MEDICAL BOARD OF CALIFORNIA
Executive Office

MEMBERS OF THE BOARD
Reginald Low, M.D., Chair
John Chin, M.D.
Sharon Levine, M.D.
Gerrie Schipske, R.N.P., J.D.

Enforcement Committee

April 29, 2010

Sheraton Gateway Los Angeles
Gateway Ballroom
6101 West Century Blvd.
Los Angeles, CA 90045
310-642-1111

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

AGENDA

10:00 a.m. – 10:45 a.m.
(or until the conclusion 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 / Roll Call

2. Public Comment on Items not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]

3. Overview and Discussion of the Function and Purpose of the Enforcement Committee – Dr. Low

4. Evolution of Expert Reviewer Training Program and Discussion of Future Enhancements – Dr. Low and Ms. Sweet

5. Update on Administrative Law Judge Decisions: Proposed versus Final – Ms. Threadgill

6. Discussion of Plan for Training of Board Members and Physicians on Enforcement Programs and Processes – Ms. Cady

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.

7. Agenda Items for July 29-30, 2010 Meeting in Sacramento, CA

8. Adjournment

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

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For additional information call (916) 263-2389.

NOTICE: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Cheryl Thompson at (916) 263-2389 or CThompson@dca.ca.gov or send a written request to Ms. Thompson. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Chronological Milestones for the Medical Board Expert Reviewer Program

- Pre-1993: No formal expert reviewer program existed. District Medical Consultants would identify experts for investigators and the pool was very small. The board was criticized for over-utilizing the same experts and was perceived as using experts who were biased.

- March 1993: Summit held at the request of the Governor. Based on recommendations by summit participants, the board created a task force charged with reviewing the use of medical resources in the enforcement process.

- March 1994: First Guidelines for Expert Consultants published.

- July 1994: the final report and recommendations of the task force are adopted by the board. (See attachment 4-2 for the entire list of improvements). Some provisions included:
    - Minimum qualifications for experts (board certification; license in good standing; no prior discipline; minimum of 5 years practice in specialty; active practice)
    - Experts had to be appointed by the DMQ after being screened
    - Appointed to a 2-year term with potential for re-appointment
    - Minimum of 8 hours training with standardized course outline

- April 1995: Experts solicited via *Action Report* yields over 400 responses.
    - Experts paid $75.00 per hour of review/$100 per hour of testimony

- June 1995: Guidelines revised.

- October 1995: Training fully under way; board has 800 approved experts.
    - Training accomplished "after hours" by Supervising Investigator I, Deputy Attorney General and District Medical Consultants with a standardized lesson plan

- 1996-1998: A variety of issues arise, despite training:
    - Checklist is created to review critical components of the expert review every single time an expert is retained (e.g., maintaining confidentiality, case turnaround, terminology).

- May 1999: Training converted into a VHS which is given to prospective experts in lieu of attending the afterhours training.

- July 1999: DMQ determines the training requirement for re-certification is no longer needed and years of practice in the specialty reduced from 5 to 3 years.
    - Recruiting experts becoming problematic with some specialties; these modifications expected to allay recruitment issues

- April 2001: Compensation for expert reviewers raised to $100.00 per hour for review and $200.00 for testimony.

- November 2001: Tracking system developed to address experts who continuously decline to provide services despite being in the program.

- April 2002: Guidelines revised.

- October 2002: Computer data base of experts becomes accessible to all enforcement staff (replaces the paper lists that had previously been sent to the field and shared among an office).

- September 2003: Survey reporting begun to gain input from experts as to their satisfaction with the expert reviewer experience. This typically reveals experts find the process satisfying with consistent concerns about the amount of pay in comparison with private firms, and difficulty defining the terms simple and extreme departure.

- February 2005: Due to concerns regarding over utilizing the same experts, policy is implemented where special permission must be obtained for any expert retained more than 5 times in a calendar year.

- October 2007: Rates increased to $150 hour per record review and remains at $200.00 per hour for testimony.

- September 2009: Guidelines revised.

- April 2010: 1155 active experts in program.

Board Adopts Major Overhaul...

(Final report adopted on July 29, 1994.)

In March 1993, a Medical Summit was held in Burbank at the request of the Governor. It was sponsored by the State and Consumer Services Agency together with the Medical Board, and attendees included representatives from:

The Medical Board of California
The State Assembly and State Senate
California Medical Association
Other Medical and Allied Health Organizations
Community Organizations
Center for Public Interest Law and other Consumer Advocates
Law Enforcement Agencies
Academics and Generalists

Over a two-day period, presentations were made and discussed in depth. In response to the final recommendations made by the summit participants, the Board created this Task Force (among others) and charged it with reviewing the use of medical resources in the enforcement process and making recommendations to the Board.

The Task Force has met publicly on nine occasions in both Northern and Southern California over the past 16 months. It has received testimony from invited guests and interested parties, and its members have read and analyzed hundreds of pages of reports, figures, plans, and comments submitted to them, notably four reports ordered by the Task Force, including a study of the duties and functions of district medical consultants by an outside analyst. They have discussed all of the points raised and consulted with staff as well as with others having specialized expertise in pertinent areas of law.

This report summarizes the Task Force's recommendations to the Board. We believe that it builds on the strengths of the existing system and will allow the Board to craft an enforcement process that is more consistent, more objective, more efficient, more responsible, and more manageable. It creates a systematic approach to the qualifications, appointment, training, oversight, evaluation, and functions of the physicians who collectively constitute the Board's medical resources. It clarifies reporting relationships and facilitates communication among the investigator, Deputy Attorneys General, District Medical Consultants, and medical experts who are the vital organs of our enforcement team. It provides greater management flexibility while emphasizing lines of communication with local and statewide medical communities. It should lead to more timely disposition of cases with the enforcement process while protecting the public and ensuring fairness to licensees. Program oversight is maintained with an increased level of participation by Board members. The recent reallocation of workload as a result of Board organization makes this not only possible—but practical.

In closing, the Task Force expresses its thanks to staff for their assistance; and to the many District Medical Consultants and others who have given generously of their time, energy, and constructive criticism in our deliberations. We also thank former Board member, Michael Weisman, M.D., who originally chaired this task force, for his dedication and insights.

Alan E. Shumacher, M.D. (Chair)
Clarence Avery, M.D.*
Robert del Junco, M.D.
Bruce Hasenkamp, J.D.
Karen McElliott
Jacquelin Trestrail, M.D.

* Dr. Avery was present and voted for Parts I and II of this report but was absent for the vote on Parts III and IV.

I. UTILIZATION OF MEDICAL EXPERTS

A. Minimum Qualifications

1. Board certification (one of 24 ABMS Boards) or an "emerging" specialty, subspecialty or qualifications that are equivalent or superior under special circumstances
2. License in good standing; no prior discipline, no current accusation pending, no complaints "closed with merit,"
3. Minimum of five years in practice in area of specialty
4. Active practice (defined as at least 80 hours/month in direct patient care or clinical activity or teaching, at least 40 hours of which is direct patient care) or non-active for no more than two years at time of appointment to panel. Under special circumstances, this qualification may be waived, and
5. Peer review experience (hospital, medical society, or equivalent) (recommended, not required)

B. Appointment

1. Appointed by Division of Medical Quality (DMQ) after meeting qualifications, successfully completing training and signing a written agreement to serve and to testify as

...Improvements in Use of Experts, Consultants

needed in any case in which a written opinion is provided. Under special circumstances, such as the immediate need for a rebuttal witness in court, this procedure may be waived.
2. Appointed to a 2-year term
3. May be reappointed to subsequent terms after positive evaluation and continued qualification.
4. Appointment agreement includes obligation to testify or complete testimony on cases pending at the time term expires.

C. Training

1. Minimum of 8 hours
2. Training faculty consists of Supervising Investigator, Deputy Attorneys General (DAG), and District Medical Consultants
3. Utilizes statewide, standardized course outline developed by faculty
4. Retraining required every four years

D. Oversight and Evaluation

1. DMQ establishes written standards of performance (completeness of reports, clarity, objectivity, timeliness, capability as a witness, etc.)
2. Statewide panel of experts maintained by Board staff on data base
3. Oversight Committee composed of two members of DMQ (of which at least one must be a physician) and representatives from the Health Quality Enforcement Section/Attorney General (HQES/AG), District Medical Consultants, and Enforcement management which performs initial evaluations and evaluations of performance prior to reappointment.

E. Assignment to Cases

1. Made by District Medical Consultant from the statewide panel of experts
2. Board certification or area of practice should match that of respondent's specialty or area of practice under review
3. Ordinarily only one expert will be assigned per case in non-quality of care cases except when it is necessary to add a specialty or subspecialty in complex cases. In quality of care cases a second expert may be engaged to confirm potential violations of the Medical Practice Act.
4. Expert should not have, or appear to have, any conflict of interest which could be construed as economically competitive or have any professional, personal or financial association which could be construed as undue influence on independent judgement.
5. All quality of care cases shall be reviewed at a meeting (in person or by teleconference) among the investigator, the supervising DAG or the DAG assigned to a specific case, if assigned, and the District Medical Consultant prior to referral to the Attorney General for filing of an accusation. The expert shall be available to participate in this meeting, if required, after he/she has filed a written opinion. The same reviewers shall meet in similar fashion to conduct a retrospective review and analysis of cases that are not successful.

Ideas for Enforcement Program Training Modules in Priority Order

Topic	Est. Presentation Length
Enforcement Program: General overview of all units and how complaints move through the process	20 minutes
Probation Unit: General overview of Unit since reorganization	10 minutes
Probation Unit: Implementing the Board's decision—conducting an intake interview	15 minutes
Probation Unit: Common complaints and challenges for new probationers	15 minutes
Probation Unit: Challenging terms and conditions – Practice Monitors. Discuss the challenges of finding a monitor, the need for training and options, benefits or alternatives to the practice monitor requirement	30 minutes
Probation Unit: Challenging terms and conditions – no solo practice. Discussion of the variety of situations presented to Probation and the goals to be accomplished with this prohibition.	30 minutes
Probation Unit: Challenging terms and conditions - third party chaperones. Is there a need to develop training for chaperones?	30 minutes
Probation Unit: Challenging terms and conditions – prohibited practice	20 minutes
Complaint Unit: General overview of complaint review process	15 minutes
Complaint Unit: A focused review of how quality of care complaints triaged in CCU. Discussion about the necessity of continuing to match the practice specialty of the physician/subject with the CCU medical consultant.	30 minutes
Complaint Unit/Field Operations: A day in the life of a quality of care case focusing on how a case is "triaged" in the Complaint Unit and investigated by the field investigator.	40 minutes
Complaint Unit/Field Operations: A day in the life of a medical malpractice case focusing on how a case is "triaged" in the Complaint Unit and investigated by the field investigator.	40 minutes
Complaint Unit: Mandated reports required by the "800" series of the Business and Professions Code and how they are triaged. • Medical Malpractice reports (801) • Hospital disciplinary reports (805) • Coroner reports (802.5) • Patient death in an outpatient surgery center (2240) • Physician Report of Criminal Action (802.1) • Court Clerks Reporting (803.5, 803.6)	20 minutes
Complaint Unit: General review of the variety of complaint issues assigned to the "Physician Conduct" unit (e.g., office practice issues, medical record abandonment/destruction; failure to sign death certificates timely; sexual misconduct; physician impairment, advertising, corporate practice of medicine, etc.) and how they are "triaged"	25-30 minutes

Complaint Unit: The role of the Deputy Attorney General in providing assistance and direction to CCU	15 minutes
Field Operations: A day in the life of an investigator	20 minutes
Field Operations: Investigating hospital discipline cases (805 reports)	25 minutes
Field Operations: The challenges of investigating cases involving care in the correctional facilities	20 minutes
OSM: How unlicensed practice of medicine cases are investigated	30 minutes
OST: So you think you want to be an Investigator? The intensive training program provided to new staff to ensure they are "worthy" to investigate medical board cases.	20 minutes
OST: The challenges of investigating cases involving internet prescribing	20 minutes
Field Operations: Investigating cases involving medical marijuana	20 minutes
Field Operations: Investigating cases which allege possible physician impairment due to physical limitations or mental health concerns	20 minutes
AG's Office: The role of the DAG when a case is referred for investigation – What does a lead prosecutor do?	20 minutes
DCU: Public Disclosure requirements and challenges, lawsuits	20 minutes
DCU: Am I an analyst or an alarm clock? The analyst's role in tracking critical dates (i.e., when the statute of limitations will expire, ensuring time lines are met by AG's Office for filing accusations, setting hearings, etc. and ensuring decisions are acted upon timely).	25 minutes

Options for Combining Modules into Training Blocks of 1-2 hours in length

Enforcement Program: General overview of all units and how complaints move through the process	20 minutes
HQES: The role of the DAG when a case is referred for investigation – What does a lead prosecutor do?	20 minutes

Probation Unit: General overview of Unit since reorganization	15 minutes
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