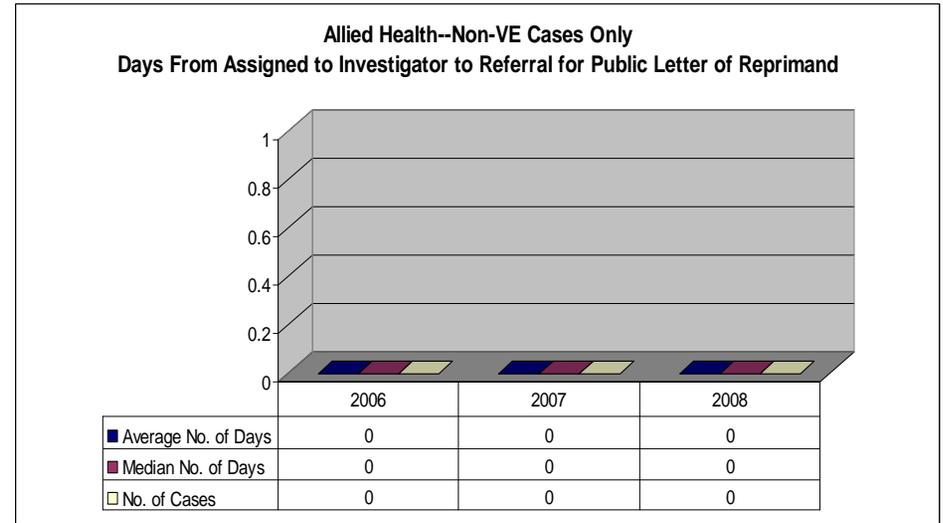
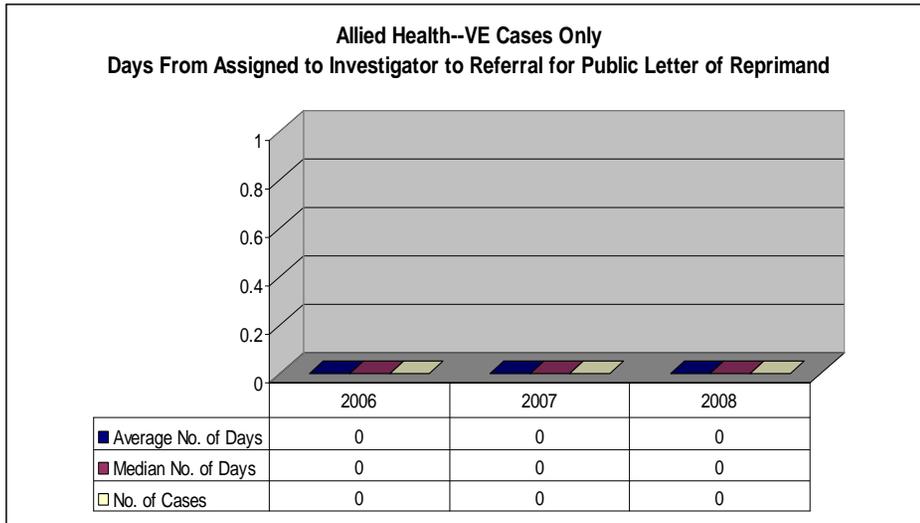
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR PUBLIC LETTER OF REPRIMAND — ALLIED HEALTH

Table 7.9 below reports the average and median calendar days aged from case assigned to investigator to referral for public letter of reprimand for Allied Health Care cases. Between 2005 and 2008, there was a 100.00% decrease in the average days aged, a 100.00% decrease in the median days aged, and a 100.00% decrease in the number of such cases (there was 1 such case in 2005 and no cases during the remainder of this period).

Table 7.9 – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Allied Health Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008						
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All						
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending						
Calendar Day Age from Investigation Assigned to Referral for Public Letter of Reprimand																
Average																-100.00%
Median (middle record - half are above and half below)																-100.00%
Record Count																-100.00%

Charts 7.9a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Allied Health Cases



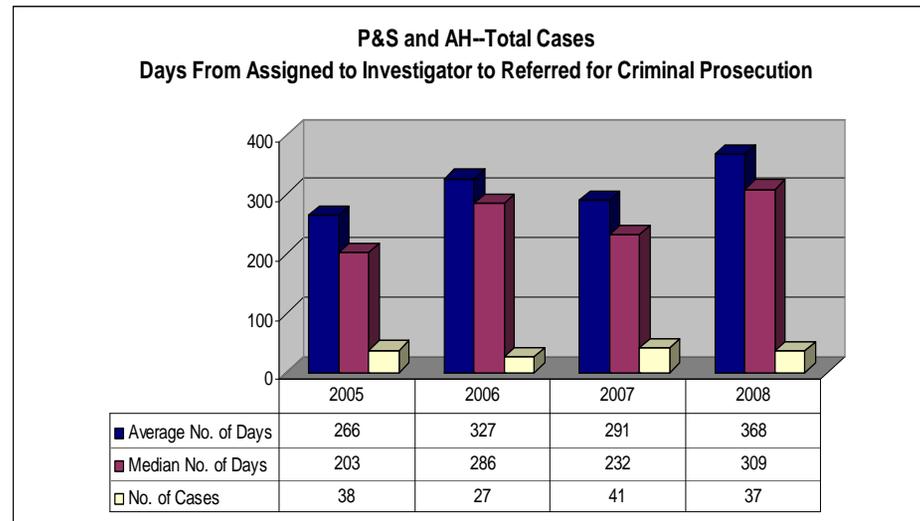
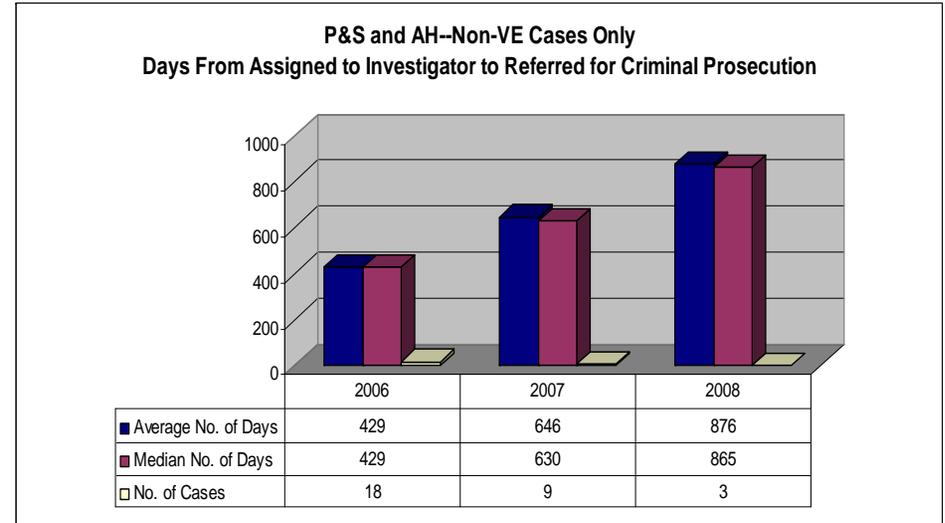
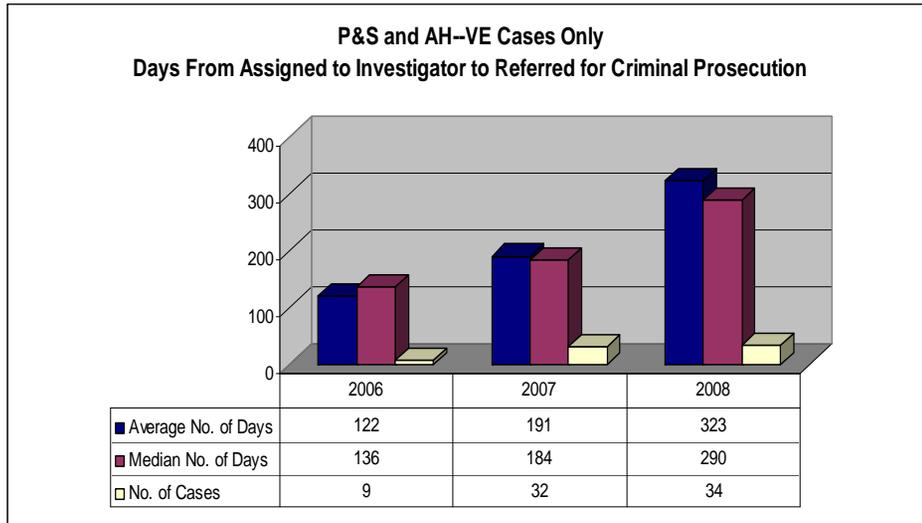
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR CRIMINAL ACTION — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 7.10 below reports the average and median calendar days aged from case assigned to investigator to referral for criminal action for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 38.35% increase in the average days aged, a 52.22% increase in the median days aged, and a 2.63% decrease in the number of such cases.

Table 7.10 – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008			
	All	Not VE		VE		All	Not VE		VE		All	Not VE		VE		All			
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending			
Calendar Day Age from Investigation Assigned to Referral for Criminal Action																			
Average	-11.01%		50.58%		56.56%		26.46%		35.60%		69.11%		12.54%		104.20%		164.75%		38.35%
Median (middle record - half are above and half below)	-18.88%		46.85%		35.29%		33.19%		37.30%		57.61%		8.04%		101.63%		113.24%		52.22%
Record Count	51.85%		-50.00%		255.56%		-9.76%		-66.67%		6.25%		37.04%		-83.33%		277.78%		-2.63%

Charts 7.10a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Physicians and Surgeons Cases and Allied Health Cases



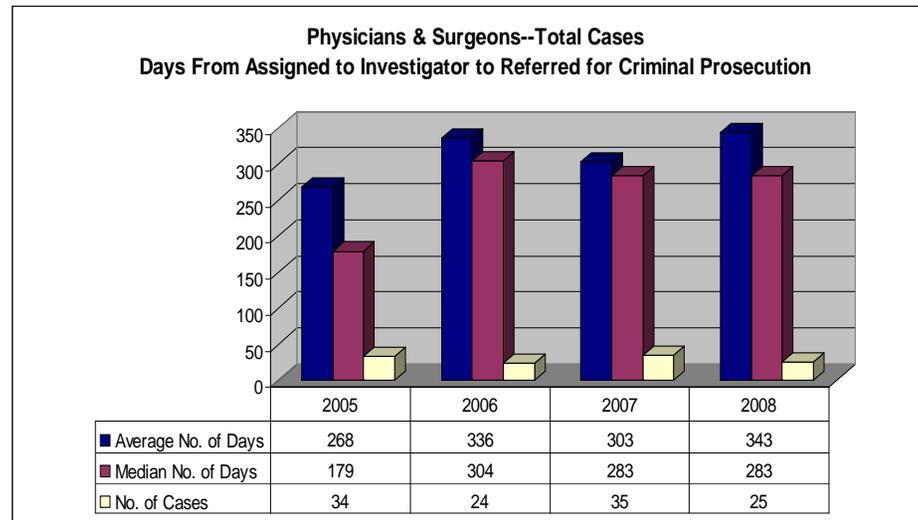
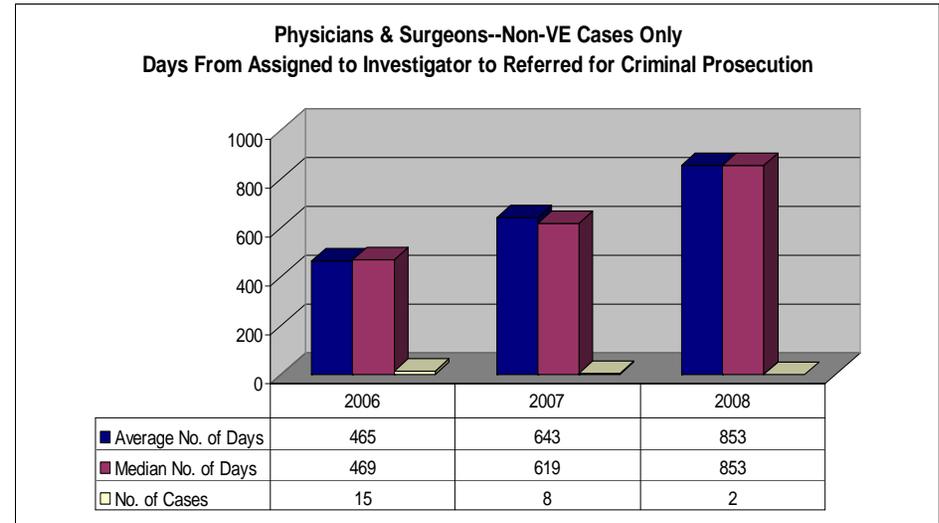
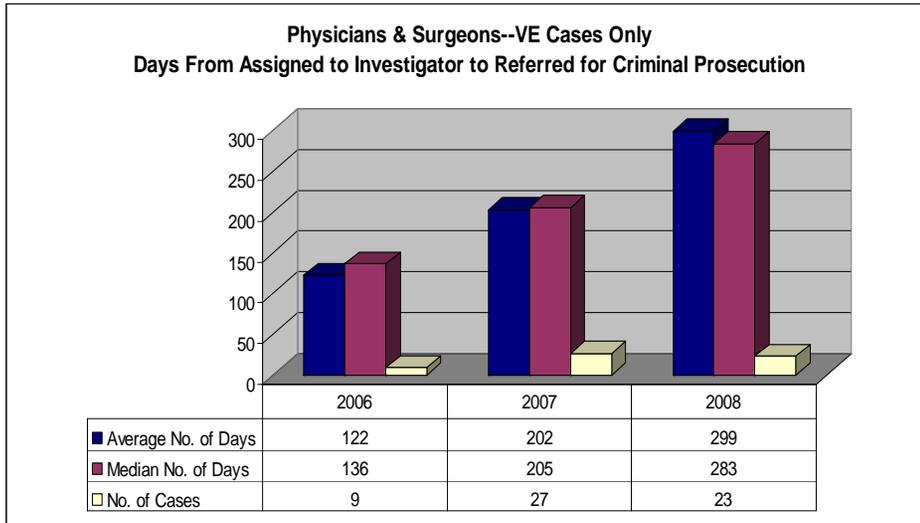
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR CRIMINAL ACTION — PHYSICIANS AND SURGEONS

Table 7.11 below reports the average and median calendar days aged from case assigned to investigator to referral for criminal action for Physicians and Surgeons cases. Between 2005 and 2008, there was a 27.99% increase in the average days aged, a 58.10% increase in the median days aged, and a 26.47% decrease in the number of such cases.

Table 7.11 – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008								
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All								
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending								
Calendar Day Age from Investigation Assigned to Referral for Criminal Action																		
Average	-9.82%	38.28%	65.57%	13.20%	32.66%	48.02%	2.08%	83.44%	145.08%	27.99%								
Median (middle record - half are above and half below)	-6.91%	31.98%	50.74%	0.00%	37.80%	38.05%	-6.91%	81.88%	108.09%	58.10%								
Record Count	45.83%	-46.67%	200.00%	-28.57%	-75.00%	-14.81%	4.17%	-86.67%	155.56%	-26.47%								

Charts 7.11a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Physicians and Surgeons Cases



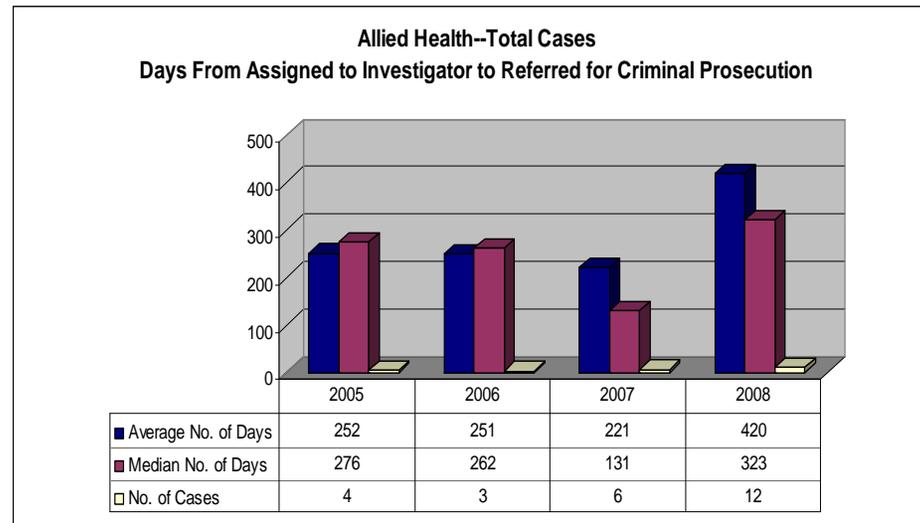
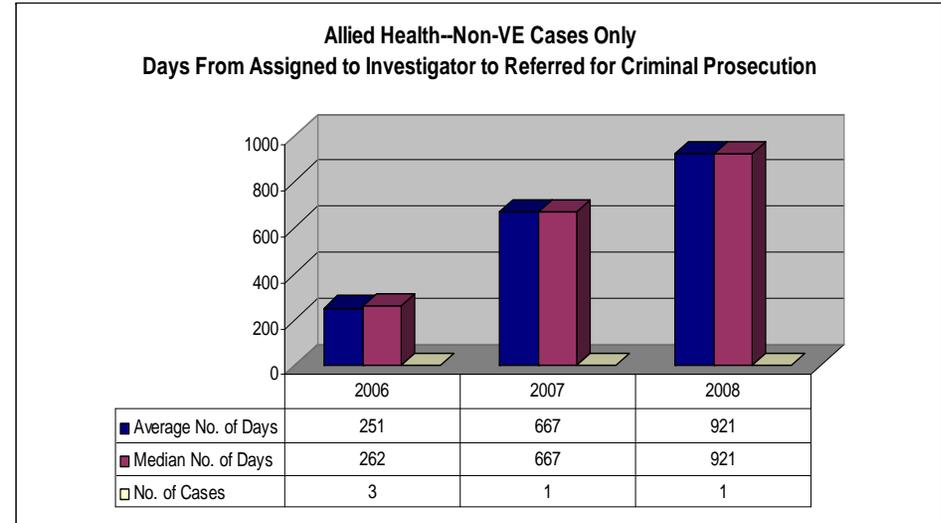
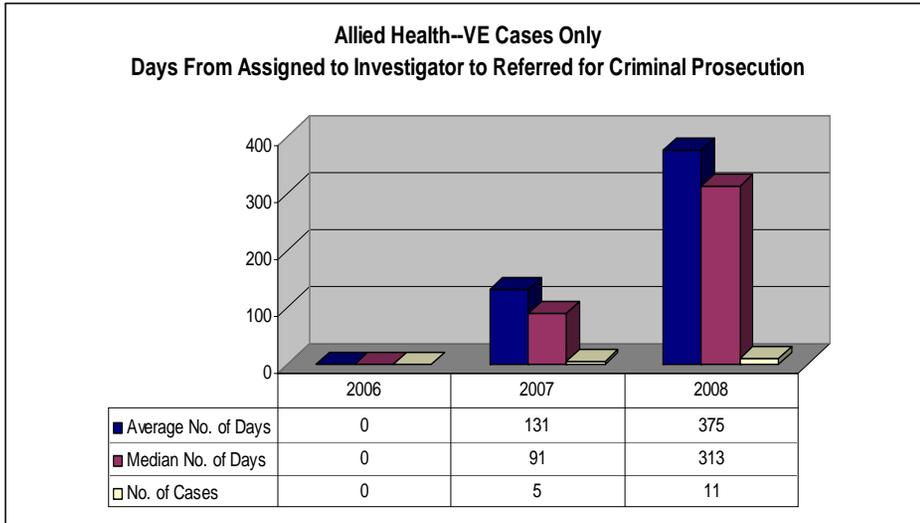
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO REFERRAL FOR CRIMINAL ACTION — ALLIED HEALTH

Table 7.12 below reports the average and median calendar days aged from case assigned to investigator to referral for criminal action for Allied Health Care cases. Between 2005 and 2008, there was a 66.67% increase in the average days aged, a 17.03% increase in the median days aged, and a 200.00% increase in the number of such cases.

Table 7.12 – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008	
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Investigation Assigned to Referral for Criminal Action																	
Average	-11.95%		165.74%				90.05%		38.08%		186.26%		67.33%		266.93%		66.67%
Median (middle record - half are above and half below)	-50.00%		154.58%				146.56%		38.08%		243.96%		23.28%		251.53%		17.03%
Record Count	100.00%		-66.67%				100.00%		0.00%		120.00%		300.00%		-66.67%		200.00%

Charts 7.12a, b & c – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Allied Health Cases



VIII. SUBPOENAS

The MBC and HQES primarily issue two types of subpoenas in the investigation phase: the investigational subpoena duces tecum (SDT) to obtain confidential medical records, and the investigational subpoena to appear and testify (SAT) to require a person to appear and testify to answer questions if the person refuses to be interviewed or declines to be taped during the interview.

SUBPOENA POLICY

SDT

The SDT's are utilized to assist in obtaining medical records relevant to an investigation. The EOM Section 5.3 indicates that medical records are obtained during the course of an investigation either by a signed patient authorization(s), by an investigation SDT, or by a search warrant. Pursuant to **Joint Vertical Enforcement Guidelines (JVEG)**, First Edition, April 2008: "While the responsibility to prepare the SDT package rests with the assigned investigator, the assigned primary DAG or lead prosecutor should assist the assigned investigator in the preparation of the SDT."

Pursuant to MBC EOM Section 5.3, the process for SDT is as follows:

- An investigator shall prepare an investigational SDT, when necessary, to compel the production of documents during an investigation;
- The SDT shall contain all of the information required and submit to Sup I for approval;
- The Sup I shall, within three business days, forward the SDT to the primary, or lead, DAG for approval;
- According to the both EOM and the JVEG, the DAG should review and approve the SDT package within 5 business days;
- If the DAG wants changes, revisions or modification made to either the SDT or support declarations(s), he/she has an additional 5 business days to do so; and
- If investigator does not receive a response from the DAG with 10 business days, the investigator shall forward the SDT package to the Sup II for signature and processing.

SAT

SAT's are utilized to assist in obtaining statements from the subject, complainant or witness in an investigation.

Pursuant to MBC EOM Section 5.4, the process for SAT is as follows:

- An investigator shall submit the investigation report and the investigational SAT to the Sup I for approval;
- If approved, forwards the SAT to the Sup II for review and signature; and
- After signature, returns the SAT to the Sup I.

Data and charts relevant to the use of SDTs and SATs are contained in Chapter IX, Medical Records, and Chapter X, Interviews.

IX. MEDICAL RECORDS

Effective January 1, 2005, there is a “zero tolerance” policy for delays in the production of medical records requested pursuant to an authorization to release medical records.

MEDICAL RECORDS POLICY

Per EOM Section 6.14, if medical records are required for an investigation, the following procedure applies:

- An authorization to release medical records must be obtained by an investigator within 30 days of case assignment;
- If unable to obtain a release, investigator to notify Sup I within 3 business days;
- If SDT is required, the investigator shall draft the SDT within 7 business days;
- The investigator has 10 business days to request the medical records;
- Once served, a physician has 15 days to produce the records and a health care facility has 30 days, per B&P Code Section 2225.5;
- When the request is overdue by one business day, the investigator must call the physician/medical facility; and
- B&P Code Section 2225.5 allows MBC to issue a fine of up to \$1000 per day for noncompliance.

CALENDAR DAYS AGED FOR RECEIPT OF MEDICAL RECORDS — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 9.1 below reports the average and median calendar days aged from request based on a medical release to receipt of medical records for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 3.51% increase in the average days aged, a 3.13% decrease in the median days aged, and a 44.80% decrease in the number of such cases.

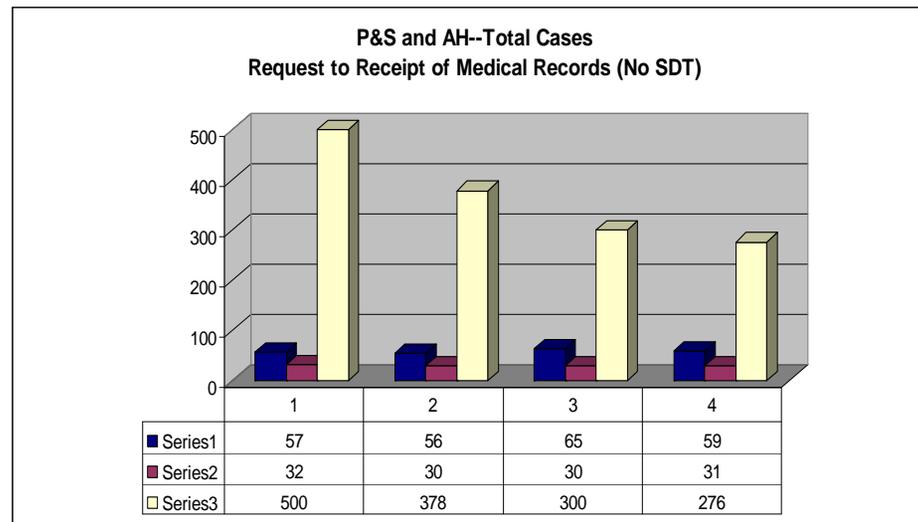
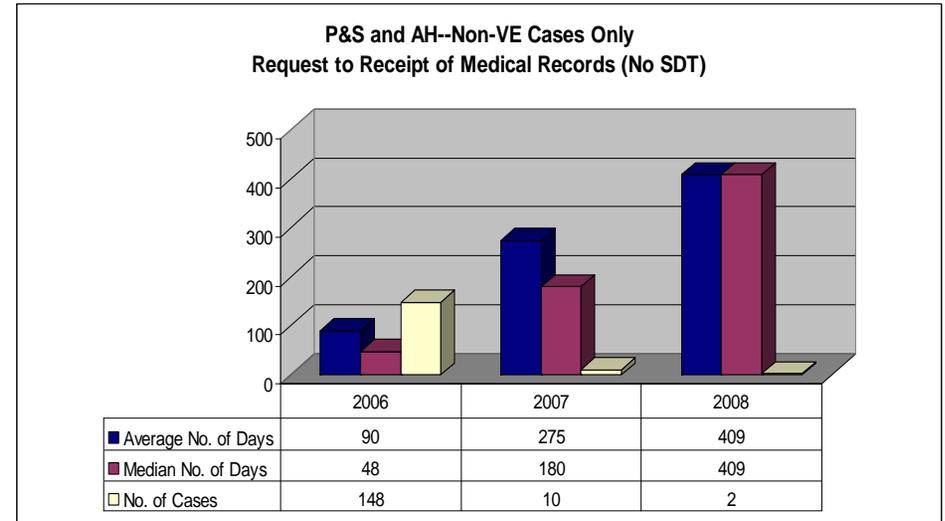
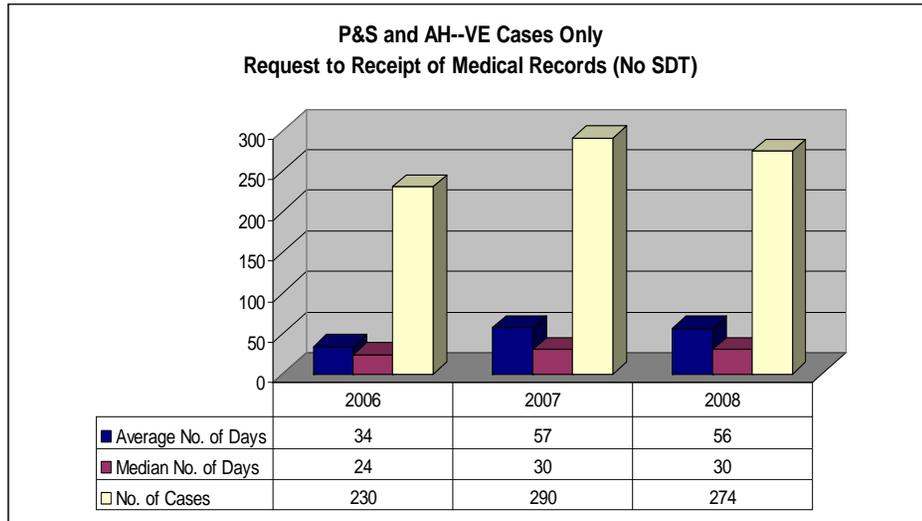
For cases in which an SDT was issued without a medical release, between 2005 and 2008 there was a 46.82% decrease in the average days aged from the date the SDT was served to receipt of the medical records, a 64.00% decrease in the median days aged, and a 2050.00% increase in the number of such cases (from 4 such cases in 2005 to 86 cases in 2008).

For cases in which both a medical release and an SDT were utilized, between 2005 and 2008 there was a 62.79% increase in the average days aged, a 30.51% decrease in the median days aged, and a 106.67% increase in the number of such cases.

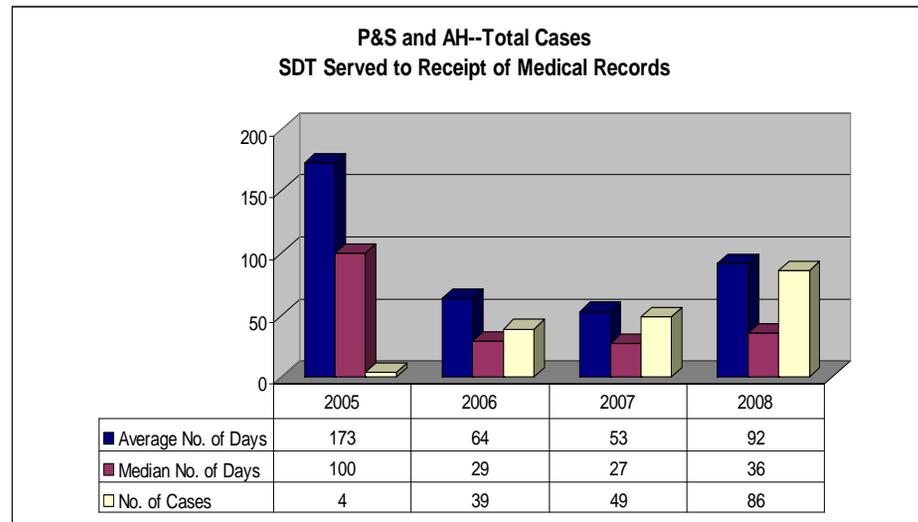
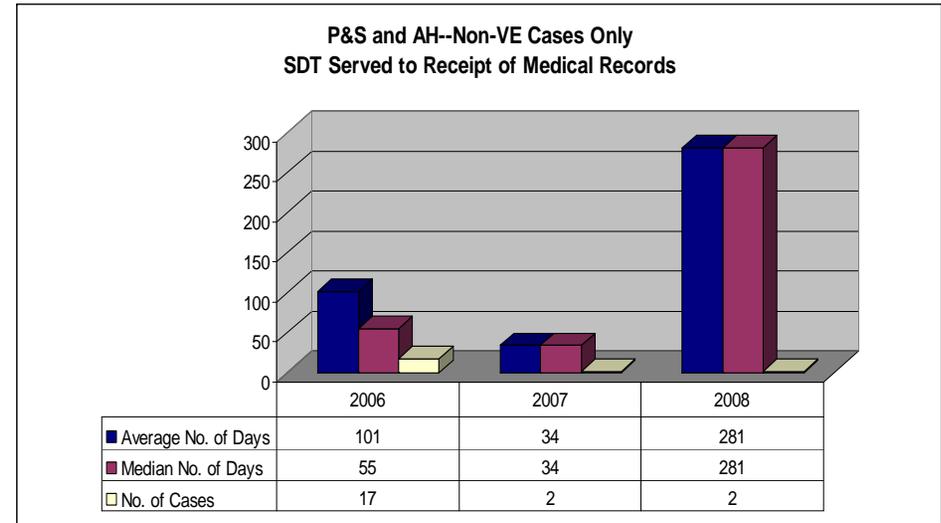
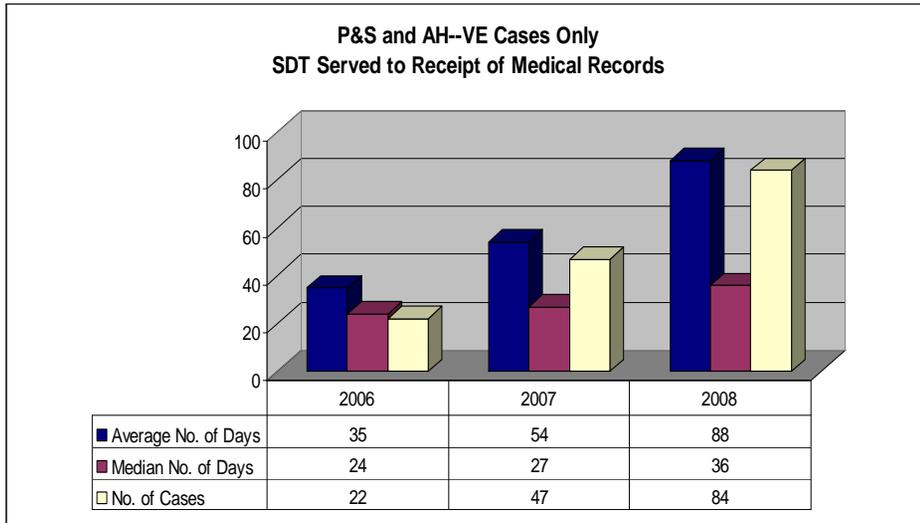
Table 9.1 – Calendar Days for Receipt of Medical Records for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference						
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All						
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending						
Calendar Day Age from Medical Release Request to Receipt of Medical Records (no SDT)																
Average	16.07%	205.56%	67.65%	-9.23%	48.73%	-1.75%	5.36%	354.44%	64.71%	3.51%						
Median (middle record - half are above and half below)	0.00%	275.00%	25.00%	3.33%	127.22%	0.00%	3.33%	752.08%	25.00%	-3.13%						
Record Count	-20.63%	-93.24%	26.09%	-8.00%	-80.00%	-5.52%	-26.98%	-98.65%	19.13%	-44.80%						
Calendar Day Age from SDT Served to Receipt of Medical Records (no Medical Release)																
Average	-17.19%	-66.34%	54.29%	73.58%	726.47%	62.96%	43.75%	178.22%	151.43%	-46.82%						
Median (middle record - half are above and half below)	-6.90%	-38.18%	12.50%	33.33%	726.47%	33.33%	24.14%	410.91%	50.00%	-64.00%						
Record Count	25.64%	-88.24%	113.64%	75.51%	0.00%	78.72%	120.51%	-88.24%	281.82%	2050.00%						
Calendar Day Age from Medical Release Request to SDT Request to Receipt of Medical Records																
Average	26.19%	97.04%	110.23%	-0.94%	84.00%	-5.95%	25.00%	262.56%	97.73%	62.79%						
Median (middle record - half are above and half below)	64.80%	117.88%	391.89%	-62.62%	123.71%	-60.99%	-38.40%	387.42%	91.89%	30.51%						
Record Count	4.35%	-81.25%	200.00%	29.17%	-33.33%	38.10%	34.78%	-87.50%	314.29%	106.67%						

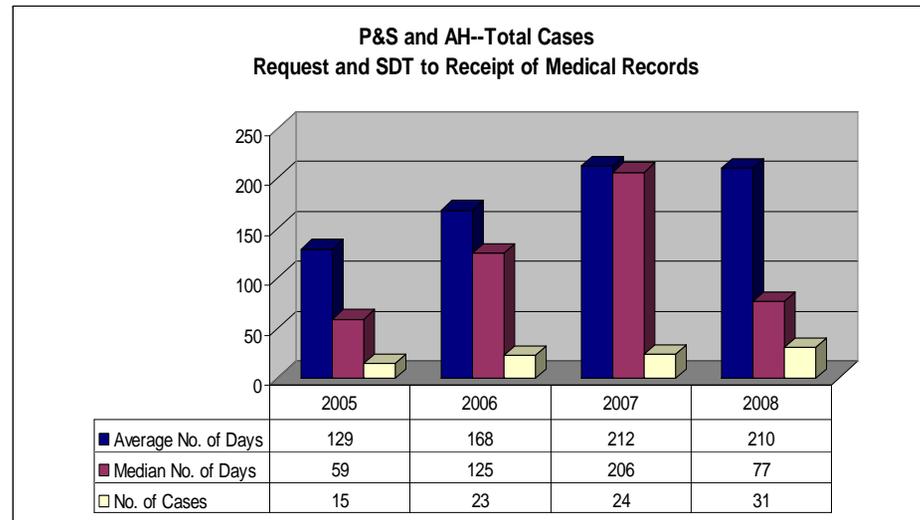
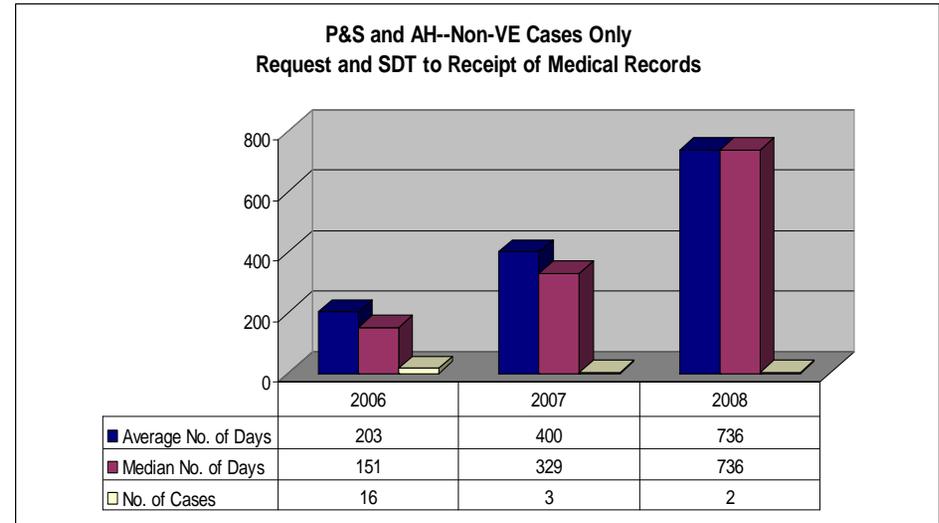
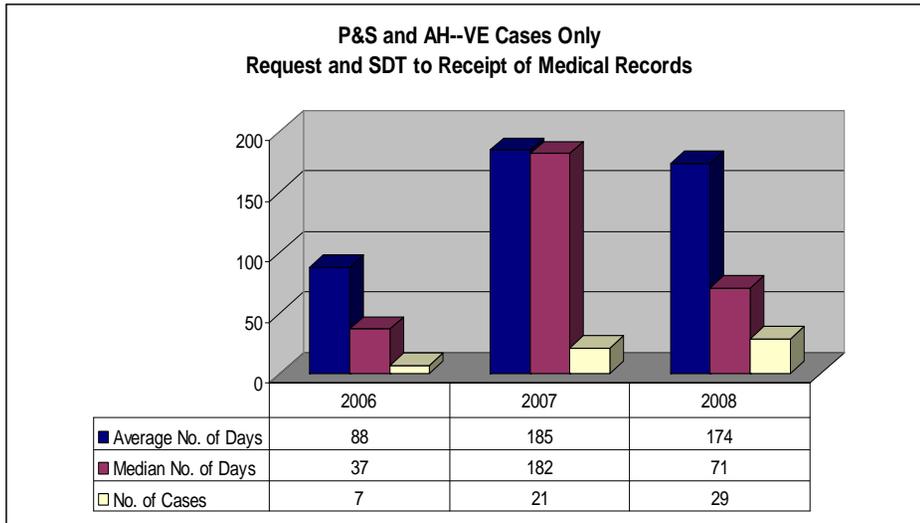
Charts 9.1a, b & c – Calendar Days Aged from Request Based on Medical Release to Receipt of Medical Records for Physicians and Surgeons and Allied Health Cases



Charts 9.1d, e & f – Calendar Days Aged from Service of SDT to Receipt of Medical Records for Physicians and Surgeons and Allied Health Cases



Charts 9.1g, h & i – Calendar Days Aged from Request Based on Medical Release through Service of SDT to Receipt of Medical Records for Physicians and Surgeons and Allied Health Cases



CALENDAR DAYS AGED FOR RECEIPT OF MEDICAL RECORDS — PHYSICIANS AND SURGEONS

Table 9.2 below reports the average and median calendar days aged from request based on a medical release to receipt of medical records for Physicians and Surgeons cases. Between 2005 and 2008, there was an 8.77% increase in the average days aged, a 3.13% decrease in the median days aged, and a 49.35% decrease in the number of such cases.

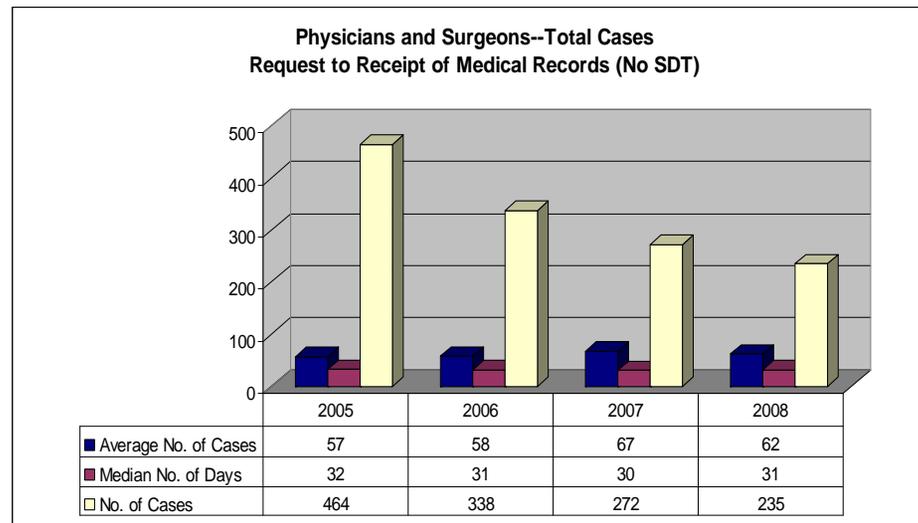
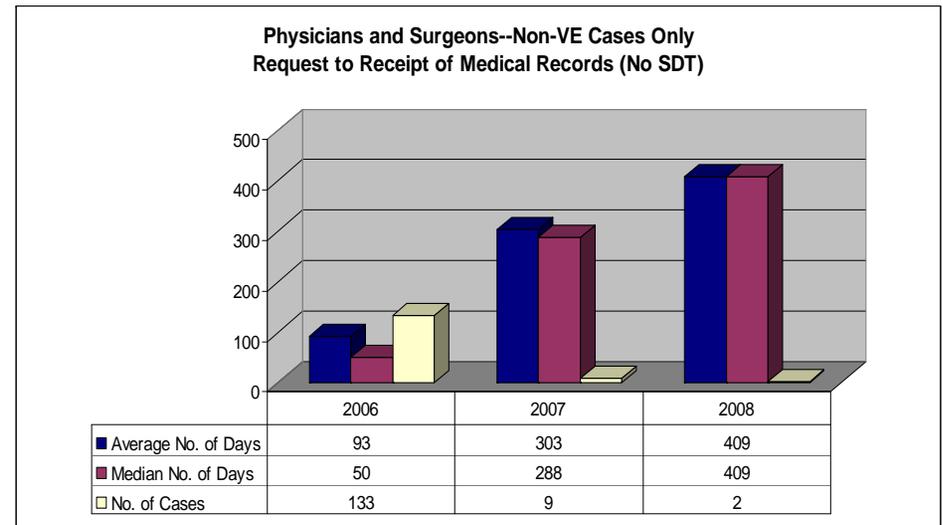
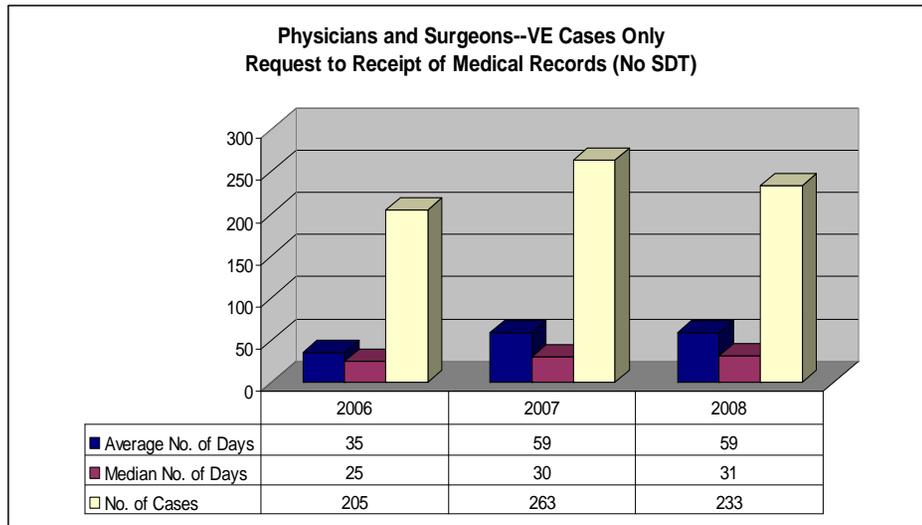
For cases in which a SDT was issued without a medical release, between 2005 and 2008 there was a 43.93% decrease in the average days aged from the date the SDT was served to receipt of the medical records, a 61.00% decrease in the median days aged, and a 1900.00% increase in the number of such cases (from 4 such cases in 2005 to 78 cases in 2008).

For cases in which both a medical release and a SDT were utilized, between 2005 and 2008 there was a 62.79% increase in the average days aged, a 30.51% decrease in the median days aged, and a 106.67% increase in the number of such cases.

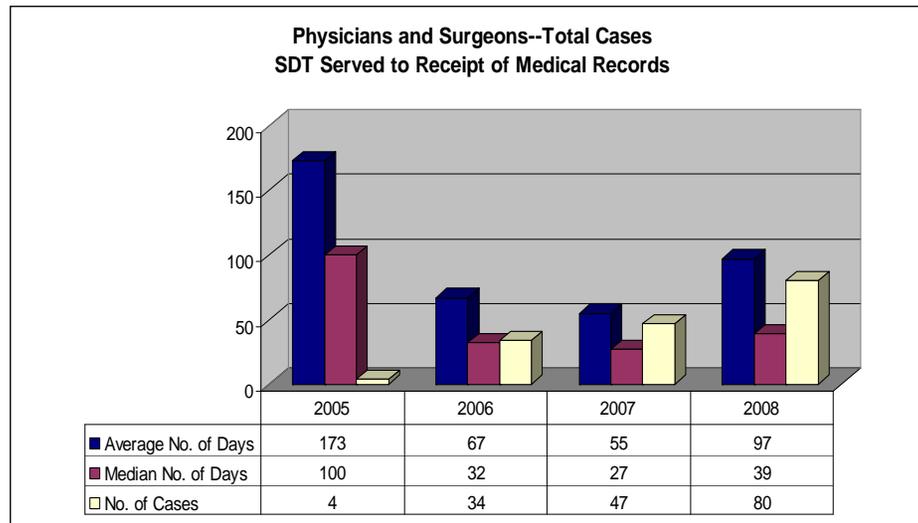
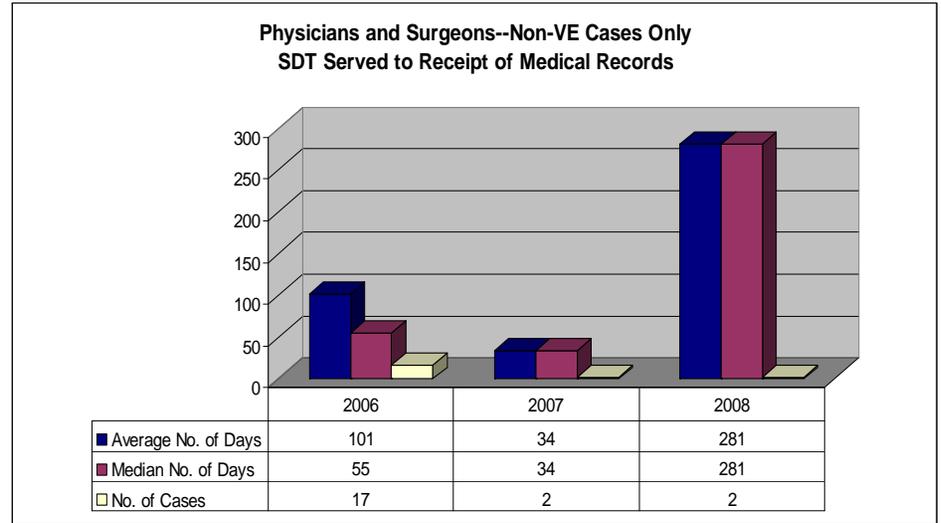
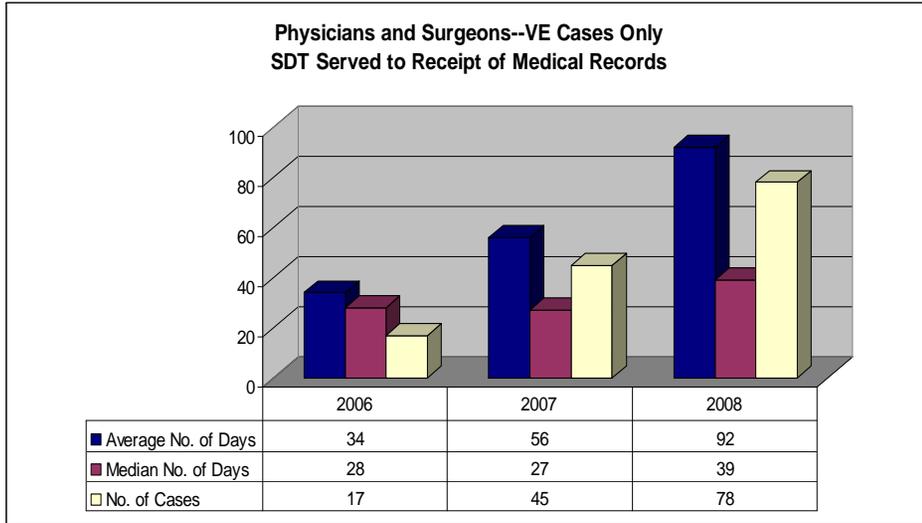
Table 9.2 – Calendar Days for Receipt of Medical Records for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008	
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All	
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	
Calendar Day Age from Medical Release Request to Receipt of Medical Records (no SDT)																	
Average	15.52%	225.81%		68.57%		-7.46%		34.98%		0.00%		6.90%		339.78%		68.57%	8.77%
Median (middle record - half are above and half below)	-3.23%	476.00%		20.00%		3.33%		42.01%		3.33%		0.00%		718.00%		24.00%	-3.13%
Record Count	-19.53%	-93.23%		28.29%		-13.60%		-77.78%		-11.41%		-30.47%		-98.50%		13.66%	-49.35%
Calendar Day Age from SDT Served to Receipt of Medical Records (no Medical Release)																	
Average	-17.91%	-66.34%		64.71%		76.36%		726.47%		64.29%		44.78%		178.22%		170.59%	-43.93%
Median (middle record - half are above and half below)	-15.63%	-38.18%		-3.57%		44.44%		726.47%		44.44%		21.88%		410.91%		39.29%	-61.00%
Record Count	38.24%	-88.24%		164.71%		70.21%		0.00%		73.33%		135.29%		-88.24%		358.82%	1900.00%
Calendar Day Age from Medical Release Request to SDT Request to Receipt of Medical Records																	
Average	23.98%	100.00%		80.81%		-0.94%		84.00%		-2.79%		22.81%		268.00%		75.76%	62.79%
Median (middle record - half are above and half below)	69.60%	145.52%		108.64%		-63.68%		123.71%		-57.99%		-38.40%		449.25%		-12.35%	30.51%
Record Count	-4.76%	-80.00%		183.33%		55.00%		-33.33%		70.59%		47.62%		-86.67%		383.33%	106.67%

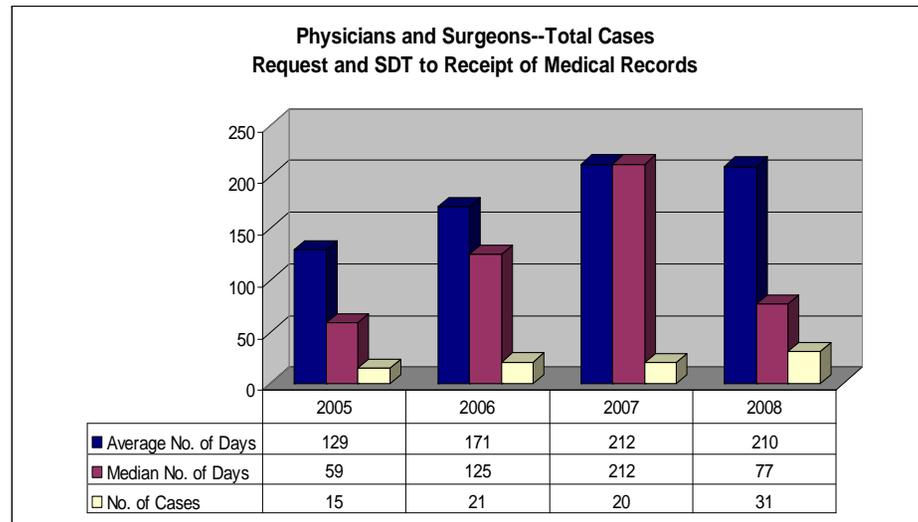
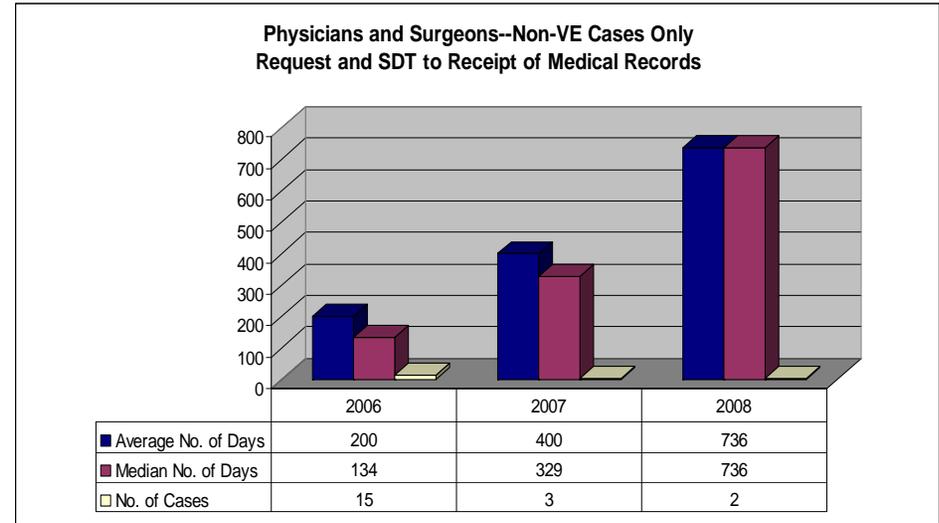
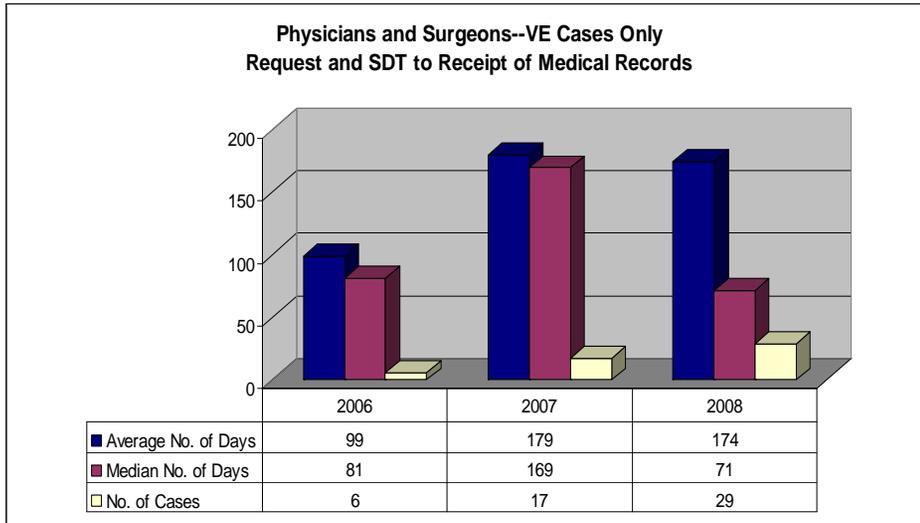
Charts 9.2a, b & c – Calendar Days Aged from Request Based on Medical Release to Receipt of Medical Records for Physicians and Surgeons Cases



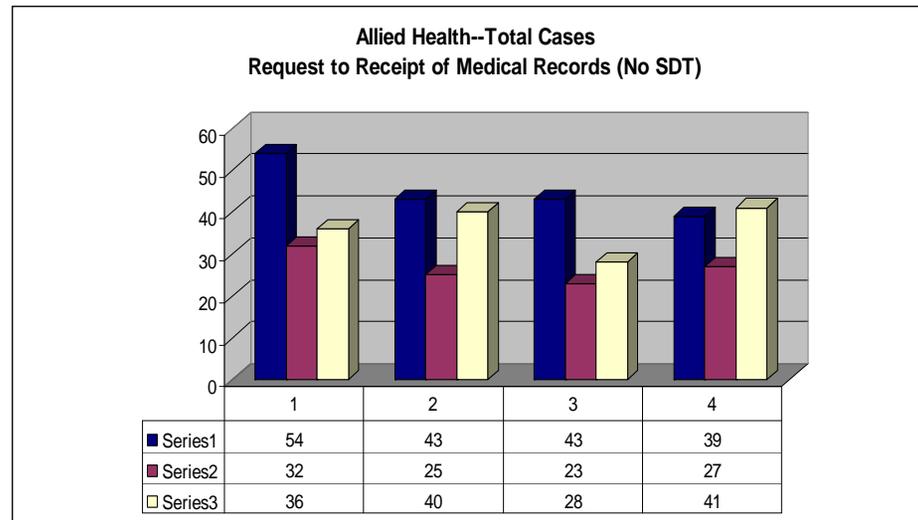
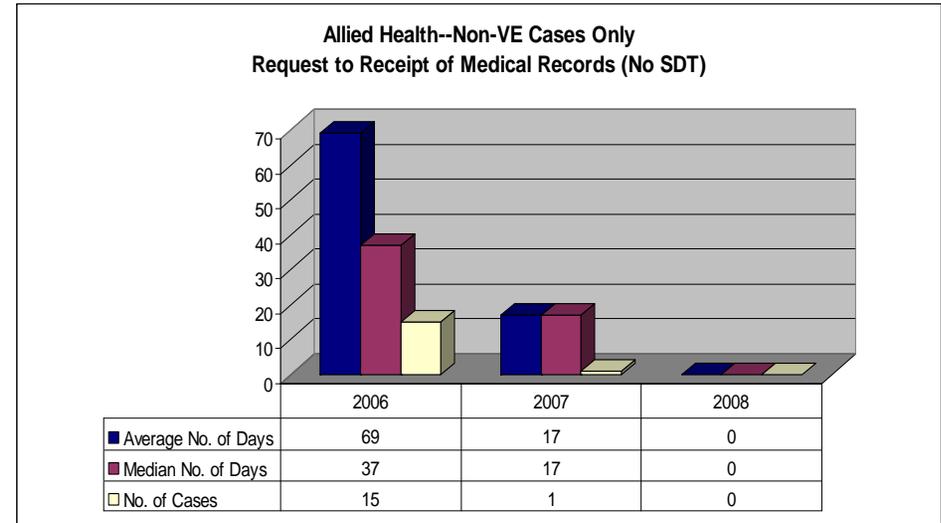
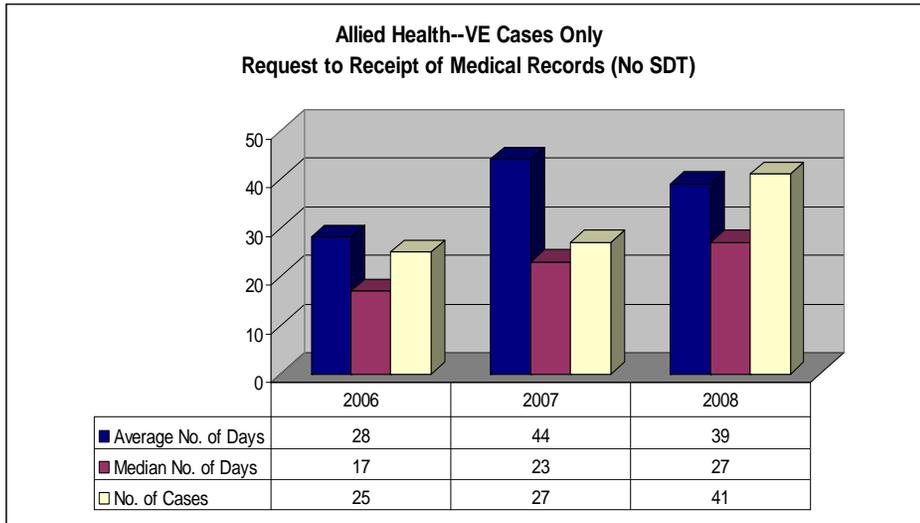
Charts 9.2d, e & f – Calendar Days Aged from Service of SDT to Receipt of Medical Records for Physicians and Surgeons Cases



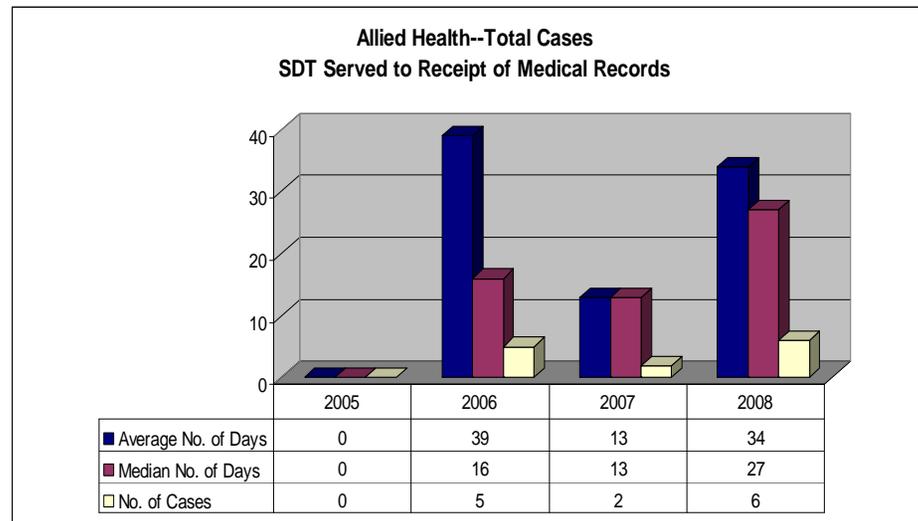
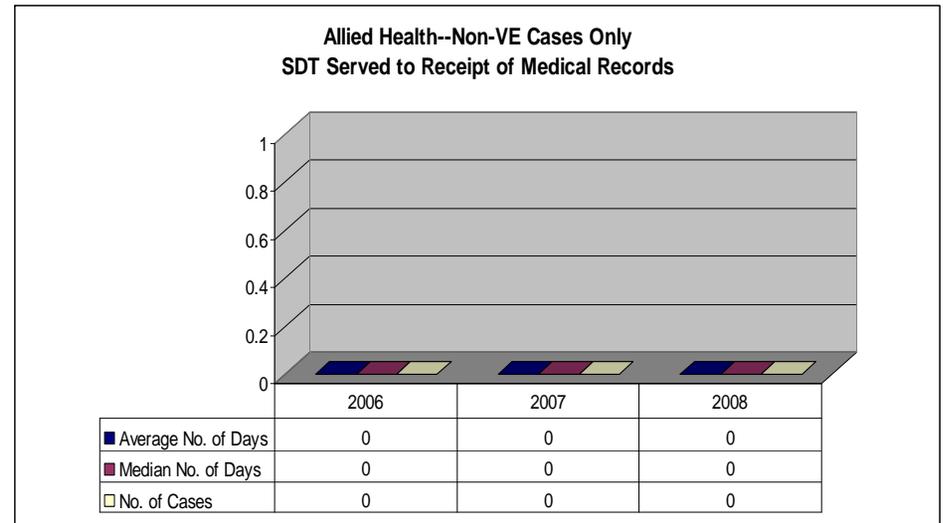
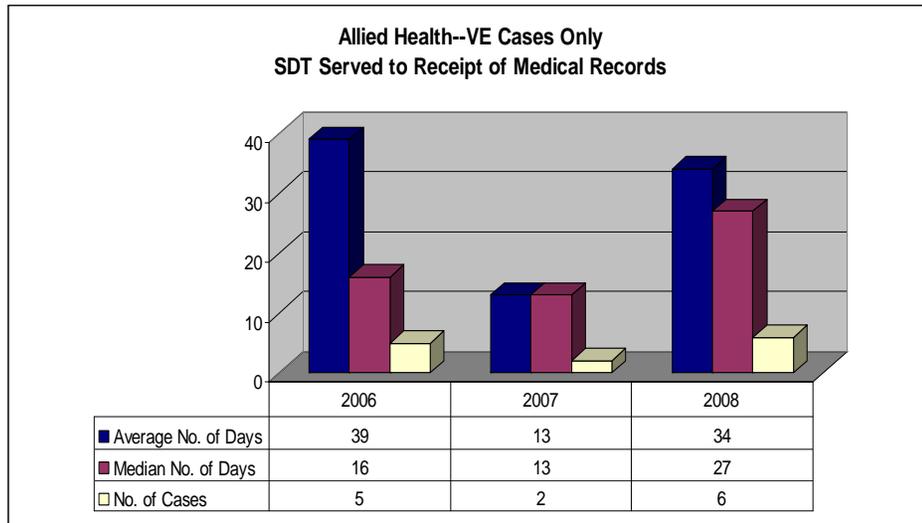
Charts 9.2g, h & i – Calendar Days Aged from Request Based on Medical Release through Service of SDT to Receipt of Medical Records for Physicians and Surgeons Cases



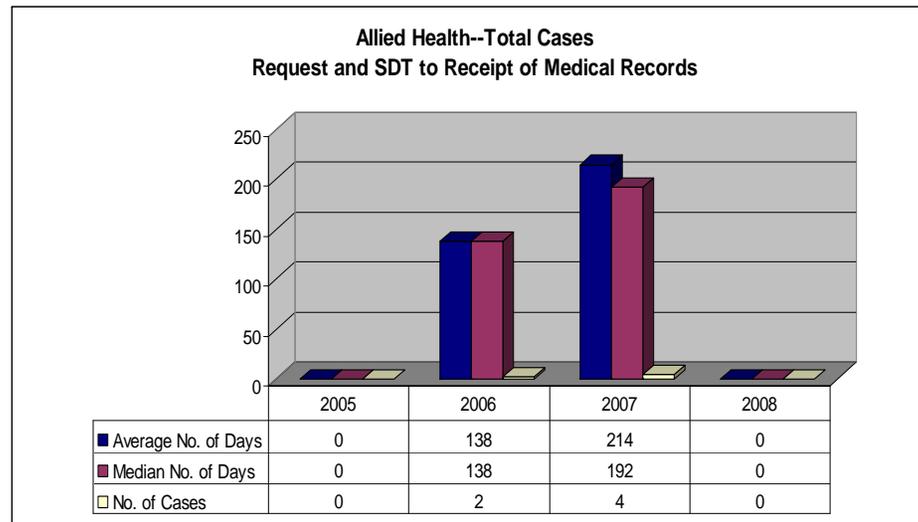
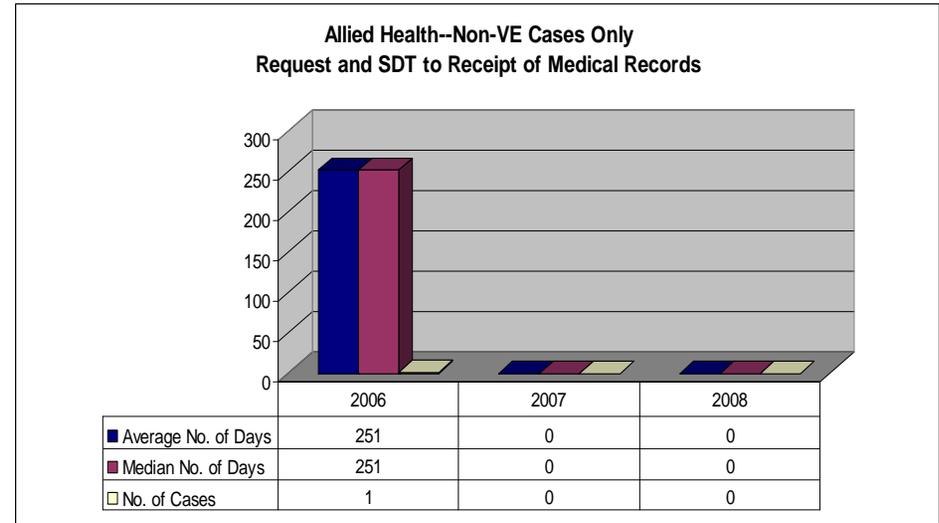
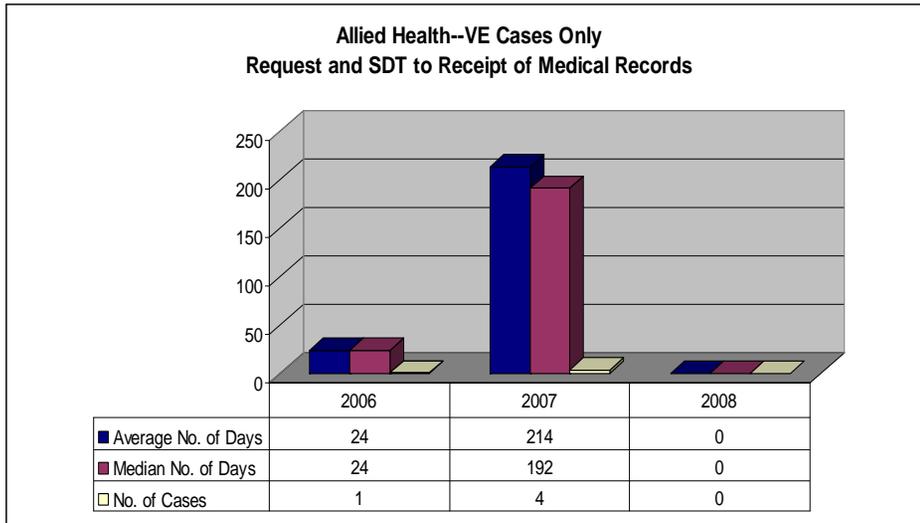
Charts 9.3a, b & c – Calendar Days Aged from Request Based on Medical Release to Receipt of Medical Records for Allied Health Cases



Charts 9.3d, e & f – Calendar Days Aged from Service of SDT to Receipt of Medical Records for Allied Health Cases



Charts 9.3g, h & i – Calendar Days Aged from Request Based on Medical Release through Service of SDT to Receipt of Medical Records for Allied Health Cases



X. INTERVIEWS

Pursuant to EOM Section 6.2, an investigator shall offer all subject physicians an opportunity to an interview prior to referring a case to the AG's office for disciplinary action.

INTERVIEW POLICY

According to the both EOM and the JVEG, the prompt scheduling and completion of interviews is critical to the overall efficiency of the VE program and should be considered a high priority for both investigators and DAGs. Investigators are responsible for setting up the interviews, which normally includes of the following: the investigator, DAG, medical consultant, subject physician, defense attorney.

The JVEG also states that the primary DAGs, or if not available, the lead DAGs, are expected to participate in all subject interviews and certain complainant interviews. Primary DAGs should communicate their intent to participate in the interview when responding to the initial Investigation Plan and Progress Report (IPPR), and list the dates and times within the next 30 business days when they are available. If the intent to participate is not communicated, the assigned investigator may schedule and conduct the interview without the primary DAG. In addition, when new witnesses are identified with proposed interview dates, if, after the second notification, the assigned investigator still does not receive a response within five (5) business days, the investigator may conduct the interview without the primary DAG.

Pursuant to the both EOM and the JVEG, before the interview, the investigator, DAG and medical consultant should meet in person for a pre-interview meeting to discuss interview tactics, assign roles, designate areas of questioning, and organize documents. The subject interview is always recorded.

Pursuant to the JVEG: "Subject interviews are extremely important. Accordingly, it is vital that such interviews be conducted in a manner that will elicit the maximum amount of reliable information from the subject." It further states: "Although the interview should be low-key and calculated to elicit all available information, the interview should be appropriately detailed."

CALENDAR DAYS AGED FROM MAILING/SERVICE TO SUBJECT INTERVIEW — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

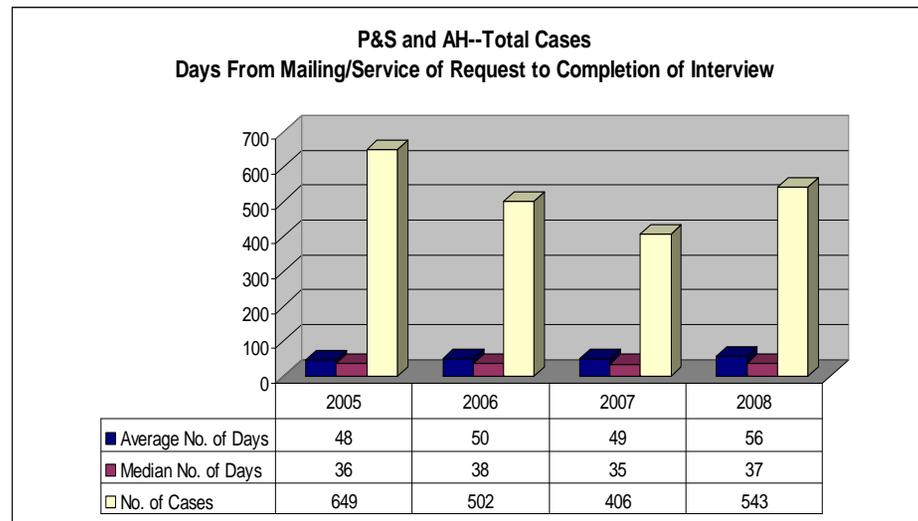
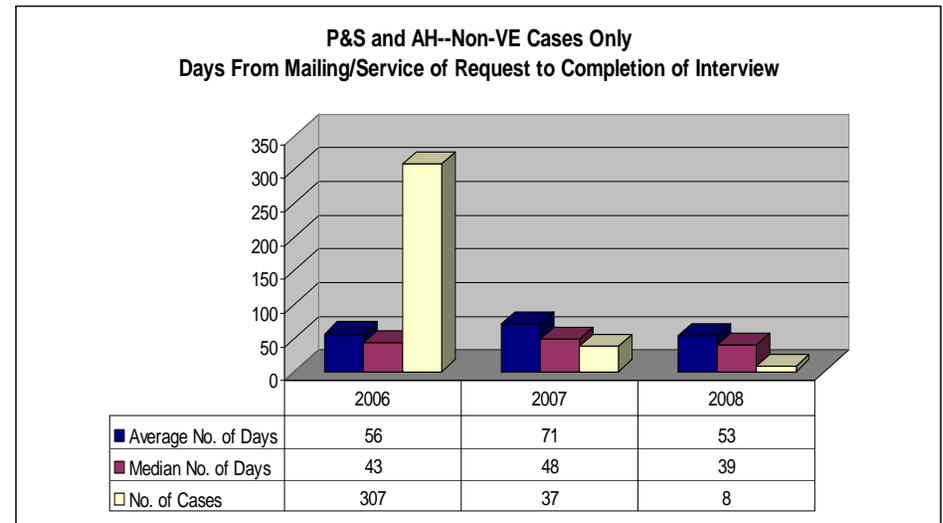
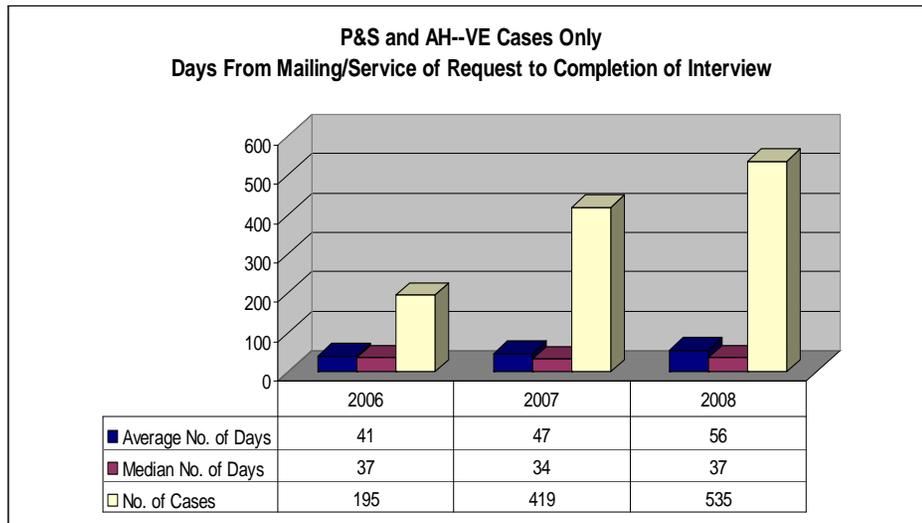
Table 10.1 below reports the average and median calendar days aged from mailing/service of the request to subject interview for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 16.67% increase in the average days aged, a 2.78% increase in the median days aged, a 16.33% decrease in the number of such cases, and a 6.86% increase in the number of such cases pending at year end.

For cases in which a subpoena was requested, the percentage difference between 2005 and 2008 for average and median days aged cannot be computed, as there were no such cases with a completed subject interview in 2005. There was a 275% increase in the number of such cases pending at year end.

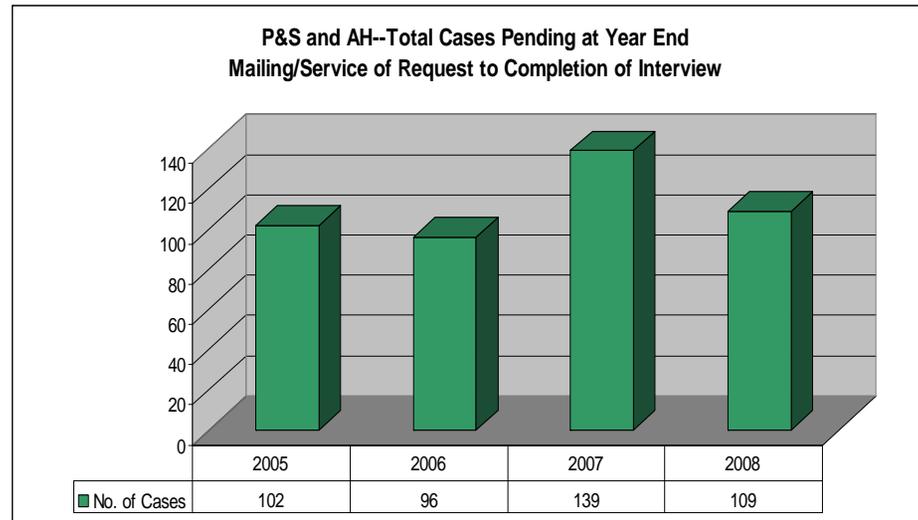
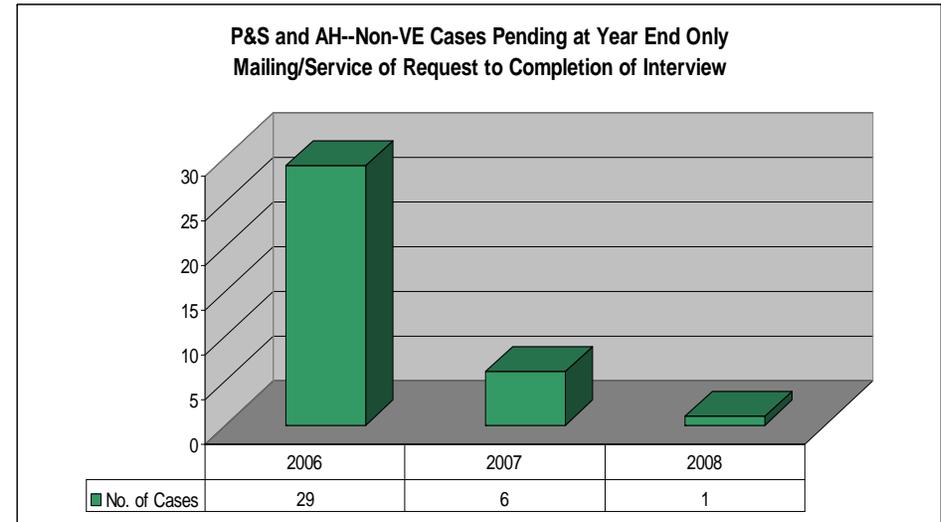
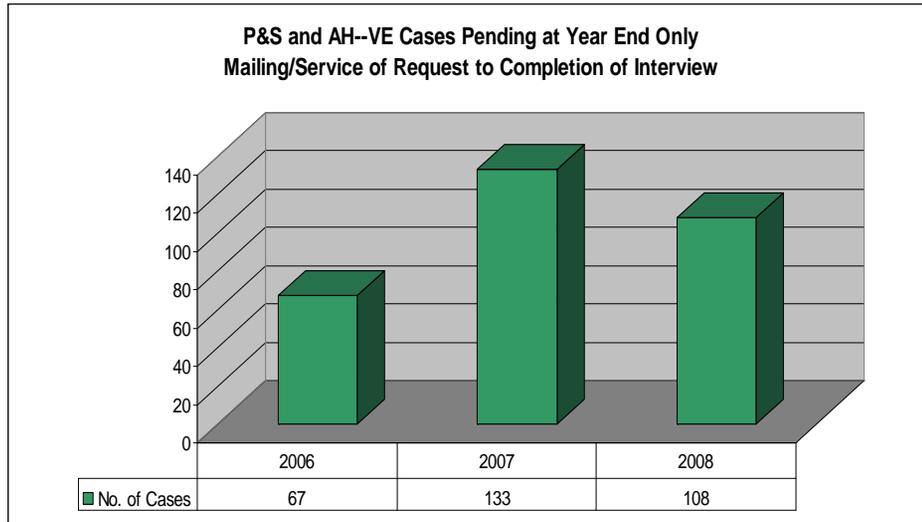
Table 10.1 – Calendar Days Aged from Request to Subject Interview for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All		Not VE	VE	All			
	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending			
Calendar Day Age from Request to Subject Interview Completed																				
Average	-2.00%		26.79%		14.63%		14.29%		-25.35%		19.15%		12.00%		-5.36%		36.59%	16.67%		
Median (middle record - half are above and half below)	-7.89%		11.63%		-8.11%		5.71%		-18.75%		8.82%		-2.63%		-9.30%		0.00%	2.78%		
Record Count	-19.12%	44.79%	-87.95%	-79.31%	114.87%	98.51%	33.74%	-21.58%	-78.38%	-83.33%	27.68%	-18.80%	8.17%	13.54%	-97.39%	-96.55%	174.36%	61.19%	-16.33%	6.86%
Calendar Day Age from Subpoena Request to Subject Interview Completed																				
Average	84.62%		128.21%				-87.50%		9.55%		-1.83%		-76.92%		150.00%					
Median (middle record - half are above and half below)	213.04%		286.96%				-71.53%		9.55%		-66.06%		-10.87%		323.91%					
Record Count	-60.00%	85.71%	-80.00%	-50.00%		900.00%	650.00%	130.77%	100.00%	-100.00%	1200.00%	200.00%	200.00%	328.57%	-60.00%	-100.00%		2900.00%		275.00%

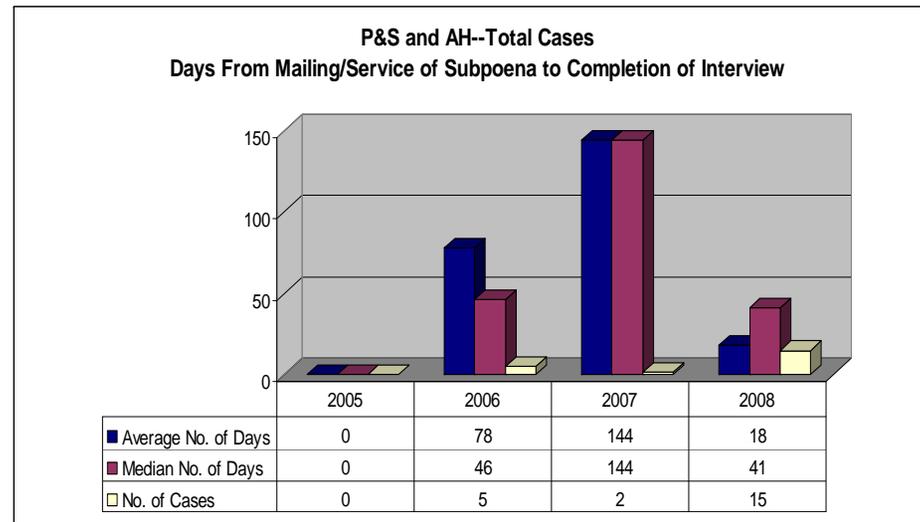
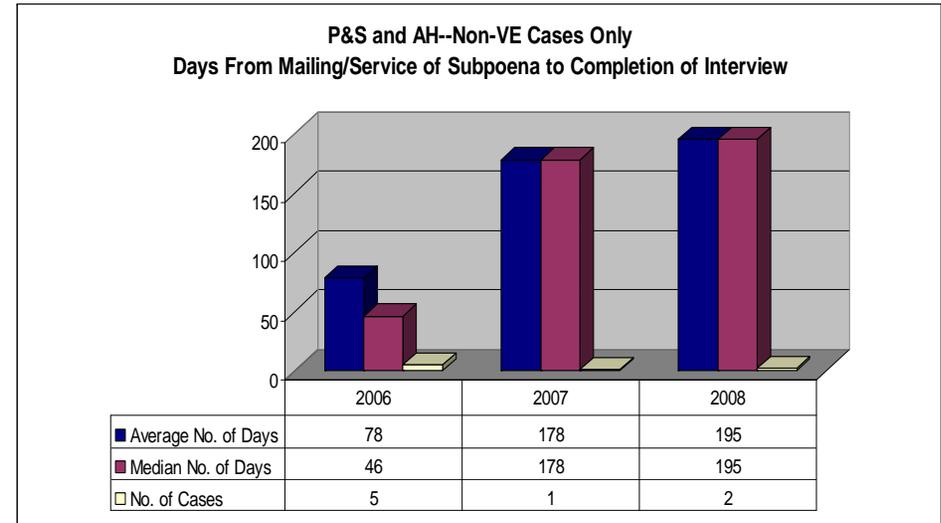
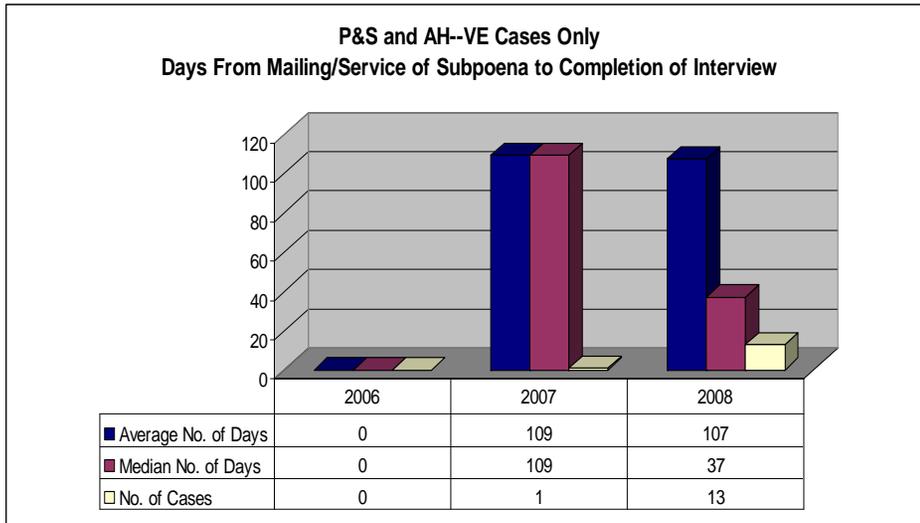
Charts 10.1a, b & c – Calendar Days Aged from Mailing/Service of Request to Subject Interview for Physicians and Surgeons and Allied Health Cases



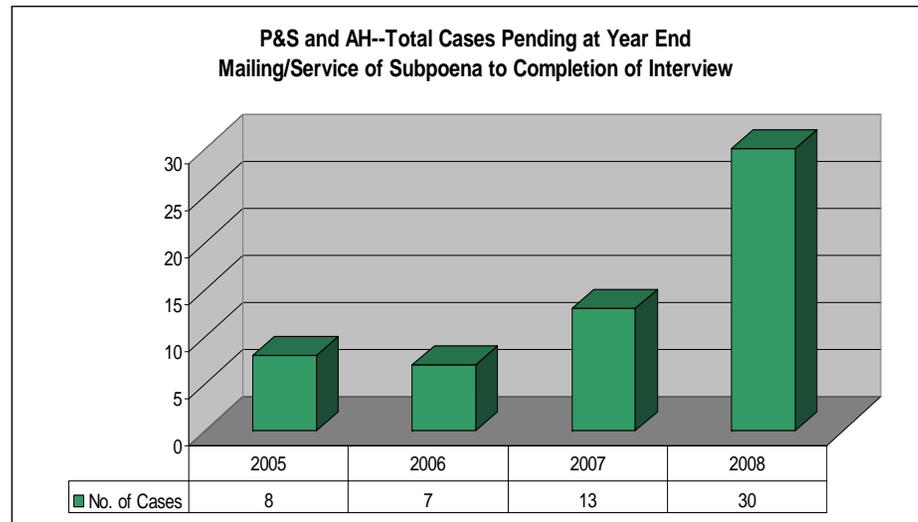
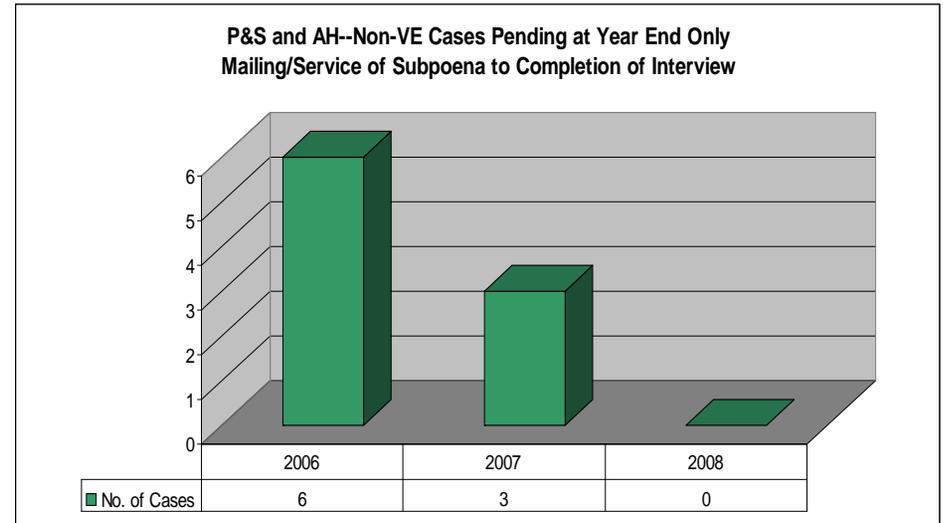
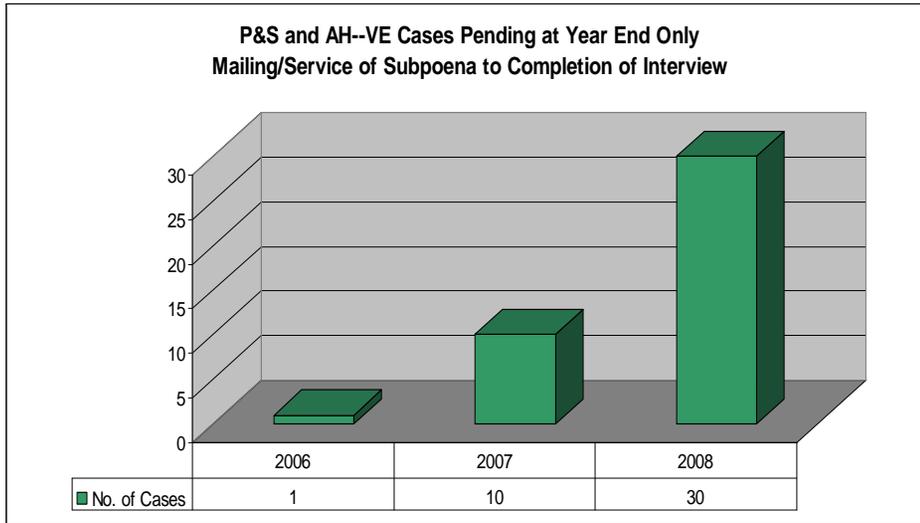
Charts 10.1d, e & f – Calendar Days Aged from Mailing/Service of Request to Subject Interview for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



Charts 10.1g, h & i – Calendar Days Aged from Mailing/Service of Subpoena to Subject Interview for Physicians and Surgeons and Allied Health Cases



Charts 10.1g, h & i – Calendar Days Aged from Mailing/Service of Subpoena to Subject Interview for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



CALENDAR DAYS AGED FROM MAILING/SERVICE TO SUBJECT INTERVIEW — PHYSICIANS AND SURGEONS

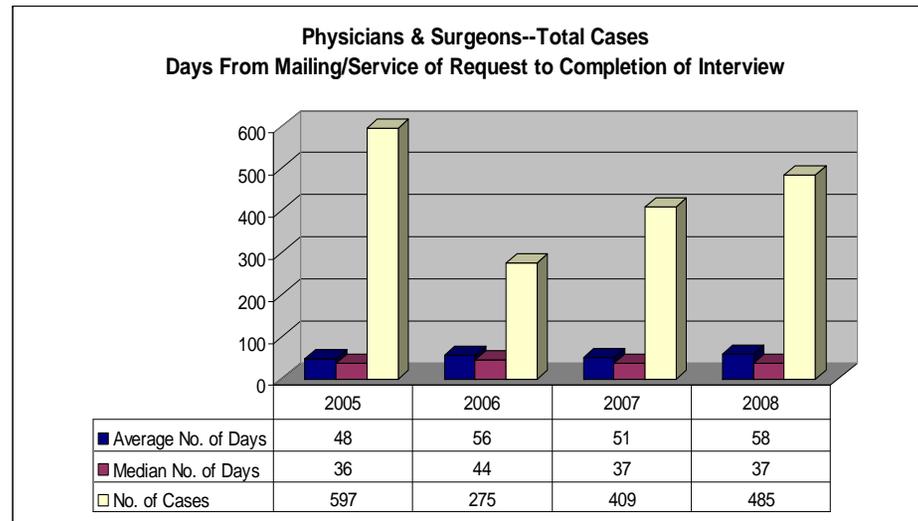
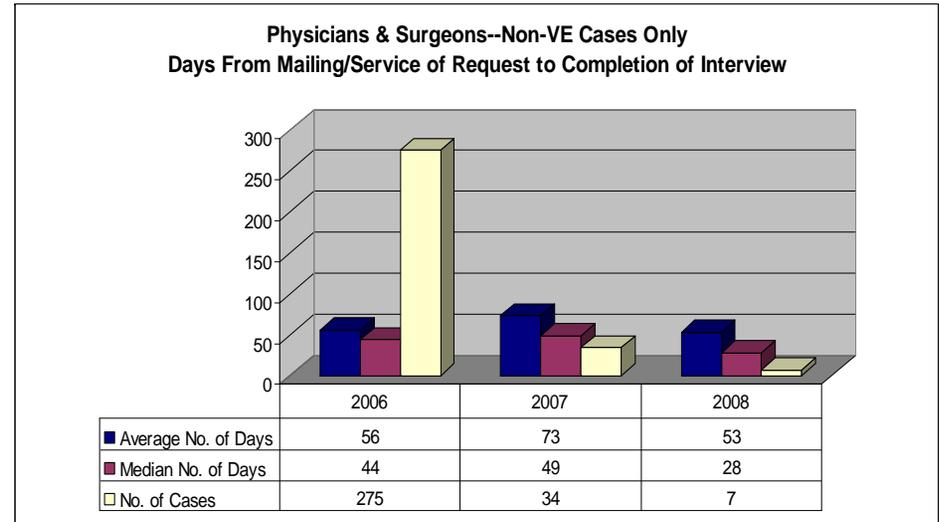
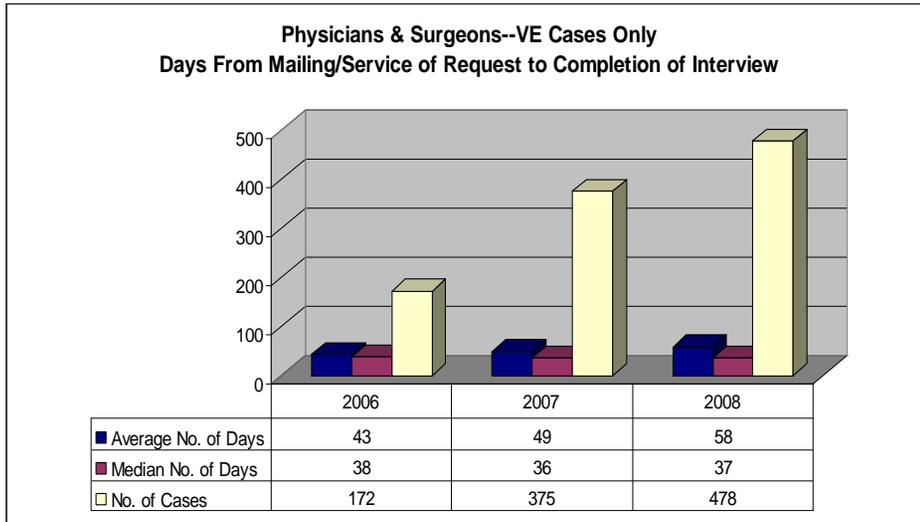
Table 10.2 below reports the average and median calendar days aged from mailing/service of the request to subject interview for Physicians and Surgeons cases. Between 2005 and 2008, there was a 20.83% increase in the average days aged, a 2.78% increase in the median days aged, an 18.76% decrease in the number of such cases, and an 11.63% increase in the number of such cases pending at year end.

For cases in which a subpoena was requested, the percentage difference between 2005 and 2008 for average and median days aged cannot be computed, as there were no such cases with a completed subject interview in 2005. There was a 285.71% increase in the number of such cases pending at year end.

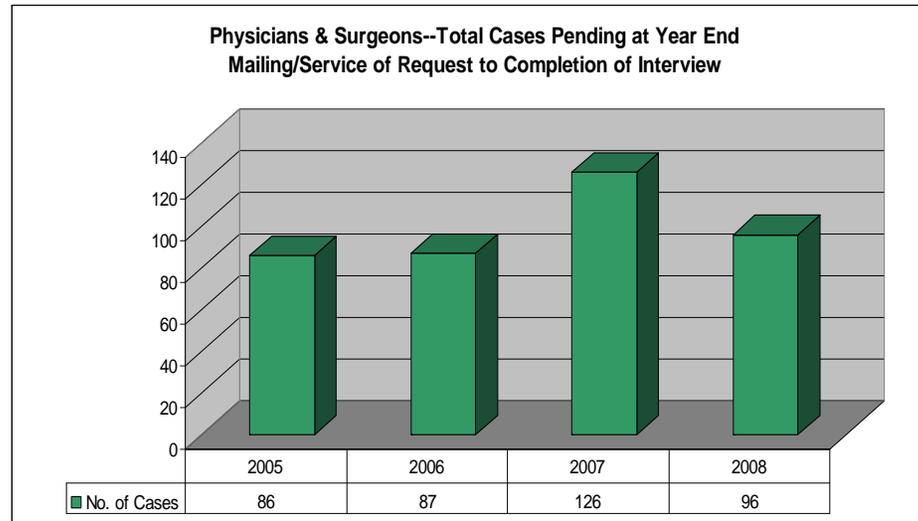
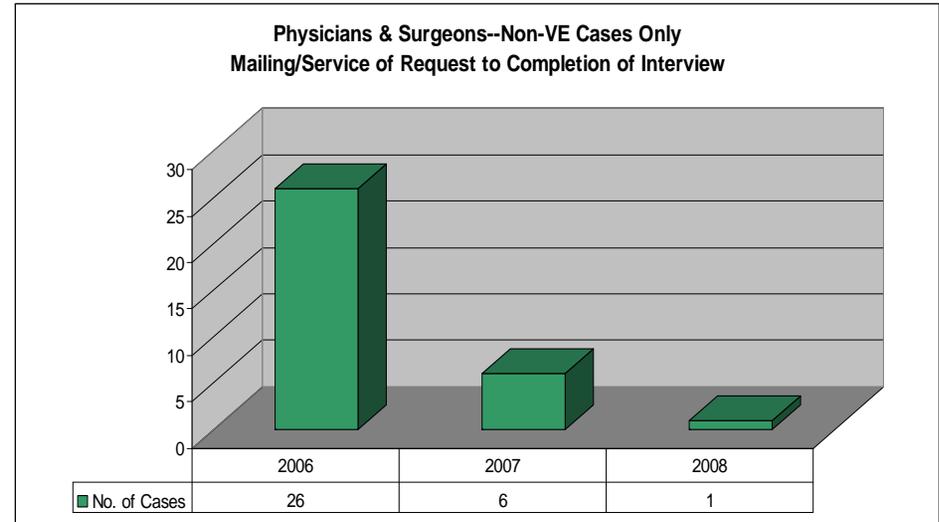
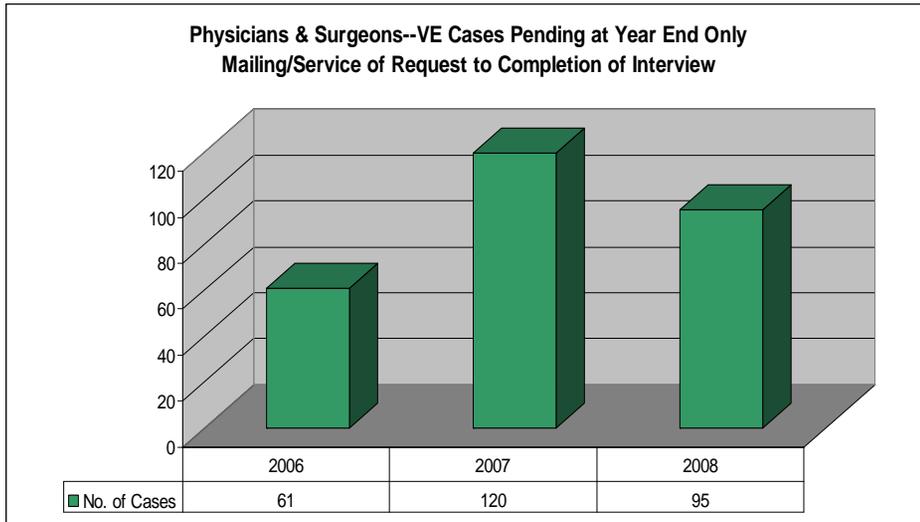
Table 10.2 – Calendar Days Aged from Request to Subject Interview for Physicians and Surgeons

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending			
Calendar Day Age from Request to Physician Interview Completed																				
Average	0.00%		30.36%		13.95%		13.73%		-27.40%		18.37%		13.73%		-5.36%		34.88%	20.83%		
Median (middle record - half are above and half below)	-11.90%		11.36%		-5.26%		0.00%		-42.86%		2.78%		-11.90%		-36.36%		-2.63%	2.78%		
Record Count	-8.50%	44.83%	-87.64%	-76.92%	118.02%	96.72%	18.58%	-23.81%	-79.41%	-83.33%	27.47%	-20.83%	8.50%	10.34%	-97.45%	-96.15%	177.91%	55.74%	-18.76%	11.63%
Calendar Day Age from Subpoena Request to Physician Interview Completed																				
Average	84.62%		128.21%				-14.58%		21.91%		6.42%		57.69%		178.21%					
Median (middle record - half are above and half below)	213.04%		286.96%				-71.53%		21.91%		-64.22%		-10.87%		371.74%					
Record Count	-60.00%	120.00%	-80.00%	-50.00%		800.00%	550.00%	145.45%	0.00%	-100.00%	1100.00%	200.00%	160.00%	440.00%	-80.00%	-100.00%		2600.00%		285.71%

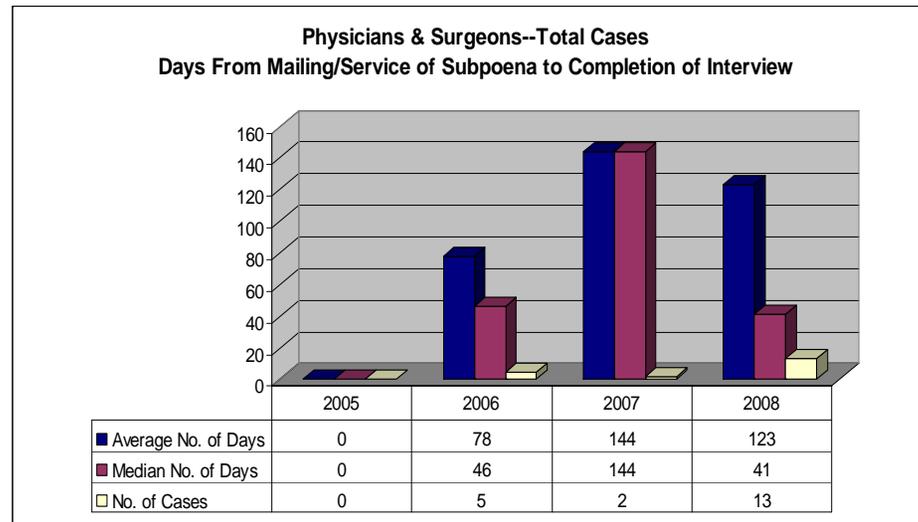
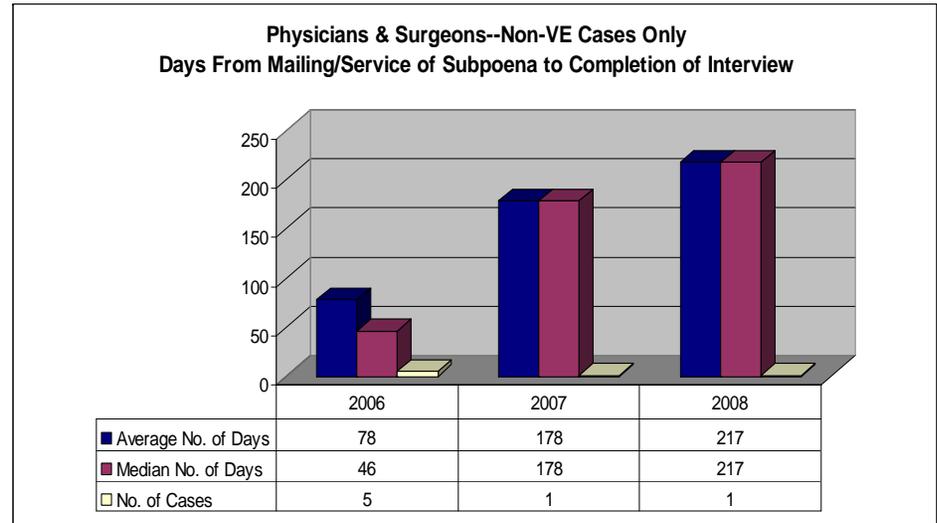
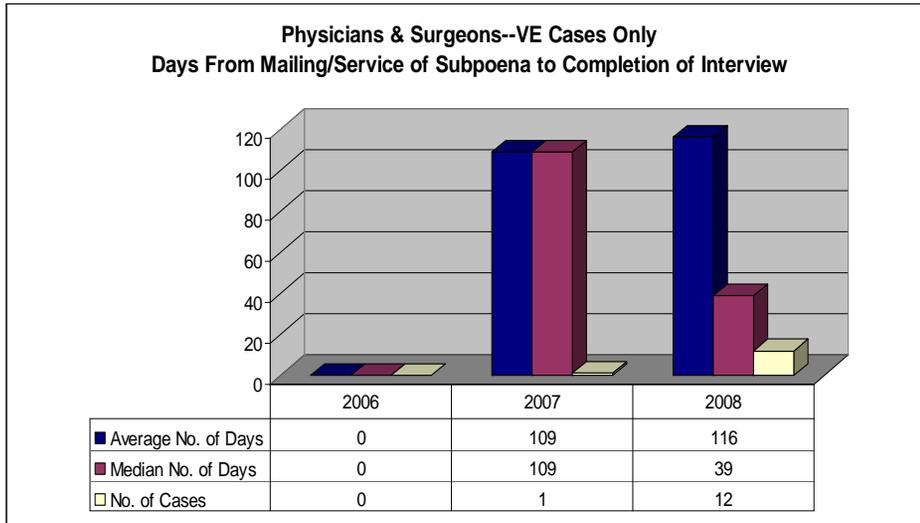
Charts 10.2a, b & c – Calendar Days Aged from Mailing/Service of Request to Subject Interview for Physicians and Surgeons Cases



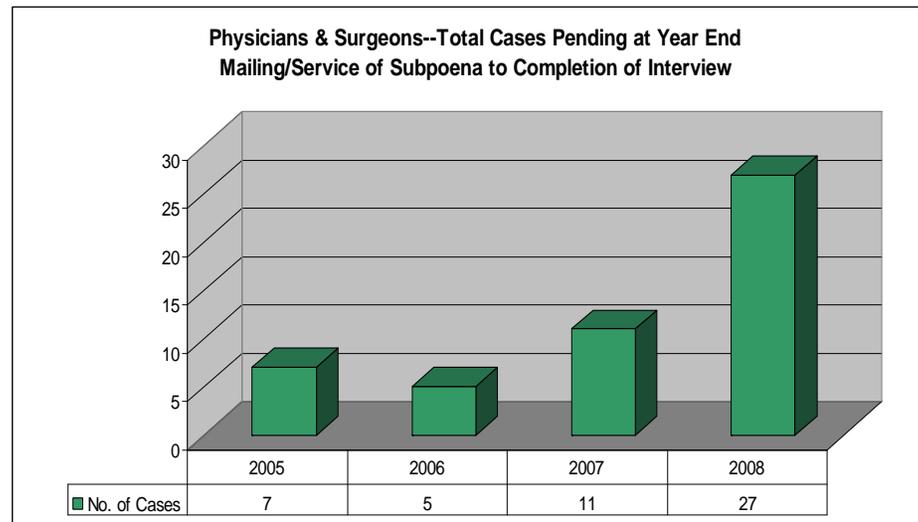
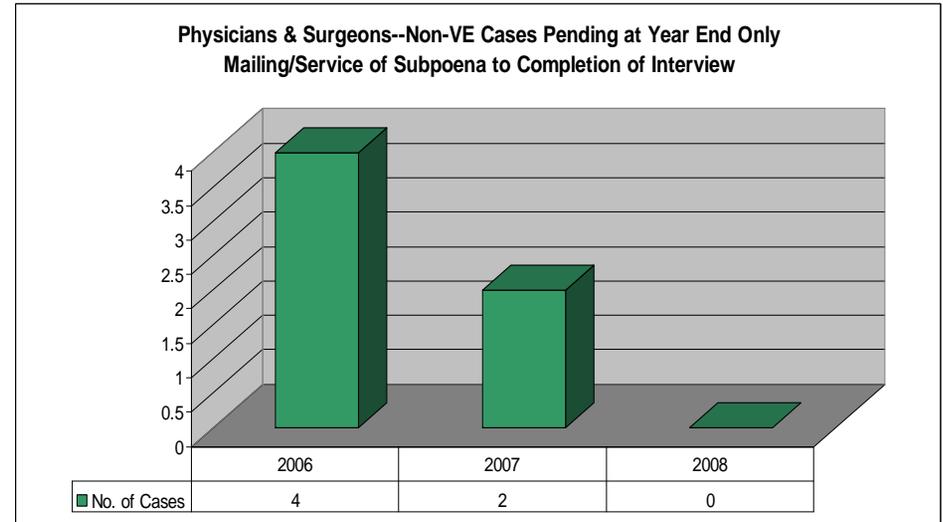
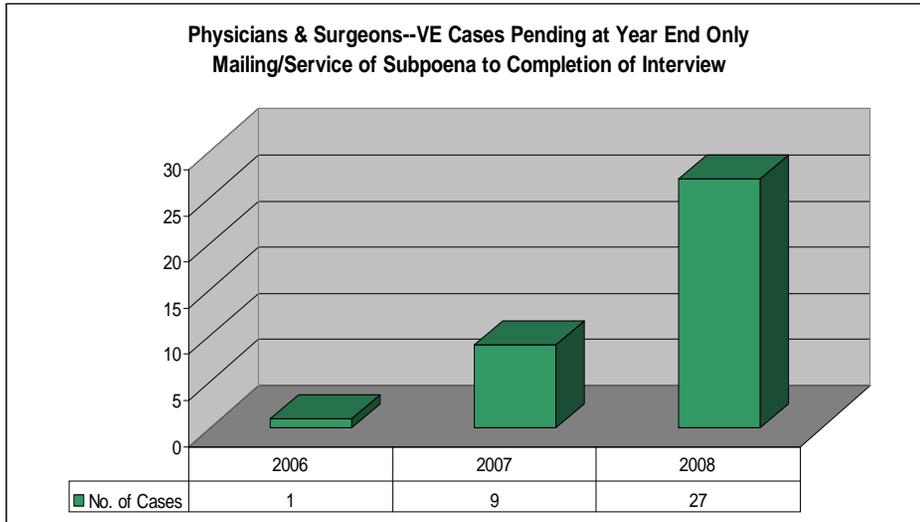
Charts 10.2d, e & f – Calendar Days Aged from Mailing/Service of Request to Subject Interview for Physicians and Surgeons – Cases Pending at Year End



Charts 10.2g, h & i – Calendar Days Aged from Mailing/Service of Subpoena to Subject Interview for Physician and Surgeon Cases



Charts 10.2g, h & i – Calendar Days Aged from Mailing/Service of Subpoena to Subject Interview for Physicians and Surgeons – Cases Pending at Year End



CALENDAR DAYS AGED FROM MAILING/SERVICE TO SUBJECT INTERVIEW — ALLIED HEALTH

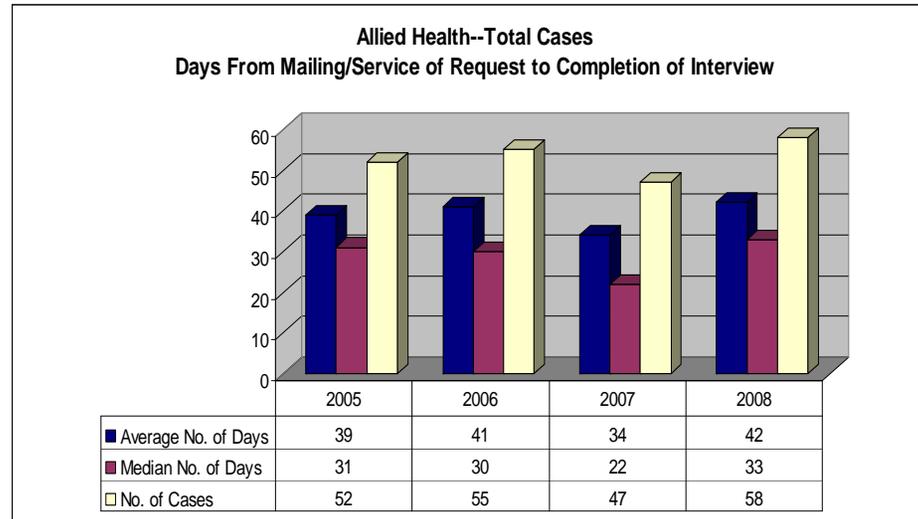
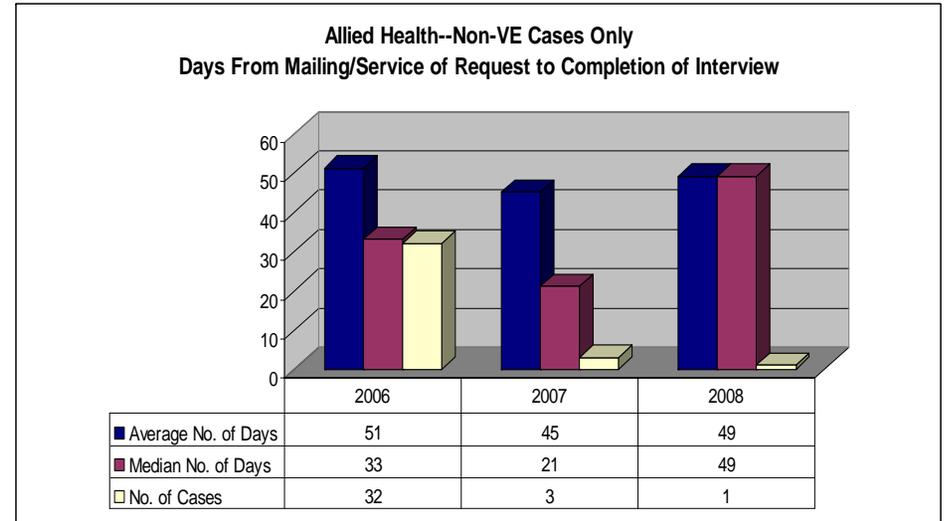
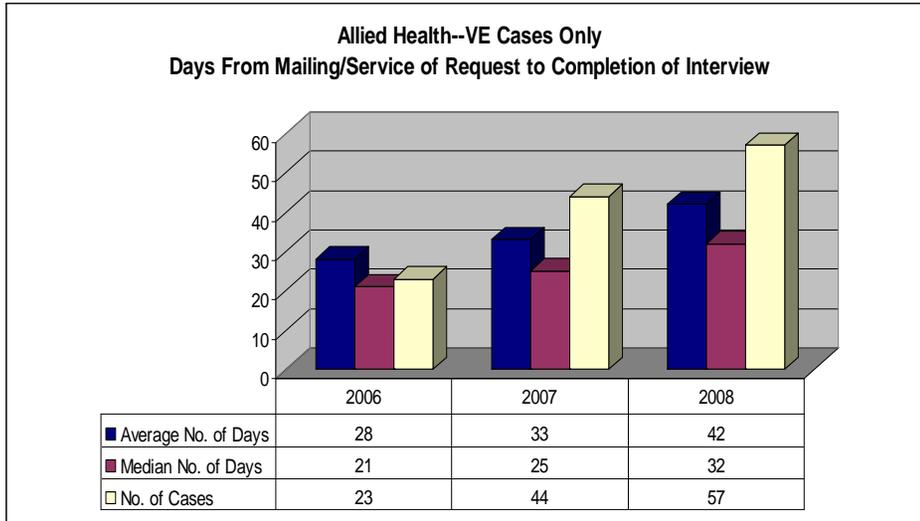
Table 10.3 below reports the average and median calendar days aged from mailing/service of the request to subject interview for Allied Health Care cases. Between 2005 and 2008, there was a 7.69% increase in the average days aged, a 6.45% increase in the median days aged, an 11.54% increase in the number of such cases, and a 31.25% decrease in the number of such cases pending at year end.

For cases in which a subpoena was requested, the percentage difference between 2005 and 2008 for average and median days aged cannot be computed, as there were no such cases with a completed subject interview in 2005. There was a 200% increase in the number of such cases pending at year end (from 1 case to 3 cases).

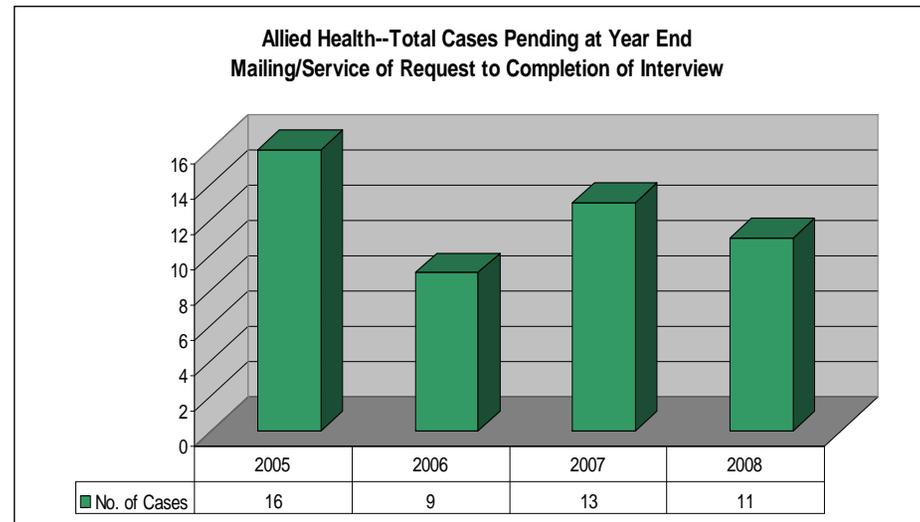
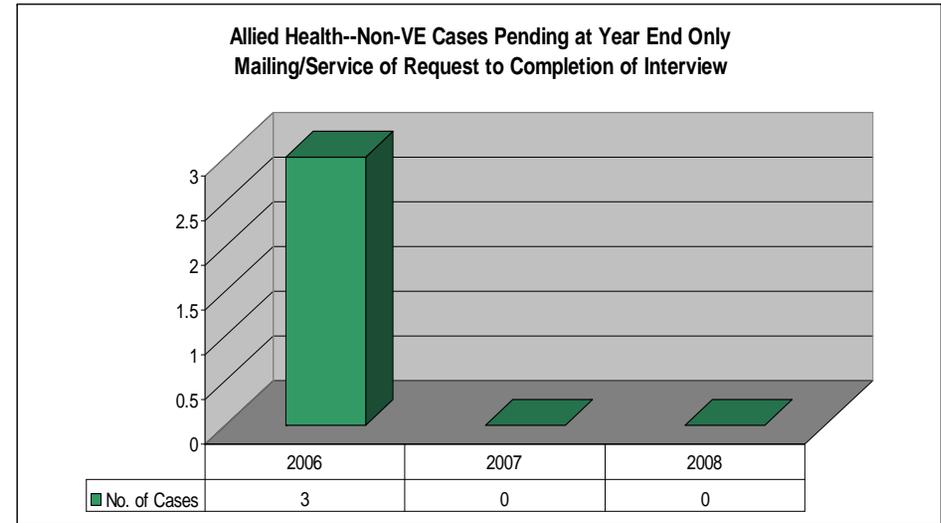
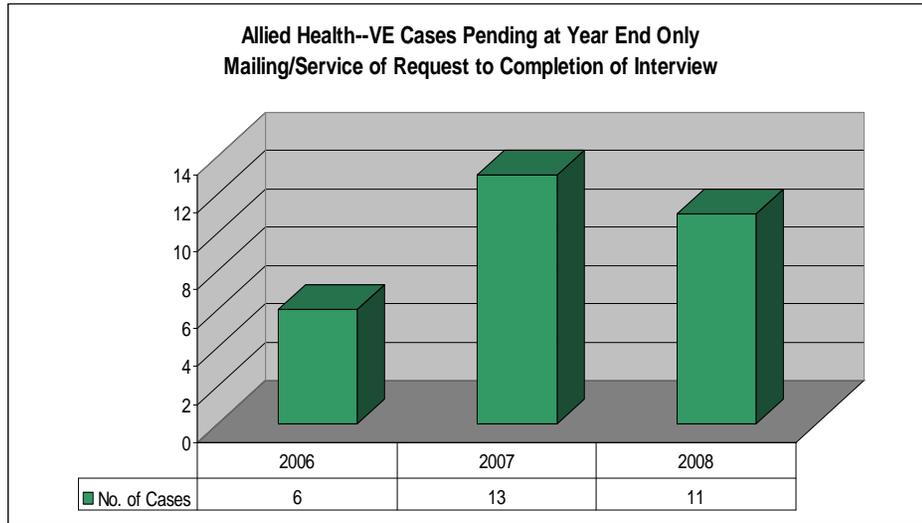
Table 10.3 – Calendar Days Aged from Request to Subject Interview for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008			
	All		Not VE		VE		All		Not VE		VE		All		Not VE	VE	All		
	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending	Completed	Pending		
Calendar Day Age from Request to Subject Interview Completed																			
Average	-17.07%		-11.76%		17.86%		23.53%		8.89%		27.27%		2.44%		-3.92%		50.00%	7.69%	
Median (middle record - half are above and half below)	-26.67%		-36.36%		19.05%		50.00%		133.33%		28.00%		10.00%		48.48%		52.38%	6.45%	
Record Count	-14.55%	44.44%	-90.63%	-100.00%	91.30%	116.67%	23.40%	-15.38%	-66.67%		29.55%	-15.38%	5.45%	22.22%	-96.88%	-100.00%	147.83%	83.33%	
Calendar Day Age from Subpoena Request to Subject Interview Completed*																			
Average																			
Median (middle record - half are above and half below)																			
Record Count		0.00%						50.00%		-100.00%		200.00%		50.00%		-100.00%			200.00%

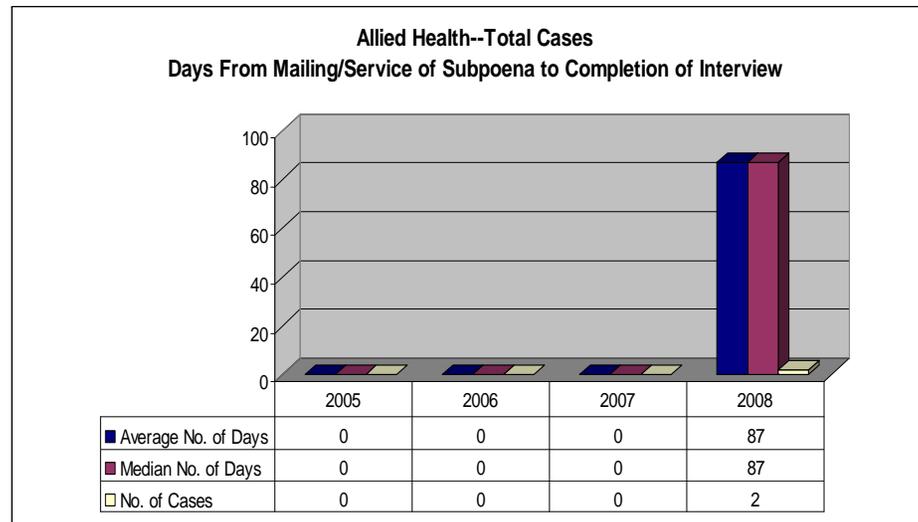
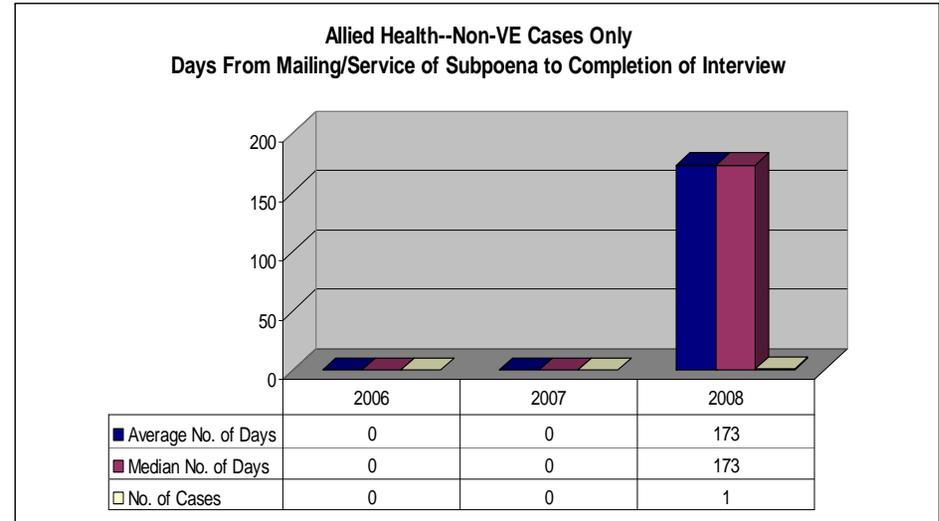
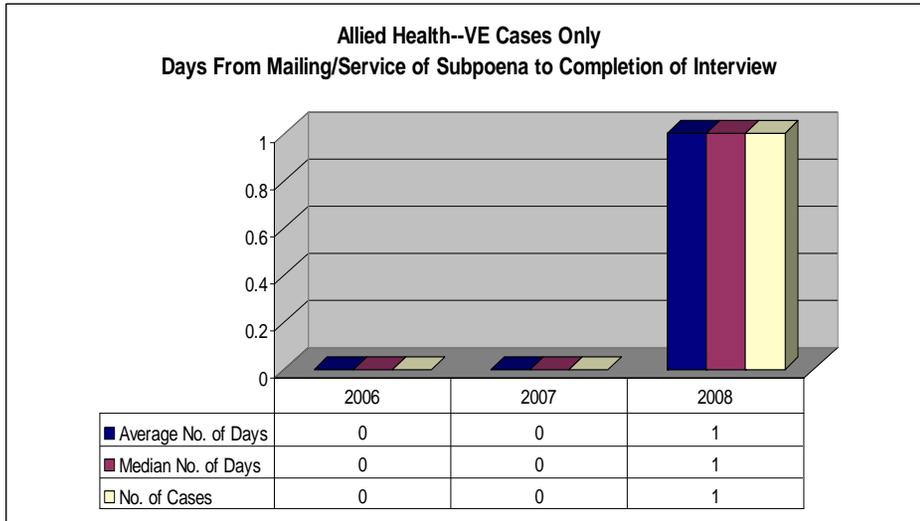
Charts 10.3a, b & c – Calendar Days Aged from Mailing/Service of Request to Subject Interview for Allied Health Cases



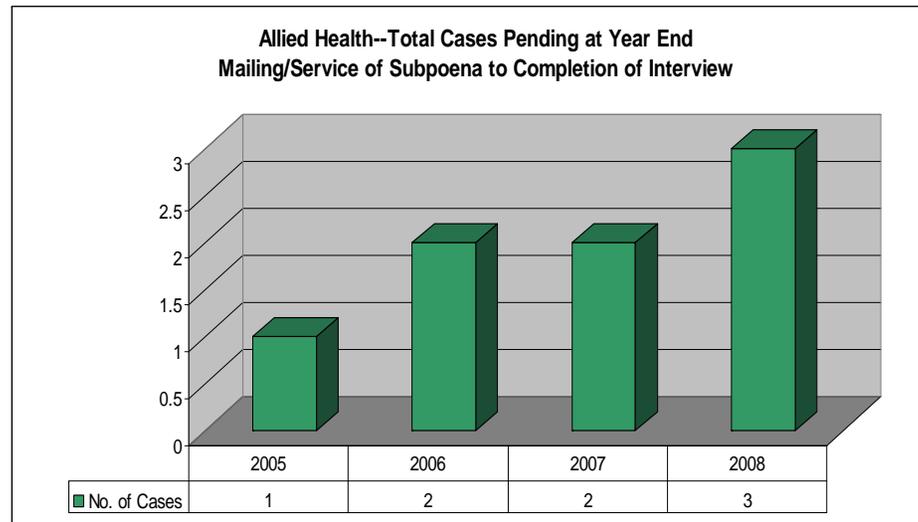
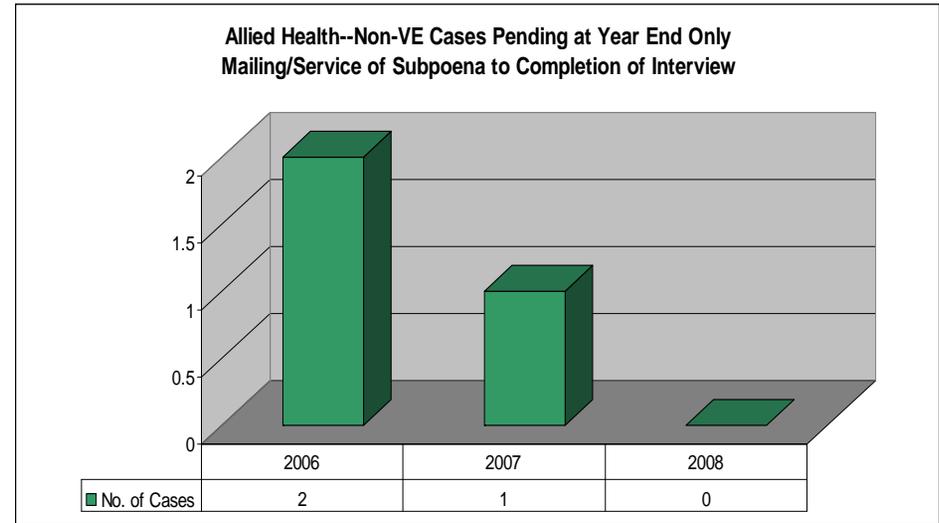
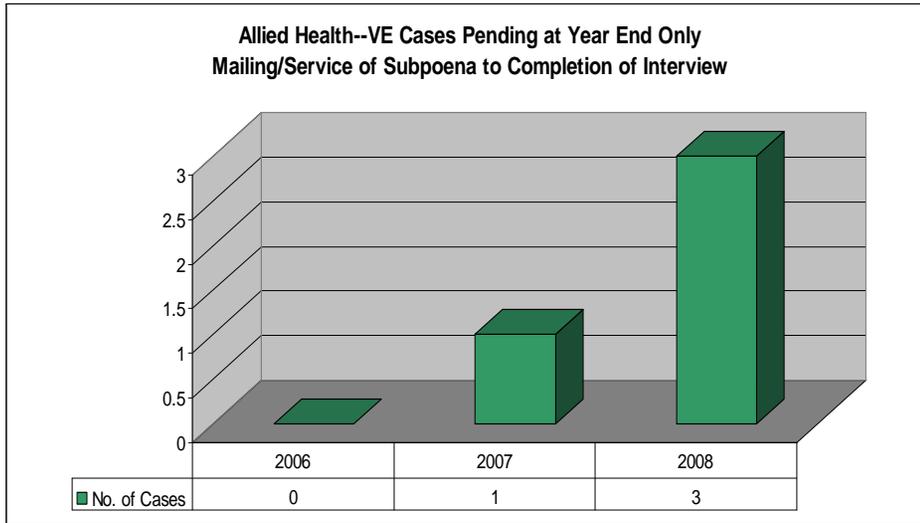
Charts 10.3d, e & f – Calendar Days Aged from Mailing/Service of Request to Subject Interview for Allied Health Cases — Cases Pending at Year End



Charts 10.3g, h & i – Calendar Days Aged from Mailing/Service of Subpoena to Subject Interview for Allied Health Cases



Charts 10.3g, h & i – Calendar Days Aged from Mailing/Service of Subpoena to Subject Interview for Allied Health Cases — Cases Pending at Year End



XI. MEDICAL CONSULTANTS

MBC Policy

Per VPM, medical consultants, who reports to the respective Sup Is in the district offices, provide medical input and assistance through review of medical records, participation in subject interviews, selection of expert reviewers and evaluation of expert opinions.

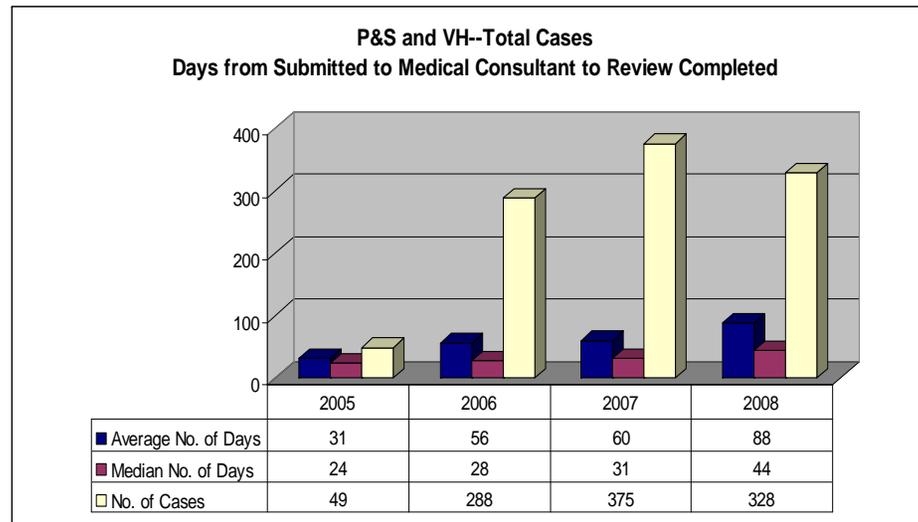
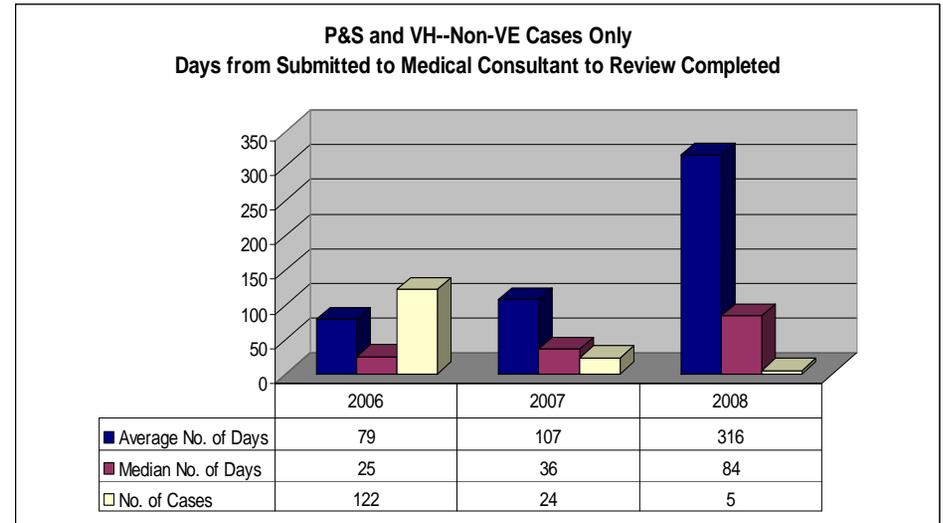
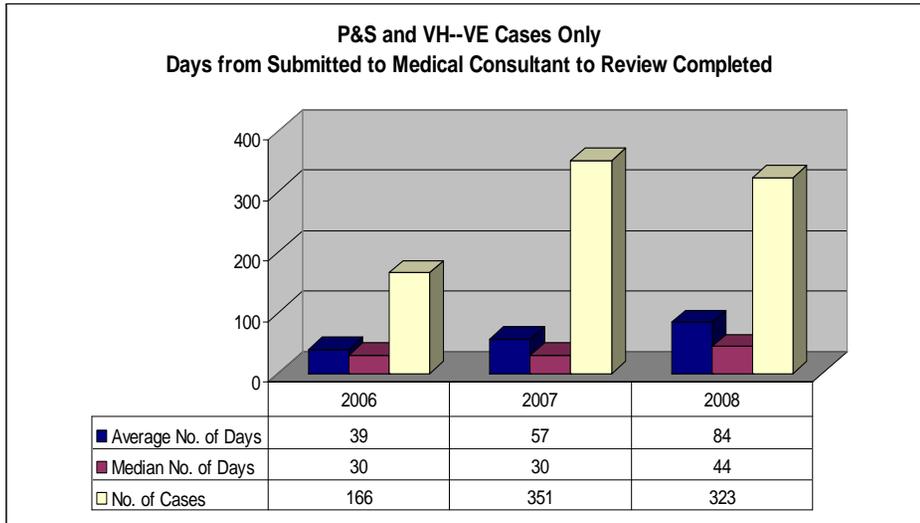
CALENDAR DAYS AGED FROM CASE SUBMITTED TO DISTRICT OFFICE MEDICAL CONSULTANT FOR REVIEW TO REVIEW COMPLETED — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 11.1 below reports the average and median calendar days aged from case submitted to district office medical consultant for review to review completed for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 183.87% increase in the average days aged, an 83.33% increase in the median days aged, a 569.39% increase in the number of such cases, and a 433.33% increase in the number of such cases pending at year end.

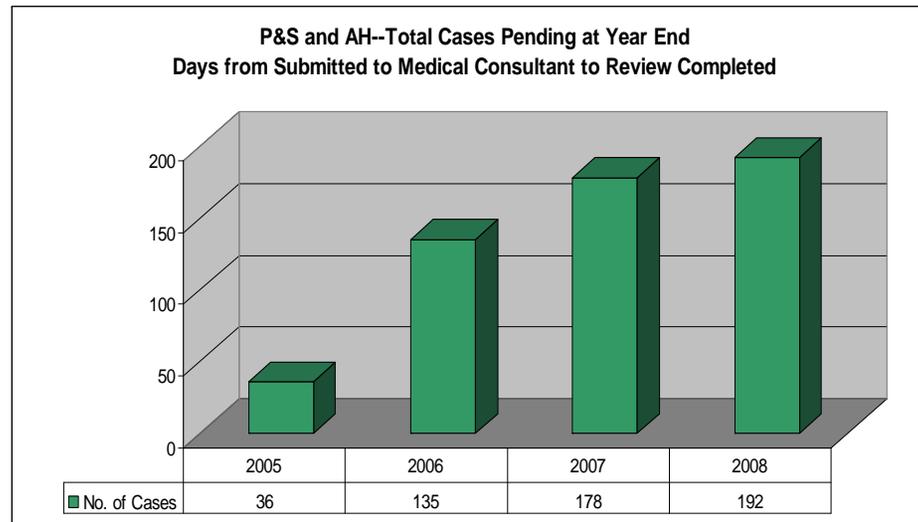
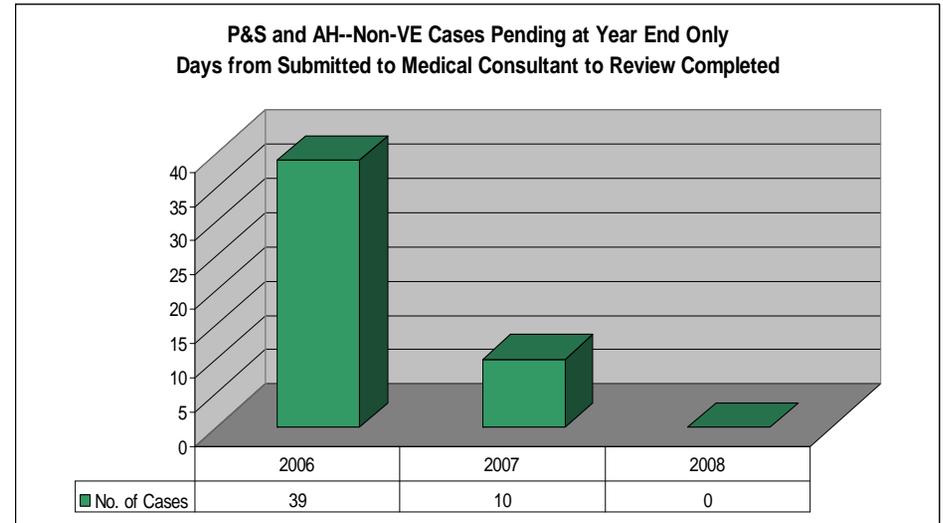
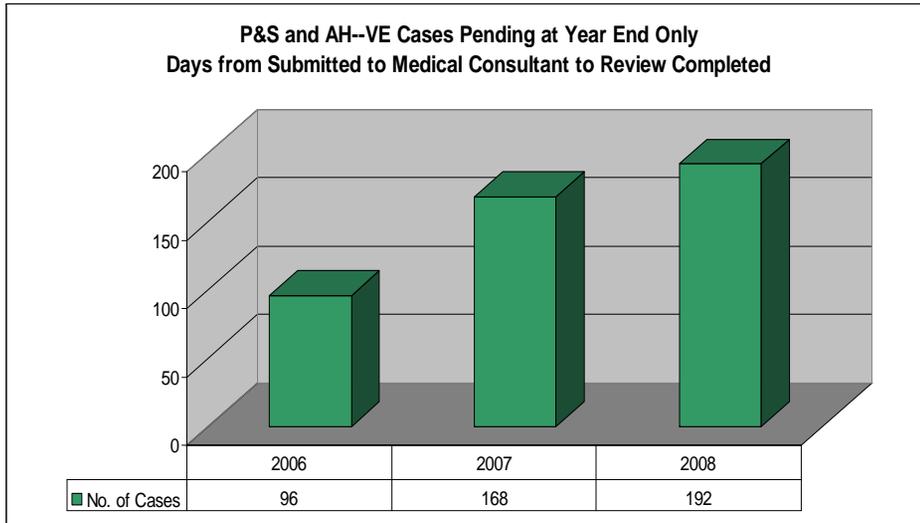
Table 11.1 – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending			
Calendar Day Age from Date Case Submitted to District Office Medical Consultant for Review to Review Completed Date																				
Average	7.14%		35.44%		46.15%		46.67%		195.33%		47.37%		57.14%		300.00%		115.38%		183.87%	
Median (middle record - half are above and half below)	10.71%		44.00%		0.00%		41.94%		133.33%		46.67%		57.14%		236.00%		46.67%		83.33%	
Record Count	30.21%	31.85%	-80.33%	-74.36%	111.45%	75.00%	-12.53%	7.87%	-79.17%	-100.00%	-7.98%	14.29%	13.89%	42.22%	-95.90%	-100.00%	94.58%	100.00%	569.39%	433.33%

Charts 11.1a, b & c – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Physicians and Surgeons and Allied Health Cases



Charts 11.1d, e & f – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



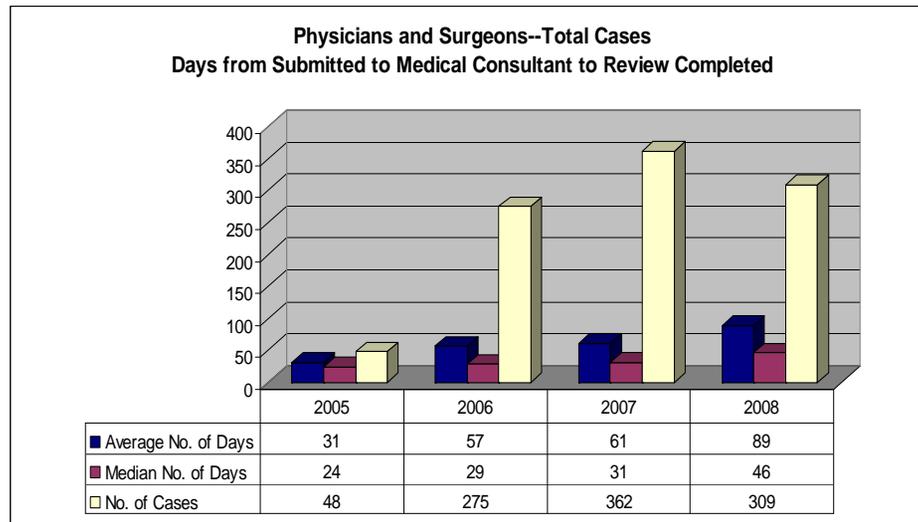
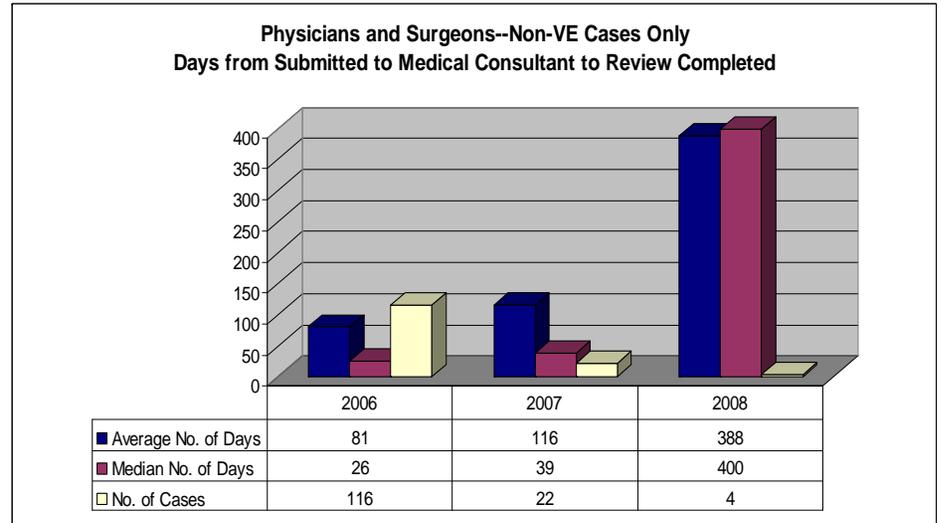
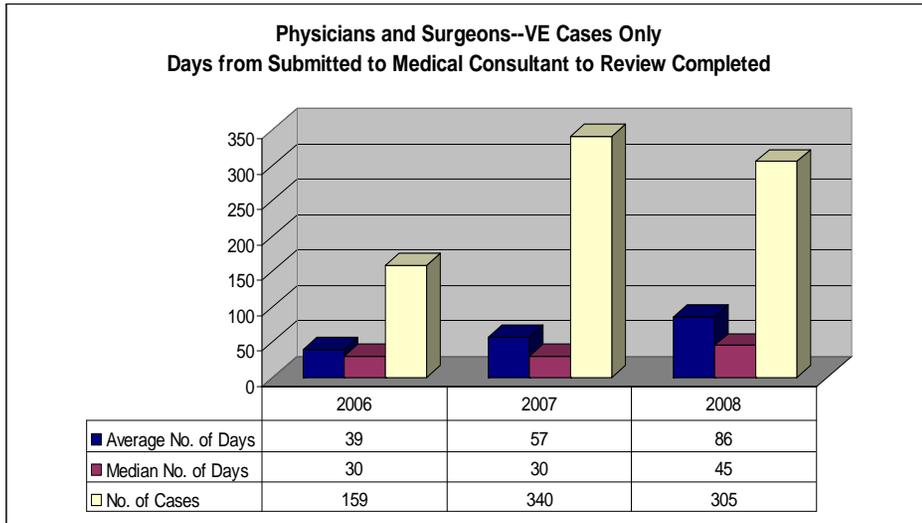
CALENDAR DAYS AGED FROM CASE SUBMITTED TO DISTRICT OFFICE MEDICAL CONSULTANT FOR REVIEW TO REVIEW COMPLETED — PHYSICIANS AND SURGEONS

Table 11.2 below reports the average and median calendar days aged from case submitted to district office medical consultant for review to review completed for Physicians and Surgeons cases. Between 2005 and 2008, there was a 187.107% increase in the average days aged, a 91.67% increase in the median days aged, a 543.75% increase in the number of such cases, and a 391.43% increase in the number of such cases pending at year end.

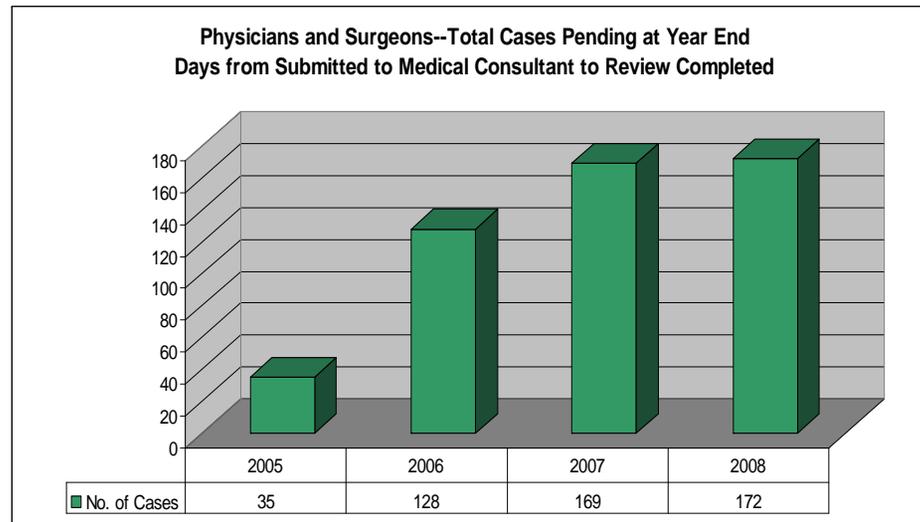
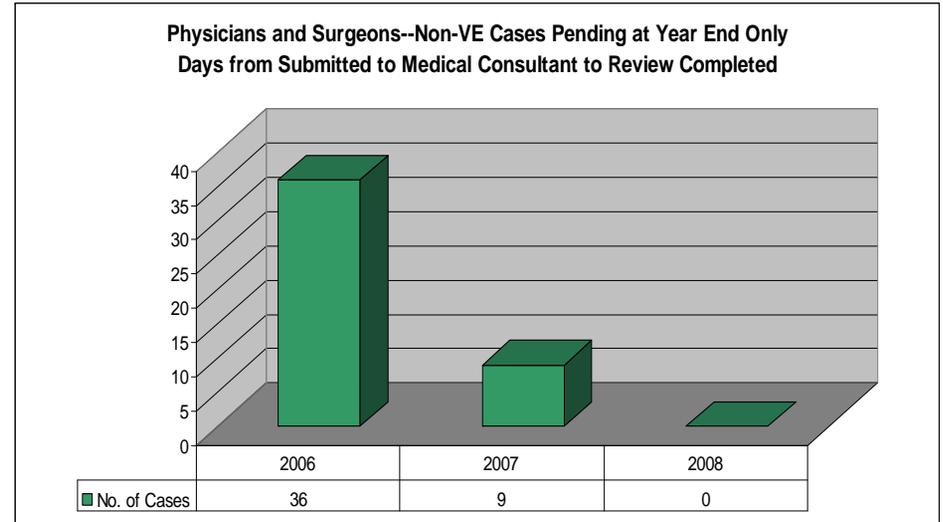
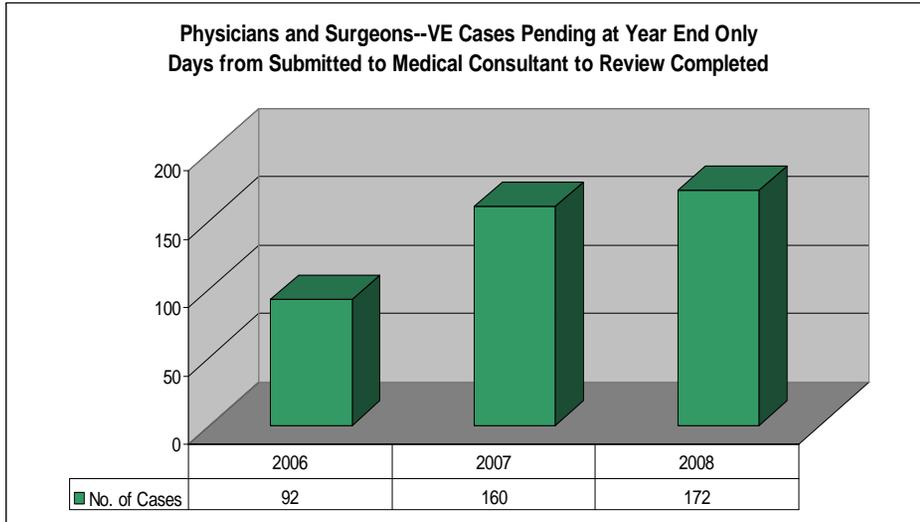
Table 11.2 – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage	
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All	
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending	
Calendar Day Age from Date Case Submitted to District Office Medical Consultant for Review to Review Completed Date																				
Average	7.02%		43.21%		46.15%		45.90%		234.48%		50.88%		56.14%		379.01%		120.51%		187.10%	
Median (middle record - half are above and half below)	6.90%		50.00%		0.00%		48.39%		925.64%		50.00%		58.62%		1438.46%		50.00%		91.67%	
Record Count	31.64%	32.03%	-81.03%	-75.00%	113.84%	73.91%	-14.64%	1.78%	-81.82%	-100.00%	-10.29%	7.50%	12.36%	34.38%	-96.55%	-100.00%	91.82%	86.96%	543.75%	391.43%

Charts 11.-2a, b & c – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Physicians and Surgeons Cases



Charts 11.2d, e & f – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Physicians and Surgeons Cases— Cases Pending at Year End



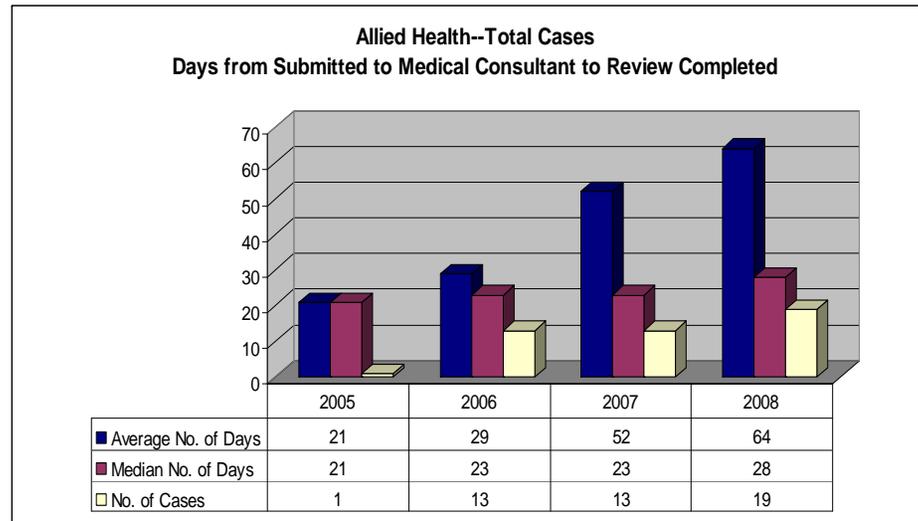
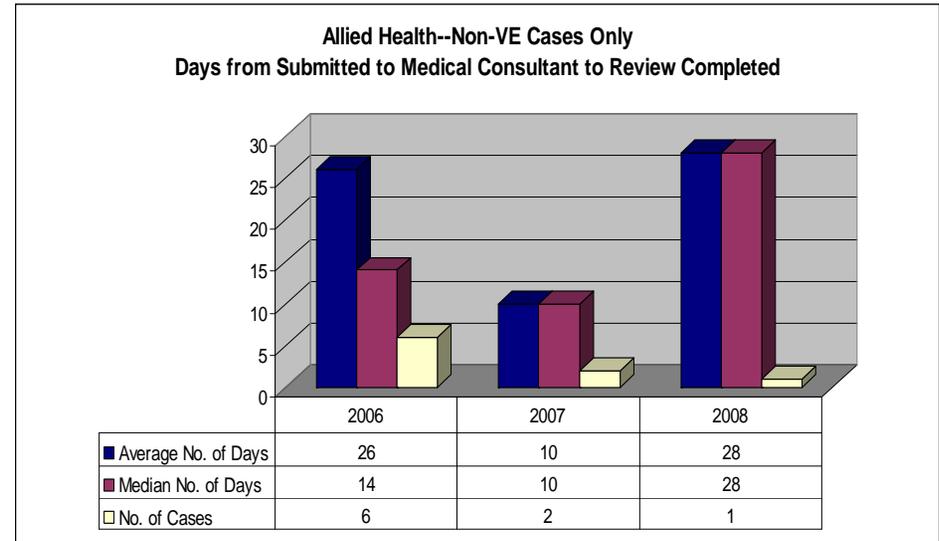
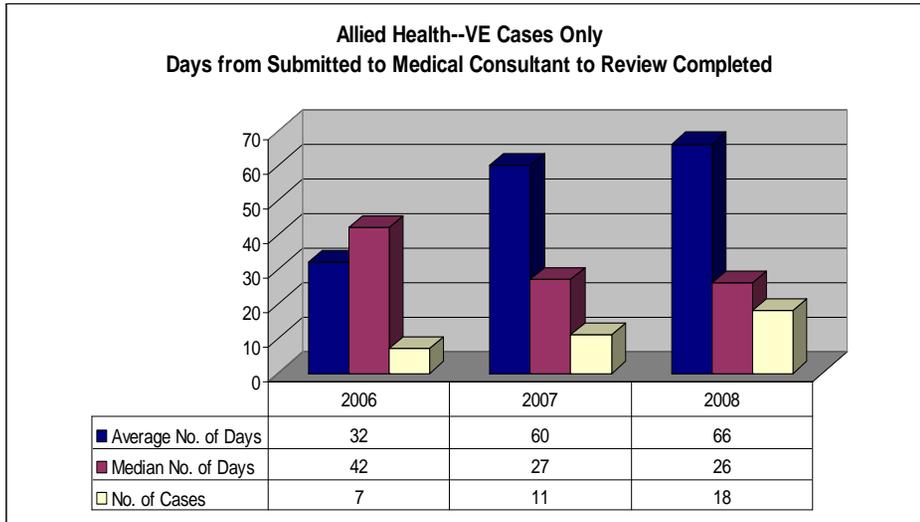
CALENDAR DAYS AGED FROM CASE SUBMITTED TO DISTRICT OFFICE MEDICAL CONSULTANT FOR REVIEW TO REVIEW COMPLETED — ALLIED HEALTH

Table 11.3 below reports the average and median calendar days aged from case submitted to district office medical consultant for review to review completed for Allied Health Care cases. Between 2005 and 2008, there was a 204.76% increase in the average days aged, a 33.33% increase in the median days aged, an 1800.00% increase in the number of such cases, and a 1900.00% increase in the number of such cases pending at year end.

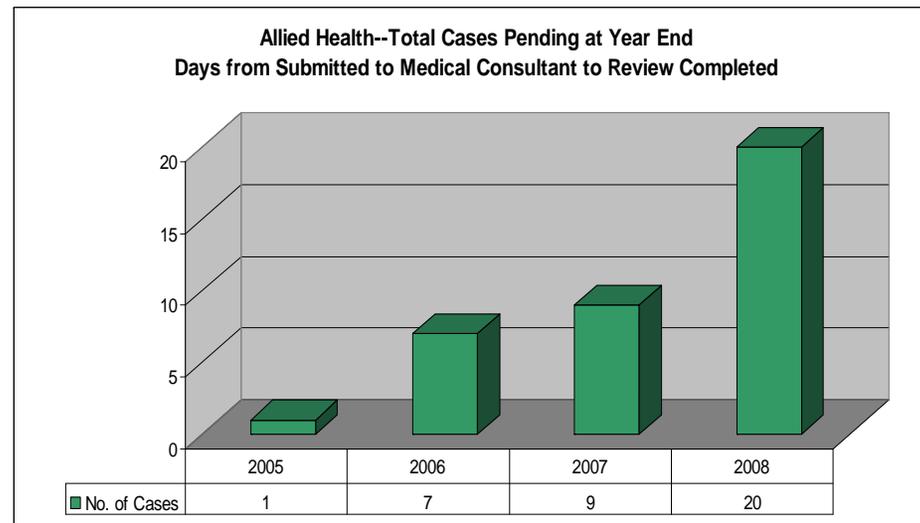
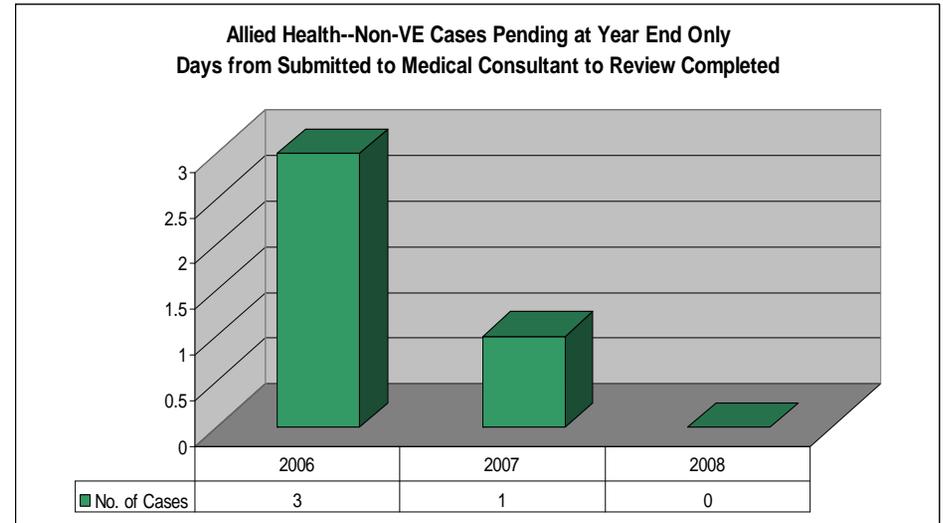
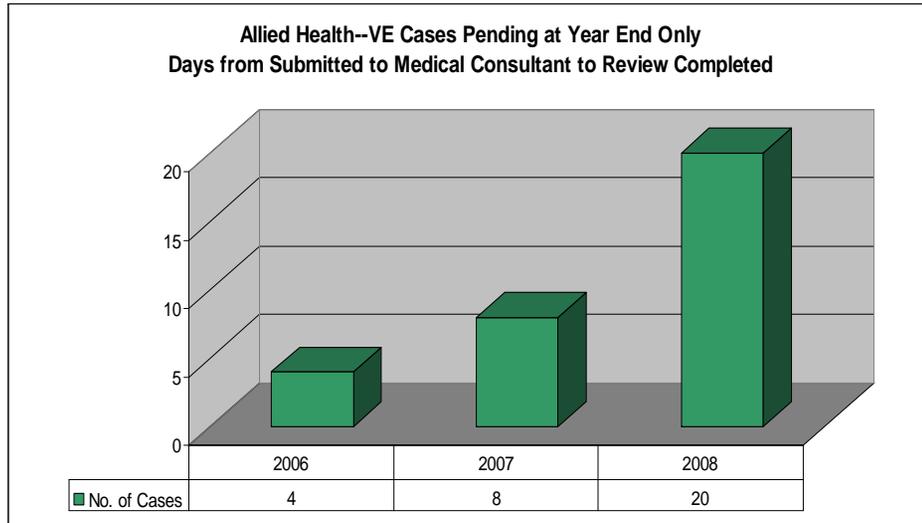
Table 11.3 – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All	Not VE		VE		All	Not VE		VE		All	Not VE		VE		All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Date Case Submitted to District Office Medical Consultant for Review to Review Completed Date																				
Average	79.31%	-61.54%	87.50%			23.08%	180.00%	10.00%			120.69%	7.69%	106.25%			204.76%				
Median (middle record - half are above and half below)	0.00%	-28.57%	-35.71%			21.74%	180.00%	-3.70%			21.74%	100.00%	-38.10%			33.33%				
Record Count	0.00%	28.57%	-66.67%	-66.67%	57.14%	100.00%	46.15%	122.22%	-50.00%	-100.00%	63.64%	150.00%	46.15%	185.71%	-83.33%	-100.00%	157.14%	400.00%	1800.00%	1900.00%

Charts 11.3a, b & c – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Allied Health Cases



Charts 11.3d, e & f – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Allied Health Cases— Cases Pending at Year End



XII. EXPERT REVIEWER PROGRAM

In quality of care cases against a physician, an expert opinion is required to prove or disprove that the physician performed in accordance with the prevailing standard of care. Since the burden of proof is on MBC, it must produce physician witness(es) with experience and expertise in the specialty or procedure at issue. The expert witness must review the evidence, testify to the standard of care and explain the basis for his/her opinion.

EXPERT REVIEWER POLICY

Per EOM Section 7.4, the investigator shall prepare the file for expert review and submit to Sup I for approval. After approval, per both the EOM and the JVEG, the investigator submits the file to the primary DAG who has 10 business days to review the package. If the primary DAG is unable to complete within this timeframe, the lead DAG should conduct the review.

Pursuant to EOM: "It is the policy of MBC to utilize the services of licensed physicians who are Board certified in their specialty area to provide expert reviews and opinions in MBC cases." Under extraordinary circumstances, supervising investigators may use an expert reviewer who is not a participant in the Expert Reviewer Program. The Sup I must obtain approval from the Sup II and the unapproved expert must meet the minimum qualifications set forth in the Expert Reviewer Program.

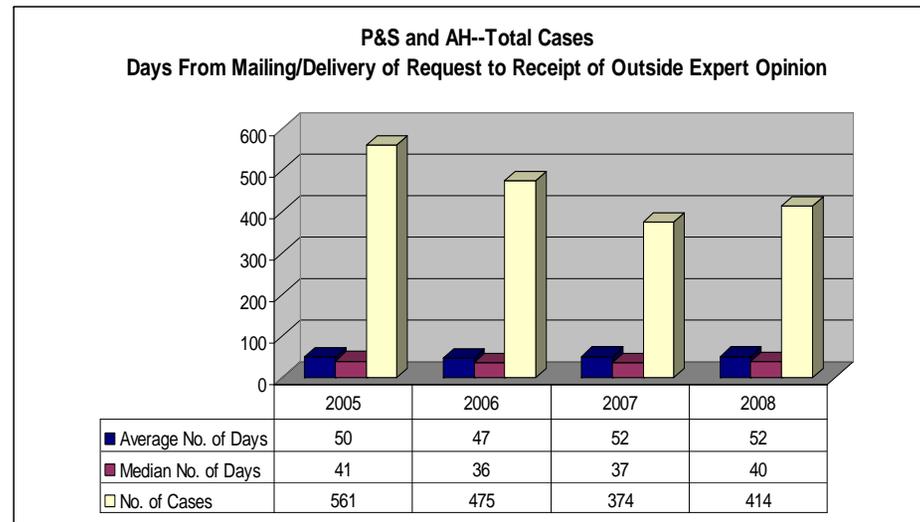
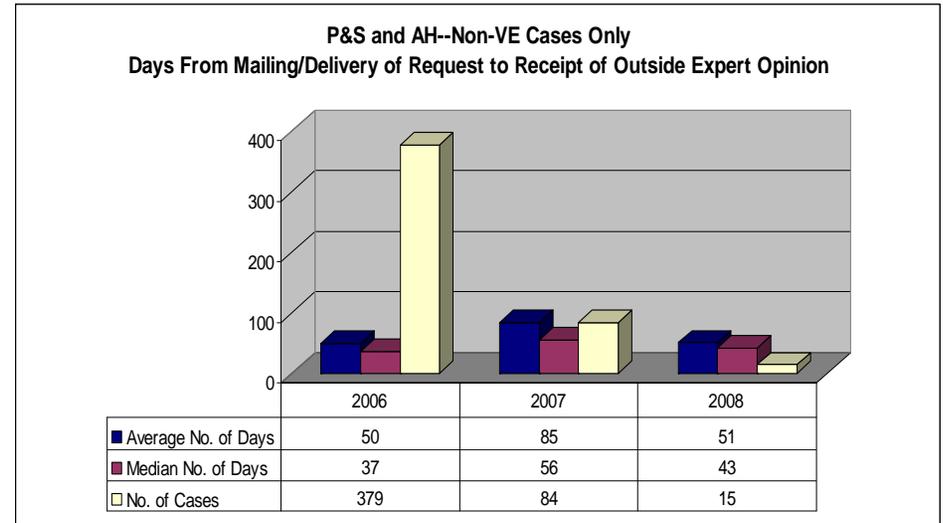
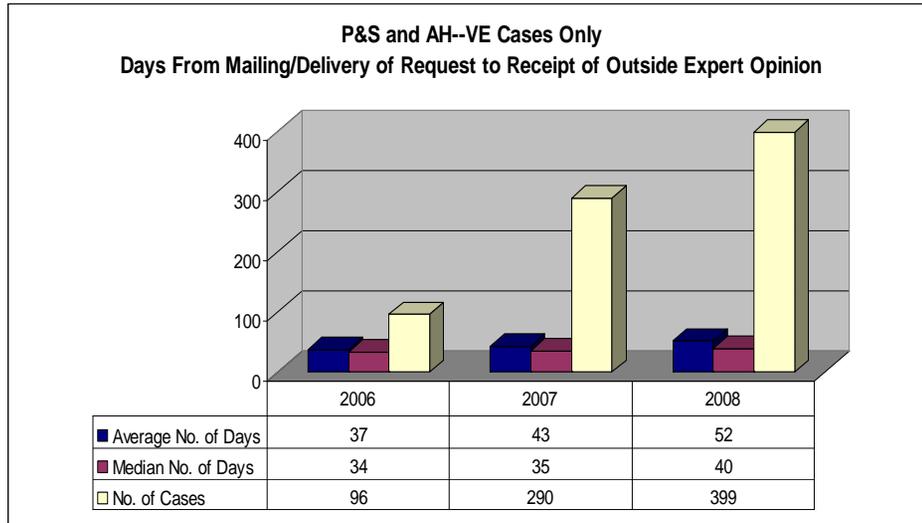
CALENDAR DAYS AGED FROM REQUEST TO RECEIPT OF EXPERT OPINION — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 12.1 below reports the average and median calendar days aged from mailing/delivery of the request to receipt of outside expert opinion for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 4.00% increase in the average days aged, a 2.44% decrease in the median days aged, a 26.20% decrease in the number of such cases, and a 17.46% decrease in the number of such cases pending at year end.

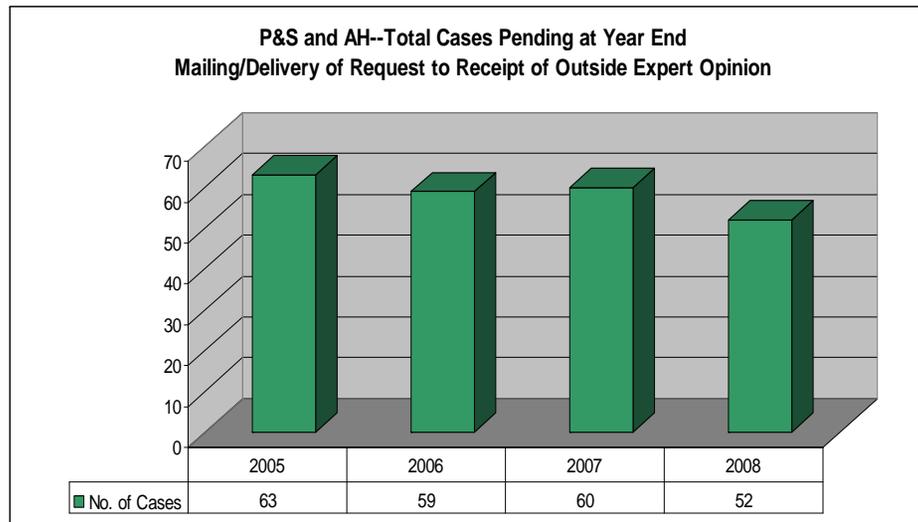
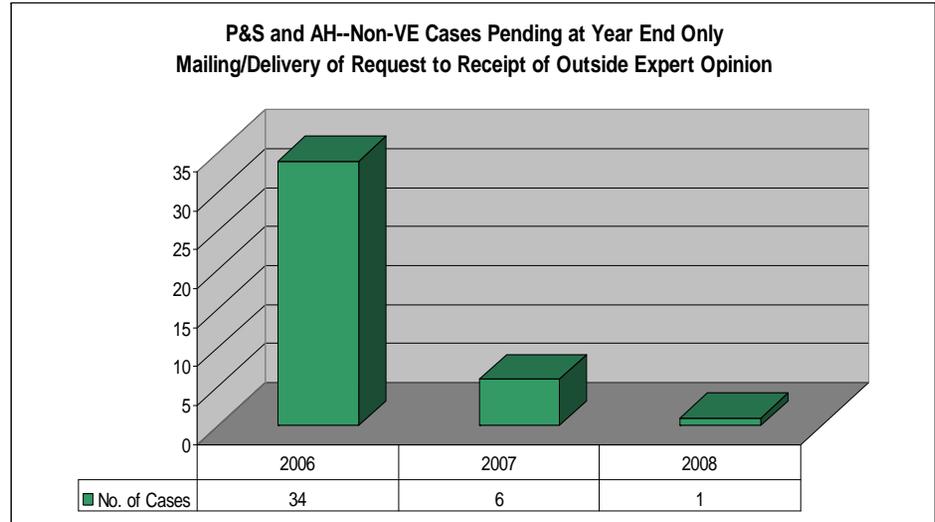
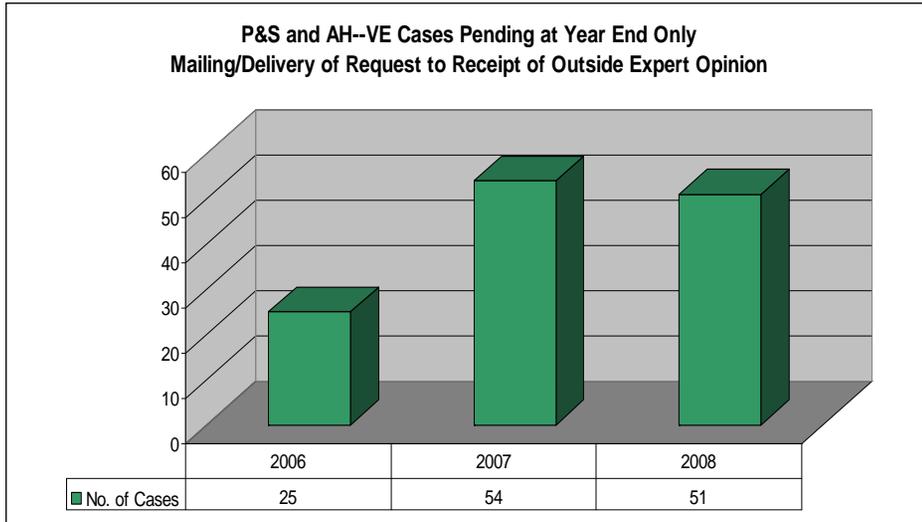
Table 12.1 – Calendar Days Aged from Request to Receipt of Expert Opinion for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage Difference 2005 to 2008			
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All			
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending			
Calendar Day Age from Request to Receipt of Expert Opinion																						
Average	10.64%		70.00%		16.22%		0.00%		-40.00%		20.93%		10.64%		2.00%		40.54%		4.00%			
Median (middle record - half are above and half below)	2.78%		51.35%		2.94%		8.11%		-23.21%		14.29%		11.11%		16.22%		17.65%		-2.44%			
Record Count	-21.26%	1.69%	-77.84%	-82.35%	202.08%	116.00%	10.70%	-13.33%	-82.14%	-83.33%	37.59%	-5.56%	-12.84%	-11.86%	-96.04%	-97.06%	315.63%	104.00%	-26.20%	-17.46%		

Charts 12.1a, b & c – Calendar Days Aged from Mailing/Delivery of Request to Receipt of Expert Opinion for Physicians and Surgeons and Allied Health Cases



Charts 12.1d, e & f – Calendar Days Aged from Mailing/Delivery of Request to Receipt of Expert Opinion for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



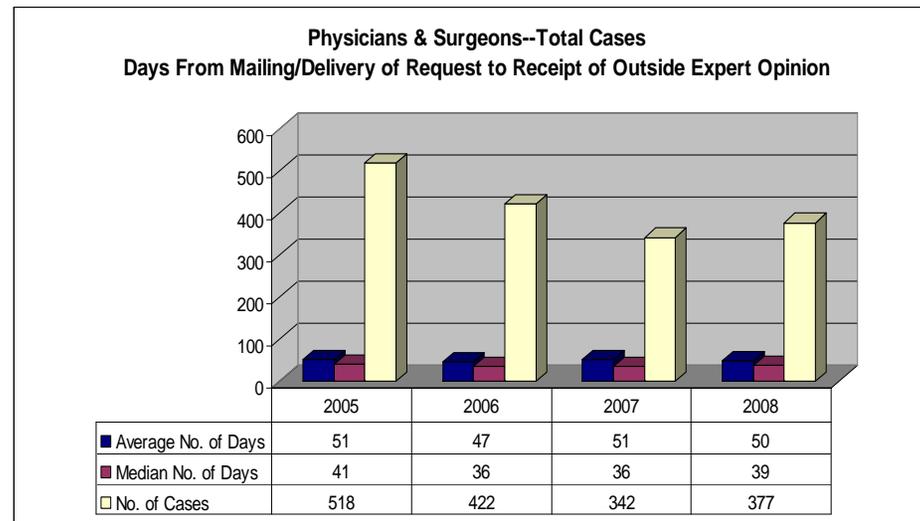
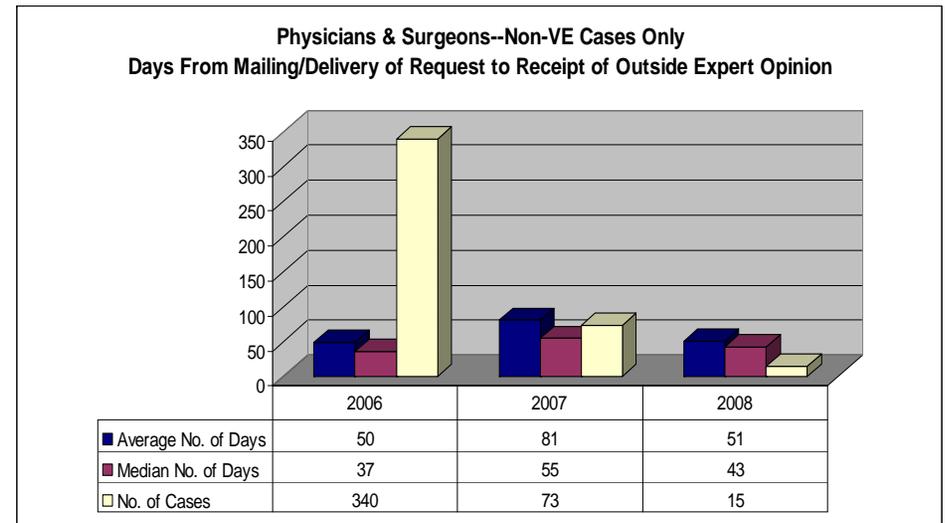
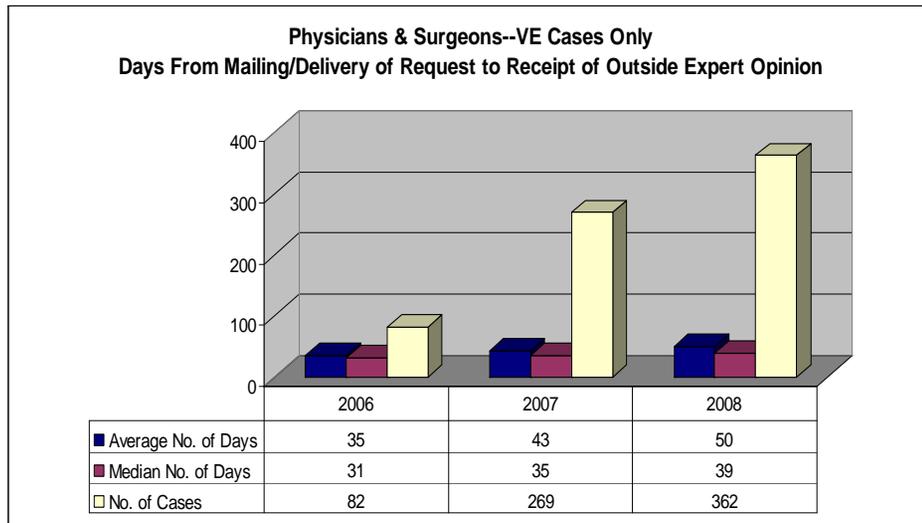
CALENDAR DAYS AGED FROM REQUEST TO RECEIPT OF EXPERT OPINION — PHYSICIANS AND SURGEONS

Table 12.2 below reports the average and median calendar days aged from mailing/delivery of the request to receipt of outside expert opinion for Physicians and Surgeons cases. Between 2005 and 2008, there was a 1.96% decrease in the average days aged, a 4.88% decrease in the median days aged, a 27.22% decrease in the number of such cases, and a 25.45% decrease in the number of such cases pending at year end.

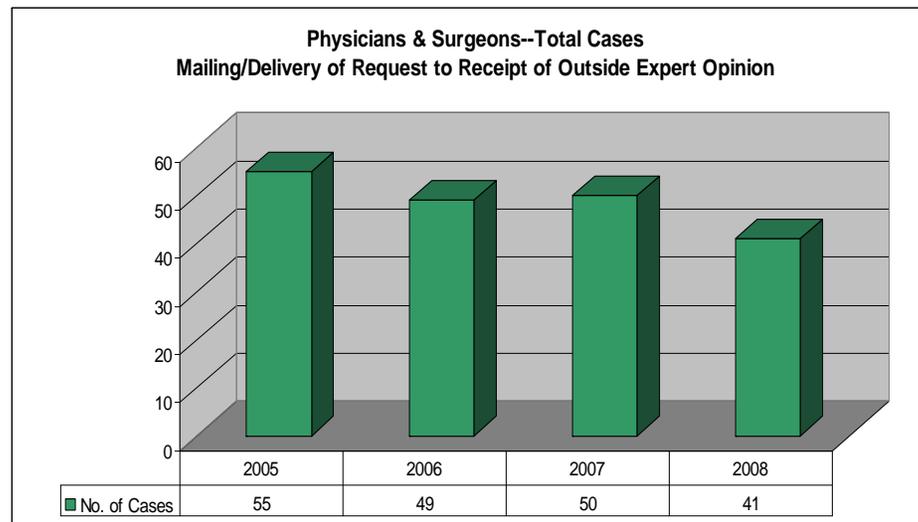
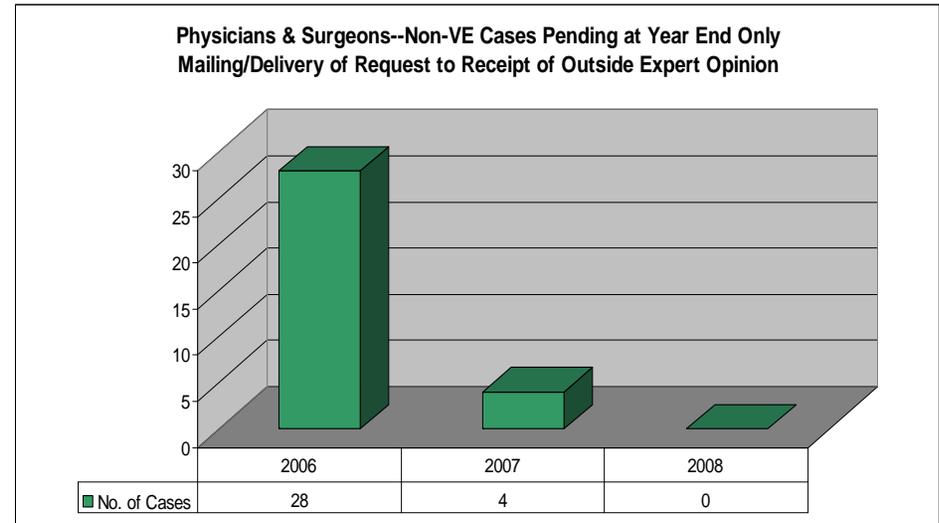
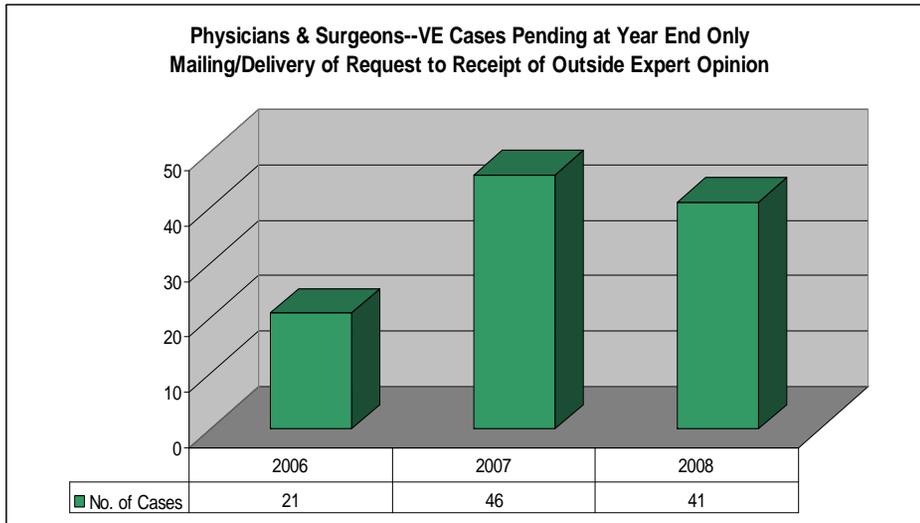
Table 12.2 – Calendar Days Aged from Request to Receipt of Expert Opinion for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage Difference 2005 to 2008			
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All			
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending			
Calendar Day Age from Request to Receipt of Expert Opinion																						
Average	8.51%		62.00%		22.86%		-1.96%		-37.04%		16.28%		6.38%		2.00%		42.86%				-1.96%	
Median (middle record - half are above and half below)	0.00%		48.65%		12.90%		8.33%		-21.82%		11.43%		8.33%		16.22%		25.81%				-4.88%	
Record Count	-18.96%	2.04%	-78.53%	-85.71%	228.05%	119.05%	10.23%	-18.00%	-79.45%	-100.00%	34.57%	-10.87%	-10.66%	-16.33%	-95.59%	-100.00%	341.46%	95.24%			-27.22%	-25.45%

Charts 12.2a, b & c – Calendar Days Aged from Mailing/Delivery of Request to Receipt of Expert Opinion for Physicians and Surgeons Cases



Charts 12.2d, e & f – Calendar Days Aged from Mailing/Delivery of Request to Receipt of Expert Opinion for Physicians and Surgeons — Cases Pending at Year End



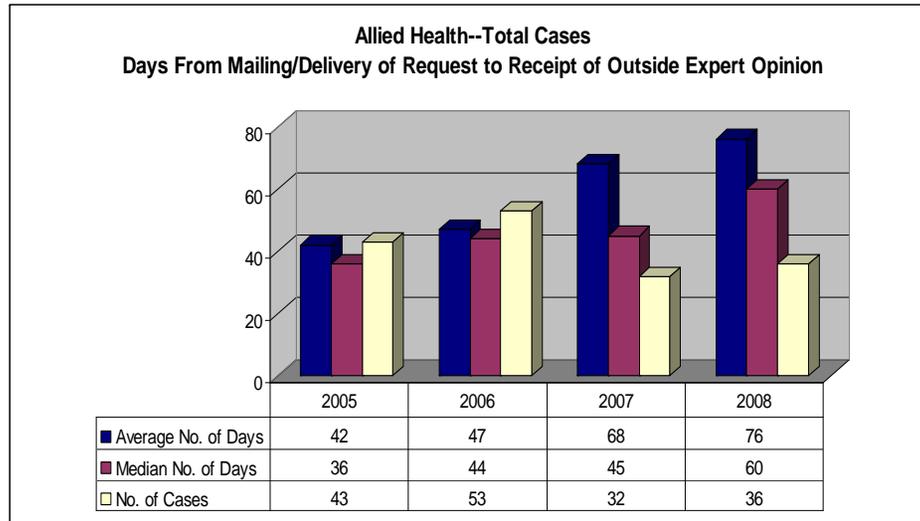
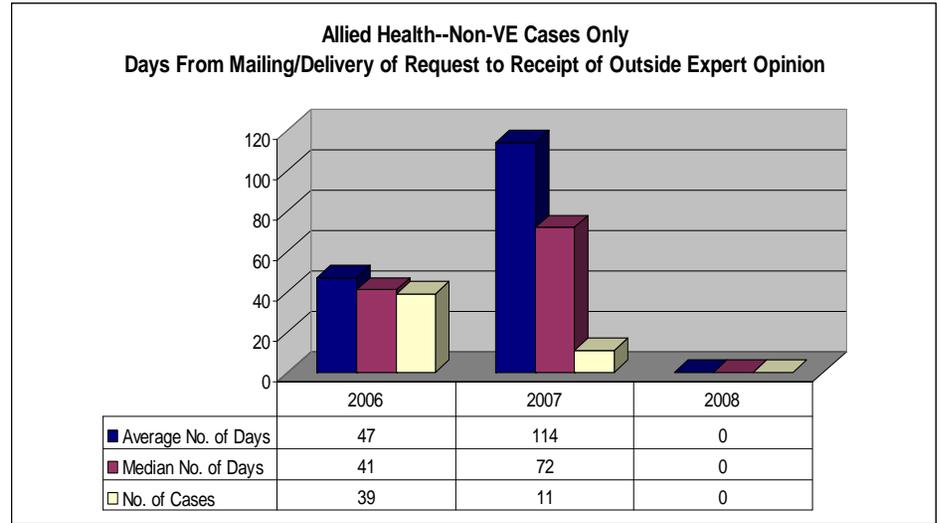
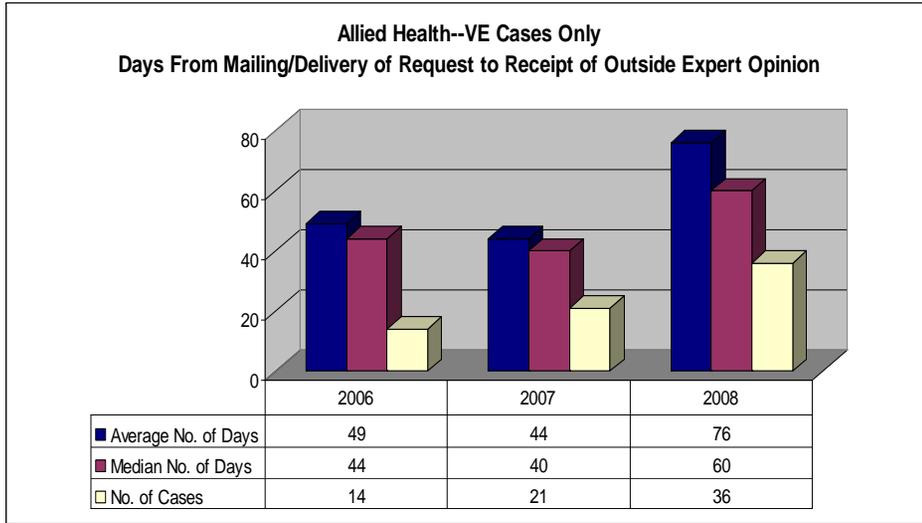
CALENDAR DAYS AGED FROM REQUEST TO RECEIPT OF EXPERT OPINION — ALLIED HEALTH

Table 12.3 below reports the average and median calendar days aged from mailing/delivery of the request to receipt of outside expert opinion for Allied Health Care cases. Between 2005 and 2008, there was an 80.95% increase in the average days aged, a 66.67% increase in the median days aged, a 16.28% decrease in the number of such cases, and a 37.50% decrease in the number of such cases pending at year end.

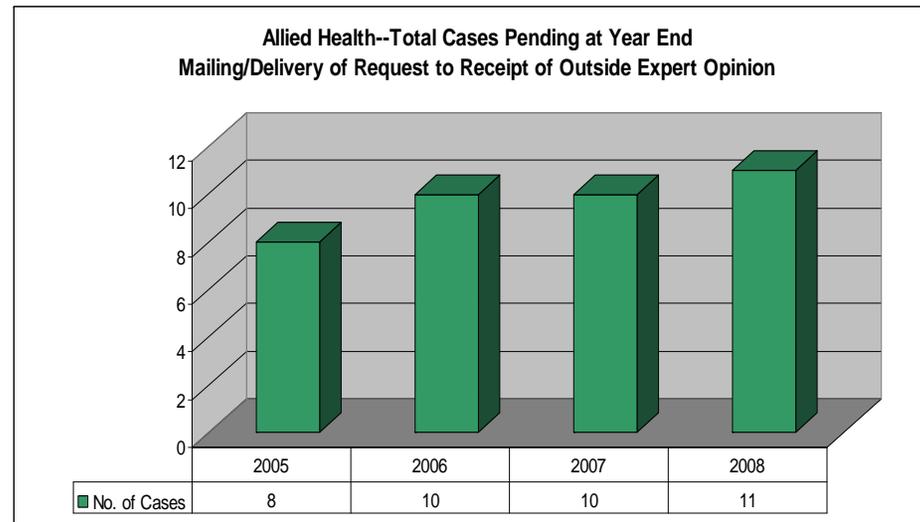
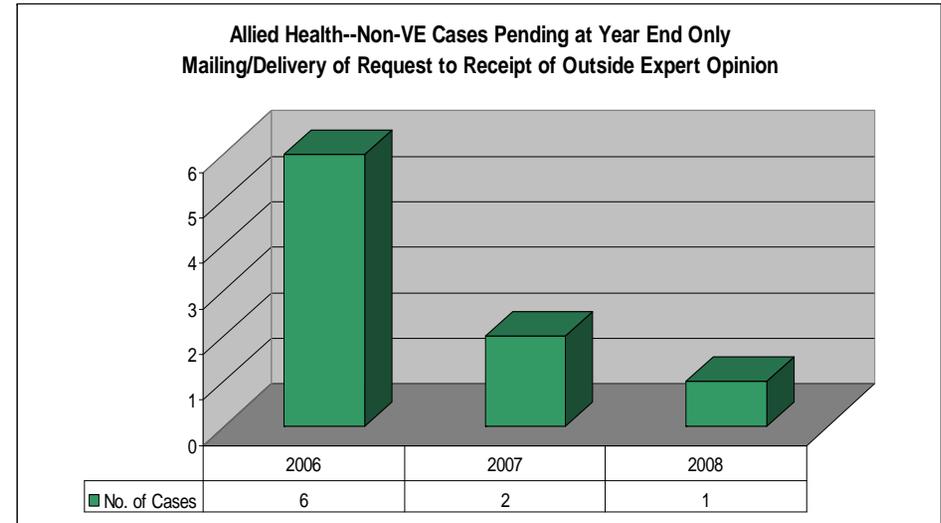
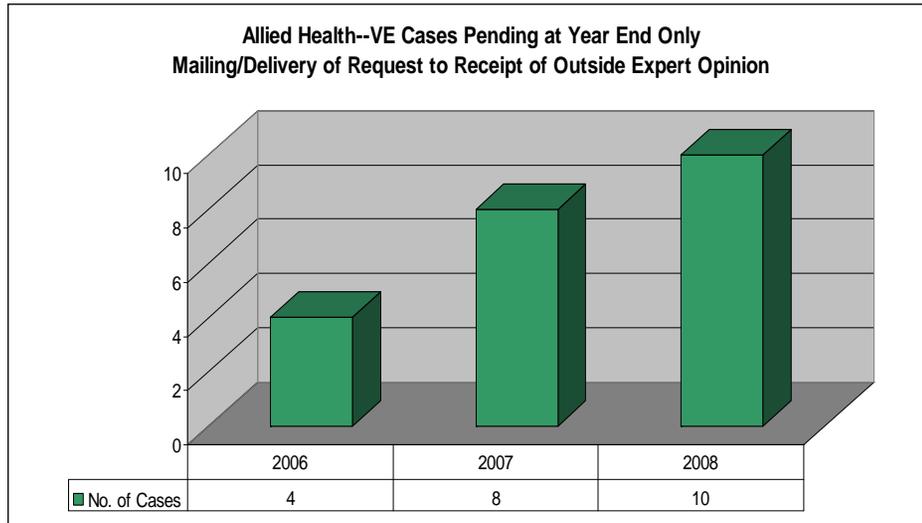
Table 12.3 – Calendar Days Aged from Request to Receipt of Expert Opinion for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending			
Calendar Day Age from Request to Receipt of Expert Opinion																				
Average	44.68%		142.55%		-10.20%		11.76%		-100.00%		72.73%		61.70%		-100.00%		55.10%		80.95%	
Median (middle record - half are above and half below)	2.27%		75.61%		-9.09%		33.33%		-100.00%		50.00%		36.36%		-100.00%		36.36%		66.67%	
Record Count	-39.62%	0.00%	-71.79%	-66.67%	50.00%	100.00%	12.50%	10.00%	-100.00%	-50.00%	71.43%	25.00%	-32.08%	10.00%	-100.00%	-83.33%	157.14%	150.00%	-16.28%	37.50%

Charts 12.3a, b & c – Calendar Days Aged from Mailing/Delivery of Request to Receipt of Expert Opinion for Allied Health Cases



Charts 12.3d, e & f – Calendar Days Aged from Mailing/Delivery of Request to Receipt of Expert Opinion for Allied Health Cases — Cases Pending at Year End



XIII. VERTICAL PROSECUTION - ASSIGNED TO COMPLETED INVESTIGATION

Pursuant to B&P Code Section 2319, MBC's average time from receipt of a complaint to completion of the investigation should be no more than six months for a non-complex case and no more than one year for a complex case. However, as previously noted, the MBC database does not differentiate between the two types of cases.

Per VPM, upon receipt of a complaint from the Central Complaint Unit (CCU), the case is assigned to both an investigator and primary DAG. Each investigation begins with the development and approval of an Investigation Plan and Progress Report (IPPR), which an investigator must prepare and submit to the primary DAG within five business days of the initial assignment. The primary DAG has five business days from receipt of the IPPR to review, approve or amend the plan. As the investigation progress, the IPPR must be updated preferably no more than five business days following the event.

Per JVEG, upon completion of an investigation, the Sup I must promptly notify the primary DAG that the case is ready for review. The primary DAG has five business days to determine whether the case is accepted for prosecution.

CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATION COMPLETED — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

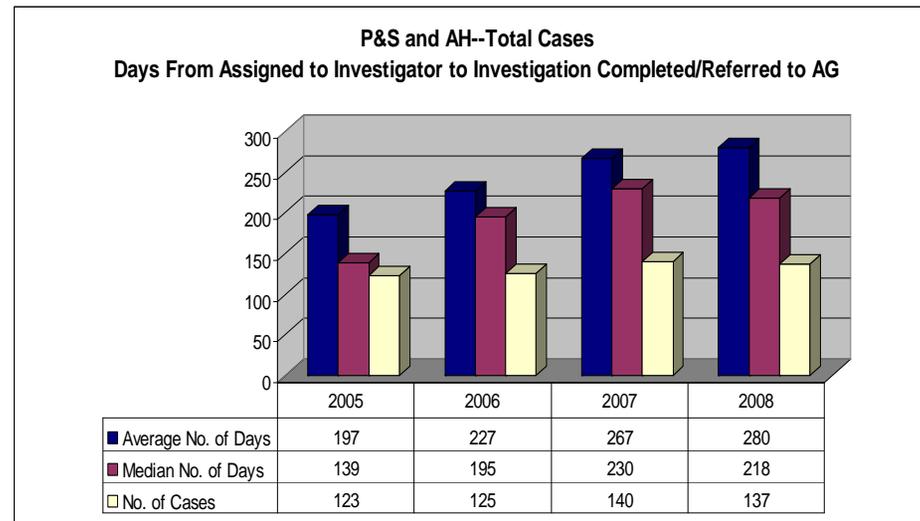
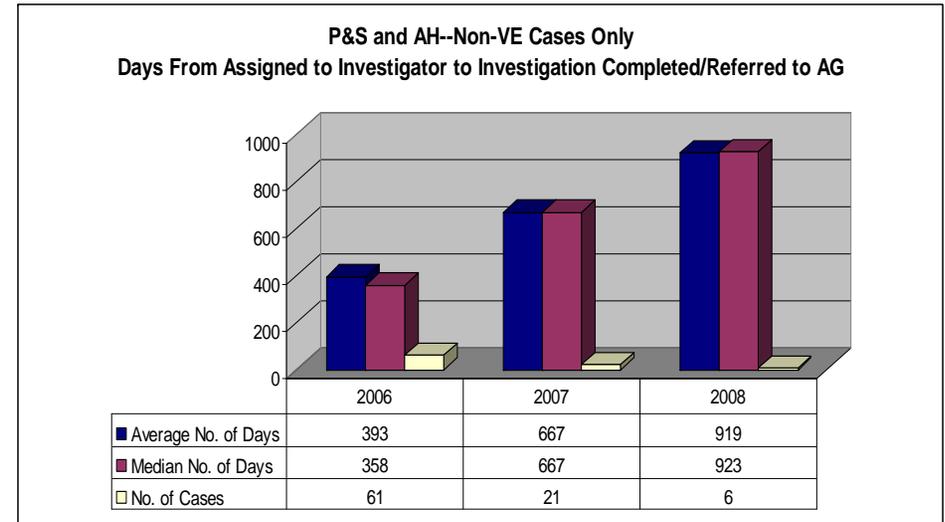
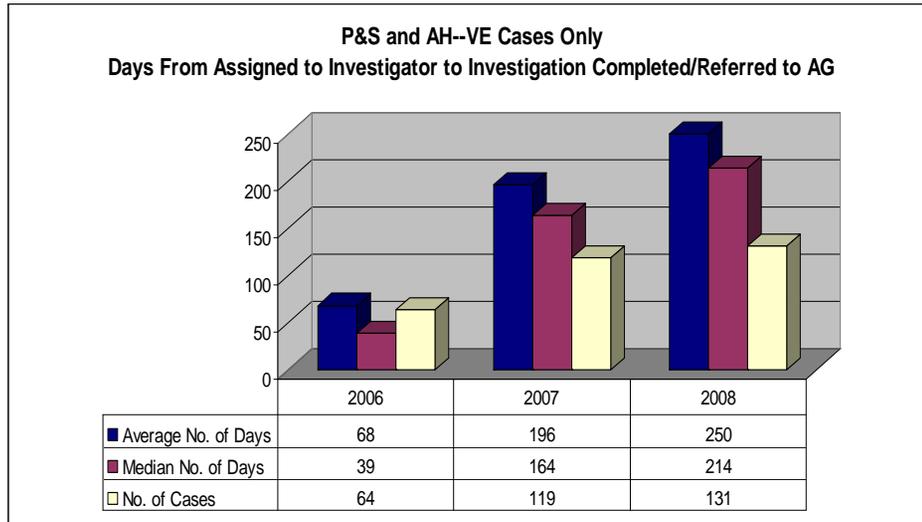
Table 13.1 below reports the average and median calendar days aged from case assigned to investigation completed for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 42.13% increase in the average days aged, a 56.83% increase in the median days aged, an 11.38% increase in the number of such cases and a 12.46% increase in the number of such cases pending at year end.

Table 13.1 – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for Physicians and Surgeons and Allied Health Cases

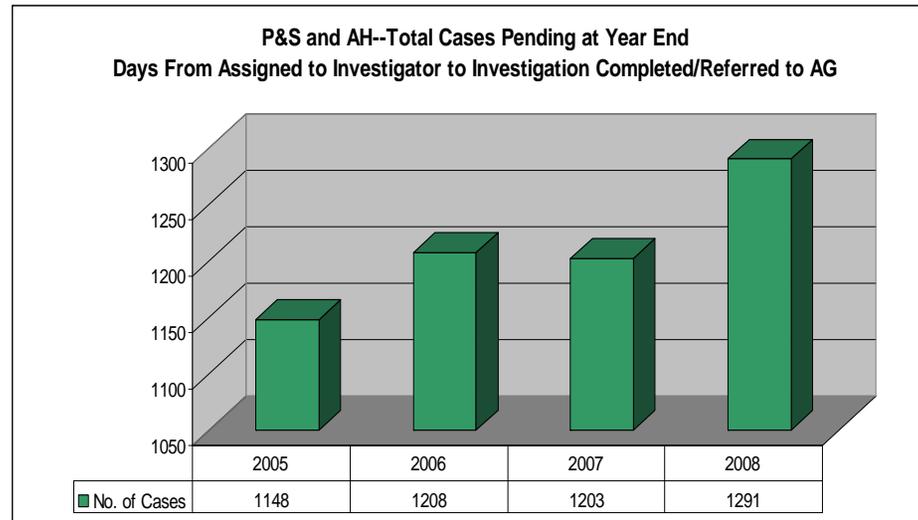
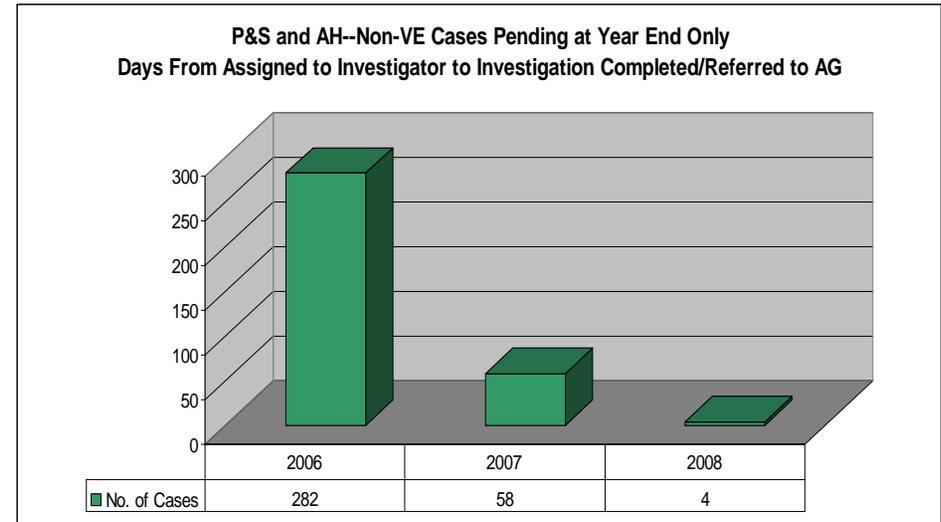
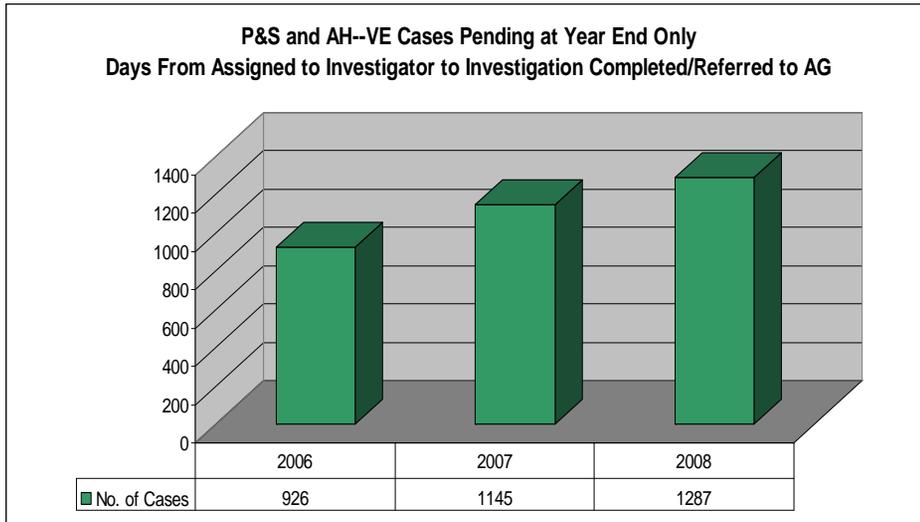
Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage	
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All	
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending	
Calendar Day Age from Case Assigned to Completed Investigation (Referred to AG)																				
Average	17.62%		69.72%		188.24%		4.87%		37.78%		27.55%		23.35%		133.84%		267.65%		42.13%	
Median (middle record-half are above and half below)	17.95%		86.31%		320.51%		-5.22%		38.38%		30.49%		11.79%		157.82%		448.72%		56.83%	
Record Count	12.00%	-0.41%	-65.57%	-79.43%	85.94%	23.65%	-2.14%	7.32%	-71.43%	-93.10%	10.08%	12.40%	9.60%	6.87%	-90.16%	-98.58%	104.69%	38.98%	11.38%	12.46%

***Excludes Outcomes where no Accusation Filed

Charts 13.1a, b & c – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for Physicians and Surgeons and Allied Health Cases



Charts 13.1d, e & f – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATION COMPLETED — PHYSICIANS AND SURGEONS

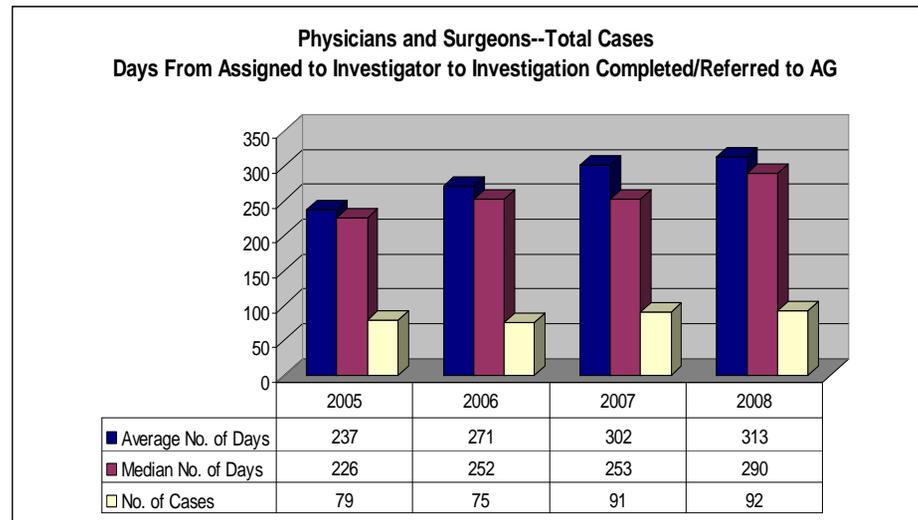
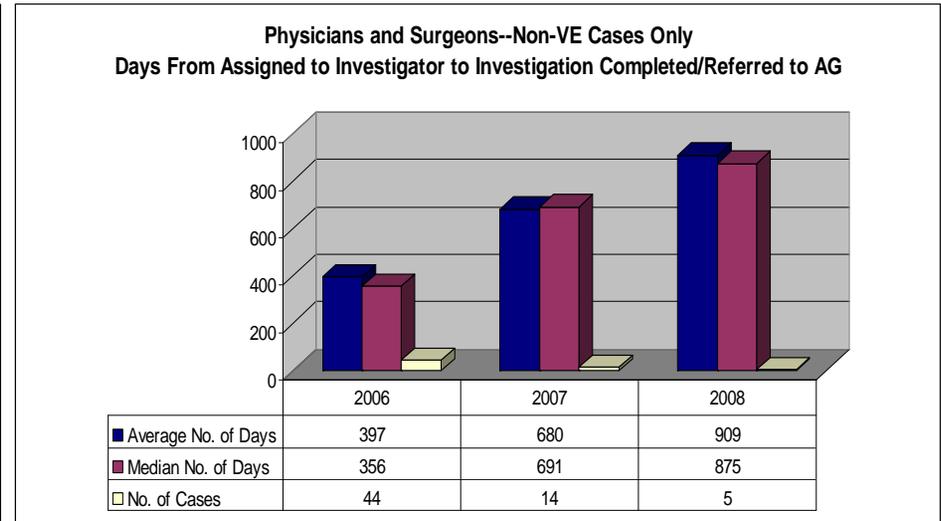
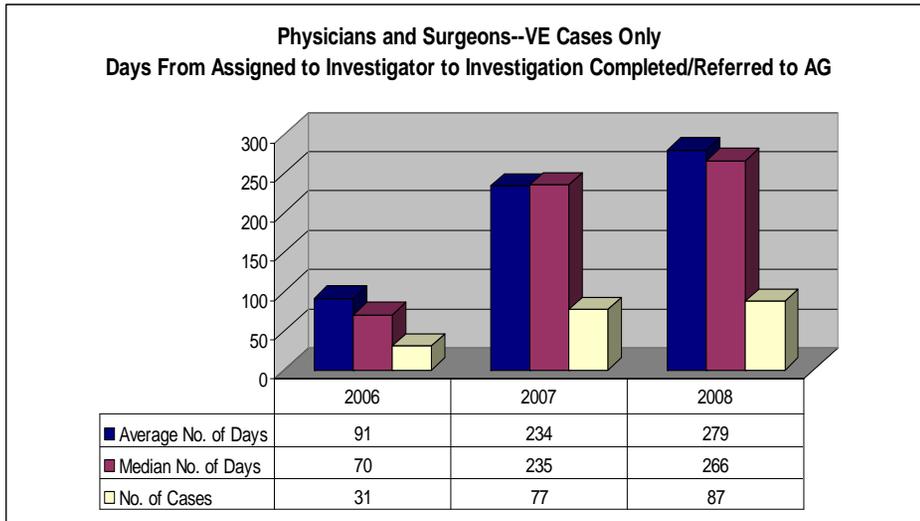
Table 13.2 below reports the average and median calendar days aged from case assigned to investigation completed for Physicians and Surgeons cases. Between 2005 and 2008, there was a 32.07% increase in the average days aged, a 28.32% increase in the median days aged, a 16.46% increase in the number of such cases and a 10.85% increase in the number of such cases pending at year end.

Table 13.2 – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for Physicians and Surgeons Cases

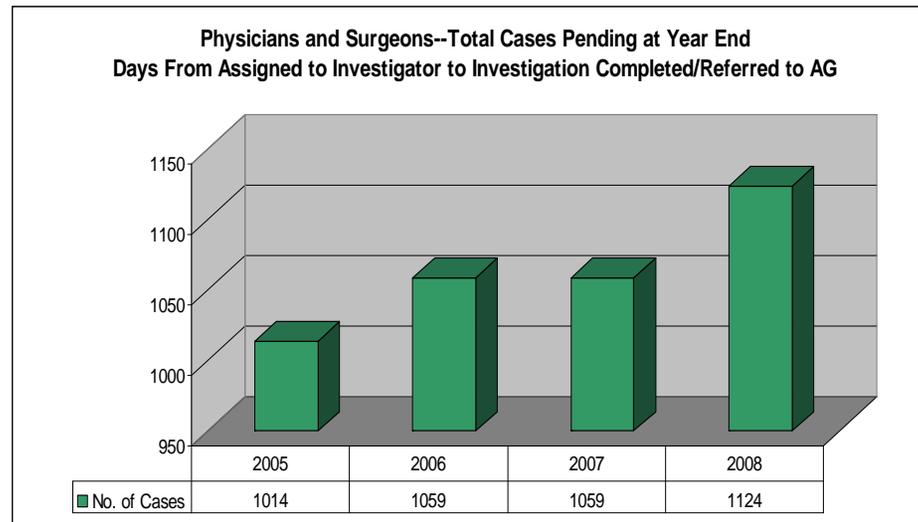
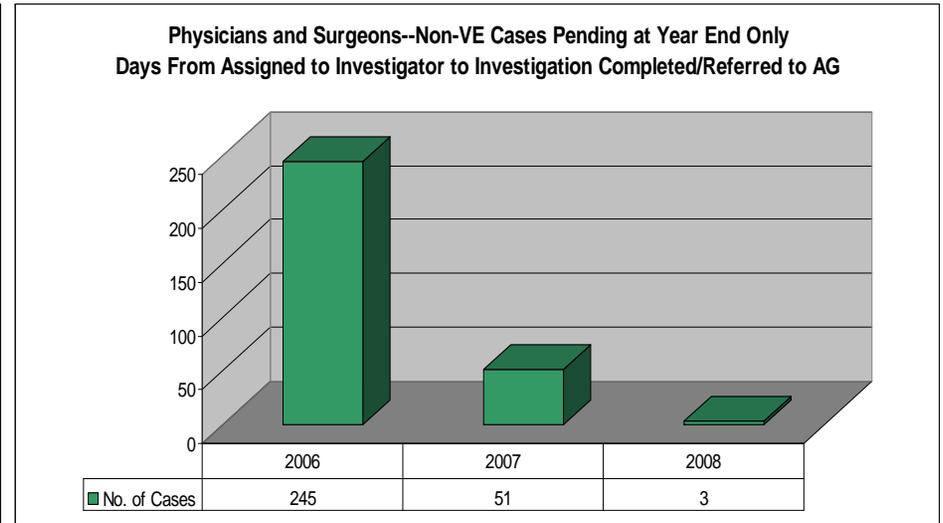
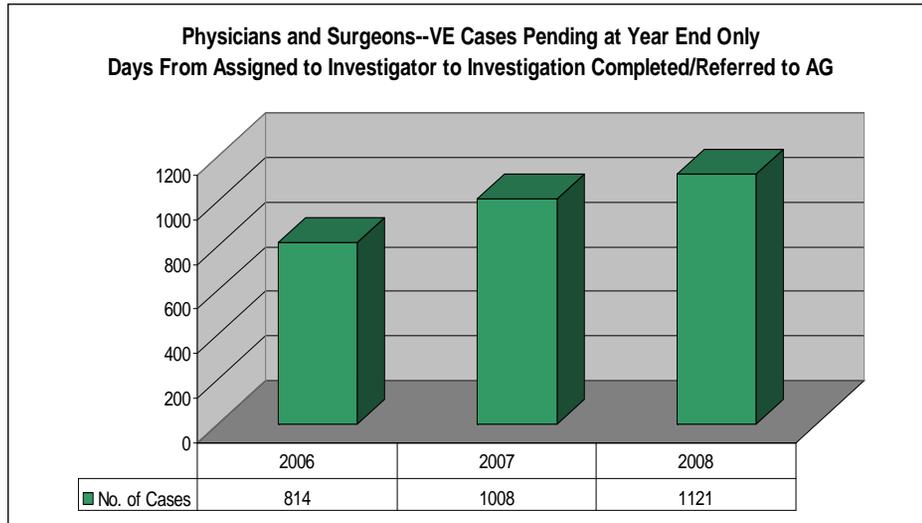
Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending					
Calendar Day Age from Case Assigned to Completed Investigation (Referred to AG)																				
Average	11.44%		71.28%		157.14%		3.64%		33.68%		19.23%		15.50%		128.97%		206.59%		32.07%	
Median (middle record-half are above and half below)	0.40%		94.10%		235.71%		14.62%		26.63%		13.19%		15.08%		145.79%		280.00%		28.32%	
Record Count	21.33%	0.00%	-68.18%	-79.18%	148.39%	23.83%	1.10%	6.14%	-64.29%	-94.12%	12.99%	11.21%	22.67%	6.14%	-88.64%	-98.78%	180.65%	37.71%	16.46%	10.85%

***Excludes Outcomes where no Accusation Filed

Charts 13.2-1a, b & c – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for Physicians and Surgeons Cases



Charts 13.2d, e & f – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed Physicians and Surgeons — Cases Pending at Year End



CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATION COMPLETED — ALLIED HEALTH

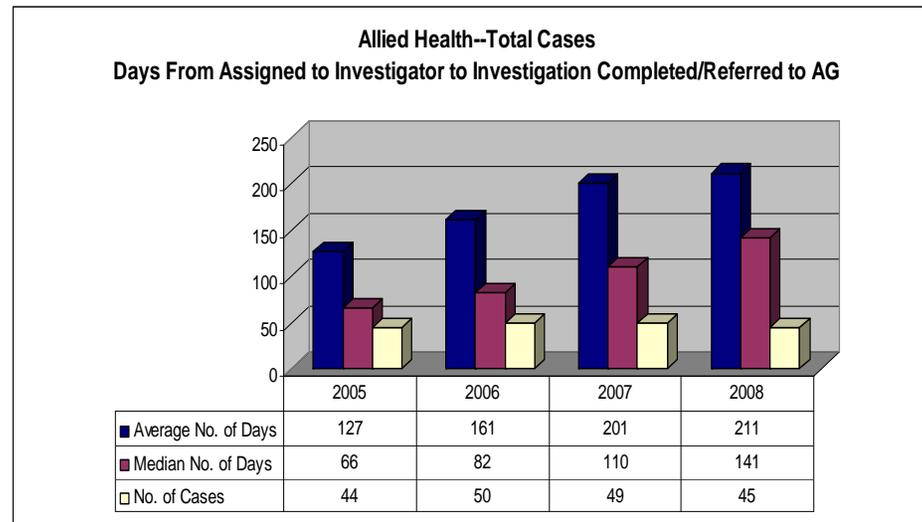
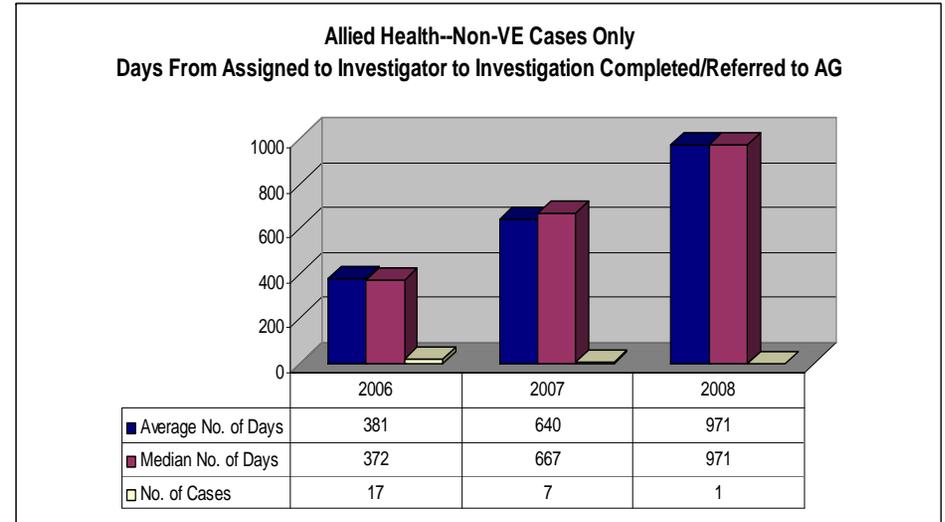
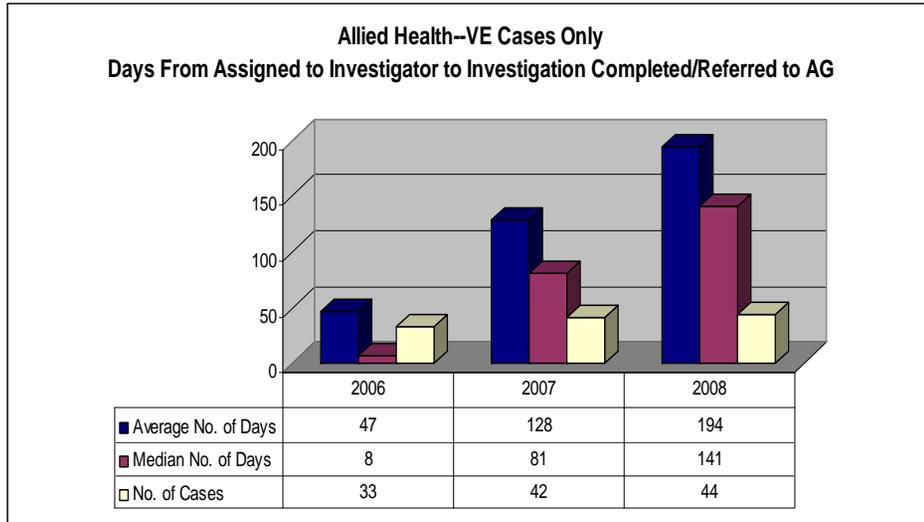
Table 13.3 below reports the average and median calendar days aged from case assigned to investigation completed for Allied Health Care cases. Between 2005 and 2008, there was a 66.14% increase in the average days aged, a 113.64% increase in the median days aged, a 2.27% increase in the number of such cases and a 24.63% increase in the number of such cases pending at year end.

Table 13.3 – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for and Allied Health Cases

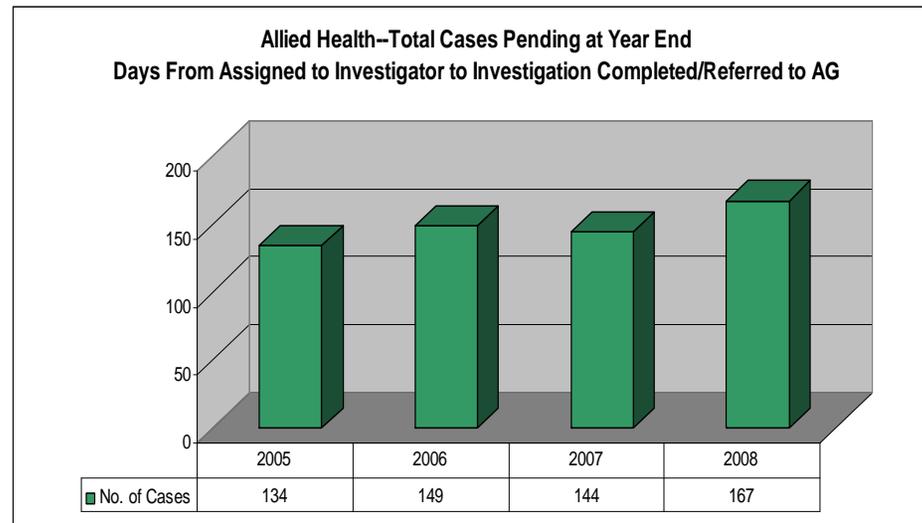
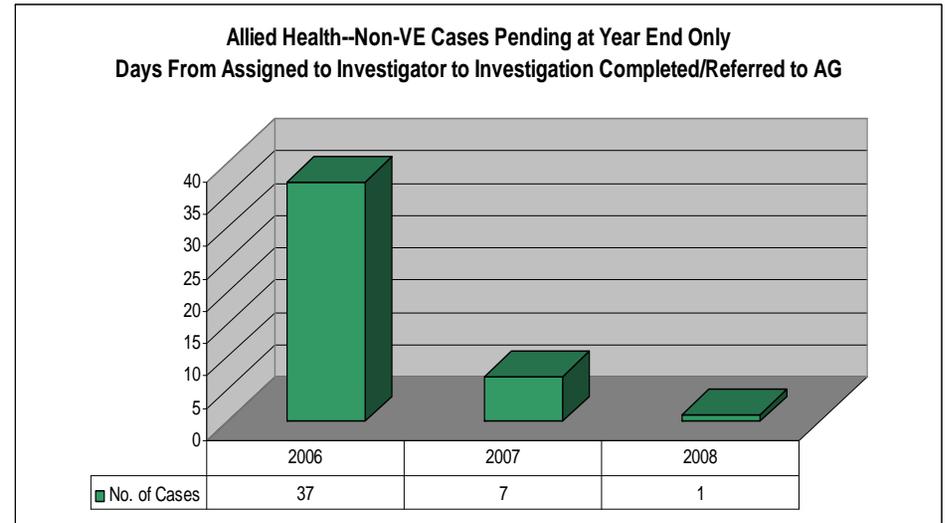
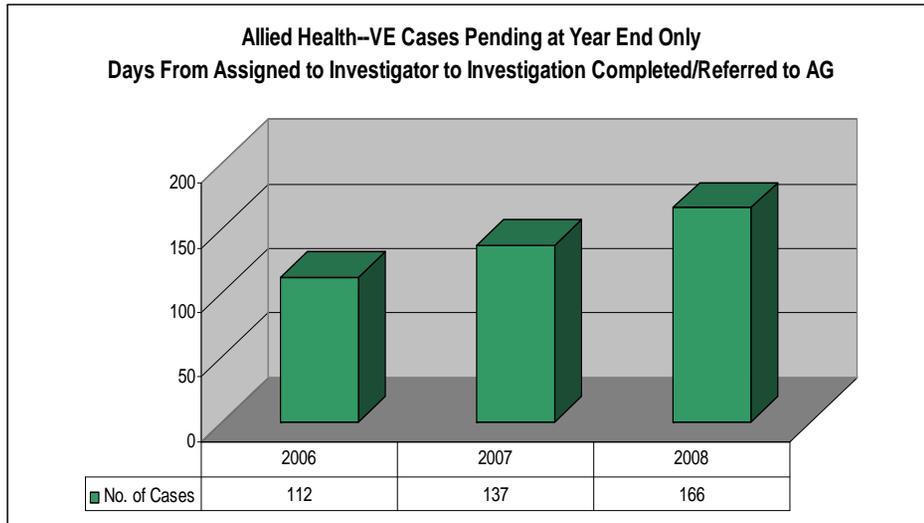
Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending					
Calendar Day Age from Case Assigned to Completed Investigation (Referred to AG)																				
Average	24.84%		67.98%		172.34%		4.98%		51.72%		51.56%		31.06%		154.86%		312.77%		66.14%	
Median (middle record-half are above and half below)	34.15%		79.30%		912.50%		28.18%		45.58%		74.07%		71.95%		161.02%		1662.50%		113.64%	
Record Count	-2.00%	-3.36%	-58.82%	-81.08%	27.27%	22.32%	-8.16%	15.97%	-85.71%	-85.71%	4.76%	21.17%	-10.00%	12.08%	-94.12%	-97.30%	33.33%	48.21%	2.27%	24.63%

***Excludes Outcomes where no Accusation Filed

Charts 13.3a, b & c – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for Allied Health Cases



Charts 13,3d, e & f – Calendar Days Aged from Case Assigned to Investigation Completed for Allied Health Cases — Cases Pending at Year End



XIV. VERTICAL PROSECUTION - ASSIGNED TO ALL OUTCOMES

The following tables and charts detail the average and median time frames that have occurred between the assignment of a case to an investigator until the ultimate outcome of the case.

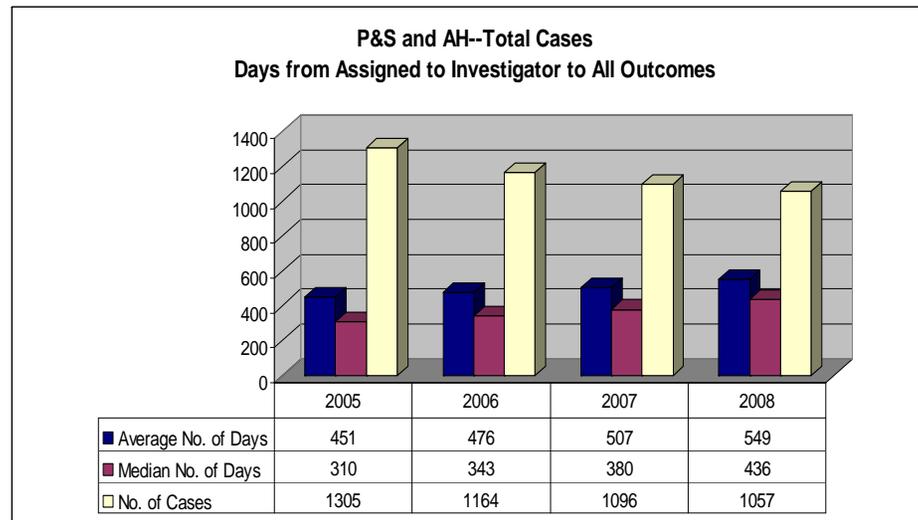
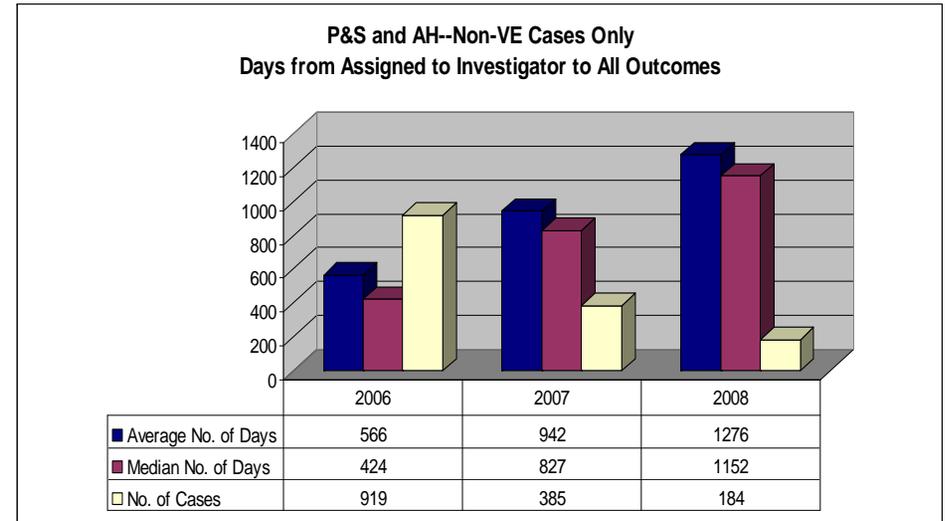
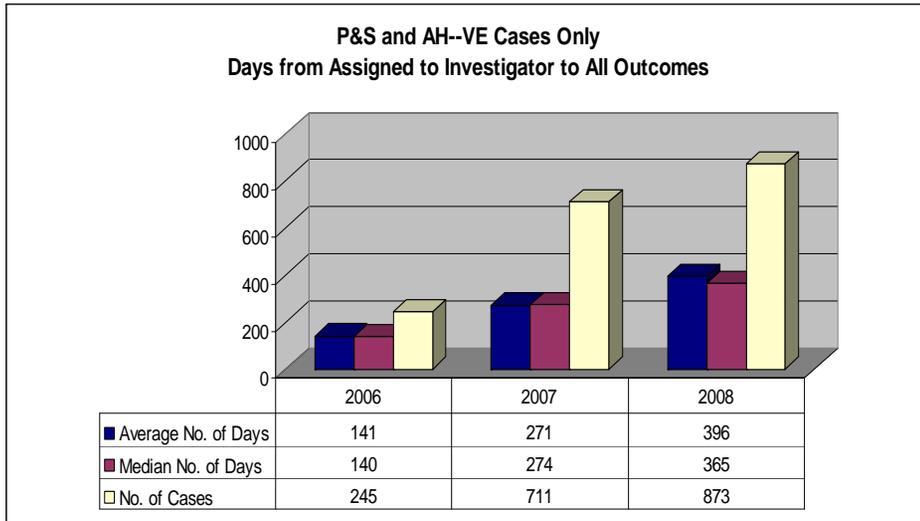
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO ALL OUTCOMES — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 14.1 below reports the average and median calendar days aged from case assigned to all outcomes for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 21.73% increase in the average days aged, a 40.65% increase in the median days aged, a 19.00% decrease in the number of such cases and a 12.24% increase in the number of such cases pending at year end.

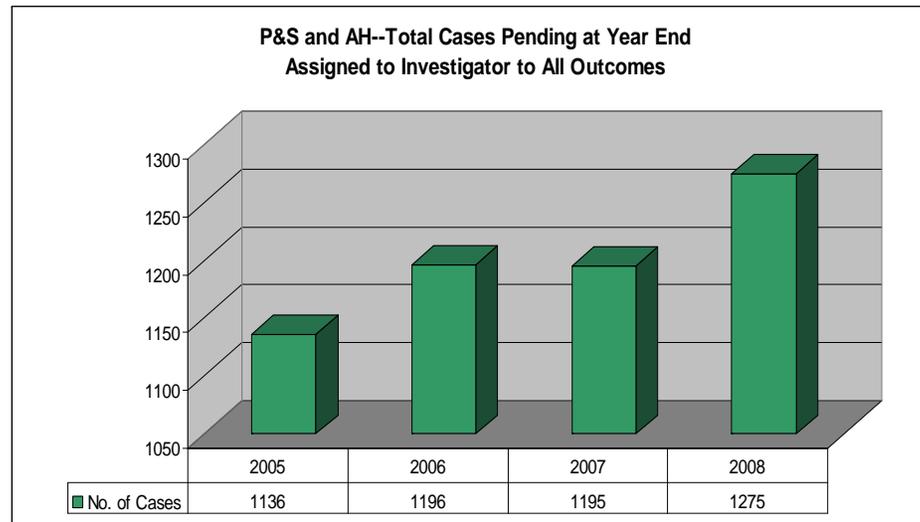
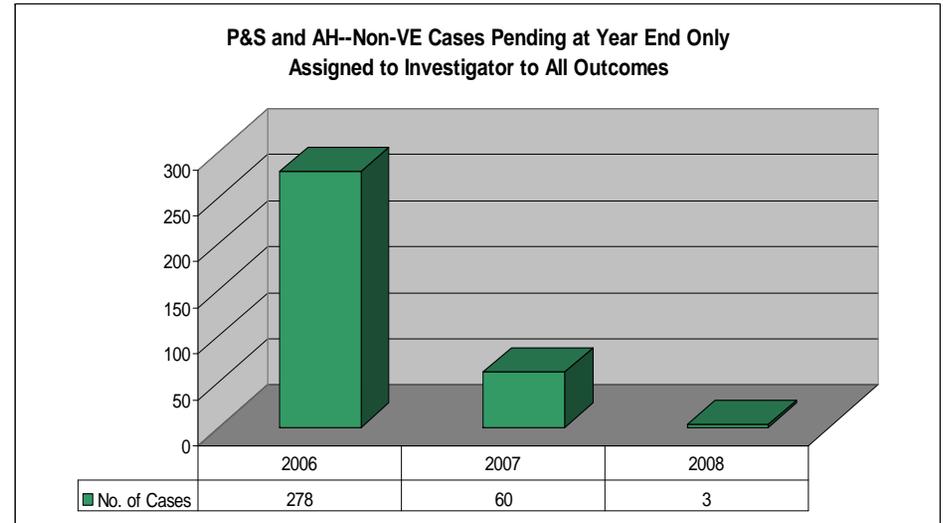
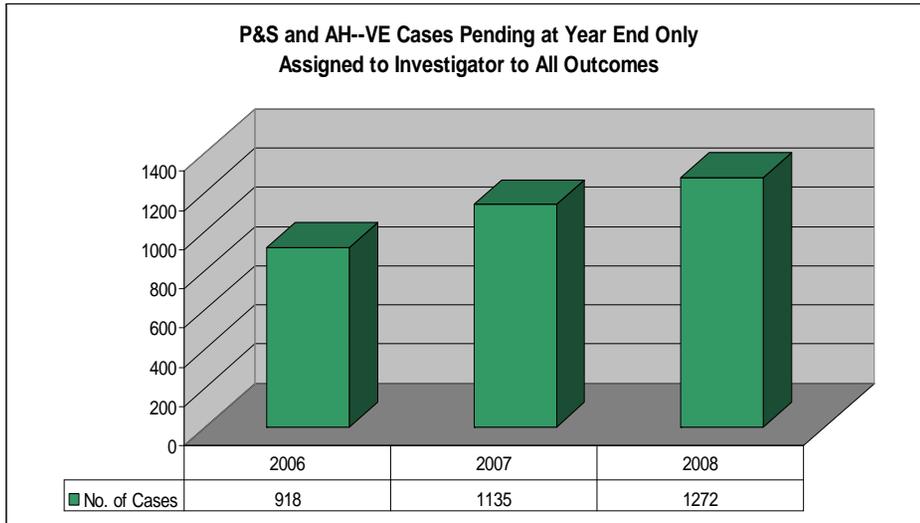
Table 14.1 – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage				
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All							
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending							
Calendar Day Age from Case Assigned to ALL Outcomes																				
Average	6.51%		66.43%		92.20%		8.28%		35.46%		46.13%		15.34%		125.44%		180.85%		21.73%	
Median (middle record - half are above and half below)	10.79%		95.05%		95.71%		14.74%		39.30%		33.21%		27.11%		171.70%		160.71%		40.65%	
Record Count	-5.84%	-0.08%	-58.11%	-78.42%	190.20%	23.64%	-3.56%	6.69%	-52.21%	-95.00%	22.78%	12.07%	-9.19%	6.61%	-79.98%	-98.92%	256.33%	38.56%	-19.00%	12.24%

Charts 14.1a, b & c – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Physicians and Surgeons and Allied Health Cases



Charts 14.1d, e & f – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



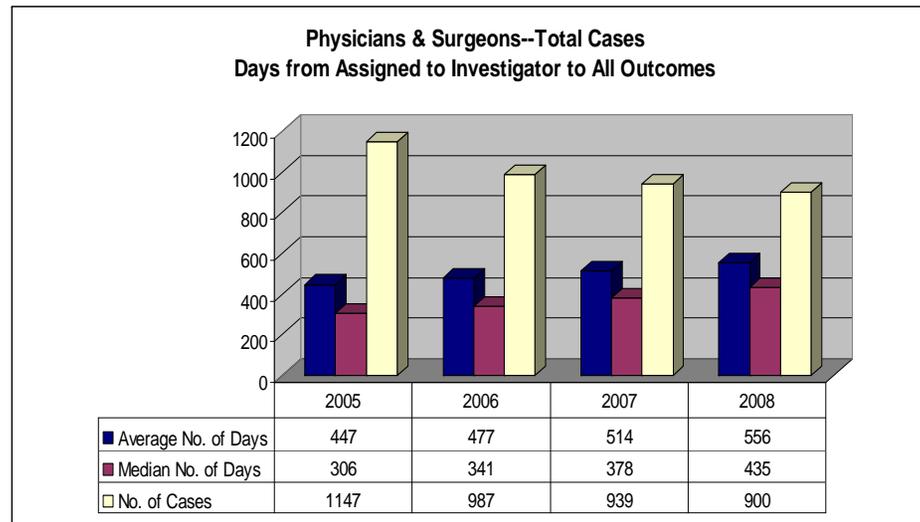
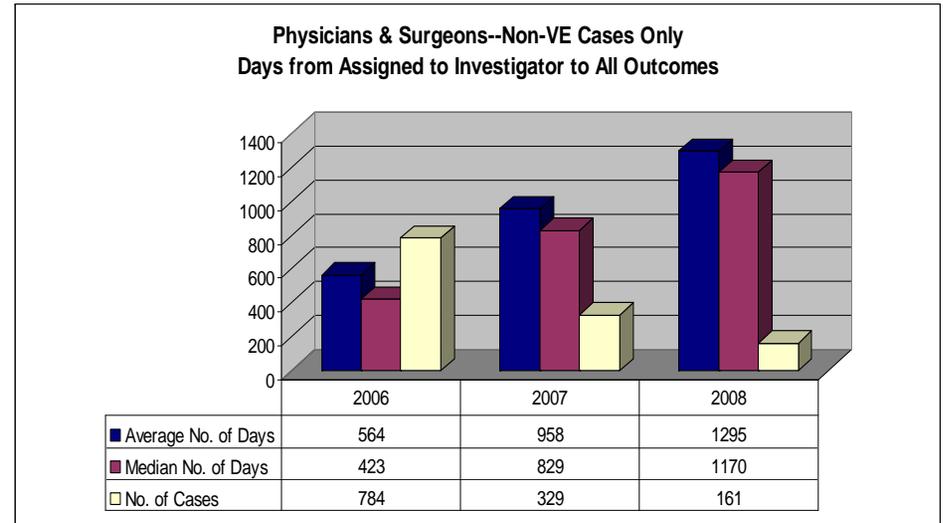
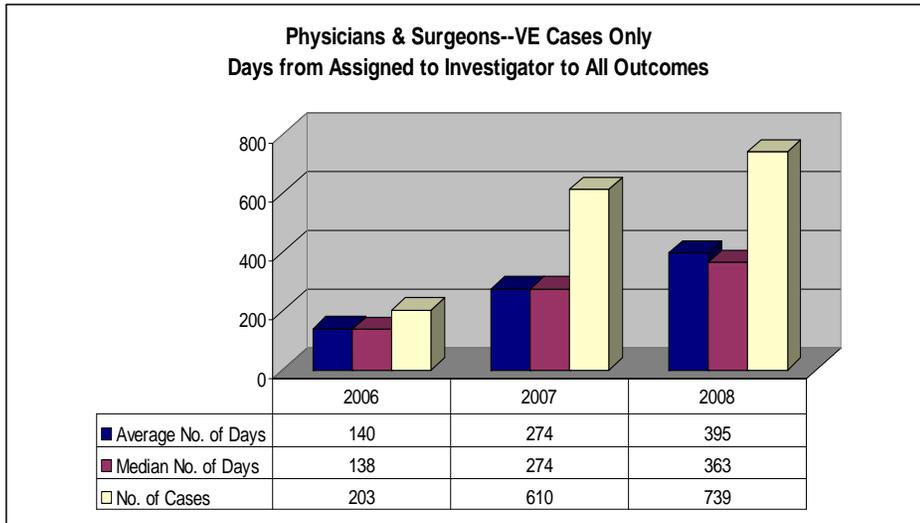
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO ALL OUTCOMES — PHYSICIANS AND SURGEONS

Table 14.2 below reports the average and median calendar days aged from case assigned to all outcomes for Physicians and Surgeons cases. Between 2005 and 2008, there was a 24.38% increase in the average days aged, a 42.16% increase in the median days aged, a 21.53% decrease in the number of such cases and an 11.96% increase in the number of such cases pending at year end.

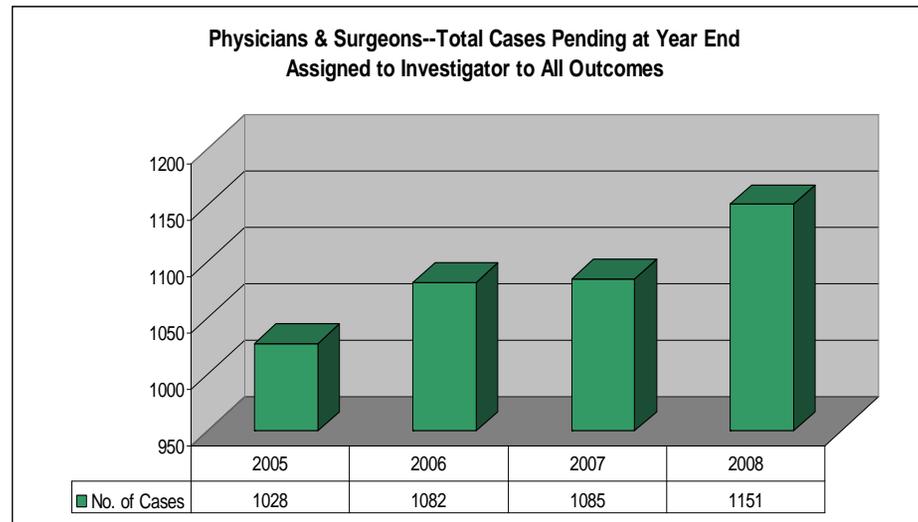
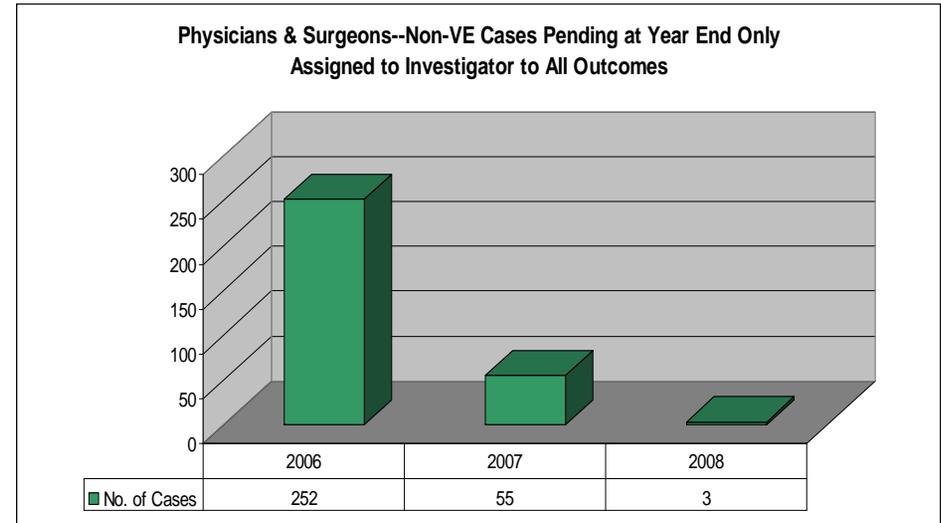
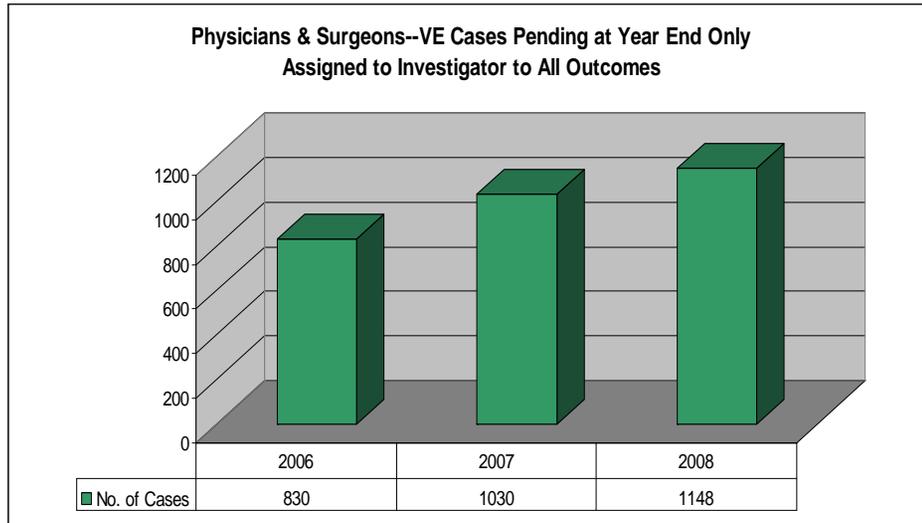
Table 14.2 – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All	Not VE		VE		All	Not VE		VE		All	Not VE		VE	All					
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending					
Calendar Day Age from Case Assigned to All Outcomes																				
Average	7.76%		69.86%		95.71%		8.17%		35.18%		44.16%		16.56%		129.61%		182.14%		24.38%	
Median (middle record - half are above and half below)	10.85%		95.98%		98.55%		15.08%		41.13%		32.48%		27.57%		176.60%		163.04%		42.16%	
Record Count	-4.86%	0.28%	-58.04%	-78.17%	200.49%	24.10%	-4.15%	6.08%	-51.06%	-94.55%	21.15%	11.46%	-8.81%	6.38%	-79.46%	-98.81%	264.04%	38.31%	-21.53%	11.96%

Charts 14.2a, b & c – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Physicians and Surgeons Cases



Charts 14.2d, e & f – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Physicians and Surgeons — Cases Pending at Year End



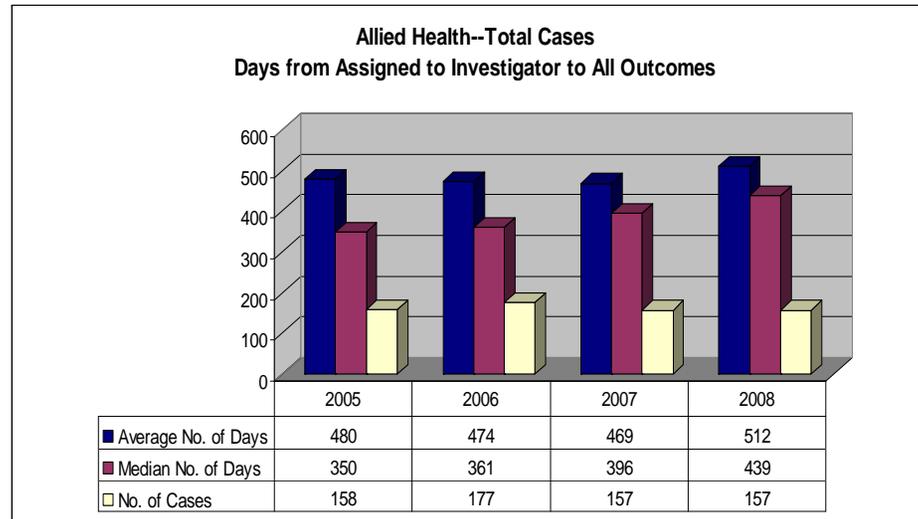
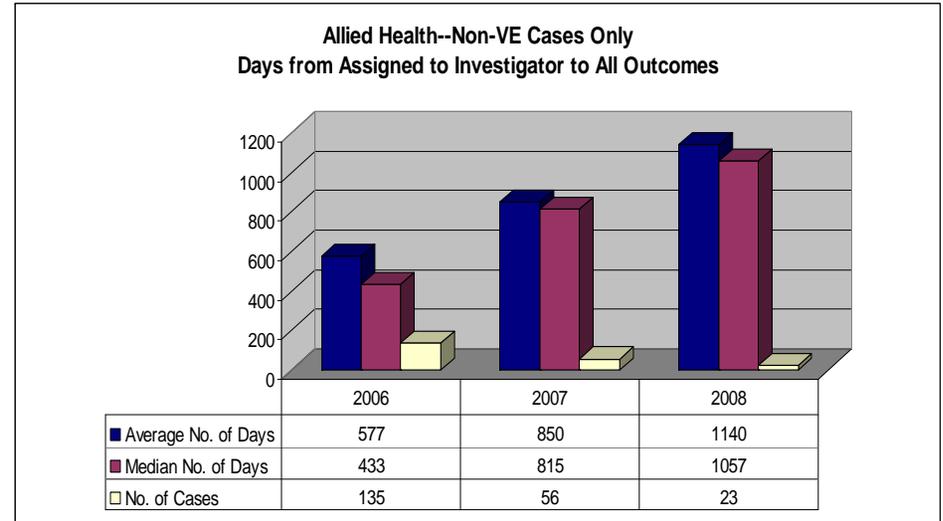
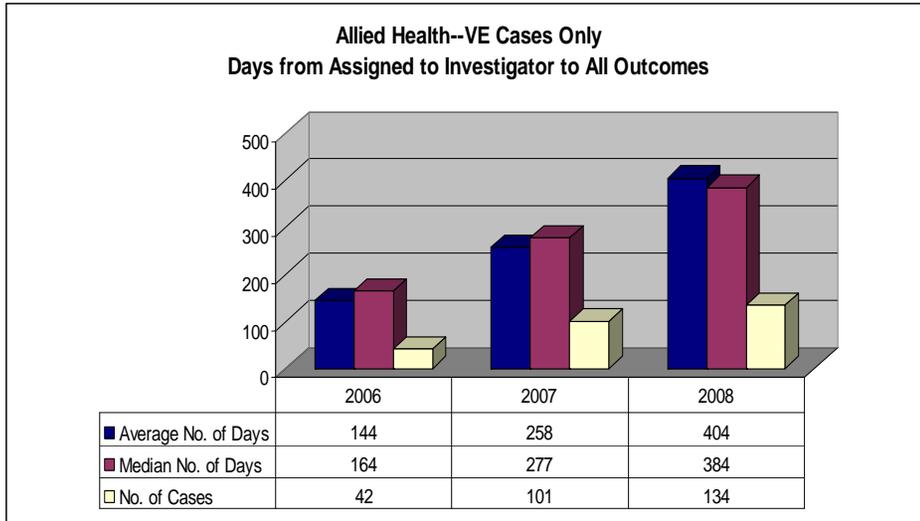
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO ALL OUTCOMES — ALLIED HEALTH

Table 14.3 below reports the average and median calendar days aged from case assigned to all outcomes for Allied Health Care cases. Between 2005 and 2008, there was a 6.67% increase in the average days aged, a 25.43% increase in the median days aged, a 0.63% decrease in the number of such cases and a 14.81% increase in the number of such cases pending at year end.

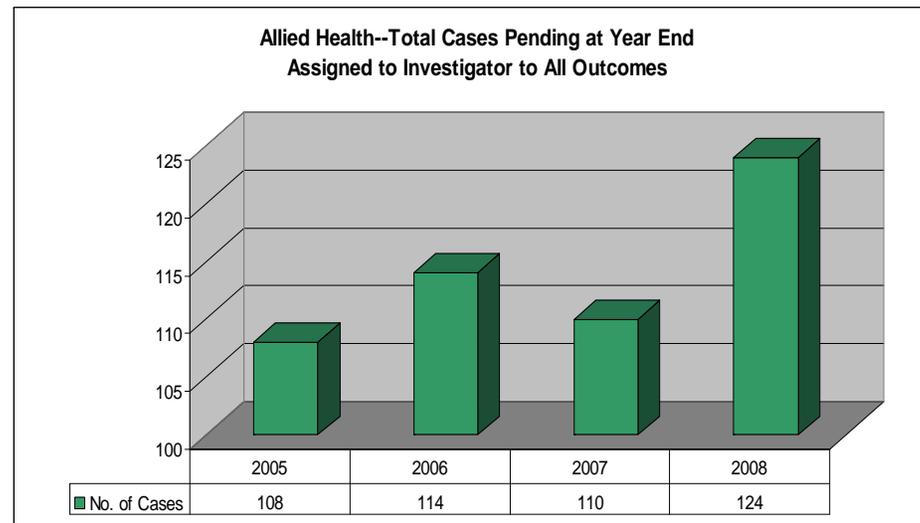
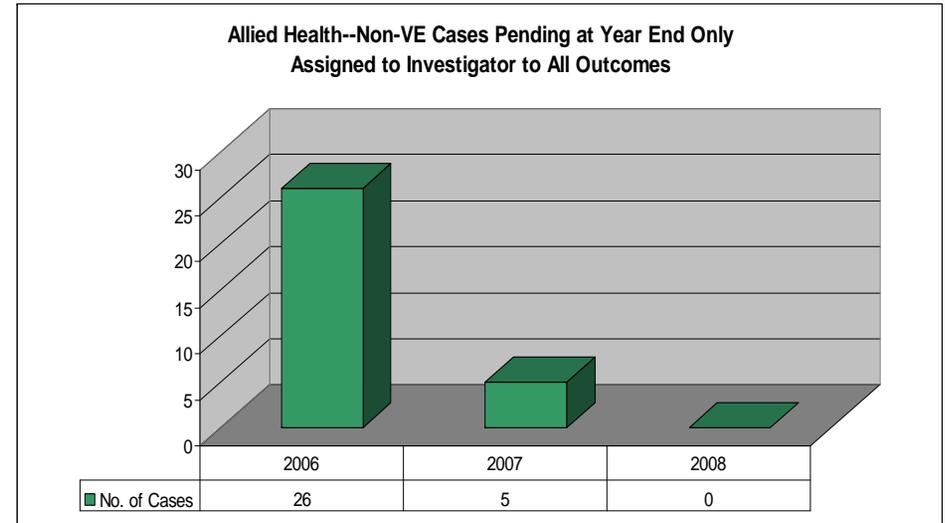
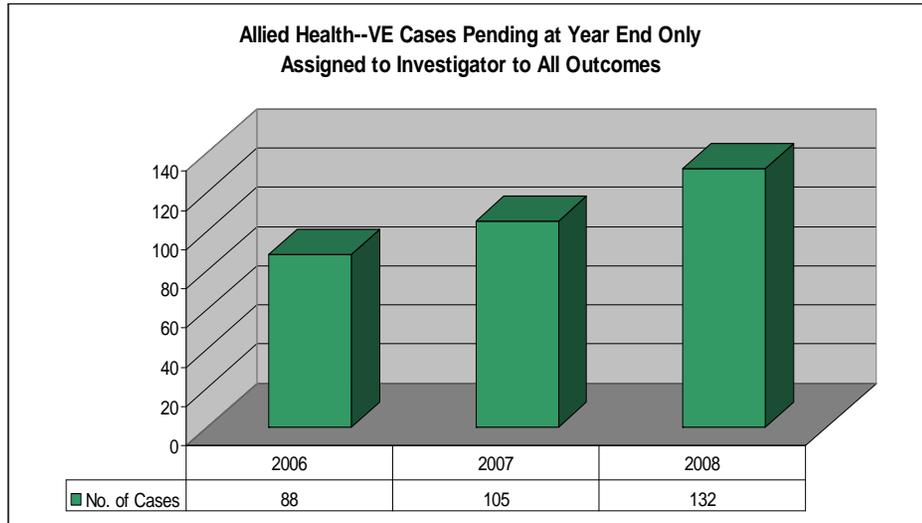
Table 14.3 – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending			
Calendar Day Age from Case Assigned to ALL Outcomes																				
Average	-1.05%		47.31%		79.17%		9.17%		34.12%		56.59%		8.02%		97.57%		180.56%		6.67%	
Median (middle record - half are above and half below)	9.70%		88.22%		68.90%		10.86%		29.69%		38.63%		21.61%		144.11%		134.15%		25.43%	
Record Count	-11.30%	-3.51%	-58.52%	-80.77%	140.48%	19.32%	0.00%	12.73%	-58.93%	-100.00%	32.67%	25.71%	-11.30%	8.77%	-82.96%	-100.00%	219.05%	50.00%	-0.63%	14.81%

Charts 14.3a, b & c – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Allied Health Cases



Charts 14.3d, e & f – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Allied Health Cases — Cases Pending at Year End



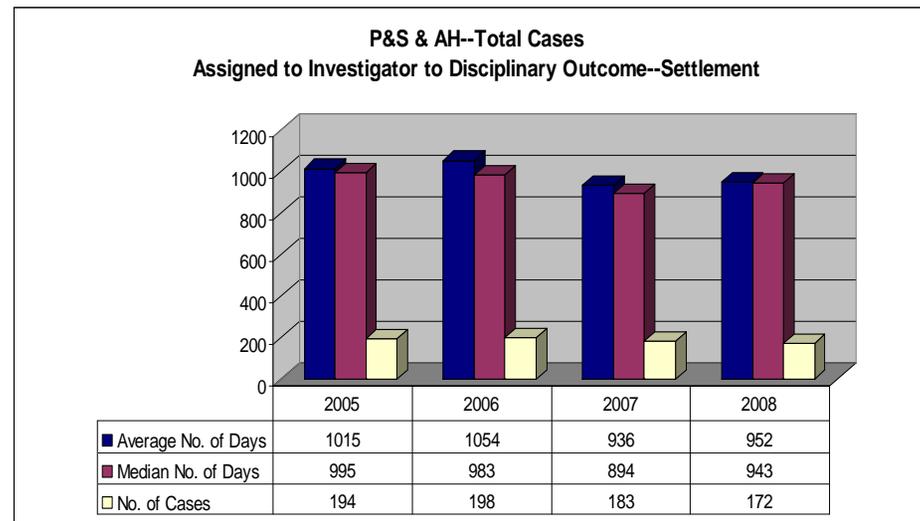
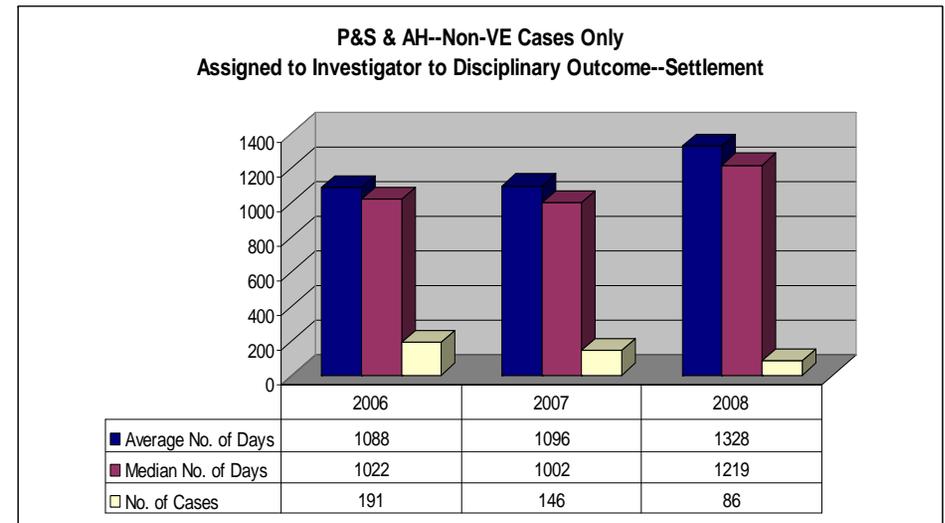
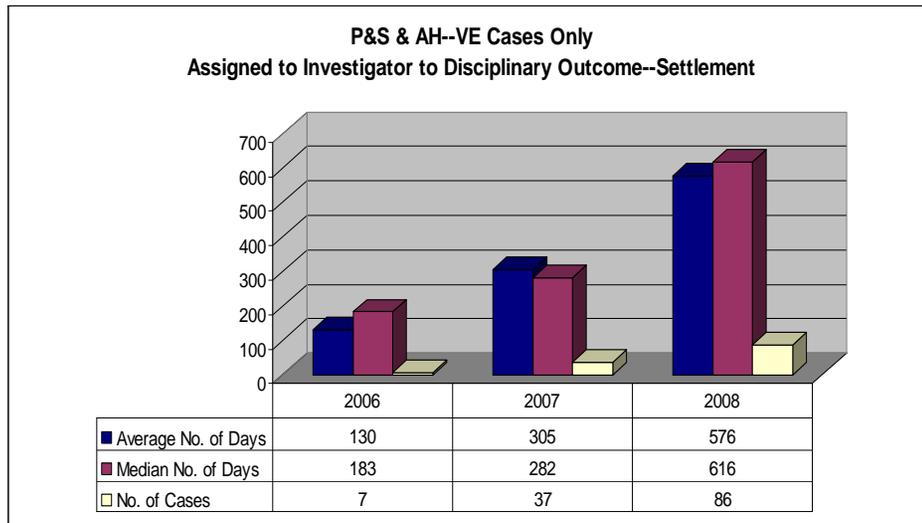
CALENDAR DAYS AGED FROM CASE ASSIGNED TO INVESTIGATOR TO SETTLEMENT — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 14.4 below reports the average and median calendar days aged from case assigned to settlement for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 6.21% decrease in the average days aged, a 5.23% decrease in the median days aged, an 11.34% decrease in the number of such cases and a 23.02% decrease in the number of such cases pending at year end.

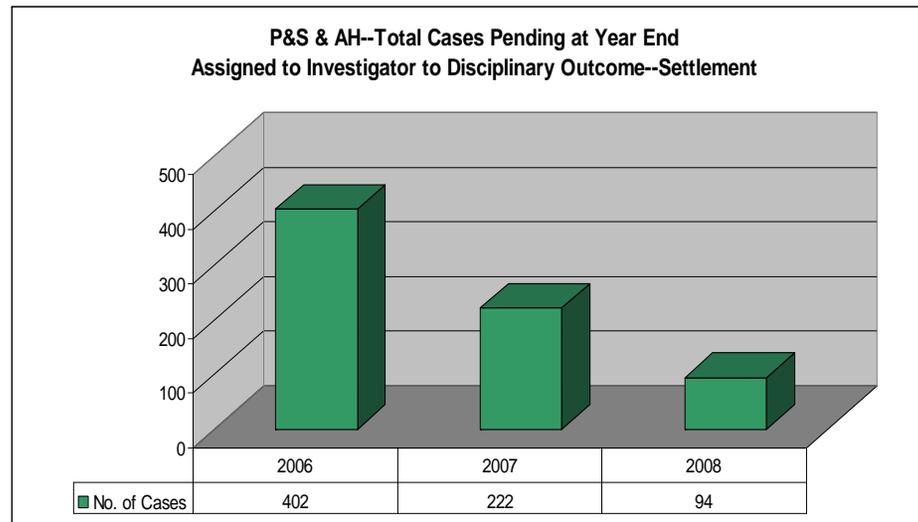
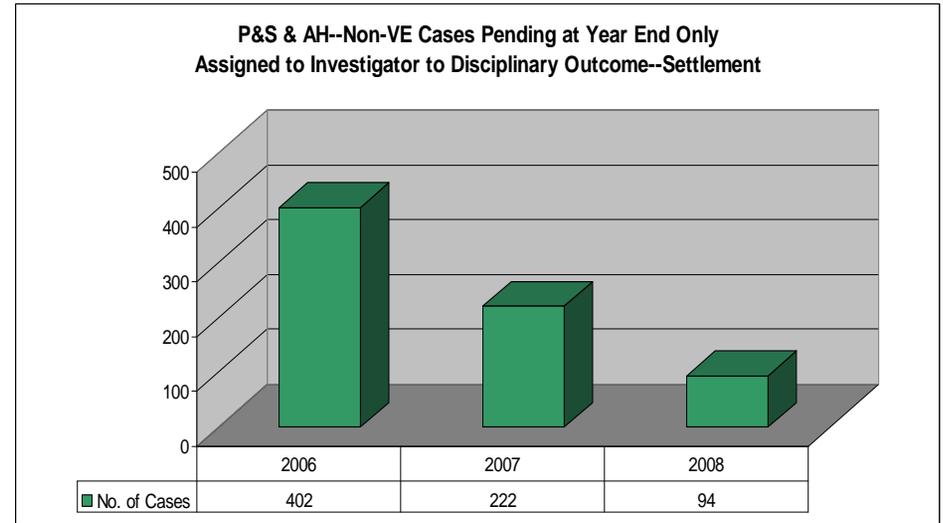
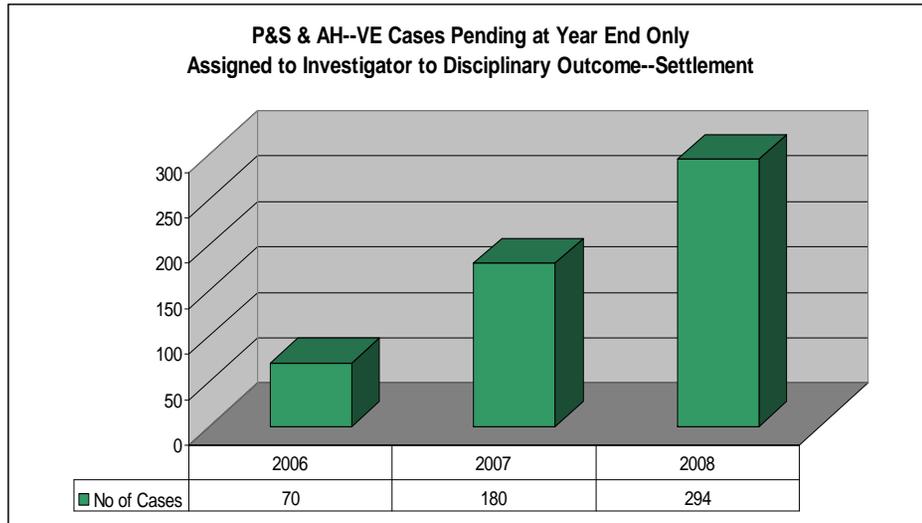
Table 14.4 – Calendar Days Aged from Case Assigned to Investigator to Settlement for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All
Calendar Day Age from Date Case Assigned to Investigator to Disciplinary Outcome--Settlement										
Average	-11.20%	0.74%	134.62%	1.71%	21.17%	88.85%	-9.68%	22.06%	343.08%	-6.21%
Median (middle record - half are above and half below)	-9.05%	-1.96%	54.10%	5.48%	21.66%	118.44%	-4.07%	19.28%	236.61%	-5.23%
Record Count	-7.58%	-23.56%	428.57%	-6.01%	-41.10%	132.43%	-13.13%	-54.97%	1128.57%	-11.34%
All Pending	-14.83%	-44.78%	157.14%	-3.48%	-57.66%	63.33%	-17.80%	-76.62%	320.00%	-23.02%

Charts 14.4a, b & c – Calendar Days Aged from Case Assigned to Investigator to Settlement Outcome for Physicians and Surgeons and Allied Health Cases



Charts 14.4d, e & f – Calendar Days Aged from Case Assigned to Investigator to Settlement Outcome for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



Separate data for Calendar Days Aged from Case Assigned to Investigator to Settlement Outcome for Physicians and Surgeons cases only and Allied Health Care cases only were not available at the time of drafting this report.

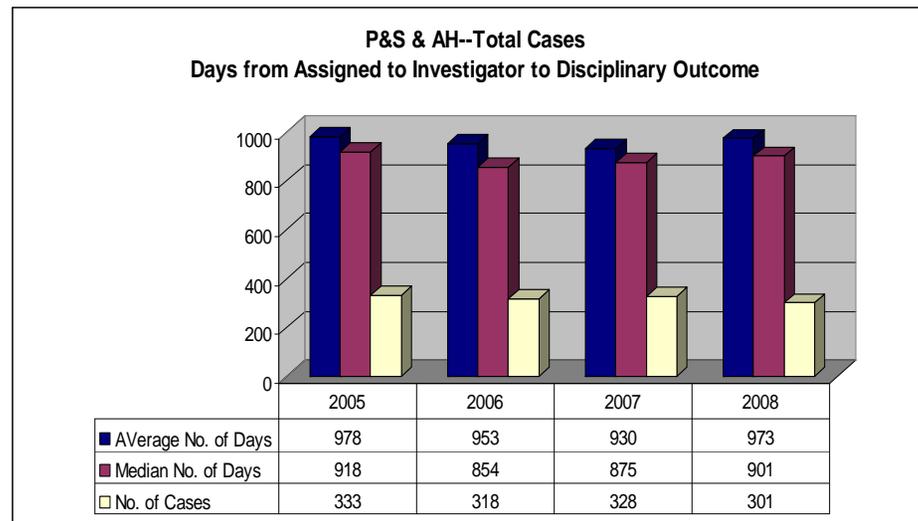
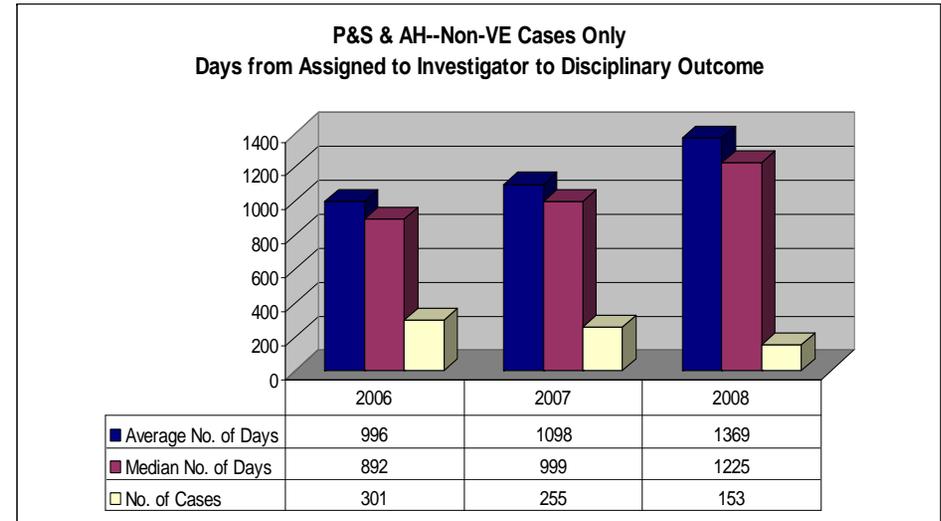
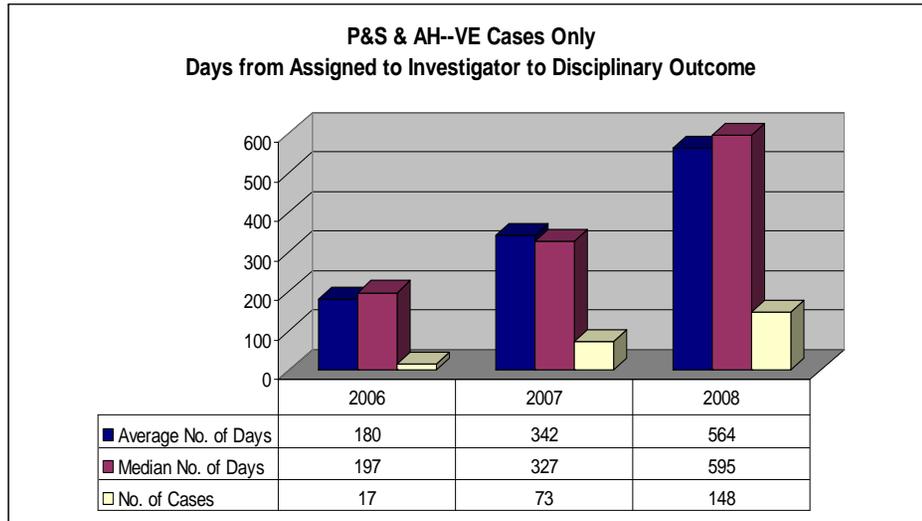
CALENDAR DAYS AGED FROM CASE ASSIGNED TO DISCIPLINARY OUTCOME — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 14.5 below reports the average and median calendar days aged from case assigned to disciplinary outcome for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 0.51% decrease in the average days aged, a 1.85% decrease in the median days aged, 9.61% decrease in the number of such cases and a 23.37% decrease in the number of such cases pending at year end.

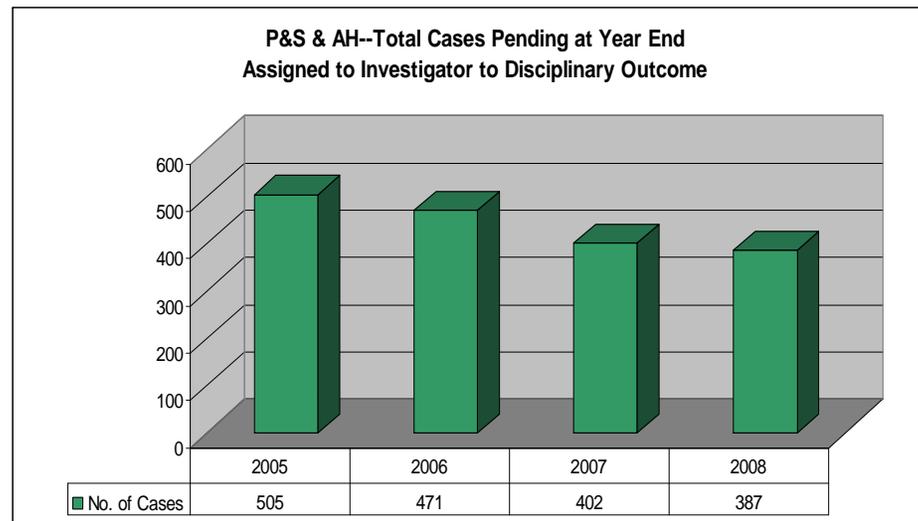
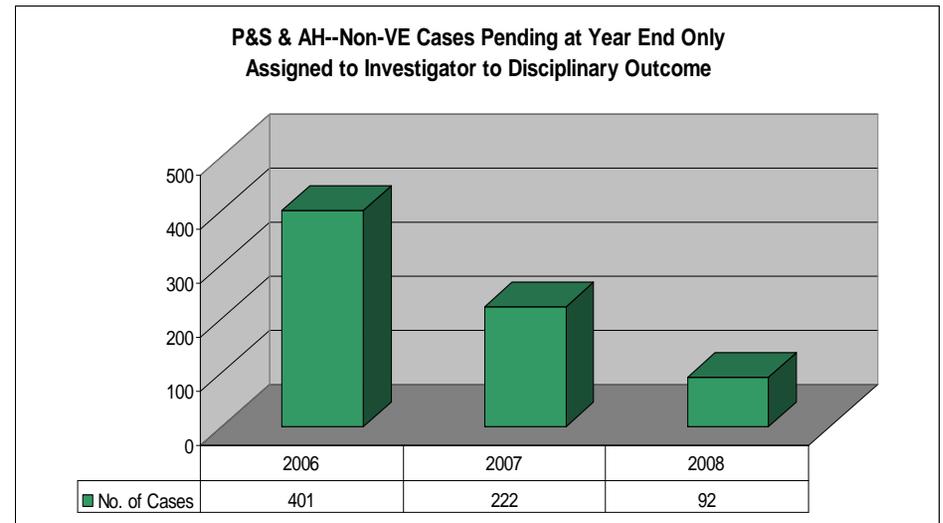
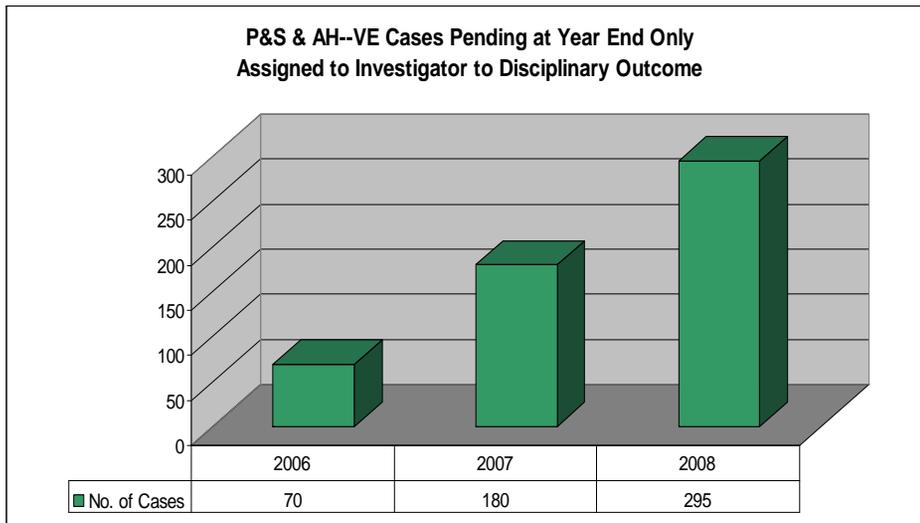
Table 14.5 – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending					
Calendar Day Age from Case Assigned to Disciplinary Outcome																				
Average	-2.41%		10.24%		90.00%		4.62%		24.68%		64.91%		2.10%		37.45%		213.33%		-0.51%	
Median (middle record - half are above and half below)	2.46%		12.00%		65.99%		2.97%		22.62%		81.96%		5.50%		37.33%		202.03%		-1.85%	
Record Count	3.14%	-14.65%	-15.28%	-44.64%	329.41%	157.14%	-8.23%	-3.73%	-40.00%	-58.56%	102.74%	63.89%	-5.35%	-17.83%	-49.17%	-77.06%	770.59%	321.43%	-9.61%	-23.37%

Charts 14.5a, b & c – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Physicians and Surgeons and Allied Health Cases



Charts 14.5d, e & f – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



CALENDAR DAYS AGED FROM CASE ASSIGNED TO DISCIPLINARY OUTCOME — PHYSICIANS AND SURGEONS

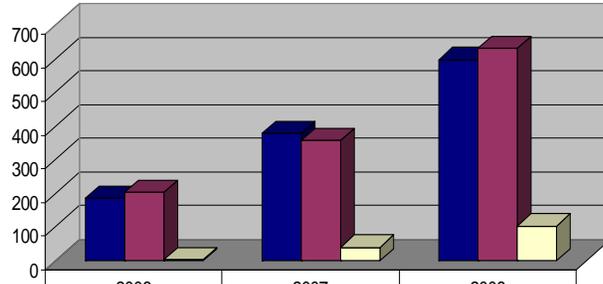
Table 14.6 below reports the average and median calendar days aged from case assigned to disciplinary outcome for Physicians and Surgeons cases. Between 2005 and 2008, there was a 0.58% increase in the average days aged, a 2.51% decrease in the median days aged, 9.54% decrease in the number of such cases and a 26.50% decrease in the number of such cases pending at year end.

Table 14.6 – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage Difference 2005 to 2008	
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All	
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending	
Calendar Day Age from Case Assigned to Disciplinary Outcome																				
Average	-3.14%		7.16%		104.86%		2.95%		23.04%		57.26%		-0.29%		31.86%		222.16%		0.58%	
Median (middle record - half are above and half below)	-4.91%		4.28%		74.51%		4.30%		20.02%		76.69%		-0.82%		25.15%		208.33%		-2.51%	
Record Count	10.00%	-18.59%	-6.17%	-45.35%	1233.33%	163.27%	-6.32%	-5.47%	-37.56%	-62.09%	160.00%	74.42%	3.04%	-23.04%	-41.41%	-79.28%	3366.67%	359.18%	-9.54%	-26.50%

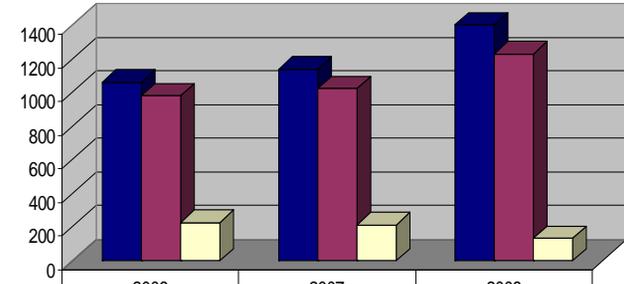
Charts 14.6a, b & c – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Physicians and Surgeons Cases

Physicians and Surgeons--VE Cases Only
Days from Assigned to Investigator to Disciplinary Outcome



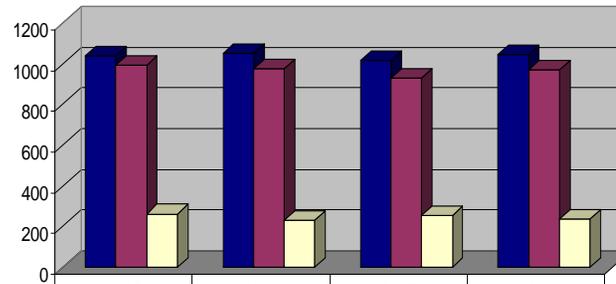
	2006	2007	2008
■ Average No. of Days	185	379	596
■ Median No. of Days	204	356	629
□ No. of Cases	3	40	104

Physicians and Surgeons--Non-VE Cases Only
Days from Assigned to Investigator to Disciplinary Outcome



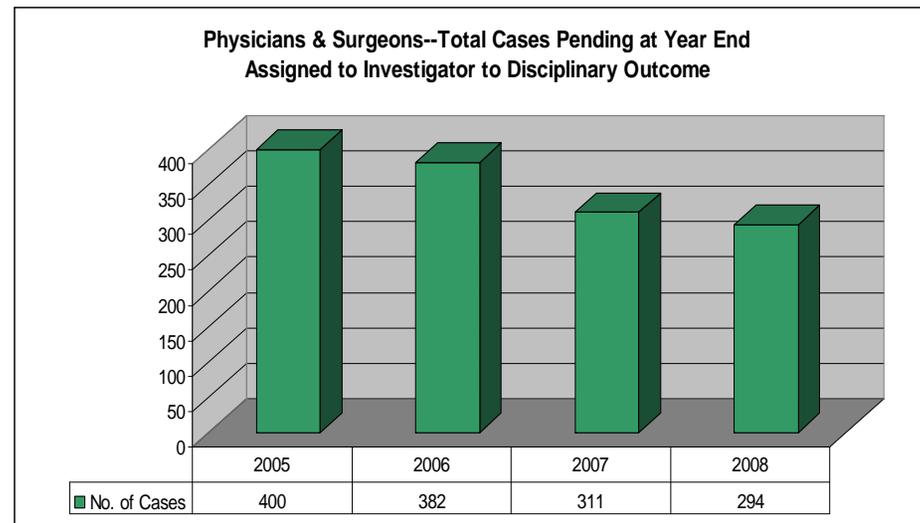
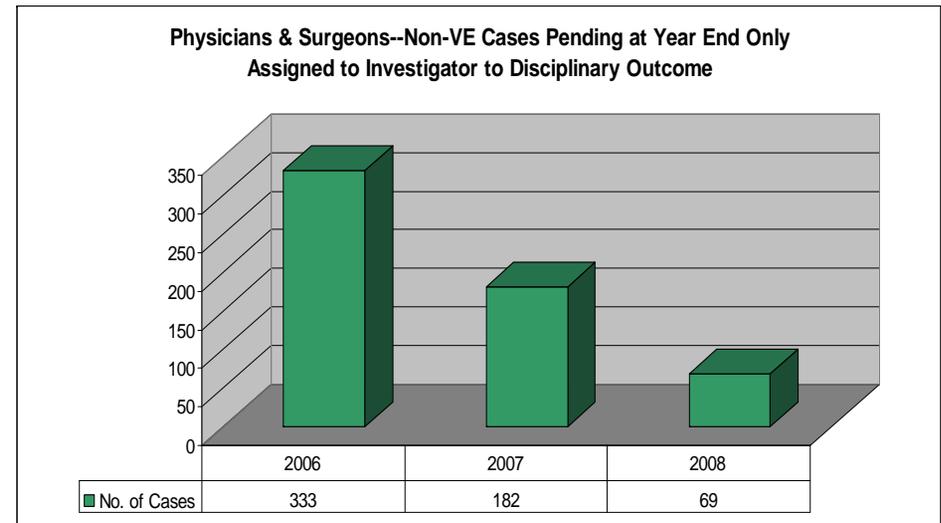
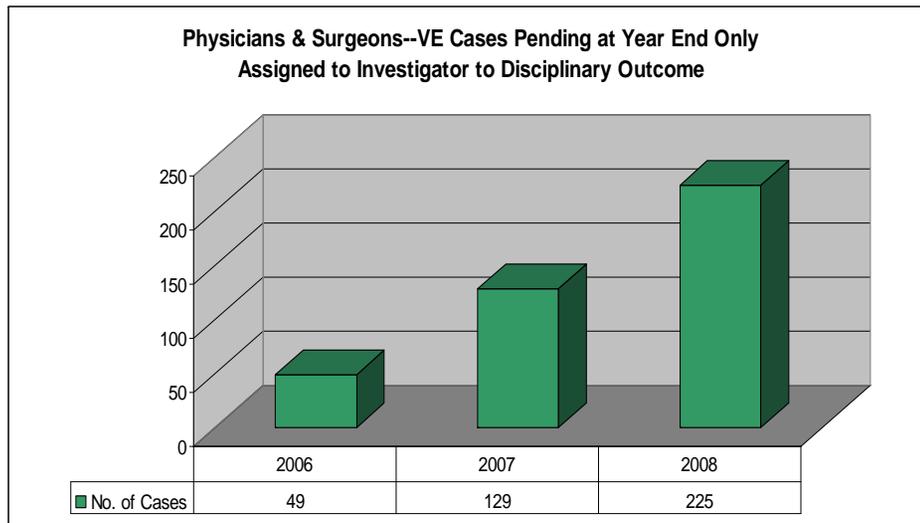
	2006	2007	2008
■ Average No. of Days	1061	1137	1399
■ Median No. of Days	982	1024	1229
□ No. of Cases	227	213	133

Physicians and Surgeons--Total Cases
Days from Assigned to Investigator to Disciplinary Outcome



	2005	2006	2007	2008
■ Average No. of Days	1041	1050	1017	1047
■ Median No. of Days	995	978	930	970
□ No. of Cases	262	230	253	237

Charts 14.6d, e & f – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Physicians and Surgeons Cases — Cases Pending at Year End



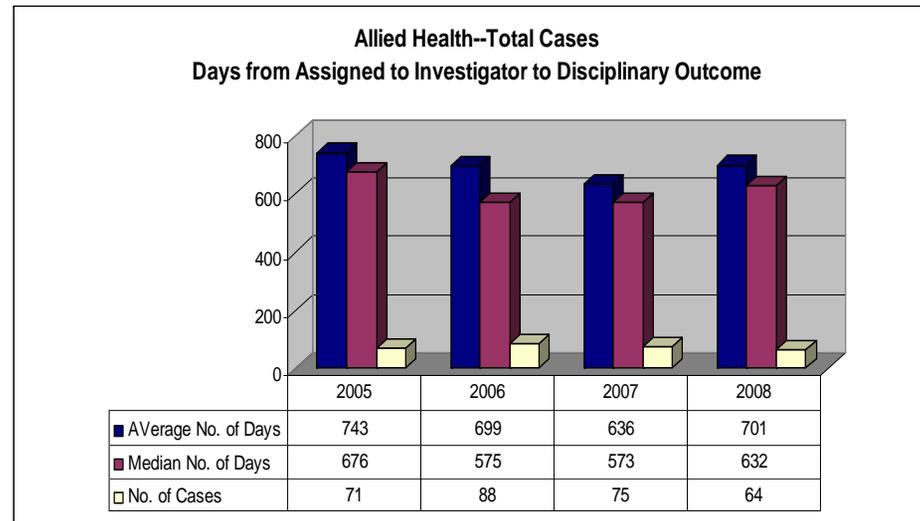
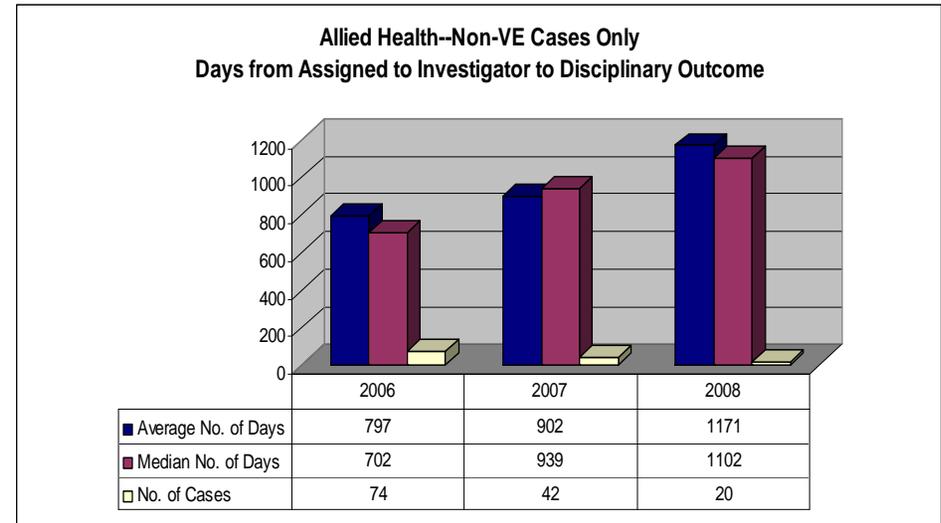
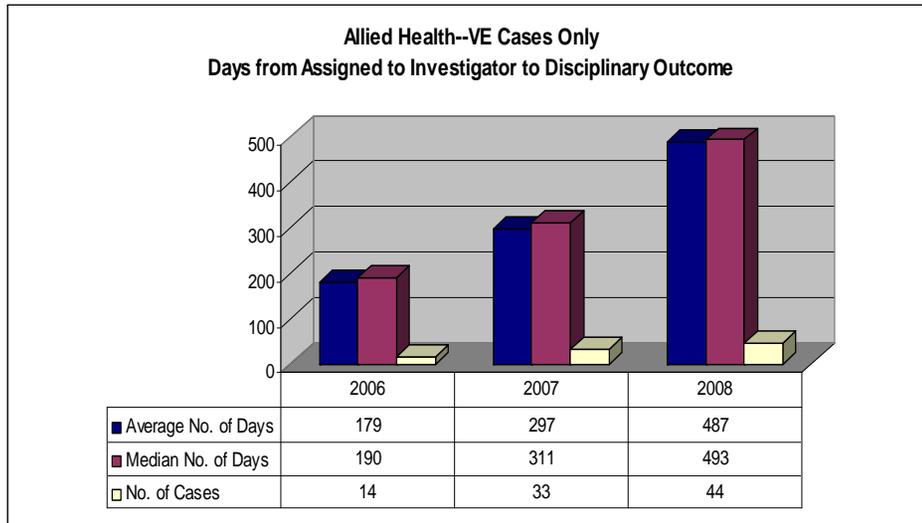
CALENDAR DAYS AGED FROM CASE ASSIGNED TO DISCIPLINARY OUTCOME —ALLIED HEALTH

Table 14.7 below reports the average and median calendar days aged from case assigned to disciplinary outcome for Allied Health Care cases. Between 2005 and 2008, there was a 5.65% decrease in the average days aged, a 6.51% decrease in the median days aged, 9.86% decrease in the number of such cases and a 11.43% decrease in the number of such cases pending at year end.

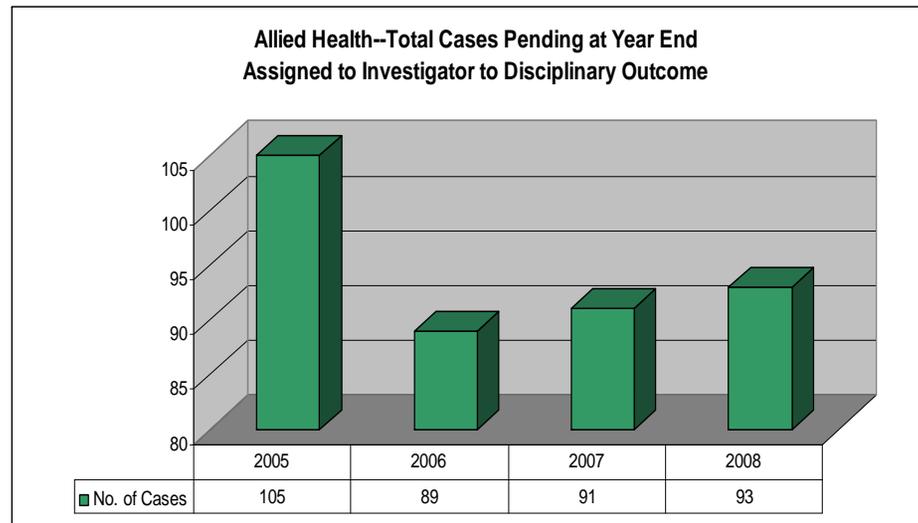
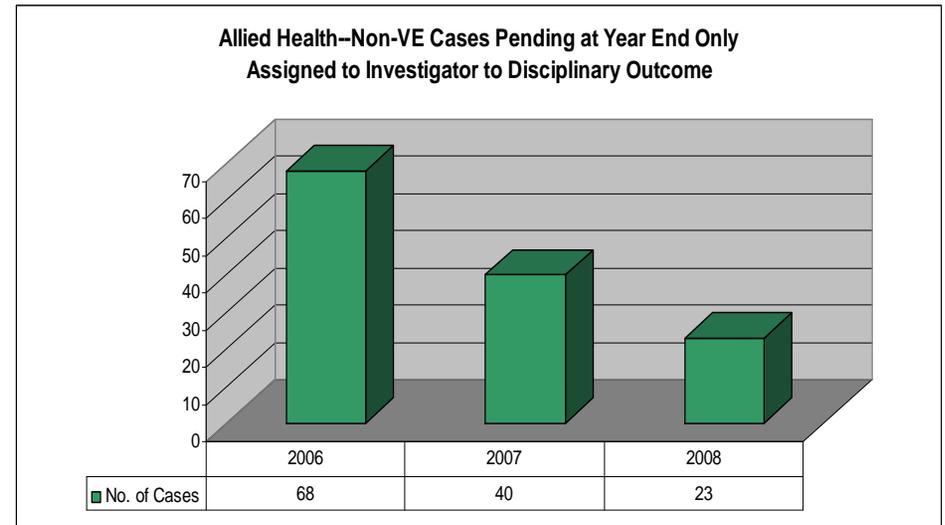
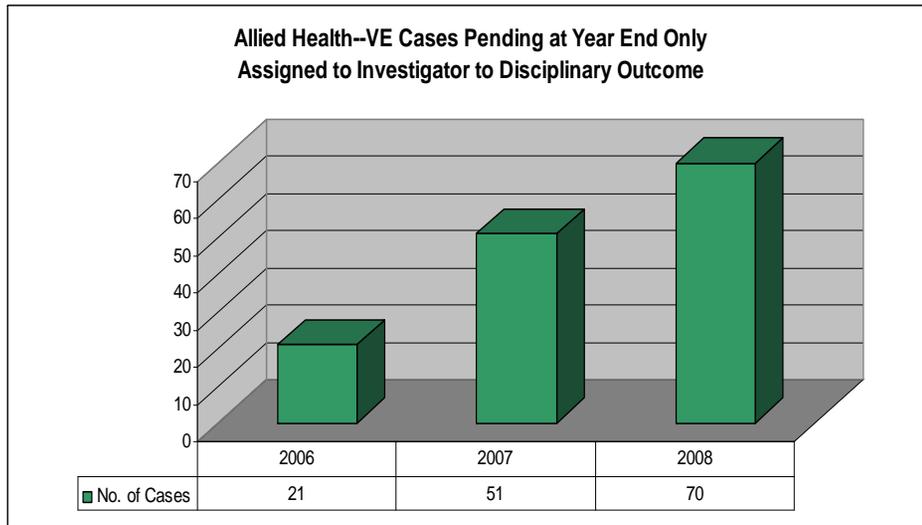
Table 14.7 – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending					
Calendar Day Age from Case Assigned to Disciplinary Outcome																				
Average	-9.01%		13.17%		65.92%		10.22%		29.82%		63.97%		0.29%		46.93%		172.07%		-5.65%	
Median (middle record - half are above and half below)	-0.35%		33.76%		63.68%		10.30%		17.36%		58.52%		9.91%		56.98%		159.47%		-6.51%	
Record Count	-14.77%	2.25%	-43.24%	-41.18%	135.71%	142.86%	-14.67%	2.20%	-52.38%	-42.50%	33.33%	37.25%	-27.27%	4.49%	-72.97%	-66.18%	214.29%	233.33%	-9.86%	-11.43%

Charts 14.7a, b & c – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome Allied Health Cases



Charts 14.7d, e & f – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Allied Health Cases — Cases Pending at Year End



CALENDAR DAYS AGED FROM CASE ASSIGNED TO ACCUSATION FILED — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

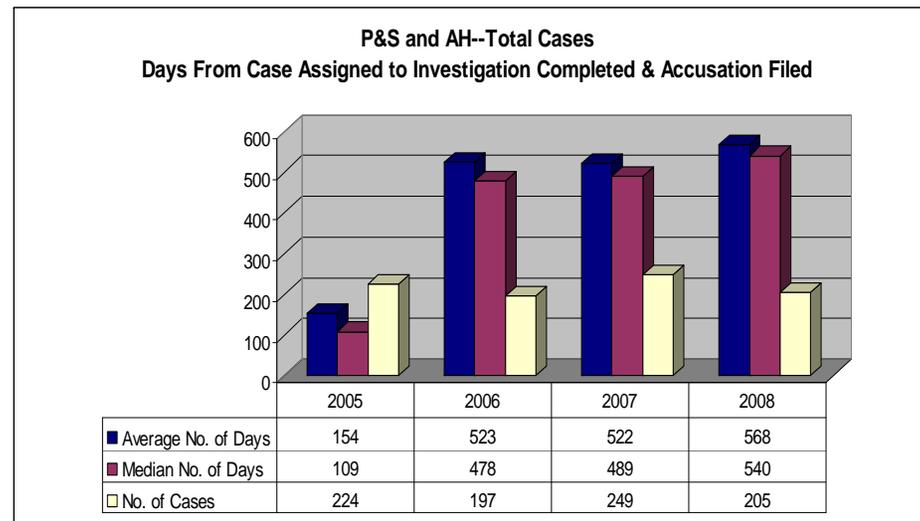
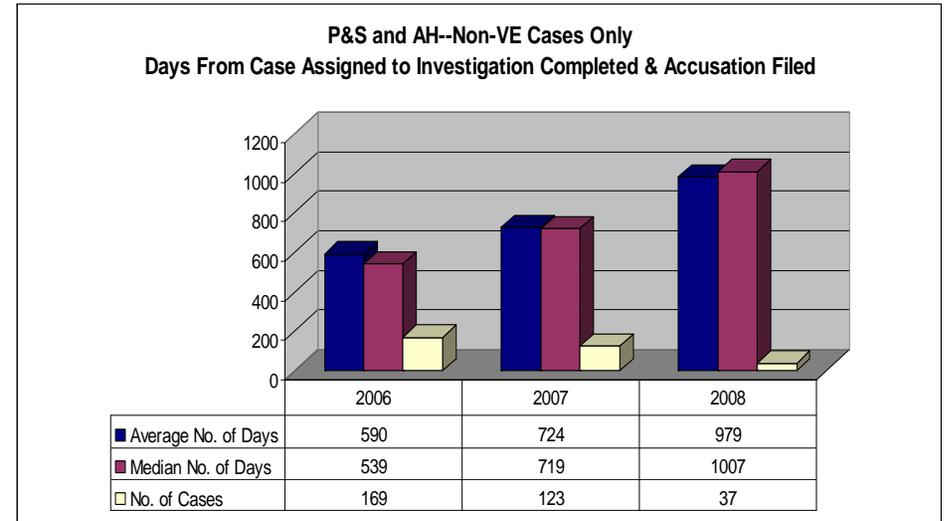
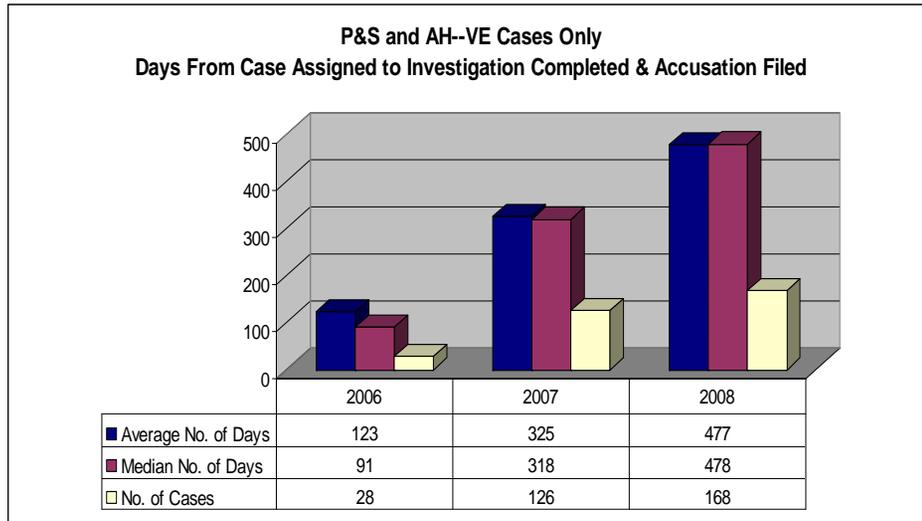
Table 14.8 below reports the average and median calendar days aged from case assigned to accusation filed for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 268.83% increase in the average days aged, a 395.41% increase in the median days aged, an 8.48% decrease in the number of such cases and a 13.41% decrease in the number of such cases pending at year end.

Table 14.8 – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Physicians and Surgeons and Allied Health Cases

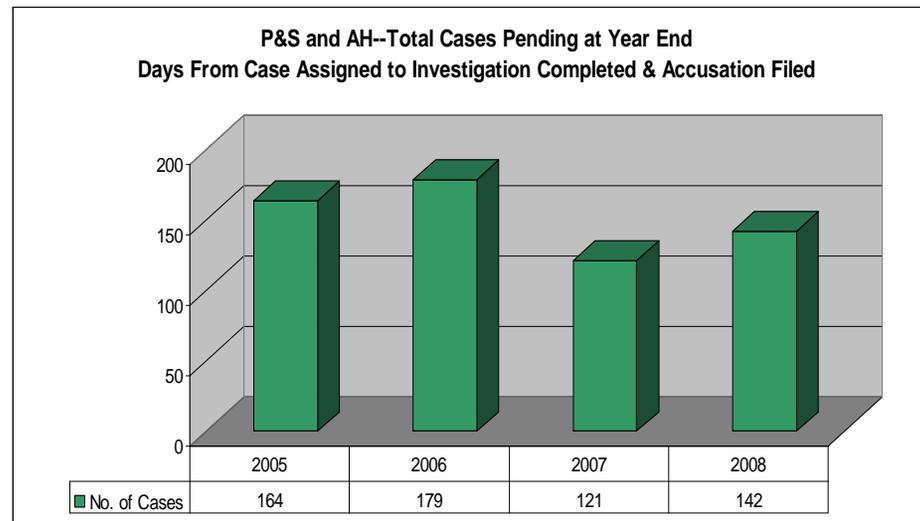
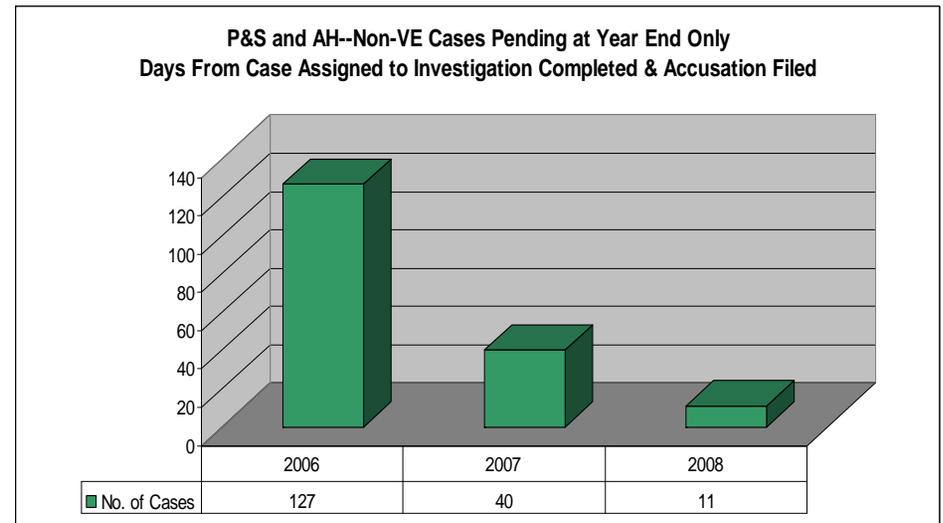
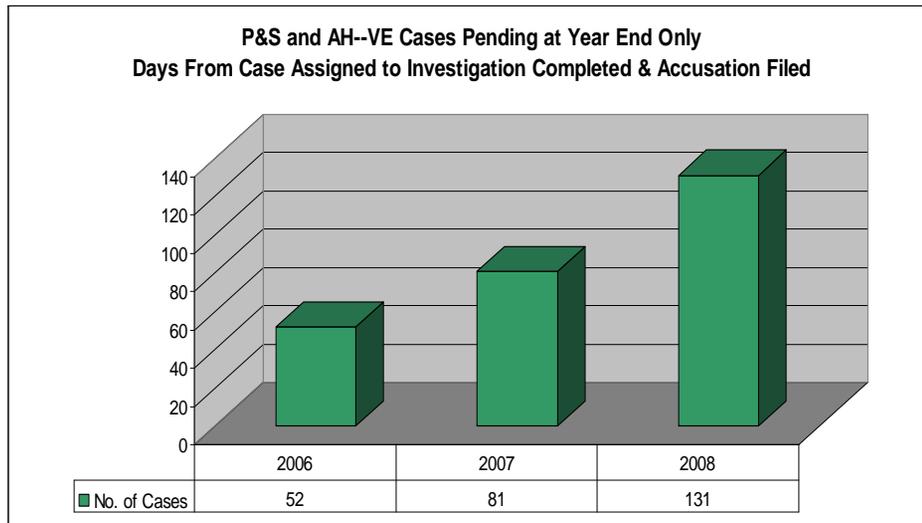
Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All	Not VE		VE		All	Not VE		VE		All	Not VE		VE		All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed																				
Average	-0.19%		22.71%		164.23%		8.81%		35.22%		46.77%		8.60%		65.93%		287.80%		268.83%	
Median (middle record - half are above and half below)	2.30%		33.40%		249.45%		10.43%		40.06%		50.31%		12.97%		86.83%		425.27%		395.41%	
Record Count	26.40%	-32.40%	-27.22%	-68.50%	350.00%	55.77%	-17.67%	17.36%	-69.92%	-72.50%	33.33%	61.73%	4.06%	-20.67%	-78.11%	-91.34%	500.00%	151.92%	-8.48%	-13.41%

***Excludes Outcomes where no Accusation Filed

Charts 14.8a, b & c – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Physicians and Surgeons and Allied Health Cases



Charts 14.8d, e & f – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



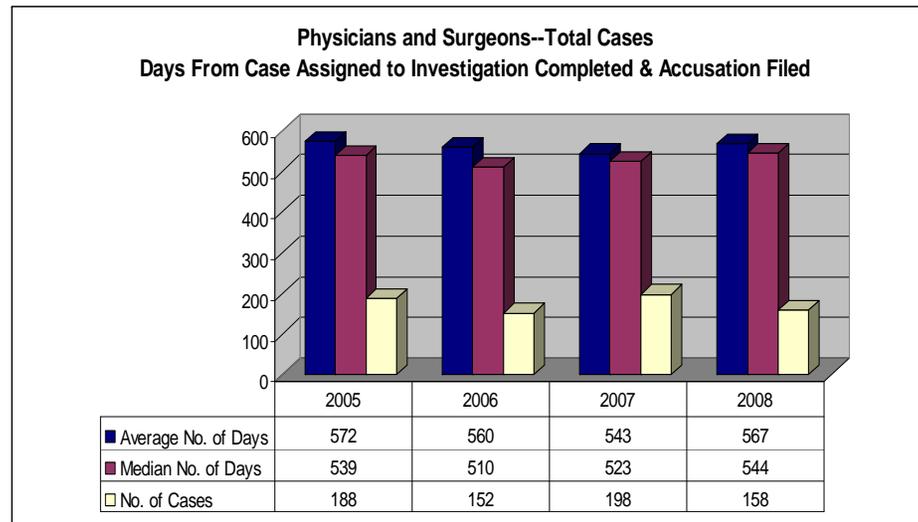
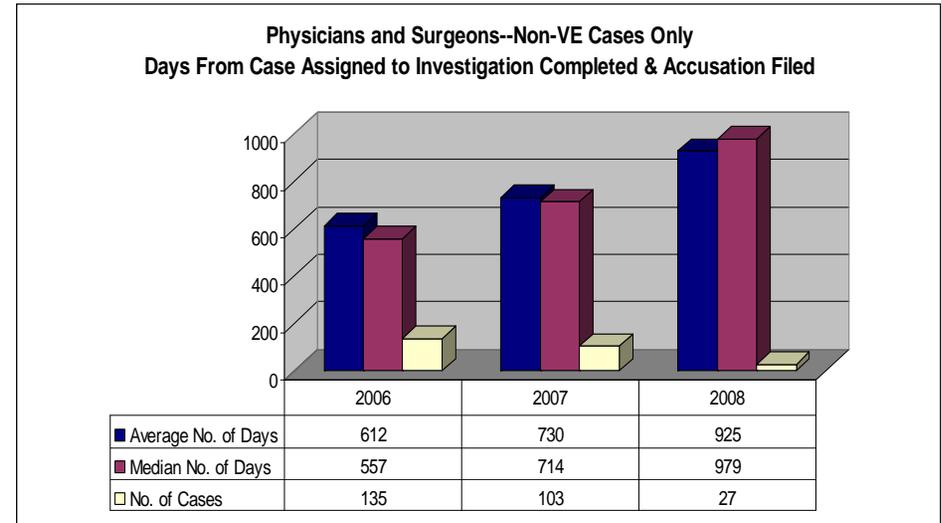
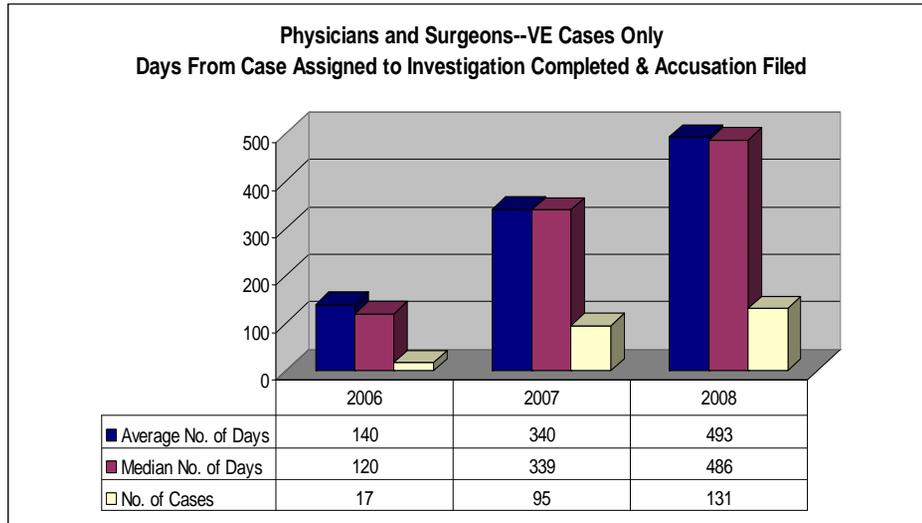
CALENDAR DAYS AGED FROM CASE ASSIGNED TO ACCUSATION FILED — PHYSICIANS AND SURGEONS

Table 14.9 below reports the average and median calendar days aged from case assigned to accusation filed for Physicians and Surgeons cases. Between 2005 and 2008, there was a 0.87% decrease in the average days aged, a 0.93% increase in the median days aged, an 15.96% decrease in the number of such cases and a 4.63% decrease in the number of such cases pending at year end.

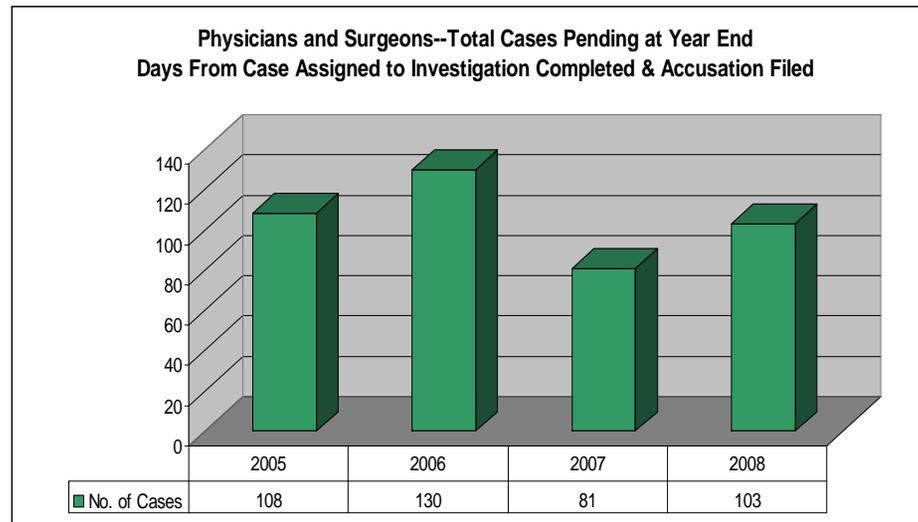
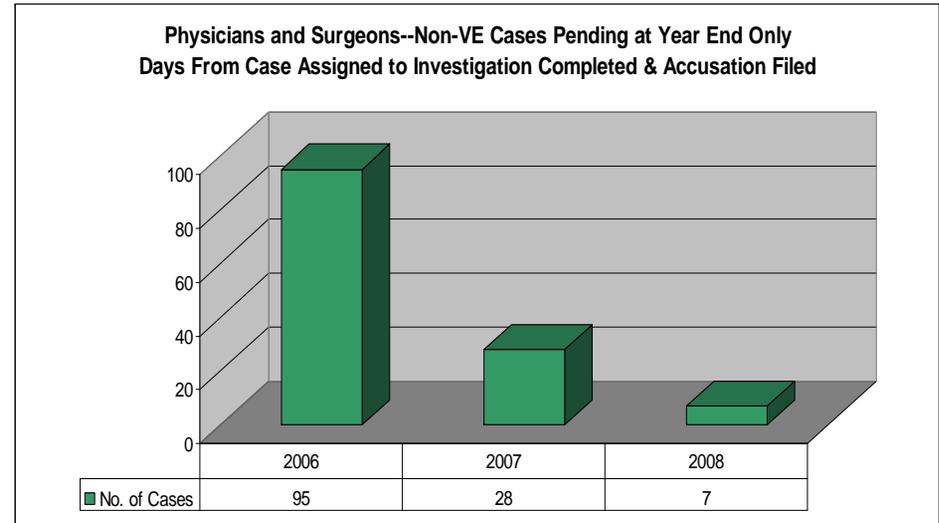
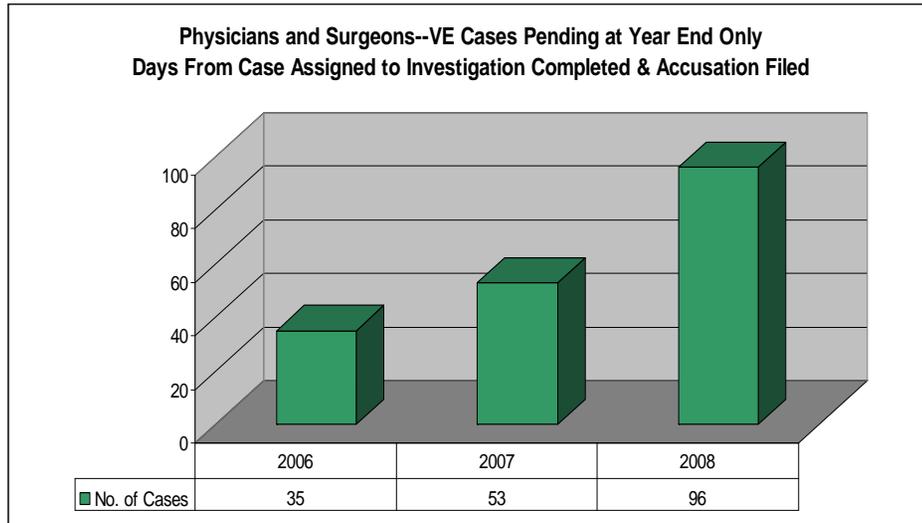
Table 14.9 – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending	Pending	Pending	Pending				
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed																				
Average	-3.04%		19.28%		142.86%		4.42%		26.71%		45.00%		1.25%		51.14%		252.14%		-0.87%	
Median (middle record - half are above and half below)	2.55%		28.19%		182.50%		4.02%		37.11%		43.36%		6.67%		75.76%		305.00%		0.93%	
Record Count	30.26%	-37.69%	-23.70%	-70.53%	458.82%	51.43%	-20.20%	27.16%	-73.79%	-75.00%	37.89%	81.13%	3.95%	-20.77%	-80.00%	-92.63%	670.59%	174.29%	-15.96%	-4.63%

Charts 14.9 a, b & c – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Physicians and Surgeons Cases



Charts 14.9 d, e & f – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Physicians and Surgeons Cases — Cases Pending at Year End



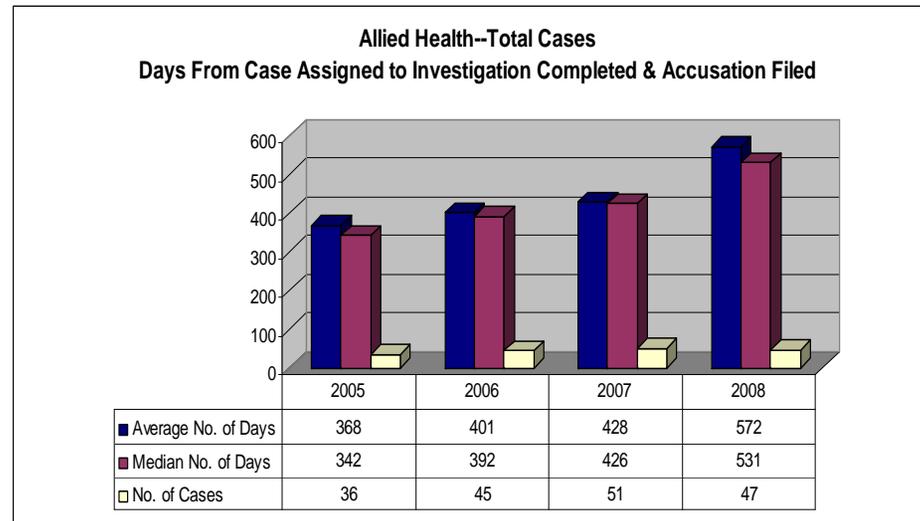
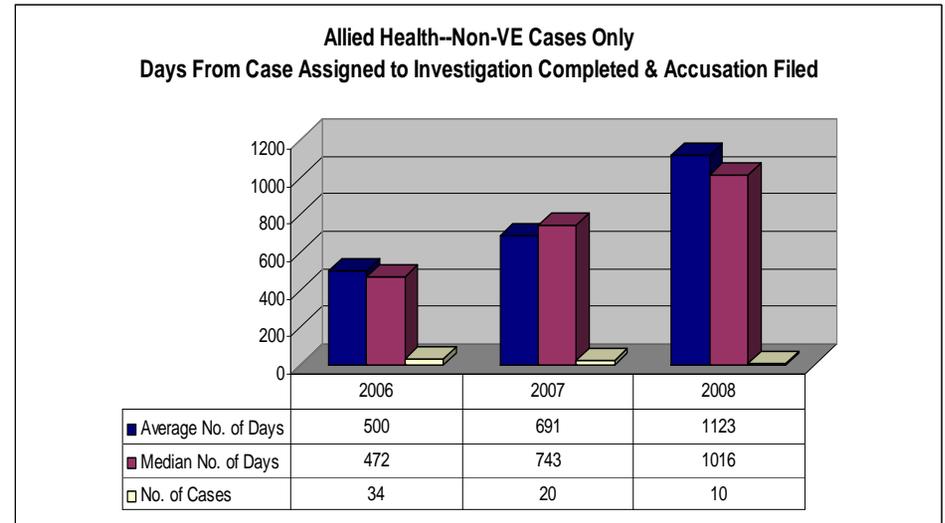
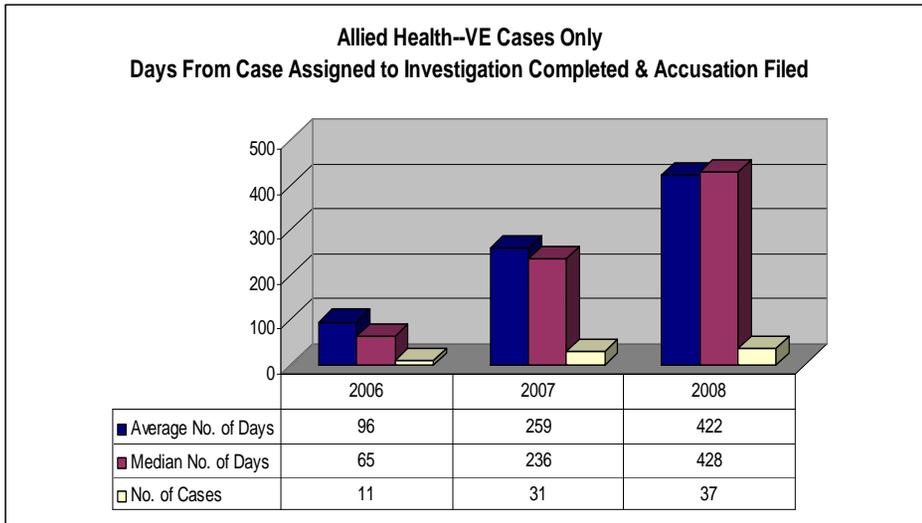
CALENDAR DAYS AGED FROM CASE ASSIGNED TO ACCUSATION FILED —ALLIED HEALTH

Table 14.10 below reports the average and median calendar days aged from case assigned to accusation filed for Allied Health Care cases. Between 2005 and 2008, there was a 55.43% increase in the average days aged, a 55.26% increase in the median days aged, a 30.56% decrease in the number of such cases and a 30.36% decrease in the number of such cases pending at year end.

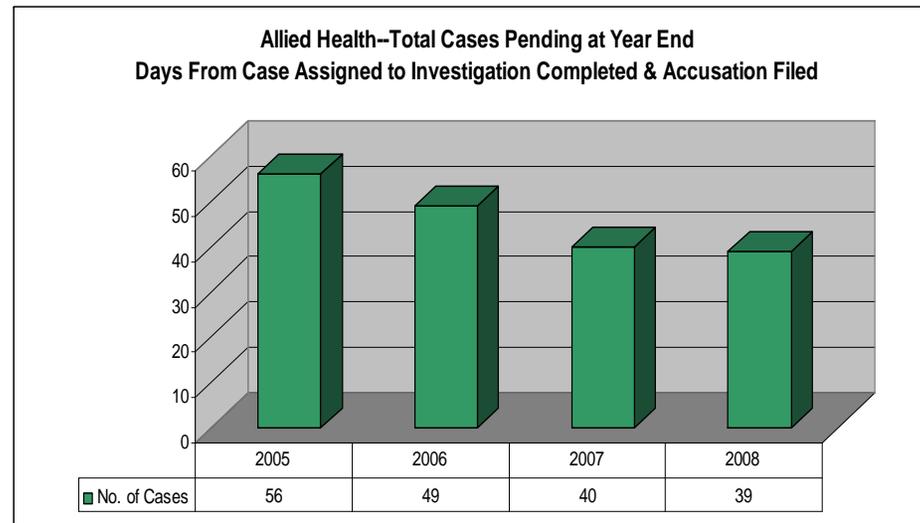
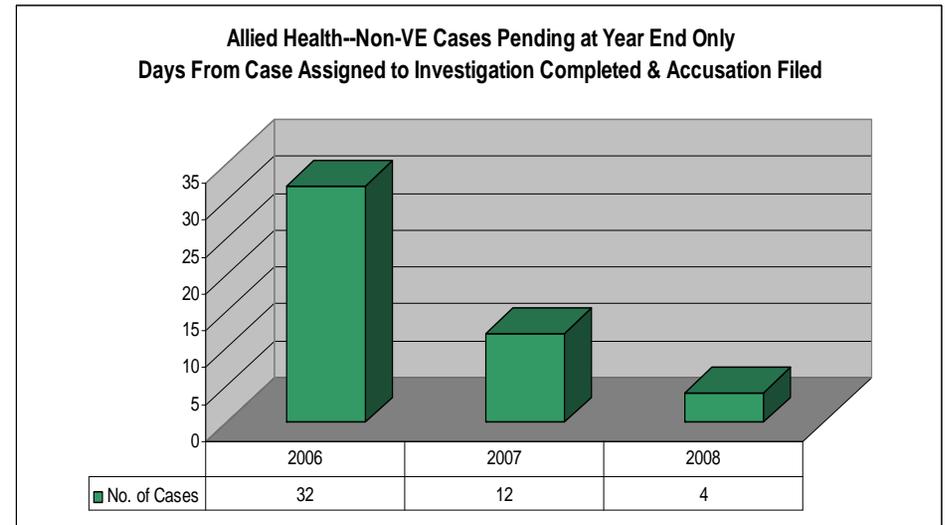
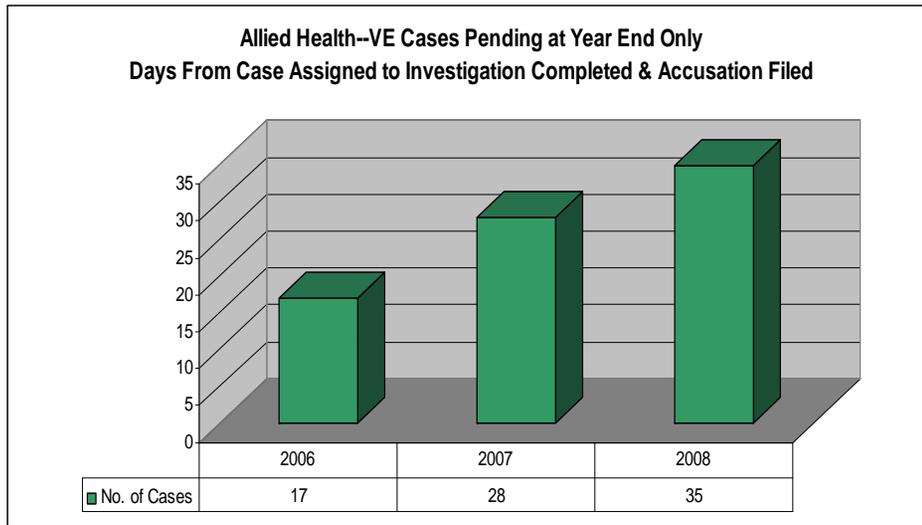
Table 14.10 – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All		Not VE	VE	All			
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending			
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed																				
Average	6.73%		38.20%		169.79%		33.64%		62.52%		62.93%		42.64%		124.60%		339.58%	55.43%		
Median (middle record - half are above and half below)	8.67%		57.42%		263.08%		24.65%		36.74%		81.36%		35.46%		115.25%		558.46%	55.26%		
Record Count	13.33%	-18.37%	-41.18%	-62.50%	181.82%	64.71%	-7.84%	-2.50%	-50.00%	-66.67%	19.35%	25.00%	4.44%	-20.41%	-70.59%	-87.50%	236.36%	105.88%	30.56%	-30.36%

Charts 14.10a, b & c – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Allied Health Cases



Charts 14.10d, e & f – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Allied Health Cases — Cases Pending at Year End



XV. VERTICAL PROSECUTION - COMPLETED INVESTIGATION TO ACCUSATION FILED

Per EOM Section 7.1, discipline cases are cases which produce sufficient evidence to warrant filing formal charges. The Sup I forwards to the primary DAG the original investigation package with copies of the evidence. At this point, the investigation is technically closed and the disciplinary case is opened.

Per EOM and the JVEG, after the Sup I submits the completed investigation, the primary DAG has five business days to determine whether the case will be accepted for prosecution. If the primary DAG is unavailable, he may request the lead DAG to review the package.

Once accepted, per VPM, the primary DAG has 30 calendar days to submit a proposed accusation to the Executive Director of MBC.

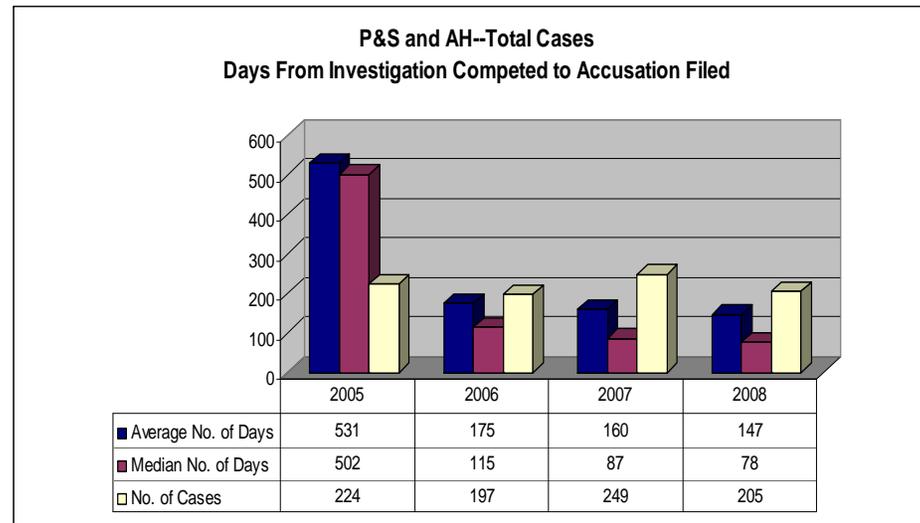
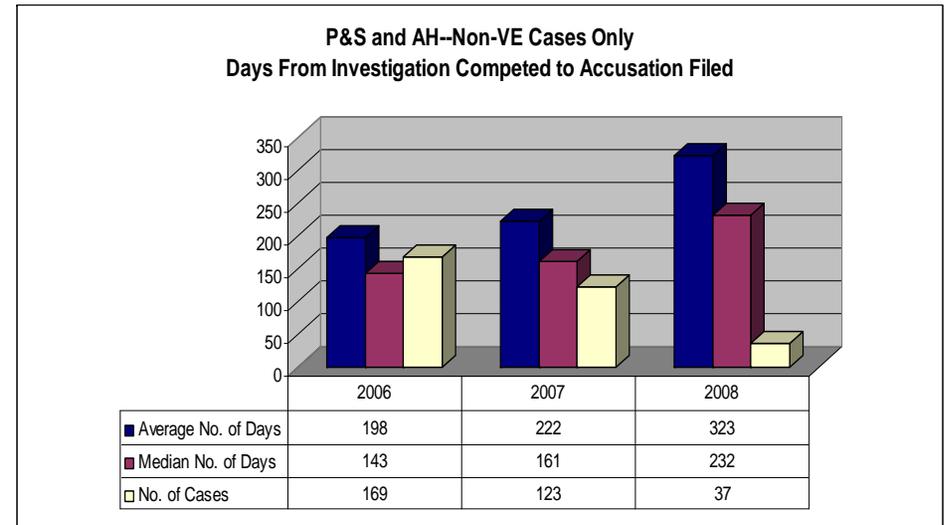
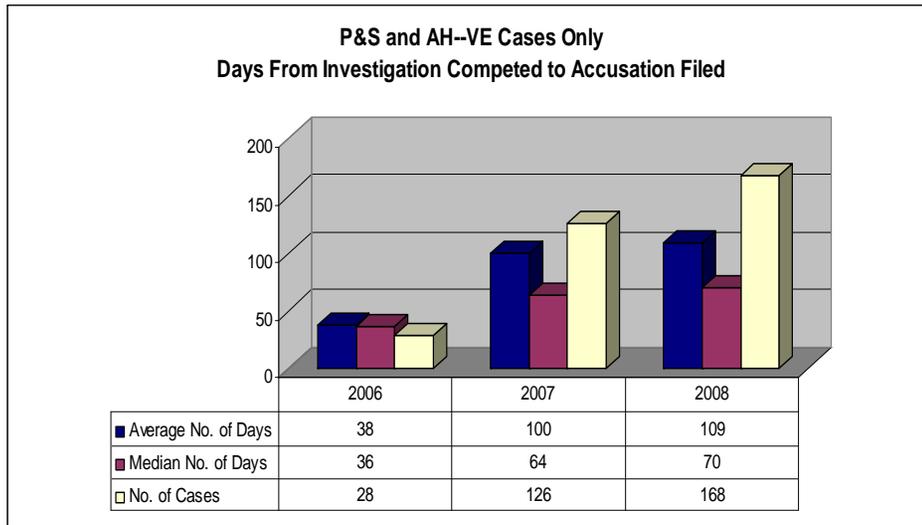
CALENDAR DAYS AGED FROM INVESTIGATION COMPLETED TO ACCUSATION FILED — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 15.1 below reports the average and median calendar days aged from case investigation completed to accusation filed for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 72.32% decrease in the average days aged, an 84.46% decrease in the median days aged, an 8.48% decrease in the number of such cases and a 13.41% decrease in the number of such cases pending at year end.

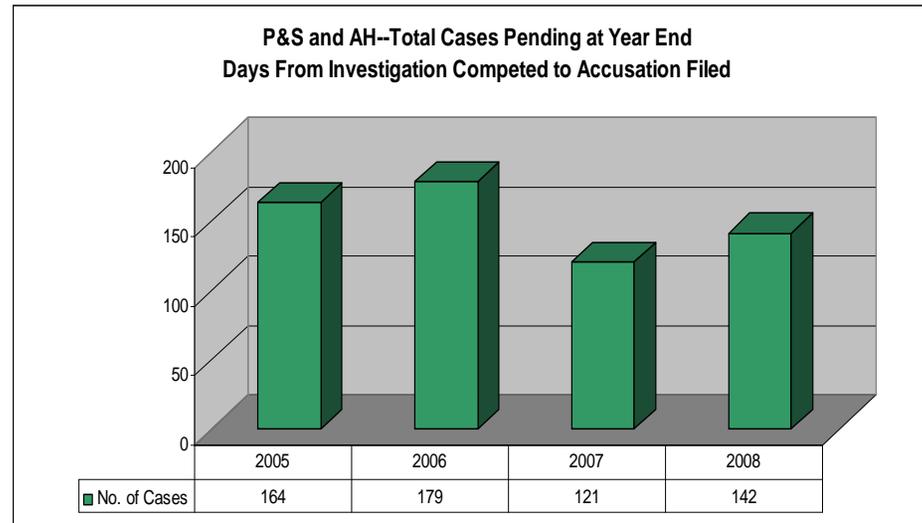
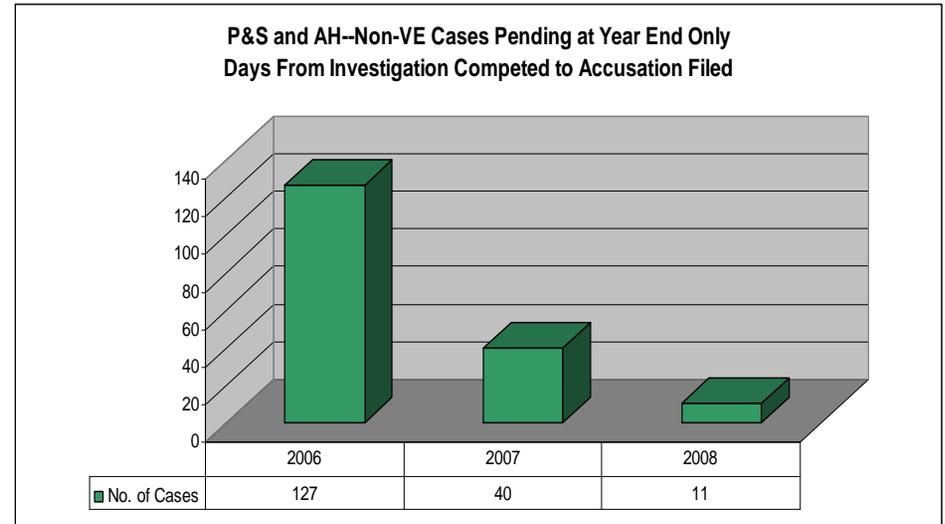
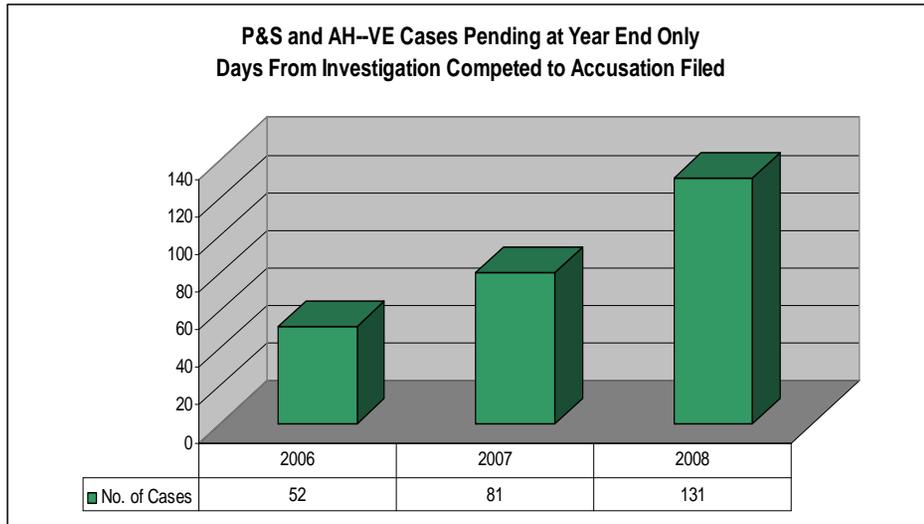
Table 15.1 – Calendar Days Aged from Investigation Completed to Accusation Filed for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All	Not VE	VE	All				
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending					
Calendar Day Age from Completed Investigation to Accusation Filed																				
Average	-8.57%		12.12%		163.16%		-8.13%		45.50%		9.00%		-16.00%		63.13%		186.84%		-72.32%	
Median (middle record-half are above and half below)	-24.35%		12.59%		77.78%		-10.34%		44.10%		9.38%		-32.17%		62.24%		94.44%		-84.46%	
Record Count	26.40%	-32.40%	-27.22%	-68.50%	350.00%	55.77%	-17.67%	17.36%	-69.92%	-72.50%	33.33%	61.73%	4.06%	-20.67%	-78.11%	-91.34%	500.00%	151.92%	-8.48%	-13.41%

Charts 15.1a, b & c – Calendar Days Aged Investigation Completed to Accusation Filed for Physicians and Surgeons and Allied Health Cases



Charts 15.1d, e & f – Calendar Days Aged from Investigation Completed to Accusation Filed for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



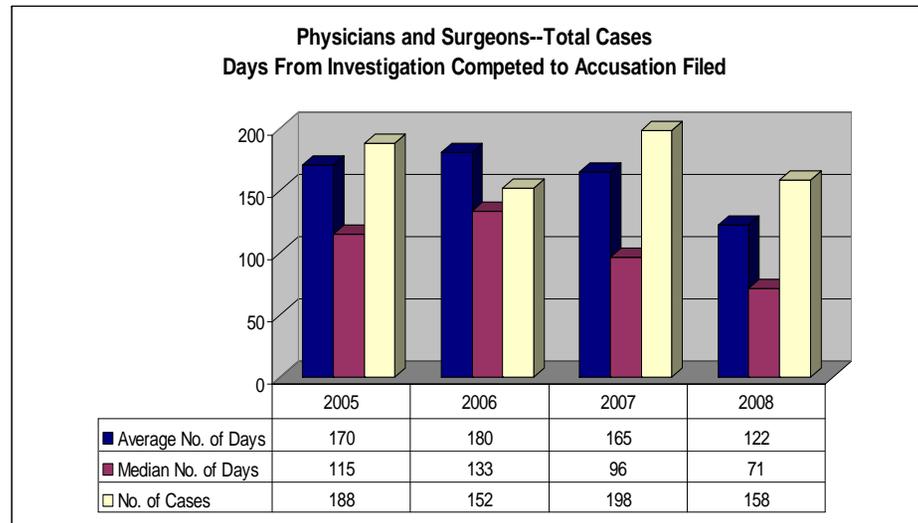
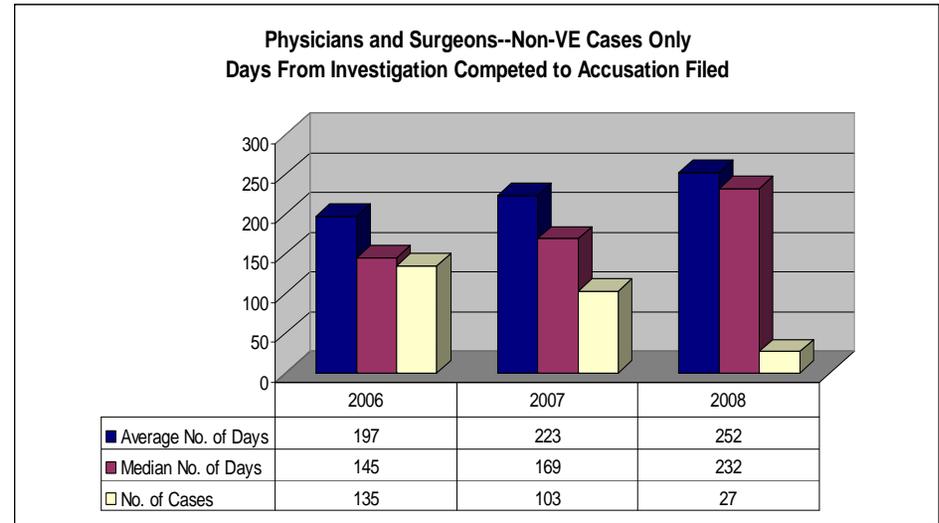
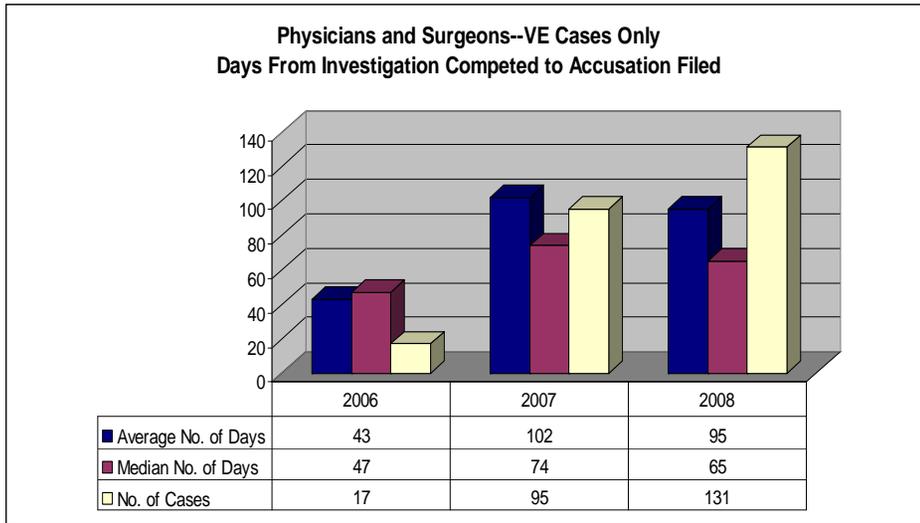
CALENDAR DAYS AGED FROM INVESTIGATION COMPLETED TO ACCUSATION FILED — PHYSICIANS AND SURGEONS

Table 15.2 below reports the average and median calendar days aged from case investigation completed to accusation filed for Physicians and Surgeons cases. Between 2005 and 2008, there was a 28.24% decrease in the average days aged, a 38.26% decrease in the median days aged, a 15.96% decrease in the number of such cases and a 4.63% decrease in the number of such cases pending at year end.

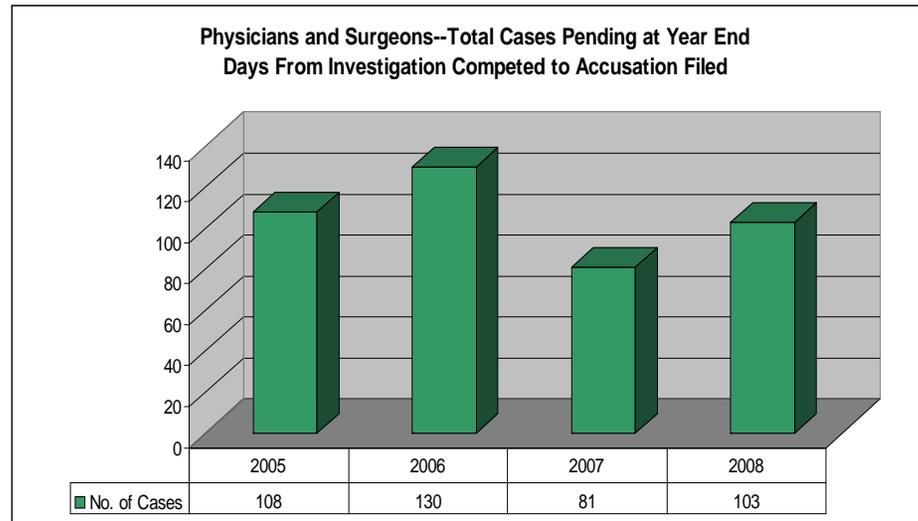
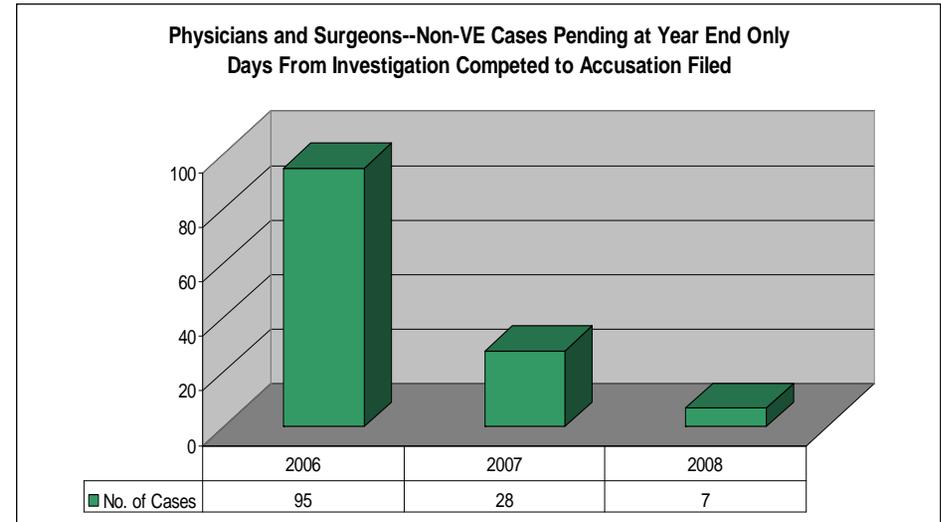
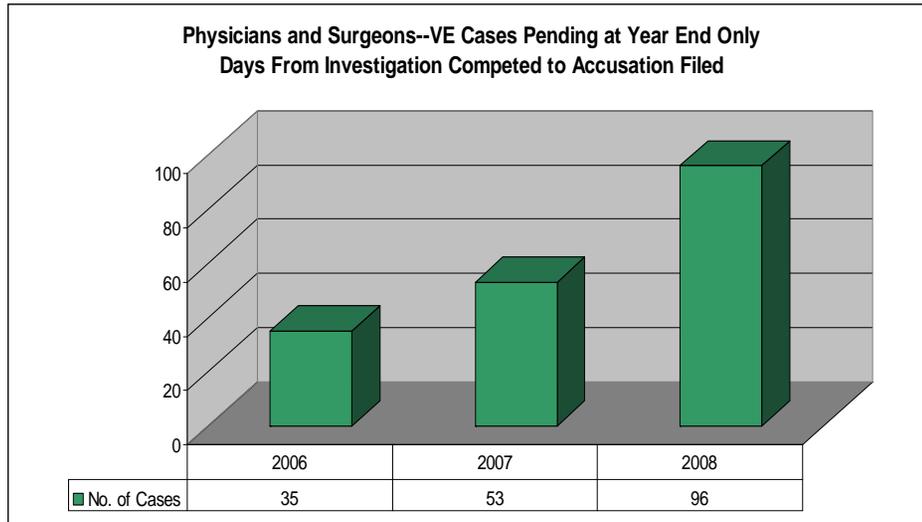
Table 15.2 – Calendar Days Aged from Investigation Completed to Accusation Filed for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All	
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending	
Calendar Day Age from Completed Investigation to Accusation Filed																				
Average	-8.33%		13.20%		137.21%		-26.06%		13.00%		-6.86%		-32.22%		27.92%		120.93%		-28.24%	
Median (middle record-half are above and half below)	-27.82%		16.55%		57.45%		-26.04%		37.28%		-12.16%		-46.62%		60.00%		38.30%		-38.26%	
Record Count	30.26%	-37.69%	-23.70%	-70.53%	458.82%	51.43%	-20.20%	27.16%	-73.79%	-75.00%	37.89%	81.13%	3.95%	-20.77%	-80.00%	-92.63%	670.59%	174.29%	-15.96%	-4.63%

Charts 15.2a, b & c – Calendar Days Aged Investigation Completed to Accusation Filed for Physicians and Surgeons Cases



Charts 15.2d, e & f – Calendar Days Aged from Investigation Completed to Accusation Filed for Physicians and Surgeons Cases — Cases Pending at Year End



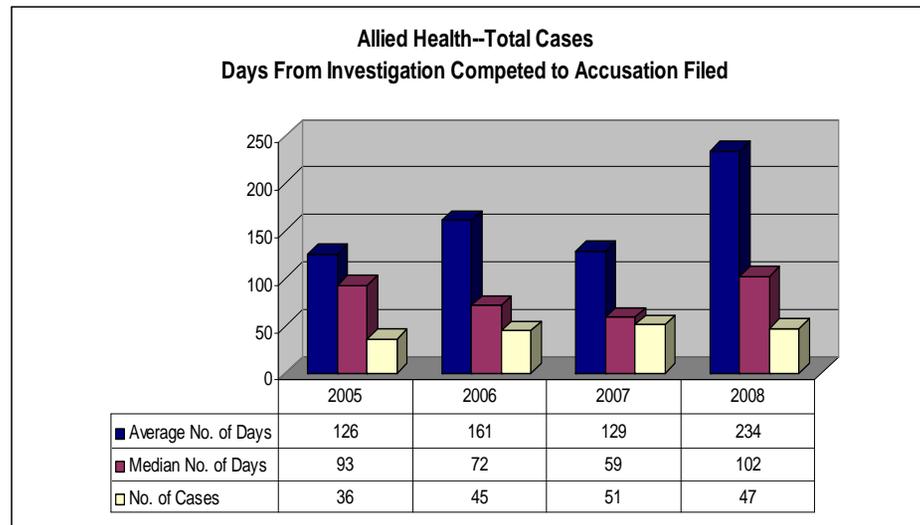
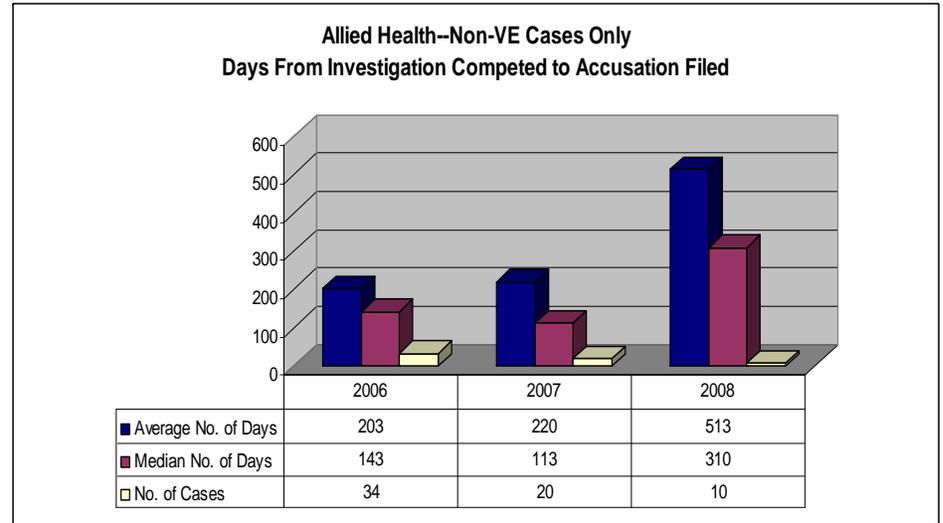
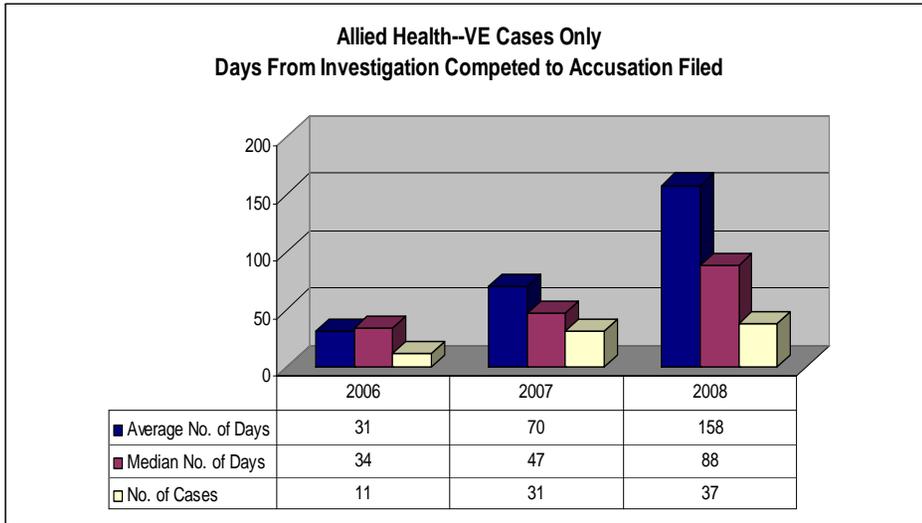
CALENDAR DAYS AGED FROM INVESTIGATION COMPLETED TO ACCUSATION FILED — ALLIED HEALTH

Table 15.3 below reports the average and median calendar days aged from case investigation completed to accusation filed for Allied Health Care cases. Between 2005 and 2008, there was an 85.71% increase in the average days aged, a 9.68% increase in the median days aged, a 30.56% increase in the number of such cases and a 30.36% decrease in the number of such cases pending at year end.

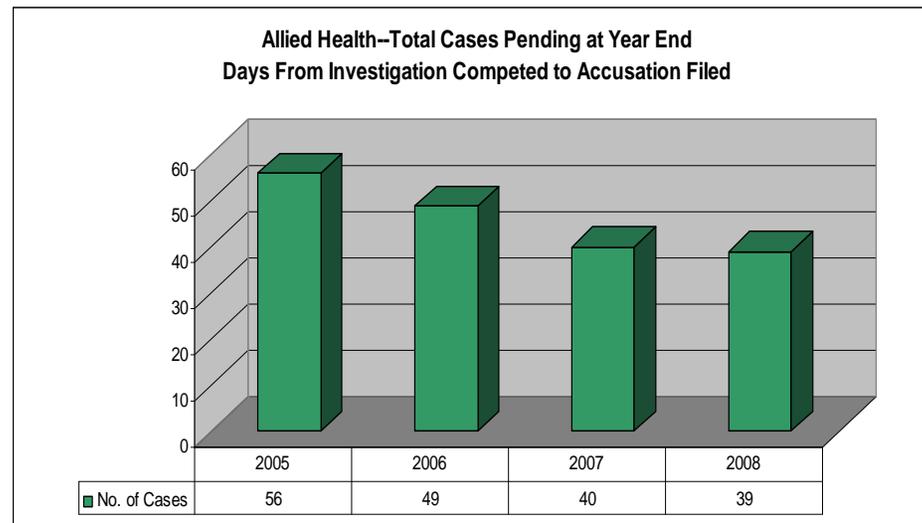
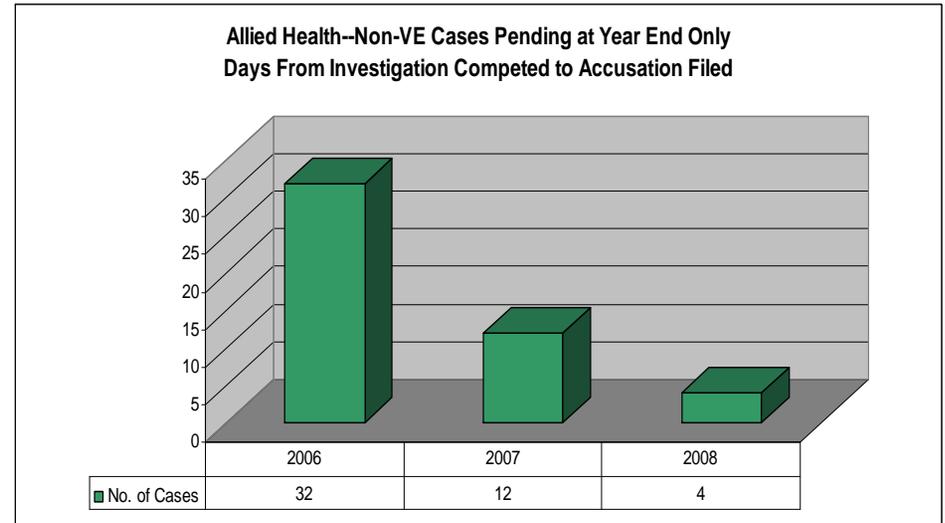
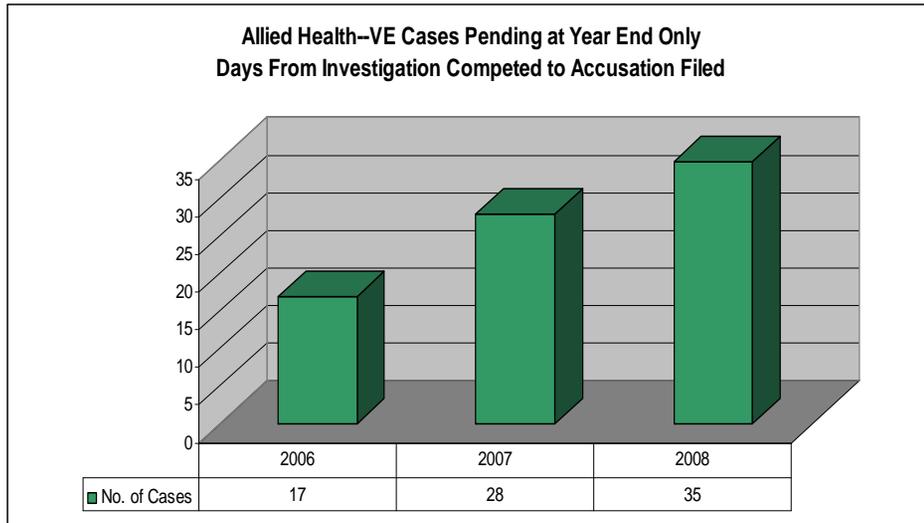
Table 15.3 – Calendar Days Aged from Investigation Completed to Accusation Filed for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All	Not VE		VE		All	Not VE		VE		All	Not VE		VE		All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Completed Investigation to Accusation Filed																				
Average	-19.88%		8.37%		125.81%		81.40%		133.18%		125.71%		45.34%		152.71%		409.68%		85.71%	
Median (middle record-half are above and half below)	-18.06%		-20.98%		38.24%		72.88%		174.34%		87.23%		41.67%		116.78%		158.82%		9.68%	
Record Count	13.33%	-18.37%	-41.18%	-62.50%	181.82%	64.71%	-7.84%	-2.50%	-50.00%	-66.67%	19.35%	25.00%	4.44%	-20.41%	-70.59%	-87.50%	236.36%	105.88%	30.56%	-30.36%

Charts 15.3a, b & c – Calendar Days Aged Investigation Completed to Accusation Filed for Allied Health Cases



Charts 15.3d, e & f – Calendar Days Aged from Investigation Completed to Accusation Filed for Allied Health Cases — Cases Pending at Year End



XVI. VERTICAL PROSECUTION - ACCUSATION TO SUBMISSION TO ADMINISTRATIVE LAW JUDGE

Per the VPM, within 15 calendar days of receipt of the Notice of Defense, the primary DAG shall submit a request to set with the Office of Administrative Hearings.

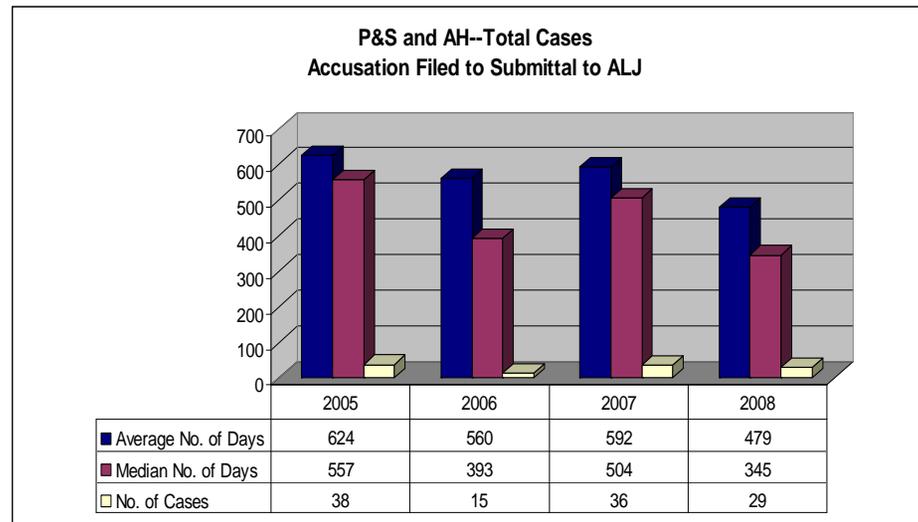
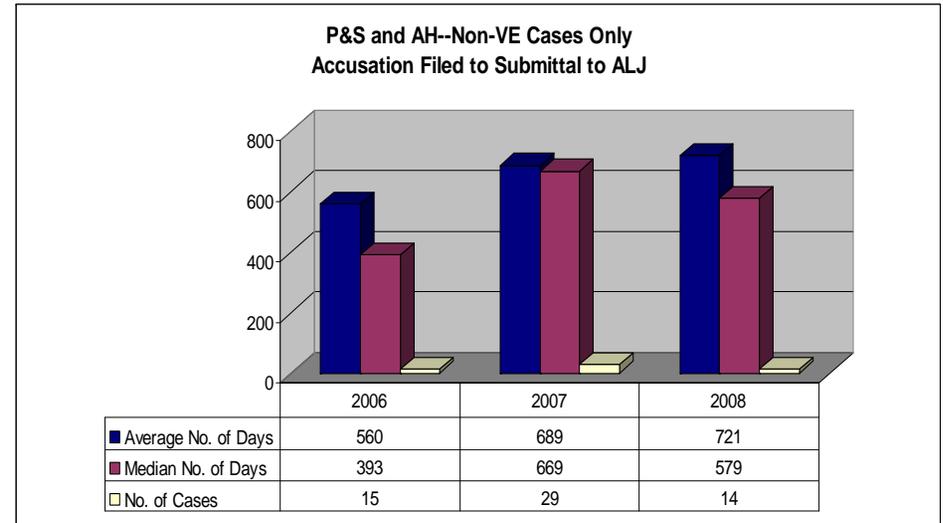
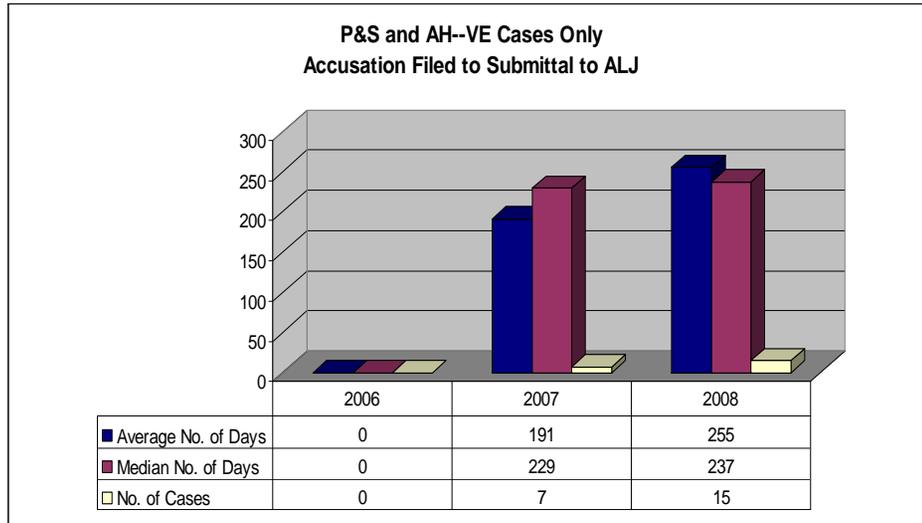
CALENDAR DAYS AGED FROM ACCUSATION FILED TO CASE SUBMITTED TO ALJ FOR DECISION — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 16.1 below reports the average and median calendar days aged from the date the accusation was filed to the date the case was submitted to the ALJ for decision for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 23.24% decrease in the average days aged, a 38.06% increase in the median days aged, and a 23.68% decrease in the number of such cases.

Table 16.1 – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008								
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All								
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending								
Calendar Day Age from Date Accusation Filed to Date Hearing Closed-Submit to ALJ																		
Average	5.71%	23.04%		-19.09%	4.64%	33.51%	-14.46%	28.75%										-23.24%
Median (middle record - half are above and half below)	28.24%	70.23%		-31.55%	-13.45%	3.49%	-12.21%	47.33%										-38.06%
Record Count	140.00%	93.33%		-19.44%	-51.72%	114.29%	93.33%	-6.67%										-23.68%

Charts 16.1a, b & c – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Physicians and Surgeons and Allied Health Cases



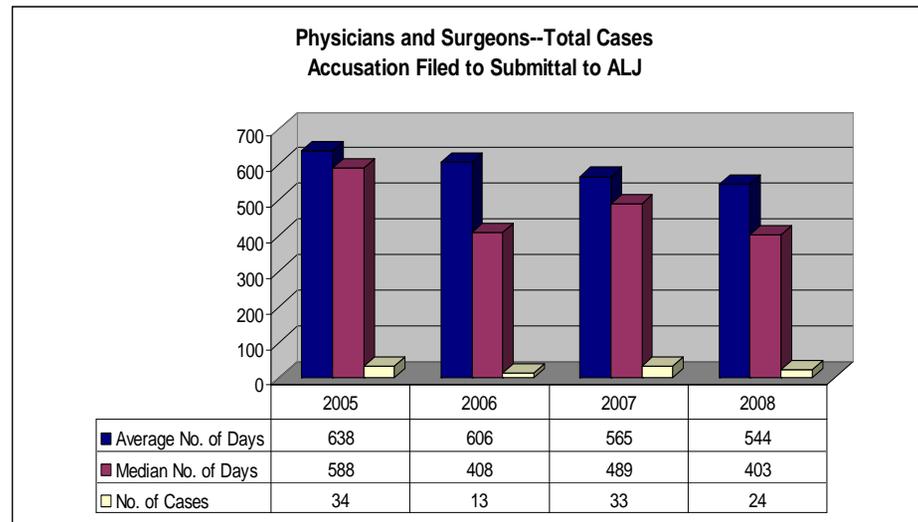
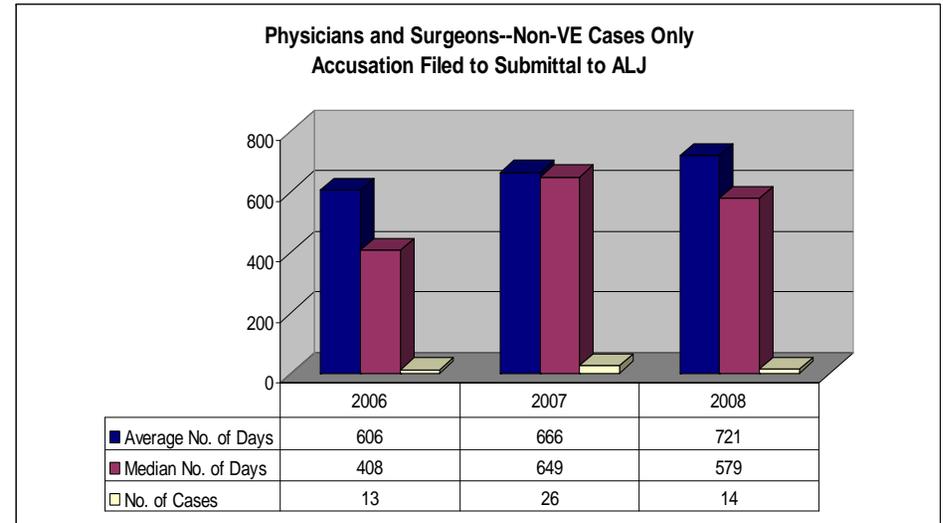
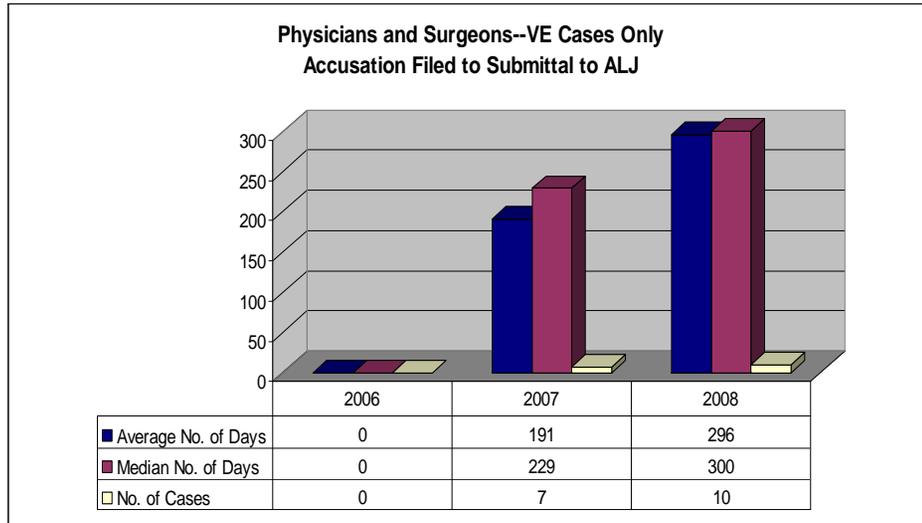
CALENDAR DAYS AGED FROM ACCUSATION FILED TO CASE SUBMITTED TO ALJ FOR DECISION — PHYSICIANS AND SURGEONS

Table 16.2 below reports the average and median calendar days aged from the date the accusation was filed to the date the case was submitted to the ALJ for decision for Physicians and Surgeons cases. Between 2005 and 2008, there was a 14.73% decrease in the average days aged, a 31.46% increase in the median days aged, and a 29.41% decrease in the number of such cases.

Table 16.2 – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Physicians and Surgeons

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008		
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All		
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending		
Calendar Day Age from Date Accusation Filed to Date Hearing Closed-Submit to ALJ												
Average	-6.77%	9.90%		-3.72%	8.26%	54.97%	-10.23%	18.98%		-14.73%		
Median (middle record - half are above and half below)	19.85%	59.07%		-17.59%	-10.79%	31.00%	-1.23%	41.91%		-31.46%		
Record Count	153.85%	100.00%		-27.27%	-46.15%	42.86%	84.62%	7.69%		-29.41%		

Charts 16.2a, b & c – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Physicians and Surgeons



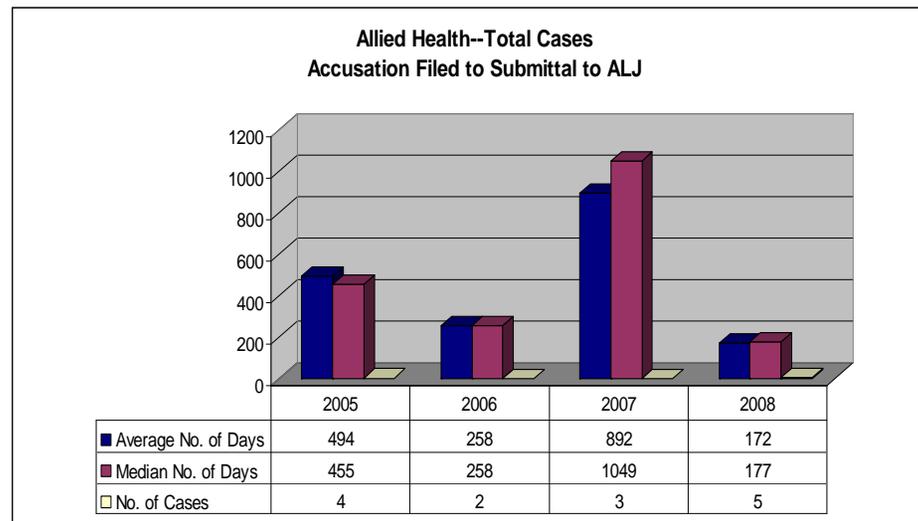
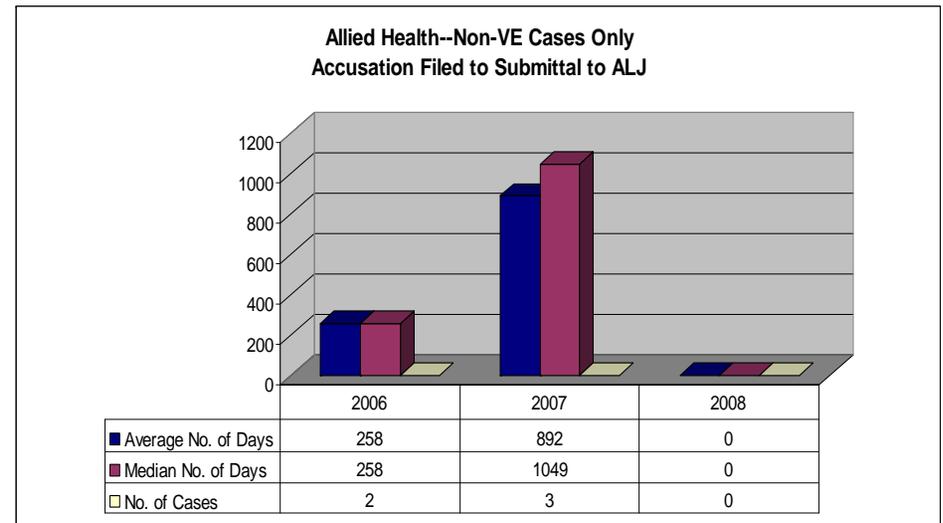
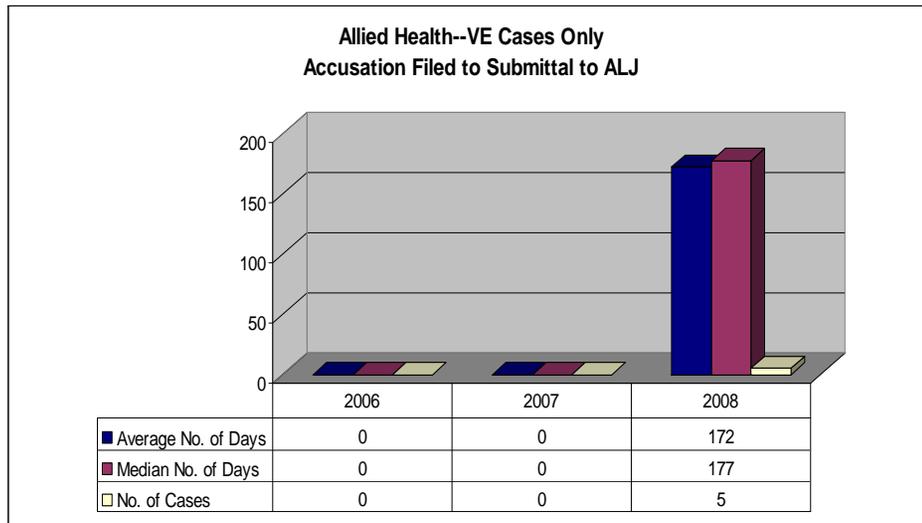
CALENDAR DAYS AGED FROM ACCUSATION FILED TO CASE SUBMITTED TO ALJ FOR DECISION — ALLIED HEALTH

Table 16.3 below reports the average and median calendar days aged from the date the accusation was filed to the date the case was submitted to the ALJ for decision for Allied Health Care cases. Between 2005 and 2008, there was a 65.18% decrease in the average days aged, a 61.10% decrease in the median days aged, and a 25.00% increase in the number of such cases.

Table 16.3 – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Allied Health Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008							
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All							
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending							
Calendar Day Age from Date Accusation Filed to Date Hearing Closed-Submit to ALJ																	
Average	245.74%	245.74%		-80.72%	-100.00%		-33.33%	-100.00%		-65.18%							
Median (middle record - half are above and half below)	306.59%	306.59%		-83.13%	-100.00%		-31.40%	-100.00%		-61.10%							
Record Count	50.00%	50.00%		66.67%	-100.00%		150.00%	-100.00%		25.00%							

Charts 16.3a, b & c – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Allied Health Cases



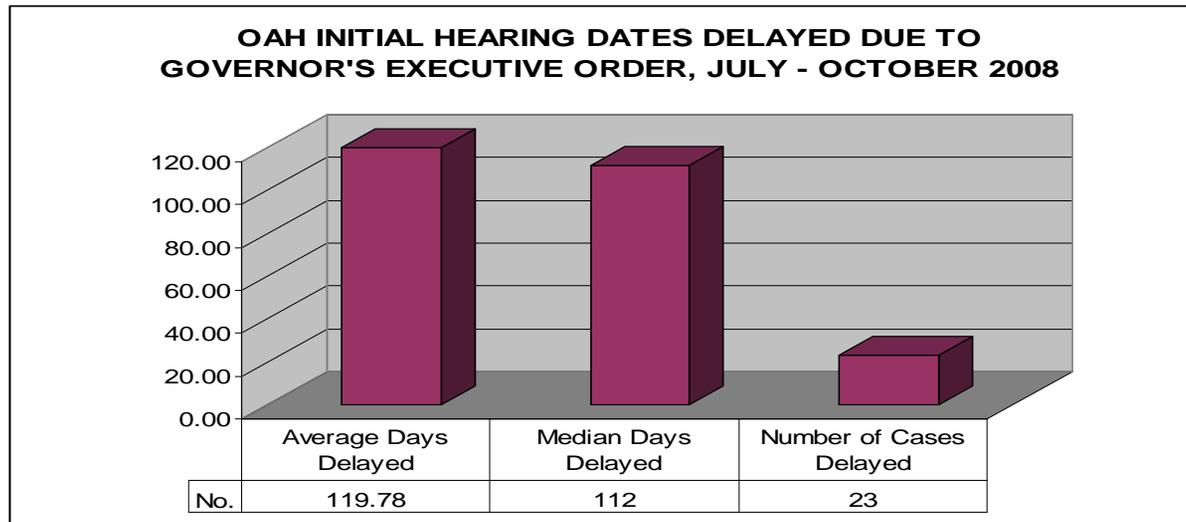
HEARINGS DELAYED DUE TO GOVERNOR’S EXECUTIVE ORDER, JULY – OCTOBER 2008

Table 16.4 below reports delays between the original initial hearing date and the continued hearing date due to a lack of available court reporters as a result of the Governor’s Executive Order. Between July and October 2008, 23 Medical Board cases scheduled for OAH hearings were delayed an average of 119.78 days and a median of 112 days.

Table 16.4 – Hearings Delayed due to Governor’s Executive Order, July – October 2008

	July - October 2008
Average Days Delayed	119.78
Median Days Delayed	112
Number of Cases Delayed	23

Chart 16.4 – Hearings Delayed due to Governor’s Executive Order, July – October 2008



XVII. VERTICAL PROSECUTION - ACCUSATION TO ADMINISTRATIVE OUTCOMES

The following tables and charts detail the average and median time frames that have occurred between the filing of an accusation and the indicated outcomes.

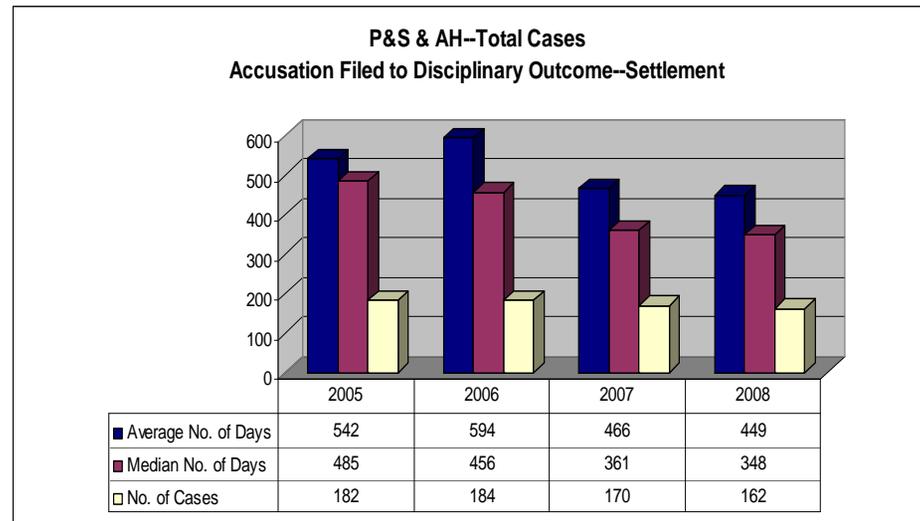
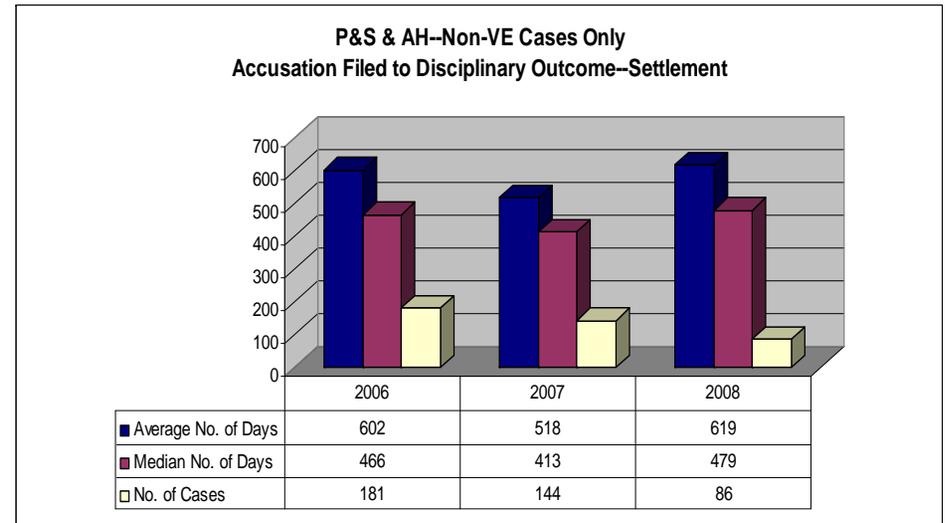
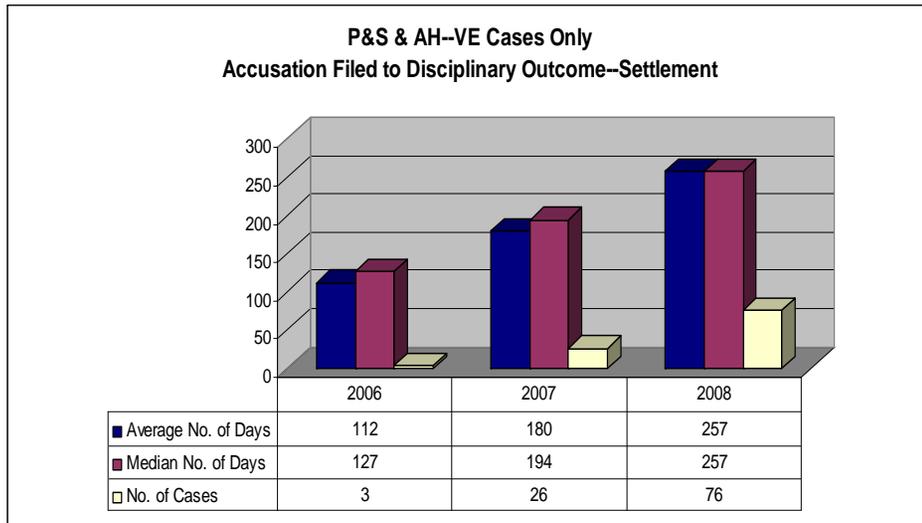
CALENDAR DAYS AGED FROM ACCUSATION FILED TO SETTLEMENT — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 17.1 below reports the average and median calendar days aged from accusation filed to settlement for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 17.16% decrease in the average days aged, a 28.25% decrease in the median days aged, a 10.99% decrease in the number of such cases and a 63.64% increase in the number of such cases pending at year end.

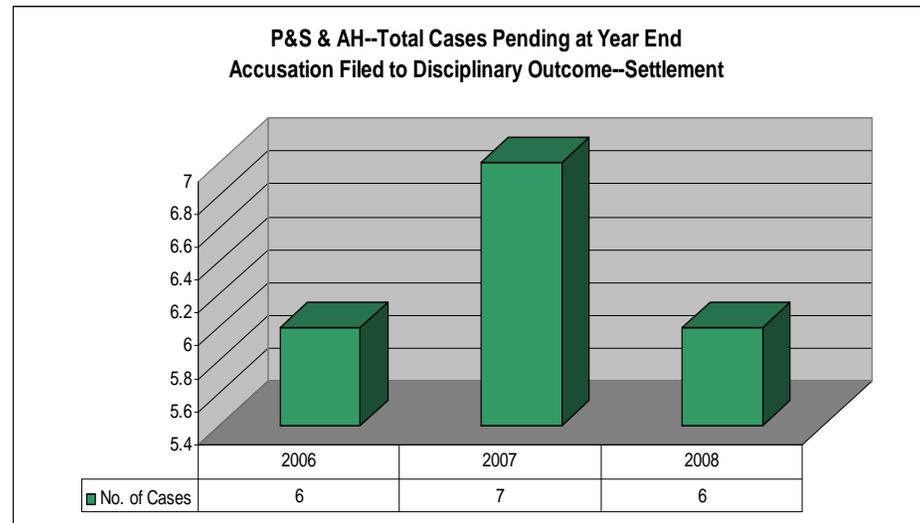
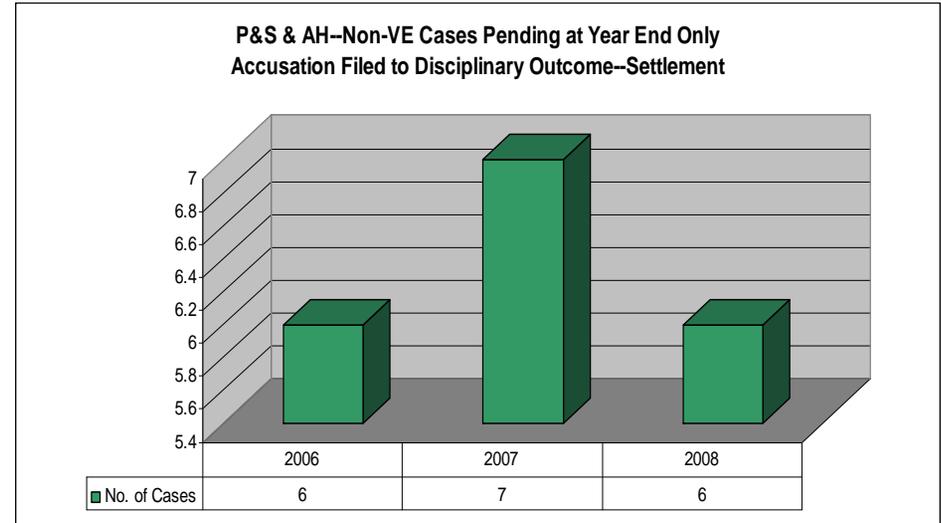
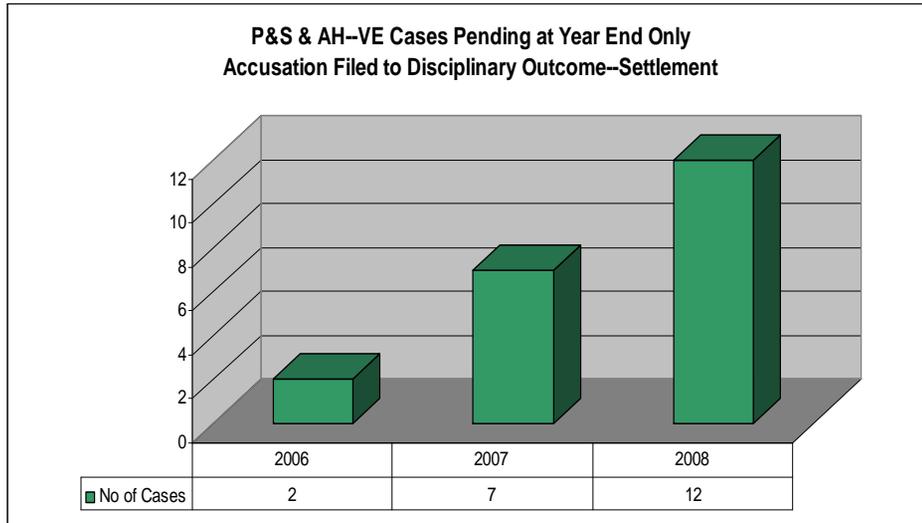
Table 17.1 – Calendar Days Aged from Accusation Filed to Disciplinary Outcome - Settlement for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All
Calendar Day Age from Date Accusation Filed to Disciplinary Outcome--Settlement										
Average	-21.55%	-13.95%	60.71%	-3.65%	19.50%	42.78%	-24.41%	2.82%	129.46%	-17.16%
Median (middle record - half are above and half below)	-20.83%	-11.37%	52.76%	-3.60%	15.98%	32.47%	-23.68%	2.79%	102.36%	-28.25%
Record Count	-7.61%	-20.44%	766.67%	-4.71%	-40.28%	192.31%	-11.96%	-52.49%	2433.33%	-10.99%
All Pending	75.00%	16.67%	250.00%	28.57%	-14.29%	71.43%	125.00%	0.00%	500.00%	63.64%

Charts 17.1a, b & c – Calendar Days Aged from Accusation Filed to Settlement for Physicians and Surgeons and Allied Health Cases



Charts 17.1d, d & f – Calendar Days Aged from Accusation Filed to Settlement for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



Separate data for Calendar Days Aged from Accusation Filed to Settlement for Physicians and Surgeons cases only and Allied Health Care cases only were not available at the time of drafting this report.

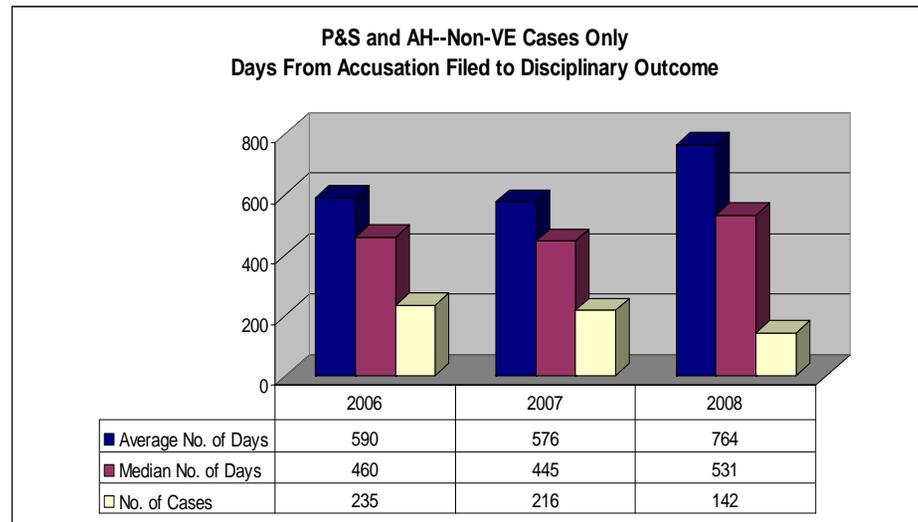
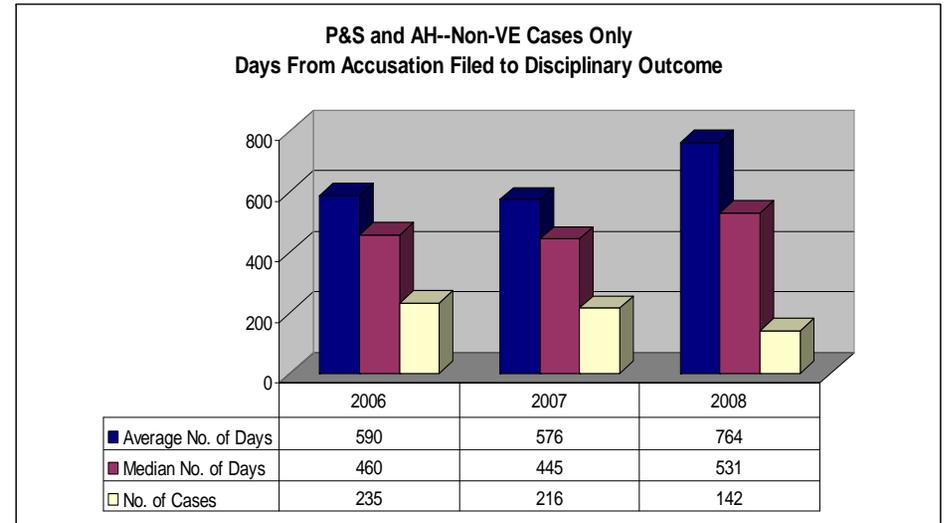
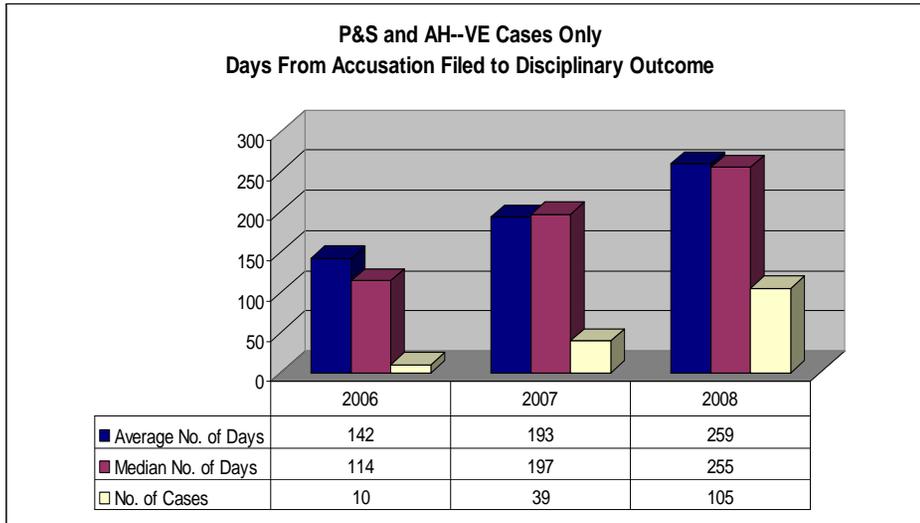
CALENDAR DAYS AGED FROM ACCUSATION FILED TO DISCIPLINARY OUTCOME — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 17.2 below reports the average and median calendar days aged from accusation filed to disciplinary outcome for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was an 8.75% decrease in the average days aged, a 27.29% decrease in the median days aged, a 6.08% decrease in the number of such cases and a 28.74% decrease in the number of such cases pending at year end.

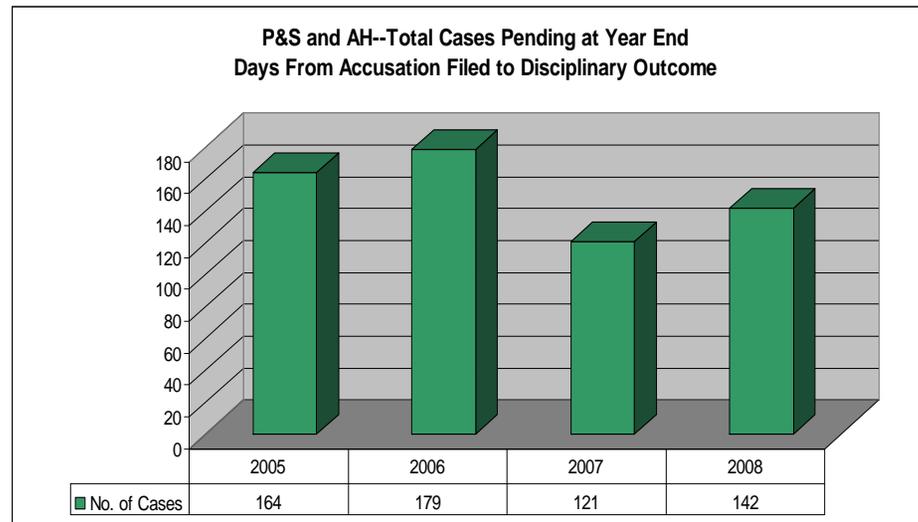
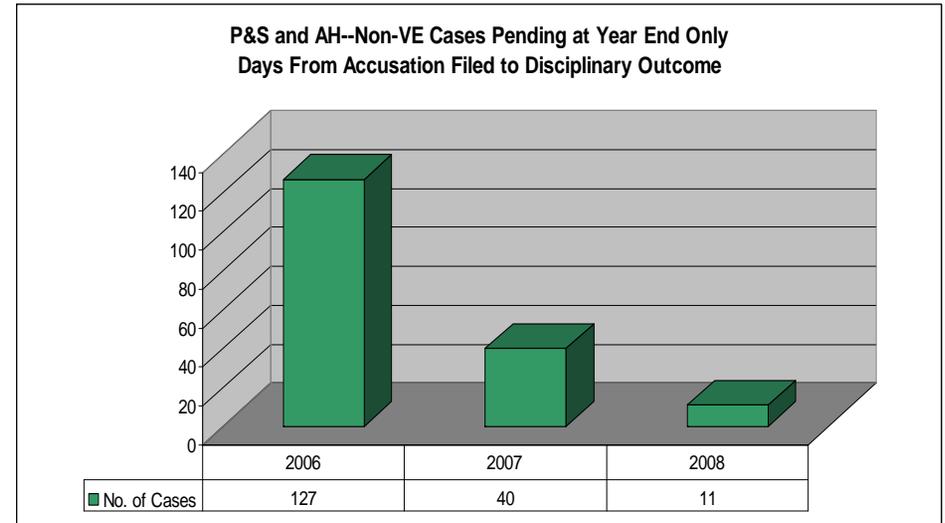
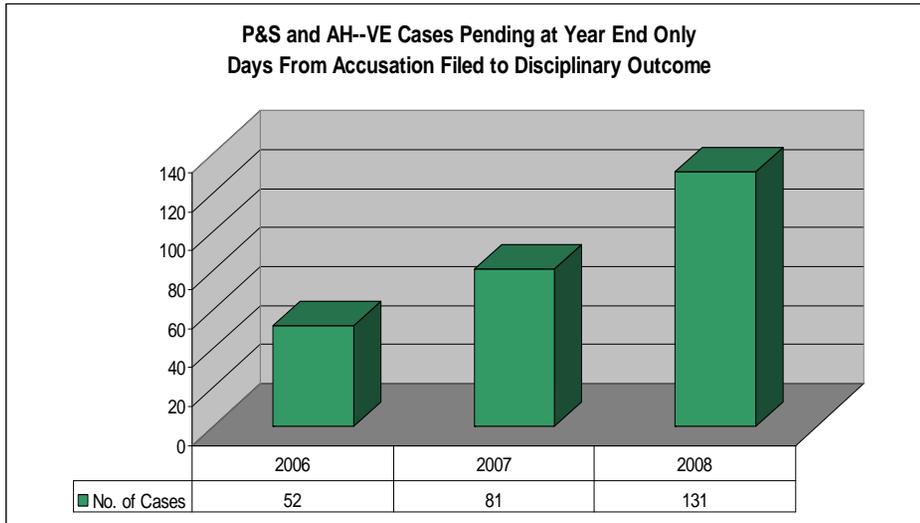
Table 17.2 – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage Difference 2005 to 2008			
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All			
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending			
Calendar Day Age from Accusation Filed to Disciplinary Outcome**																						
Average	-9.62%		-2.37%		35.92%		2.90%		32.64%		34.20%		-6.99%		29.49%		82.39%				-8.75%	
Median (middle record-half are above and half below)	-13.33%		-3.26%		72.81%		-1.06%		19.33%		29.44%		-14.25%		15.43%		123.68%				-27.29%	
Record Count	4.08%	-1.68%	-8.09%	-32.86%	290.00%	483.33%	-3.14%	-15.36%	-34.26%	-57.45%	169.23%	60.00%	0.82%	-16.78%	-39.57%	-71.43%	950.00%	833.33%			-6.08%	-28.74%

Charts 17.2a, b & c – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Physicians and Surgeons and Allied Health Cases



Charts 17.2d, d & f – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



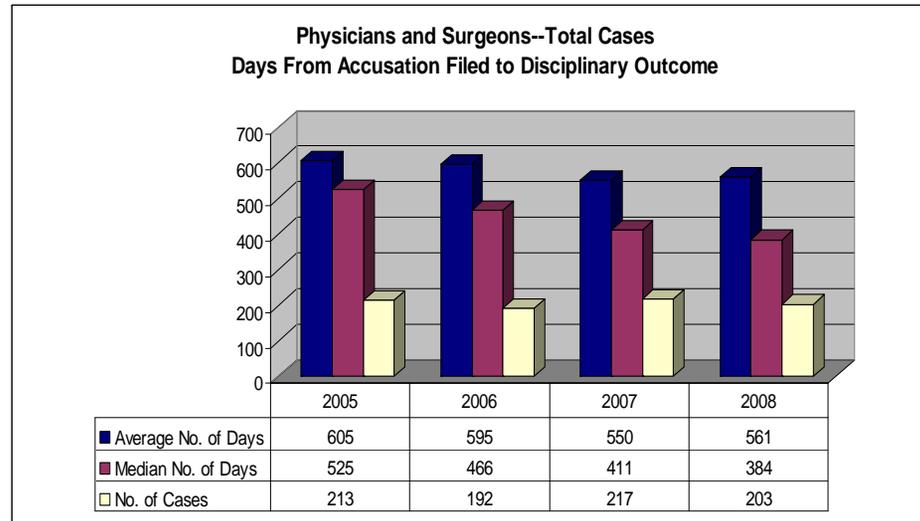
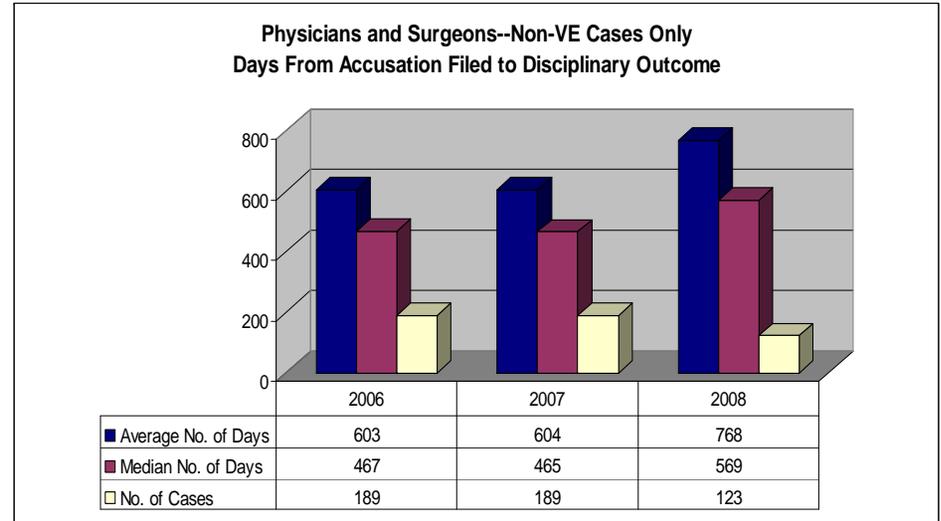
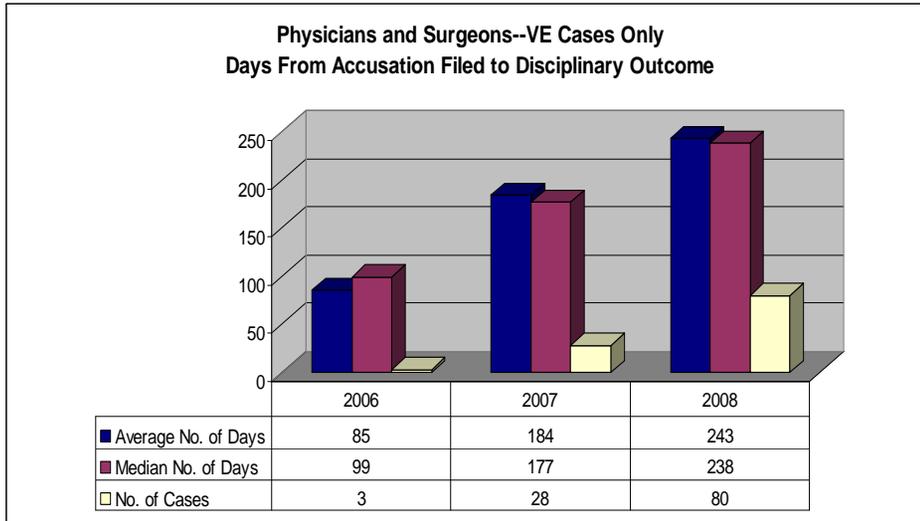
CALENDAR DAYS AGED FROM ACCUSATION FILED TO DISCIPLINARY OUTCOME — PHYSICIANS AND SURGEONS

Table 17.3 below reports the average and median calendar days aged from accusation filed to disciplinary outcome for Physicians and Surgeons cases. Between 2005 and 2008, there was a 7.27% decrease in the average days aged, a 26.86% decrease in the median days aged, a 4.69% decrease in the number of such cases and a 35.55% decrease in the number of such cases pending at year end.

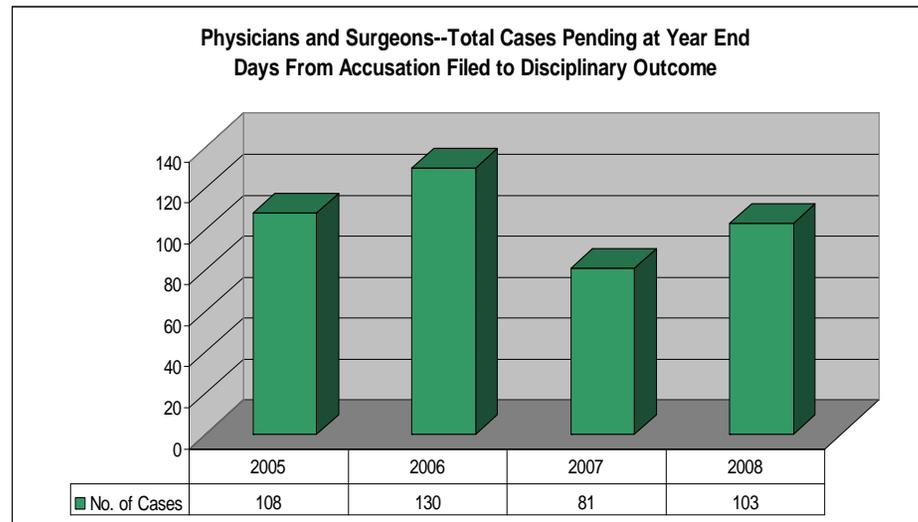
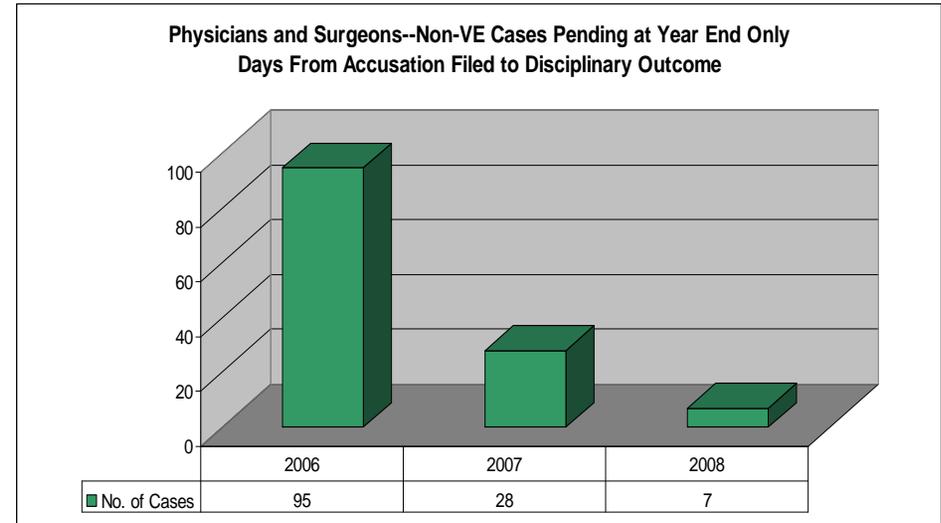
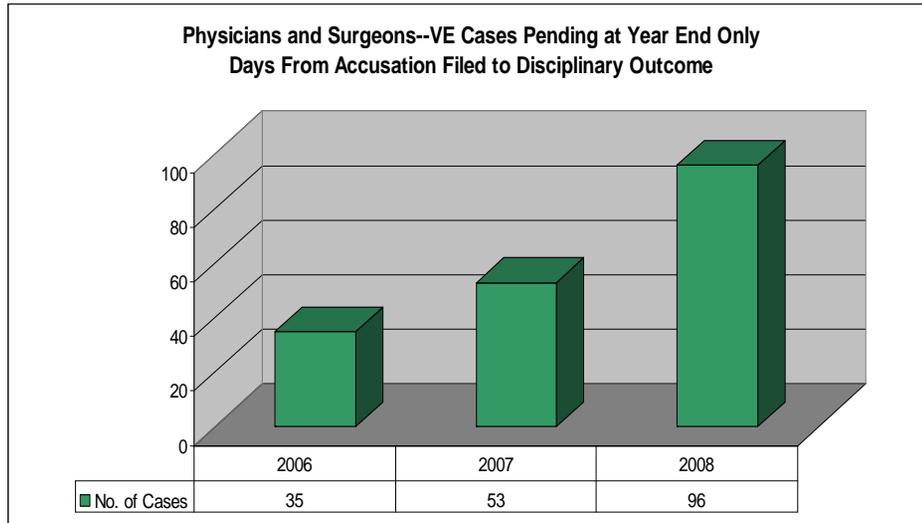
Table 17.3 – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Physicians and Surgeons Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All	Not VE		VE		All	Not VE		VE		All	Not VE		VE		All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Accusation Filed to Disciplinary Outcome**																				
Average	-7.56%		0.17%		116.47%		2.00%		27.15%		32.07%		-5.71%		27.36%		185.88%		-7.27%	
Median (middle record-half are above and half below)	-11.80%		-0.43%		78.79%		-6.57%		22.37%		34.46%		-17.60%		21.84%		140.40%		-26.86%	
Record Count	13.02%	-6.95%	0.00%	-34.69%	833.33%	478.57%	-6.45%	-19.50%	-34.92%	-61.25%	185.71%	62.96%	5.73%	-25.10%	-34.92%	-74.69%	2566.67%	842.86%	-4.69%	-35.55%

Charts 17.3a, b & c – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Physicians and Surgeons Cases



Charts 17.3d, d & f – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Physicians and Surgeons Cases — Cases Pending at Year End



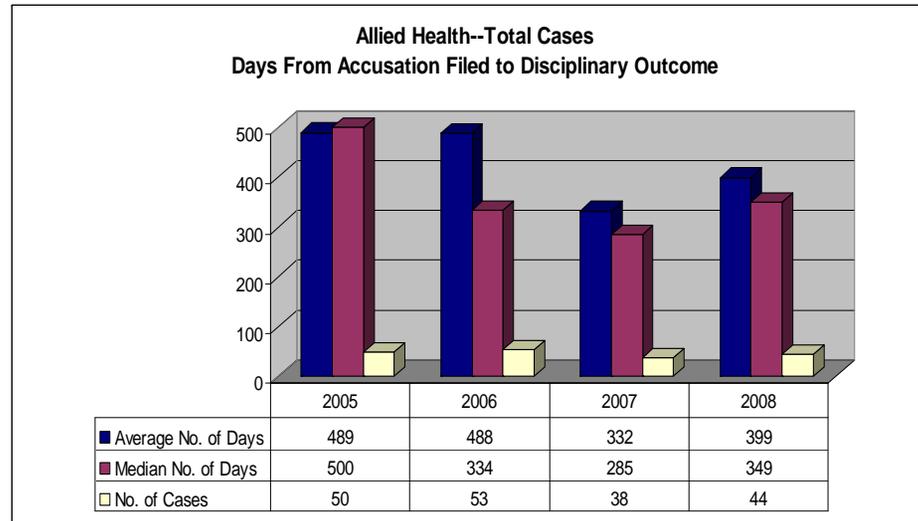
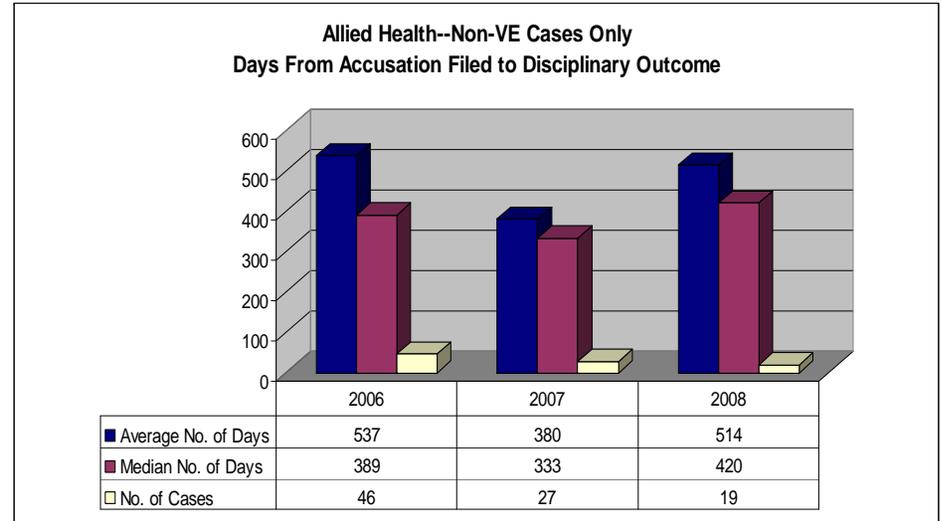
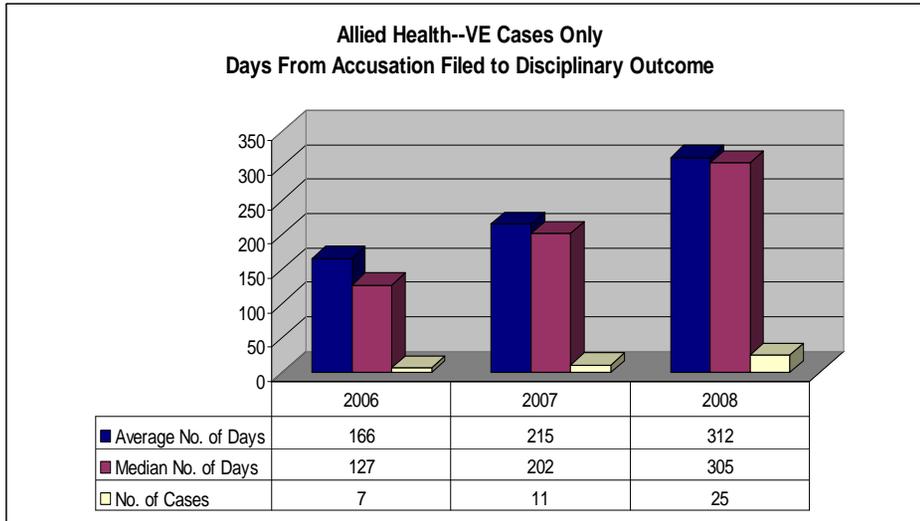
CALENDAR DAYS AGED FROM ACCUSATION FILED TO DISCIPLINARY OUTCOME — ALLIED HEALTH

Table 17.4 below reports the average and median calendar days aged from accusation filed to disciplinary outcome for Allied Health Care cases. Between 2005 and 2008, there was an 18.40% decrease in the average days aged, a 30.20% decrease in the median days aged, a 12.00% decrease in the number of such cases and a 14.89% increase in the number of such cases pending at year end.

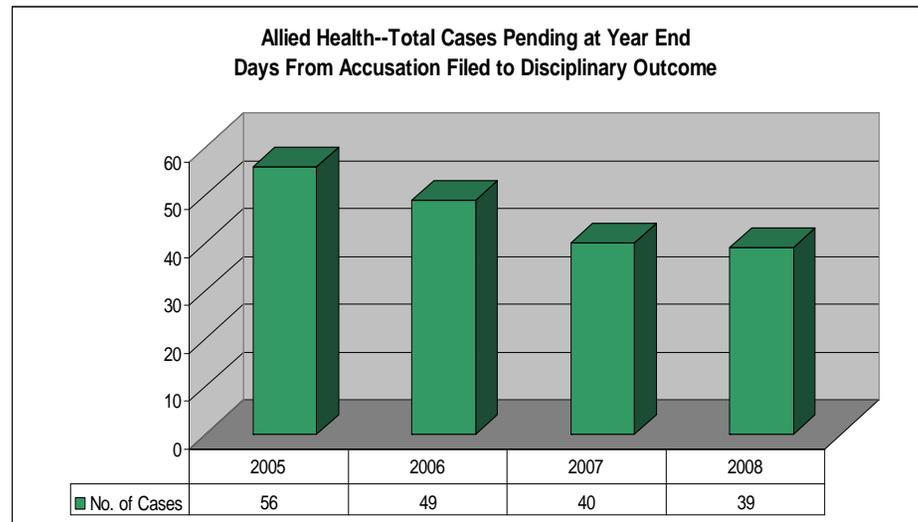
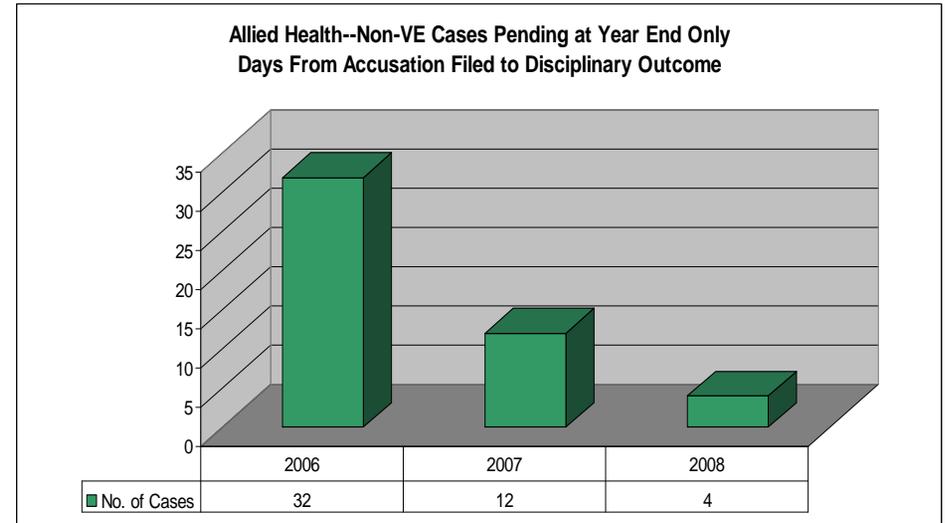
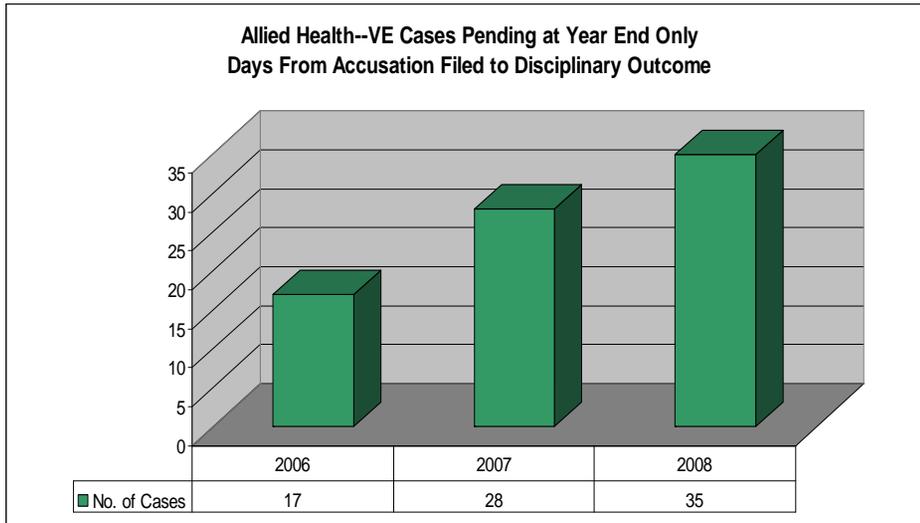
Table 17.4 – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All	Not VE		VE		All	Not VE		VE		All	Not VE		VE	All					
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending					
Calendar Day Age from Accusation Filed to Disciplinary Outcome**																				
Average	-31.97%		-29.24%		29.52%		20.18%		35.26%		45.12%		-18.24%		-4.28%		87.95%		-18.40%	
Median (middle record-half are above and half below)	-14.67%		-14.40%		59.06%		22.46%		26.13%		50.99%		4.49%		7.97%		140.16%		-30.20%	
Record Count	-28.30%	33.33%	-41.30%	-20.00%	57.14%	500.00%	15.79%	3.85%	-29.63%	-35.71%	127.27%	50.00%	-16.98%	38.46%	-58.70%	-48.57%	257.14%	800.00%	-12.00%	14.89%

Charts 17.4a, b & c – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Allied Health Cases



Charts 17.4d, d & f – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Allied Health Cases — Cases Pending at Year End



CALENDAR DAYS AGED FROM ACCUSATION FILED TO ADMINISTRATIVE OUTCOMES — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 17.5 below reports the average and median calendar days aged from the date the accusation was filed to the indicated administrative outcome for Physicians and Surgeons and Allied Health Care cases.

For cases resulting in revocation of license, between 2005 and 2008 there was a 10.11% decrease in the average days aged, a 39.45% decrease in the median days aged, and a 12.00% decrease in the number of such cases.

For cases resulting in surrender of license, between 2005 and 2008 there was a 14.88% decrease in the average days aged, a 49.86% decrease in the median days aged, and a 10.26% decrease in the number of such cases.

For cases resulting in suspension of license only, the percentage increase or decrease could not be calculated as there were no such cases in 2005.

For cases resulting in probation, between 2005 and 2008 there was a 22.04% decrease in the average days aged, a 27.11% decrease in the median days aged, and a 6.82% decrease in the number of such cases.

For cases resulting in probation with suspension, between 2005 and 2008 there was a 4.32% decrease in the average days aged, a 16.39% decrease in the median days aged, and a 58.62% decrease in the number of such cases.

For cases resulting in public reprimand, between 2005 and 2008 there was an 11.35% decrease in the average days aged, a 31.86% decrease in the median days aged, and no change in the number of such cases.

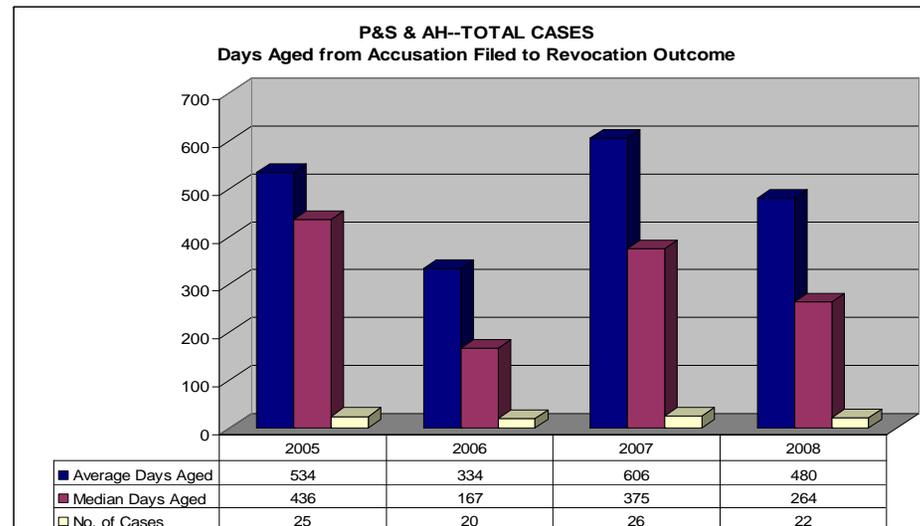
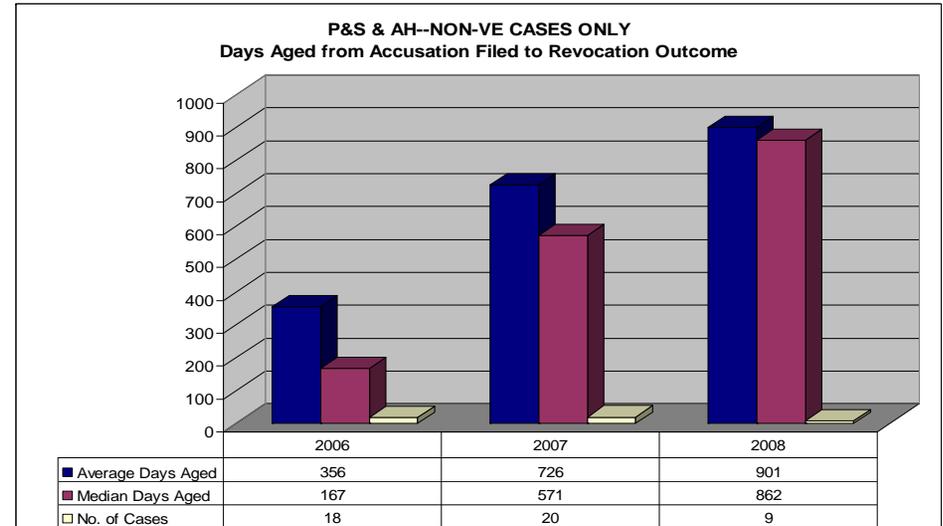
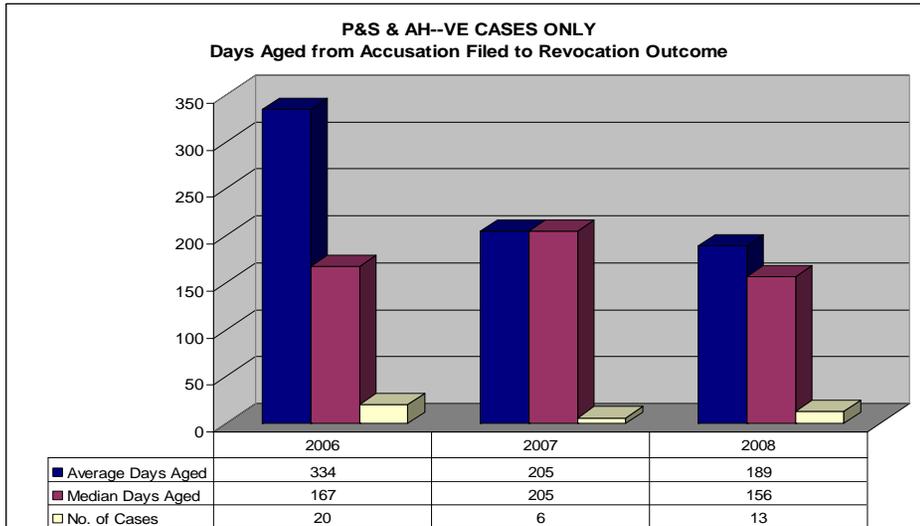
For cases resulting in other decisions, between 2005 and 2008 there was a 33.52% increase in the average days aged, a 5.90% decrease in the median days aged, and a 300.00% increase in the number of such cases.

For cases resulting in a withdrawal or dismissal, between 2005 and 2008 there was a 16.67% increase in the average days aged, a 23.64% decrease in the median days aged, and a 24.00% increase in the number of such cases.

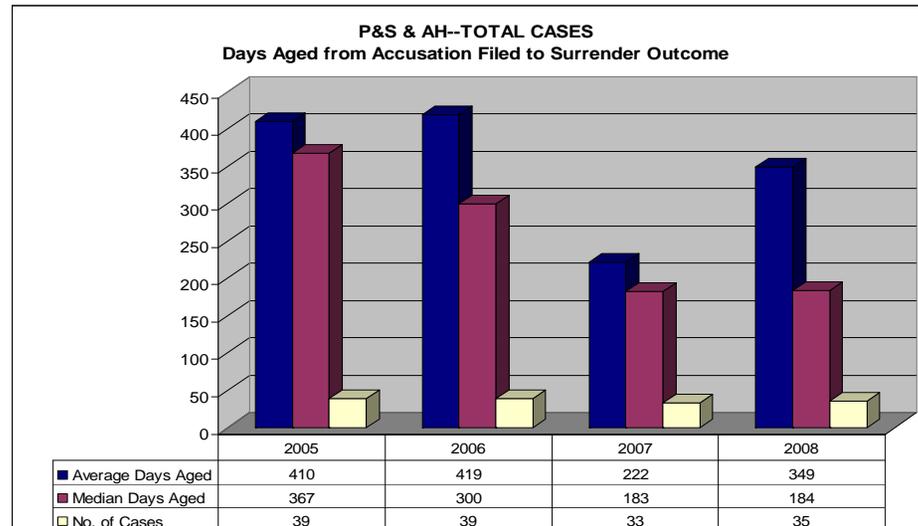
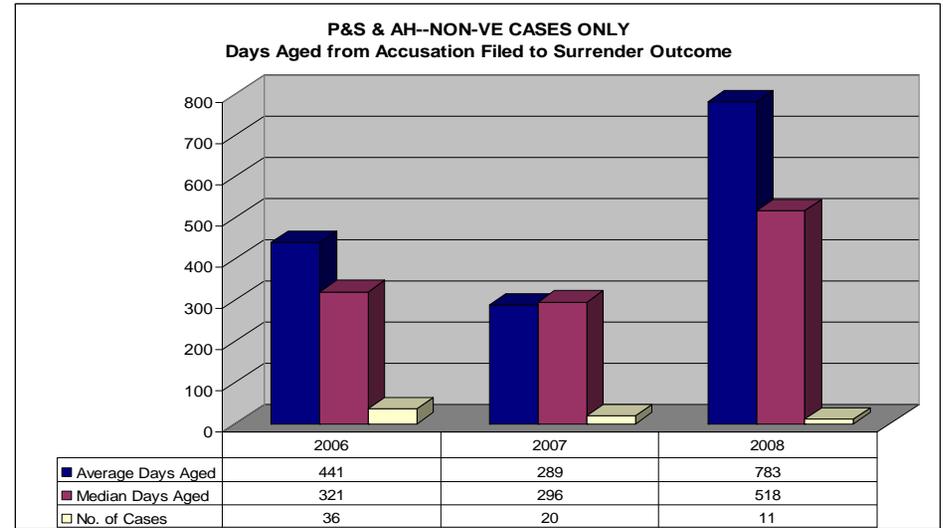
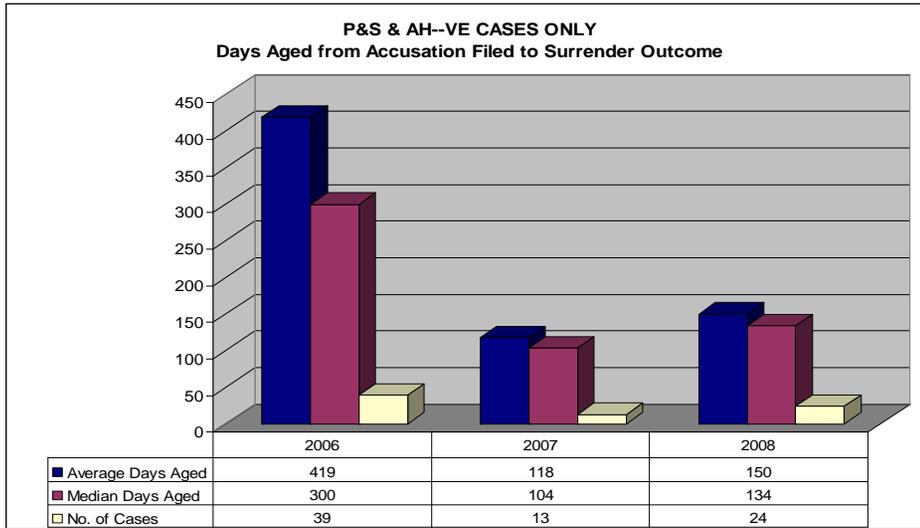
Table 17.5 – Calendar Days Aged from Accusation Filed to Indicated Administrative Outcome for Physicians and Surgeons and Allied Health Cases

	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All
REVOCAION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	81.44%	103.93%	-38.62%	-20.79%	24.10%	-7.80%	43.71%	153.09%	-43.41%	-10.11%
Median (middle record - half are above and half below)	124.55%	241.92%	22.75%	-29.60%	50.96%	-23.90%	58.08%	416.17%	-6.59%	-39.45%
Record Count	30.00%	11.11%	-70.00%	-15.38%	-55.00%	116.67%	10.00%	-50.00%	-35.00%	-12.00%
SURRENDER										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-47.02%	-34.47%	-71.84%	57.21%	170.93%	27.12%	-16.71%	77.55%	-64.20%	-14.88%
Median (middle record - half are above and half below)	-39.00%	-7.79%	-65.33%	0.55%	75.00%	28.85%	-38.67%	61.37%	-55.33%	-49.86%
Record Count	-15.38%	-44.44%	-66.67%	6.06%	-45.00%	84.62%	-10.26%	-69.44%	-38.46%	-10.26%
SUSPENSION ONLY										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-100.00%	-100.00%	-100.00%				-100.00%	-100.00%	-100.00%	
Median (middle record - half are above and half below)	-100.00%	-100.00%	-100.00%				-100.00%	-100.00%	-100.00%	
Record Count	-100.00%	-100.00%	-100.00%				-100.00%	-100.00%	-100.00%	
PROBATION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-6.96%	-1.25%	-52.32%	-10.36%	3.07%	11.24%	-16.61%	1.79%	-46.96%	-22.04%
Median (middle record - half are above and half below)	-9.49%	4.63%	-39.35%	-7.16%	-5.75%	1.15%	-15.97%	-1.39%	-38.66%	-27.11%
Record Count	20.27%	6.76%	-86.49%	-7.87%	-35.44%	210.00%	10.81%	-31.08%	-58.11%	-6.82%
PROBATION W/SUSPENSION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-6.03%	-7.50%	-59.70%	2.00%	36.49%	45.33%	-4.14%	26.25%	-41.43%	-4.32%
Median (middle record - half are above and half below)	-23.76%	-23.15%	-57.62%	5.97%	59.01%	29.91%	-19.21%	22.20%	-44.95%	-16.39%
Record Count	-5.88%	-6.25%	-94.12%	-25.00%	-60.00%	500.00%	-29.41%	-62.50%	-64.71%	-58.62%
PUBLIC REPRIMAND										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-14.96%	-12.40%	-60.51%	-3.49%	-12.31%	15.36%	-17.92%	-1.62%	-54.45%	-11.35%
Median (middle record - half are above and half below)	-29.09%	-22.58%	-63.82%	-2.24%	-17.01%	23.60%	-30.68%	-9.41%	-55.28%	-31.86%
Record Count	-19.12%	-23.53%	-95.59%	0.00%	26.92%	466.67%	-19.12%	-44.12%	-75.00%	0.00%
OTHER DECISION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-61.58%	-56.30%	-82.64%	37.72%	87.22%	38.70%	-47.09%	-18.19%	-75.92%	33.52%
Median (middle record - half are above and half below)	-27.06%	-4.62%	-62.05%	11.76%	18.17%	41.30%	-18.48%	12.71%	-46.37%	-5.90%
Record Count	66.67%	33.33%	-66.67%	60.00%	0.00%	300.00%	166.67%	33.33%	33.33%	300.00%
ACCUSATION WITHDRAWN/DISMISSED										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	10.04%	8.15%	-70.08%	41.50%	59.97%	103.95%	55.71%	73.01%	-38.98%	16.67%
Median (middle record - half are above and half below)	5.19%	29.43%	-56.82%	25.62%	80.57%	168.42%	32.14%	133.71%	15.91%	-23.64%
Record Count	34.78%	36.84%	-78.26%	0.00%	-19.23%	100.00%	34.78%	10.53%	-56.52%	24.00%

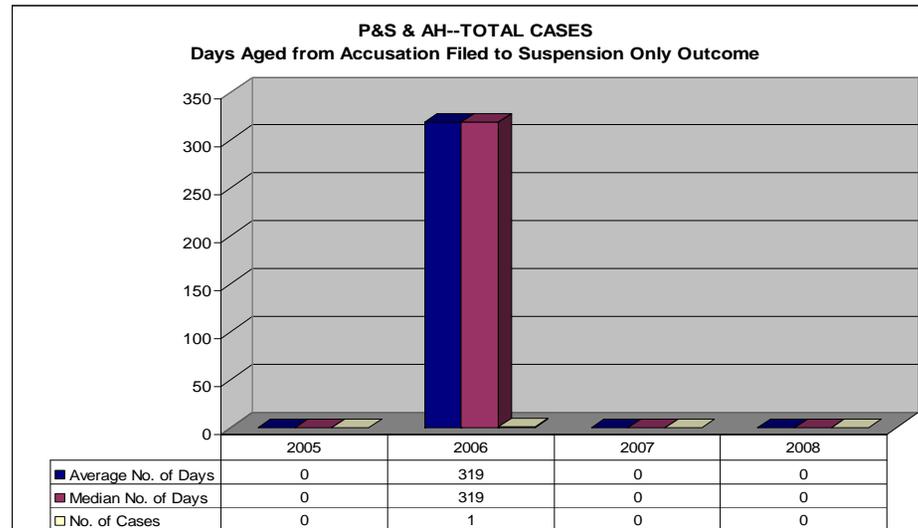
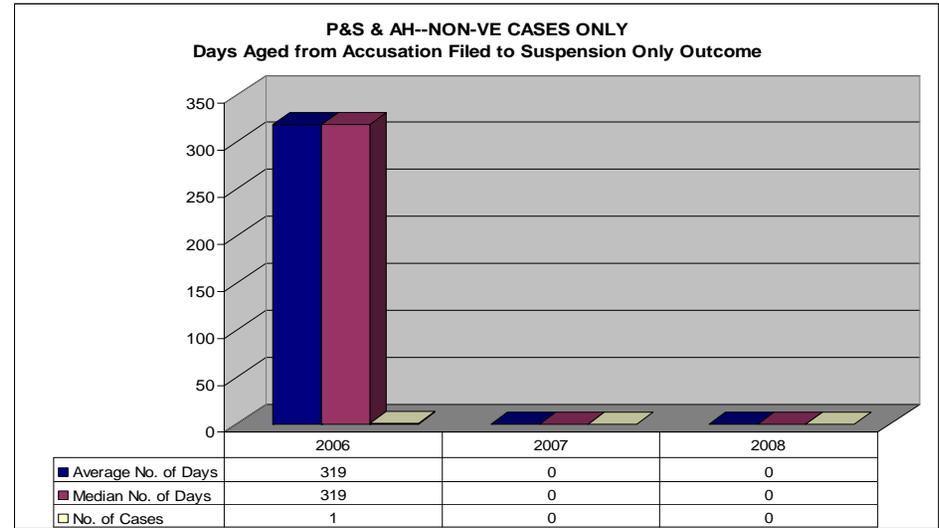
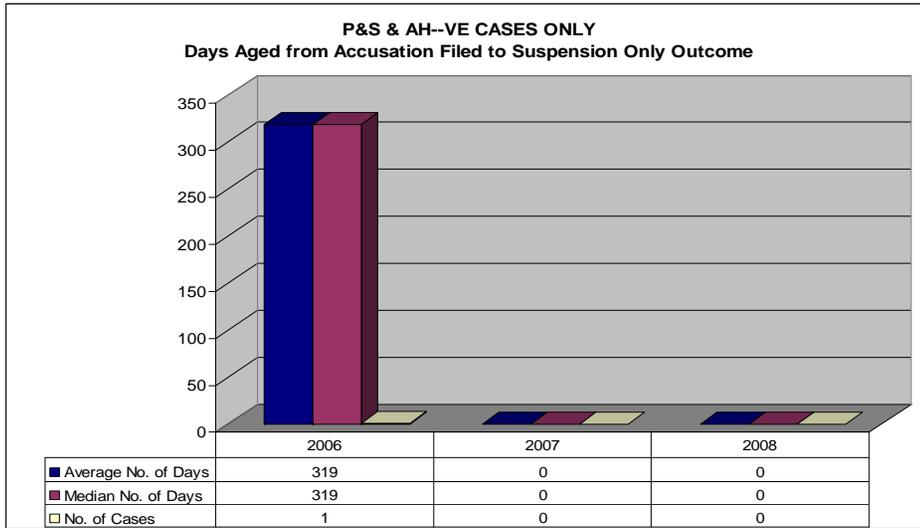
Charts 17.5a, b& c – Calendar Days Aged from Accusation Filed to Revocation Outcome for Physicians and Surgeons and Allied Health Cases



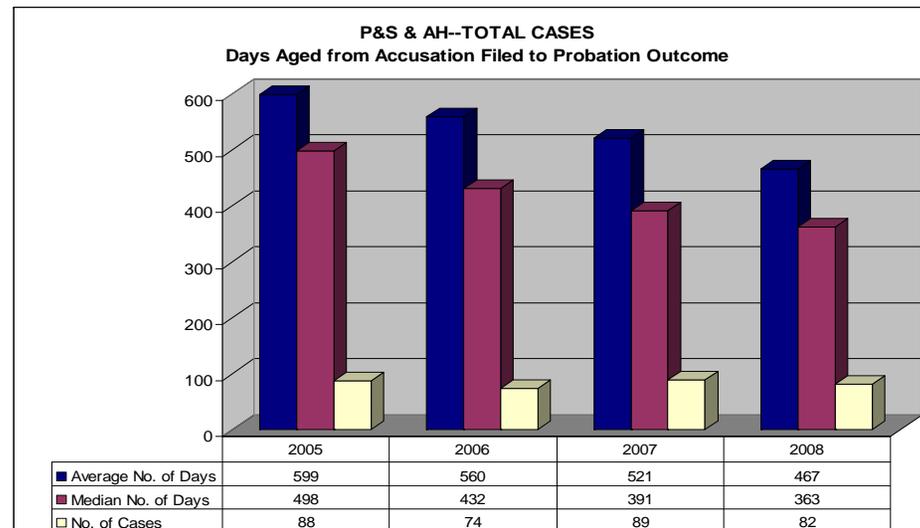
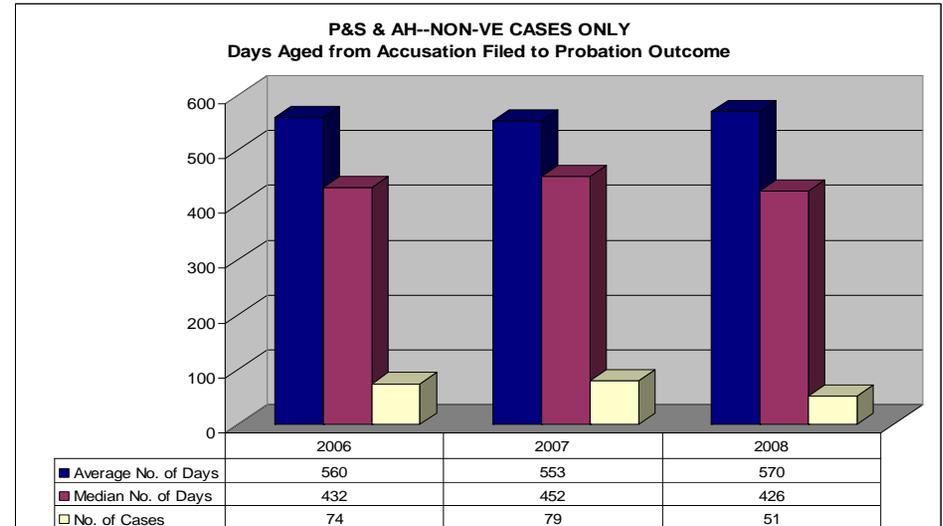
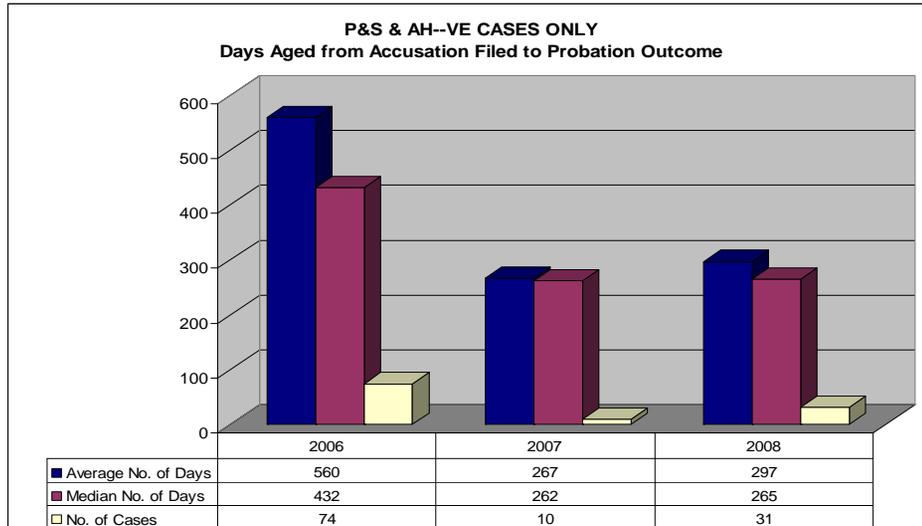
Charts 17.5d, e& f – Calendar Days Aged from Accusation Filed to Surrender Outcome for Physicians and Surgeons and Allied Health Cases



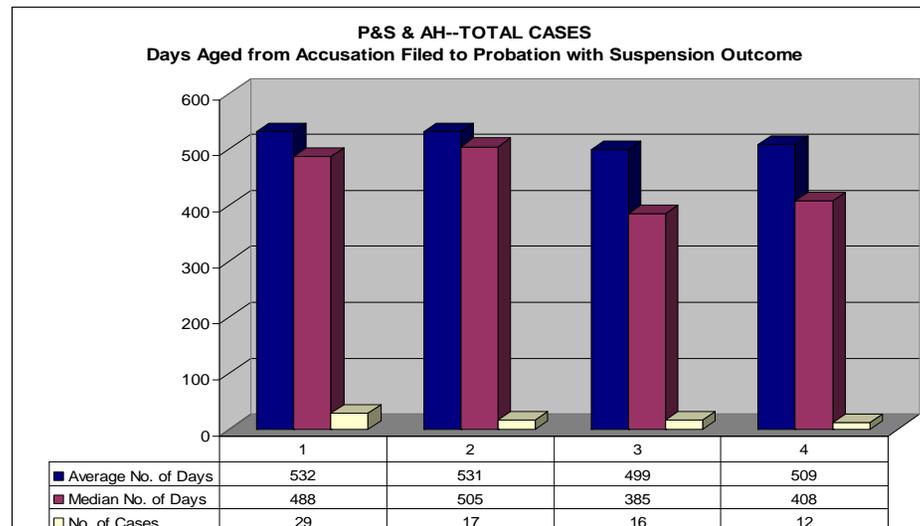
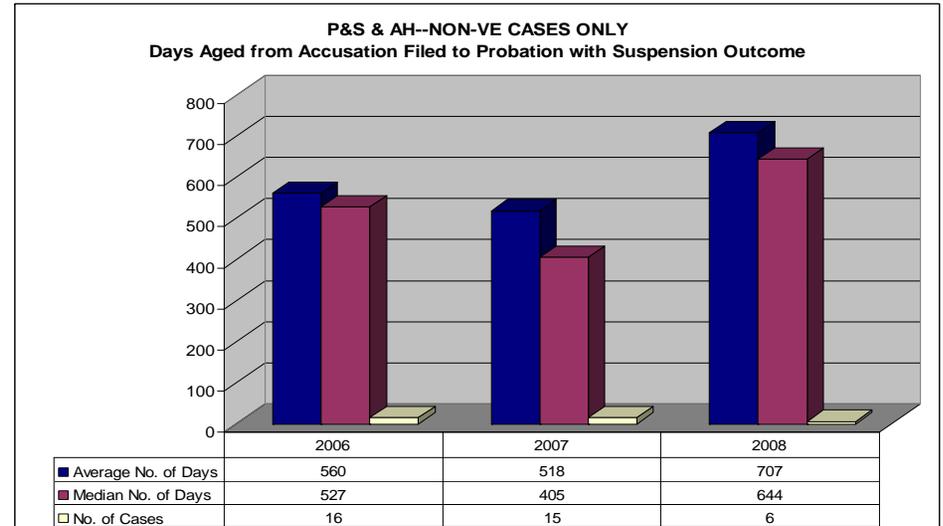
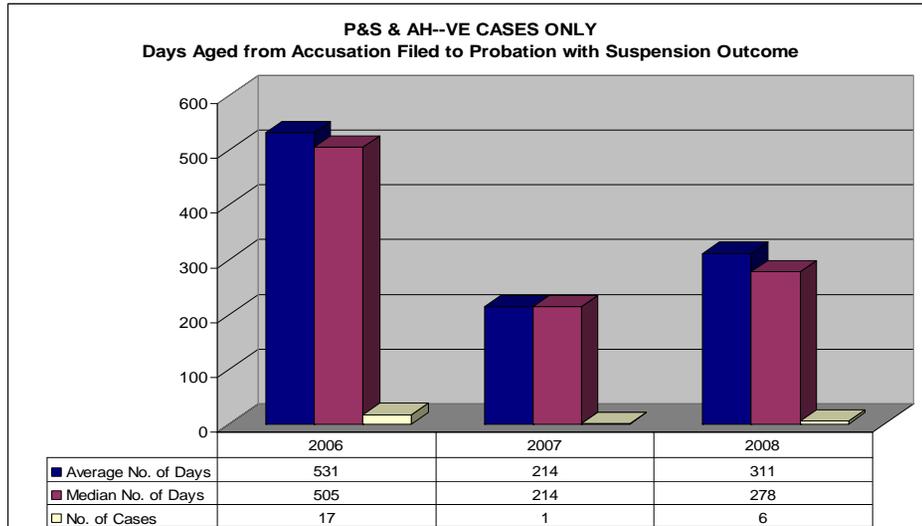
Charts 17.5g, h & i – Calendar Days Aged from Accusation Filed to Suspension Only Outcome for Physicians and Surgeons and Allied Health Cases



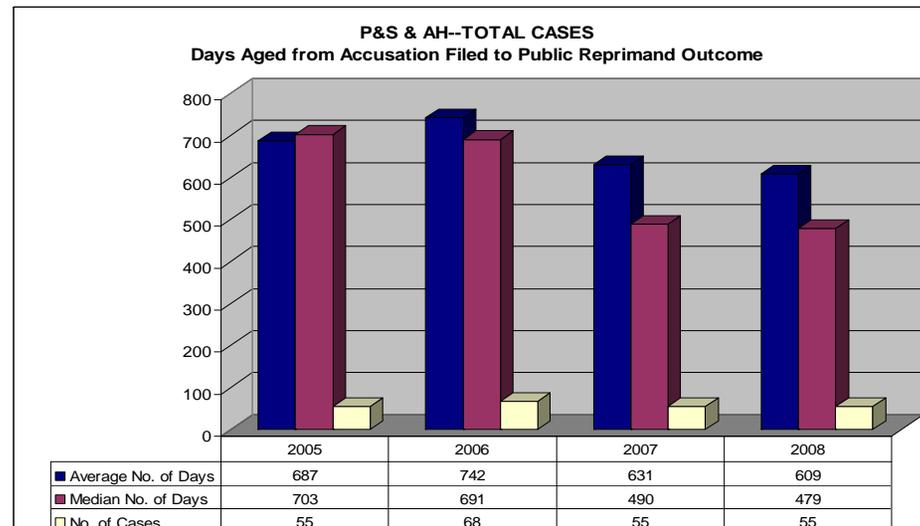
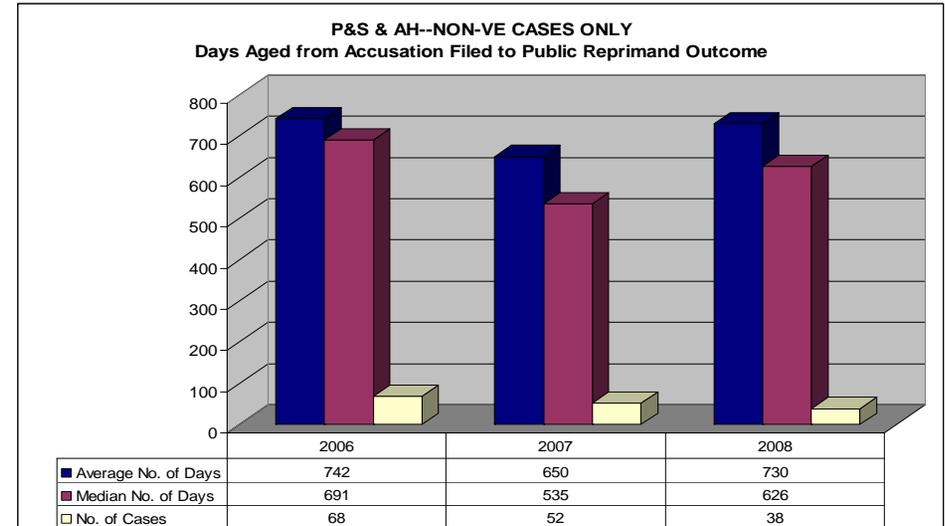
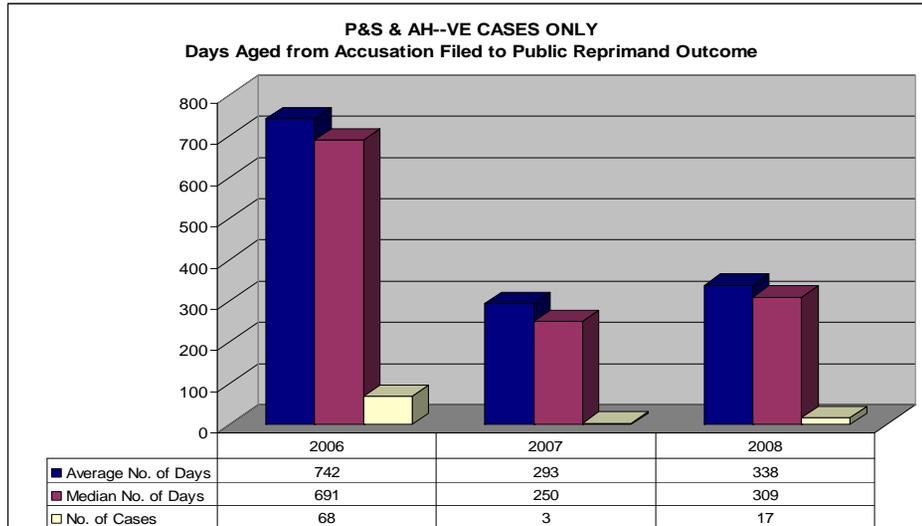
Charts 17.5j, k & l – Calendar Days Aged from Accusation Filed to Probation Outcome for Physicians and Surgeons and Allied Health Cases



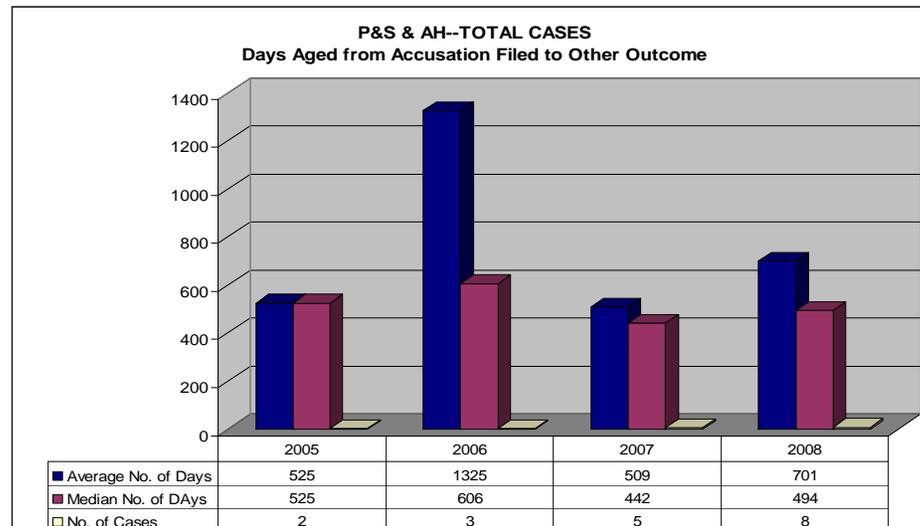
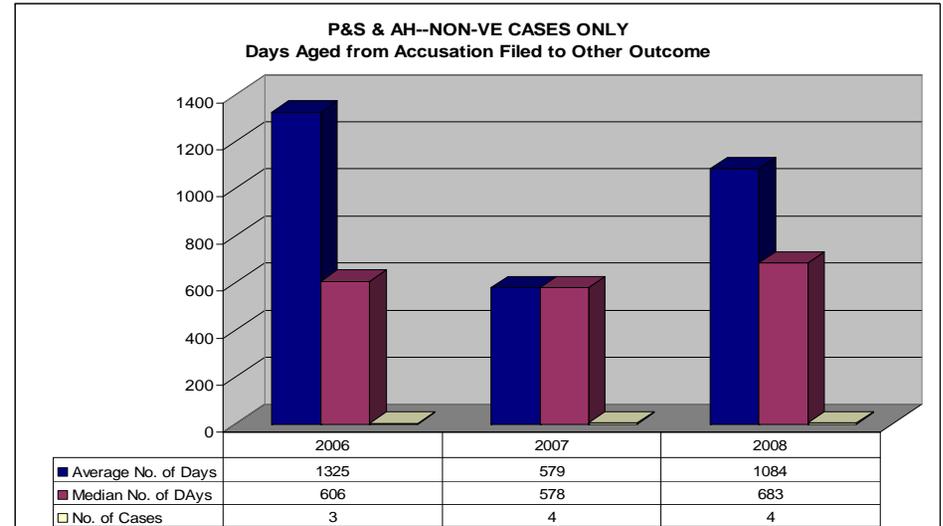
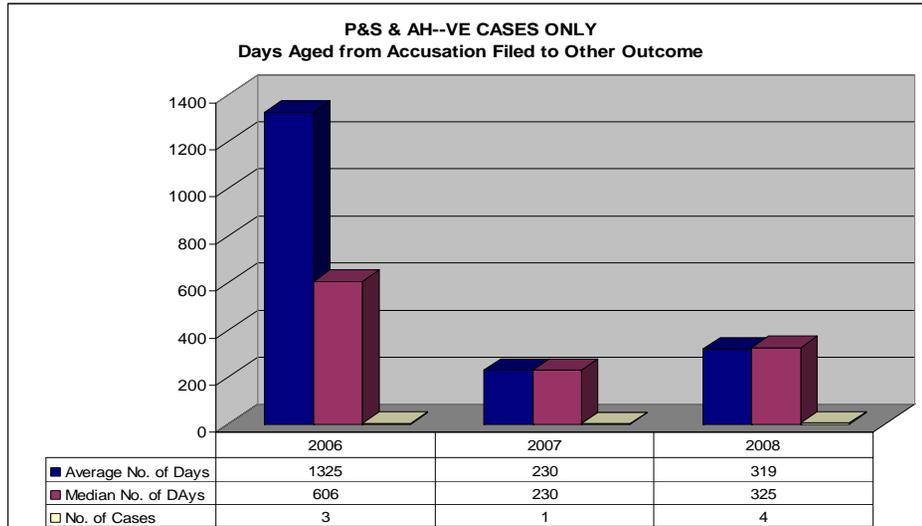
Charts 17.5m, n & o – Calendar Days Aged from Accusation Filed to Probation with Suspension Outcome for Physicians and Surgeons and Allied Health Cases



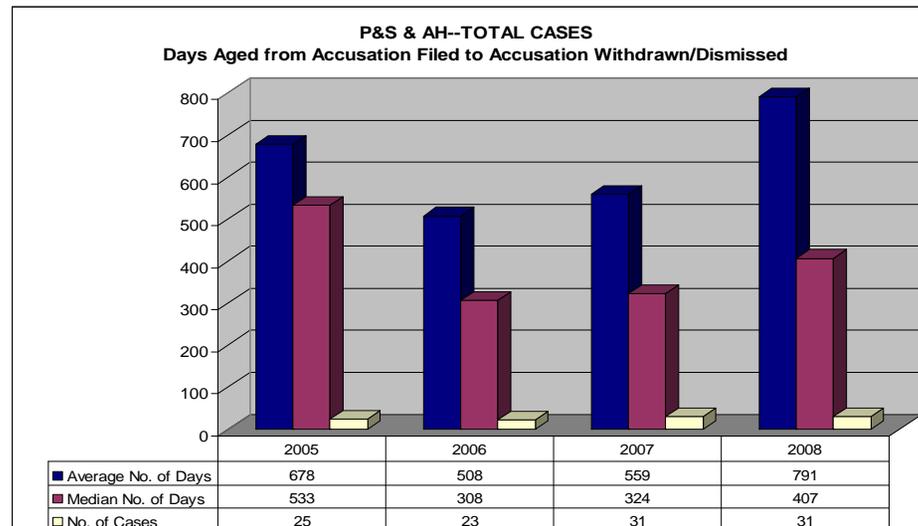
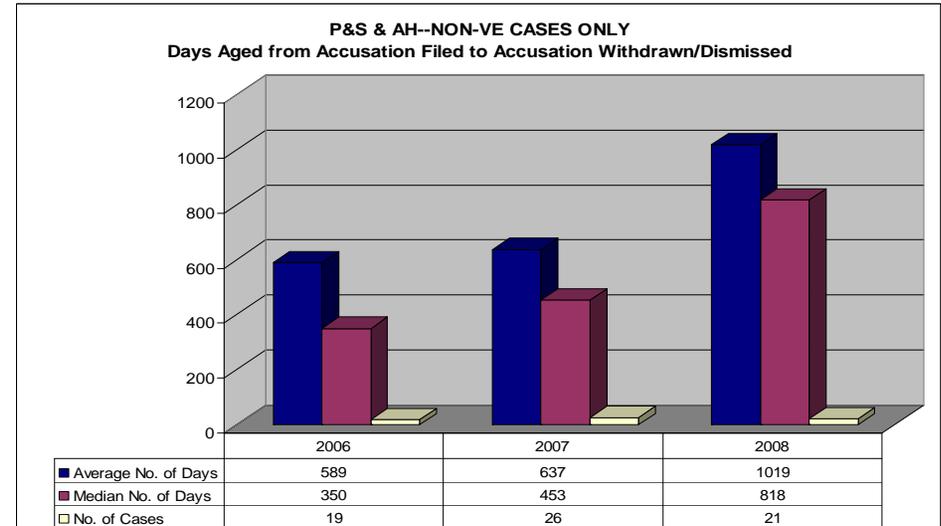
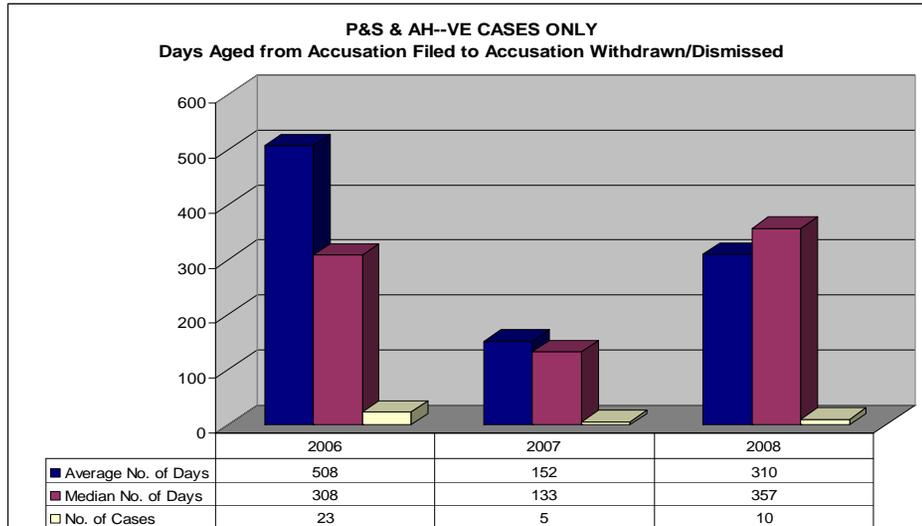
Charts 17.5p, q & r – Calendar Days Aged from Accusation Filed to Public Reprimand Outcome for Physicians and Surgeons and Allied Health Cases



Charts 17.5s, t & u – Calendar Days Aged from Accusation Filed to Other Outcome for Physicians and Surgeons and Allied Health Cases



Charts 17.5v, w & x – Calendar Days Aged from Accusation Filed to Withdrawn/Dismissed Outcome for Physicians and Surgeons and Allied Health Cases



CALENDAR DAYS AGED FROM ACCUSATION FILED TO ADMINISTRATIVE OUTCOMES — PHYSICIANS AND SURGEONS

Table 17.6 below reports the average and median calendar days aged from the date the accusation was filed to the indicated administrative outcome for Physicians and Surgeons cases.

For cases resulting in revocation of license, between 2005 and 2008 there was a 14.43% decrease in the average days aged, a 56.65% decrease in the median days aged, and a 16.67% decrease in the number of such cases.

For cases resulting in surrender of license, between 2005 and 2008 there was a 14.66% decrease in the average days aged, a 50.14% decrease in the median days aged, and a 14.29% increase in the number of such cases.

For cases resulting in suspension of license only, the percentage increase or decrease could not be calculated as there were no such cases in 2005.

For cases resulting in probation, between 2005 and 2008 there was a 1.65% decrease in the average days aged, a 20.59% decrease in the median days aged, and a 20.00% decrease in the number of such cases.

For cases resulting in probation with suspension, between 2005 and 2008 there was a 4.78% decrease in the average days aged, a 28.69% decrease in the median days aged, and a 62.50% decrease in the number of such cases.

For cases resulting in public reprimand, between 2005 and 2008 there was a 9.49% decrease in the average days aged, a 29.39% decrease in the median days aged, and an 8.16% increase in the number of such cases.

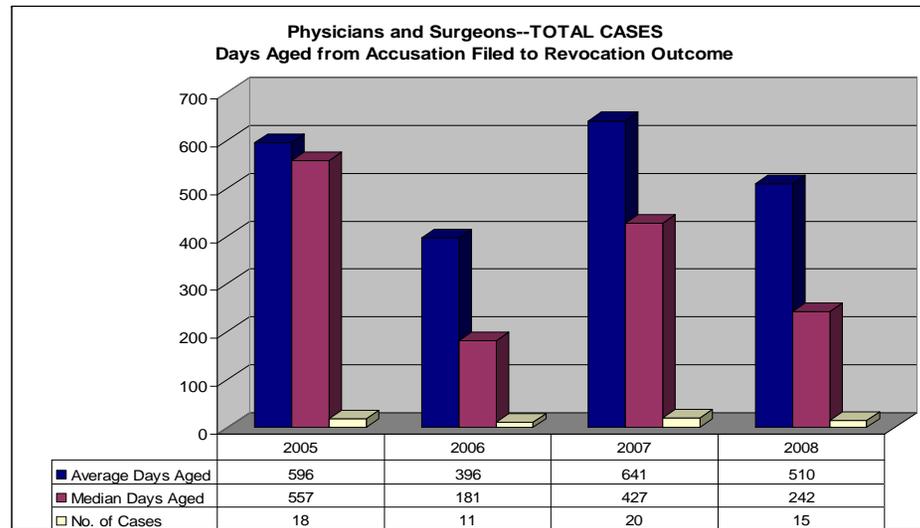
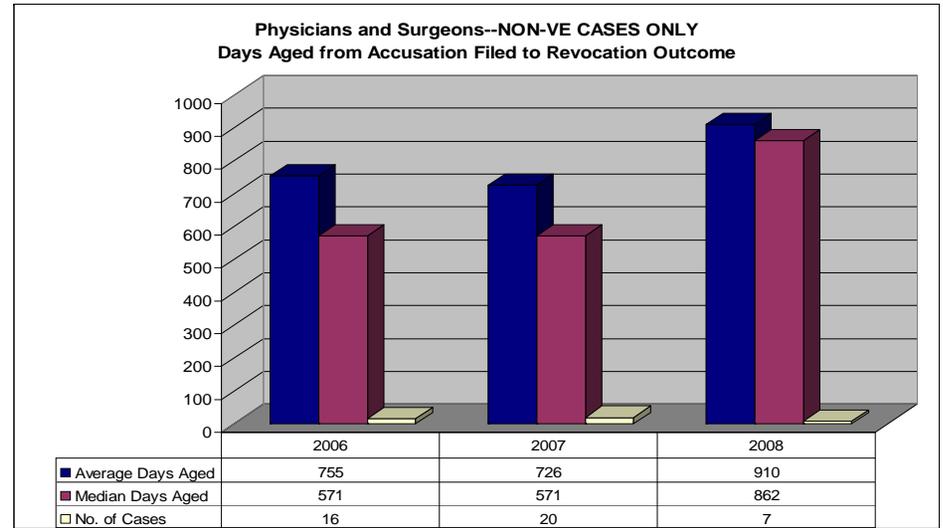
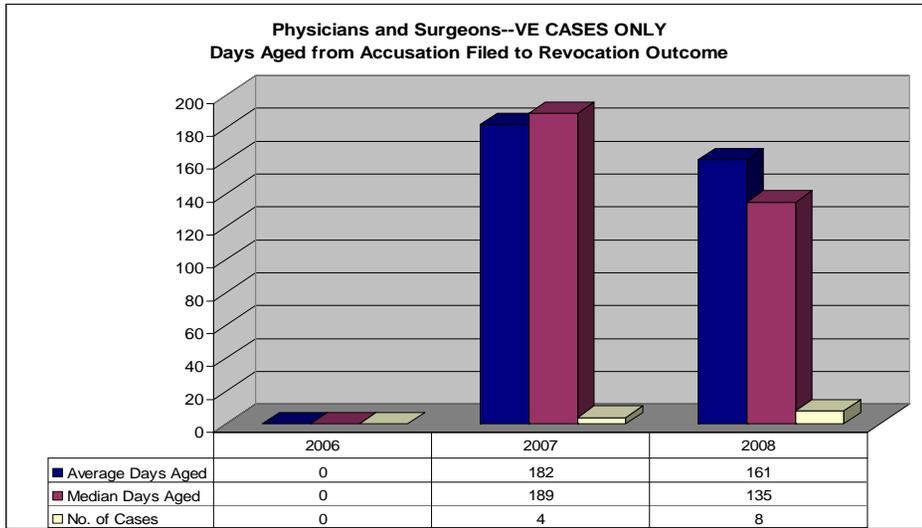
For cases resulting in other decisions, between 2005 and 2008 there was a 93.42% increase in the average days aged, a 15.34% decrease in the median days aged, and a 600.00% increase in the number of such cases.

For cases resulting in a withdrawal or dismissal between 2005 and 2008 there was a 2.78% increase in the average days aged, a 25.73% decrease in the median days aged, and a 26.09% increase in the number of such cases.

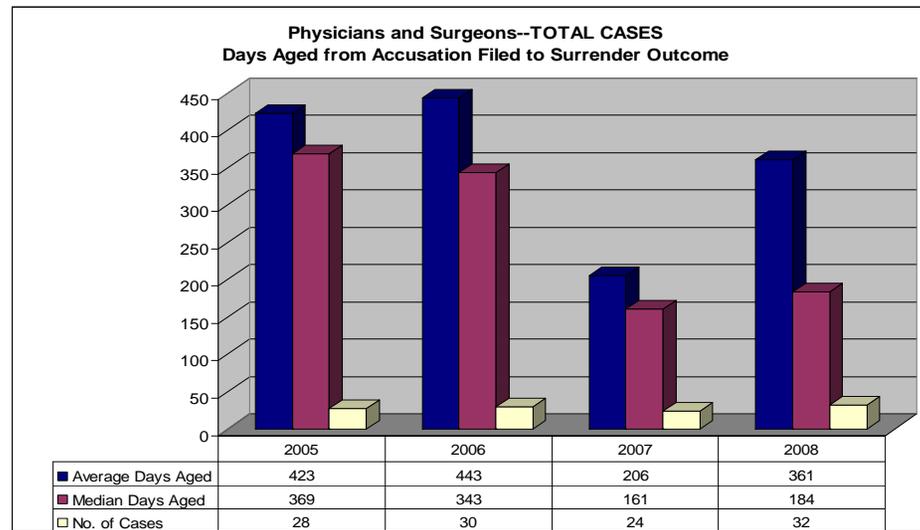
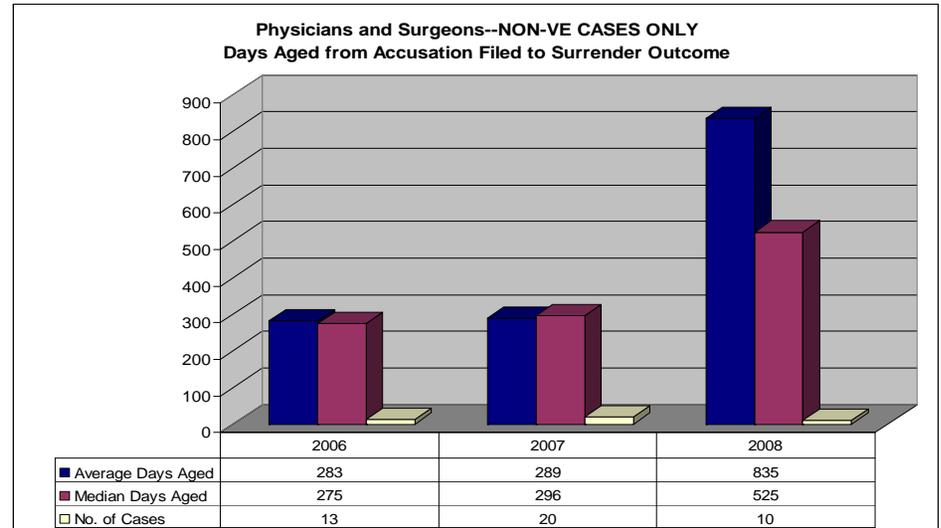
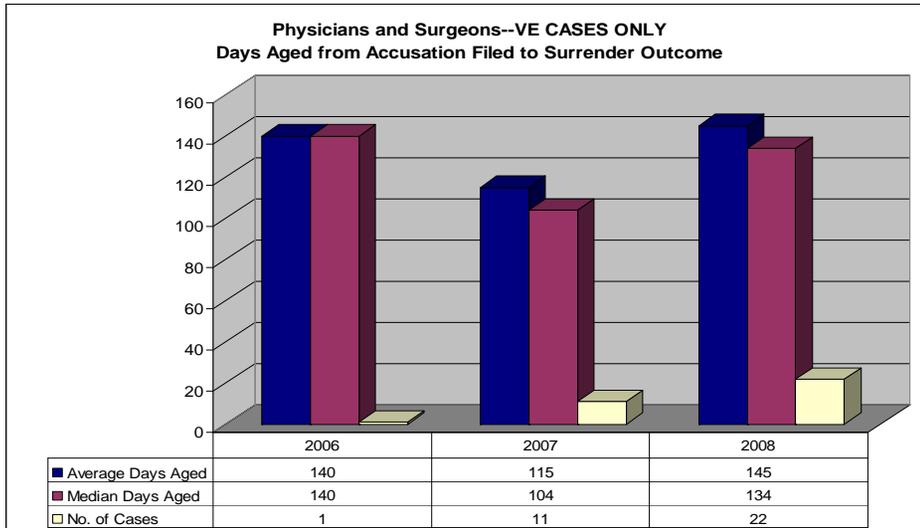
Table 17.6 – Calendar Days Aged from Accusation Filed to Indicated Administrative Outcome for Physicians and Surgeons Cases

	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All
REVOCATION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	61.87%	-3.84%		-20.44%	25.34%	-11.54%	28.79%	20.53%		-14.43%
Median (middle record - half are above and half below)	135.91%	0.00%		-43.33%	50.96%	-28.57%	33.70%	50.96%		-56.55%
Record Count	81.82%	25.00%		-25.00%	-65.00%	100.00%	36.36%	-56.25%		-16.67%
SURRENDER										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-53.50%	2.12%	-17.86%	75.24%	188.93%	26.09%	-18.51%	195.05%	3.57%	-14.66%
Median (middle record - half are above and half below)	-53.06%	7.64%	-25.71%	14.29%	77.36%	28.85%	-46.36%	90.91%	-4.29%	-50.14%
Record Count	-20.00%	53.85%	1000.00%	33.33%	-50.00%	100.00%	6.67%	-23.08%	2100.00%	14.29%
SUSPENSION ONLY										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-100.00%						-100.00%			
Median (middle record - half are above and half below)	-100.00%						-100.00%			
Record Count	-100.00%						-100.00%			
PROBATION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-8.07%	-4.98%		6.81%	8.14%	-9.06%	-1.81%	2.75%		-1.65%
Median (middle record - half are above and half below)	-2.59%	-7.76%		-16.37%	5.09%	-3.82%	-18.53%	-3.06%		-20.59%
Record Count	29.31%	14.49%		-25.33%	-50.63%	183.33%	-3.45%	-43.48%		-20.00%
PROBATION W/SUSPENSION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-4.67%	1.57%		5.49%	48.26%		0.56%	50.59%		-4.78%
Median (middle record - half are above and half below)	-25.51%	10.96%		13.70%	73.33%		-15.31%	92.33%		-28.69%
Record Count	-7.14%	15.38%		-30.77%	-66.67%		-35.71%	-61.54%		-62.50%
PUBLIC REPRIMAND										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-12.82%	-2.55%		-5.05%	-12.31%	9.21%	-17.22%	9.45%		-9.49%
Median (middle record - half are above and half below)	-25.17%	-2.01%		-9.72%	-17.01%	-1.90%	-32.45%	14.65%		-29.39%
Record Count	-13.33%	4.00%		1.92%	26.92%	650.00%	-11.67%	-24.00%		8.16%
OTHER DECISION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-69.90%	0.00%		38.70%	110.88%	38.70%	-58.25%	110.88%		93.42%
Median (middle record - half are above and half below)	-73.86%	0.00%		-4.75%	20.07%	8.70%	-75.10%	20.07%		15.34%
Record Count	150.00%	0.00%		40.00%	-25.00%	300.00%	250.00%	-25.00%		600.00%
ACCUSATION WITHDRAWN/DISMISSED										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	80.43%	-4.21%	143.10%	37.63%	68.92%	119.86%	148.32%	61.80%	434.48%	2.78%
Median (middle record - half are above and half below)	34.25%	0.00%	87.93%	19.35%	85.21%	227.52%	60.24%	85.21%	515.52%	-25.73%
Record Count	75.00%	8.33%	100.00%	3.57%	-26.92%	150.00%	81.25%	-20.83%	400.00%	26.09%

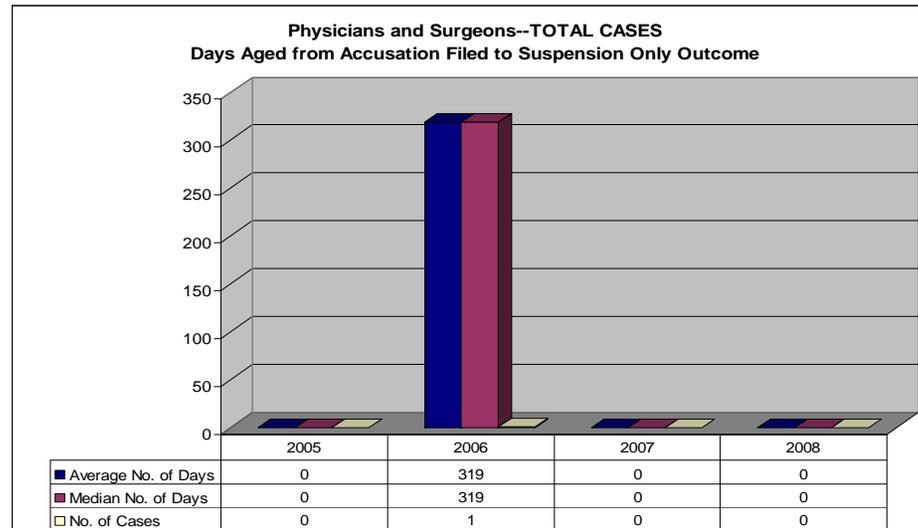
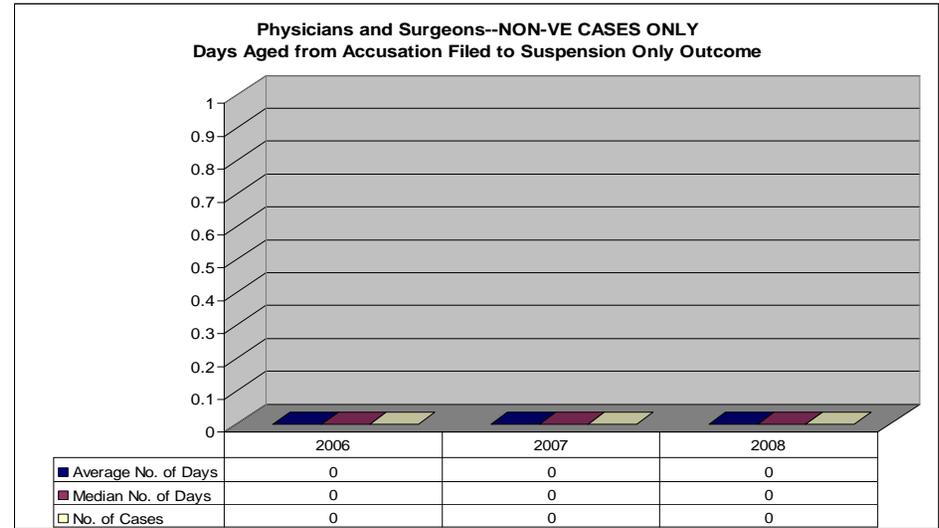
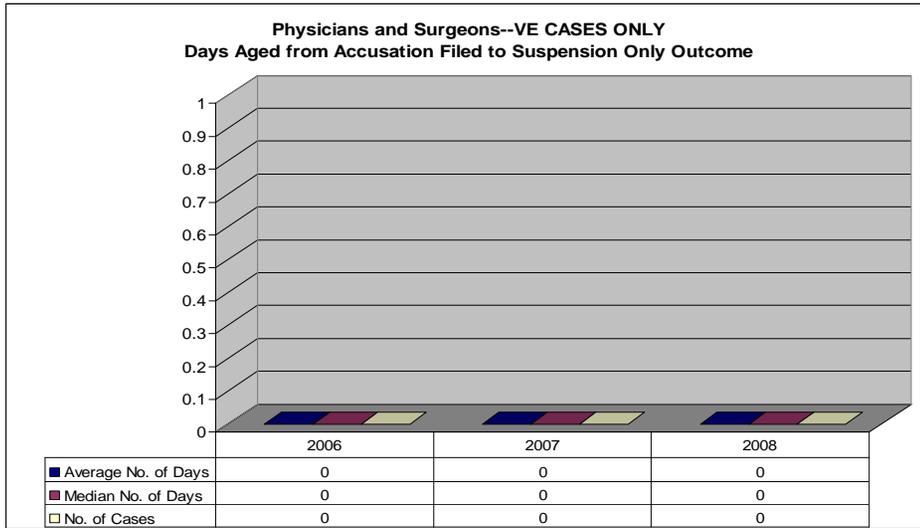
Charts 17.6a, b& c – Calendar Days Aged from Accusation Filed to Revocation Outcome for Physicians and Surgeons Cases



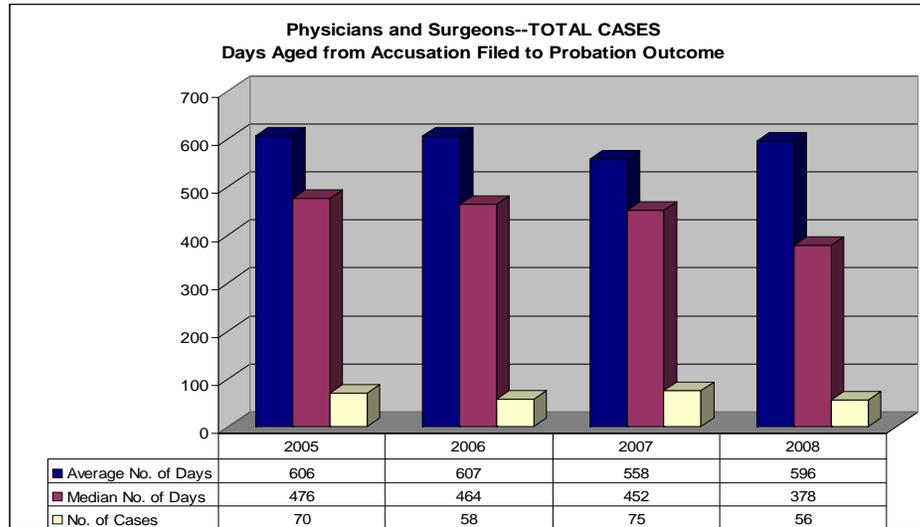
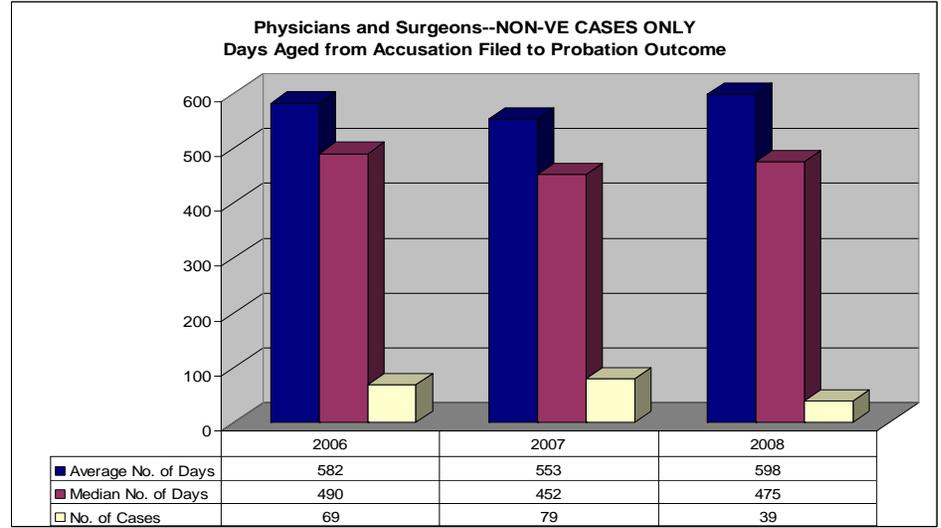
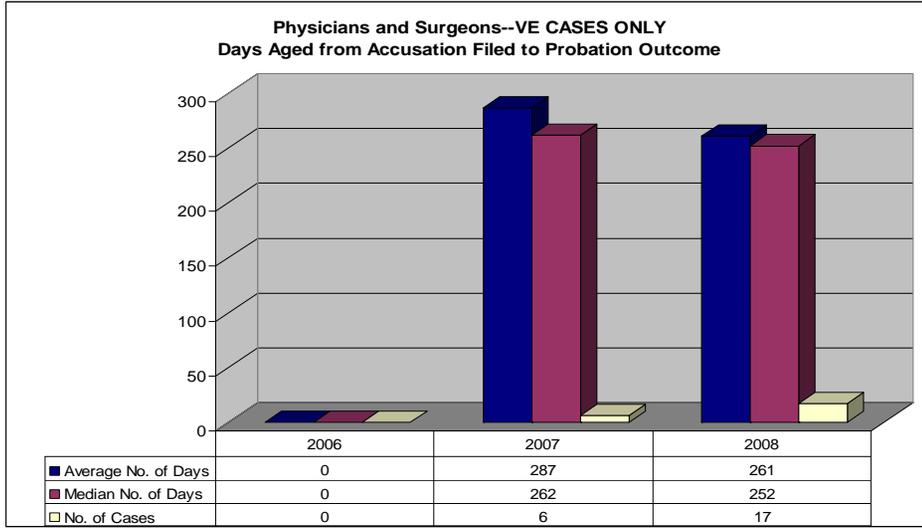
Charts 17.6d, e& f – Calendar Days Aged from Accusation Filed to Surrender Outcome for Physicians and Surgeons Cases



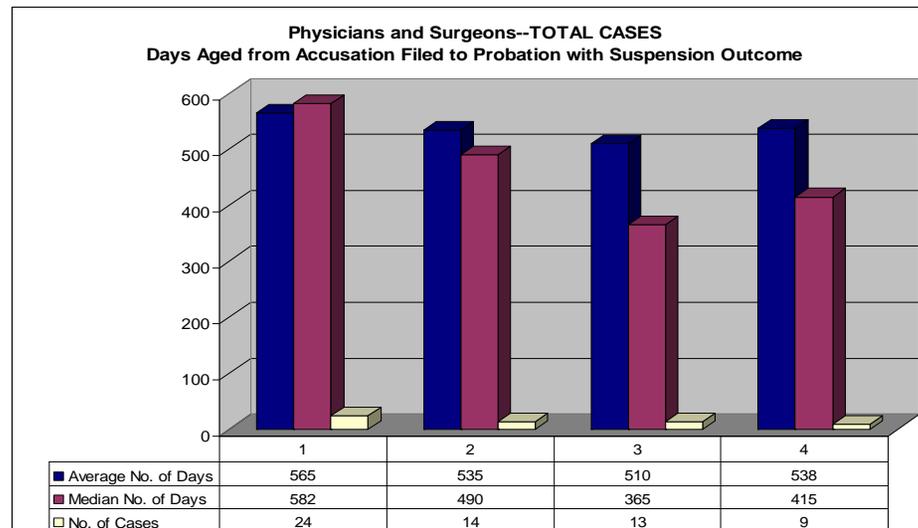
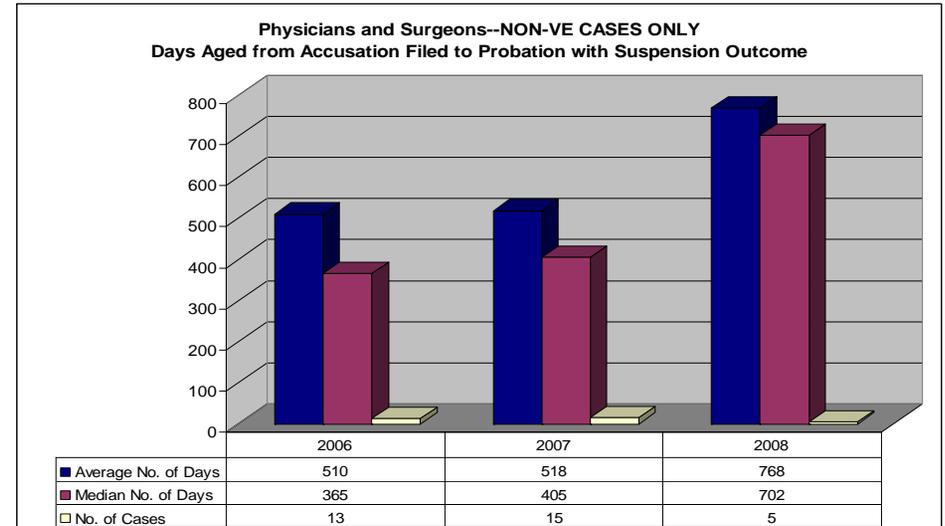
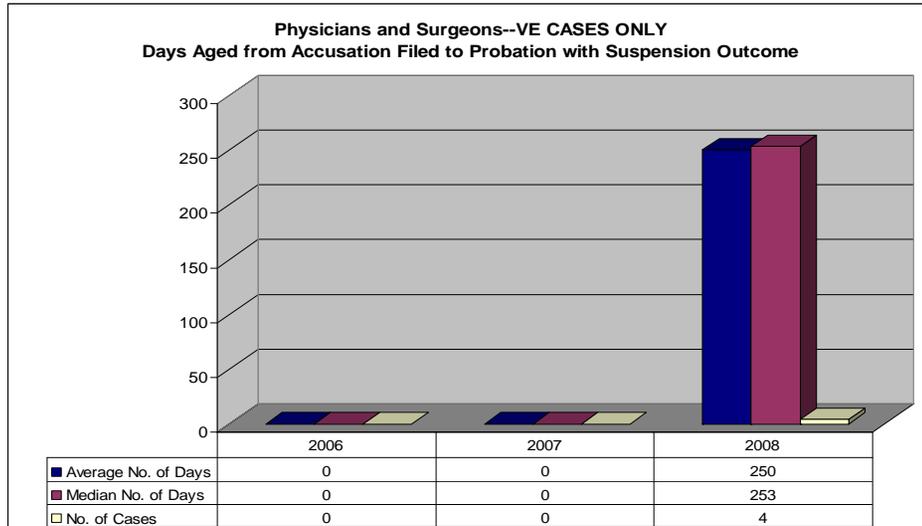
Charts 17.6g, h & i – Calendar Days Aged from Accusation Filed to Suspension Only Outcome for Physicians and Surgeons Cases



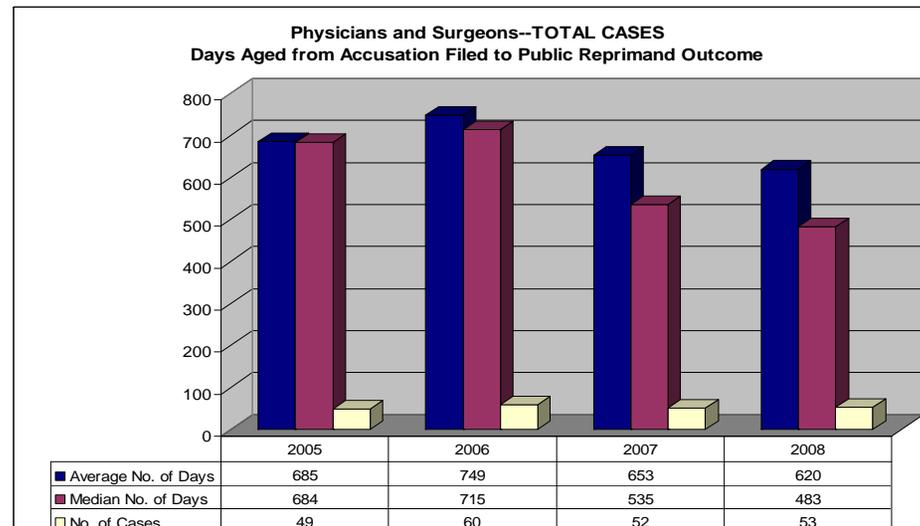
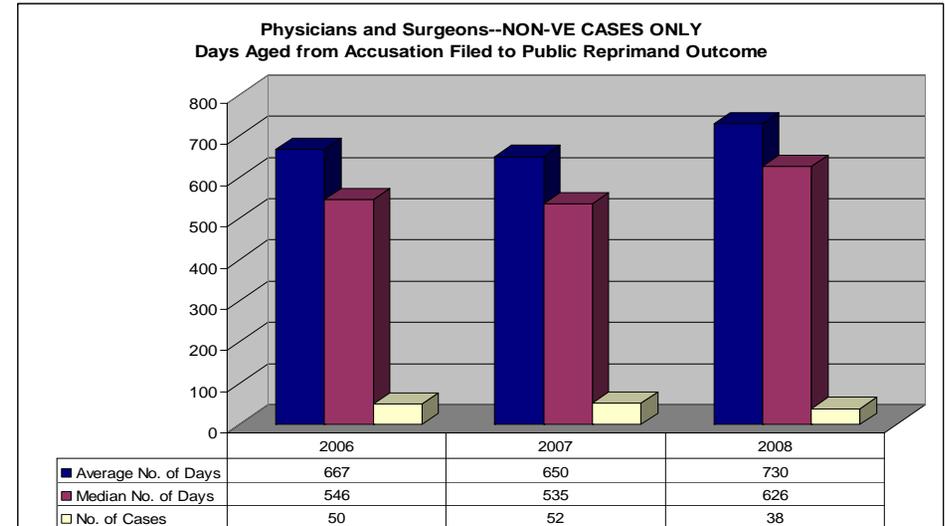
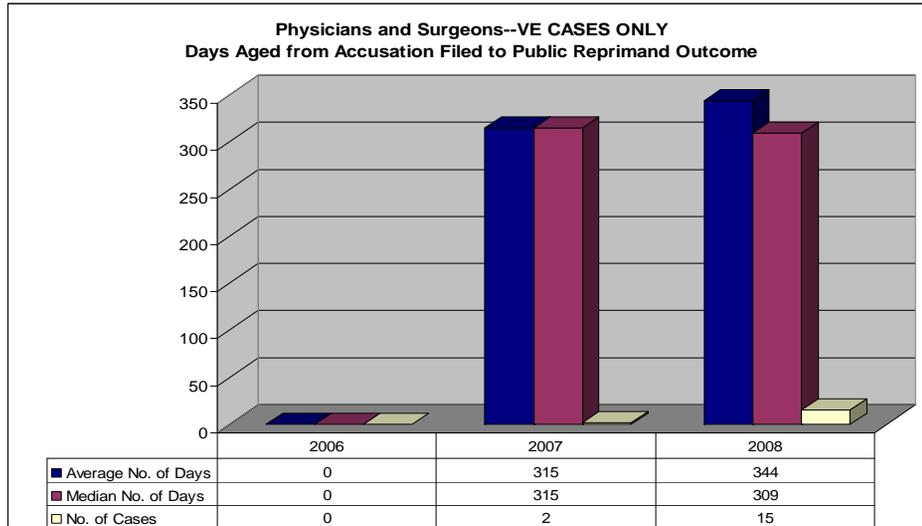
Charts 17.6j, k & l – Calendar Days Aged from Accusation Filed to Probation Outcome for Physicians and Surgeons Cases



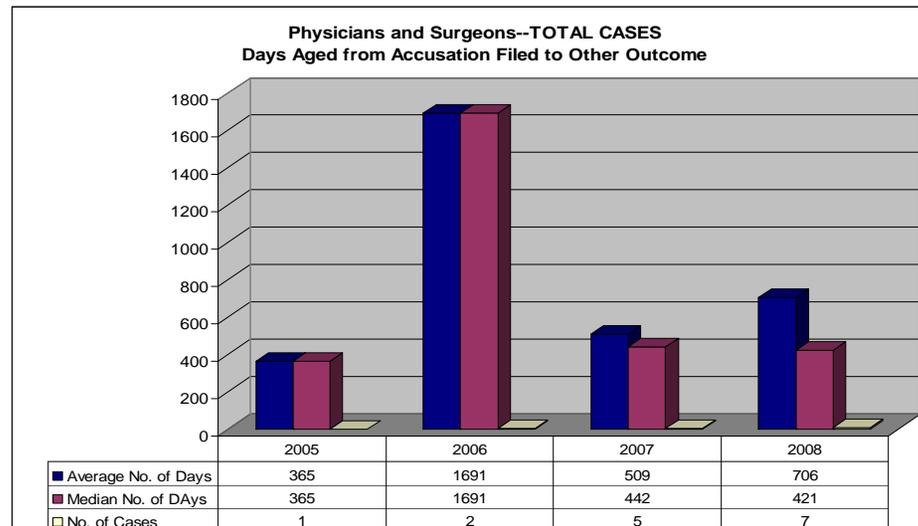
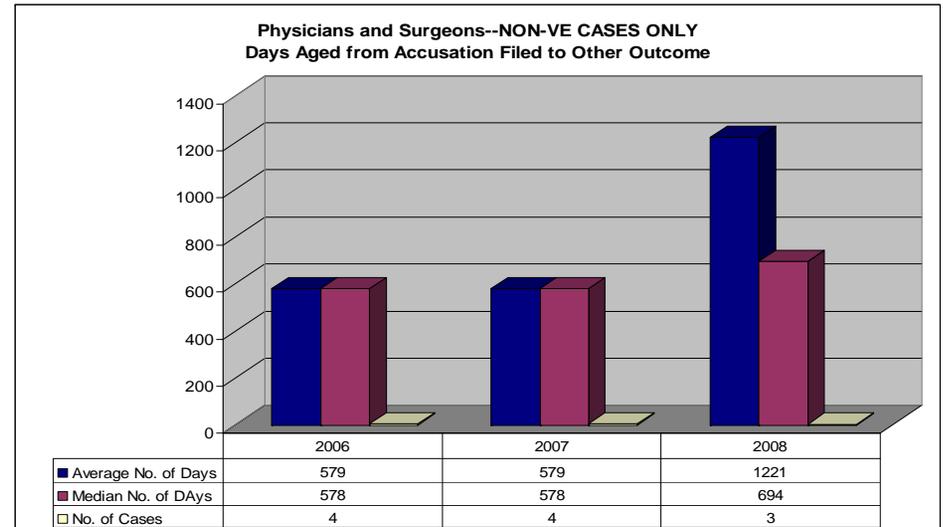
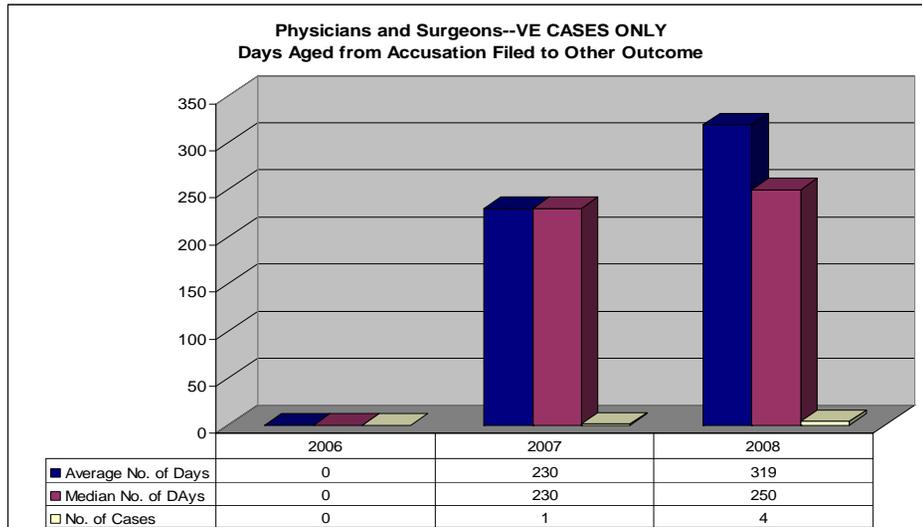
Charts 17.6m, n & o – Calendar Days Aged from Accusation Filed to Probation with Suspension Outcome for Physicians and Surgeons Cases



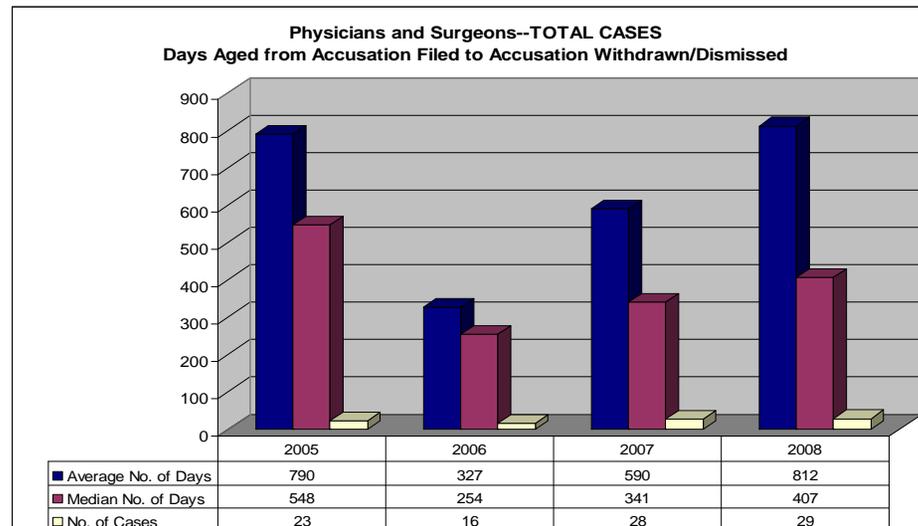
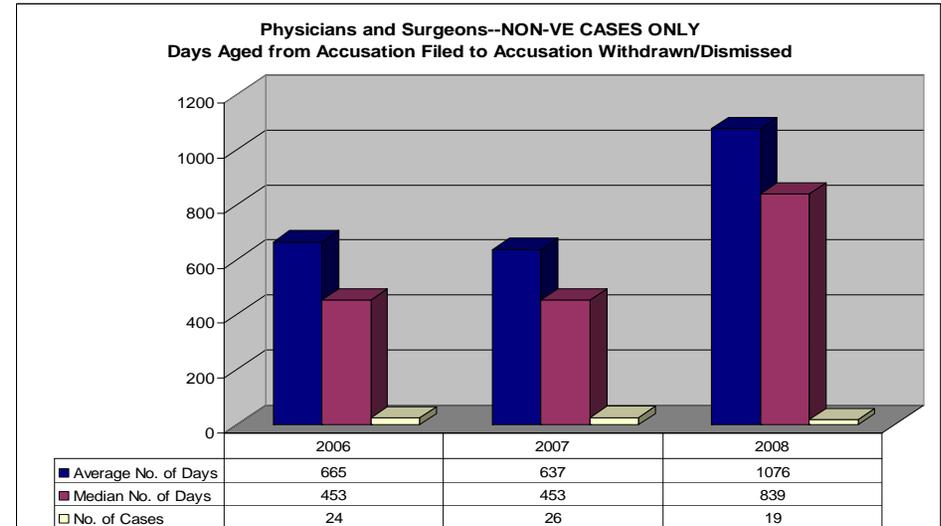
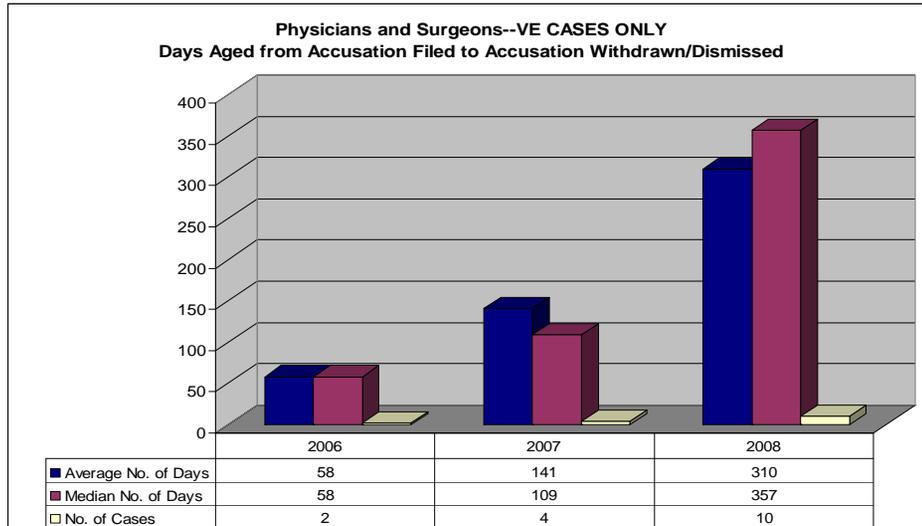
Charts 17.6p, q & r – Calendar Days Aged from Accusation Filed to Public Reprimand Outcome for Physicians and Surgeons Cases



Charts 17.6s, t & u – Calendar Days Aged from Accusation Filed to Other Outcome for Physicians and Surgeons Cases



Charts 17.6v, w & x – Calendar Days Aged from Accusation Filed to Withdrawn/Dismissed Outcome for Physicians and Surgeons Cases



CALENDAR DAYS AGED FROM ACCUSATION FILED TO ADMINISTRATIVE OUTCOMES —ALLIED HEALTH

Table 17.7 below reports the average and median calendar days aged from the date the accusation was filed to the indicated administrative outcome for Allied Health Care cases.

For cases resulting in revocation of license, between 2005 and 2008 there was a 10.64% increase in the average days aged, a 6.23% increase in the median days aged, and no change in the number of such cases.

For cases resulting in surrender of license, between 2005 and 2008 there was a 41.38% decrease in the average days aged, a 20.92% decrease in the median days aged, and a 72.73% decrease in the number of such cases.

For cases resulting in suspension of license only, the percentage increase or decrease could not be calculated as there were no such cases in 2005.

For cases resulting in probation, between 2005 and 2008 there was a 29.12% decrease in the average days aged, a 32.32% decrease in the median days aged, and a 44.44% decrease in the number of such cases.

For cases resulting in probation with suspension, between 2005 and 2008 there was a 12.53% increase in the average days aged, a 21.21% increase in the median days aged, and a 40.00% decrease in the number of such cases.

For cases resulting in public reprimand, between 2005 and 2008 there was an 11.35% decrease in the average days aged, a 31.86% decrease in the median days aged, and no change in the number of such cases.

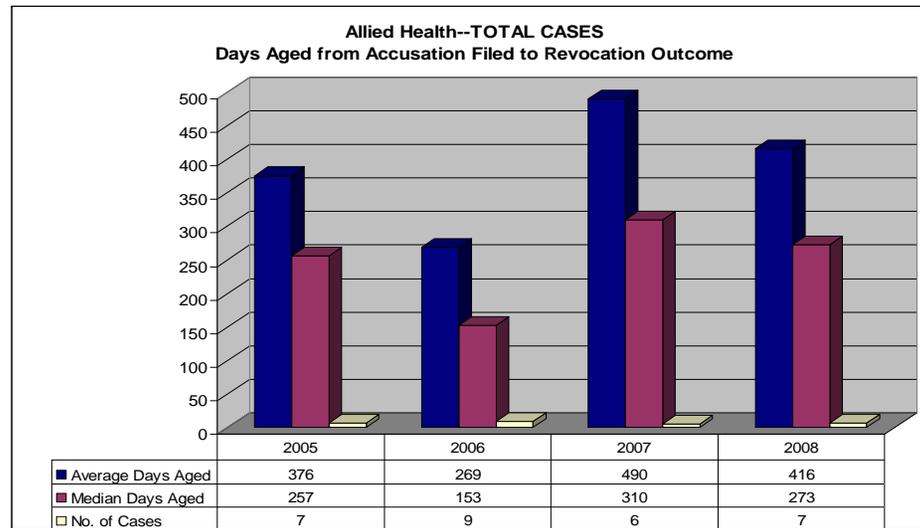
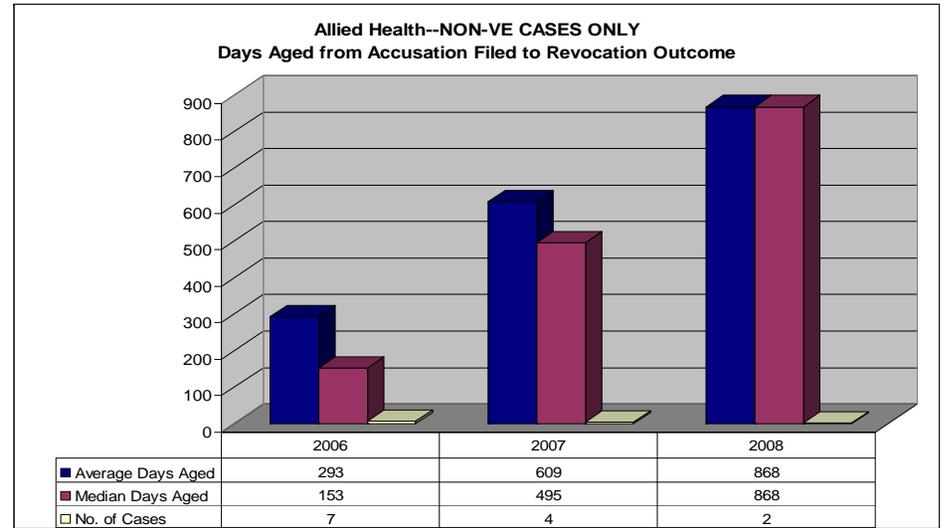
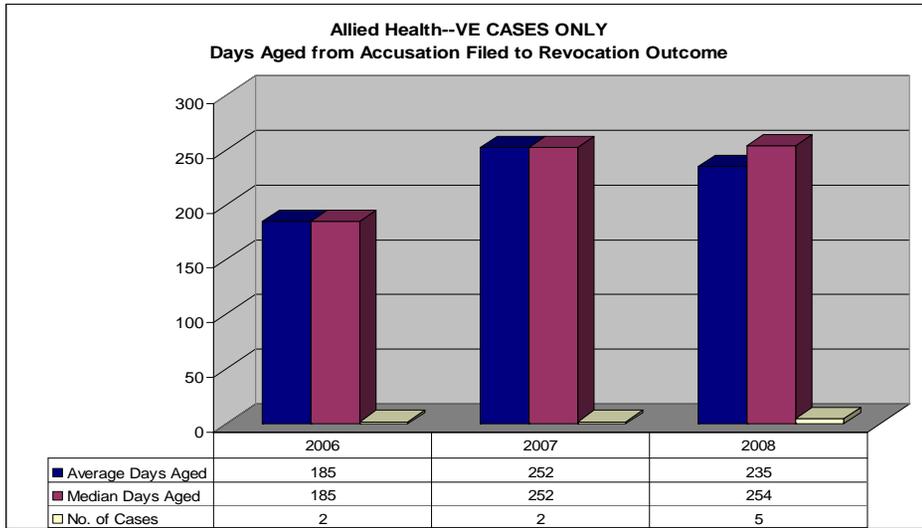
For cases resulting in other decisions, between 2005 and 2008 there was a 1.90% decrease in the average days aged, a 1.90% decrease in the median days aged, and no change in the number of such cases.

For cases resulting in a withdrawal or dismissal, between 2005 and 2008 there was a 51.42% increase in the average days aged, a 51.42% increase in the median days aged, and no change in the number of such cases.

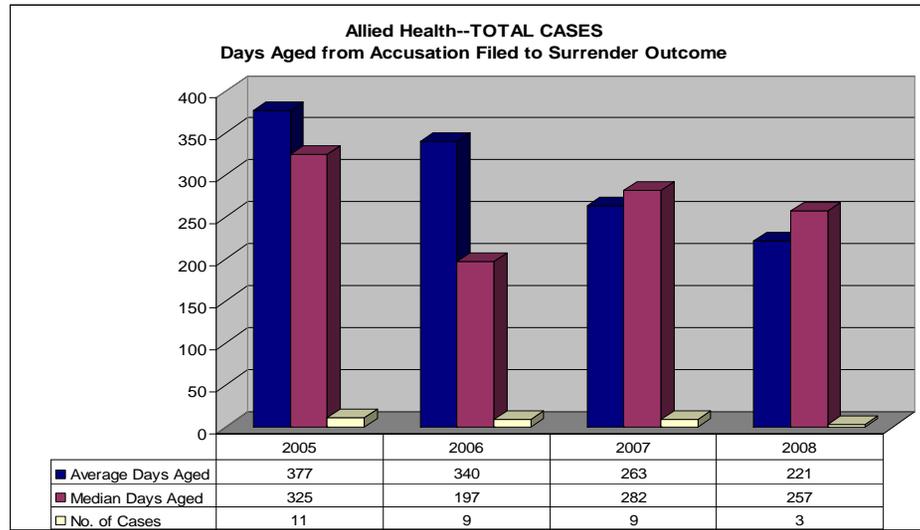
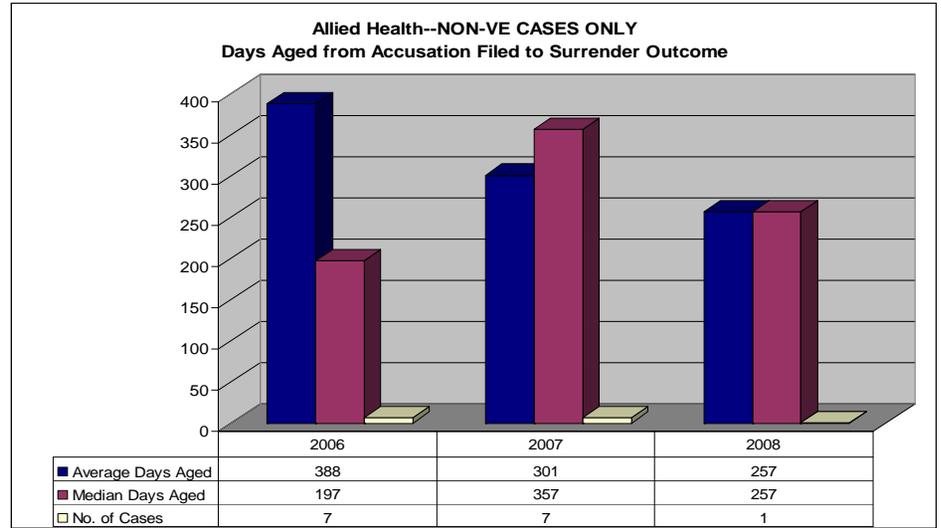
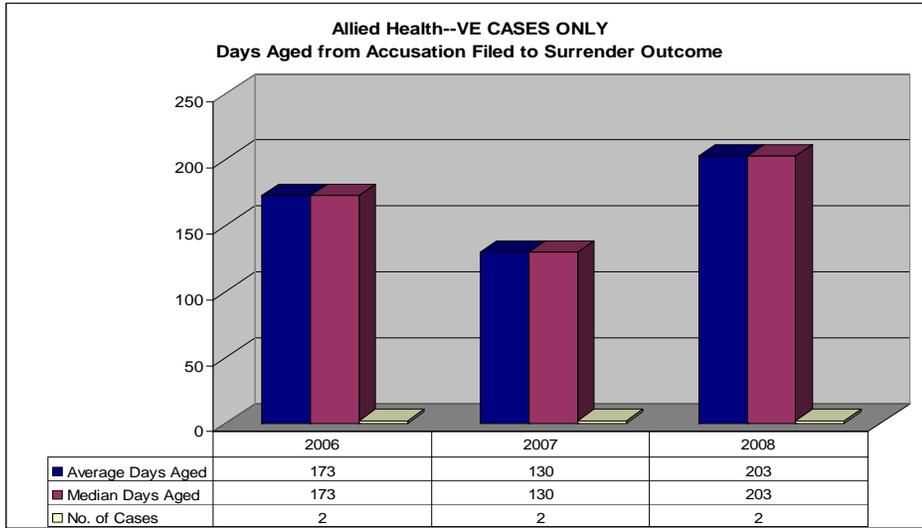
Table 17.7 – Calendar Days Aged from Accusation Filed to Indicated Administrative Outcome for Allied Health Cases

	Percentage Difference 2006 to 2007			Percentage Difference 2007 to 2008			Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008
	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	All
REVOCACTION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	82.16%	107.85%	36.22%	-15.10%	42.53%	-6.75%	54.65%	196.25%	27.03%	10.64%
Median (middle record - half are above and half below)	102.61%	223.53%	36.22%	-11.94%	75.35%	0.79%	78.43%	467.32%	37.30%	6.23%
Record Count	-33.33%	-42.86%	0.00%	16.67%	-50.00%	150.00%	-22.22%	-71.43%	150.00%	0.00%
SURRENDER										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-22.65%	-22.42%	-24.86%	-15.97%	-14.62%	56.15%	-35.00%	-33.76%	17.34%	-41.38%
Median (middle record - half are above and half below)	43.15%	81.22%	-24.86%	-8.87%	-28.01%	56.15%	30.46%	30.46%	17.34%	-20.92%
Record Count	0.00%	0.00%	0.00%	-66.67%	-85.71%	0.00%	-66.67%	-85.71%	0.00%	-72.73%
SUSPENSION ONLY										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average										
Median (middle record - half are above and half below)										
Record Count										
PROBATION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-18.46%	-10.00%		27.04%	36.18%	44.49%	3.59%	22.56%		-29.12%
Median (middle record - half are above and half below)	-18.32%	-15.32%		30.88%	38.30%	35.39%	6.91%	17.12%		-32.32%
Record Count	-12.50%	-37.50%		85.71%	20.00%	250.00%	62.50%	-25.00%		44.44%
PROBATION W/SUSPENSION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-11.15%	-21.58%	205.71%	-7.05%	-30.31%	102.34%	-17.42%	-45.36%	518.57%	12.53%
Median (middle record - half are above and half below)	3.17%	-21.58%	205.71%	-23.22%	-30.31%	102.34%	-20.79%	-45.36%	518.57%	21.21%
Record Count	0.00%	0.00%	0.00%	0.00%	-50.00%	100.00%	0.00%	-50.00%	100.00%	-40.00%
PUBLIC REPRIMAND										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-65.51%	-66.23%		24.27%	100.00%	18.80%	-57.14%	-100.00%		-57.93%
Median (middle record - half are above and half below)	-50.59%	-53.75%		18.80%	100.00%	18.80%	-41.30%	-100.00%		-62.12%
Record Count	-62.50%	-75.00%		-33.33%	100.00%	100.00%	-75.00%	-100.00%		-66.67%
OTHER DECISION										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-100.00%	-100.00%					13.13%	13.13%		-1.90%
Median (middle record - half are above and half below)	-100.00%	-100.00%					13.13%	13.13%		-1.90%
Record Count	-100.00%	-100.00%					0.00%	0.00%		0.00%
ACCUSATION WITHDRAWN/DISMISSED										
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year										
Average	-71.48%	-75.64%	4.23%	82.51%	62.16%	-100.00%	-47.94%	-60.49%	-100.00%	51.42%
Median (middle record - half are above and half below)	-83.42%	-76.80%	4.23%	143.65%	62.16%	-100.00%	-59.60%	-62.38%	-100.00%	51.42%
Record Count	-57.14%	-60.00%	-50.00%	-33.33%	0.00%	-100.00%	-71.43%	-60.00%	-100.00%	0.00%

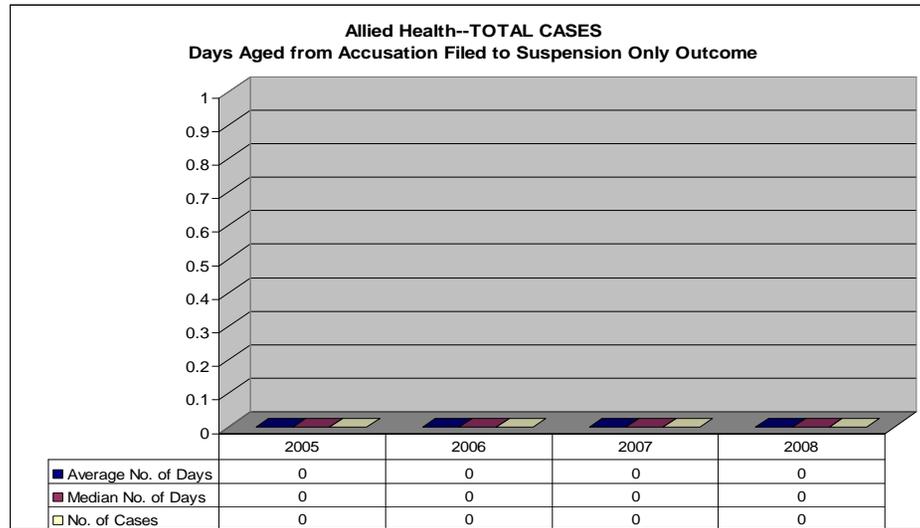
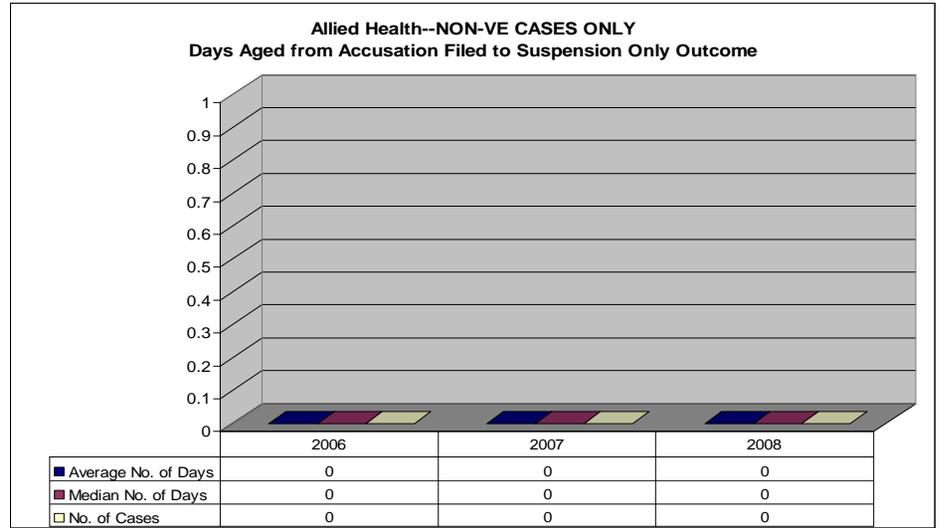
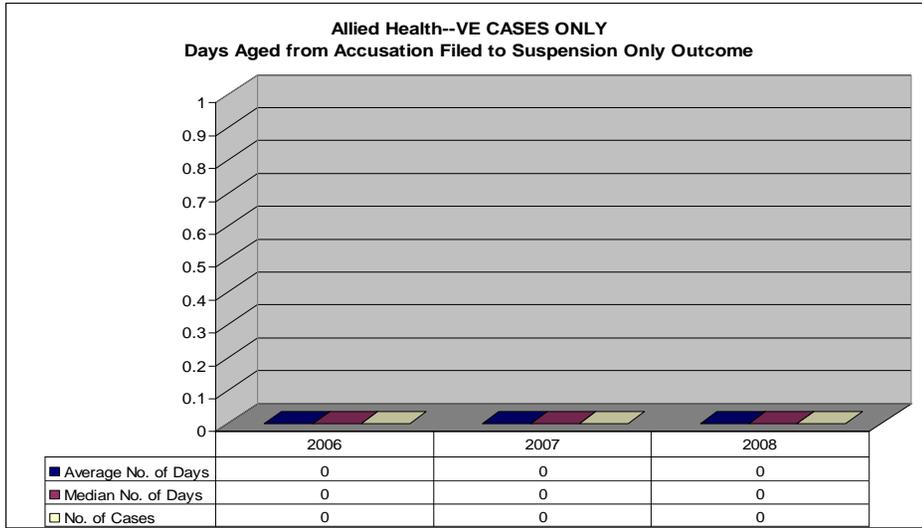
Charts 17.7a, b& c – Calendar Days Aged from Accusation Filed to Revocation Outcome for Allied Health Cases



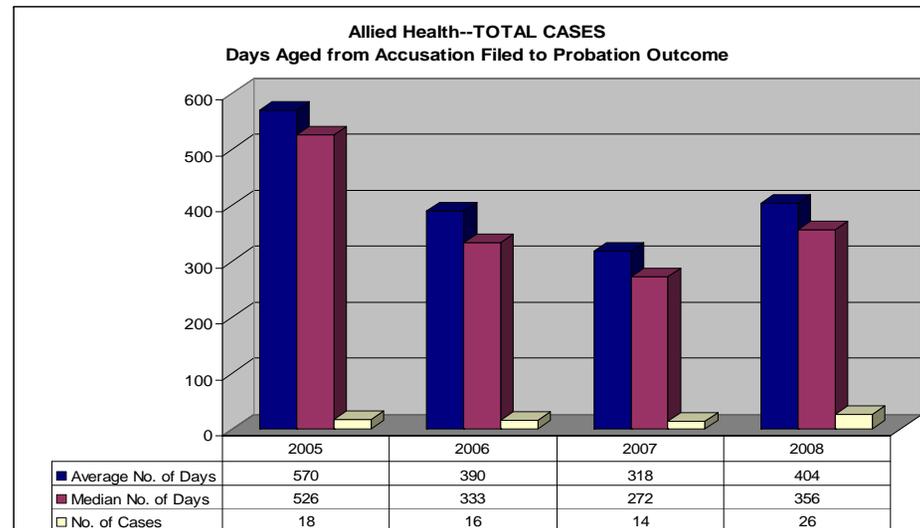
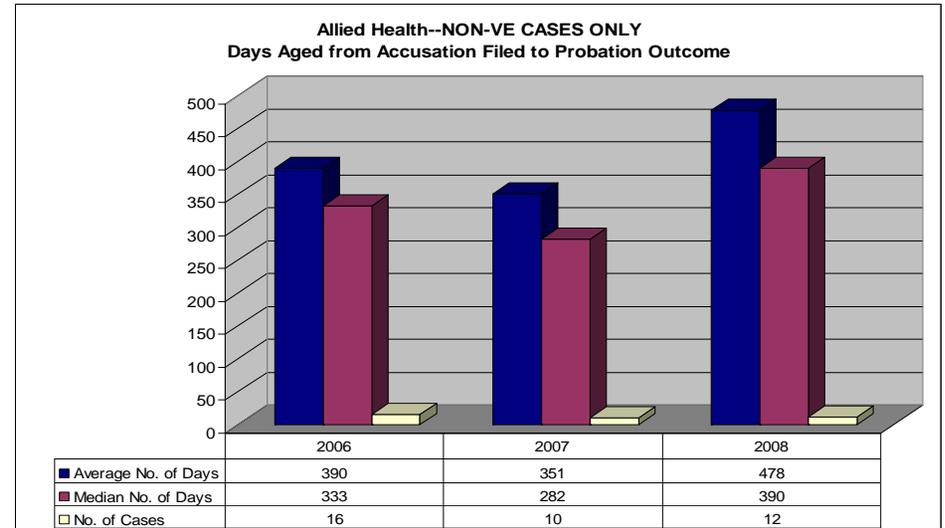
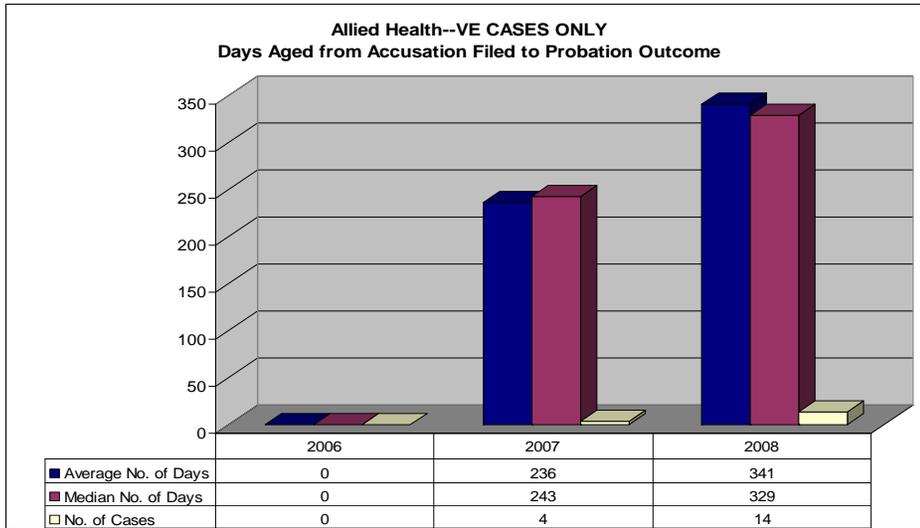
Charts 17.7d, e& f – Calendar Days Aged from Accusation Filed to Surrender Outcome for Allied Health Cases



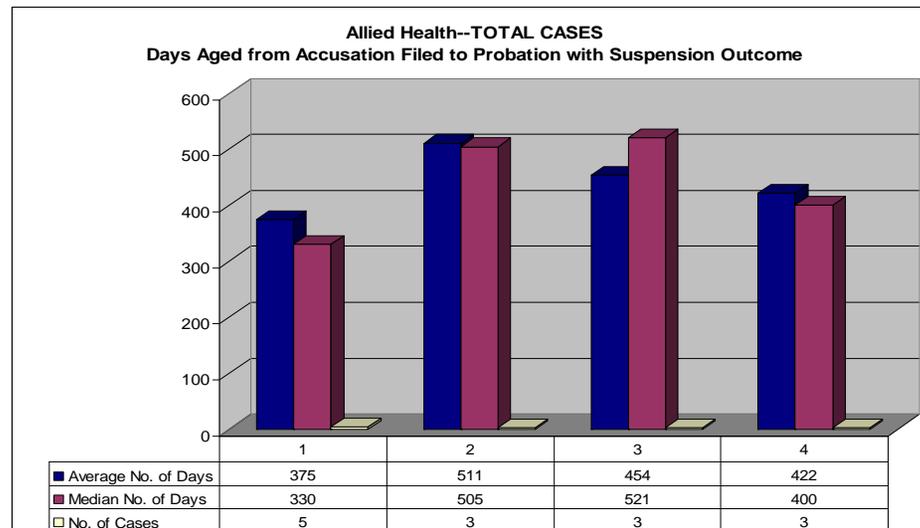
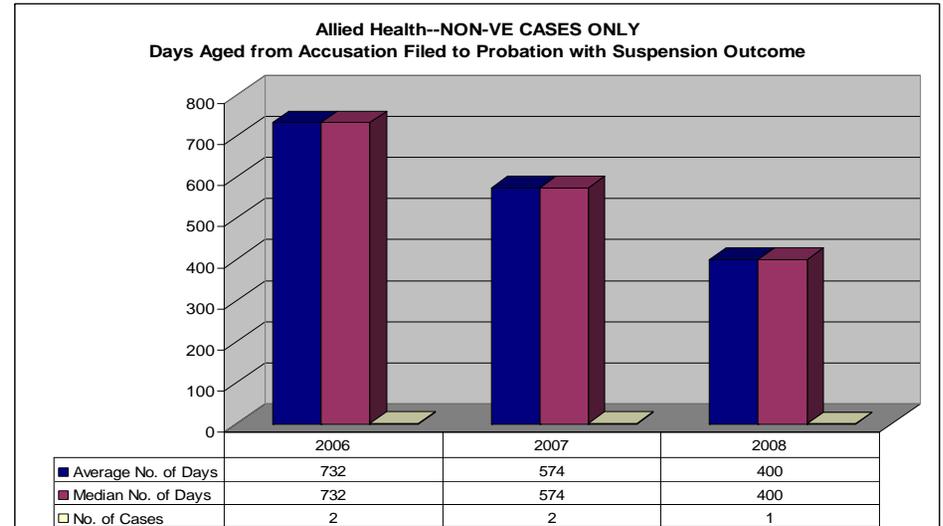
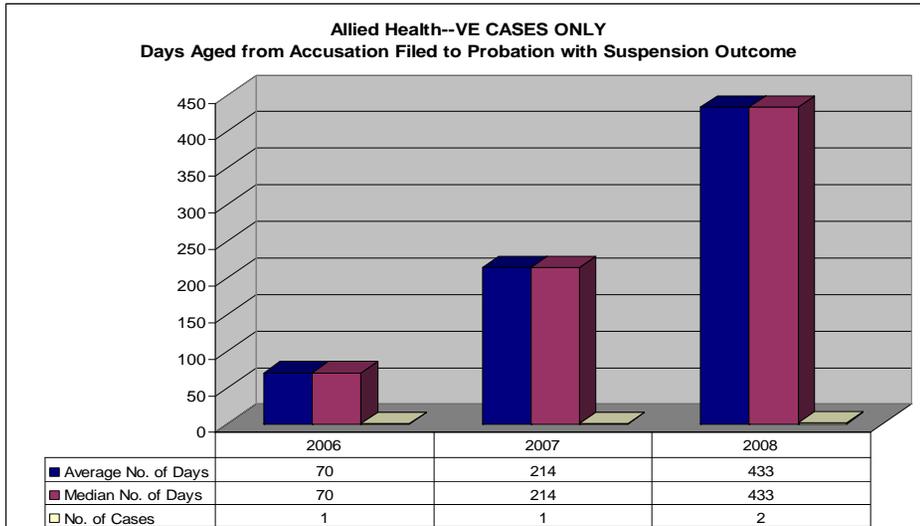
Charts 17.7g, h & i – Calendar Days Aged from Accusation Filed to Suspension Only Outcome for Allied Health Cases



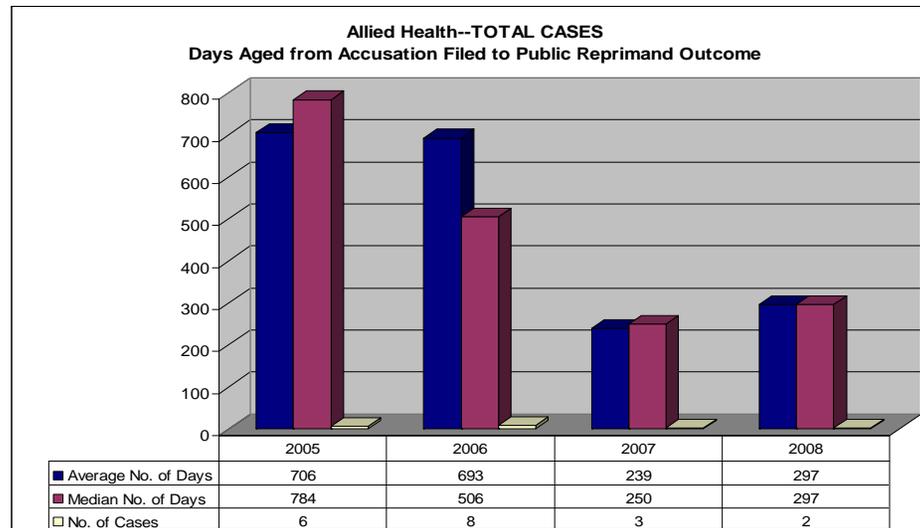
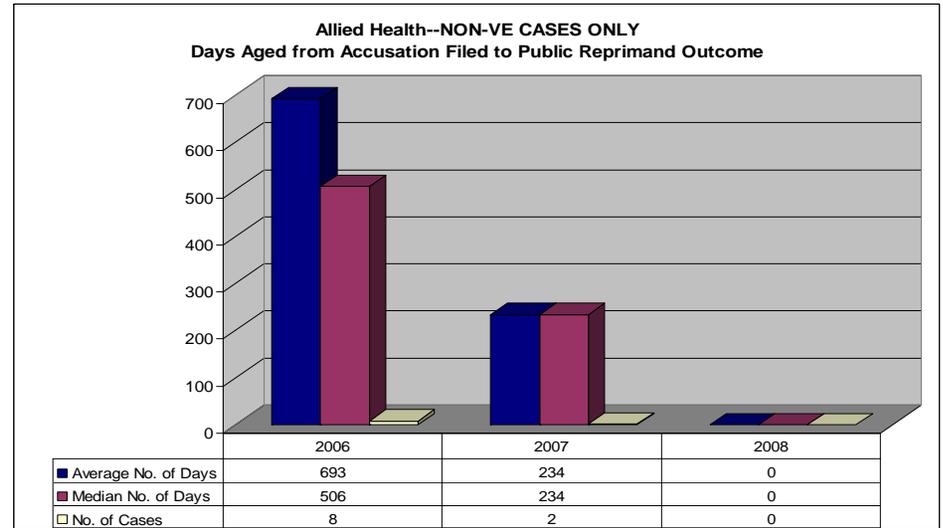
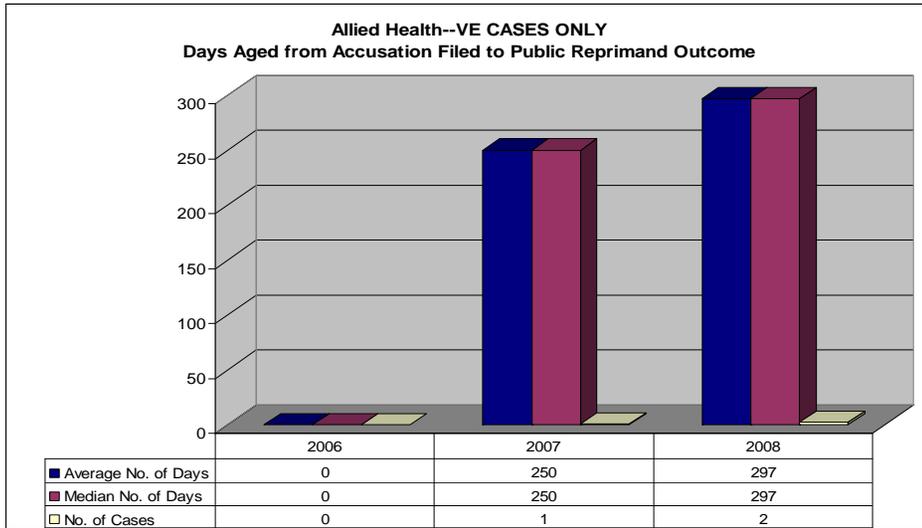
Charts 17.7j, k & l – Calendar Days Aged from Accusation Filed to Probation Outcome for Allied Health Cases



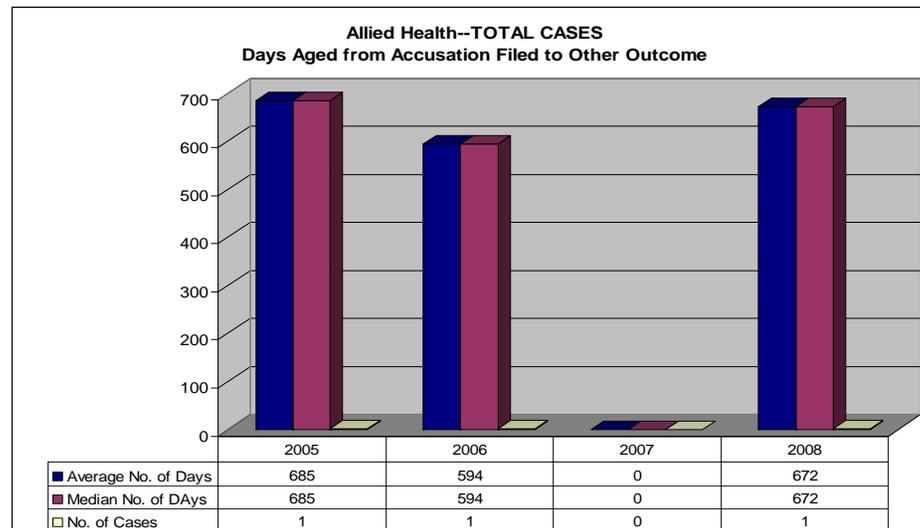
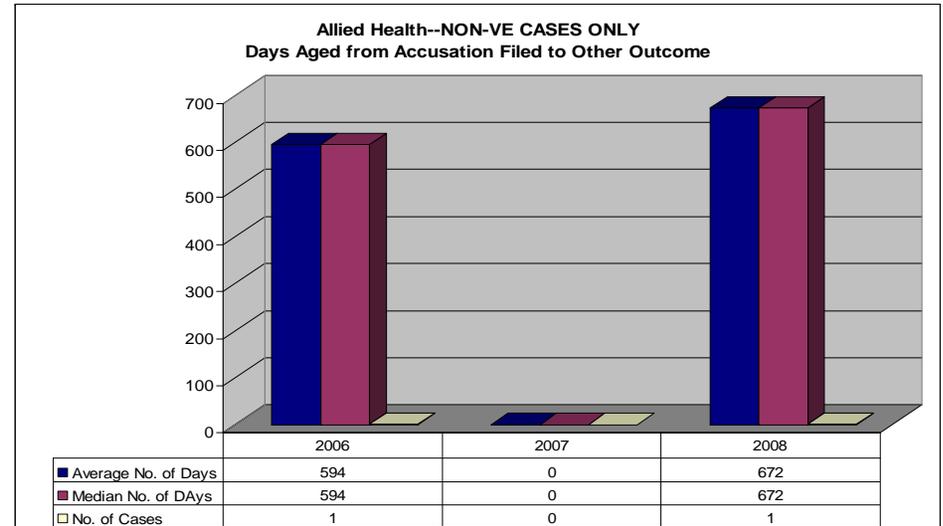
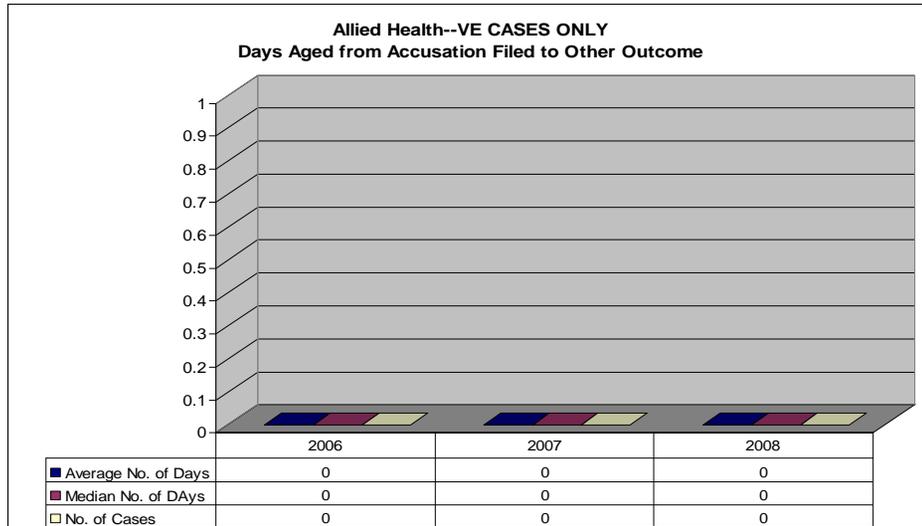
Charts 17.7m, n & o – Calendar Days Aged from Accusation Filed to Probation with Suspension Outcome for Allied Health Cases



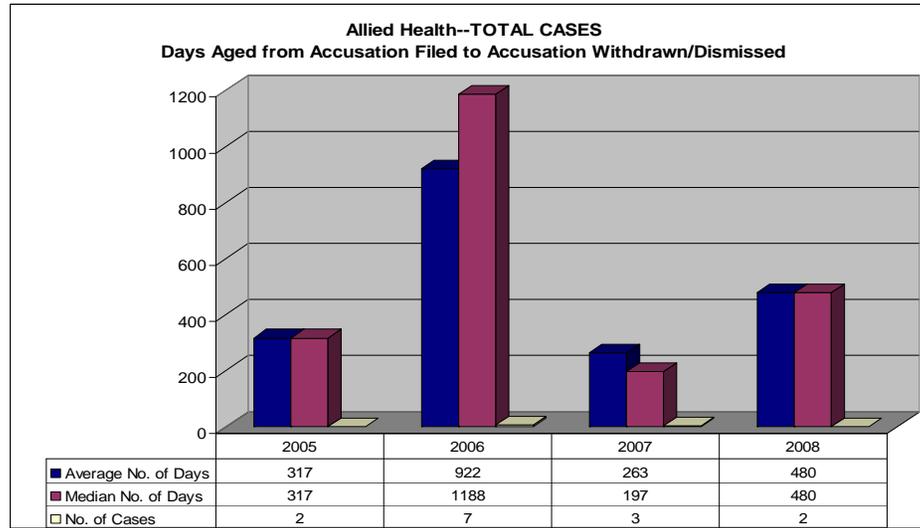
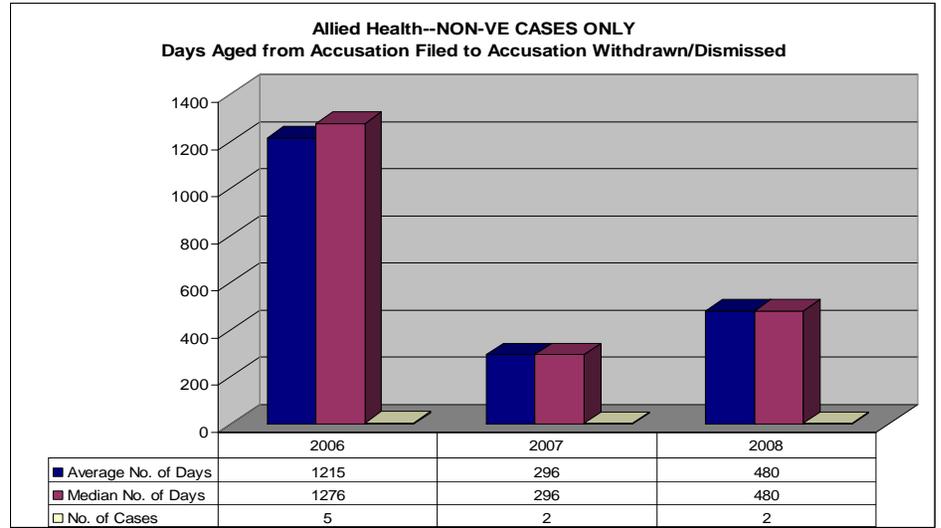
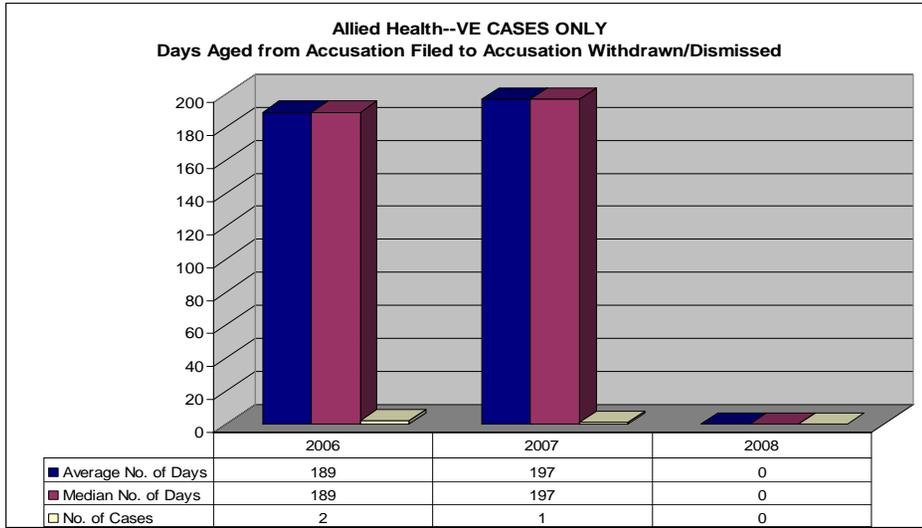
Charts 17.7p, q & r – Calendar Days Aged from Accusation Filed to Public Reprimand Outcome for Allied Health Cases



Charts 17.7s, t & u – Calendar Days Aged from Accusation Filed to Other Outcome for Allied Health Cases



Charts 17.7v, w & x – Calendar Days Aged from Accusation Filed to Withdrawn/Dismissed Outcome for Allied Health Cases



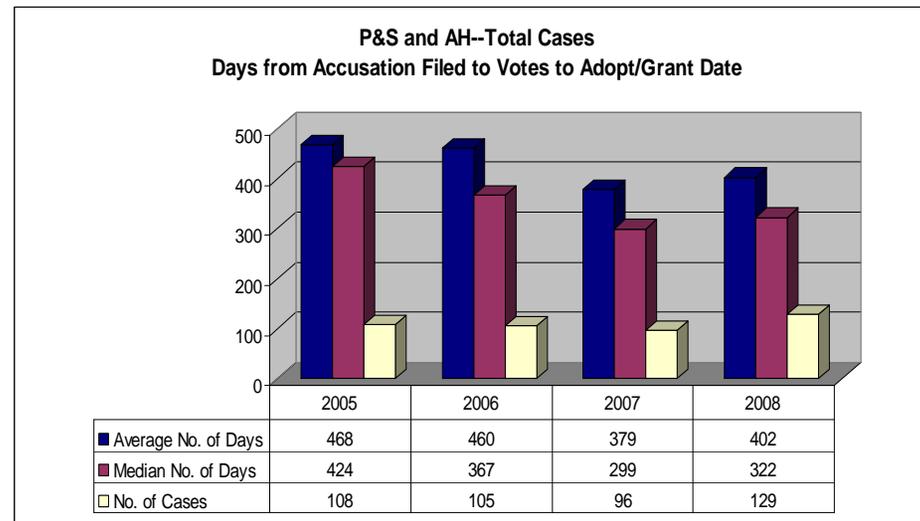
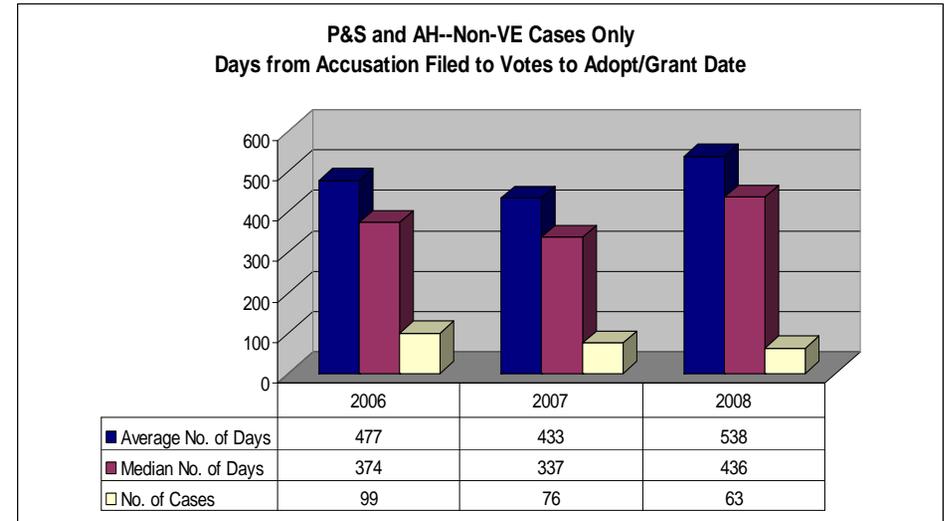
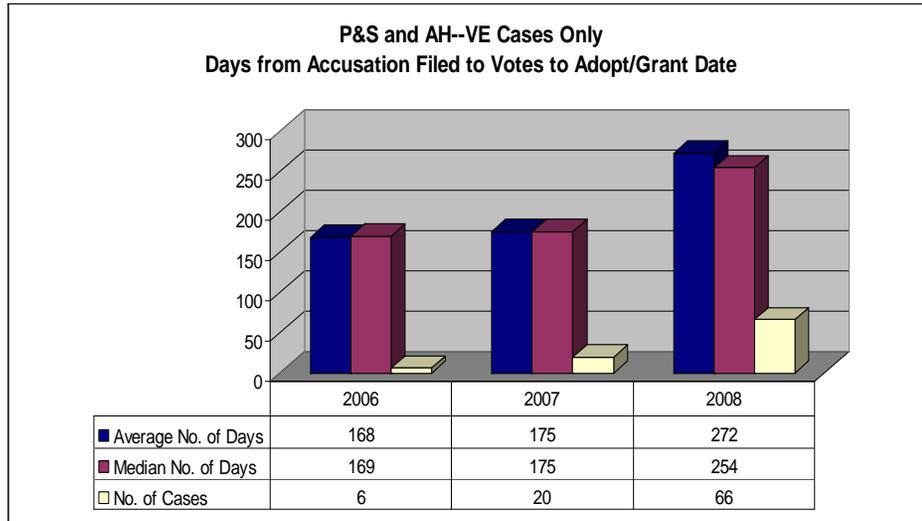
CALENDAR DAYS AGED FROM ACCUSATION FILED TO MBC VOTE TO ADOPT/GRANT — PHYSICIANS AND SURGEONS AND ALLIED HEALTH COMBINED

Table 17.8 below reports the average and median calendar days aged from accusation filed to MBC vote to adopt/grant for Physicians and Surgeons and Allied Health Care cases. Between 2005 and 2008, there was a 14.10% decrease in the average days aged, a 24.06% decrease in the median days aged, a 19.44% increase in the number of such cases and a 28.48% decrease in the number of such cases pending at year end.

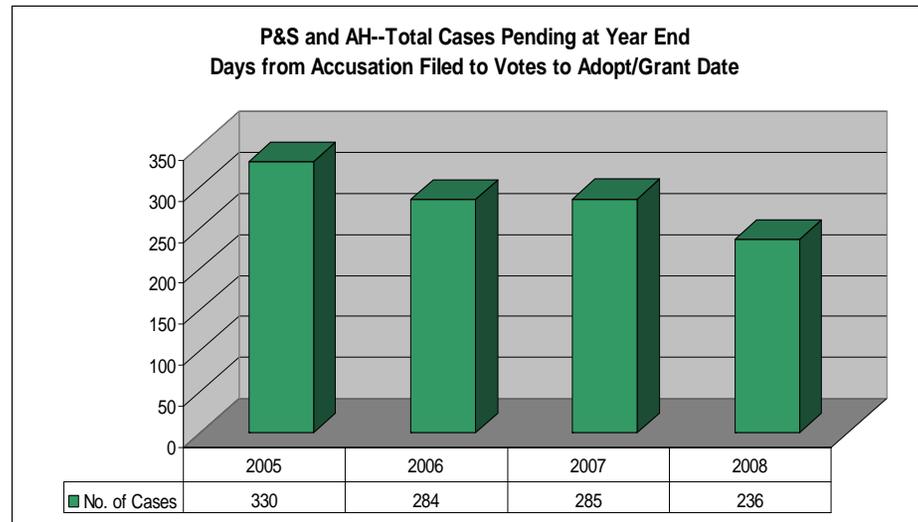
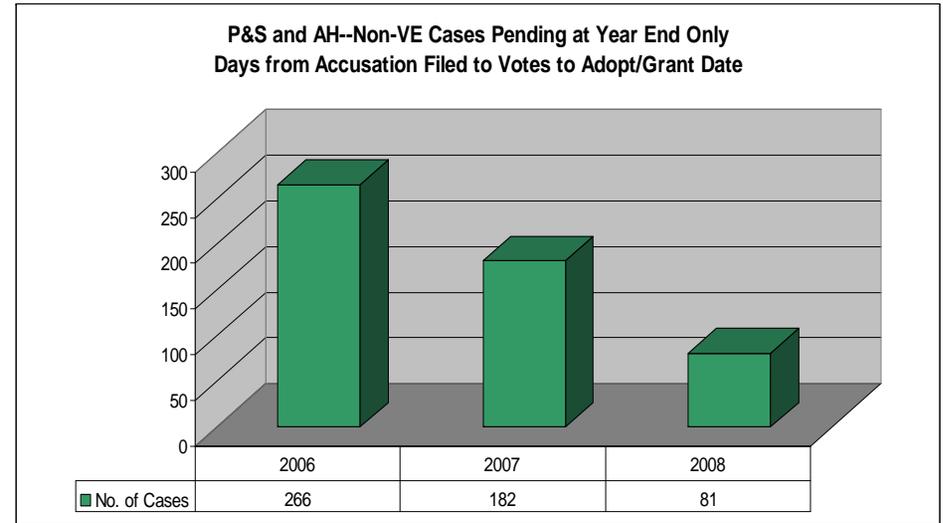
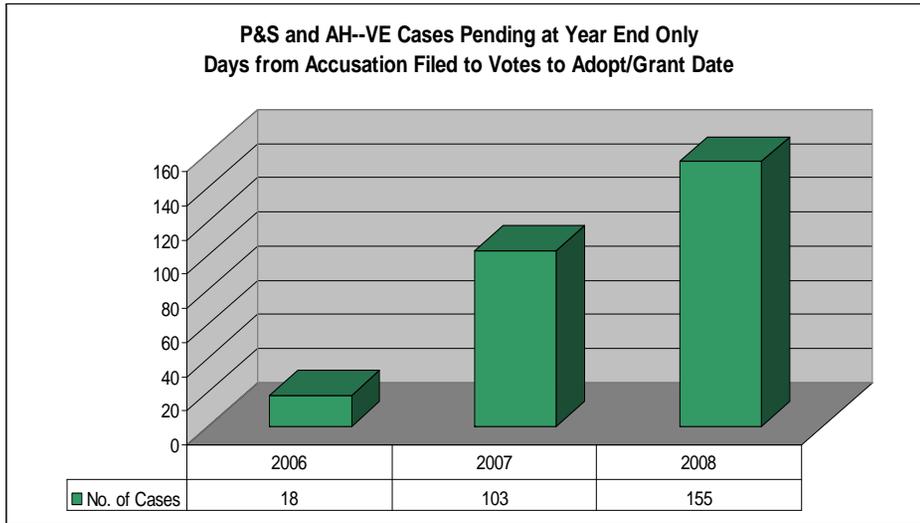
Table 17.8 – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Physicians and Surgeons and Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage Difference 2005 to 2008	
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All	
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending	
Calendar Day Age from Date Accusation Filed to Votes to Adopt/Grant Date																				
Average	-17.61%		-9.22%		4.17%		6.07%		24.25%		55.43%		-12.61%		12.79%		61.90%		-14.10%	
Median (middle record - half are above and half below)	-18.53%		-9.89%		3.55%		7.69%		29.38%		45.14%		-12.26%		16.58%		50.30%		-24.06%	
Record Count	-8.57%	0.35%	-23.23%	-31.58%	233.33%	472.22%	34.38%	-17.19%	-17.11%	-55.49%	230.00%	50.49%	22.86%	-16.90%	-36.36%	-69.55%	1000.00%	761.11%	19.44%	-28.48%

Charts 17.9a, b & c – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Physicians and Surgeons and Allied Health Cases



Charts 17.8d, e & f – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Physicians and Surgeons and Allied Health Cases — Cases Pending at Year End



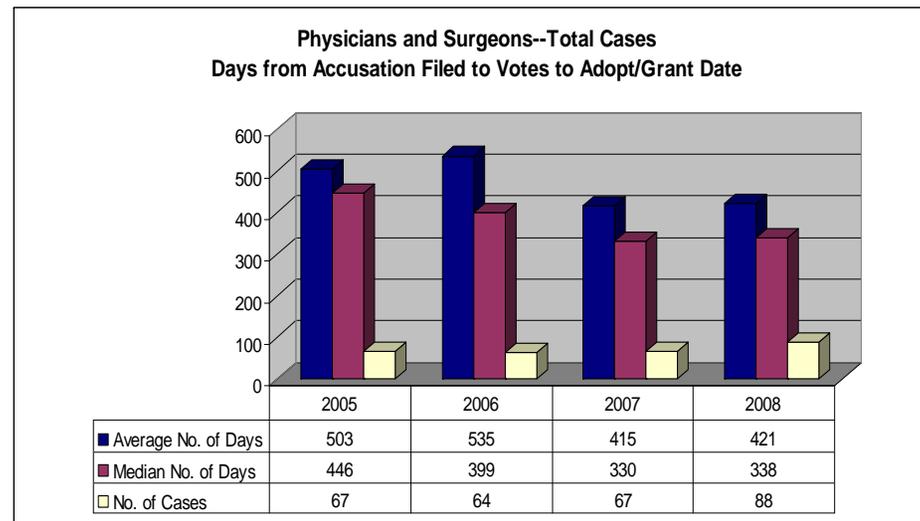
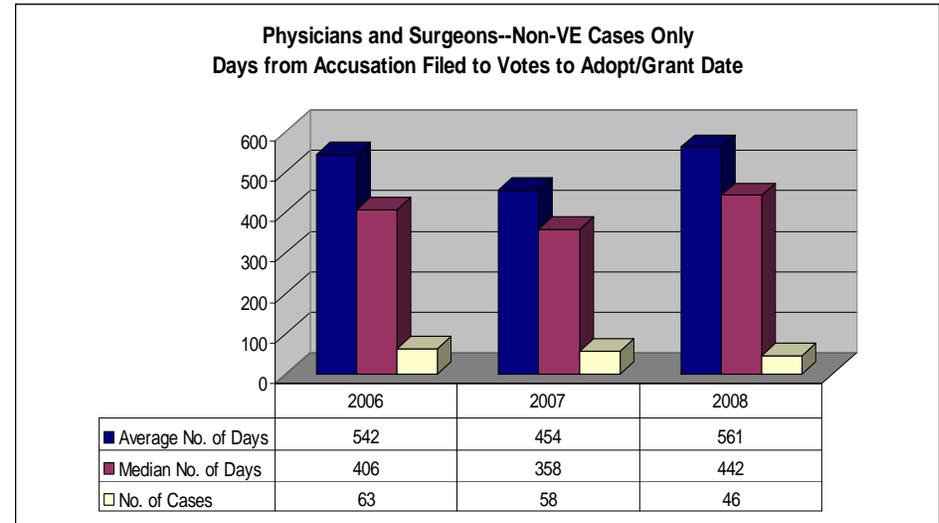
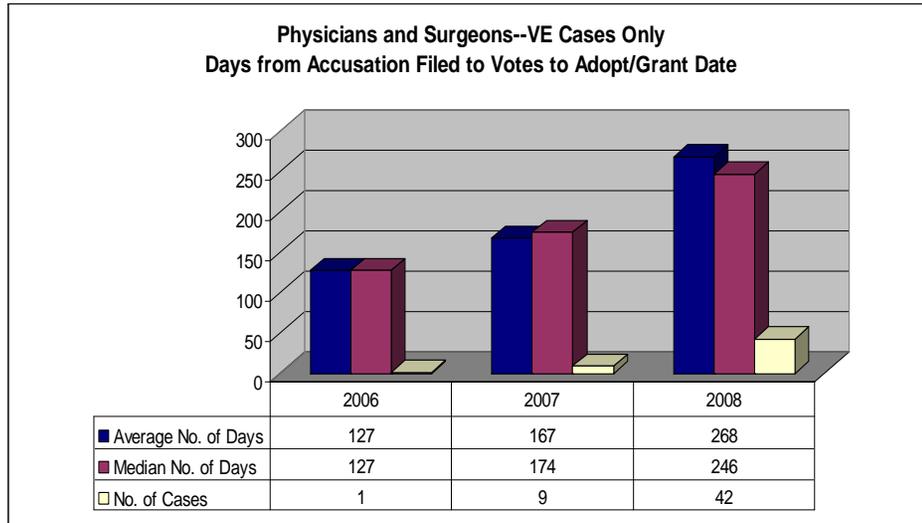
CALENDAR DAYS AGED FROM ACCUSATION FILED TO MBC VOTE TO ADOPT/GRANT — PHYSICIANS AND SURGEONS

Table 17.9 below reports the average and median calendar days aged from accusation filed to MBC vote to adopt/grant for Physicians and Surgeons cases. Between 2005 and 2008, there was a 16.30% decrease in the average days aged, a 24.22% decrease in the median days aged, a 31.34% increase in the number of such cases and a 35.66% decrease in the number of such cases pending at year end.

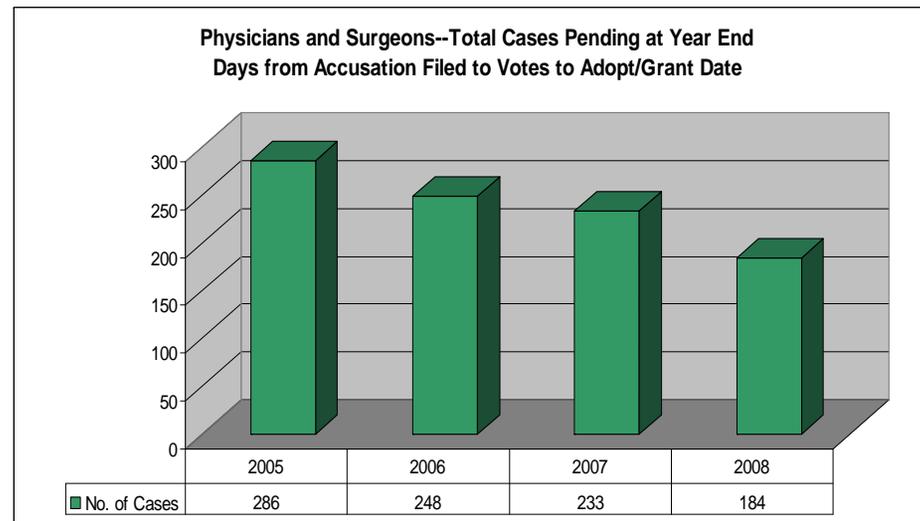
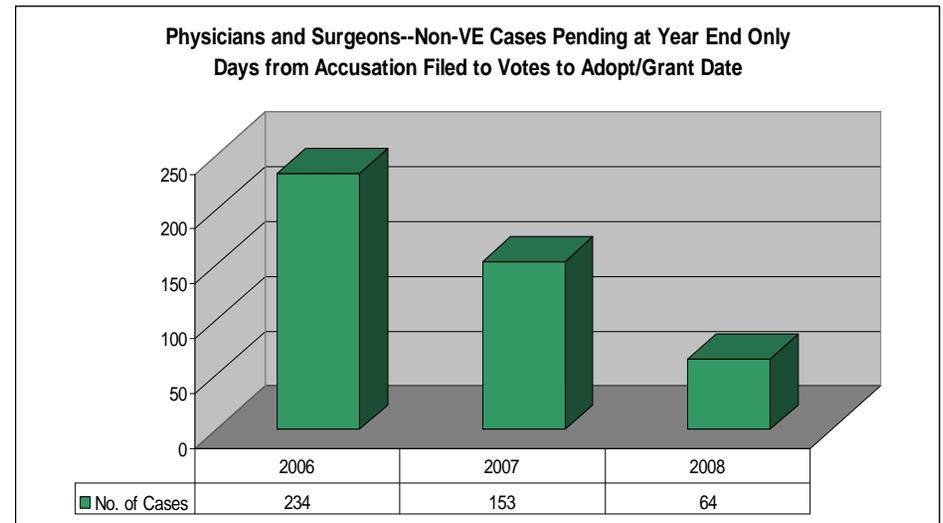
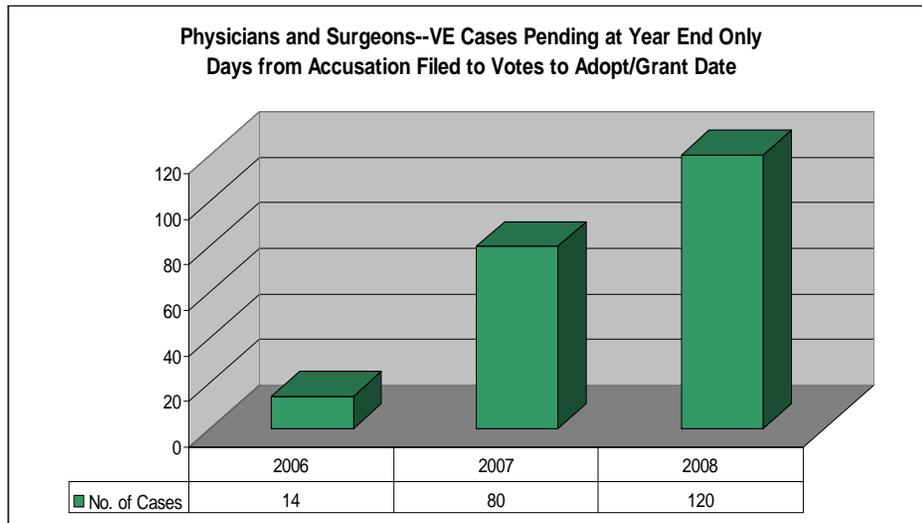
Table 17.9 – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Physicians and Surgeons

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008						Percentage Difference 2005 to 2008			
	All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		All			
	Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending		Pending			
Calendar Day Age from Date Accusation Filed to Votes to Adopt/Grant Date																						
Average	-22.43%		-16.24%		31.50%		1.45%		23.57%		60.48%		-21.31%		3.51%		111.02%				-16.30%	
Median (middle record - half are above and half below)	-17.29%		-11.82%		37.01%		2.42%		23.46%		41.38%		-15.29%		8.87%		93.70%				-24.22%	
Record Count	4.69%	-6.05%	-7.94%	-34.62%	800.00%	471.43%	31.34%	-21.03%	-20.69%	-58.17%	366.67%	50.00%	37.50%	-25.81%	-26.98%	-72.65%	4100.00%	757.14%			31.34%	-35.66%

Charts 17.9a, b & c – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Physicians and Surgeons Cases



Charts 17.9d, e & f – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Physicians and Surgeons Cases — Cases Pending at Year End



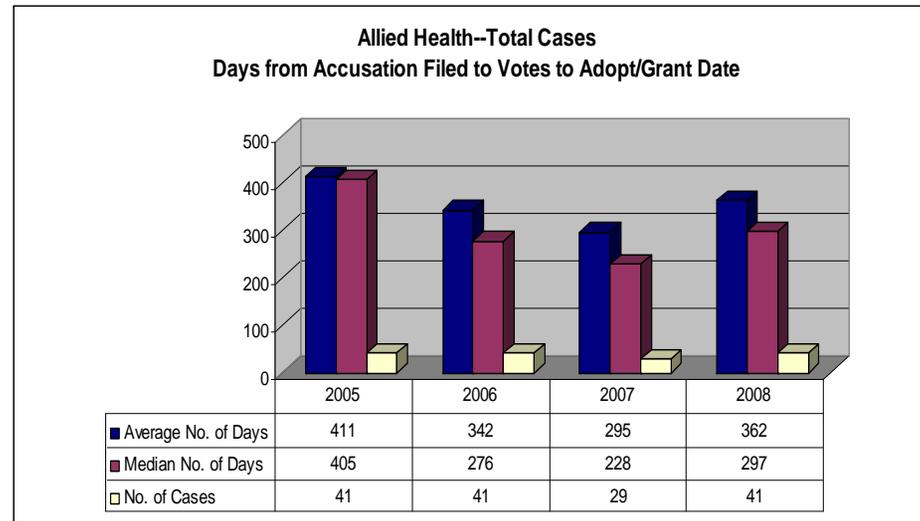
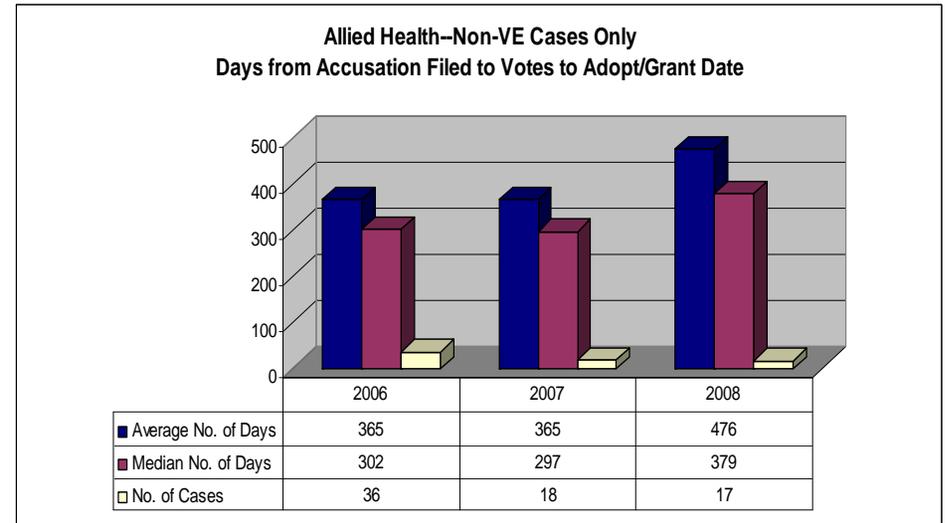
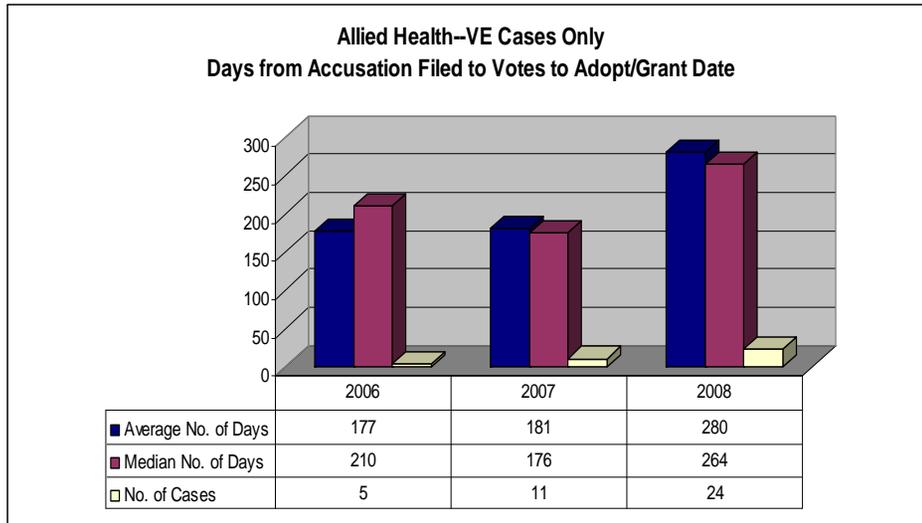
CALENDAR DAYS AGED FROM ACCUSATION FILED TO MBC VOTE TO ADOPT/GRANT — ALLIED HEALTH

Table 17.10 below reports the average and median calendar days aged from accusation filed to MBC vote to adopt/grant for Allied Health Care cases. Between 2005 and 2008, there was an 11.92% decrease in the average days aged, a 26.67% decrease in the median days aged, no change in the number of such cases and an 18.18% increase in the number of such cases pending at year end.

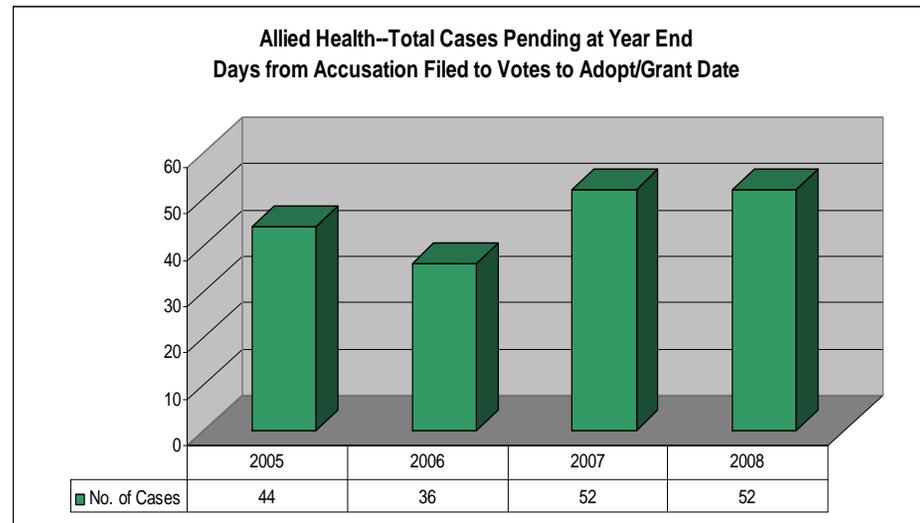
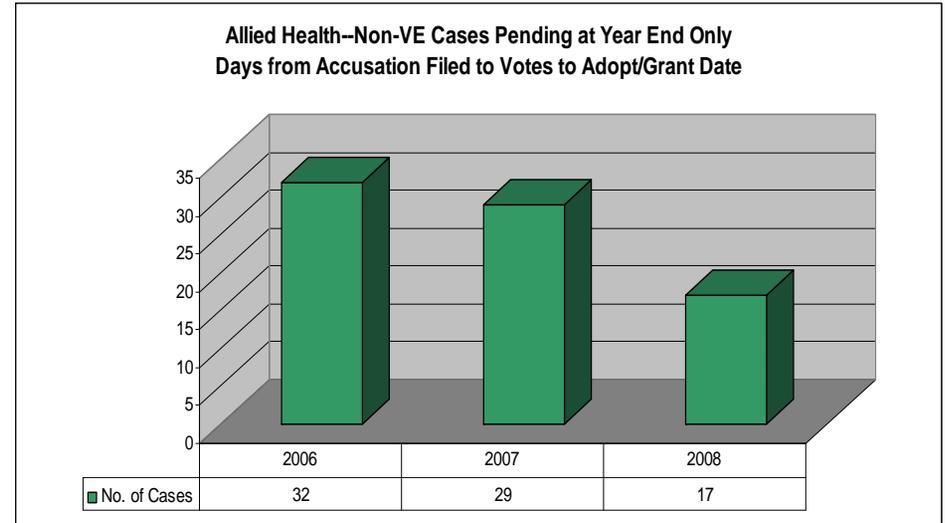
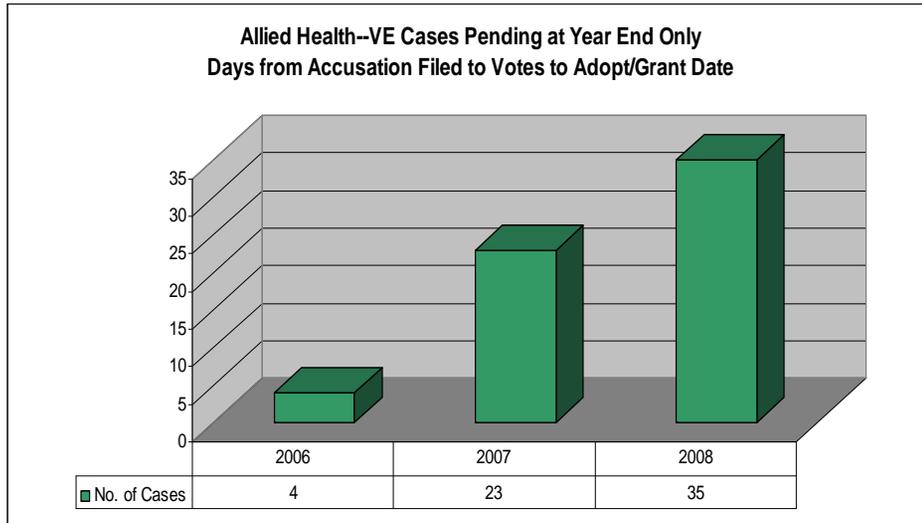
Table 17.10 – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Allied Health Cases

Activity	Percentage Difference 2006 to 2007						Percentage Difference 2007 to 2008						Percentage Difference 2006 to 2008			Percentage Difference 2005 to 2008				
	All	Not VE		VE		All	Not VE		VE		All	Not VE		VE		All				
	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending				
Calendar Day Age from Date Accusation Filed to Votes to Adopt/Grant Date																				
Average	-13.74%		0.00%		2.26%		22.71%		30.41%		54.70%		5.85%		30.41%		58.19%		-11.92%	
Median (middle record - half are above and half below)	-17.39%		-1.66%		-16.19%		30.26%		27.61%		50.00%		7.61%		25.50%		25.71%		-26.67%	
Record Count	-29.27%	44.44%	-50.00%	-9.38%	120.00%	475.00%	41.38%	0.00%	-5.56%	-41.38%	118.18%	52.17%	0.00%	44.44%	-52.78%	-46.88%	380.00%	775.00%	0.00%	18.18%

Charts 17.10a, b & c – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Allied Health Cases



Charts 17.10d, e & f – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Allied Health Cases – Cases Pending at Year End



XVIII. STAFF INTERVIEWS

Since statistical data alone does not fully describe the effectiveness of the VE model, interviews of MBC and HQES staff were conducted from April 9 through 15, 2009. Eleven (11) MBC enforcement staff were interviewed at the management, supervisory and investigative levels, all of whom were present since the onset of VE, with an average of 13 years with MBC. Additionally, 11 HQES staff were interviewed at the management, supervisory, primary and lead levels, all of whom were present since the onset of VE, with an average of 14 years experience with HQES.

All of the staff interviewed expressed dedication and a conscious desire to ensure public safety for the citizens of California as their primary goal. In addition, in general, they like their respective professions.

Interviewees were asked a number of questions relevant to the implementation and effectiveness of VE and its intended purpose as specified in the reports of the Monitor, legislation and select internal manuals and guidelines, as well as for recommendations for improvement. Along with what has already been stated elsewhere in this report, the below is a synopsis of the results of these interviews.

COMMUNICATION

The Monitor stated that the VE process will “improve the communication between the MBC investigators and DAGs with the goal of creating more efficient investigations and quicker case resolution”.

The MBC and HQES management recognized the importance of interpersonal communications in attempting to implement a successful VE program. To that end, the JVEG states that investigators and DAGs are expected to treat each other, and all individuals with whom they come into contact in their official capacities, professionally, respectfully and with courtesy. The number one rule for effective email communication is professionalism and courtesy. Investigators and DAGs should be responsive to each other.

The Monitor also recognized the significance of such issues and stated: “It is critical to note that the vertical prosecution model works best where all participants recognize and respect the contributions of all team members, and where attorneys, investigators, and other team members perform the functions for which they are trained and best suited.

Although most DAGs interviewed reported that communication with investigators has improved, some believe that it has increased only out of necessity. Some MBC investigators feel that their investigation abilities are constantly questioned and the communication is negative. Even in districts where there appears to be a good

relationship between the two offices, staff in both departments stated that the relationship is restrained with underlying friction.

The GC Section 12529.6 states that: “During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.”

According to the VPM: “Direction,” as that term is used in GC Section 12529.6, includes, but is not limited to, the authority and responsibility to direct the assigned investigator to complete investigative tasks, obtain required testimonial and documentary evidence, make periodic reports regarding the progress of the investigation, and complete additional tasks necessary to prepare and present the case for hearing.”

The Monitor stated that in the vertical prosecution model, investigators are “responsible for the tasks which are appropriately theirs, including essentially all the field investigative tasks involving witnesses, evidence, and related procedures”, and prosecutors “perform the tasks for which they are trained and licensed, including the legal analysis and advocacy essential to preparing evidence for trial and presenting that evidence at trial”.

All three manuals (EOM, VPM and JVEG) direct that the MBC investigators and DAGs must work together as a team, and communicate and confer with each other in a professional, respectful and courteous manner. In addition, the VPM states that since the authority and responsibility to supervise investigators remains with the Sups I/II, deputies should be careful not to exercise their authority in a manner that undermines the authority of the Sups I/II. Likewise, Sups I/II must be careful not to undermine the authority of DAGs.

However, it appears from those interviewed that the term “direction” is not consistently understood or interpreted by the DAGs and investigators. Various DAGs indicated that they: direct and control the investigations; direct the investigators, as well as the investigations; or direct the investigation, not the investigator. Various MBC investigators stated that: DAGs want to control the investigations, as well as the investigators; DAGs are in charge and direct them on how to conduct the investigations; or DAGs work cooperatively and give direction when appropriate.

Time Spent by Attorneys in MBC District Offices

The GC Section 12529.6 provides that: “The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter.” The VPM requires that a lead DAG be assigned to each of the MBC’s district offices and that this person must be physically present to fully discharge his/her responsibilities. Since

the lead DAG's responsibility is to review each complaint referred to the district office for investigation and determine whether a complaint warrants further investigation or should be closed, in addition to acting as the primary DAG until and unless replaced by a primary DAG, the amount of time the lead DAG spent in a district office is a factor in the success in the VE process. Comments received during the interviews ranged from the attorneys not spending enough time in the district offices to be of assistance to not being aware when the attorney is in the field office because he/she just drops in, picks up information and leaves. It was also stated that attorneys spend the right amount of time in the district offices and are valued partners. Interviewees indicated that lead DAGs are in the district offices as follows:

- San Diego – twice a week
- San Bernardino – twice a week
- Tustin – once a week
- Rancho Cucamonga – once a week
- Glendale – twice a week
- Diamond Bar – twice a week but most often once a week or sometimes once or twice a month
- Cerritos – twice a week
- Valencia – twice a week
- Fresno – twice a month
- Sacramento – once a week (SDAG covers for lead DAG twice a month when lead is in Fresno)
- Pleasant Hill – once a week
- San Jose – once a week

With regard to the primary DAG:

- Rarely seen in most MBC field offices except for subject interview
- Primary DAG in SF is physically present couple days a week; 40 hours a week via email and phone

SUBPOENA PROCESS

Subpoena Duces Tecum (SDT)

According to the VPM, after determination is made that a subpoena is necessary, the preparation of the subpoena and supporting declaration is the responsibility of the investigator and must be submitted for review and approval by the primary DAG within 10 business days. Subpoena enforcement is the responsibility of the primary DAG and must be filed in the appropriate Superior Court within 30 business days of acceptance of MBC's request for enforcement.

The JVEG states that while the responsibility to prepare the SDT package rests with the investigator, the primary or lead DAG should assist the investigator in the preparation of

the SDT when requested. The SDT is approved by the primary or in his/her absence, the lead DAG. If the investigator does not receive a response from the DAG within 10 business days, the SDT is required to be forwarded to the Sup II for signature and processing.

The EOM requires that the investigator submit completed SDT requests to his/her supervisor and that the supervisor forward the SDT to the primary DAG within three business days.

When asked if the SDT process is working, most DAGs indicated that the process was satisfactory. However, some interviewees stated that in one office if investigators adhered to the written policy and forwarded the SDTs to the Sup II after 10 business days without approval of the DAG, there would be repercussions; while in another office, if an investigator is having problems with the SDT, the DAG will assist. In still another office, the DAGs write the SDT. Multiple people interviewed indicated that, even though a new template for SDTs was developed and approved by both departments, individual DAGs continue to change the template language.

Subpoena to Appear and Testify (SAT)

The EOM requires that investigators submit the investigation report and SAT to the Sup I for approval. If the Sup I approves, the SAT is forwarded to the Sup II for review and signature. Although the written policy does not appear to require it, the practice has been to then submit the SAT to the DAG for approval.

Some DAGs indicated they do not believe it is necessary for them to approve SATs since it is basically a standard form. In addition, some investigators stated that there is no practical need for approval of a standard SAT, and that investigators should be able to issue them without higher review.

INTERVIEW PROCESS

The interview process consists of scheduling the interview, pre-interview meeting and the interview.

Scheduling Interviews

The JVEG requires that the primary DAG must communicate his/her intention to participate in the interview in the IPPR, and list the dates and times within the next 30 business days when he/she is available. When a primary DAG does not communicate an intention to participate, the investigator is permitted to schedule and conduct the interview without the primary DAG's participation. If new witnesses are identified, the primary DAG must inform the investigator if he/she elects to participate in the interview. If the investigator does not hear from the primary DAG within five business days, the

investigator is authorized to schedule and conduct the new witness interview without the primary DAG.

Even with this policy, interviewees stated that many do not adhere to it and that scheduling subject interviews has become a “nightmare”. On the other hand, some DAGs indicated it takes investigators one to two months to schedule an interview, while others stated that interviews are not conducted in a timely manner and that it is not uncommon to take six months to schedule an interview.

Reasons provided by interviewees for the delays included that investigators not only have to coordinate the schedules of the subject physician, physician’s attorney and the medical consultant, but now also the schedule of the primary DAG, or, if not available, the lead DAG. In addition, they indicated that in some HQES offices the primary DAG does not allow the lead DAG to participate in the interviews, there are larger caseloads due to vacancies, and last minute cancellations and rescheduling problems contributed to the delays.

Participating in Interviews

The VPM provides that the primary DAG may elect to participate in interviews, including subject interviews, while the JVEG states that primary DAGs are expected to participate in all subject interviews.

In one district office, the DAGs estimated that they participate in 50 percent of the subject interviews while the investigators estimated that DAGs participate in 90 percent of the interviews. In another district office, the DAGs stated that they participate in only 50 percent of the interviews because they do not believe it is necessary for them to participate in all subject interviews and that such interviews should never be delayed merely because of the unavailability of a DAG. In one office, interviewees reported that the primary DAG participates in 90 percent of subject interviews, while in another office it was indicated that the primary or lead DAG participates in 80 percent of the interviews. Most DAGs stated that they don’t participate in complainant and key witness interviews, except for a DAG from one office who stated that sometimes they participate in complainant interviews and that they attempt to participate in most key witness interviews.

Pre-Interview Meetings

Pursuant to the EOM, VPM and JVEG, before any interview the MBC and AG participants should meet in person for a pre-interview meeting to discuss interview tactics, assign roles if necessary, designate areas of questioning, and identify and organize all documents about which the person to be interviewed will be questioned. Both the EOM and the JVEG instruct that: “It is important that all participants allocate sufficient time for the pre-interview meeting.”

However, it appears from interviews with MBC and AG staff that in most instances, such pre-interview meetings do not occur or that, in a few cases, a pre-interview meeting only occurs by phone.

Interviews

Pursuant to the JVEG: “Subject interviews are extremely important. Accordingly, it is vital that such interviews be conducted in a manner that will elicit the maximum amount of reliable information from the subject.” It further states: “Although the interview should be low-key and calculated to elicit all available information, the interview should be appropriately detailed.”

There were multiple comments regarding the interview process ranging from some of the interviewees stating that MBC investigators must interview all subjects, whether there appears to be a case or not to reports that participation in interviews by certain DAGs elevated the interviews to an adversarial instead of a fact-finding process.

Some opined that it is not necessary for DAGs to be involved in all subject interviews and that if DAGs have additional questions, a second interview could be scheduled. Others stated that if a lead or primary DAG is not available in a timely manner, they should provide the investigator with the specific questions that they want asked.

EXPERT WITNESS PROGRAM

Per EOM: “It is the policy of MBC to utilize the services of licensed physicians who are Board certified in their specialty area to provide expert reviews and opinions in MBC cases.” To accomplish this, MBC maintains a panel of pre-approved expert reviewers. Under certain circumstances, a request may be made for the use an expert reviewer who is not a participant in the Expert Reviewer Program, which is submitted to the Sup I and II for approval. Interviewees reported that such requests often also require approval from Headquarters. Such outside experts are required to meet the minimum qualifications set forth in the Expert Reviewer Program.

There were multiple comments from those interviewed regarding the quality of the expert reviewers. Most DAGs, and some investigators, believe that there needs to be a better pool of experts. In addition, there were comments that the approval process to obtain an outside expert does not comply with the EOM and that the approval process needs to be streamlined.

Staff interviewed also expressed concerns regarding the contents of the experts’ reports and the appropriateness of pre-report contact with the expert.

VERTICAL ENFORCEMENT

Per VPM, the fundamental purpose underlying the VE program is “to bring investigators and deputy attorneys general together from the beginning of an investigation in order to improve coordination and teamwork, increase efficiency, and reduce investigation completion delays, all with the overall goal of increasing public protection.”

Multiple, sometimes conflicting, comments were received from the staff interviewed regarding their perception of the impact of VE as implemented to date. Comments from DAGs interviewed included:

- More effective, but not necessarily more efficient;
- Vastly improves the way things are being done;
- Works well for complex cases;
- Weeds out bad cases earlier;
- Resolves cases sooner;
- Cases moving quicker out of investigation;
- Investigation takes too long;
- Timelines have increased;
- VE works well, acceptance is the problem
- Investigators can anticipate what is required to put a viable case together ;
- Quality of cases has improved;
- Can identify problematic cases earlier and quicker;
- Cases are stronger;
- Cases are better and consequently easier to settle;
- Fewer cases are going to OAH;
- Cases that go to hearing are much better;
- There are fewer problems in obtaining certified medical records;
- Fewer cases require additional investigation after referral for prosecution;
- Cases require additional investigation after referral for prosecution;
- Positive learning experience for investigators in understanding the prosecution process;
- Affidavits in support of subpoenas are better; and
- Too many layers of approval.

Comments from MBC investigators regarding their perceptions of the VE process included:

- No difference, haven't seen any real change;
- Quality of cases have remained the same;
- Cases are not being closed any faster;
- Number of cases going to hearing has not changed;
- Most cases are settled, but that's the same as pre VE;
- Time required to obtain certified medical records is the same;
- Since VE is not a true vertical prosecution process, same problems with repeat investigations because lead DAGs want different things than the primary DAGs;

- Learn a lot by attending OAH hearings;
- Work with too many DAGs, all with different styles and different requirements;
- Aging cases have increased;
- Time to complete investigations has increased;
- Resolution of cases takes longer;
- Everything must be approved by a DAG;
- Forever chasing DAGs to get their approval;
- Efficiency has not increased, but instead has declined;
- Too many levels of review/approval;
- Too many attorneys involved;
- A lot of delays and unreasonable requests drag out the investigations;
- Increased caseload due to DAGs not turning over the cases;
- Caseload increased because taking longer to get DAG approval;
- Many cases get reassigned;
- Trying to get a case moving with all the roadblocks is very frustrating;
- Since accusations must be filed within 30 days of receipt, DAGs return cases to investigators for more information;
- Caseload has not increased, but time to complete cases has;
- Too many delays; everything takes much longer;
- DAGs are finally being held accountable for aging cases; and
- Liked the DIDO program better.

Attorney/Client Relationship

Disparate comments were received regarding MBC's status as HQES' client since implementation of VE, ranging from MBC is still the client, to only certain people at MBC are the clients, to MBC is no longer the client.

Responsiveness

Per JVEG: Investigators and DAGs must be responsive to each other and should check and respond to telephone messages and emails regularly and promptly. Nevertheless, some investigators complained of a lack of responsiveness by certain DAGs to emails and phone calls.

During the interviews, there were multiple comments that investigators are frequently chasing DAGs because their approval is required for every step. Others stated that some DAGs kept cases on their desk so long that when the statute of limitations is approaching, the case is sent back asking for more information, knowing that the investigator cannot obtain the information in time.

Clarity of Roles

Although the VPM identifies the VE team members and their respective roles, many of those interviewed from both departments stated that there needs to be a greater clarity of their individual responsibilities.

For example, many DAGs were unclear as to the need for both a Sup I and a Sup II and the Assistant Chief of Enforcement and stated that their functions need to be clearly articulated. Some also questioned the need for both a medical consultant and an expert witness.

Some investigators stated that the functions of the lead and primary DAGs must be clarified because different HQES offices appear to utilize these roles differently. Some investigators also stated that it is not uncommon for the lead and primary DAG to give conflicting directions, and that the involvement of the SDAG varies depending on the HQES office. Some investigators also stated that they lost their autonomy and are basically secretaries since the DAGs now make all of the decisions, that they are constantly duplicating records for DAGs and are spending too much time coordinating DAGs' schedules for participation in subject interviews.

Dispute Resolution

The JVEG states that investigators and DAGs are expected to treat each other, and all individuals with whom they come into contact in their official capacities, professionally, respectfully and with courtesy. It further states that while disagreements may arise, investigators and DAGs are expected to ensure that such disagreements are resolved professionally, respectfully and with courtesy, never losing sight of the fact that we are all working toward the same goal, public protection for all Californians.

The EOM states that when disagreements arise between an investigator and DAG, the investigator should first discuss his/her concerns directly with the DAG in an effort to resolve the dispute. If the dispute remains unresolved, the investigator and DAG should discuss the matter with the lead DAG, Sup I and/or Sup II. If the dispute remains unresolved, the matter must be documented on a Dispute Resolution form and submitted to the SDAG whose determination shall be final.

Interviewees suggested that most conflicts requiring dispute resolution emanate from a single office and often require elevation to the Senior Assistant AG and the MBC Assistant Chief and Chief of Enforcement at Headquarters. Some supervisors estimated that 80 percent of their time is spent on disputes.

Shared Computer System and Combined Location

The GC Section 12529.6 (e) states: The Medical Board of California shall do both of the following:

- (1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.
- (2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

Shared Computer System

According to DAGs, only investigators who are part of DOJ are permitted access to their ProLaw system. MBC indicated that DAGs are able to access their system when onsite at a MBC District Office but that attempts to integrate data between the two systems have so far been unsuccessful.

DAGs and investigators both indicated that at a minimum, a shared computer drive that both DAGs and investigators could access would be helpful to enable joint access to case specific documents. They also indicated that a better method of sharing up-to-date calendar information would help in reducing the time required to schedule subject and other interviews.

Same Location

The DAGs, in general, suggested that it would be beneficial for investigators to be part of DOJ and located in the same facility. However, only some investigators agreed with this opinion.

DAGS stated that if investigators move to DOJ:

- They would acquire special agent status and receive higher pay;
- They would have greater status working at DOJ;
- Retention problems would be eliminated;
- There would be clearer lines of supervision;
- DAGs would have more authority to push cases through the process;
- There would be more direct paring of investigators and attorneys; and
- It would create greater bonding and team building.

Some DAGs suggested that only investigators, and not supervising investigators, be transferred to DOJ and that SDAGs assume responsibility for supervising the transferred investigators. Other DAGs recommended that only investigators and Sup Is be transferred.

MBC investigators suggested that:

- Special agent status would not be automatic since passage of a physical fitness test is required;
- They like working for MBC because physicians do not realize they are armed peace officers and believe this is safer;
- They are uncertain that transferring to DOJ would be desirable, but being located in the same facility could be beneficial;
- Transferring to DOJ would not eliminate disagreements with DAGs, significantly improve the current situation, and would likely negatively impact investigator retention;

- The likely pay increase would not offset the negative impact on their health of working directly for the DAGs;
- They do not believe that attorneys should directly supervise sworn peace officers; and
- They would prefer that MBC have their own attorneys.

It is apparent from the interviews that there is a significant diversity of opinion between and amongst investigators and DAGS, both as to how VE is currently implemented and as to how it should be implemented in the future.

XIX. VE ALTERNATIVES

Six alternatives are apparent regarding the future of the VE model based on the statistical data and other information gathered to date.

The first alternative, canceling the VE pilot and resuming the previous method of investigating and prosecuting complaints, would return matters to the way they were prior to the implementation of VE, which was already deemed by the Legislature to be unacceptable.

The second alternative, continuing the current pilot unmodified for a period of time to gather additional statistical data, would continue a process that has increased an already unacceptable time frame to investigate complaints.

The third alternative, transferring MBC investigators to DOJ and consolidating responsibility for the investigation and prosecution of complaints under the AG, is not supported by the results of the current VE pilot as likely to decrease investigative time frames.

The fourth alternative, transferring responsibility for prosecuting cases to MBC and allowing MBC to hire in-house legal staff necessary to assume these duties, would be a major change that would likely result in an initial increase in case resolution timelines. The ability of MBC to timely recruit highly skilled legal staff experienced in the nuances of MBC's cases is also unknown.

The fifth alternative, co-location of DAGs and investigators in the same facility would potentially afford benefits, but the associated costs, as well as other potential issues regarding such a move, suggest that this alternative is premature. In addition, to be successful, implementation and evaluation of the results of the recommendations in the next chapter is essential.

The sixth alternative, continuing the pilot with modifications to improve its implementation and assess its effectiveness and success in two years, is the most feasible alternative. This alternative would modify the current pilot with improvements recommended in the following chapter which are imperative for the VE model to succeed. Furthermore, additional commitment to the VE process by executive management and every manager and supervisor in each department is essential to the success of this modified VE model.

XX. RECOMMENDATIONS

Although noteworthy efforts were expended by both HQES and MBC staff toward implementation of the VE model and some successes achieved, it is evident that room for improvement exists. Recommendations for a more successful implementation of the VE model include the following:

Recommendation #1: Zero Tolerance of Negative Communication

As noted by the Monitor, teamwork is based on “mutual respect and collegueship” and “doesn’t mean attorneys become dictatorial or inflexible” or that “investigators lose reasonable professional independence in handling their fieldwork or are asked to do tasks beneath their job descriptions”.

While both the MBC and HQES have made considerable progress in their working relationship, additional work is necessary to ensure mutual respect and appreciation for the vital roles each bring to the process and, ultimately, to public protection. Poor interpersonal communications between some MBC investigators and HQES attorneys are aggravated by a lack of commonly understood and mutually accepted appreciation of each others’ roles and professional contributions towards resolving cases in the VE model. It is recommended that the tone be uniformly set by executive management and every manager and supervisor of both departments that all staff work together as partners in a professional and respectful manner, and that all communications demonstrate mutual respect, courtesy and responsiveness, without exception. Any inappropriate communication must be addressed immediately, fairly and effectively.

Consideration should be given to engaging a knowledgeable outside consultant respected by both MBC and HQES to help identify, isolate and eliminate the cause(s) of such negative communications.

Recommendation #2: Clarity of Roles

It is recommended that clear and consistent direction be provided by top management regarding the roles of DAGs and MBC staff at all levels. Although the VPM identifies the VE team members and their respective roles, many of those interviewed from both departments stated that there needs to be a greater clarity of their respective roles.

For example, many DAGs were unclear as to the need for both a Sup I and Sup II and the Assistant Chief of Enforcement and stated that the chain of command needs to be clearly delineated. Some questioned the need for both a medical consultant and an expert witness. On the MBC side, some investigators stated that the roles between the lead and primary DAGs must be clarified because each HQES office appears to manage the roles differently. Some investigators also stated that it is not uncommon for

the lead and primary DAG to give conflicting directions and that the role of the SDAG varies depending on which HQES office or team is handling a case.

The meaning of GC Section 12529.6 wording “under the direction of” must be clearly defined and adhered to in a consistent manner throughout both departments in a manner that emphasizes teamwork and recognizes the unique training, expertise and contributions of all members of the team. If necessary, legislative changes should be sought to provide additional clarity.

Although HQES management stated that it has been HQES’ position that MBC is the client, interview responses indicate that this is not clearly understood or accepted. Therefore, management must clarify and ensure a consistent understanding and application of the term, which should be included in the joint training recommended below and incorporated in all appropriate manuals.

Recommendation #3: Consistent and Unified VE Process

Since the VE process varies from one office to the other, it is recommended that there be a consistent and uniform statewide VE process, including appropriate levels of approval, which are adhered to in every office. Exceptions, if any, should have an appropriate basis, be clearly documented and published to avoid the appearance of being arbitrary or unfair. It is also recommended that consideration be given to implementing a single joint manual that includes input from all who are part of the VE process, through a joint task force or committee, to ensure consistency and uniform understanding of the VE model and each person’s role in the VE process.

Recommendation #4: Consider Limiting VE to Specified Types or Categories of Cases or Circumstances

The data provided indicates that although there is a decrease in the time to complete a case once it is referred to the AG for prosecution, there is an overall increase in the investigatory phase of cases in the VE model.

As the Monitor noted, the vertical prosecution model is widely and successfully used by law enforcement, district attorney offices and others for specialized or complex cases. In light of the demonstrated increase in the time to complete the investigatory phase that has resulted from inclusion of all cases in the VE model, it is recommended that consideration be given to identifying specific types or categories of cases or circumstances under which VE would likely be of benefit and limit its use to those situations.

A working group consisting of management and staff from both departments should evaluate and recommend the categories of cases, circumstances or guidelines for determining which cases warrant handling in the VE process. In addition, consideration should be given to designating an intake officer(s) in the field offices to determine cases

warrant VE handling in accordance with the final guidelines. An outside consultant experienced in vertical prosecution should be considered to assist in this process.

Recommendation #5: Joint Statewide Training

As part of or in addition to the joint statewide training noted in Recommendation #2, it is recommended that a mandated joint statewide training for all DAGs and investigators, regardless of their level, experience or past training, should be held to assist in team building and ensure a common and consistent knowledge base. Based on the comments received from interviewees, such training should, at a minimum, include:

- Effective and efficient communication;
- Workload prioritization;
- Roles, background and training of investigators, supervisors, lead and primary DAGs and SDAGs, and the needs of each to efficiently and appropriately perform their functions;
- Definition of “client” and “direction”;
- Interviews and interview strategies;
- Obtaining appropriate expert witnesses;
- Subpoena use and preparation;
- Administrative hearing process and investigator’s role at a hearing; and
- The role and purpose of the Central Complaint Unit (CCU).

Recommendation #6: Staffing Vacancies

It is recommended that the departments continue to give priority to resolving current staffing vacancy issues. Areas to pursue include:

- Methods to increase investigators’ salaries;
- Use of overtime pay;
- Use of telecommunication and alternate work schedules; and/or
- Wage subsidization in high turnover, hard to fill vacancy locations.

Consideration should be given to engage a knowledgeable consultant to survey past and current employees to identify and, if appropriate, help resolve areas of dissatisfaction that are contributing to the problem.

Staff from both departments also recommended, during the interviews, revisiting the Investigator Assistant classification to reduce reliance on sworn investigators performing tasks that could be accomplished by non-sworn personnel.

Recommendation #7: Common Server

One of the recommendations of the Monitor’s reports and the previous **Report to the Legislature, Vertical Enforcement**, was to implement an “information technology system interoperable with the current system used at DOJ”. The MBC and AG have

agreed to an interoperable database and are in the process of obtaining necessary approvals. Although immediate implementation may consequently not be feasible at this time, there was support from many of those interviewed for implementation of a common or shared server accessible to both DAGs and investigators for storage of common documents and their calendars as an interim measure.

It is recommended that a working group of both AG and MBC staff be established to explore an effective and efficient method of sharing documents and information to eliminate repetitive duplication of documents and unnecessary delays in scheduling and rescheduling of subject interviews.

XXI. CONCLUSION

One of the primary goals leading to the implementation of VE was the perception that doing so would significantly reduce the time to investigate and resolve complaints against licensees of MBC, thereby providing for increased public protection. While the data collected suggests overall reductions have occurred in the prosecution phase of such matters, the investigation phase has not realized such benefits, and, as a result, the overall time to resolve complaints with a disciplinary outcome has only minimally improved. Furthermore, the time to resolve all complaints regardless of the type of outcome has actually increased.

The results suggest improvement is possible if the recommended modifications are made to the current model, staff receives appropriate training in interpersonal communications and concerted efforts are made towards team building, complemented by a unified effort to provide joint oversight and consistent direction by the executive levels of both agencies.

It is, therefore, recommended that the pilot be continued with the modifications contained in Recommendations 1 through 7 to improve its implementation with a reassessment of its success after two years as the most prudent course of action at this time. It is important to note that additional commitment to the VE process by executive management and every manager and supervisor in each department is essential to the success of this modified VE model.

APPENDICES

Appendix A – Summary Data Chart

Appendix B – Primary Data

APPENDIX A
SUMMARY DATA CHART

Table A1 –Summary of Data Analysis -- Combined Physicians and Surgeons and Allied Health Cases

	(Percentage Increase or Decrease)*					
	2008 vs 2005 (2005 Data Rre VE, 2008 Data Combined VE & Non VE Cases)	2008 vs 2006 (Combined VE & Non VE cases)	2008 vs 2005 (2005 Data Rre VE, 2008 Data Combined VE & Non VE Cases)	2008 vs 2006 (Combined VE & Non VE cases)	2008 vs 2005 (2005 Data Rre VE, 2008 Data Combined VE & Non VE Cases)	2008 vs 2006 (Combined VE & Non VE cases)
Misc. Stats						
Attorney Services Hours Billed by AG	37.71%	18.72%				
Legal Assistant/Paralegal Hours Billed by AG	39.81%	15.04%				
Enforcement Temp Help Hours Worked (excludes Med. Consultants)	86.83%	61.68%				
Enforment Medical Consultant Hours Worked	4.11%	5.02%				
No. of Filled Enforcement Field Investigaor Positions	10.91%	19.61%				
Average Caseload per Filled Field Investigator Postion	0.00%	-9.52%				
No. of Authorized Field Investigator Postions	16.39%	24.56%				
Average Caseload per Authorized Field Investigator Postion	-5.88%	-15.79%				
	Combined Physician and Surgeon & Allied Health		Physician and Surgeon Stats		Allied Health Care Stats	
Cases Referred to Investigations	-14.36%	-5.71%	-14.17%	-6.78%	-15.38%	0.54%
Days Aged from Request to Suspension Order Granted						
Average	-48.57%	-65.38%	-52.50%	-66.67%	36.36%	-59.46%
Median	25.00%	233.33%	25.00%	400.00%	0.00%	-20.00%
No of Cases	-20.00%	-20.00%	-27.59%	-22.22%	16.67%	-12.50%
Pending at Year End						
Days Aged from Assigned to Investigator to Closed, No Prosecution						
Average	37.65%	26.44%	38.01%	24.67%	35.21%	43.25%
Median	-61.54%	-52.38%	32.94%	17.13%	-30.00%	7.69%
No of Cases	-24.31%	-12.52%	-26.36%	-13.00%	-3.75%	-7.23%
Pending at Year End	12.46%	6.87%	10.85%	6.14%	18.57%	11.41%
Days Aged from Assigned to Investigator To Referral for Citation/Fine						
Average	75.72%	46.08%	67.14%	42.90%	170.62%	51.30%
Median	61.48%	34.57%	64.10%	43.59%	116.92%	22.61%
No of Cases	-19.61%	-22.64%	-34.04%	-36.73%	150.00%	150.00%
Pending at Year End						
Days Aged from Assigned to Investigator To Referral for Public Letter of Reprimand						
Average	12.50%	-24.85%	8.22%	-23.30%	-100.00%	
Median	44.04%	-21.62%	35.99%	-23.06%	-100.00%	
No of Cases	-78.57%	-70.00%	-69.23%	-60.00%	-100.00%	
Pending at Year End						
Days Aged from Assigned to Investigator To Referral for Criminal Action						
Average	38.35%	12.54%	27.99%	2.08%	66.67%	67.33%
Median	52.22%	8.04%	58.10%	-6.91%	17.03%	23.38%
No of Cases	-2.63%	37.04%	-26.47%	4.17%	200.00%	300.00%
Pending at Year End						
Days Aged from Medical Release Request to Receipt of Medical Records (No SDT)						
Average	3.51%	5.36%	8.77%	6.90%	-27.78%	-9.30%
Median	-3.13%	3.33%	-3.13%	0.00%	-15.63%	8.00%
No of Cases	-44.80%	-26.98%	-49.35%	-30.47%	13.89%	2.50%
Pending at Year End						
Days Aged from SDT Served to Receipt of Medical Record						
Average	-46.82%	43.75%	-43.93%	44.78%		-12.82%
Median	-64.00%	24.14%	-61.00%	21.88%		68.75%
No of Cases	2050.00%	120.51%	1900.00%	135.29%		20.00%
Pending at Year End						

Days Aged from Medical Release Request to SDT to Receipt of Medical Records						
Average	62.79%	25.00%	62.79%	22.81%		-100.00%
Median	30.51%	-38.40%	30.51%	-38.40%		-100.00%
No of Cases	106.67%	34.78%	106.67%	47.62%		-100.00%
Pending at Year End						
Days Aged from Mailing/Service of Request to Subject Interview Completed						
Average	16.67%	12.00%	20.83%	13.73%	7.69%	2.44%
Median	2.78%	-2.63%	2.78%	-11.90%	6.45%	10.00%
No of Cases	-16.33%	8.17%	-18.76%	8.50%	11.54%	5.45%
Pending at Year End	6.86%	13.54%	11.63%	10.34%	-31.25%	
Days Aged from Mailing/Service of Subpoena to Subject Interview Completed						
Average		-76.92%		57.69%		
Median		-10.87%		-10.87%		
No of Cases		200.00%		160.00%		
Pending at Year End	275.00%	328.57%	285.71%	440.00%	200.00%	50.00%
Days Aged from Case Submitted to D.O. Medical Consultant to Review Completed						
Average	183.87%	57.14%	187.10%	56.14%	204.76%	120.69%
Median	83.33%	57.14%	91.67%	58.62%	33.33%	21.74%
No of Cases	569.39%	13.89%	543.75%	12.36%	1800.00%	46.15%
Pending at Year End	433.33%	42.22%	391.43%	34.38%	1900.00%	185.71%
Days Aged from Request to Receipt of Expert Opinion						
Average	4.00%	10.64%	-1.96%	6.38%	80.95%	61.70%
Median	-2.44%	11.11%	-4.88%	8.33%	66.67%	36.36%
No of Cases	-26.20%	-12.84%	-27.22%	-10.66%	-16.28%	-32.08%
Pending at Year End	-17.46%	-11.86%	-25.45%	-16.33%	37.50%	10.00%
Days Aged from Case Assigned to Completed Investigation (Referred to AG)						
Average	42.13%	23.35%	32.07%	15.50%	66.14%	31.06%
Median	56.83%	11.79%	28.32%	15.08%	113.64%	71.95%
No of Cases	11.38%	9.60%	16.46%	22.67%	2.27%	-10.00%
Pending at Year End	12.46%	6.87%	10.85%	6.14%	24.63%	12.08%
Days Aged from Assigned to Investigator to All Outcomes						
Average	21.73%	15.34%	24.38%	16.56%	6.67%	8.02%
Median	40.65%	27.11%	42.16%	27.57%	25.43%	21.61%
No of Cases	-19.00%	-9.19%	-21.53%	-8.81%	-0.63%	-11.30%
Pending at Year End	12.24%	6.61%	11.96%	6.38%	14.81%	8.77%
Days Aged from Assigned to Investigator to Settlement						
Average	-6.21%	-9.68%				
Median	-5.23%	-4.07%				
No of Cases	-11.34%	-13.13%				
Pending at Year End	-23.02%	-17.80%				
Days Aged from Assigned to Investigator to Disciplinary Outcome						
Average	-0.51%	2.10%	0.58%	-0.29%	-5.65%	0.29%
Median	-1.85%	5.50%	-2.51%	-0.82%	-6.51%	9.91%
No of Cases	-9.61%	-5.35%	9.54%	3.04%	-9.86%	-27.27%
Pending at Year End	-23.37%	-17.83%	-26.50%	-23.04%	-11.43%	4.49%
Days Aged from Case Assigned to Investigation Completed and Accusation Filed						
Average	268.83%	8.60%	-0.87%	1.25%	55.43%	42.64%
Median	395.41%	12.97%	0.93%	6.67%	55.26%	35.46%
No of Cases	-8.48%	4.06%	-15.96%	3.95%	30.56%	4.44%
Pending at Year End	-13.41%	-20.67%	-4.63%	-20.77%	-30.36%	-20.41%
Days Aged from Completed Investigation to Accusation Filed						
Average	-72.32%	-16.00%	-28.24%	-32.22%	85.71%	45.34%
Median	-84.46%	-32.17%	-38.26%	-46.62%	9.68%	41.67%
No of Cases	-8.48%	4.06%	-15.96%	3.95%	30.56%	4.44%
Pending at Year End	-13.41%	-20.67%	-4.63%	-20.77%	-30.36%	-20.41%

Days Aged from Accusation Filed to Case Submitted to ALJ for Decision						
Average	-23.24%	-14.46%	-14.73%	-10.23%	-65.18%	-33.33%
Median	-38.06%	-12.21%	-31.46%	-1.23%	-61.10%	-31.40%
No of Cases	-23.68%	93.33%	-29.41%	84.62%	25.00%	150.00%
Days Aged from Accusation Filed to Settlement						
Average	-17.16%	-24.41%				
Median	-28.25%	-23.68%				
No of Cases	-10.99%	-11.96%				
Pending at Year End	63.64%	125.00%				
Days Aged from Accusation Filed to Disciplinary Outcome						
Average	-8.75%	-6.99%	0	-5.71%	-18.40%	-18.24%
Median	-27.29%	-14.25%	-26.86%	-17.60%	-30.20%	4.49%
No of Cases	-6.08%	0.82%	-4.69%	5.73%	-12.00%	-16.98%
Pending at Year End	-28.74%	-16.78%	-35.55%	-25.10%	14.89%	38.46%
Days Aged from Accusation Filed to Revocation Outcome						
Average	-10.11%	43.71%	-14.43%	28.79%	10.64%	54.65%
Median	-39.45%	58.08%	-56.55%	33.70%	6.23%	78.43%
No of Cases	-12.00%	10.00%	-16.67%	36.36%	0.00%	-22.22%
Days Aged from Accusation Filed to Surrender Outcome						
Average	-14.88%	-16.71%	-14.66%	-18.51%	-41.38%	-35.00%
Median	-49.86%	-38.67%	-50.14%	-46.36%	-20.92%	30.46%
No of Cases	-10.26%	-10.26%	14.29%	6.67%	-72.73%	-66.67%
Days Aged from Accusation Filed to Suspension Only Outcome						
Average		-100.00%		-100.00%		
Median		-100.00%		-100.00%		
No of Cases		100.00%		-100.00%		
Days Aged from Accusation Filed to Probation Outcome						
Average	-22.04%	-16.61%	-1.65%	-1.81%	-29.12%	3.59%
Median	-27.11%	-15.97%	-20.59%	-18.53%	-32.32%	6.91%
No of Cases	-6.82%	10.81%	-20.00%	-3.45%	44.44%	62.50%
Days Aged from Accusation Filed to Probation with Suspension Outcome						
Average	-4.32%	-4.14%	-4.78%	0.56%	12.53%	-17.42%
Median	-16.39%	-19.21%	-28.69%	-15.31%	21.21%	-20.79%
No of Cases	-58.62%	-29.41%	-62.50%	-35.71%	-40.00%	0.00%
Days Aged from Accusation Filed to Public Reprimand Outcome						
Average	-11.35%	-17.92%	-9.49%	-17.21%	-57.93%	-57.14%
Median	-31.86%	-30.68%	-29.39%	-32.45%	-62.12%	-41.30%
No of Cases	0.00%	-19.21%	8.16%	-11.67%	-66.67%	-75.00%
Days Aged from Accusation Filed to Other Decision Outcome						
Average	33.52%	-47.09%	93.42%	-58.25%	-1.90%	13.13%
Median	-5.90%	-18.48%	15.34%	-75.10%	-1.90%	13.13%
No of Cases	300.00%	-166.67%	600.00%	250.00%	0.00%	0.00%
Days Aged from Accusation Filed to Accusation Withdrawn/Dismissed Outcome						
Average	16.67%	55.71%	2.78%	148.32%	51.42%	-47.94%
Median	-23.64%	32.14%	-25.73%	60.24%	51.42%	-59.60%
No of Cases	24.00%	34.78%	26.09%	81.25%	0.00%	-71.43%
Days Aged from Accusation Filed to Date MBC Vote to Adopt/Grant Decision						
Average	-14.10%	-12.61%	-16.30%	-21.31%	-11.92%	5.85%
Median	-24.06%	-12.26%	-24.22%	-26.29%	-26.67%	7.61%
No of Cases	19.44%	22.86%	31.34%	37.50%	0.00%	0.00%
Pending at Year End	-28.48%	-16.90%	-35.66%	-25.81%	18.18%	44.44%
Other Stats						
OAH Initial Hearing Dates Delayed Due to Governor's Executive Order, July - October 2008						
Average Days Delay	119.78					
Median Days Delayed	112.00					
Number of Cases Delayed	23.00					

*The absence of a percentage increase or decrease indicates there was either no data applicable or that the denominator was "0" and that no percentage calculation is therefore possible.

APPENDIX B
PRIMARY DATA

Table B3.1 – Attorney General Health Quality Enforcement Section Attorney Services Hours Billed to Medical Board

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	TOT
CY 05 hours													
Attorney Services	4,905.75	4,455.50	4,336.25	4,177.75	4,487.75	4,808.00	4,445.25	4,390.50	4,374.00	4,182.50	4,627.25	4,043.25	53,233.75
Legal Asst	195.50	182.00	166.75	211.50	185.75	220.50	203.75	255.00	228.00	180.50	131.00	116.00	2,276.25
CY 06 hours													
Attorney Services	4,689.75	4,661.50	5,199.75	4,527.25	5,446.00	5,406.75	4,711.25	5,760.25	5,178.00	5,433.50	5,576.25	5,156.50	61,746.75
Legal Asst	248.00	229.00	245.00	162.75	234.25	253.25	225.00	220.25	269.25	291.75	217.25	170.75	2,766.50
CY 07 hours													
Attorney Services	6,320.50	5,526.50	6,232.25	5,769.25	6,478.00	5,990.50	6,180.75	6,933.50	6,143.50	6,653.25	5,532.25	5,153.50	72,913.75
Legal Asst (Paralegal as of Jul 07)	241.25	227.25	262.50	190.00	263.50	251.50	134.00	65.25	240.00	241.50	253.50	227.75	2,598.00
CY 08 hours													
Attorney Services	6,339.75	5,958.50	5,989.75	6,703.50	6,566.25	6,363.00	6,321.75	5,689.25	5,936.00	6,487.75	5,134.25	5,816.00	73,305.75
Paralegal	277.25	286.75	278.25	315.50	235.50	356.50	320.25	216.50	248.75	219.75	179.25	248.25	3,182.50

Table B3.2 – Medical Board Enforcement Temporary Help Hours Worked (Excluding Medical Consultants)

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	TOT
Enforce (170-184) CY 05 hours	462.00	680.00	726.00	645.00	549.50	430.50	323.75	356.00	463.50	354.00	404.00	330.50	5,724.75
\$	12,890.00	19,188.00	20,258.00	18,081.00	15,276.00	11,156.00	9,379.00	8,823.00	10,885.00	7,914.00	9,308.00	7,222.00	150,380.00
Enforce (170-184) CY 06 hours	627.80	615.00	779.30	359.50	426.00	342.50	307.50	536.50	721.50	668.00	680.25	551.25	6,615.10
\$	17,496.00	17,069.00	20,325.00	8,708.00	10,628.00	8,013.00	7,829.00	12,538.00	18,447.00	19,453.00	19,450.00	15,482.00	175,438.00
Enforce (170-184) CY 07 hours	522.00	504.25	468.00	563.95	632.00	524.50	519.00	326.50	392.00	831.75	1,076.50	902.00	7,262.45
\$	13,802.00	13,419.00	11,719.00	16,666.00	18,822.00	12,975.00	10,060.00	9,385.00	11,988.00	27,898.00	34,277.00	24,045.00	205,056.00
Enforce (170-184) CY 08 hours	1,355.00	1,274.50	1,178.50	1,182.00	1,109.75	842.25	975.75	182.00	181.00	302.50	1,031.00	1,081.25	10,695.50
\$	40,699.00	36,607.00	33,726.00	30,737.00	28,434.00	22,418.00	23,668.00	4,571.00	4,692.00	8,567.00	26,256.00	29,539.00	289,914.00

Table B3.3 – Enforcement Medical Consultant Hours Worked

No. of Consultants	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	TOT
CY 05 20-23	1,004.8	1,164.3	1,287.0	1,161.8	1,179.8	1,226.3	1,081.3	1,065.5	1,086.3	1,082.8	1,092.0	950.3	13,381.8
CY 06 20	1,158.0	1,216.3	1,167.8	1,123.0	1,203.3	1,116.0	1,065.0	1,020.8	0,984.3	1,115.8	1,118.8	0,977.3	13,266.0
CY 07 20-25	1,121.3	1,049.0	1,086.0	1,009.5	1,326.5	1,183.8	1,169.0	1,142.0	1,204.5	1,402.5	1,444.3	1,303.3	14,441.5
CY 08 25-26	1,384.8	1,348.2	1,201.3	1,351.1	1,658.3	1,313.2	1,581.3	163.0	0.0	818.8	1,567.3	1,544.5	13,931.5

Table B3.4 – Medical Board Field Investigators and Average Caseload

	2005	2006	2007	2008
No. of Filled Enforcement Field Investigator Positions	55	51	51	61
Avg Cases per Filled Enforcement Field Investigator	19	21	12	19
No. of Authorized Enforcement Field Investigator Positions	61	57	59	71
Avg Cases per Authorized Field Investigator Position	17	19	16	16

Table B6.1 – Calendar Days Aged from Request to Suspension Order Granted for Physicians and Surgeon and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending	Granted	Pending																
Calendar Day Age from Request to Suspension Order Granted																				
Average	35		52		100		7		54		98		31		18		14		19	
Median (middle record-half are above and half below)	8		3		8		2		7		1		21		10		5		10	
Record Count	35	0	35	0	17	0	18	0	29	0	10	0	19	0	28	0	5	0	23	0

*Allied Health Care Professionals Cases Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives
**Excludes Out of state and Headquarters Cases

Table B6.2 – Calendar Days Aged from Request to Suspension Order Granted for Physicians and Surgeons Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending	Granted	Pending																
Calendar Day Age from Request to Suspension Order Granted																				
Average	40		57		105		4		61		98		36		19		17		20	
Median (middle record-half are above and half below)	8		2		6		1		13		1		23		10		17		10	
Record Count	29	0	27	0	14	0	13	0	24	0	10	0	14	0	21	0	4	0	17	0

*Excludes Out of State and Headquarters Cases

Table B6.3 – Calendar Days Aged from Request to Suspension Order Granted for Allied Health Cases

Activity	2005		2006				2007				2008										
	All		All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		
	Prior to VE	Pending	Granted	Pending																	
Calendar Day Age from Request to Suspension Order Granted																					
Average	11		37		72		16		18		0		18		15		1		17		
Median (middle record-half are above and half below)	8		10		57		4		7		0		7		8		1		12		
Record Count	6	0	8	0	3	0	5	0	5	0	0	0	5	0	7	0	1	0	6	0	

**Allied Health Care Professionals Cases Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B7.1 & B7.1a – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons and Allied Health Cases

Complaints Referred to Investigation	2005		2006				2007				2008									
	1407		1278				1109				1205									
	All		All		Not VE		VE		All		Not VE		VE		All		Not VE		VE	
Activity	Prior to VE	Pending	Closed	Pending																
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution																				
Average	271		295		355		138		333		646		269		373		849		356	
Median (middle record - half are above and half below)	26		21		61		13		22		400		16		10		74		10	
Record Count	905	1148	783	1208	566	282	217	926	715	1203	121	58	594	1145	685	1291	23	4	662	1287

*Allied Health Care Professions Cases Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Tables B7.2 & B7.2a – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Physicians and Surgeons Cases

Complaints Referred to Investigation	2005		2006				2007				2008									
	1186		1092				949				1018									
	All	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE										
Activity	Prior to VE	Pending	Closed	Pending																
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution																				
Average	271		300		359		139		332		641		269		374		840		358	
Median (middle record - half are above and half below)	252		286		337		135		305		627		272		335		906		324	
Record Count	827	1014	700	1059	511	245	189	814	644	1059	108	51	536	1008	609	1124	21	3	588	1121

*Excludes Out of State and Headquarters Cases

Tables B7.3 & B7.3a – Calendar Days Aged from Case Assigned to Investigator to Case Closed with No Prosecution for Allied Health Cases

Complaints Referred to Investigation	2005		2006				2007				2008									
	221		186				160				187									
	All	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE										
Activity	Prior to VE	Pending	Closed	Pending																
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution																				
Average	267		252		316		126		342		685		265		361		944		345	
Median (middle record - half are above and half below)	100		65		135		23		99		472		84		70		448		70	
Record Count	80	140	83	149	55	37	28	112	71	144	13	7	58	137	77	166	2	1	75	165

*Allied Health Care Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B7.4 – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Investigation Assigned to Referral for Citation/Fine																				
Average	276		332		372		138		392		690		313		485		548		480	
Median (middle record - half are above and half below)	270		324		361		142		405		695		342		436		492		415	
Record Count	51	0	53	0	44	0	9	0	38	0	8	0	30	0	41	0	3	0	38	0

*Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

Table B7.5 – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for Physicians and Surgeons Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending	Activity	Pending																
Calendar Day Age from Investigation Assigned to Referral for Citation/Fine																				
Average	283		331		375		138		451		677		380		473		548		464	
Median (middle record - half are above and half below)	273		312		361		142		453		655		382		448		492		415	
Record Count	47	0	49	0	40	0	9	0	29	0	7	0	22	0	31	0	3	0	28	0

*Excludes Out of State and Headquarters Cases

Table B7.6 – Calendar Days Aged from Case Assigned to Investigator to Referral for Citation/Fine for and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Investigation Assigned to Referral for Citation/Fine																				
Average	194		347		347		0		201		776		129		525		0		525	
Median (middle record - half are above and half below)	195		345		345		0		106		776		56		423		0		423	
Record Count	4	0	4	0	4	0	0	0	9	0	1	0	8	0	10	0	0	0	10	0

*May include time from initial request for interview if there was no response and a subsequent subpoena was issued.

**Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B7.7 – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Request to Subject Interview Completed																				
Average	48		50		56		41		49		71		47		56		53		56	
Median (middle record - half are above and half below)	36		38		43		37		35		48		34		37		39		37	
Record Count	649	102	502	96	307	29	195	67	406	139	37	6	419	133	543	109	8	1	535	108
Calendar Day Age from Subpoena Request to Subject Interview Completed																				
Average	0		78		78		0		144		178		109		18		195		107	
Median (middle record - half are above and half below)	0		48		45		0		144		178		109		41		135		37	
Record Count	0	8	5	7	5	6	0	1	2	13	1	3	1	10	15	30	2	0	15	30
Calendar Day Age from Request to Receipt of Expert Opinion																				
Average	50		47		50		37		52		85		43		52		51		52	
Median (middle record - half are above and half below)	41		36		37		34		37		56		35		40		43		40	
Record Count	561	63	475	59	379	34	96	25	374	60	84	6	290	54	414	52	15	1	399	51
Calendar Day Age from Investigation Assigned to Referral for Criminal Action																				
Average	266		327		429		122		291		648		191		368		876		323	
Median (middle record - half are above and half below)	203		286		429		136		232		630		184		309		865		290	
Record Count	38	0	27	0	18	0	9	0	41	0	9	0	32	0	37	0	3	0	34	0
Calendar Day Age from Investigation Assigned to Referral for Public Letter of Reprimand																				
Average	344		515		515		0		463		716		337		387		0		387	
Median (middle record - half are above and half below)	302		555		555		0		405		716		341		435		0		435	
Record Count	14	0	10	0	10	0	0	0	5	0	2	0	4	0	3	0	0	0	3	0
Calendar Day Age from Investigation Assigned to Referral for Citation/Fine																				
Average	276		332		372		138		392		690		313		485		548		480	
Median (middle record - half are above and half below)	270		324		361		142		405		695		342		436		492		415	
Record Count	51	0	53	0	44	0	9	0	38	0	8	0	30	0	41	0	3	0	38	0

*Allied Health Care Professionals Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

Table B7.8 – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Physicians and Surgeons Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending	Activity	Pending																
Calendar Day Age from Investigation Assigned to Referral for Public Letter of Reprimand																				
Average	365		515		515		0		463		716		337		395		0		395	
Median (middle record - half are above and half below)	314		555		555		0		405		716		341		427		0		427	
Record Count	13	0	10	0	10	0	0	0	6	0	2	0	4	0	4	0	0	0	4	0

*Excludes Out of State and Headquarters Cases

Table B7.9 – Calendar Days Aged from Case Assigned to Investigator to Referral for Public Letter of Reprimand for Allied Health Cases

Activity	2005		2006				2007				2008								
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE								
	Prior to VE	Pending																	
Calendar Day Age from Investigation Assigned to Referral for Public Letter of Reprimand																			
Average	59		0		0		0		0		0		0		0		0		0
Median (middle record - half are above and half below)	59		0		0		0		0		0		0		0		0		0
Record Count	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

*May include time from initial request for interview if there was no response and a subsequent subpoena was issued.

**Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B7.10 – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006					2007				2008								
	All		All	Not VE	VE	VE	All	Not VE	VE	All	Not VE	VE								
	Prior to VE	Pending																		
Record Count	561	63	475	59	379	34	96	25	374	60	84	6	290	54	414	52	15	1	399	51
Calendar Day Age from Investigation Assigned to Referral for Criminal Action																				
Average	266		327		429		122		291		646		191		368		876		323	
Median (middle record - half are above and half below)	203		286		429		136		232		630		184		309		865		290	
Record Count	38	0	27	0	18	0	9	0	41	0	9	0	32	0	37	0	3	0	34	0

*Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

Table B7.11 – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Physicians and Surgeons Cases

Activity	2005		2006					2007				2008								
	All		All	Not VE	VE	VE	All	Not VE	VE	All	Not VE	VE								
	Prior to VE	Pending	Activity	Pending																
Calendar Day Age from Investigation Assigned to Referral for Criminal Action CRIMINL CASES CASES																				
Average	268		336		465		122		303		643		202		343		853		299	
Median (middle record - half are above and half below)	179		304		469		136		283		619		205		283		853		283	
Record Count	34	0	24	0	15	0	9	0	35	0	8	0	27	0	25	0	2	0	23	0

*Excludes Out of State and Headquarters Cases

Table B7.12 – Calendar Days Aged from Case Assigned to Investigator to Referral for Criminal Action for Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Investigation Assigned to Referral for Criminal Action																				
Average	252		251		251		0		221		667		131		420		921		375	
Median (middle record - half are above and half below)	276		262		262		0		131		667		91		323		921		313	
Record Count	4	0	3	0	3	0	0	0	6	0	1	0	5	0	12	0	1	0	11	0

*May include time from initial request for interview if there was no response and a subsequent subpoena was issued.

**Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B9.1 – Calendar Days for Receipt of Medical Records for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006			2007			2008											
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE																			
Calendar Day Age from Medical Release Request to Receipt of Medical Records (no SDT)																				
Average	57		56		90		34		65		275		57		59		409		56	
Median (middle record - half are above and half below)	32		30		48		24		30		180		30		31		409		30	
Record Count	500		378		148		230		300		10		290		276		2		274	
Calendar Day Age from SDT Served to Receipt of Medical Records (no Medical Release)																				
Average	173		64		101		35		53		34		54		92		281		88	
Median (middle record - half are above and half below)	100		29		55		24		27		34		27		36		281		36	
Record Count	4		39		17		22		49		2		47		86		2		84	
Calendar Day Age from Medical Release Request to SDT Request to Receipt of Medical Records																				
Average	129		168		203		88		212		400		185		210		736		174	
Median (middle record - half are above and half below)	59		125		151		37		206		329		182		77		736		71	
Record Count	15		23		16		7		24		3		21		31		2		29	

*Allied Health Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

Table B9.2 – Calendar Days for Receipt of Medical Records for Physicians and Surgeons Cases

Activity	2005		2006			2007			2008		
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE
Calendar Day Age from Medical Release Request to Receipt of Medical Records (no SDT)	Prior to VE										
Average	57		58	93	35	67	303	59	62	409	59
Median (middle record - half are above and half below)	32		31	50	25	30	288	30	31	409	31
Record Count	464		338	133	205	272	9	263	235	2	233
Calendar Day Age from SDT Served to Receipt of Medical Records (no Medical Release)											
Average	173		67	101	34	55	34	56	97	281	92
Median (middle record - half are above and half below)	100		32	55	28	27	34	27	39	281	39
Record Count	4		34	17	17	47	2	45	80	2	78
Calendar Day Age from Medical Release Request to SDT Request to Receipt of Medical Records											
Average	129		171	200	99	212	400	179	210	736	174
Median (middle record - half are above and half below)	59		125	134	81	212	329	169	77	736	71
Record Count	15		21	15	6	20	3	17	31	2	29

*Excludes Out of State and Headquarters Cases.

Table B9.3 – Calendar Days for Receipt of Medical Records for Allied Health Cases

Activity	2005		2006				2007			2008		
	All	Prior to VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE	
Calendar Day Age from Medical Release Request to Receipt of Medical Records (no SDT)												
Average	54		43	69	28	43	17	44	39	0	39	
Median (middle record - half are above and half below)	32		25	37	17	23	17	23	27	0	27	
Record Count	36		40	15	25	28	1	27	41	0	41	
Calendar Day Age from SDT Served to Receipt of Medical Records (no Medical Release)												
Average	0		39	0	39	13	0	13	34	0	34	
Median (middle record - half are above and half below)	0		16	0	16	13	0	13	27	0	27	
Record Count	0		5	0	5	2	0	2	6	0	6	
Calendar Day Age from Medical Release Request to SDT Request to Receipt of Medical Records												
Average	0		138	251	24	214	0	214	0	0	0	
Median (middle record - half are above and half below)	0		138	251	24	192	0	192	0	0	0	
Record Count	0		2	1	1	4	0	4	0	0	0	

**Allied Health Professions Cases Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B10.1 – Calendar Days Aged from Request to Subject Interview for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Request to Subject Interview Completed																				
Average	48		50		56		41		49		71		47		56		53		56	
Median (middle record - half are above and half below)	36		38		43		37		35		48		34		37		39		37	
Record Count	649	102	502	96	307	29	195	67	406	139	37	6	419	133	543	109	8	1	535	108
Calendar Day Age from Subpoena Request to Subject Interview Completed																				
Average	0		78		78		0		144		178		109		18		195		107	
Median (middle record - half are above and half below)	0		46		46		0		144		178		109		41		195		37	
Record Count	0	8	5	7	5	6	0	1	2	13	1	3	1	10	15	30	2	0	13	30

*Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

Table B10.2 – Calendar Days Aged from Request to Subject Interview for Physicians and Surgeons

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending	Activity	Pending																
Calendar Day Age from Request to Physician Interview Completed																				
Average	48		51		56		43		51		73		49		58		53		58	
Median (middle record - half are above and half below)	36		42		44		38		37		49		36		37		28		37	
Record Count	597	86	447	87	275	26	172	61	409	126	34	6	375	120	485	96	7	1	478	95
Calendar Day Age from Subpoena Request to Physician Interview Completed																				
Average	0		78		78		0		144		178		109		123		217		116	
Median (middle record - half are above and half below)	0		46		46		0		144		178		109		41		217		39	
Record Count	0	7	5	5	5	4	0	1	2	11	1	2	1	9	13	27	1	0	12	27

*Excludes Out of State and Headquarters Cases

Table B10.3 – Calendar Days Aged from Request to Subject Interview for Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Request to Subject Interview Completed																				
Average	39		41		51		28		34		45		33		42		49		42	
Median (middle record - half are above and half below)	31		30		33		21		22		21		25		33		49		32	
Record Count	52	16	55	9	32	3	23	6	47	13	3	0	44	13	58	11	1	0	57	11
Calendar Day Age from Subpoena Request to Subject Interview Completed*																				
Average	0		0		0		0		0		0		0		87		173		1	
Median (middle record - half are above and half below)	0		0		0		0		0		0		0		87		173		1	
Record Count	0	1	0	2	0	2	0	0	0	2	0	1	0	1	2	3	1	0	1	3

*May include time from initial request for interview if there was no response and a subsequent subpoena was issued.

**Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B11.1 – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Date Case Submitted to District Office Medical Consultant for Review to Review Completed Date																				
Average	31		56		79		39		60		107		57		88		316		84	
Median (middle record - half are above and half below)	24		28		25		30		31		36		30		44		84		44	
Record Count	49	36	288	135	122	39	166	96	375	178	24	10	351	168	328	192	5	0	323	192

*Allied Health Care professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarter Cases

Table B11.2 – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Physicians and Surgeons Cases

Activity	2005		2006			2007			2008											
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Date Case Submitted to District Office Medical Consultant for Review to Review Completed Date																				
Average	31		57		81		39		61		116		57		89		388		86	
Median (middle record - half are above and half below)	24		29		26		30		31		39		30		46		400		45	
Record Count	48	35	275	128	116	36	159	92	362	169	22	9	340	160	309	172	4	0	305	172

*Excludes Out of State and Headquarter Cases

Table B11.3 – Calendar Days Aged from Case Submitted to District Office Medical Consultant for Review to Review Completed for Allied Health Cases

Activity	2005		2006			2007			2008											
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Date Case Submitted to District Office Medical Consultant for Review to Review Completed Date																				
Average	21		29		26		32		52		10		60		64		28		66	
Median (middle record - half are above and half below)	21		23		14		42		23		10		27		28		28		26	
Record Count	1	1	13	7	6	3	7	4	13	9	2	1	11	8	19	20	1	0	18	20

**Allied Health Care professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B12.1 – Calendar Days Aged from Request to Receipt of Expert Opinion for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Request to Receipt of Expert Opinion																				
Average	50		47		50		37		52		85		43		52		51		52	
Median (middle record - half are above and half below)	41		36		37		34		37		56		35		40		43		40	
Record Count	561	63	475	59	379	34	96	25	374	60	84	6	290	54	414	52	15	1	399	51

*Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

Table B12.2 – Calendar Days Aged from Request to Receipt of Expert Opinion for Physicians and Surgeons Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending	Activity	Pending																
Calendar Day Age from Request to Receipt of Expert Opinion																				
Average	51		47		50		35		51		81		43		50		51		50	
Median (middle record - half are above and half below)	41		36		37		31		36		55		35		39		43		39	
Record Count	518	55	422	49	340	28	82	21	342	50	73	4	269	46	377	41	15	0	362	41

*Excludes Out of State and Headquarters Cases

Table B12.3 – Calendar Days Aged from Request to Receipt of Expert Opinion for Allied Health Cases

Activity	2005		2006				2007			2008										
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Request to Receipt of Expert Opinion																				
Average	42		47		47		49		68		114		44		76		0		76	
Median (middle record - half are above and half below)	36		44		41		44		45		72		40		60		0		60	
Record Count	43	8	53	10	39	6	14	4	32	10	11	2	21	8	36	11	0	1	36	10

*May include time from initial request for interview if there was no response and a subsequent subpoena was issued.

**Allied Health Care Professionals Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B13.1 – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007			2008										
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Case Assigned to Completed Investigation (Referred to AG)																				
Average	197		227		393		68		267		667		196		280		919		250	
Median (middle record-half are above and half below)	139		195		358		39		230		667		164		218		923		214	
Record Count	123	1148	125	1208	61	282	64	926	140	1203	21	58	119	1145	137	1291	6	4	131	1287

*Allied Health Care Professionals Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives
**Excludes Out of State and Headquarters Cases
***Excludes Outcomes where no Accusation Filed

Table B13.2 – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for Physicians and Surgeons Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Case Assigned to Completed Investigation (Referred to AG)																				
Average	237		271		397		91		302		680		234		313		909		279	
Median (middle record-half are above and half below)	226		252		356		70		253		691		235		290		875		266	
Record Count	79	1014	75	1059	44	245	31	814	91	1059	14	51	77	1008	92	1124	5	3	87	1121

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B13.3 – Calendar Days Aged from Case Assigned to Investigator to Investigation Completed for and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Case Assigned to Completed Investigation (Referred to AG)																				
Average	127		161		381		47		201		640		128		211		971		194	
Median (middle record-half are above and half below)	66		82		372		8		110		667		81		141		971		141	
Record Count	44	134	50	149	17	37	33	112	49	144	7	7	42	137	45	167	1	1	44	166

*Allied Health Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B14.1 – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008										
	All		All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		
	Prior to VE	Pending	Closed	Pending																	
Calendar Day Age from Case Assigned to ALL Outcomes																					
Average	451		476		566		141		507		942		271		549		1276		396		
Median (middle record - half are above and half below)	310		343		424		140		380		827		274		436		1152		365		
Record Count	1305	1136	1164	1196	919	278	245	918	1096	1195	385	60	711	1135	1057	1275	184	3	873	1272	

*Excludes Out of State and Headquarter Cases

**Allied Health Care Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B14.2 – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Physicians and Surgeons Cases

Activity	2005		2006				2007				2008									
	All		All		Not VE		VE		All		Not VE		VE		All		Not VE		VE	
	Prior to VE	Pending	Closed	Pending																
Calendar Day Age from Case Assigned to All Outcomes																				
Average	447		477		564		140		514		958		274		556		1295		395	
Median (middle record - half are above and half below)	306		341		423		138		378		829		274		435		1170		363	
Record Count	1147	1028	987	1082	784	252	203	830	939	1085	329	55	610	1030	900	1151	161	3	739	1148

*Excludes Out of State and Headquarters Cases

Table B14.3 – Calendar Days Aged from Case Assigned to Investigator to All Outcomes for Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All		Not VE	VE	All		Not VE	VE	All		Not VE	VE						
	Prior to VE	Pending	Closed	Pending																
Calendar Day Age from Case Assigned to ALL Outcomes																				
Average	480		474		577		144		469		850		258		512		1140		404	
Median (middle record - half are above and half below)	350		361		433		164		396		815		277		439		1057		384	
Record Count	158	108	177	114	135	26	42	88	157	110	56	5	101	105	157	124	23	0	134	132

**Allied Health Care Professions Cases Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B 14.4 – Calendar Days Aged from Case Assigned to Investigator to Settlement for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006			2007			2008											
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE																			
Calendar Day Age from Date Case Assigned to Investigator to Disciplinary Outcome--Settlement																				
Average	1015		1054		1088		130		936		1096		305		952		1328		576	
Median (middle record - half are above and half below)	995		983		1022		183		894		1002		282		943		1219		616	
Record Count	194		198		191		7		183		146		37		172		86		86	
All Pending	504		472		402		70		402		222		180		388		94		294	

*Excludes Out of State and Headquarter Cases
**Allied health Care Professions Cases Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Separate Calendar Days Aged from Case Assigned to Investigator to Settlement Outcome data for Physicians and Surgeons cases alone and Allied Health Care cases alone was not available as of the time this report was prepared.

Table B14.5 – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008										
	All		All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		
	Prior to VE	Pending	Closed	Pending																	
Calendar Day Age from Case Assigned to Disciplinary Outcome																					
Average	978		953		996		180		930		1098		342		973		1369		564		
Median (middle record - half are above and half below)	918		854		892		197		875		999		327		901		1225		595		
Record Count	333	505	318	471	301	401	17	70	328	402	255	222	73	180	301	387	153	92	148	295	

* Excludes Out of State and Headquarters Cases

**Allied Health Care Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B14.6 – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Physicians and Surgeons Cases

Activity	2005		2006				2007				2008										
	All		All		Not VE		VE		All		Not VE		VE		All		Not VE		VE		
	Prior to VE	Pending	Closed	Pending																	
Calendar Day Age from Case Assigned to Disciplinary Outcome																					
Average	1041		1050		1061		185		1017		1137		379		1047		1399		596		
Median (middle record - half are above and half below)	995		978		982		204		930		1024		356		970		1229		629		
Record Count	262	400	230	382	227	333	3	49	253	311	213	182	40	129	237	294	133	69	104	225	

*Excludes Out of State and Headquarters Cases

Table B14.7 – Calendar Days Aged from Case Assigned to Investigator to Disciplinary Outcome for Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending	Closed	Pending																
Calendar Day Age from Case Assigned to Disciplinary Outcome																				
Average	743		699		797		179		636		902		297		701		1171		487	
Median (middle record - half are above and half below)	676		575		702		190		573		939		311		632		1102		493	
Record Count	71	105	88	89	74	68	14	21	75	91	42	40	33	51	64	93	20	23	44	70

**Allied Health Care Professions Cases Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B14.8 – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed																				
Average	154		523		590		123		522		724		325		568		979		477	
Median (middle record - half are above and half below)	109		478		539		91		489		719		318		540		1007		478	
Record Count	224	164	197	179	169	127	28	52	249	121	123	40	126	81	205	142	37	11	168	131

*Allied Health Care Professionals Includes:
osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B14.9 – Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Physicians and Surgeons Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed																				
Average	572		560		612		140		543		730		340		567		925		493	
Median (middle record - half are above and half below)	539		510		557		120		523		714		339		544		979		486	
Record Count	188	108	152	130	135	95	17	35	198	81	103	28	95	53	158	103	27	7	131	96

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B14.10– Calendar Days Aged from Case Assigned to Investigator to Accusation Filed for Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed																				
Average	368		401		500		96		428		691		259		572		1123		422	
Median (middle record - half are above and half below)	342		392		472		65		426		743		236		531		1016		428	
Record Count	36	56	45	49	34	32	11	17	51	40	20	12	31	28	47	39	10	4	37	35

*Allied Health Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B15.1 – Calendar Days Aged from Investigation Completed to Accusation Filed for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007			2008										
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Completed Investigation to Accusation Filed																				
Average	531		175		198		38		160		222		100		147		323		109	
Median (middle record-half are above and half below)	502		115		143		36		87		161		64		78		232		70	
Record Count	224	164	197	179	169	127	28	52	249	121	123	40	126	81	205	142	37	11	168	131

*Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B15.2 – Calendar Days Aged from Investigation Completed to Accusation Filed for Physicians and Surgeons Cases

Activity	2005		2006				2007			2008										
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Completed Investigation to Accusation Filed																				
Average	170		180		197		43		165		223		102		122		252		95	
Median (middle record-half are above and half below)	115		133		145		47		96		169		74		71		232		65	
Record Count	188	108	152	130	135	95	17	35	198	81	103	28	95	53	158	103	27	7	131	96

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B15.3 – Calendar Days Aged from Investigation Completed to Accusation Filed for Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE	Pending																		
Calendar Day Age from Completed Investigation to Accusation Filed																				
Average	126		161		203		31		129		220		70		234		513		158	
Median (middle record-half are above and half below)	93		72		143		34		59		113		47		102		310		88	
Record Count	36	56	45	49	34	32	11	17	51	40	20	12	31	28	47	39	10	4	37	35

*Allied Health Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B16.1 – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All		All	Not VE	VE	All	Not VE	VE	All	Not VE	VE									
	Prior to VE																			
Calendar Day Age from Date Accusation Filed to Date Hearing Closed-Submit to ALJ																				
Average	624		560		560		0		592		689		191		479		721		255	
Median (middle record - half are above and half below)	557		393		393		0		504		669		229		345		579		237	
Record Count	38		15		15		0		36		29		7		29		14		15	

*Allied Health Care professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarter Cases

Table B16.2 – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Physicians and Surgeons

Activity	2005		2006				2007			2008							
	All	Prior to VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE						
Calendar Day Age from Date Accusation Filed to Date Hearing Closed-Submit to ALJ																	
Average	638		606		606	0		565		666	191		544		721		296
Median (middle record - half are above and half below)	588		408		408	0		489		649	229		403		579		300
Record Count	34		13		13	0		33		26	7		24		14		10

**Excludes Out of State and Headquarter Cases

Table B16.3 – Calendar Days Aged from Accusation Filed to Case Submitted to ALJ for Decision for Allied Health Cases

Activity	2005		2006				2007			2008							
	All	Prior to VE	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE						
Calendar Day Age from Date Accusation Filed to Date Hearing Closed-Submit to ALJ																	
Average	494		258		258	0		892		892	0		172		0		172
Median (middle record - half are above and half below)	455		258		258	0		1049		1049	0		177		0		177
Record Count	4		2		2	0		3		3	0		5		0		5

*Allied Health Care professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B17.1 – Calendar Days Aged from Accusation Filed to Disciplinary Outcome-Settlement for Physicians and Surgeons and Allied Health Cases

Activity	2005	2006			2007			2008		
	All	All	Not VE	VE	All	Not VE	VE	All	Not VE	VE
Calendar Day Age from Date Case Assigned to Investigator to Disciplinary Outcome--Settlement	Prior to VE									
Average	1015	1054	1088	130	936	1096	305	952	1328	576
Median (middle record - half are above and half below)	995	983	1022	183	894	1002	282	943	1219	616
Record Count	194	198	191	7	183	146	37	172	86	86
All Pending	504	472	402	70	402	222	180	388	94	294

*Excludes Out of State and Headquarter Cases

**Allied health Care Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

Table B17.2 – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All	Pending	All	Not VE	VE	Pending	All	Not VE	VE	Pending	All	Not VE	VE	Pending						
Calendar Day Age from Accusation Filed to Disciplinary Outcome***																				
Average	583		572		590	142	517		576	193	532		764	259						
Median (middle record-half are above and half below)	513		435		460	114	377		445	197	373		531	255						
Record Count	263	348	245	298	235	280	10	18	255	293	216	188	39	105	247	248	142	80	105	168

*Allied Health Care Professionals Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B17.3 – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Physicians and Surgeons Cases

Activity	2005		2006					2007					2008							
	All		All	Not VE	VE															
	Prior to VE	Pending																		
Calendar Day Age from Accusation Filed to Disciplinary Outcome***																				
Average	605		595		603		85		550		604		184		561		768		243	
Median (middle record-half are above and half below)	525		466		467		99		411		465		177		384		569		238	
Record Count	213	301	192	259	189	245	3	14	217	241	189	160	28	81	203	194	123	62	80	132

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table 17.4 – Calendar Days Aged from Accusation Filed to Disciplinary Outcome for Allied Health Cases

Activity	2005		2006					2007					2008							
	All		All	Not VE	VE															
	Prior to VE	Pending																		
Calendar Day Age from Accusation Filed to Disciplinary Outcome***																				
Average	489		488		537		166		332		380		215		399		514		312	
Median (middle record-half are above and half below)	500		334		389		127		285		333		202		349		420		305	
Record Count	50	47	53	39	46	35	7	4	38	52	27	28	11	24	44	54	19	18	25	36

*Allied Health Professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarters Cases

***Excludes Outcomes where no Accusation Filed

Table B17.5 – Calendar Days Aged from Accusation Filed to Indicated Administrative Outcome for Physicians and Surgeons and Allied Health Cases

Combined VE & Non-VE:

Revocation	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	534	334	606	480
Median (middle record - half are above and half below)	436	167	375	264
Record Count	25	20	26	22

Surrender	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	410	419	222	349
Median (middle record - half are above and half below)	367	300	183	184
Record Count	39	39	33	35

Suspension Only	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	0	319	0	0
Median (middle record - half are above and half below)	0	319	0	0
Record Count	0	1	0	0

Probation	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	599	560	521	467
Median (middle record - half are above and half below)	498	432	391	363
Record Count	88	74	89	82

Probation w/Suspension	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	532	531	499	509
Median (middle record - half are above and half below)	488	505	385	408
Record Count	29	17	16	12

Public Reprimand	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	687	742	631	609
Median (middle record - half are above and half below)	703	691	490	479
Record Count	55	68	55	55

Other Decision	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	525	1325	509	701
Median (middle record - half are above and half below)	525	606	442	494
Record Count	2	3	5	8

Accusation Withdrawn/Dismissed	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	678	508	559	791
Median (middle record - half are above and half below)	533	308	324	407
Record Count	25	23	31	31

VE Only:

Revocation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	334	205	189
Median (middle record - half are above and half below)	167	205	156
Record Count	20	6	13

Surrender	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	419	118	150
Median (middle record - half are above and half below)	300	104	134
Record Count	39	13	24

Suspension Only	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	319	0	0
Median (middle record - half are above and half below)	319	0	0
Record Count	1	0	0

Probation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	560	267	297
Median (middle record - half are above and half below)	432	262	265
Record Count	74	10	31

Probation w/Suspension	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	531	214	311
Median (middle record - half are above and half below)	505	214	278
Record Count	17	1	6

Public Reprimand	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	742	293	338
Median (middle record - half are above and half below)	691	250	309
Record Count	68	3	17

Other Decision	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	1325	230	319
Median (middle record - half are above and half below)	606	230	325
Record Count	3	1	4

Accusation Withdrawn/Dismissed	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	508	152	310
Median (middle record - half are above and half below)	308	133	357
Record Count	23	5	10

Non-VE Only:

Revocation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	356	726	901
Median (middle record - half are above and half below)	167	571	862
Record Count	18	20	9

Surrender	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	441	289	783
Median (middle record - half are above and half below)	321	296	518
Record Count	36	20	11

Suspension Only	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	319	0	0
Median (middle record - half are above and half below)	319	0	0
Record Count	1	0	0

Probation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	560	553	570
Median (middle record - half are above and half below)	432	452	426
Record Count	74	79	51

Probation w/Suspension	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	560	518	707
Median (middle record - half are above and half below)	527	405	644
Record Count	16	15	6

Public Reprimand	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	742	650	730
Median (middle record - half are above and half below)	691	535	626
Record Count	68	52	38

Other Decision	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	1325	579	1084
Median (middle record - half are above and half below)	606	578	683
Record Count	3	4	4

Accusation Withdrawn/Dismissed	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	589	637	1019
Median (middle record - half are above and half below)	350	453	818
Record Count	19	26	21

Table B17.6 – Calendar Days Aged from Accusation Filed to Indicated Administrative Outcome for Physicians and Surgeons Cases

Combined VE and Non-VE

Revocation	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	596	396	641	510
Median (middle record - half are above and half below)	557	181	427	242
Record Count	18	11	20	15

Surrender	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	423	443	206	361
Median (middle record - half are above and half below)	369	343	161	184
Record Count	28	30	24	32

Suspension Only	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	0	319	0	0
Median (middle record - half are above and half below)	0	319	0	0
Record Count	0	1	0	0

Probation	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	606	607	558	596
Median (middle record - half are above and half below)	476	464	452	378
Record Count	70	58	75	56

Probation w/Suspension	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	565	535	510	538
Median (middle record - half are above and half below)	582	490	365	415
Record Count	24	14	13	9

Public Reprimand	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	685	749	653	620
Median (middle record - half are above and half below)	684	715	535	483
Record Count	49	60	52	53

Other Decision	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	365	1691	509	706
Median (middle record - half are above and half below)	365	1691	442	421
Record Count	1	2	5	7

Accusation Withdrawn/Dismissed	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	790	327	590	812
Median (middle record - half are above and half below)	548	254	341	407
Record Count	23	16	28	29

VE Only:

Revocation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	182	161
Median (middle record - half are above and half below)	0	189	135
Record Count	0	4	8

Surrender	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	140	115	145
Median (middle record - half are above and half below)	140	104	134
Record Count	1	11	22

Suspension Only	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	0	0
Median (middle record - half are above and half below)	0	0	0
Record Count	0	0	0

Probation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	287	261
Median (middle record - half are above and half below)	0	262	252
Record Count	0	6	17

Probation w/Suspension	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	0	250
Median (middle record - half are above and half below)	0	0	253
Record Count	0	0	4

Public Reprimand	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	315	344
Median (middle record - half are above and half below)	0	315	309
Record Count	0	2	15

Other Decision	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	230	319
Median (middle record - half are above and half below)	0	230	250
Record Count	0	1	4

Accusation Withdrawn/Dismissed	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	58	141	310
Median (middle record - half are above and half below)	58	109	357
Record Count	2	4	10

Non-VE Only:

Revocation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	755	726	910
Median (middle record - half are above and half below)	571	571	862
Record Count	16	20	7

Surrender	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	283	289	835
Median (middle record - half are above and half below)	275	296	525
Record Count	13	20	10

Suspension Only	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	0	0
Median (middle record - half are above and half below)	0	0	0
Record Count	0	0	0

Probation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	582	553	598
Median (middle record - half are above and half below)	490	452	475
Record Count	69	79	39

Probation w/Suspension	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	510	518	768
Median (middle record - half are above and half below)	365	405	702
Record Count	13	15	5

Public Reprimand	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	667	650	730
Median (middle record - half are above and half below)	546	535	626
Record Count	50	52	38

Other Decision	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	579	579	1221
Median (middle record - half are above and half below)	578	578	694
Record Count	4	4	3

Accusation Withdrawn/Dismissed	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	665	637	1076
Median (middle record - half are above and half below)	453	453	839
Record Count	24	26	19

Table B17.7 – Calendar Days Aged from Accusation Filed to Indicated Administrative Outcome for Allied Health Cases

Combined VE and Non-VE:

Revocation	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	376	269	490	416
Median (middle record - half are above and half below)	257	153	310	273
Record Count	7	9	6	7

Surrender	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	377	340	263	221
Median (middle record - half are above and half below)	325	197	282	257
Record Count	11	9	9	3

Suspension Only	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	0	0	0	0
Median (middle record - half are above and half below)	0	0	0	0
Record Count	0	0	0	0

Probation	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	570	390	318	404
Median (middle record - half are above and half below)	526	333	272	356
Record Count	18	16	14	26

Probation w/Suspension	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	375	511	454	422
Median (middle record - half are above and half below)	330	505	521	400
Record Count	5	3	3	3

Public Reprimand	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	706	693	239	297
Median (middle record - half are above and half below)	784	506	250	297
Record Count	6	8	3	2

Other Decision	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	685	594	0	672
Median (middle record - half are above and half below)	685	594	0	672
Record Count	1	1	0	1

Accusation Withdrawn/Dismissed	2005	2006	2007	2008
Activity				
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year				
Average	317	922	263	480
Median (middle record - half are above and half below)	317	1188	197	480
Record Count	2	7	3	2

VE Only:

Revocation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	185	252	235
Median (middle record - half are above and half below)	185	252	254
Record Count	2	2	5

Surrender	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	173	130	203
Median (middle record - half are above and half below)	173	130	203
Record Count	2	2	2

Suspension Only	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	0	0
Median (middle record - half are above and half below)	0	0	0
Record Count	0	0	0

Probation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	236	341
Median (middle record - half are above and half below)	0	243	329
Record Count	0	4	14

Probation w/Suspension	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	70	214	433
Median (middle record - half are above and half below)	70	214	433
Record Count	1	1	2

Public Reprimand	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	250	297
Median (middle record - half are above and half below)	0	250	297
Record Count	0	1	2

Other Decision	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	0	0
Median (middle record - half are above and half below)	0	0	0
Record Count	0	0	0

Accusation Withdrawn/Dismissed	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	189	197	0
Median (middle record - half are above and half below)	189	197	0
Record Count	2	1	0

Non-VE Only:

Revocation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	293	609	868
Median (middle record - half are above and half below)	153	495	868
Record Count	7	4	2

Surrender	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	388	301	257
Median (middle record - half are above and half below)	197	357	257
Record Count	7	7	1

Suspension Only	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	0	0	0
Median (middle record - half are above and half below)	0	0	0
Record Count	0	0	0

Probation	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	390	351	478
Median (middle record - half are above and half below)	333	282	390
Record Count	16	10	12

Probation w/Suspension	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	732	574	400
Median (middle record - half are above and half below)	732	574	400
Record Count	2	2	1

Public Reprimand	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	693	234	0
Median (middle record - half are above and half below)	506	234	0
Record Count	8	2	0

Other Decision	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	594	0	672
Median (middle record - half are above and half below)	594	0	672
Record Count	1	0	1

Accusation Withdrawn/Dismissed	2006	2007	2008
Activity			
Calendar Day Age from Date Accusation Filed to Indicated Outcome in Calendar Year			
Average	1215	296	480
Median (middle record - half are above and half below)	1276	296	480
Record Count	5	2	2

Table B17.8 – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Physicians and Surgeons and Allied Health Cases

Activity	2005		2006				2007				2008									
	All	Pending	All	Not VE	VE	Pending	All	Not VE	VE	Pending	All	Not VE	VE	Pending						
Calendar Day Age from Date Accusation Filed to Votes to Adopt/Grant Date																				
Average	468		460		477		168		379		433		175		402		538		272	
Median (middle record - half are above and half below)	424		367		374		169		299		337		175		322		436		254	
Record Count	108	330	105	284	99	266	6	18	96	285	76	182	20	103	129	236	63	81	66	155

*Allied Health Care professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives

**Excludes Out of State and Headquarter Cases

Table B17.9 – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Physicians and Surgeons

Activity	2005		2006				2007			2008										
	All	Pending	All	Not VE	VE	Pending	All	Not VE	VE	All	Not VE	VE								
Calendar Day Age from Date Accusation Filed to Votes to Adopt/Grant Date																				
Average	503		535		542		127		415		454		167		421		561		268	
Median (middle record - half are above and half below)	446		399		406		127		330		358		174		338		442		246	
Record Count	67	286	64	248	63	234	1	14	67	233	58	153	9	80	88	184	46	64	42	120

**Excludes Out of State and Headquarter Cases

Table 17.10 – Calendar Days Aged from Accusation Filed to MBC Vote to Adopt/Grant for Allied Health Cases

Activity	2005		2006				2007			2008										
	All	Pending	All	Not VE	VE	Pending	All	Not VE	VE	All	Not VE	VE								
Calendar Day Age from Date Accusation Filed to Votes to Adopt/Grant Date																				
Average	411		342		365		177		295		365		181		362		476		280	
Median (middle record - half are above and half below)	405		276		302		210		228		297		176		297		379		264	
Record Count	41	44	41	36	36	32	5	4	29	52	18	29	11	23	41	52	17	17	24	35

*Allied Health Care professions Cases Includes:

osteopathic physicians and surgeons, podiatrists, physician assistants, psychologists, research psychoanalysts, dispensing opticians, licensed midwives



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